Division of Family and Children Services

Medicaid

2024-09-26

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2000 General Medicaid Information

2000 General Program Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	General Program Overview		
	Effective Date:	December 2022		
	Chapter:	2000	**Policy Number:**	2000
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-68

Requirements

The General Program Chapter contains policy on topics that are related to or associated with the Medicaid Program.

Basic Considerations

The following topics are included in this chapter:

- Computer Matches provides an overview of matches with the files of various governmental agencies including Income and Eligibility Verification System (IEVS), Internal Revenue Service and Beneficiary Earnings Exchange Records System (IRS/BEERS), Clearinghouse and SSN Validation.
- The section on Confidentiality provides policy based on laws that govern the AU's right to keep knowledge of case information limited to certain individuals.
- Mandated Reporting explains the requirement and process of agency employees to report suspected child abuse.
- Americans with Disabilities Act (ADA) gives policy guidance for providing reasonable access to programs for persons with disabilities.

2001 Computer Matches Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Computer Matches Overview		
	Effective Date:	December 2019		
	Chapter:	2000	**Policy Number:**	2001
	Previous Policy Number(s):	MT 01	**Updated or Reviewed in MT:**	MT-57

Requirements

Applicants and recipients whose resources and income are used to determine eligibility are matched with the files of various governmental agencies.

Basic Considerations

The applicant's and recipient's (A/R's) primary social security numbers (SSN) are matched with SSNs contained in other governmental agency files. The information associated with the SSNs is compared. Discrepancies are identified for follow-up and investigation.

Computer matches through the use of the A/R's SSN are designed to detect income, resources, and to provide other pertinent information required to establish eligibility and benefit levels.

Information obtained from the computer matches is used for the following purposes:

- to verify eligibility of A/Rs,
- to verify the proper amount of benefits,
- to determine whether recipients are receiving the benefits to which they are entitled,
- to obtain information to use to conduct criminal or civil prosecutions based on receipt of benefits to which recipients are not entitled.

Computer matches are accessed via system terminals or through personal computers connected to the system.

Users must have a valid password which is obtained from the State Office.

Unlawful access is prohibited. A record of all inquiries by password is kept and monitored by the system.

2002 Income And Eligibility Verification System

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Income And Eligibility Verification System		
	Effective Date:	May 2023		
	Chapter:	2000	**Policy Number:**	2002
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-69

Requirements

The Income and Eligibility Verification System (IEVS) is a federally operated system through which agencies request data, wage and benefit information on program applicants and recipients from other state and federal agencies.

Basic Considerations

IEVS computer matches are performed by Gateway with the following files from other agencies:

- SSA Beneficiary Earnings Exchange Record (BEER)
- United States Internal Revenue Service (IRS)
- Interstate Files
- SSA Prisoner Verification Inquiry
- SSA Death Verification Inquiry
- SSA Bendex
- SDX

A wage and benefit match is completed to compare the information in Gateway and other computer files. If a match is found and the information in a computer file differs from the information in Gateway, a system-generated alert is sent to inform the worker of the discrepancy. The worker takes action to resolve the discrepancy and documents those actions in the A/R's case notes. Refer to Gateway Documentation Standards for documentation requirements.

The SSA Prisoner Verification Inquiry and SSA Death Verification Inquiry match the files of the Social Security Administration with Gateway files to determine if A/Rs are incarcerated or deceased.

Information received by the IRS and BEERS systems is no longer received by the Medicaid program and is not updated in the Gateway system for Medicaid purposes. This information is no longer subject to the special security considerations. Refer to Section 2003, IRS/BEERS Security for more information.

Procedures

Processing Match Data

Follow the procedures below to process data received from the computer matches. Use information received from the matches to determine eligibility and benefit level.

Complete case actions to resolve discrepancies within 45 days of receipt of the information.

Completion of case actions may be postponed to the next review if the actions cannot be completed due to non-receipt of verification already requested from a collateral contact.

Verifications

Consider the following information as a lead and verify the income information when a match is received:

- RSDI benefits,

  Verify gross RSDI income on Clearinghouse.

- DOL earned income matches
- IRS earned income and pension matches
- questionable IEVS information
- prisoner verification data.

Documentation

Record the following information:

- results of the case record screening
- the reason a discrepancy does not exist, if applicable
- date verification was requested and from whom verification was requested
- date action has been taken to correct ongoing benefits
- date of completion of the case action to resolve the discrepancy

2003 IRS And BEERS Information Security

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Internal Revenue Service (IRS) And Beneficiary Earnings Exchange Records (BEERS) Information Security		
	Effective Date:	December 2022		
	Chapter:	2000	**Policy Number:**	2003
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

It is the responsibility of the Department of Human Services (DHS) to protect the Federal Tax Information (FTI) provided through the Internal Revenue Services (IRS) to the state agencies.

Unauthorized use or access of Federal Tax Information, i.e., IRS/ Beneficiary Earnings Exchange Record System (BEERS) information, earning records and/or unearned income records maintained by Social Security Administration, is forbidden. The confidentiality and security of FTI must be protected and maintained at the level of federal standards and requirements.

Basic Considerations

As a condition of receiving IRS/BEERS information, DFCS is required to establish and maintain certain safeguards designed to prevent unauthorized use of the information and to protect the confidentiality of the information.

There are two criminal penalties associated with unauthorized access and/or unauthorized disclosure of Federal Tax Information (FTI).

The penalties for unauthorized access of FTI (IRS/BEERS) include the following:

- a fine of up to $1,000, or imprisonment of up to 1 year, or both
- costs of prosecution for felony access.

Penalties for unauthorized disclosure of IRS information include the following:

- a fine of up to $5,000, or imprisonment of up to 5 years, or both
- costs of prosecution for felony disclosure
- termination from employment upon conviction of unauthorized disclosure
- payment of civil damages to the individual about whom information was illegally disclosed if that individual brings a civil action.

The accused employee can be guilty of both offenses and prosecuted for both.

In addition to that, there is a civil penalty for unauthorized access or unauthorized disclosure. In the case of a state employee, the employee is personally liable as opposed to the agency.

Information received by the IRS and BEERS systems is no longer received by the Medicaid program and is not updated in the GA Gateway system for Medicaid purposes. For more information on the special security considerations regarding IRS and BEERS information received by DFCS agency please refer to TANF Manual 3390, Policy Section 1410.

2004 Clearinghouse

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Clearinghouse		
	Effective Date:	May 2023		
	Chapter:	2000	**Policy Number:**	2004
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-69

Requirements

Clearinghouse is an automated on-line computer interface through which wage and benefit information on applicants, recipients and financially responsible members of a budget group is matched with files in other state and federal agencies.

Basic Considerations

Clearinghouse matches are performed with the following agencies and contain the following information:

- Department of Labor (DOL) Wage Files - the most recent five quarters of employment history by employer name, employer number and amount of wages earned.
- Department of Labor (DOL) Employer Address Files – the work location and/or the address of the accounting office
- Department of Labor (DOL) Unemployment Compensation Benefits (UCB) - the monthly UCB amounts for the most recent 13 months and a list of individual checks for the last ten weeks
- Department of Labor (DOL) Unemployment Compensation Benefits (UCB) Claimant Address File – the address of each UCB recipient
- Department of Labor (DOL) W-4 Employer Reporting System – the name and address of any new employer and the date of hire
- BENDEX – RSDI benefit information on individuals who are current or past recipients of public assistance.
- Child Support Inquiry ($TARS) – verifies child support data provided through Division of Child Support Services.
- State Data Exchange (SDX) – SSI benefit information.
- Federal Data Services Hub (FDSH) – provides income and employment information received from IRS records, health and entitlements from HHS records, identity from Social Security, citizenship from Department of Homeland Security records, criminality from Department of Justice records and residency from state records.
- State Online Query (SOLQ) – verifies SSN, RSDI and SSI benefit information.
- State Verification Exchange System (SVES) – verifies Citizenship/ID or nationality of Medicaid or CHIP applicants declaring to be U.S. citizens or nationals.

- Systematic Alien Verification for Entitlements (SAVE) – verifies Alien Status.
- Work Number- verifies wages provided by employers contracted through Work Number.

Clearinghouse files are accessed on any individual who is in active or pending status, is age 16 or older and who may affect eligibility for benefits such as the following:

- applicants
- recipients
- ineligible aliens
- sanctioned individuals

Clearinghouse is accessed on pending or active AU's at the following times:

- at registration or finalization of a new AU or reopening of an AU
- in the month prior to the review month, when the AU is selected for review
- if a primary SSN is changed
- adding a person to the AU at an interim change

Use the following procedures for documenting and establishing Clearinghouse history:

Chart 2004.1 - Documenting and Establishing Clearinghouse History

Data Source	Method of Documentation
DOL Wage Files	DOL Wage Inquiry is an interface within Gateway that creates a historical record that can be accessed through Interfaces Module if results are found. Document any discrepancies between information found on the interface, reported by the AR, and entered into Gateway.
DOL UCB Files	DOL UCB Inquiry is an interface within Gateway that creates a historical record that can be accessed through Interfaces Module if results are found. Document any discrepancies between information found on the interface, reported by the AR, and entered into Gateway.
DOL W-4 New Hire Files	New Hire is an interface within Gateway that creates a historical record that can be accessed through Interfaces Module if results are found. Document any discrepancies between information found on the interface, reported by the AR, and entered into Gateway.
BENDEX	BENDEX is an interface within Gateway that creates a historical record that can be accessed through Interfaces Module if results are found. Document any discrepancies between information found on the interface, reported by the AR, and entered into Gateway.
State Data Exchange (SDX)	SDX is an interface within Gateway that creates a historical record that can be accessed through Interfaces Module if results are found. Document any discrepancies between information found on the interface, reported by the AR, and entered into Gateway.

Data Source	Method of Documentation
State Vital Records	Do not print or copy and paste from Birth Index Inquiry System, Death Index Search, Divorce Index Search or Marriage Index Search Screen. Document case notes that Vital Records was used for verification and document any discrepancies.
Systematic Alien Verification for Entitlements (SAVE)	SAVE is an interface within Gateway that is used to verify Alien status. SAVE interface is accessible via the Alien Details screen within Gateway. Document case notes if results require secondary or tertiary verification and results indicated when received.
Child Support Data ($TARS)	$TARS is an interface within Gateway that creates a historical record that can be accessed through Interfaces Module if results are found. Document any discrepancies found between the information on found on the interface, reported by the AR, and entered into Gateway.

2005 SSN Validation

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	SSN Validation		
	Effective Date:	December 2019		
	Chapter:	2000	**Policy Number:**	2005
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-57

Requirements

The system interfaces with the files at the Social Security Administration (SSA) to verify the accuracy of the SSN of an AU member.

Basic Considerations

All SSNs entered in the system will interface with SSA files.

Procedures

Use the following procedures to complete the validation requirements:

Chart 2005.1 – SSN Validation

IF AN AU MEMBER'S SSN	THEN
Is valid	The system will annotate the SSN with "Electronically verified by SVES", "Electronically verified by SOLQ" or "Electronically verified by FDSH" (federally verified). No further action is required.
Appears on the system generated enumeration or validation discrepancy lists An alert is generated.	determine if the AU member's full name, DOB, and SSN matches information on the individual's official documents. Correct any information that is in error. Refer the A/R to SSA for corrective action if the SSA information is the source of the error.
matches with another SSN known in the system	determine which number on the system is correctly assigned. Correct any SSNs erroneously entered in the system OR refer the AU member to SSA for corrective action if multiple individuals are assigned the same SSN. Determine which number on the system is correctly assigned. Correct any SSNs erroneously entered in the system OR refer the AU member to SSA for corrective action if multiple individuals are assigned the same SSN.
is validated by the system but differs from the verification (SSN card) obtained from the A/R	follow the steps under How to Change a Validated SSN in this section.

Please note if the SSN is showing “Electronically verified by SOLQ” or “Electronically verified by FDSH”, generated by running the State Online Query or Federal Data Hub Services interfaces respectively, these are also considered federally verified SSNs.

How to Change a Validated SSN

Step 1 Gather the following case identifying information and report it in the order listed:

- worker’s name
- worker’s telephone number
- county, office, supervisor, user ID
- AU number
- AU name
- AU member’s name
- AU member’s ID number

Step 2 Contact the EMPI Help Desk at empi.helpdesk@dhs.ga.gov.

Step 3 Correct the SSN when the EMPI Helpdesk provides notification that the validation code has been removed.

2010 Confidentiality

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Confidentiality		
	Effective Date:	May 2023		
	Chapter:	2000	**Policy Number:**	2010
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-69

Requirements

Any information related to individual applicants and recipients of programs administered by DFCS is confidential and is governed by regulations, which specifically forbid the release of this information to unauthorized persons or agency representatives.

Basic Considerations

All case record material is confidential, including the names and addresses of applicants and recipients, as well as the types and amount of benefits provided.

Refer to 2011 Health Information Portability and Accountability Act of 1996 for additional information regarding privacy of health information.

Case record information may be released to the following:

- the applicant/recipient (A/R)
- the personal representative (PR)
- an individual or agency if the A/R signs Form 5459, Authorization of Release of Information

The county office may charge for photostatic copies of case record material.

The following information may **not** be released to **anyone**, including the A/R:

- medical or psychiatric information marked *confidential* if the information in the record could be harmful to the A/R
- information provided by an individual who has requested confidentiality
- confidential information regarding pending criminal prosecution
- information obtained from the IRS

Penalties for release of IRS information include:

- fine not exceeding $5,000 or imprisonment of not more than 5 years, or both, including costs of prosecution for felony disclosure
- dismissal from employment
- discharge from employment upon conviction for such offense

- civil action for damages against the taxpayer brought by that taxpayer in a district court of the United States.

If the A/R requests any of the above information, refer the A/R to the source of the information.

Procedures

Release the requested information pertinent to service delivery to the following agencies or their representatives without obtaining the A/R's permission:

- the Department of Community Health (DCH)
- individuals directly connected with the administration of the DFCS, Child Support Program, Office of Investigation Services, Department of Behavioral Health and Developmental Disabilities (DBHDD), Division of Aging, Health and Human Services and SSA employees as necessary to assist in establishing or verifying eligibility benefits under Titles II and XVI of the Social Security Act
- individuals directly connected with other federal assistance programs and federally assisted state programs providing assistance on a means tested basis to low-income individuals
- persons directly connected with the administration of the Income and Eligibility Verification System (IEVS)
- employees of the Comptroller General's Office of the United States for an audit examination
- the current address of any fugitive felon or assistance unit (AU) member who has knowledge of the fugitive felon's whereabouts may be given to a law enforcement officer if the name and social security number (SSN) of the felon is known by the officer.
- name(s) and address(es) only of participating AUs to persons directly connected with nutrition education,
- researchers authorized in writing by the agency,
- public officials who request information in writing and the request originated from an inquiry by the AU,
- emergency situations in which the County Director, Regional Director, or Division Director judges that the release is necessary to prevent loss of or risk of life or health upon approval from the State Office. Notify A/R immediately of this release.

Employee Cases

An employee may be eligible for certain public assistance benefits. Employees who apply for or are receiving benefits as a member of a household must notify their supervisor. All employees' cases must be handled by a supervisor or supervisor designee. Each county should develop a plan for limited access to these cases by other staff members and the employee himself. The Regional Manager must approve the plan for handling employee cases and is to be notified of any employee receiving benefits.

Employees should not handle relatives or personal friend's applications or cases and should notify his/her supervisor when such situations occur. Employees should not be authorized representatives unless approved by the Regional Manager.

The employee/client must comply with all requirements of the program in which he or she is participating including the prompt and accurate reporting of all changes in income or circumstances. If an employee takes action on or views the case of another employee, a relative or an individual of personal interest, he may be subject to disciplinary action and prosecution for a second- or third-degree felony.

2011 Health Information Portability and Accountability Act of 1996

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Health Information Portability and Accountability Act of 1996		
	Effective Date:	December 2019		
	Chapter:	2000	**Policy Number:**	2011
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-57

Requirements

DFCS is required to comply with the Health Information Portability and Accountability Act (HIPAA) of 1996, including its rules regarding security and privacy of confidential health information.

Basic Considerations

HIPAA was enacted by Congress to provide group and individual insurance reform, introduce tax-related health care provisions, control healthcare fraud and abuse, and to ensure improvement in healthcare systems.

Covered Entity Status

The Georgia Department of Human Services (DHS) has chosen Covered Entity status to promote simplification of information sharing within the Department.

Who Must Comply

This policy applies to all individuals who are Georgia Department of Human Services (DHS) employees, volunteers, trainees, and contractors who perform duties in conjunction with the access, distribution, dissemination, modification, and management of protected health information.

Other Related Confidentiality Requirements

DHS administers programs and provides services that have more stringent requirements than those provided by the Privacy Rule. In the administration of such programs and provision of such services, the Department will adhere to the more stringent requirements.

Privacy Rule

The Privacy Rule, effective April 14, 2003, ensures privacy protection by limiting the ways that Protected Health Information (PHI) can be used and released.

Notice of Privacy Practices

Each adult AU/BG member and, if applicable, each PR must be provided with a Notice of Privacy Practices upon receipt of an application for assistance, or when he/she is added to an existing

AU/BG. This includes instances in which an A/R is currently receiving benefits in another program, such as food stamps, and applies for Medicaid. The notice **must** be mailed to each adult who is not present for a face-to-face interview. It is preferable, but not required, that each adult sign and return his/her notice, however the case record must be documented that the notice(s) was sent.

Personally Identifiable Information (PHI)

PHI is individually identifiable health information. Examples of PHI include, but are not limited to the following:

- demographic information, such as name, age, gender
- health status information
- prescription drug information
- healthcare payment information
- prior existing conditions
- eligibility information
- authorization and referral certifications PHI may be in electronic, paper-based, or oral form.

Minimum Necessary

Covered entities may use and share only the minimum amount of protected information necessary to accomplish a particular purpose.

DHS is responsible for determining the amount of PHI required per function. Upon determination of minimum necessary PHI, DHS will communicate this decision to all affected parties.

Use and Disclosure

The Privacy Rule prohibits the use and disclosure of PHI for purposes not related to treatment, payment, or health care operations. The identity of a person requesting PHI and his/her authority to receive such information must be verified prior to release of PHI. Computer matches are accessed via system terminals or through personal computers connected to the system.

As a covered entity, DHS is permitted, but not required, to use and disclose PHI, without an individual's authorization in certain situations and for specific purposes.

The following uses and disclosures do **not** require authorization from the individual:

- treatment, payment, and health care operations (TPO)
- public health agencies activities
- health oversight and regulatory agency activities
- judicial proceedings and law enforcement investigations
- healthcare fraud investigations
- emergency situations
- de-identified information (health information not connected with information identifying the

individual)

The following uses and disclosures **do** require authorization from the individual:

- third party disclosures
- marketing and fund raising activities
- non-health related affiliates
- underwriting or related affiliates
- employment determinations
- sale, rental or barter of PHI
- psychotherapy records other than psychotherapy notes

Form 5459

Prior to the release of PHI that requires authorization, the A/R must complete and sign DHS Form 5459 (rev. 07/2016), Authorization for Release of Information.

Signed, blank Forms 5459 are not permissible and may not be obtained or used for any purpose. Form 5459 may be used to release or obtain information only if the A/R or PR has specified on the Form 5459 to whom information is to be released or from whom information is to be obtained. At the point the A/R signs Form 5459 it must be dated. Form 5459 should be used within 30 days from the date it is signed.

Administrative Requirements

DHS will maintain compliance with HIPAA Privacy Rule administrative requirements including, but not limited to:

- designation of a privacy officer who is responsible for the development, implementation and maintenance of privacy policies and procedures
- development, implementation, and documentation of timely and effective privacy training
- development, maintenance, and enforcement of complaint procedures
- enforcement of appropriate sanctions for failure to comply with HIPAA regulations

Security Rule

The HIPAA Security Rule ensures the security of PHI by specifying how PHI is stored, transmitted, and accessed.

PHI Safeguarding Practices

Guidelines for safeguarding PHI include, but not limited to:

- PHI will be discussed with the A/R or PR only in private areas
- PHI will be discussed with staff members on a need-to-know basis and in non-public areas only
- telephone calls regarding PHI will be held in areas in which the conversation cannot be over-

heard

- computer monitors will be positioned in a way that does not permit observation by anyone other than the A/R or PR
- computer passwords will not be shared and will be recorded only in secure locations
- PHI will be disclosed only by those staff members authorized to do so
- access to fax machines will be limited to authorized staff
- case records, mail, documentation, and other materials containing PHI will be maintained in locked or otherwise secure locations, away from the general public
- staff members will wear appropriate agency-issued identification at all times
- PHI will be discarded in appropriate secure containers.

2015 Mandated Reporting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Mandated Reporting		
	Effective Date:	December 2019		
	Chapter:	2000	**Policy Number:**	2015
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-57

Requirements

The Official Code Section 19-7-5 updated through the 2000 Session of the General Assembly states: The purpose of this code section is to provide for the protection of children whose health and welfare are adversely affected and further threatened by the conduct of those responsible for their care and protection. It is intended that the mandatory reporting of such cases will cause the protective services of the state to be brought to bear on the situation in an effort to prevent further abuses, to protect and enhance the welfare of these children, and to preserve family life whenever possible.

Basic Considerations

Section One (1) of the above-stated law mandates that all DFCS employees are responsible for reporting suspected child abuse or neglect to Child Protective Services (CPS). The following is a list of what must be reported to CPS:

- observed signs of physical abuse on a child
- observed abusive action imposed on a child
- information about suspected abuse or neglect toward a child disclosed to you during an interview or conversation
- information about suspected abuse or neglect toward a child disclosed to you during a phone call. Refer this person to CPS Intake. Follow-up the conversation with a written referral to CPS Intake. Maintain a copy of the referral in the case record

If there is doubt as to whether or not a report should be made, make the report. CPS intake workers screen all reports and determine whether or not to open an investigation. If there is doubt, err on the side of the child's safety.

Procedures

The following steps should be taken when making a CPS referral:

Step 1 Suspected acts of abuse or neglect toward a child are observed or discovered through conversation.

Step 2 If the behavior is being exhibited in the county office, arrange for the CPS intake worker to talk with the client. Follow up the request to CPS in writing. Make a copy of written referral for case record.

Step 3 If CPS intake is not available or the client is not present, make a written referral to CPS and make a copy of the referral for the case record. Include the following information in the referral:

- child's name, age, gender, address and current location if different from the address
- parent/guardian's name, address, phone number
- reason for referral
- reporter's name, address, phone number and relationship to the child.

The Reporter has the right to remain anonymous. Note that on the referral if this request is made.

2020 Americans with Disabilities Act (ADA) and Section 504

	Georgia Division of Family and Children Services Civil Rights Policy Manual			
	Policy Title:	Americans with Disabilities Act and Section 504 of the Rehabilitation Act		
	Chapter:	3600	**Effective Date:**	December 4, 2020
	Policy Number:	3601	**Previous Policy Number(s):**	FS Policy 3025, MA Policy 2020, TANF Policy 1004

Policy

No qualified individual with a disability shall, on the basis of disability, be excluded from participation in or be denied the benefits of the services, programs, or activities of the Division of Family and Children Services (DFCS).

Scope

This policy of non-discrimination is equally applicable to DFCS and Georgia Department of Human Services staff, including volunteers and interns, and its subrecipients, contractors, grantees, agents, and providers of services (“Providers”), who assist with or administer programs, services, and activities that fall under DFCS' Office of Family Independence (OFI). This policy is not applicable to child welfare and employment matters.

Requirements

DFCS must:

- Make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability, unless it is demonstrated that making the modification would fundamentally alter the nature of the service, program, or activity or would result in undue financial and administrative burdens;
- Provide public notices regarding the right of qualified individuals with disabilities to make a request for reasonable modifications and auxiliary aids and services;
- Provide equally effective communication with primary consideration given to the person with a disability by considering the nature, length, complexity, and context of the communication and the person’s normal method(s) of communication; and,
- Administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

Authorities/References (This list is not exhaustive)

- Section 504 of the Rehabilitation Act of 1973, as amended, 29 U.S.C. § 794; 7 C.F.R. §§ 15b et seq. [USDA], 45 C.F.R. §§ 84.1 et seq. [HHS]

- Title II of the Americans with Disabilities Act of 1990 ("ADA") as amended by the ADA Amendments Act of 2008, 42 U.S.C. §§ 12131 et seq., 28 C.F.R. §§ 35.101 et seq. [DOJ]
- Title III of the ADA as amended by the ADA Amendments Act of 2008, 42 U.S.C. §§ 12181 et seq., 42 U.S.C. §12205a; 28 C.F.R. §§ 36.101 et seq. [DOJ]) (as applicable)
- Section 11(c) of the Food and Nutrition Act of 2008, as amended, 7 U.S.C. § 2020(c) [USDA]
- R.H. et al. v. Rawlings et al., CAFN: 1:17-CV-01434-TWT (N.D. Ga. 2019) (Consent Order, filed on June 4, 2019)
- FNS Nondiscrimination Compliance, 7 C.F.R § 247.4(c)(6), 7 C.F.R § 251.10(c), and 7 C.F.R. § 272.6
- FNS Instruction 113-1: Civil Rights Compliance and Enforcement – Nutrition Programs and Activities and its Appendix A and Appendix C

Definitions

Some of the definitions below are available at ADA.gov and are derived from the ADA, the Rehabilitation Act, and implementing regulations.

Auxiliary Aids and Services - Includes but is not limited to: qualified sign language interpreters, telephone handset amplifiers, assistive listening devices, closed caption decoders, real time captioning, TTY/TTD relay services for deaf and hard-of-hearing, screen reader software, Braille Embossers, text to Braille converter, large print materials, alternative keyboards for individual who are blind and have low vision.

Companion - any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

Disability - means, with respect to an individual: (i) A physical or mental impairment that substantially limits one or more of the major life activities of such individual; (ii) A record of such an impairment; or (iii) Being regarded as having such an impairment as described in paragraph (f) of this section.

Mobility Aids and Other Power-Driven Mobility Devices - any mobility device powered by batteries, fuel, or other engines… that is used by individuals with mobility disabilities for the purpose of locomotion, including golf cars, electronic personal assistance mobility devices… such as the Segway® PT, or any mobility device designed to operate in areas without defined pedestrian routes, but that is not a wheelchair.

Qualified Individual with a Disability - An individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by the Department.

Qualified Interpreter - An interpreter who, via a video remote interpreting (VRI) service or an onsite appearance, is able to interpret effectively, accurately, and impartially, both receptively and expressively, using any necessary specialized vocabulary. Qualified interpreters include, for example, sign language interpreters, oral transliterators, and cued-language transliterators.

Reasonable Modification - Modifications to rules, policies, practices, or procedures, the removal of architectural, or transportation barriers as described in 28 C.F.R. § 35.130(b)(7). This definition excludes modifications that would result in a fundamental alteration in the nature of a service, program, or activity or that would result in undue financial and administrative burdens, under the conditions specified in 28 C.F.R. § 35.130(b)(7), 28 C.F.R. § 35.164 and elsewhere.

> R.H. et al. v. Rawlings et al., CAFN: 1:17-CV-01434-TWT (N.D. Ga. 2019) (Consent Order, filed on June 4, 2019) considers provision of auxiliary aids and services a reasonable modification. However, the ADA regulations list equally effective communication requirements and auxiliary aids and services separate and distinct from reasonable modifications. DFCS will ensure equally effective communication as described in 28 C.F.R § 35.160 and 28 C.F.R § 36.303.

Reasonable Modification and Communication Assistance Request Form - A form, either in paper or electronic format that can be used, at the option of the customer with a disability, to request a reasonable modification or communication assistance and for purposes of tracking the request and response.

Request for Reasonable Modification and Communication Assistance - Any specific written or oral statement by or made appropriately on behalf of a customer with a disability, including through the "Reasonable Modification and Communication Assistance Request Form" that indicates the individual has a disability for which he or she needs a reasonable modification or communication assistance to access all DFCS programs, benefits, or activities. A request for reasonable modification includes instances where the individual initiates the request for assistance.

Service Animal - Any dog that is individually trained to do work or perform tasks for the benefit of an individual with disabilities.

Video Relay Service (VRS) - A free, subscriber-based service for people who use sign language and have videophones, smart phones, or computers with video communication capabilities. For outgoing calls, the subscriber contacts the VRS interpreter, who places the call and serves as an intermediary between the subscriber and a person who uses a standard voice telephone. The interpreter tells the telephone user what the subscriber is signing and signs to the subscriber what the telephone user is saying.

Video Remote Interpreting (VRI) - An interpreting service that uses video conference technology over dedicated lines or wireless technology offering high-speed, wide-bandwidth video connection that delivers high-quality video images as provided in 28 C.F.R. § 35.160(d).

Wheelchair - A manually operated or power-driven device designed primarily for use by an individual with a mobility disability for the main purpose of indoor or of both indoor and outdoor locomotion.

Coordination of Services/Self-Assessment/Monitoring

DFCS must designate an individual to serve as the point of contact for staff and the general public regarding ADA disability access matters and to coordinate implementation of this policy. Local government agencies and other public entities with whom the DFCS contracts that employ 50 or more persons must also designate at least one employee to coordinate its efforts to comply with the ADA. (Reference: 28 C.F.R. § 35.105)

DFCS and its Providers that receive federal financial assistance (FFA) from the USDA and that employ 15 or more individuals must also appoint a Section 504 coordinator to coordinate services and resources for individuals with disabilities. One person may coordinate implementing regulations, directives, and guidance for both statutes. The name, office address, and telephone number of the ADA/Section 504 Coordinator must be provided to all interested persons. (References: 7 C.F.R. § 15b.6 and 45 C.F.R. § 84.7)

The primary responsibilities of the ADA/Section 504 Coordinator are listed in Attachment 1. The State DFCS ADA/Section 504 Coordinator must convene regular meetings with ADA/Section 504 Coordinators serving the DFCS local agencies, subrecipients and contractors that deliver services directly to the public. For a list of DFCS OFI District ADA Coordinators, please visit: dfcs.georgia.gov/adasection-504-and-civil-rights.

Qualified Individual with a Disability

An individual with a disability under the ADA is defined as a person with a physical or mental impairment that substantially limits one or more major life activity; a person who has a record of such an impairment; or a person who is regarded as having such an impairment. The term individual with a disability does not include an individual who is currently engaging in the illegal use of drugs or alcohol.

Qualified individual with a disability means an individual with a disability who, with or without reasonable modifications to rules, policies, or practices, the removal of architectural, communication, or transportation barriers, or the provision of auxiliary aids and services, meets the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.

Public Notifications

DFCS and its Providers must notify individuals with disabilities about the availability of free reasonable modifications and auxiliary aids and services and how to request them in a format that individuals can understand. DFCS and its Providers also must notify the public about the right to file a discrimination complaint.

The DFCS Notice of ADA/Section 504 Rights regarding the rights of people with disabilities and provisions of services are available on Gateway, in all applications and renewal forms for Supplemental Nutrition Assistance Program (SNAP) also known as “Food Stamps”, Temporary Assistance for Needy Families (TANF), and Medicaid programs, in all county offices, and online at: dhs.georgia.gov/forms-notices and dfcs.georgia.gov/adasection-504-and-civil-rights.

DFCS and its Providers must post signage at all inaccessible entrances to each of its facilities, directing users to an accessible entrance or to a location at which they can obtain information about accessible facilities. The international symbol for accessibility must be used at each accessible entrance of a facility.

Notices must be provided in alternative formats upon request. Copies of the ADA/Section 504 Notice of Rights and Request for Reasonable Modification and Communication Assistance forms must be available in waiting rooms. Staff must read the Notice of ADA/Section 504 Rights to individuals upon request or as necessary to ensure understanding and to complete the Request for Reasonable

Modifications and Communication Assistance form. More information can be found online at: dfcs.georgia.gov/adasection-504-and-civil-rights.

Notices regarding a right to file a discrimination complaint must be posted in accordance with federal agency directives. Refer to MAN 3700 (DFCS Civil Rights Policy) in ODIS. The joint U.S. Department of Agriculture ("USDA"), U.S. Department of Health and Human Services' ("HHS") Joint Notice of Nondiscrimination must be posted in accordance with FNS Instruction 113-1 and subsequent FNS directives. It is located online at dfcs.georgia.gov/adasection-504-and-civil-rights.

The appropriate "And Justice for All" poster must be prominently displayed in all offices where there is a USDA presence and where it may be read by customers. Please note that institutions participating in or administering USDA programs, such as SNAP, The Emergency Food Assistance Program (TEFAP), and the Commodity Supplemental Food Program (CSFP) are required to display the appropriate "And Justice for All" poster in their facilities where it can be viewed by customers. All "And Justice for All" posters must be displayed in a specific size: 11" width x 17" height. Information can be found online at: www.fns.usda.gov/cr/and-justice-all-posters-guidance-and-translations. Contact the appropriate program director to obtain a hardcopy of the AJFA poster.

Procedures for Processing Customer Requests for Reasonable Modification(s)

Reasonable modifications afford an individual with a disability an equal opportunity to participate in all DFCS programs and receive all benefits and services for which that individual is otherwise eligible. Providing a reasonable modification may take many forms including, but not limited to, policy or procedural modifications, deferral from certain activities, and extensions of deadlines. Examples of making reasonable modifications at the administrative level include making existing facilities readily accessible to and usable by an individual with a disability and acquiring or modifying equipment.

With reasonable modifications, a person with a disability can participate fully in programs, services, and activities. Reasonable modifications are fact-specific and tailored to the individual circumstances of the person with a disability. Assessing possible reasonable modifications is a collaborative, interactive process. The starting point should always be, if possible, the customer's preferred modification. The customer's preference should provide the context for determining what a reasonable modification might be. When processing a request for reasonable modification or communication assistance, staff must not request or require verification of a customer's or companion's disability. While staff cannot ask customers to identify their disability, staff may ask what major life activity is substantially impaired or limited by their disability.

Once a customer requests a reasonable modification, eligibility workers are required to document the following in Gateway: The date(s) and type(s) of reasonable modifications requested by the customer, the date a request for reasonable modification was granted or denied, the reason the request for reasonable modification was denied, if applicable, and the specific approved or denied reasonable modification(s).

If the customer expresses a need for assistance related to a disability, expresses difficulty completing any task in the application/renewal process, and/or has a disability that is documented in Gateway, eligibility workers are required to explain tasks to the customer. Workers must complete in the application and/or renewal process, inquire whether the customer experiences difficulty com-

pleting any task or may need assistance completing any task, the reason(s) for the difficulty and/or need for assistance and possible reasonable modifications with the customer.

When a written request for reasonable modification is mailed, faxed, emailed, or hand-delivered to a local county DFCS office or other appropriate staff, that staff must forward the request to an eligibility worker for processing. Eligibility workers are required to review the customer's case file in Gateway prior to or during every interaction with the customer and before taking any action on the customer's case. Current processes for documenting in Gateway for reasonable modifications can be found in the Gateway Training.

Staff are required to provide reasonable modifications to qualified individuals with a disability at every point of interaction with customers in the OFI eligibility process, whether in person, on-line, by telephone, or by mail, including inquiries about applications for benefits. Staff must assess requests for reasonable modifications as part of a collaborative, interactive process, applying a fact-specific, individualized analysis of the person's circumstances and the modification requested to assist the individual to access OFI programs and provide the necessary information to determine program eligibility. Decisions concerning a customer's request for a reasonable modification may incorporate the following factors, assessed cooperatively with the customer: (1) how the customer's disability impairs access to OFI programs; (2) how the disability limits the customer's ability to comply with program eligibility procedures; (3) reasonable modification options that address those limitations; and (4) the effectiveness and feasibility of the proposed options. Provisions of reasonable modifications are based on a fact-specific inquiry that is to be assessed on a case-by-case basis and may be limited by regulation

All eligibility workers have the responsibility and authority to offer, grant, and implement necessary reasonable modifications to customers with disabilities. DFCS staff do not have authority to grant a request for reasonable modification to program policy rules, such as income verification. Common examples of reasonable modifications, include, but are not limited to:

- Assistance gathering documents required by the program to support initial and ongoing eligibility for benefits;
- Flexible appointments and training requirements including scheduling appointments, so they do not conflict with customer's medical appointments, rehabilitation, or therapy;
- Allowing customers to reschedule appointments, potentially multiple times, when a disability prevents attendance;
- Giving a customer more time to submit documents or complete other tasks;
- Reading and explaining notices, rights and responsibilities forms, and other program materials to the customer, repeatedly, if necessary, to help ensure understanding;
- Modifying work activities unless not authorized by program policy and regulations
- Providing access for persons with disabilities who rely on service animals, wheelchairs, mobility aids or Other Power-Driven Mobility Devices (OPMD).

How to Request Reasonable Modification(s)

- Individuals with disabilities may require reasonable modifications to assist them with accessing DFCS programs and services, complying with program requirements, avoiding potential sanc-

tions for noncompliance. All customers have the right to request a reasonable modification. Customers may direct a request for a reasonable modification to any appropriate DFCS staff member at any time. Customers may make a request for reasonable modifications orally or in any written form. Staff who do not have access to Gateway, such as receptionists, should forward the requests to an eligibility worker for processing.

- They may also complete the Reasonable Modification and Communication Assistance Request Form (Form 101). Customers are not required to use the form to make a request for reasonable modifications. Customers may obtain the reasonable modification request form in customer waiting rooms in each county DFCS office and RSM location. The form is also available online at dhs.georgia.gov/forms-notices and dfcs.georgia.gov/adasection-504-and-civil-rights. DFCS Office of Family Independence (OFI) eligibility staff are required to document any oral request or written requests for reasonable modifications in the customer's Gateway case file.
- Staff must provide the Reasonable Modification and Communication Assistance Request Form ("Form 101") to any customer upon request and may provide this form to any customer if a staff member believes they may require a reasonable modification. Forms are to be made available to customers in alternate formats as requested (i.e. large print or braille). Staff are required to assist customers with the completion of Form 101, if necessary. If a customer discloses a disability, staff members will inform the customer of his/her right to make a request for reasonable modifications and will be provided examples of reasonable modifications.

Denial of Request for Reasonable Modification(s)

Only the DFCS Division Director and his/her designee has the authority to deny, in whole or in part, reasonable modification requests or otherwise refuse requests for reasonable modifications.

DFCS and its Providers are not required to provide a reasonable modification that would fundamentally alter the program, service, or activity or would result in an undue financial or administrative burden. The determination that undue burdens would result must be based on all resources available for use by DFCS or its Providers. If the modification requested would cause undue financial burden on the program or activity to the level that it would make continued operation of the program unfeasible, the modification need not be provided. However, denying a modification(s) under the fundamental alteration exception should not result in the denial of access to the program or other benefits or services. DFCS and its Providers still must provide services to the person with a disability as appropriate to the maximum extent possible.

If eligibility workers are unsure about whether a reasonable modification can or should be provided, they must consult with a supervisor at the time the request for reasonable modification is received or as soon as reasonably possible thereafter. If a supervisor agrees that a reasonable modification can and should be provided, the eligibility worker is required to provide the requested modification to the customer. However, if the supervisor recommends that the request for reasonable modification be denied, the supervisor must submit the DFCS Reasonable Modifications (RM) and Communication Assistance (CA) Tracking Form and any supporting documentation with recommendations for review to the District ADA/Section 504 Coordinator.

The District ADA/Section 504 Coordinator reviews the supervisor's denial request and forwards the Reasonable Modification and Communication Assistance Request Tracking Form 102 (Please see Attachment 2) to the State DFCS ADA/Section 504 Coordinator. For instructions on how to complete

Form 101 and/or Form 102, please see Attachment 3. The State DFCS ADA/Section 504 Coordinator will review the complaint involving request for reasonable modification and the denial request and will consult with the appropriate DFCS OFI Program Unit Manager and/or OFI Director. Only the DFCS Division Director or his/her designee has the authority to deny, in whole or in part, reasonable modification requests or otherwise refuse requests for reasonable modifications. After the final agency decision on the request for reasonable modifications is made, the DFCS District ADA/Section 504 Coordinator is responsible for drafting and providing a written decision to the customer, after consultation with the State DFCS ADA/Section 504 Coordinator.

Procedures for Equally Effective Communication

DFCS and its Providers must ensure communications with applicants, participants, members of the public and companions with disabilities are as effective as communications with other. In some situations, DFCS may communicate with a customer's companion with disability. A companion is any family member, friend, or associate of a person seeking or receiving an entity's goods or services who is an appropriate person with whom the entity should communicate.

DFCS and its Providers must provide appropriate auxiliary aids and services when necessary to ensure effective communication with individuals with disabilities. This includes an obligation to provide effective communication to companions with disabilities. These aids and services must be provided at no cost to the customer and in a timely manner that protects the privacy and independence of customers with a disability.

Auxiliary aids and services refer to the ways to communicate with people who have communication disabilities (e.g., DFCS customers with hearing, vision, and speech disabilities). Auxiliary aids and services include but are not limited to qualified sign language interpreters, telephone handset amplifiers, assistive listening devices, closed caption decoders, real time captioning, TTY/TTD relay services for Deaf and hard-of- hearing, screen reader software, Braille Embossers, text to Braille converter, large print materials, alternative keyboards for individuals who are blind and have low vision.

Examples of auxiliary aids and services for people who are blind, have vision loss, or are DeafBlind might be:

- Providing a qualified reader, information in large print, Braille, or electronically for use with a computer screen-reading program, or an audio recording of printed information.

Examples of auxiliary aids and services for people who are Deaf, have hearing loss, or are DeafBlind might be:

- • Providing a qualified note taker, a qualified sign language interpreter, oral interpreter (non-language), cued-speech interpreter, or tactile interpreter; real-time captioning; or written materials

Examples of auxiliary aids and services for people who have speech disabilities might include:

- Providing a qualified speech-to-speech transliterator (a person trained to recognize unclear speech and repeat it clearly), especially if the person will be speaking at length, or just taking more time to communicate with someone who uses a communication board.

Video remote interpreting (VRI) services also provide qualified interpreters. A public entity that chooses to provide qualified interpreters via VRI services must ensure that the computer or other device meets the technological requirements of the ADA at 28 CFR 35.160(d).

Eligibility workers are required to provide application and renewal forms, system-generated individual and household communications and notices of decision (i.e. approvals, changes, terminations, and denials) and renewal notices in large print, Braille, audio format, or data format to qualified individuals with a disability upon request and as required by law.

The key to communicating effectively is to consider the nature, length, complexity, and context of the communication and the person's normal method(s) of communication. This may also involve verifying that the communication is understood, using multiple methods of explanation to the individual.

With respect to communication disabilities, state or local government agencies must give primary consideration to the person's choice of auxiliary aid and service, unless it can demonstrate that another equally effective means of communication is available, or that the use of the means chosen would result in a fundamental alteration or a financial or administrative undue burden. [28 C.F.R. § 35.160(b)(2)]. If the choice expressed by the person with a disability would result in an undue burden or a fundamental alteration, the public entity still has an obligation to provide an alternative aid or service that provides effective communication if one is available. The decision that a particular aid or service would result in an undue burden or fundamental alteration must be made by the DFCS Division Director or his/her designee and must be accompanied by a written statement of the reasons for reaching that conclusion.

Public accommodations (e.g. private community partner agencies) that provide DFCS services are *encouraged* to consult with the person with a disability to discuss what aid or service is appropriate. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person's method of communicating.

When an eligibility worker or other staff becomes aware that a customer has a disability that substantially limits the customer's ability to see, hear or speak, the eligibility worker or staff must inquire as to the customer's potential need for auxiliary aids and services. If a customer expresses a need for assistance related to a disability, or if the customer has a disability that is documented in Gateway, eligibility workers who have access to Gateway are required to discuss the possible need for auxiliary aids and services with the customer using the Gateway written prompts. If a customer indicates that he or she does not wish to disclose or to discuss their disability, staff will not make further inquiries on these subjects.

Individuals with disabilities may request an auxiliary aid or service by completing the Reasonable Modification and Communication Assistance Request Form (Form 101). Please refer to the Reasonable Modifications Section above for procedures handling documenting requests for assistance in Gateway.

DFCS and its Providers must assure that any interpreter used to communicate with a DFCS customer with a disability is qualified to do so. This includes qualified interpreters (i.e. American Sign Language, signed exact English interpreters, cued speech interpreters, oral interpreters, tactile interpreters, and Computer Assisted Real-time Transcription (CART)]. When a customer who is deaf or hard-of-hearing notifies staff that the interpreter provided is not qualified to interpret for that

customer, either DFCS or its Provider staff must arrange for a qualified interpreter service or other appropriate auxiliary aid and service, as required by law.

DFCS and Provider staff are prohibited from requiring a customer to bring a person to serve as the interpreter. Staff will not rely on an adult accompanying a customer with a disability to interpret or facilitate communications except (a) in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available, or (b) where the customer with a disability specifically requests that the accompanying adult interpret or facilitate communication, the accompanying adult agrees to provide such assistance, and reliance on that adult for such assistance is appropriate under the circumstances.

Staff will not rely on a minor child to interpret or facilitate communications with a customer, except in an emergency involving an imminent threat to the safety or welfare of an individual or the public where there is no interpreter available.

Wheelchairs, Mobility Aids and Other Power-Driven Mobility Devices

DFCS and its Providers must allow individuals with disabilities who use wheelchairs, mobility aids or other power-driven mobility devices (OPDMD) into all areas where the public is allowed to go, unless the entity can demonstrate that the particular type of device cannot be accommodated because of legitimate safety requirements. Such safety requirements must be based on actual risks, not on speculation or stereotypes about a particular class of devices or how individuals will operate them.

Staff must consider these factors in determining whether to permit OPDMDs on their premises:

- the type, size, weight, dimensions, and speed of the device;
- the volume of pedestrian traffic (which may vary at different times of the day, week, month, or year);
- the facility's design and operational characteristics, such as its square footage, whether it is indoors or outdoors, the placement of stationary equipment, devices, or furniture, and whether it has storage space for the device if requested by the individual;
- whether legitimate safety standards can be established to permit the safe operation of the device; and
- whether the use of the device creates a substantial risk of serious harm to the environment or natural or cultural resources or poses a conflict with Federal land management laws and regulations.

Communicate clearly to the public any OPDMD not permitted in an area where DFCS programs, services and activities are offered. Staff may not ask individuals using such devices about their disability but may ask for a credible assurance that the device is required because of a disability. If the person presents a valid, State-issued disability parking placard or card or a State-issued proof of disability, it must be accepted as credible assurance on its face. If the person does not have this documentation, but states verbally that the device is being used because of a mobility disability, that also must be accepted as credible assurance, unless the person is observed doing something that contradicts the assurance.

Service Animals

Under the ADA, a service animal is defined as a dog that has been individually trained to do work or perform tasks for a person with a disability. DFCS and its Providers must provide individuals with disabilities with service animals an equal opportunity to participate in DFCS programs, services, and activities.

Staff may ask two questions in relation to a service animal:

1. Is the dog a service animal required because of a disability?
2. What work or task has the dog been trained to perform?

Service animals must be allowed in all areas of a facility where the public is allowed except where the dog's presence would create a legitimate safety risk or would fundamentally alter the nature of a public entity's services. Service animals may be excluded only if 1) the dog is out of control and the handler cannot or does not regain control; or 2) the dog is not housebroken. If a service animal is excluded, staff must allow individuals to enter the facility without the service animal.

A service animal must have a harness, leash or other tether, unless the handler is unable to use a tether because of a disability or the use of a tether would interfere with the service animal's ability to safely perform its work or tasks. In these cases, the service animal must be under the handler's control through voice commands, hand signals, or other effective means. If a service animal is excluded, the individual with a disability must still be offered the opportunity to obtain goods, services, and accommodations without having the service animal on the premises.

DFCS employees may ask an individual with a disability to remove a service animal if the animal is not housebroken or is out of control and the individual is not able to control it. If DFCS properly excludes a service animal, DFCS cannot unlawfully exclude the customer from accessing its services, programs, or activities and must give the individual with a disability the opportunity to participate in programs, services, or activities without the service animal being present.

Staff may not require individuals with disabilities to provide documentation, such as proof that the animal has been certified, trained, or licensed as a service animal, as a condition for entry. Service animals are not required to wear service animal vests or patches, or to use a specific type of harness.

Allergies and fear of dogs are not valid reasons for denying access or refusing service to people using service animals. When a person who is allergic to dog dander and a person who uses a service animal must spend time in the same room or facility, they both should be accommodated by assigning them, if possible, to different locations within the room or different rooms in the building. But, as with any reasonable modification, determination on how to address allegations involving allergies or other direct threat or safety concerns is done on a case-by-case basis.

Miniature Horses

Although not service animals, miniature horses have similar protections under the ADA. DFCS and its Providers must permit access where reasonable for miniature horses that are individually trained to do work or perform tasks for individuals with disabilities. Federal regulations set out four assessment factors to assist staff in determining whether miniature horses can be accommo-

dated in their facility. The assessment factors are (1) whether the miniature horse is housebroken; (2) whether the miniature horse is under the owner's control; (3) whether the facility can accommodate the miniature horse's type, size, and weight; and (4) whether the miniature horse's presence will not compromise legitimate safety requirements necessary for safe operation of the facility.

Access to Websites and Online Systems

DFCS and its Providers must ensure program websites and online systems are accessible to persons with disabilities. DFCS and its Providers should ensure that in- house staff and contractors responsible for web page and content development are properly trained. DFCS and its Providers must provide a way for visitors to request accessible information or services to the extent required by law. Information for web developers interested in making their web pages as accessible as possible, including the current version of the **Web Content Accessibility Guidelines** (and associated checklists), can be found at www.w3c.org/WAI/Resources.

Physical Access to Buildings and Facilities

DFCS and its Providers must ensure individuals with disabilities are not excluded from programs and services because facilities are unusable or inaccessible to them. These entities must ensure that individuals with disabilities have access to programs and services under the same terms and conditions as individuals without disabilities. These entities must abide by the ADA Standards for Accessible Design.

Safety

DFCS and its Providers may impose legitimate safety requirements necessary for the safe operation of its services, programs, or activities. However, the public entity must ensure that its safety requirements are based on real risks, not on speculation, stereotypes, or generalizations about individuals with disabilities.

Direct Threat

Direct Threat means a significant risk to the health or safety of others that cannot be eliminated by a modification of policies, practices or procedures, or by the provision of auxiliary aids or services as provided in 28 C.F.R. § 35.139 (Title II) and 28 C.F.R. § 36.208 (Title III).

The ADA does not require DFCS or its Providers to permit an individual to participate in or benefit from the services, programs, or activities of that DFCS when that individual poses a direct threat to the health or safety of others (not to self). In determining whether an individual poses a direct threat to the health or safety of others, DFCS and its Providers must make an individualized assessment, based on reasonable judgment that relies on current medical knowledge or on the best available objective evidence, to ascertain: the nature, duration, and severity of the risk; the probability that the potential injury will actually occur; and whether reasonable modifications of policies, practices, or procedures or the provision of auxiliary aids or services will mitigate the risk.

Fundamental Alteration/Undue Burden

The State agency, local agency, subrecipients and contractors are not required to modify its policies, practices, or procedures if the entity can demonstrate that making the modification would fundamentally alter the nature of the service, program, or activity. If the modification requested would cause undue financial burden on the program or activity to the level that it would make continued operation of the program unfeasible, the modification need not be provided. However, denying a modification(s) under the fundamental alteration exception should not result in the denial of access to the program or other benefits or services.

The decision that a particular aid or service would result in an undue burden or fundamental alteration must be made by the DFCS Division Director or his/her designee and must be accompanied by a written statement of the reasons for reaching that conclusion. The State agency, local agency, sub recipients and contractors still must provide services to the maximum extent possible.

Staff Training

For Civil Rights training requirements, please refer to the DFCS Civil Rights Policy – MAN 3700.

Complaints Processing

All DFCS customers and the public have a right to file a complaint of discrimination on the basis race, color, national origin, disability, age, sex and in some cases religion or political beliefs, or for reprisal or retaliation for engaging in prior civil rights activity. For more information, reference the DFCS Civil Rights and ADA/Section 504 Complaint Process and the DFCS Civil Rights, ADA/Section 504 Complaint Form on the DFCS Nondiscrimination and Disability webpage at: dfcs.georgia.gov/adasection-504-and-civil-rights.

Attachments

Attachment 1: DFCS District and State ADA/Section 504 Coordinator Duties
Attachment 2: Reasonable Modification and Communication Assistance Request Tracking Form (102)
Attachment 3: ADA/RM Form 101 and 102 Instructions
Attachment 4: ADA RM Form 101 and 102 County Tracking Log 1_24_20
Attachment 5: US Department of Justice (DOJ), ADA Requirements: Effective Communication
Attachment 6: DOJ ADA Title II Primer
Attachment 7: DOJ Accessibility of State and Local Government Websites to People with Disabilities
Attachment 8: Reasonable Modification and Communication Assistance Request Tracking Form (102)
Attachment 9: ADA/RM Form 101 and 102 Instructions
Attachment 10: ADA RM Form 101 and 102 Manual Tracking Log 1_24_20
Attachment 11: US Department of Justice (DOJ), ADA Requirements: Effective Communication
Attachment 12: DOJ ADA Title II Primer
Attachment 13: DOJ Accessibility of State and Local Government Websites to People with Disabilities
Attachment 14: DFCS Civil Rights and ADA/Section 504 Complaint Process
Attachment 15: DFCS Civil Rights, ADA/Section 504 Complaint Form

2025 Civil Rights

	Georgia Division of Family and Children Services Civil Rights Policy Manual			
	Policy Title:	Civil Rights		
	Chapter:	3700	**Effective Date:**	March 1, 2023
	Policy Number:	3701	**Previous Policy Number(s):**	FS Policy 3030, MA Policy 2025, TANF Policy 1003

Policy

The Georgia Department of Human Services (“DHS”), Division of Family and Children Services' (“DFCS”) Civil Rights Compliance policy is created to ensure DHS/DFCS and its contractors comply with laws, regulations, and policies prohibiting unlawful discrimination in the administration of DFCS programs, services, and activities.

Scope

This policy applies Department-wide to all staff who are involved with the administration of any DFCS programs, services, and activities; and extends to DFCS' subrecipients, contractors, grantees, agents, and providers of services (“Providers”) as required by law or contract. This policy only covers program access, not employment matters.

Basic Considerations

This policy establishes DHS'/DFCS' and its Providers' compliance with Civil Rights laws and regulations, including the methods of administration and reasonable assurances described in 45 C.F.R. § 80.4(b) [U.S. Department of Health and Human Services (“HHS”)]; 7 C.F.R. § 272.2(b) [U.S. Department of Agriculture (“USDA”) Supplemental Nutrition Assistance Program (“SNAP”)]; 7 C.F.R §§ 247.4(c)(6) [USDA-Commodity Supplemental Food Program (“CSFP”)], 7 C.F.R. § 251.10(c) [USDA-The Emergency Food Assistance Program (“TEFAP”)]; 7 C.F.R, § 250.4 [CSFP and TEFAP].

This policy substitutes and replaces all prior Methods of Administration that conflict with or that are otherwise inconsistent with the DFCS policies, procedures, forms, and other related Civil Rights documents that are referenced within this policy. DHS documents that concern Civil Rights and that are applicable to DFCS' programs, services, and activities are referenced within this document.

DFCS and its Providers must incorporate the appropriate assurance of nondiscrimination language in its agreements and contracts with subrecipients and contractors. **Attachment A** contains samples of the current assurances for USDA and HHS programs. Refer to *FNS Instruction 113-1 - Civil Rights Compliance and Enforcement – Nutrition Programs and Activities, Section X* and *Appendix A* and *C* for additional information regarding assurances of nondiscrimination in USDA programs.

Requirements

A. Nondiscrimination in DFCS programs, services and activities

DHS/DFCS and its Providers are prohibited from unlawfully discriminating in the administration of DFCS programs, services, and activities on the basis of race, color, national origin, disability, age, and sex (including gender identity and sexual orientation). In any USDA SNAP program or activity, DFCS and its Providers are also prohibited from discriminating on the basis of religious creed and political beliefs. In any HHS program or activity, DFCS and its Providers are also prohibited from discriminating based on religion. These entities also are prohibited from engaging in reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by a federal agency.

To access DFCS' Notice of ADA/Section 504 Rights and the joint U.S. Department of Agriculture, U.S. Department of Health and Human Services' Notice of Nondiscrimination, click here.

DFCS is prohibited from disclosing Personally Identifiable Information (PII) or Protected Health Information (PHI) to unauthorized individuals. Therefore, DFCS will not disclose or allow access to the complainant's PII or PHI without the appropriate authorization. In situations where a companion or other individual requests a reasonable modification or communication assistance on behalf of a person with a disability, DFCS will contact the person with a disability or authorized representative to clarify the request.

B. Right to file a Civil Rights, ADA/Section 504 Complaint

Customers who allege unlawful discrimination have the right to file a civil rights complaint, which includes complaints about decisions made regarding requests for reasonable modifications for individuals with disabilities and requests for language assistance services (interpreters and translated materials) for individuals who have limited English proficiency ("LEP").

All written or verbal complaints alleging discrimination on the basis of race, color, national origin, age, sex (including gender identity and sexual orientation), disability, political beliefs or religion or retaliation for engaging in prior Civil Rights activity in any of the DFCS's programs, activities or services are processed in accordance with the *DFCS Civil Rights, ADA/Section 504 Complaint Process*.

DFCS and its local agencies, subrecipients and contactors must forward all discrimination complaints to the DFCS Civil Rights and ADA/Section 504 Coordinator as required by DFCS' Complaint Process. **For more information about DFCS' Civil Rights, ADA/Section 504 complaint process and form, follow the link here or visit dfcs.georgia.gov/adasection-504-and-civil-rights.**

C. Right to Request Reasonable Modifications and Free Communication Assistance

1. Reasonable Modifications

Reasonable modifications afford an individual with a disability an equal opportunity to participate in all DFCS programs and receive all benefits and services for which that individual is otherwise eligible. DFCS must make reasonable modifications in policies, practices, or procedures when necessary to avoid discrimination on the basis of disability, unless it is demonstrated that making the modification would fundamentally alter the nature of the service, program, or activity or would result in undue financial and administrative burdens. **For more information about the requirement to provide reasonable modifications to**

customers with disabilities, follow the link here or visit dfcs.georgia.gov/adasection-504-and-civil-rights.

2. Auxiliary Aids and Services for Communication

   DHS/DFCS and its Providers must provide free auxiliary aids and services for DFCS customers and their companions with disabilities (e.g., DFCS customers with hearing, vision, and speech disabilities) to ensure equally effective communication in accordance with the ADA and Section 504. A companion is any family member, friend, or associate of a DFCS customer and who is an appropriate person with whom the entity should communicate. **For more information about communication assistance for individuals with disabilities, follow the link here or visit dfcs.georgia.gov/adasection-504-and-civil-rights.**

3. Language Assistance Services for Communication

   DHS/DFCS and its Providers must provide free qualified interpreters and translated information in a timely manner when communicating with DFCS' LEP customers. LEP individuals do not speak English as their primary language and have a limited ability to read, write, speak, and/or understand English. LEP individuals may be competent in English for certain types of communication (e.g., speaking or understanding), but still be LEP for other purposes (e.g., reading or writing). A customer may be considered LEP if he/she prefers to communicate with DHS/DFCS in a language other than English, orally or in writing.

   For more information about providing customers language assistance services, DHS/DFCS staff must refer to DHS LEP/SI Policy 2001 found in ODIS.

D. Public Notifications

DHS/DFCS and its Providers must inform participants, applicants, and the general public of their program rights and responsibilities, their protection against discrimination and the procedures for filing a discrimination complaint. Additionally, DHS/DFCS and its Providers must provide effective notice to individuals with LEP regarding the availability of free language assistance services (interpreters and translated information) in languages that they can understand. Similarly, DHS/DFCS must notify individuals with disabilities about the availability of free auxiliary aids and services and reasonable modifications and how to request them in a format that they can understand.

For USDA programs: Public notices, including the appropriate USDA nondiscrimination statement, should appear in reception areas, within vital documents, on websites, online systems, and telephone voice mail menus on customer service lines. Staff should also notify individuals with LEP or with disabilities that these services are provided at no cost to them. For more information about public notices for persons with LEP, staff must refer to DHS LEP/SI Policy 2001 found in ODIS.

To obtain a copy or for more information about public notices for individuals with disabilities, follow the link here or visit dfcs.georgia.gov/adasection-504-and-civil-rights.

USDA programs have specific requirements for displaying the appropriate nondiscrimination statement that advertises how to file a complaint on all information materials and sources and websites used by State agencies, local agencies, or other subrecipients to inform the public

about Food and Nutrition Service (FNS) programs. The electronic versions of the USDA Nondiscrimination Statement are found at www.fns.usda.gov/cr/fns-nondiscrimination-statement.

Similarly, the USDA issued directives on posting the appropriate *And Justice for All Poster* (AJFA). The AJFA poster Form AD-475-A is the poster that applies to CSFP and TEFAP; Form AD-475-B is the poster that applies to SNAP. The applicable AJFA posters must be prominently displayed in all offices where there is a USDA presence and where customers can view it. See *FNS Instruction 113-1, Section IX, Appendix A and Appendix C*; and the *USDA Departmental Regulation 4300-003 – Equal Opportunity Public Notification Policy.* To obtain a poster, contact the DFCS Food and Nutrition Unit Director.

E. Civil Rights and ADA/Section 504 Training

DFCS requires all DHS/DFCS and Provider staff involved in administering or delivering DFCS programs, activities, and services to meet Civil Rights training requirements. All DFCS staff and Provider staff are required to take the Civil Rights training, ADA/Section 504 training, and Customer Service and Communication training annually and within 30-days from the date of hire. Office of Family Independence and child welfare staff may be required to take additional training specific to the operation of their respective programs, services, and systems. Training for DFCS staff is available on IOTIS.

Additional training requirements for USDA programs: Training is required so that staff involved in all levels of administration of programs that receive Federal financial assistance understand civil rights related laws, regulations, procedures, and directives. Staff responsible for reviewing Civil Rights compliance must receive training to assist them in performing their review responsibilities. This training may be carried out as part of ongoing technical assistance. The FNS Regional Civil Rights Officer trains DFCS state-level personnel. DFCS is responsible for training the appropriate state-level personnel, local DFCS office personnel, and its Providers, including “frontline staff”. “Frontline staff” who interact with program applicants or participants, and those persons who supervise “frontline staff”, must receive civil rights training on an annual basis. “Frontline staff” also includes Providers.

According to FNS Instruction 113-1, Section IX, Civil Rights training that covers USDA programs (e.g., SNAP, CSFP and TEFAP) must include but is not limited to the following specific topics: collection and use of data, effective public notification systems, complaint procedures, compliance review techniques, resolution of noncompliance, requirements for reasonable modifications and auxiliary aids and services for individuals with disabilities, requirements for language assistance, conflict resolution, customer service and, when applicable, verification of citizenship, immigration status and social security numbers. **To access Civil Rights and ADA/Section 504 training, refer to IOTIS.**

F. Race and Ethnicity Data Collection, Maintenance, and Reporting

DFCS must ensure that the appropriate data is collected and maintained by its local agencies and its Providers when required by federal and state statutes, regulations and directives. This includes collection of race and ethnicity in accordance with the U.S. Office of Management and Budget and each federal or state agency requirements. This data is to determine how effectively DFCS' programs, activities, and services are reaching potentially eligible persons and beneficiaries, identify areas where additional outreach is needed, assist in the selection of locations for

Civil Rights compliance reviews, and complete reports as required. Each federal agency has collection, maintenance, and reporting requirements. Refer to each DFCS program's policies/procedures for specific program data collection requirements.

DFCS programs, services and activities funded by the USDA (e.g., SNAP, CSFP and TEFAP) must follow the applicable "Data Collection and Reporting" requirements in *FNS Instruction 113-1, Section XII and is Appendix A and Appendix C* and in subsequent FNS policies and directives **Attachment B** contains minimum requirements for data collection in USDA programs.

G. Collection of Citizenship, Immigration Status, and Social Security Numbers

Each DFCS program must adhere to any applicable federal and state requirements regarding noncitizen eligibility and collection of this data. However, each DFCS program must ensure that collection and verification of citizenship, immigration status and social security numbers, when required by federal statutes and regulation, does not result in an access barrier or unlawful discrimination in DFCS' programs, services and activities. Those who are eligible for DFCS' programs must not be deterred from applying because of insufficient public notifications or inappropriate data collection methods.

For USDA programs: Citizenship, immigration status and social security numbers should not be requested for CSFP and TEFAP. For collection of this data in SNAP, staff cannot require any information about the citizenship, immigration status or social security number of anyone who is not applying for SNAP or, deny SNAP to applying household members because a non-applicant household member has not disclosed his or her citizenship or immigration status or social security number. Under no circumstances may DFCS or its Providers: 1) Require any information about the citizenship or immigration status of anyone who is not applying for SNAP; 2) Deny SNAP to applying household members because a non-applicant household member has not disclosed his or her citizenship or immigration status or Social Security number; or 3) Try to establish or verify immigration status through any means other than the procedures outlined in the SNAP Guidance on Non-Citizen Eligibility. DHS has primary responsibility to determine the status of non-citizens.

For additional information, refer to the USDA FNS SNAP Guidance on Non-Citizen Eligibility at www.fns.usda.gov/snap/eligibility/non-citizen-eligibility.

H. Evaluating Civil Rights Compliance/Resolution of Noncompliance

DFCS program staff monitor all Civil Rights criteria captured within each program's management evaluations, quality assurance reviews, compliance reports, and civil rights reviews of its local agencies and its Providers and ensures resolution of noncompliance is accomplished in accordance with applicable federal guidelines. Staff must report concerns and instances of noncompliance with civil rights policies to the DFCS Civil Rights and ADA/Section 504 Coordinator. The DFCS Civil Rights and ADA/Section 504 Coordinator and program staff must work together to resolve noncompliance matters in a timely manner.

For USDA programs (refer to FNS Instruction 113-1, Sections XIII and XIV and Appendix A and Appendix C): The program staff performing compliance reviews must notify the noncompliant DFCS local agency or Provider, in writing, of the review findings and requirements/recommendations immediately after the review is completed.

Noncompliance is a factual finding that any Civil Rights requirement, as provided by law, regulation, policy, instruction, or guidelines, is not being adhered to by the DHS/DFCS or its local agencies, subrecipients or contractors. The effective date of the finding of noncompliance is the date a written notice of noncompliance is provided to the entity under review. All programs must cooperate with the DFCS Civil Rights and ADA/Section 504 Coordinator and the DHS LEP/SI Program Manager (for LEP only) to resolve Civil Rights findings or concerns within 60 days of the effective date.

Additionally, DFCS must resolve instances of noncompliance in USDA programs in accordance with *FNS Instruction 113-1, Section XIV*. For any finding in a USDA program that is not resolved in 60 days of the effective date, the DFCS Civil Rights and ADA/Section 504 Coordinator must submit a report of Findings of Noncompliance with appropriate documentation to the FNS Regional Civil Rights Officer.

Authorities (This list is not exhaustive)

A. **Title VI of the Civil Rights Act of 1964** (42 U.S.C. § 2000d et seq., 28 C.F.R. § 42.101 et seq. [DOJ], 7 C.F.R. § 15.1 et seq.,15.60 et seq. [USDA]; 45 C.F.R. § 80.1 et seq. [HHS]);
B. **Title IX of the Education Amendments of 1972** (20 U.S.C. § 1681 et seq., 28 C.F.R. § 54.100 et seq. [DOJ], 34 C.F.R. § 106 et seq. [DOE], 7 C.F.R. Part 15a [USDA], 45 C.F.R. § 86.1 et seq. [HHS]);
C. **Section 504 of the Rehabilitation Act of 1973** (29 U.S.C. § 794, 28 C.F.R. § 42.501 et seq. [DOJ], 7 C.F.R. § 15b et seq. [USDA], 45 C.F.R. § 84.1 et seq. [HHS]);
D. **Age Discrimination Act of 1975** (42 U.S.C. § 6101 et seq., 7 C.F.R. Part 15c [USDA], 45 C.F.R. § 91.1 et seq. [HHS]);
E. **The Food and Nutrition Act of 2008**, as amended, Supplemental Nutrition Assistance Program (SNAP), formerly the Food Stamp Program (7 USC § 2011 et seq. 7 CFR 271, 272, 273, and 276)
F. **Indian Child Welfare Act of 1978** (25 U.S.C. § 1901 et seq., 25 C.F.R. § 23.101 et seq.);
G. **Title II of the Americans with Disabilities Act of 1990, as amended** (42 U.S.C. § 12131 et seq., 28 C.F.R. § 35.101 et seq. [DOJ]);
H. **Title III of the Americans with Disabilities Act of 1990, as amended** (42 U.S.C. § 12181 et seq., 42 U.S.C. §12205a, 28 C.F.R. § 36.101 et seq. [DOJ]) (as applicable);
I. **Americans with Disabilities Act Amendment Act of 2008 (ADAAA)** (42 USC § 12101 et seq. at 28 CFR 35),
J. **Presidential Executive Order 13166** "Improving Access To Services For Persons With Limited English Proficiency" (Aug. 11,)
K. **Multiethnic Placement Act of 1994** (42 U.S.C. § 1996b, 45 C.F.R. §1355.38);
L. **Section 11(c) of the Food and Nutrition Act of 2008, as amended** (7 U.S.C. § 2020(c) [USDA]);
M. **FNS Nondiscrimination Compliance**, 7 C.F.R. § 247.4(c)(6), 251.10(c), (e)(3), 272.4, 272.6 [USDA];
N. **FNS Instruction 113-1: Civil Rights Compliance and Enforcement – Nutrition Programs and Activities** and its Appendix A and Appendix C;
O. O.C.G.A. § 30-3-1 et seq.;
P. O.C.G.A. § 30-4-1 et seq.

Document References and Links (The lists may not be exhaustive)

The following are references to applicable DHS and DFCS Civil Rights and ADA/Section 504 notices, policies, procedures, forms, tools, posters, and other documents. Generally, policies and procedures are available on ODIS. Additional forms and documents may be referenced in each of the documents referenced below:

A. Applicable to all DFCS programs, activities, and services

1. Policies, procedures, and forms:
    a. DFCS MAN 3400 (POL 3401) – American with Disabilities Act and Section 504
    b. DFCS Civil Rights and ADA/Section 504 Complaint Process (Available in English and Spanish)
    c. DFCS Civil Rights, ADA/Section 504 Complaint Form (Form 724 - Available in English and Spanish)
    d. ADA Reasonable Modification Form 101 and 102 Instructions
    e. DFCS Reasonable Modification and Communication Assistance Request Form for Persons with Disabilities (Form 101-Available in English, English Large Print, Spanish, Spanish Large Print)
    f. DFCS Reasonable Modifications (RM) and Communication Assistance (CA) Tracking Form (Form 102)
    g. ADA Reasonable Modification Form 101 and 102 Manual Tracking Log
    h. DHS POL 2001: DHS LEP/SI policy
    i. DHS MAN 2001: Access Plan for Constituents with Limited English Proficiency (LEP) and Sensory Impairments (SI) (with Attachments)
2. Training (Available on DFCS' IOTIS training site):
    a. DHS 1100 - Civil Rights and LEP (All DFCS and OFI Community Partners, required annually and within 30-days of hire)
3. Required signage and posters:
    a. DFCS “Notice of ADA/Section 504 Rights” and the attached joint U.S. Department of Agriculture, U.S. Department of Health and Human Services' Nondiscrimination Statement
    b. Georgia Department of Human Services Notice of Free Interpretation Services
    c. “AND JUSTICE FOR ALL” posters
        1. For TEFAP and CSFP (FNS Form AD-475A)
        2. For SNAP (FNS Form AD-475B)

> DFCS programs, services and activities funded by the USDA (e.g., SNAP) must follow applicable “Public Notification” requirements (see e.g., FNS Instruction 113-1).

4. Link(s):
    a. DFCS Nondiscrimination and Disability webpage – dfcs.georgia.gov/adasection-504-and-

civil-rights

b. ADA/Section 504 documents and forms – dfcs.georgia.gov/adasection-504-and-civil-rights

c. LEP/SI - dhs.georgia.gov/organization/about/language-access

B. Office of Family Independence (OFI)

1. Policies, procedures, and forms:

a. All OFI programs

1. DFCS' "Duties of the Office of Family Independence District ADA/Section 504 Coordinators" (Available in ODIS)
2. DFCS OFI "ADA/Section 504 District Coordinator List"
3. DFCS' "Quality Assurance Unit's Plan for Periodic Random Sampling of Fair Hearing Requests and ADA/Section 504 DFCS County" (DFCS Management Evaluation (ME) Plan)
4. DFCS' "County Department Civil Rights/ADA Reasonable Modifications Compliance Review Guide" (Form 723)

b. Food Stamp Program

1. 3025 General Program Overview: Americans with Disabilities Act/Section 504
2. 3030 General Program Overview: Civil Rights

c. Medicaid Program

1. 2020 General Program Overview: Americans with Disabilities Act/Section 504
2. 2025 General Program Overview: Civil Rights

d. TANF Program

1. 1003 General Program Overview: Civil Rights
2. 1004 General Program Overview: Americans with Disabilities Act and Section 504 of the Rehabilitation Act

e. Energy Assistance Program

1. 800 General Program Overview: Americans with Disabilities Act/Section 504

f. Community Services Block Grant (CSBG) Program

1. 800 General Program Overview: Americans with Disabilities Act/Section 504

2. Training (*Available on DFCS' IOTIS training site):

a. *DHS 1100 - Civil Rights and LEP (All DFCS and Gateway Community Partners, required annually and within 30-days of hire)

b. *ADA 204 - ADA Section 504 Training (OFI and Gateway Community Partners only)

c. *WEX 242: ADA Training Updates (OFI only, Gateway training)

d. *WEX 243: CR 675021 Civil Rights Updates (OFI only, Gateway training)

e. ADA/Section 504 DFCS District Coordinator Training (OFI only)

f. DHS 3000: Customer Service and Communication

C. Child Welfare

1. Policies, procedures, and forms:
    a. All child welfare programs
        1. 1.4 Administration: Non-Discriminatory Child Welfare Practices
        2. 1.5 Administration: Americans with Disabilities Act (ADA)/Section 504 and Reasonable Modifications
        3. 1.6 Administration: Indian Child Welfare Act (ICWA) and Transfer of Responsibility for Placement and Care to a Tribal Agency
        4. DFCS Child Welfare “ADA/Section 504 Regional Coordinator List”
        5. 1.16 Administration: Civil Rights Complaint Process
    b. Foster care and adoption
        1. 14.11 Resource Development: Individualized Assessment
        2. Individualized Assessment Tool for Prospective and Existing Caregivers
2. Training (*Available on DFCS' IOTIS training site):
    a. *DHS 1100 - Civil Rights and LEP (All DFCS, required annually and within 30-days of hire)
    b. *OCP 833 – ADA/504 Individualized Assessment
    c. *ADA/Section 504 DFCS Regional Coordinator Training –“WEB 153: Regional FC/Ado ADA Coordinator Training” (Foster care & adoption)
    d. *OCP 777 - Indian Child Welfare Act (ICWA)
    e. *OCP 131 – Multi-Ethnic Placement Act (MEPA)/Inter-Ethnic Adoption Provisions Act (IEPA)
    f. *ADA 205 - Part 2: Civil Rights Protections for Individuals with Opioid Use Disorder

Responsibilities

While the DFCS Division Director is responsible for the Division’s Civil Rights and ADA/Section 504 compliance, all DHS/DFCS staff administering DFCS programs, services, and/or activities are required to adhere to DFCS' Civil Rights Compliance policy.

The DFCS Civil Rights and ADA/Section 504 Coordinator is the official designee responsible for ensuring the Division’s compliance with Civil Rights statutes and regulations, including Title VI, the ADA, and Section 504. Such compliance includes but is not limited to: ensuring DFCS customer requests for Reasonable Modifications and the provision of auxiliary aids and services (e.g., assisting DFCS staff with sensory impaired customers). In coordination with the DFCS Civil Rights and ADA/Section 504 Coordinator, DFCS District ADA/Section 504 Coordinators are designated to provide support to the Office of Family Independence relating to compliance with disability related laws, and DFCS Child Welfare Regional ADA Coordinators provide related support for child welfare (adoptions, foster care, and/or child abuse and neglect).

The DFCS Quality Assurance Unit provides various Civil Rights and ADA/Section 504 compliance activities for DFCS' Office of Family Independence. The DHS LEP/SI office provides support to DFCS

regarding matters involving DFCS customers who are LEP. Staff must report concerns and instances of noncompliance with civil rights policies to the DFCS Civil Rights and ADA/Section 504 Coordinator.

For questions regarding this and other Civil Rights and ADA/Section 504 policies/procedures, contact the DFCS Civil Rights and ADA/Section 504 Coordinator.

History

This policy replaces: (1) all prior DFCS Methods of Administration (e.g., executed in 1999 and 2000); (2) DFCS Food Stamp Policy 3030 (General Program Overview: Civil Rights); (3) DFCS Medicaid Policy 2025 (General Program Overview: Title VI/Section 504 Civil Rights); and (4) DFCS TANF Policy 1003 (General Program Overview: Title VI/Section 504 Civil Rights).

Attachments

Attachment A – USDA and HHS Assurances of Nondiscrimination
Attachment B – FNS Instruction 113-1-Data Reporting Attachment A

Attachment A

FY23 Sample Assurance Language for State SNAP Agency Contracts and Subrecipient Agreements

The **[contractor/subrecipient]** agrees to comply with Title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*), Title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.*), Section 504 of the Rehabilitation Act of 1973 (29 U.S.C. 794), the Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq.*), section 11(c) of the Food and Nutrition Act of 2008, as amended (7 U.S.C. 2020), Title II and Title III of the Americans with Disabilities Act (ADA) of 1990 as amended by the ADA Amendments Act of 2008 (42 U.S.C. 12131-12189) as implemented by Department of Justice regulations at 28 CFR part 35 and 36, Executive Order 13166, "Improving Access to Services for Persons with Limited English Proficiency" (August 11, 2000), and all requirements imposed by the regulations issued by the Department of Agriculture to the effect that, no person in the United States shall, on the grounds of sex, including gender identity and sexual orientation, race, color, age, political belief, religious creed, disability, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subject to discrimination under SNAP. This includes program-specific requirements found at 7 CFR part 15 *et seq.* and 7 CFR 272.6.

This assurance is given in consideration of and for the purpose of obtaining any and all Federal assistance extended to the **[contractor/subrecipient]** under the authority of the Food and Nutrition Act of 2008, as amended. Federal financial assistance includes grants, and loans of Federal funds; reimbursable expenditures, grants, or donations of Federal property and interest in property; the detail of Federal personnel; the sale, lease of, or permission to use Federal property or interest in such property; the furnishing of services without consideration, or at a nominal consideration, or at a consideration that is reduced for the purpose of assisting the recipient or in recognition of the public interest to be served by such sale, lease, or furnishing of services to the recipient; or any improvements made with Federal financial assistance extended to the **[contractor/subrecipient]** by the USDA, State agency or local agency. This assistance also includes any Federal agreement, arrangement, or other contract that has as one of its purposes the provision of cash assistance for the purchase of food, cash assistance for purchase or rental of food service equipment or

any other financial assistance extended in reliance on the representations and agreements made in this assurance.

By accepting this assurance, the **[contractor/subrecipient]** agrees to compile data, maintain records, and submit records and reports as required, to permit effective enforcement of nondiscrimination laws and permit authorized State agency and/or USDA personnel during hours of program operation to review and copy such records, books, and accounts, access such facilities and interview such personnel as needed to ascertain compliance with the nondiscrimination laws. If there are any violations of this assurance, USDA, FNS, shall have the right to seek judicial enforcement of this assurance. This assurance is binding on the **[contractor/subrecipient]**, its successors, transferees, and assignees as long as it receives assistance or retains possession of any assistance from USDA. The person or persons whose signatures appear below are authorized to sign this assurance on behalf of the **[contractor/subrecipient].** Attachment A

Sample Assurance Language for U.S. Health and Human Services (HHS) State Agency Contracts and Subrecipient Agreements

ASSURANCE OF COMPLIANCE WITH TITLE VI OF THE CIVIL RIGHTS ACT OF 1964, SECTION 504 OF THE REHABILITATION ACT OF 1973, TITLE IX OF THE EDUCATION AMENDMENTS OF 1972, THE AGE DISCRIMINATION ACT OF 1975, SECTION 1557 OF THE PATIENT PROTECTION AND AFFORDABLE CARE ACT, AND FEDERAL CONSCIENCE AND ANTI-DISCRIMINATION LAWS

*With respect to compliance with 45 C.F.R. Part 88, the signatory is providing assurance of compliance with such Part to the extent it is in effect during the term of the award. Consistent with applicable court orders, the version of Part 88 in effect as of December 2, 2019, is found at 76 Fed. Reg. 9,976-77 (February 23, 2011).

The Applicant provides this assurance in consideration of and for the purpose of obtaining Federal grants, loans, contracts, property, discounts or other Federal financial assistance from the U.S. Department of Health and Human Services.

THE APPLICANT HEREBY AGREES THAT IT WILL COMPLY WITH:

1. Title VI of the Civil Rights Act of 1964, as amended (codified at 42 U.S.C. § 2000d et seq.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 80), to the end that, in accordance with Title VI of that Act and the Regulation, no person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
2. Section 504 of the Rehabilitation Act of 1973, as amended (codified at 29 U.S.C. § 794), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 84), to the end that, in accordance with Section 504 of that Act and the Regulation, no otherwise qualified individual with a disability in the United States shall, solely by reason of her or his disability, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
3. Title IX of the Education Amendments of 1972, as amended (codified at 20 U.S.C. § 1681 et seq.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and

Human Services (45 C.F.R. Part 86), to the end that, in accordance with Title IX and the Regulation, no person in the United States shall, on the basis of sex, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any education program or activity for which the Applicant receives Federal financial assistance from the Department.

4. The Age Discrimination Act of 1975, as amended (codified at 42 U.S.C. § 6101 et seq.), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 91), to the end that, in accordance with the Act and the Regulation, no person in the United States shall, on the basis of age, be denied the benefits of, be excluded from participation in, or be subjected to discrimination under any program or activity for which the Applicant receives Federal financial assistance from the Department.
5. Section 1557 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18116), and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 CFR Part 92), to the end that, in accordance with Section 1557 and the Regulation, no person in the United States shall, on the ground of race, color, national origin, sex, age, or disability be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any health program or activity for which the Applicant receives Federal financial assistance from the Department.
6. As applicable, the Church Amendments, as amended (codified at 42 U.S.C. § 300a-7), the Coats-Snowe Amendment (codified at 42 U.S.C. § 238n), the Weldon Amendment (e.g., Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriations Act, 2019, Div. B., sec. 507(d), Pub. L. No. 115-245, 132 Stat. 2981, 3118 (Sept. 28, 2018), as extended by the Continuing Appropriations Act, 2020, and Health Extenders Act of 2019, Pub. L. No. 116-59, Div. A., sec. 101(8), 133 Stat. 1093, 1094 (Sept. 27, 2019)), Section 1553 of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18113), and Section 1303(b)(4) of the Patient Protection and Affordable Care Act, as amended (codified at 42 U.S.C. § 18023(b)(4)), and other Federal conscience and anti- discrimination laws, including but not limited to those listed at www.hhs.gov/conscience/conscience-protections, and all requirements imposed by or pursuant to the Regulation of the Department of Health and Human Services (45 C.F.R. Part 88), to the end that the rights of conscience are protected and associated discrimination and coercion are prohibited, in any program or activity for which the Applicant receives Federal financial assistance or other Federal funds from the Department for which the Federal conscience and anti-discrimination laws and 45 C.F.R. Part 88 apply.

The Applicant agrees that compliance with this assurance constitutes a condition of continued receipt of Federal financial assistance, and that it is binding upon the Applicant, its successors, transferees and assignees for the period during which such assistance is provided. If any real property or structure thereon is provided or improved with the aid of Federal financial assistance extended to the Applicant by the Department, this assurance shall obligate the Applicant, or in the case of any transfer of such property, any transferee, for the period during which the real property or structure is used for a purpose for which the Federal financial assistance is extended or for another purpose involving the provision of similar services or benefits. If any personal property is so provided, this assurance shall obligate the Applicant for the period during which it retains ownership or possession of the property. The Applicant further recognizes and agrees that the United States shall have the right to seek judicial enforcement of this assurance.

Attachment B

FNS Instruction 113-1

XII. Data Collection and Reporting

FNS Headquarters and Regional Offices, State agencies, local agencies, and other subrecipients must provide for and maintain a system to collect the racial and ethnic data in accordance with FNS policy. These data will be used to determine how effectively FNS programs are reaching potential eligible persons and beneficiaries, identify areas where additional outreach is needed, assist in the selection of locations for compliance reviews, and complete reports as required.

A. Collecting and Reporting Participation Data

1. State agencies, local agencies, and other subrecipients are required to obtain data by race and ethnic category on potentially eligible populations, applicants, and participants in their program service area.
2. Systems for collecting actual racial and ethnic data must be established and maintained for all programs. FNS requires recipients of Federal financial assistance to ask all program applicants and participants to identify all the racial categories that apply. This is consistent with existing OMB guidance. OMB states: "Respect for individual dignity should guide the processes and methods for collecting data on race and ethnicity; ideally, respondent self-identification should be facilitated to the greatest extent possible, recognizing that in some data collection systems observer identification is more practical." FNS also believes that self-identification or self-reporting is the preferred method of obtaining characteristic data. Program applicants and participants should be encouraged to provide the information by explaining the use of the statistical data. The following is an example that may be utilized when soliciting characteristic data from a program applicant/participant:

   "This information is requested solely for the purpose of determining the State's compliance with Federal civil rights laws, and your response will not affect consideration of your application, and may be protected by the Privacy Act. By providing this information, you will assist us in assuring that this program is administered in a nondiscriminatory manner." If the applicant declines to self-identify, the applicant should be informed that a visual identification of his or her race and ethnicity will be made and recorded in the data system.

   In instances where demographic data, specifically racial/ethnic data, is collected via an online system, provisions must be made for the program applicant/participant to self-identify. Once the data is collected via the online system, the program applicant/participant must then be able to verify this data by signing some type of summary printout of this information or correctness and accuracy of the data in some manner.

3. Such systems must ensure that data collected about potentially eligible persons, program applicants, and participants are:
   a. Collected and retained by the service delivery point for each program as specified in the program regulations, instructions, policies, and guidelines,
   b. Based on documented records and maintained for 3 years,
   c. Maintained under safeguards that restrict access of records only to authorized personnel, and,

d. Submitted, as requested, to the FNS Regional or Headquarters Offices.

4. Race and Ethnic Categories, Two-Question Format: To provide flexibility and ensure data quality, separate categories shall be used when collecting and reporting race and ethnicity. Ethnicity shall be collected first. Respondents shall be offered the option of selecting one or more racial designations. Recommended instructions accompanying the multiple response for race should specify "Mark one or more" or "Select one or more." The minimum designations for collection are:

   a. Ethnicity:

      1. *Hispanic or Latino.* A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term "Spanish origin" can be used in addition to "Hispanic or Latino."

      2. *Not Hispanic or Latino.*

   b. Race:

      1. *American Indian or Alaskan Native*. A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

      2. *Asian*. A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent, including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

      3. *Black or African American.* A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to 'Black or African American.'

      4. *Native Hawaiian or Other Pacific Islander*. A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

      5. *White*. A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

5. A State agency may have categories for race in addition to the ones required by FNS; however, the additional categories must be mapped and extracted to the FNS- required categories. Provision shall be made to report the number of respondents in each racial category who are Hispanic or Latino.

6. Program applicants/participants may not be required to furnish information on their race or ethnicity unless this information is necessary to determine the applicant's eligibility to receive a benefit or to determine the amount of benefit to which an eligible participant may be entitled. Self-identification by the applicant/participant is the preferred method of obtaining characteristic data. Where an applicant does not provide this information, the data collector shall through visual observation secure and record the information where possible. However, the data collector may not "second guess," or in any other way change or challenge a self-declaration made by the applicant as to his or her race or ethnic background unless such declarations are patently false.

Refer to FNS Program appendices for additional information.

B. Determining the Eligible Population. State agencies must identify the population of potentially

eligible persons to participate in an FNS program by racial and ethnic data category for each service delivery area, project area or county. The information may be derived from standard statistical sources such as reports issued by the U.S. Census Bureau or Bureau of Vital Statistics. State agencies may also use data or information collected by other Federal and State agencies (e.g., Department of Education (DOEd).)

Appendix A: Food Stamp Program (FSP)

I. Data Collection

As specified at 7 CFR Part 272.6(g), State agencies must obtain racial and ethnic data on participating food stamp households and report the information to FNS on the *FNS 101, Participation in Food Programs*. State agencies may request applicant households to identify voluntarily their race and ethnicity on the application form. The application form must clearly indicate that the information is voluntary, that it will not affect the applicant's eligibility or benefit level, and that the information is to assure that program benefits are distributed without regard to race, color, or national origin. The data must be maintained on file for 3 years.

State agencies are responsible for using current racial or ethnic data to determine if the program is reaching potentially eligible, low-income households. Unexplained discrepancies in participation data that indicate a project area is not in compliance with CR requirements must be reviewed or investigated further. Trend analyses must also be conducted to determine if significant changes in racial and ethnic data warrant further review or investigation.

Appendix C: Food Distribution

D. DATA COLLECTION AND REPORTING (Section VI)

State agencies and local agencies or other subrecipients that operate FDPIR and CSFP must collect and maintain racial or ethnic data as specified below. The other commodity programs listed under this Appendix are exempt from this requirement.

Participant Racial or Ethnic Data Collection and Retention

The State agency must establish a system for collecting and maintaining racial or ethnic participation data. Recording the racial or ethnic identification of applicants and participants may include the utilization of self-identification where a written application is required. Other methods of recording such data may include card files, rosters, logbooks, or any written record used by local agencies or other subrecipients. The racial and ethnic identification categories are listed in the Definitions section of this Instruction at Section V. The State agency must:

1. Ensure that racial or ethnic participation data is collected by the local agency or other subrecipient and retained at the service delivery point.
2. Ensure that documentation for the data collected by the local agency or other subrecipient is on file and maintained for the required 3 years. Data obtained shall be made available at the time of each compliance review by the State agency or FNSRO.
3. Use Form FNS-101, Participation in Food Programs – By Race, to record and submit to FNS racial or ethnic participation data for FDPIR households. Use Form FNS-191, Racial or Ethic Group Participation – Commodity Supplemental Food Program, to record and submits to

FNS racial or ethnic participation data for CSFP households. These reports must be submitted in accordance with the instructions contained on the respective forms.

4. Ensure that access to data is limited to authorized personnel.

2050 Application Processing

2050 Application Processing Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Application Processing Overview		
	Effective Date:	September 2024		
	Chapter:	2050	**Policy Number:**	2050
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-73

Requirements

The Medical Assistance application process begins with the agency's receipt of a signed application for assistance and is complete upon notification to the Assistance Unit (AU) of the eligibility determination.

Basic Considerations

Request for Information and Application

An inquiry regarding public assistance programs can be made at any time, either in person, by mail, by telephone, fax, secure email, or at another designated agency. Information regarding public assistance programs must be provided to any individual without requiring that an application be filed.

An application **must** be provided to anyone **upon request**.

An application may be requested in person, by mail, telephone, facsimile, secure e-mail, or at any designated agency.

Where to Apply

The A/R may apply for Medical Assistance at numerous locations throughout the state. These include the local county DFCS office, Social Security Administration, health departments, and some hospitals and nursing homes. The A/R may apply online at www.gateway.ga.gov/. Applications are also available at local RSM Assistance Group offices. The A/R can use the Georgia Department of Community Health website (dch.georgia.gov/) to locate an application.

Who May Apply

Anyone may apply for Medical Assistance benefits, including the following individuals:

- the individual requesting assistance
- an authorized representative (AREP) acting on behalf of the applicant. The AREP can be a relative, friend, guardian, or any person in a position to know the applicant's circumstances. An elected AREP may have verbal or written designation. If the designation is written, the applicant's signature is required.
- the parent, specified relative or individual who provides/provided care and control of a child or

deceased individual

- an individual acting on behalf of an AU, including a representative of a private law firm or cost recovery company
- a child requesting assistance for himself/herself
- a Medicaid provider, via Newborn Eligibility Certification Form or via the web portal.

DMA Form 550 is no longer used. DMA Form 551 is used for twins only.

The applicant/recipient (A/R) is the primary source of information for him/herself. The A/R may authorize an AREP to apply and provide information on his/her behalf, however the A/R is considered the best source of information and must be contacted to confirm that the information received is correct. This may be accomplished either by telephone, by mail, or in person, unless contact is precluded by physical or mental limitations of the A/R.

A face-to-face interview is **NOT** a requirement of any Medicaid Class of Assistance (COA).

The A/R may withdraw, at any time, authorization for an AREP to act on his/her behalf. This request should be made in writing and signed by the A/R.

An application may be filed on behalf of a deceased individual. Refer to Section 2068 - Special Considerations.

The Completed Application

A complete application consists of a signed (either written or electronic such as on a Gateway application) application submitted with a name and information adequate to contact the applicant or AREP. A typed name on the signature line of a paper application is not acceptable. It is **NOT** necessary for the applicant to complete all questions, as missing or incomplete information may be obtained by telephone, by mail, fax, secure email, or in person. See Section 2060 - ABD Medicaid Application Processing and Section 2065 - Family Medicaid Application Processing for more program specific instructions.

An application received from the Federally Facilitated Marketplace (FFM) which has been assessed as potentially eligible for Medical Assistance should be processed based on the information provided in the application. Do not request additional or duplicate information that has already been obtained by the FFM.

Assist the AU as needed to complete the application form.

The application form may be completed by the applicant, an AREP, or an agency representative. An application must be accepted without prior screening or interview.

An individual has the right to file an application on the day of initial request for benefits. The agency will not refuse anyone the right to same day filing. The agency must inform the individual of the right to file an application on the same day s/he or his/her AREP contacts the agency in person, by telephone, mail, facsimile or secure email, expressing interest in obtaining assistance.

If an individual requests an application by mail, the right to same day filing is met if the application is mailed to the individual on the same day s/he makes the request to the agency.

“Right to Same Day Filing” affects the following:

- beginning date for processing standard
- determination of which three prior months may be considered for eligibility

Application Date

The date of application is the date the application form is received by the county office, whether in person, or by mail. When received via internet or facsimile, the date of application is the date the form was transmitted.

The application date is the day an application is received by a health department, disproportionate share hospital, public hospital or a federally funded, 330 health center, regardless of when the application is forwarded to the county office for processing.

Application Processing

An application must be registered within 24 hours of receipt by the agency.

Eligibility for Medical Assistance must be determined under all COAs before an application is denied. Refer to Section 2052 - Continuing Medicaid Determination (CMD).

Eligibility for Medicaid coverage for the three months prior to the month of application must be considered for every Medical Assistance application filed.

Completion of the application process is defined as notification to the applicant of the approval or denial of Medical Assistance benefits.

An individual may withdraw an application for Medical Assistance at any time during the application process. A withdrawn application must be registered and denied. The applicant must be notified of the disposition of the withdrawn application.

Refer to Section 2011 - Health Information Portability and Accountability Act for information regarding privacy of health information.

If an individual receives Medical Assistance, and it is determined that documents are inconsistent with pre-existing information, are counterfeit or altered, the Division of Family and Children Services shall investigate for potential fraud and abuse and refer to Georgia Department of Community Health, Office of Inspector General; in Metro Atlanta (404)463-7590, and statewide at (1-800-533-0686); by email oiganonymous@dch.ga.gov; by mail at Department of Community Health, OIG PI Section, 2 Martin Luther King Jr Drive SE, 19th Floor, East Tower, Atlanta, GA 30334; or visit dch.georgia.gov/report-medicaidpeachcare-kids-fraud. Refer to (Section 2060 - ABD Medicaid Application Processing and Section 2065 - Family Medicaid Application Processing).

2051 Verification

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Verification		
	Effective Date:	September 2024		
	Chapter:	2050	**Policy Number:**	2051
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-73

Requirements

Verification is the use of electronic data sources/computer matches, related active program(s), client statements, documents, collateral contacts with a third party, home visits, computer matches and documentation which confirm the accuracy of statements and information.

Basic Considerations

This verification policy applies at the following times:

- application
- renewals
- interim changes

An assistance unit (AU) may provide verification using any of the following methods:

- via mail
- secure e-mail
- in person
- by facsimile or other electronic device
- through an authorized representative (AREP)
- by upload through Gateway or Document Imaging System (DIS) self-service kiosk
- through a Community Partner agency

The agency may not require the AU to present verification in person.

Self-Attestation

Eligibility determinations must be based, to the maximum extent possible, on self-attestation of income that is verified by information from electronic data sources. When information from electronic data sources is consistent with an individual's attestation of income, the income is considered verified.

Self-attestation may be accepted from the following:

- The applicant

- An adult in the applicant's household
- An authorized representative (AREP)
- Someone acting responsibly for the individual (if the individual is a minor or incapacitated)

If verification is received by another program (e.g. SNAP or TANF), the verification should be used for Medical Assistance as well.

Resolving Inconsistencies

If there is a mismatch of information between what is provided to the agency by an A/R and the available electronic data sources, the EW must determine which source is most reliable or if the A/R needs to provide additional verification.

1. If the A/R's statement and electronic data sources are above the applicable income limit, no additional verification is required. Enter the income as A/R's attestation.
2. If both sources are at or below the applicable income limit, no additional verification is needed. Enter the income as A/R's attestation but code as Other Acceptable Verification (OAV) and document.
3. If electronic source is above the applicable income limit and client attestation is below the applicable income limit, request 3rd party verification to verify income and deductions.
4. If the A/R attests to income over the applicable income limit and electronic data source has income below the applicable limit, take the A/R's attestation.
5. Refer ineligible adults or child(ren) to the Federally Facilitated Marketplace (FFM).

If the A/R's attestation of self-employment income exceeds all applicable income limits, no additional verification is required. Enter the self-employment as the A/R's attestation.

Client Statement

Client statement is accepted as verification for all criteria of Family Medicaid except for the following:

- resources (for non-MAGI COAs) Refer to Section 2301 - Family Medicaid Resources Overview
- citizenship/immigration status/identity

  See Section 2215 - Citizenship/Immigration/Identity for complete policy regarding procedures for verifying citizenship/immigration status/identity.

- medical bills used in determining eligibility for Medically Needy Medicaid
- questionable information
- MAGI Deductions. Refer to Section 2655 - Family Medicaid Deductions

Client statement is acceptable for income verification in Pregnant Women and Newborn COAs.

Client statement is accepted as verification for all Q-Track criteria in ABD Medicaid, except for citizenship/immigration status/identity, or when circumstances are questionable.

The eligibility worker must document that the client's statement was accepted or the reason why the information was questionable, and the method chosen to verify the information. Annotation of client statement in the verification field is acceptable documentation that client statement is accepted as verification.

Medicaid Verifications

The following situations must be verified from the source.

- Citizenship/immigration status/identity must be verified for all COAs. Refer to Section 2215 - Citizenship/Immigration/Identity for acceptable forms of verification.

  > Verification of immigration status is not required if eligibility is determined using Emergency Medical Assistance (EMA) procedures.

- If a pregnant woman is claiming multiple births, the number of fetuses is not required to be medically verified to increase the size of the budget group unless questionable. If questionable, document in case notes why verification is required. If verification is not returned, the pregnant woman would count as a BG of 2.
- Resources must be verified for Family Medicaid Medically Needy if the total value of the resources is at or above 75% of the resource limit. Refer to Section 2301 - Family Medicaid Resources Overview.
- Medical bills used to meet Medically Needy Spenddown.
- Any questionable situation or information must be verified. Verification must be requested for any information provided by the applicant/recipient that conflicts with information known to the agency, or that is otherwise questionable. Document the reason that the information is conflicting and/or questionable.
- For ABD Medicaid verification requirements, see the sections pertaining to the specific COA and the Income and Resource Chapters.

The applicant/recipient's statement is acceptable as verification for all other Family Medicaid and Q-Track eligibility situations.

Verify information, if required, to determine eligibility as follows:

- Utilize Data sources prior to requesting any verification that cannot be located through the data sources.
- Determine if verification is available from agency sources prior to requesting verification from the AU.
- Requests for verification may be made verbally but must also be made in writing. The request for verification is provided to the applicant/recipient and, if applicable, the AREP.
- Verbally or orally inform the applicant/recipient of any contacts that will be made with the verification source by the agency.
- Allow sufficient time for the applicant/recipient to obtain verification.
- Allow additional time to provide verification if requested by the applicant/recipient and the request is made within the SOP.

- If incomplete verification is returned, send another checklist specifying what is required; establish a new reasonable deadline for returning requested verification.
- Consider verification received for one program to be received for all programs.
- Accept the applicant/recipient's oral or written statement as verification when allowed by policy.
- Do not require verification if the applicant/recipient's oral or written statement establishes ineligibility (e.g. c/s of self-employment exceeds all applicable income limits, then no additional verification is required).
- All Medical Assistance cases (except QMB and P4HB COAs) that close for failing to return verification will be reinstated if all the verification is returned within **90 days of closure**; an application will not be required. Refer to Section 2706 - Medicaid Renewals.

Third Party Verification

Third party verification includes the following:

- documents – legal agreements, contracts, bills, leases, medical or doctor's statements, prescription receipts, check stubs, employer statements, social security cards, driver's license, etc.
- collateral contacts – an oral or written statement from a third party, contact with a social service agency, etc.

> A collateral contact alone is not sufficient for verification of income. Documentary evidence such as a signed statement or Form 809 must be received, with the collateral contact made to validate. For more information, please see Collateral Contacts section below.

- home visits – visits made by DFCS personnel or other state, local, community or federal agencies to confirm the accuracy of statements and information.
- documentation – staff recording of AU's statements, information and observations.
- Data sources/computer matches – Gateway interface with other federal, state and local computer systems to compare and provide data regarding AU recipients.

> This list is not all-inclusive.

The AU has the primary responsibility for providing verification to support statements or to resolve questionable information. The AU should be given sufficient time to verify information. When the value of a vehicle is obtained through blue book/NADA etc. and the listed value puts the AU over the resource limit, the AU must be given the opportunity to produce evidence of the value of the vehicle from someone who would have the expertise to make that determination such as a dealership.

The agency is responsible for assisting applicants/recipients in obtaining verification when the applicant/recipient requests assistance. Refer to Section 2020 - Americans with Disability Act (ADA) and Section 504.

The agency must accept reasonable verification.

Documents

When possible, documents are used as the primary source of verification. Documents provide written evidence of the AU's statements. Documents or photocopies of documents are filed in the case record and/or scanned into the Document Imaging System (DIS) as proof of the AU's circumstances. All documents scanned into DIS will be tagged, at a minimum, with the Client ID(s) of the individual(s) the document(s) pertain(s) to, the ID(s) of the case(s) impacted, and with the appropriate document "type" (e.g. pay stubs as Proof of Income).

Collateral Contacts

A collateral contact is an oral or written confirmation of the AU's circumstances by a non-AU member. The collateral contact may be made in person, over the telephone, or in writing.

A collateral contact alone is not sufficient for verification of income. Documentary evidence such as a signed statement or Form 809 must be received, with the collateral contact made to validate.

If a written statement is provided by the collateral contact, the statement must be signed by the individual who wrote the statement. The statement should be dated but, if not dated, DFCS must date stamp or record on the statement the date it is received. The telephone number and/or address or way to contact the collateral contact must be furnished. This information may be provided as a part of the written collateral statement or recorded in the case file.

If a collateral statement is unacceptable to the agency because it is not completed correctly or lacks the required information and the AU is cooperating with providing information, then the agency must offer assistance to the AU. The agency may ask the AU to provide another collateral contact or contact the collateral contact directly.

The agency may substitute a home visit or select an alternative form of verification if circumstances warrant.

The agency must make sure that the AU understands what information is needed from the collateral contact. The request for verification form should specify what information is needed and the preferred format.

When taking a collateral statement on the telephone or in person, document in the case file the name, address, or telephone number of the contact, the date of the contact and the collateral contact's statements regarding the AU.

The agency may select a collateral contact if the AU fails to designate one or designates one who is unacceptable to the agency. Examples of acceptable collateral contacts include employers, landlords, neighbors, social service agencies, etc.

When speaking with a collateral contact, the agency must disclose only the information that is absolutely necessary to obtain the information being sought. Avoid disclosing the following information:

- that the AU has applied for/is receiving benefits
- information supplied by the AU
- information that cannot be released to anyone, including the AU, as provided in Section 2010 -

Confidentiality.

- that the AU is suspected of any wrongdoing.

> The intent of this policy is to minimize the disclosure of information. Refer to Section 2010 - Confidentiality and Section 2011 - Health Information Portability and Accountability Act.

Refer to Section 2001 - Computer Matches Overview, Section 2002 - Income and Eligibility Verification System (IEVS) and Section 2004 - Clearinghouse. These sections provide policy regarding verification of case information by computer matching.

If appropriate, prearranged home visits may be used as verification. DFCS employees may use home visits if any of the following situations occur:

- Third party verification is insufficient to make a firm determination of eligibility.
- Third party verification cannot be obtained and the AU's statement is questionable.

> A home visit cannot be made or used as verification solely because an AU fits the profile of an error-prone AU as determined by the agency.

Documentation

Case files must be documented in accordance with the standard documentation requirements. Case notes, the Document Imaging System (DIS) and Gateway together are considered the case file. A written recording of the information and statements provided by the AU is considered verification. This is the AU's statement of its circumstances. The agency may also request that the AU make a separate, written statement to verify and/or clarify a specific point of eligibility.

Procedures

Verify AU information as provided by the policy found in the manual.

2052 Continuing Medicaid Determination

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Continuing Medicaid Determination		
	Effective Date:	July 2023		
	Chapter:	2050	**Policy Number:**	2052
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-70

Requirements

Eligibility must be reviewed under all Medicaid Classes of Assistance (COAs) before denying a Medical Assistance application or an individual in a Medicaid Assistance Unit (AU), and prior to termination of ongoing Medicaid eligibility for an entire AU or individual in an AU. For individuals who have been terminated SSI, DFCS will redetermine their Medicaid eligibility prior to DCH terminating their Supplemental Security Income (SSI) Medicaid.

Basic Considerations

Do **not** deny or terminate Medicaid eligibility before completing a Continuing Medicaid Determination (CMD) to consider eligibility under all other Medicaid COAs.

Complete a CMD on all SSI terminations that appear on DCH generated reports or transmitted via the Ex-Parte interface. Refer to 2750 DCH Reports-Ex Parte Lists for processing instructions.

> If the MES becomes aware of A/Rs who, because of an SSI denial/termination, have been inappropriately receiving Medicaid under an Ex Parte COA, follow the same instruction found in 2750 DCH Reports-Ex Parte Lists.

Process the CMD according to which COA is most advantageous to the applicant/recipient (A/R).

Any Medicaid application form may be used to consider eligibility under any Medicaid COA. However, additional requirements may need to be satisfied depending on the specific COA under consideration. EXAMPLE: A Form 700 used for another ABD COA may require verification. Refer to 2060 ABD Medicaid Application Processing and 2065 Family Medicaid Application Processing for acceptable application forms.

ABD Medicaid

For ABD Medicaid, consider eligibility under all COAs in the following order:

- FBR COAs
- LA-D/Medicaid CAP COAs
- Q-Track COAs
- AMN

Q-Track COAs may be approved while the A/R is waiting to meet an ABD Medically Needy spenddown. Refer Medicare recipients to Georgia SHIP (formerly known as GeorgiaCares) for help with applying for Medicare Part D. See 2931 Medicare Part D and Low-Income Subsidy.

QI-1 recipients cannot be dually eligible ongoing with another COA with exception of AMN.

Family Medicaid

For Family Medicaid, consider eligibility in the following order:

- Newborn
- Pregnant Women
- Parent/Caretaker
- Other Family Medicaid COAs based on Parent/Caretaker eligibility criteria, i.e., TMA, 4MEx
- Children Under 19
- PeachCare for Kids®
- Family Medicaid Medically Needy
- Women's Health Medicaid (WHM)
- Pathways
- Planning for Health Babies®

If all verification requirements are met for Pregnant Women and/or Children Under 19, eligibility may be approved for either of these COAs while eligibility is being determined under Parent/Caretaker.

Medicaid eligibility for a child in foster care is determined first under the IV-E FC program. If ineligible under the IV-E FC program, Medicaid eligibility is determined under CWFC Medicaid.

Chafee Independence Program Medicaid

Reference 2818 Chafee Independence Program Medicaid for eligibility criteria and procedures for Revenue Maximization, RSM Project and county offices.

CMD Application Requirements

A new application is **not** required at CMD when eligibility for a COA is terminated, and previously eligible AU members are subsequently approved for another COA.

A new application is **not** required if the previously eligible AU received a Q-track Medicaid COA based on an original application filed using Form DCH 700.

A new application is not required while completing a CMD for an AU member that is going to a higher or lower COA. For Family Medicaid, if the existing AU has trickled to a lower COA, a new application is required in order to process a CMD to a higher COA (such as from Children under 19 to Parent/Caretaker) if you are adding an existing BG member or new individual to the AU. If a CMD

is processed to a higher COA, and all of the existing AU members are still covered (such as from TMA to Parent/Caretaker) a new application is not required. Refer to 2065 Family Medicaid Application Processing.

A new application is **never** required when approving Newborn Medicaid COA.

CMD Interview Requirements

An interview is not required as part of the CMD process, including when adding an individual to an existing AU and when a new individual is included in the approval of a new COA as part of the CMD process. It may be necessary, however, to contact the AU by telephone, by mail or in person if the new COA requires information not included at the time of application for the terminated COA.

Procedures

ABD and Family Medicaid

Follow the steps below to complete a CMD for an ABD or Family Medicaid denial or termination:

Step 1 Consider eligibility under all COAs (both ABD and Family Medicaid) prior to denial or termination of Medicaid.

Step 2 Approve Medicaid under the COA that will provide the most medical coverage if the A/R meets all eligibility requirements for the COA.

Step 3 Deny or terminate Medicaid if the A/R does not meet the requirements for any Medicaid COA.

Step 4 Notify the A/R of his/her Medicaid eligibility as follows:

- Send **adequate** notice when completing the CMD on an application or changing COAs for a current Medicaid recipient
- Send **timely** notice if the CMD results in termination of Medicaid eligibility or the reduction of Medicaid benefits for a current recipient.

When completing CMD from Parent/Caretaker to TMA or 4MEX, timely notice is required.

SSI Terminations

Federal Law mandates that a CMD be completed on all SSI terminations before Medicaid can be terminated by DCH. As part of this CMD process, DCH will determine if continued eligibility:

- should exist under SSA Section 1619(a) or (b) Work Incentives and, therefore, should be referred to SSA (See 2579 SSI 1619 Individuals);

  OR

- exists under another Medicaid coverage group and switch the individual to this new Medicaid coverage group.

As part of the automated Ex-Parte process, reports listing the names of individuals who have been

converted to a new coverage group will be generated and received via Gateway. Refer to 2750 DCH Reports-Ex Parte Lists for specific instructions on how to complete the CMD process for an A/R terminated from SSI.

The Personal Responsibility and Work Opportunity Act of 1996, commonly referred to as the Welfare Reform Act, specifically prohibits individuals wanted in connection with a felony or in violation of the terms of their parole or probation or an outstanding warrant, from receiving SSI, Food Stamps, TANF benefits, and federal housing assistance. There is no prohibition written into federal law that prohibits these so called “fugitives” from receiving Medicaid. If someone is terminated from SSI due to their “fugitive” status Medicaid cannot be denied for the same reason. The fugitive could still be eligible for Medicaid provided he/she meets the requirements for some other group covered under the State’s Medicaid plan, such as the Adult Medically Needy program.

2053 Retroactive Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Retroactive Medicaid		
	Effective Date:	June 2021		
	Chapter:	2050	**Policy Number:**	2053
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-64

Requirements

Retroactive Medicaid provides Medicaid coverage for eligible individuals for the following time periods:

- Three months prior to the month of application for ABD Medicaid, Family Medicaid and Supplemental Security Income (SSI).
- SSI Intervening months - the month of application through the month of case disposition for SSI.

Basic Considerations

SSI Intervening Months

SSI Intervening Months are defined as follows:

- the month of SSI application through the month of case disposition

Prior Months

Prior Months are defined as any of the following:

- the three months prior to the month of a Medicaid application (ABD or Family Medicaid) filed with DFCS
- the three months prior to the month of SSI application

DFCS determines eligibility for an SSI intervening Month only if SSI was denied for a financial reason or for a non-financial reason other than failure to meet disability.

Chafee Independence Program Medicaid was authorized as of July 1, 2008. No prior months are available under this COA prior to this date. Former Foster Care Medicaid was authorized as of January 1, 2014. No prior months are available under this COA prior to this date. Parent/Caretaker with Child(ren) Medicaid was authorized as of January 1, 2014. Prior months are available under Low Income Medicaid (LIM) regulations only. Children Under 19 Years of Age Medicaid was authorized as of January 1, 2014. Prior months are available under Right from the Start (RSM) Medicaid regulations only.

Eligibility may be determined for each retroactive/SSI intervening month under any ABD or Family Medicaid Class of Assistance (COA), regardless of the ongoing disposition of the application. See SSI

prior month exceptions on page 3.

Potential eligibility for Medicaid for all retroactive/SSI intervening months is protected indefinitely for all Medicaid COAs including SSI. Medicaid can be approved at any time for any retroactive month if all eligibility criteria are met. (See “Prior Months for SSI Applicants” in this section for exceptions for use of SSI COA for SSI applicants).

DFCS does not make a determination on the same prior month(s) more than one time if the initial determination was a financial denial (over income, over resources, etc.) or a basic eligibility denial (citizenship/immigration status/identity, residency, disability, etc.).

For retroactive/SSI intervening months, the following criteria are not required:

- enumeration
- application for other benefits
- cooperation with DCSS

Eligibility may be reconsidered for any month in which the denial was for a procedural reason (i.e. failure to provide verification, lack of information, etc.)

The A/R does not have to be re-interviewed or sign forms that were previously completed for the retroactive/SSI intervening month(s).

Medicaid eligibility is determined only for prior months in which the AU has incurred a Medicaid covered expense that remains unpaid. Verification of the expense is not required.

Services covered by Medicaid and **NOT** requiring Prior Authorization will be paid for approved retroactive months.

Do not make a DCSS referral if Medicaid is approved for retroactive Medicaid only.

Medicaid may be requested for the three prior months when adding an individual to a case. The day the request to add an individual is made determines the three prior months time period and is the application date for determining the three months prior.

Prior Month for SSI Applicants

Effective for all SSI applications filed on or after August 22, 1996, Social Security will not issue an SSI check for an eligible individual for the month of SSI application. The first month an SSI payment is made is the first month following the month of application, or the first month following the month that the individual becomes eligible for SSI with respect to that application, whichever is later.

The SSI status for the first month of payment is C01; the SSI status for the preceding month is E02. However, the E02 month is not an automatically Medicaid eligible month in DCH’s system unless it is followed by a month in pay status (C01). In those instances, treat the E02 month as a prior month.

The first month of SSI payment is not relevant to prior month(s) eligibility. The three months prior for an approved or denied SSI application are the three months prior to the month of SSI application.

Determine eligibility under any Medicaid COA for the **first and/or second month(s)** prior to the month of an **approved** SSI application.

Determine eligibility for the **third month** prior to the month of an **approved** SSI application under **any** Medicaid COA **except** SSI Medicaid.

EXAMPLE: If the SSI application month is January, the first prior month is December, the second prior month is November, and the third prior month is October.

Determine eligibility under any COA for the three months prior to an SSI **denial.**

Do **not** determine Medicaid eligibility for any month prior to a SSI application until SSA has completed its determination. Once SSA has made the determination, determine eligibility for the three months prior using the procedures outlined in this section. Abide by decisions made by SSA for intervening months except when Medicaid policy for a particular COA differs from SSI policy.

Determine retroactive ABD Medicaid eligibility through the month of death for the following individuals:

- An individual who dies **prior** to applying for SSI
- An individual who dies **after** applying for SSI

SSA will complete the SSI application process for a deceased individual only if s/he has a surviving spouse. If SSI is approved, SSI will be awarded for the month following the month of application through the month of the A/R's death.

Procedures

Retroactive Months

Follow the steps below to determine retroactive Medicaid Eligibility.

Step 1 For Family Medicaid, determine the AU and BG for each month requested. Refer to Chapter 2600, Assistance Units, for Family Medicaid.

For ABD Medicaid, determine financial responsibility for each month. Refer to 2500 ABD Financial Responsibility and Budgeting Overview.

An interview is not required. Additional required information may be obtained by telephone or by mail. Contact the A/R or personal representative (PR) acting on his/her behalf. A PR may provide information for a deceased A/R. This person should be knowledgeable about the A/R's circumstances

Step 2 Determine for which month(s) retroactive Medicaid is being requested and establish a class of assistance (COA) for each month. Refer to Chapter 2100, Medicaid Classes of Assistance.

Step 3 Establish basic eligibility criteria for each month. Refer to Chapter 2200, Basic Eligibility Criteria.

If the A/R applies for prior months as a disabled individual, disability must be verified for each prior month. Refer to 2205 Aged, Blind, Disabled Requirement for ABD Medicaid.

Step 4 Determine financial eligibility for each month. Refer to Chapters 2500, ABD Financial Responsibility and Budgeting and 2650, Family Medicaid Budgeting.

- Use actual income and expenses for prior months.
- Use anticipated income and expenses for intervening months or actual income if available.

For Family Medicaid COAs, if multiple, non-financial changes occurred in a retroactive month, use the circumstances on any day of the month that is most advantageous to the AU in determining eligibility.

Step 5 Budget each prior month separately using the budgeting procedures for the COA chosen for that month.

Step 6 Approve Medicaid under the appropriate COA if the A/R meets all eligibility criteria. Deny any ineligible months.

If any AU members are ineligible, complete a CMD to consider Medicaid eligibility under all other COAs. Refer to 2052 Continuing Medicaid Determination.

Step 7 Notify the AU.

For MN cases, include the Begin Authorization Date (BAD) and spenddown information, if required.

Step 8 Complete a Form 962 only if the retroactive month(s) cannot be transmitted electronically (i.e. more than 13 in the past and cannot be entered on GA Gateway). If Form 962 is necessary, annotate Form 962, “Please enter manually, cannot transmit via GA Gateway”. Forward Form 962 to the Gainwell Technologies Contact Center and upload a copy of the form with fax transmission report through Document Management in GA Gateway. Refer to Appendix C for the Member Contact Center mailing address.

2054 Emergency Medical Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Emergency Medical Assistance		
	Effective Date:	November		
	Chapter:	2050	**Policy Number:**	2054
	Previous Policy Number(s):	MT 70	**Updated or Reviewed in MT:**	MT-71

Requirements

Emergency Medical Assistance (EMA) provides medical coverage to individuals who meet all requirements for a Medicaid Class of Assistance (COA) except for citizenship/immigration status and enumeration requirements and have received an emergency medical service.

EMA does **not** provide coverage for Planning for Healthy Babies®, PeachCare for Kids®, Pathways, Nursing Home, or Waivered COAs. Other COAs such as AMN may provide potential coverage for those in LA-D.

Basic Considerations

A non-qualified immigrant applicant is potentially eligible for EMA under any Medicaid COA (except for P4HB, PCK, Pathways, NH, IH, EDWP, ICWP, NOW/COMP, Katie Beckett, or Hospice).

The applicant must meet all eligibility criteria for the COA with the following **exceptions**:

- citizenship/immigration status
- enumeration

Approval for EMA will be for a service that was provided prior to the date of application. Emergency Medical Assistance applications are not to be approved prior to an emergency, including labor and delivery. **No future eligibility dates are to be used.**

Chafee Independence Program Medicaid was authorized as of July 1, 2008. No EMA is available under this COA prior to this date.

Emergency Medical Assistance provides payment for the treatment of emergency services as defined in federal law in 1903 (v) of the Social Security Act and 42 CFR 440.255 when such care and services are necessary for the treatment of an emergency medical condition, provided such care and services are not related to either an organ transplant procedure or routine prenatal or postpartum care. An emergency is defined as acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- placing the patient's health in serious jeopardy
- serious impairment of bodily functions; or
- serious dysfunction of any bodily organ or part

Services can include labor and delivery, from active labor until delivery is complete and mother and baby are stabilized.

A physician must determine the need for an emergency medical service and verify that the service has been rendered. The physician verifies emergency medical services by completing DMA Form 526, "Physician's Statement for Emergency Medical Assistance", or another written statement.

A written statement must include all information on the DMA Form 526, specifying the date(s) an emergency medical service has been rendered. No future eligibility dates are to be used. The form must contain an original signature.

The EW will accept DMA Form 526 and proceed with the eligibility determination, regardless of level or type of medical service rendered. DMA will determine if claims submitted by providers meet the definition of an emergency medical service. Only emergency medical services should be reimbursed.

Georgia residency is required and is established by the A/R's verbal or written statement that s/he lives or has intent to live in the state and is physically present in Georgia.

An application for EMA is processed within 45/90 days. If an individual applies for an emergency medical service to be received at a future date, the application is denied, and the applicant may reapply after emergency services are provided.

A woman who is approved for Pregnant Women Medicaid EMA may also be eligible for EMA during the 12-month extended postpartum period if she receives emergency medical treatment during this period.

EMA is approved only for the date(s) specified on the DMA Form 526 or a physician's written statement. In order for a Form 526 to be valid, it must have both a begin and an end date for services provided and the dates of service must be prior to the date the form is signed by the physician. No future eligibility dates should appear on the DMA Form 526.

A child born to a woman approved for EMA for the delivery is eligible for Newborn Medicaid. Refer to Section 2174, Newborn Medicaid.

An EMA applicant/member has the right to request a Fair Hearing. Refer to Appendix B, Fair Hearings, for additional information.

A Continuing Medicaid Determination (CMD) is not required upon termination of EMA.

Other family members who meet citizenship/immigration status and enumeration requirements can request Medicaid coverage. Follow application procedures appropriate for any other COA for those family members.

Determine eligibility and provide notification of case disposition within the following Standards of Promptness (SOP):

- within 45 days for pregnant women
- within 45 days for Family Medicaid COAs and ABD COAs for aged, blind applicants
- within 90 days for ABD COAs for disabled applicants

Procedures

Follow the steps below to approve EMA:

Step 1 Obtain a signed application from the applicant and determine the appropriate COA under which EMA will be processed.

Step 2 Review and obtain a signed Notification of Eligibility – Emergency Medical Assistance Program form from each individual making application for EMA. A copy of the signed notice should be placed in the case record. If the applicant is not present for a face-to-face interview, the EMA Notification form must be mailed to the applicant. It is preferable that the notice be signed and returned but it is not required.

Step 3 Determine the AU and BG and complete the budgeting process for the appropriate COA.

Step 4 Establish basic eligibility for the AU with the exception of citizenship/immigration status, and enumeration.

Step 5 Obtain DMA Form 526 or a written, signed statement from the physician verifying the need for emergency medical services. The signature should be the original signature of the physician, or a medically trained employee of the physician designated to act on his/her behalf. Forms using the physician's stamped signature are not acceptable. Faxes are acceptable if the form is faxed from the physician's office and the signature on the faxed form was original. When questionable, contact the physician's office to verify.

> The following providers are authorized to sign Form 526: Any qualified licensed professional (i.e., RN, MD, advanced practice RNs, midwife, PA, etc.) DMA Form 526 or physician's statement should not indicate a period of emergency service exceeding 30 days from condition onset date. No future dates are to appear on DMA Form 526. In order for a Form 526 to be valid, it must have both a begin and an end date for services provided and the dates of service must be prior to the date the form is signed by the physician or qualified licensed professional.

Step 6 Approve the case using the appropriate COA if the applicant meets all eligibility criteria. Notify the AU of the eligibility determination. The notice should include the following:

- approval/disposition date
- Gateway Client ID number
- date(s) of eligibility

Step 7 A CMD is not required. Applicants will need to complete a new application for subsequent emergency services received.

Special Considerations

Hearings

Refer to Appendix B, Hearings.

Claim Submission and Prior Approval

Providers should submit claims for services rendered to EMA applicants, on the web portal at www.mmis.georgia.gov/portal with supporting documentation. Supporting clinical documentation should include form 520 (Provider Inquiry Form), history and physical, any emergency room records, physician's progress notes, physician order sheets, discharge summary, consultation record, nurse's notes, and death summary if applicable. Claims without supporting documentation will be denied as incomplete. Providers can follow the procedures for prior approval for clearance as to whether a medical charge or prescription will be covered. However, prior approval does not guarantee payment. Providers who do not routinely submit EMA claims for review and possible payment by Department of Community Health (DCH) should attempt to provide some notice of such policy to the potential EMA member. DCH strongly encourages providers to negotiate payment plans that assist these members with payment of these services. If DCH determines that the EMA claim contains both emergent and non-emergent services, payment will only be rendered for emergency services. Providers will be informed by Gainwell of the need to submit additional documentation to facilitate the rendering of such payment.

Failure to submit the required documentation within 30 days of the date of the split decision notice will result in the denial of the entire claim. If DCH determines that services rendered were non-emergent, providers may bill EMA members for those services. DCH strongly encourages providers to negotiate payment plans that assist these members with payment of these services. Denial of EMA claims are subject to the administrative appeal process as outlined in Part I, Chapter 500. EMA claim denials that result from a provider's failure to submit these claims according to this subsection are subject to the provisions of Part I, § 106(Q).

For instructions on prior approval providers can refer to Part I Policy and Procedure in the Gainwell Technologies Billing Manual.

2055 Sponsored Aliens

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Sponsored Aliens		
	Effective Date:	December 2019		
	Chapter:	2050	**Policy Number:**	2055
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-57

Requirements

Aliens who are ineligible for SSI because of income or resources deemed from a sponsor may be determined eligible for Medicaid without considering the income or resources of the sponsor.

Basic Considerations

Aliens who are admitted to the United States as permanent residents often have a sponsor. The income and resources of a sponsor and his/her spouse are used by SSI in determining the financial eligibility of an alien.

The Social Security Administration (SSA) deems the sponsor's income and resources in the SSI eligibility determination for up to five years. The five-year period begins with the month the alien is admitted to the U.S. for permanent residence or is granted permanent resident status.

SSA may waive deeming from the sponsor when the alien's disability or blindness begins at either of the following points:

- After entry into the U.S. for permanent residence
- After becoming a permanent resident

The income and resources of a sponsor are not considered in Family Medicaid budgeting.

Procedures

Follow the steps below to process the Medicaid application of a sponsored alien.

Step 1 Verify the alien's SSI application was denied based on the sponsor's income or resources.

If the A/R is denied SSI solely due to the sponsor's deemed income or resources, consider eligibility for Medicaid under any class of assistance, including SSI Medicaid.

Step 2 Determine eligibility for Medicaid without considering the income and resources of the sponsor. Consider retroactive and ongoing eligibility.

> A reduction in the income and resources of the sponsor, the sponsor's spouse or the A/R may make the A/R eligible for SSI. Remind the A/R and sponsor to report changes in financial circumstances.

Step 3 Verify the month SSI will stop counting the income and resources of the sponsor.

Step 4 Complete the CMD at least one month before the month SSI will stop counting the income and resources of the sponsor to determine if the alien is SSI eligible or eligible under a COA other than SSI Medicaid. Refer to 2052 Continuing Medicaid Determination.

Step 5 Obtain DMA Form 526 or a written, signed statement from the physician verifying the need for emergency medical services. The signature should be the original signature of the physician or a medically trained employee of the physician designated to act on his/her behalf. Forms using the physician's stamped signature are not acceptable. Faxes are acceptable if the form is faxed from the physician's office and the signature on the faxed form was original. When questionable, contact the physician's office to verify.

2060 ABD Medicaid Application Processing

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Medicaid Application Processing		
	Effective Date:	September 2024		
	Chapter:	2050	**Policy Number:**	2060
	Previous Policy Number(s):	MT 72	**Updated or Reviewed in MT:**	MT-73

Requirements

The ABD Medicaid application process begins with the receipt of a signed application for medical assistance and ends with written notification to the applicant/recipient (A/R) of the eligibility determination.

Basic Considerations

Eligibility for ABD Medicaid Classes of Assistance (COA) is determined in the following order:

- FBR COAs
- LA-D/ Medicaid Cap COAs
- Q-Track
- ABD Medically Needy

QMB and SLMB may be approved while an eligibility determination for FS, TANF or another Medicaid COA is pending. A Medicaid member cannot be dually eligible for QI-1 and another Medicaid COA with the exception of AMN Spenddown.

Procedures

Application Requirements

The application date is the date a signed application is received by any county DFCS office. An application for any ABD Medicaid COA may be processed from any of the following application documents:

- Form 297 Application for TANF, SNAP, or Medical Assistance
- Form 508 SNAP, TANF, Medical Assistance Renewal Form
- Form 632 Presumptive Eligibility (PE) for Pregnancy
- Form 632H Qualified Hospital Presumptive Eligibility Application
- Form 632W Presumptive Eligibility (PE) Women's Health Medicaid Application
- Form 700 Application for Medicaid & Medicare Savings for Qualified Beneficiaries
- Form 94 Medicaid Application

- Form 94A Medicaid Streamlined Application
- Federally Facilitated Marketplace (FFM) application
- Gateway Medical Assistance Online Application
- Gateway Medical Assistance Renewal
- Low Income Subsidy Application – SSA 1020B (LISA- application for Medicare Part D)
- PeachCare for Kids® Application **(Obsolete as of 09/2017)**
- Provider Portal Online Application
- SSA Model Medicare Savings Plan (MSP) application
- SUCCESS Application for Assistance (AFA) **(Obsolete as of 09/05/2017)**
- Women's Health Medicaid Review Form **(Obsolete as of 12/2022)**

A completed application consists of a signed (not typed name on signature line) application with information sufficient to contact the A/R or AREP. The signature does not necessarily have to be that of the A/R. Any other information that is missing, incomplete or otherwise unclear may be obtained from the A/R or AREP after the signed application is received and registered in the system by the agency.

A new signed application is required in the following situations:

- Adding a program for an A/R who has been an ineligible spouse in an active Medicaid AU and who is now requesting Medicaid for him/herself under a different COA from a recipient spouse.
- An application was previously correctly denied due to failure to provide required verification. A/R wants to reapply in a subsequent month. Although the application date of the first application is protected, have the A/R sign another application for the subsequent month(s) unless there is good cause for not initially providing the verification.
- An application was previously correctly denied due to not meeting a basic or financial eligibility criteria. A/R now meets these criteria. Have the A/R complete and sign another application for subsequent month(s).

A new application is NOT required in the following situations:

- If the system denies the application because the worker has not acted timely on the case
- If the A/R is already a Medicaid recipient and is changing to another COA, a continuing Medicaid determination (CMD) is being completed or if an SSI recipient is entering a NH
- If a current Medicaid recipient is being added as a recipient to an existing Medicaid AU, such as SSI added to Q-Track or Q-Track added to AMN
- A non-Medicaid applicant (NM, NA, etc.) is added to an existing Medicaid AU, even if the AU trickles to a lower COA or the spenddown amount is increased.

Application Screening

Screen the application to determine the following:

- Current receipt of the benefits for which the A/R is applying

- Current receipt of other benefits available through the agency.

Interview Requirements

A face-to-face (FTF) interview is **not** a requirement for any Medicaid COA. At the eligibility worker's (EW) discretion or the request of the A/R or AREP, a FTF interview may be scheduled; however, an application may **not** be denied for failure to appear for an interview.

A telephone interview **is** required for ABD LA-D COAs and Adult Medically Needy (AMN) COAs.

Case Worker will attempt to reach the A/R or AREP by conducting two unscheduled telephone attempts prior to scheduling an interview.

The A/R is the primary source of information for him/herself. The A/R may authorize an AREP to apply, interview and provide information on his/her behalf. An elected AREP may have verbal or written designation. If the designation is written, the applicant's signature is required. However, because the A/R is considered the best source of information, s/he must be contacted to confirm that the information obtained is correct. This may be accomplished either by telephone, by mail, fax or in person, unless contact with the A/R is precluded by physical or mental limitations.

Information necessary to complete an eligibility determination may be obtained by any of the following methods:

- telephone call
- mail
- FTF interview
- home visit
- secure e-mail
- facsimile

Orally or in writing, inform the A/R about the Medicaid program(s) for which s/he may be entitled. Provide relevant information pamphlets or other printed material.

Explain the following information to the A/R and/or AREP:

- Services provided by DFCS and the right to apply for them
- Requirements of eligibility and the A/R's responsibility to provide information to establish eligibility and benefit level, including the following:
    - basic eligibility requirements
    - financial requirements
    - periodic renewals
    - timely reporting of changes
    - assignment of TPL
    - medically needy requirements, if applicable
    - vendor payment/cost share, if applicable

- The applicant's right to the following:
  - a fair hearing
  - prompt action within the standard of promptness (SOP)
  - confidentiality
  - non-discrimination in the processing of the application
  - services available to the family from other agencies

Mandatory Forms

Complete the mandatory forms below when processing an ABD Medicaid application. Refer to Chart 2060.1 in this section.

- Application for assistance
- Form 297A, Rights and Responsibilities (**only** if Form 297 is used to apply)
- Form 5460 - Notice of Privacy Practices (HIPAA)

> Notice of Privacy Practices and Form 297A may be mailed to the applicant. The applicant is **NOT** required to sign and return either form, provided the case record is documented that these forms were sent.

- Form 216 - Declaration of Citizenship (conditionally mandatory, please see Note below)

> This form is not required if 94 (rev. 5/10 or later), Form 94A, 297, 508 (Rev. 5/12 or later), 700 (Rev.11/09 or later), Gateway Medical Assistance application, or FFM application are used as they contain the required language to meet the needs of the declaration.

- Form DMA 285, Third Party Liability Health Insurance Questionnaire, when the person has other health insurance coverage. See Section 2230 - Third Party Liability for requirements.

> A DMA 285 is **not** required when application is made for QMB, SLMB, or QI-1 via Form 700. Send a copy of Form 700 to DCH/TPL in lieu of Form DMA 285 if the client has medical insurance. Attach a copy of the insurance card, front and back, if available.

Other Required Actions

Complete any other forms as necessary depending on the COA and the A/R's circumstances.

Determine if the A/R meets all points of eligibility.

Complete mandatory clearinghouse requirements.

Follow appropriate documentation standards for ABD Medicaid.

Explore Medicaid eligibility for the three prior months.

Obtain required verification.

For LA-D A/Rs whose income exceeds the Medicaid Cap, provide the following as a handout to the

A/R or AREP:

- Form 945 - Qualified Income Trust (QIT) – A Guide for Trustees
- Form 946 - Qualified Income Trust (QIT) Worksheet
- Form 936 - Certification of DCH Approved Qualified Income Trust
- Copy of the approved QIT templates

Standard of Promptness (SOP)

Eligibility should be processed as soon as all verification is received, this should take no longer than the following time frames:

- 45 calendar days beginning with the application date for aged or blind applicants.
- 90 calendar days beginning with the application date for disabled applicants whose disability that has not already been established by Disability Adjudication Section (DAS) for the Social Security Administration (SSA) or the State Medical Eligibility Unit (SMEU)
- 10 working days beginning with the application date for all Q-Track applicants.

The standard of promptness is 90 calendar days when a disability decision is required before the eligibility determination can be completed. However, if a separate disability decision is not required, the 45-calendar day standard of promptness applies.

If the 45/90-day SOP date falls on a weekend or holiday, complete the application by the last workday prior to the weekend or holiday.

Application Processing Standards

Observe the following standards in processing ABD applications:

- Register the application within **24 hours** of the agency's receipt of the application.
- If the A/R or AREP is not interviewed on the same day an institutional COA application is filed, contact the A/R or AREP within a reasonable timeframe to conduct the required telephone interview.
- If the A/R or AREP is not interviewed on the same day a non-institutional COA application is filed, and additional information is required, contact the A/R or AREP within a reasonable timeframe.
- If verification or additional information is required, complete a verification checklist and mail or give to the A/R or AREP. Establish a reasonable deadline for returning requested verification.
- If the A/R or AREP fails to meet the deadline for providing additional information, attempt to contact the A/R or AREP to assess the need for an extension of the deadline or the possibility of assisting in obtaining required verification.

  Do not deny an application for failure to provide verification if the verification can be obtained by the Case Worker.

- Contact the nursing home or appropriate case manager by the 30th calendar day from the application date if the LOC instrument has not been received. Document and follow-up as necessary.

- Deny an application at the first point ineligibility is established. Do **not** leave a case pending in anticipation of the A/R becoming eligible at a date beyond the ongoing benefit month.
- Deny the application within two days of SOP if the nursing home or case manager has failed to submit the LOC instrument to the authorized approval source.

> If the LOC approval source has received the LOC instrument but has not yet completed it, do **not** deny the application.

- Do **not** deny an application solely because the 45th/90th/10th day has been reached and eligibility cannot yet be determined.
- Deny an application before the SOP if the A/R or AREP fails to cooperate in the application process or fails to supply necessary information that s/he is capable of obtaining and DFCS has no direct means of obtaining.

Disposition of the Application

Determine if the A/R meets all points of eligibility.

Process applications in chronological order, when possible, with the exception of Q-Track applications, based on the following:

- date of application
- whether all information is available to determine eligibility.

> See Standard of Promptness (SOP) for SOP guidelines.

If eligible, approve the application ongoing and for any retroactive months, if appropriate.

Notification

Provide adequate notification to the A/R of the eligibility determination. A copy may also be sent to a AREP at the request of the A/R. Adequate notification includes the reason(s) for any action taken.

The notice must include the following:

- the basis for the approval/denial/termination
- the period of eligibility
- the reason for the action
- the A/R's right to request a fair hearing
- the telephone number of the county DFCS office
- the telephone number of legal services
- the amount of medical expenses required to meet the ABD Medically Needy spenddown, if the A/R meets all eligibility requirements other than income.
- For LA-D cases in which a penalty is imposed: the duration of the penalty, the Undue Hardship Waiver Form and information that the A/R has 14 days in which to submit the form with supporting info to the MES.

See Section 2342 - Transfer of Assets and Appendix F - TOC for the form.

Period of Eligibility

Approve Medicaid and continue eligibility as long as the A/R continues to meet the requirements of the COA under which they are approved. A CMD must be completed prior to denial or termination of any Medicaid COA. Refer to Section 2052 - Continuing Medicaid Determination.

A COA that has been approved using EMA criteria does not require a CMD when terminated.

Property Search Requirements

Conduct a property search on required ABD Medicaid applicants for the following reasons:

- to verify the value and status of all real property in which the A/R or deemor declare ownership interest.
- to detect any undisclosed property in which the A/R or deemor may have ownership interest.
- to detect and verify any transfer of real property affected by the A/R.

A property search must be completed if a questionable situation regarding ownership of property is discovered during the eligibility determination process.

If necessary, conduct a property search by checking the current tax digest and transfers for the past 60 months in the grantee/grantor book for the county in which the A/R resides or did reside prior to entering LA-D.

Chart 2060.1 – ABD Medicaid Property Search Requirements

If:	then a search of the TAX DIGEST is:	and a search of the GRANTEE/GRANTOR record is:
the COA is AMN	Not required, unless questionable	Not required, unless questionable
the COA is LA-D (See Chart page 9)	Required	Required
the COA is a Public Law or SSI	Required	Not required, unless questionable
the COA is Q-Track only	Not required, unless questionable	Not required, unless questionable
the A/R has not lived in Georgia during the 24 months prior to the month of application	Not required	Not required, unless questionable

Out of County Property Search

Request assistance in completing a property search from the DFCS office in another county where the client may have resided for a substantial period of time before moving to the current county of residence using Form 991, MAO Property Record Search. Review the exceptions to property search requirements to determine the necessity for a property search.

Special Considerations

Special Considerations for SSI Applicants

The Social Security Administration (SSA) accepts and processes applications for Supplemental Security Income (SSI) at local SSA offices. Any individual applying for ABD Medicaid at DFCS who appears to be financially eligible for SSI should be referred to the local SSA office to file an application. DFCS will also accept the ABD application for a Medicaid determination and begin the SMEU process. An exception to this may be QMB in some situations.

SSI applicants have the right to have any month for which they have been determined ineligible for an SSI payment for a reason other than failure to meet the disability criteria examined for eligibility under ABD Medicaid. Refer to Section 2053 - Retroactive Medicaid.

DFCS is responsible for determining Medicaid eligibility on SSI applicants in the following circumstances:

- the three months prior to the month of SSI application for SSI approvals and denials
- months associated with an SSI application for which the applicant is ineligible for an SSI payment for a reason other than failure to meet disability
- if an individual is alleging a disability regardless of SSI application status.

An SSI applicant who wants a determination of ABD Medicaid eligibility for months associated with a denied SSI application for reasons other than disability or prior months should contact DFCS to apply for that period of time. The prior months are protected indefinitely until such time as an eligibility determination has been made.

Refer to Section 2053 - Retroactive Medicaid, for processing procedures for retroactive months associated with an SSI application.

Chart 2060.2 - ABD MEDICAL ASSISTANCE FORM REQUIREMENTS

		ABD MEDCAID CLASS OF ASSISTANCE																	
	FORMS	SSI Medicaid - Retroactive Months	Pickle	Disabled Adult Child (DAC)	Former SSI-Disabled Child	Disabled Widow(er) 50-59	Disabled Widow(er) 60-64	EDWP/CCSP	NOW / COMP	Katie Beckett	Hospice (at-home or institutionalized)	30-day Hospital	Independent Care Waiver Program (ICWP)	Nursing Home	QMB	SLMB	QI-1	QDWI	ABD Adult Medically Needy (AMN)
	Application		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MANDATORY	*216- Declaration of Citizenship/ Immigration																		
MANDATORY	285 - TPL	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y			Y	Y
MANDATORY	5460-Notice of Privacy Practices (HIPAA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MANDATORY	EDWP/CCSP - Communicator							Y											
MANDATORY	EDWP/CCSP -Level of Care (LOC)							Y											
MANDATORY	DMA - 59 Authorization for Nursing Facility Reimbursement													Y					
MANDATORY	DMA 6 or 6A, other LOC Instrument								Y	Y			Y						
MANDATORY	1098 - NOW/COMP Communicator								Y										
MANDATORY	704 - Katie Beckett Cost Effectiveness									Y									
MANDATORY	705 - Katie Beckett LOC Determination									Y									
MANDATORY	Katie Beckett Worksheet									Y									
MANDATORY	Hospice Care Communicator										Y								
MANDATORY	Independent Care Waiver (ICWP) Communicator												Y						
CONDITIONAL	129 - Transfer of Assets to Spouse / Diversion Acknowledgement							Y	Y		Y	Y	Y	Y					
CONDITIONAL	184 - SMEU Data Report	Y						Y	Y		Y	Y	Y	Y					
CONDITIONAL	245 - SMEU Cover Letter (if SMEU is required)	Y						Y	Y		Y	Y	Y	Y					
CONDITIONAL	297A - Rights / Responsibilities (if application submitted via Form 297)		Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CONDITIONAL	315 - Estate Recovery							Y	Y		Y		Y	Y					
CONDITIONAL	985 - Burial Exclusion & Designation Form	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y					Y
CONDITIONAL	Property Search	Y	Y	Y	Y	Y	Y	Y	Y		Y		Y	Y					

Form 216 - Declaration of Citizenship/Immigration status is not required if the A/R has declared their citizenship or immigration status on the eligibility application (94, 94A, 297, 508, 700 or via Gateway Customer Portal application) and signed application under penalty of perjury. Also, declaration of citizenship/immigration status/identity is not required if the A/R is determined under EMA procedures. Refer to Section 2215 - Citizenship/Immigration/Identity.

2065 Family Medicaid Application Processing

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Application Processing		
	Effective Date:	September 2024		
	Chapter:	2050	**Policy Number:**	2065
	Previous Policy Number(s):	MT 70	**Updated or Reviewed in MT:**	MT-73

Requirements

The Family Medicaid application process begins with the request for health coverage and ends with notification to the Assistance Unit (AU) of its eligibility status.

Basic Considerations

Order of Eligibility

Family Medicaid eligibility is determined in the following order:

- Newborn
- Pregnant Women Medicaid
- Parent/Caretaker with Child(ren) Medicaid
- other Family Medicaid COAs based on Parent/Caretaker with Child(ren) eligibility criteria, i.e., TMA, 4MEx
- Children Under 19 Years of Age Medicaid
- PeachCare for Kids®
- Family Medicaid Medically Needy
- Women's Health Medicaid (WHM)
- Pathways
- Planning for Healthy Babies (P4HB)
- Federally Facilitated Marketplace (FFM)

Medicaid eligibility for a child in foster care is determined first under the IV-E FC program. If ineligible under IV-E FC, Medicaid eligibility is determined under CWFC Medicaid. Refer to Chapter 2800, Assistance to Children in Placement.

Application Requirements

An application for any Family Medicaid class of assistance may be made with any of the following forms:

- Form 297 Application for TANF, SNAP, or Medical Assistance

- Form 508 SNAP, TANF, Medical Assistance Renewal Form
- Form 632 Presumptive Eligibility (PE) for Pregnancy
- Form 632H Qualified Hospital Presumptive Eligibility Application
- Form 632W Presumptive Eligibility (PE) Women's Health Medicaid Application
- Form 700 Application for Medicaid & Medicare Savings for Qualified Beneficiaries
- Form 94 Medicaid Application
- Form 94A Medicaid Streamlined Application
- Federally Facilitated Marketplace (FFM) application
- Gateway Medical Assistance Online Application
- Gateway Medical Assistance Renewal
- Low Income Subsidy Application – SSA 1020B (LISA- application for Medicare Part D)
- PeachCare for Kids® Application **(Obsolete as of 09/2017)**
- Provider Portal Online Application
- SUCCESS Application for Assistance (AFA) **(Obsolete as of 09/05/2017)**

A completed application consists of a signed (either written or electronic such as on a Gateway application) with information sufficient to contact the A/R or authorized representative (AREP). The signature does not necessarily have to be that of the A/R. Any information that is missing, incomplete or otherwise unclear may be obtained from the A/R or AREP after the signed application is received and registered in the system by the agency.

A new signed application is required in the following situations:

- When completing an add a program for a BG member who is now requesting Medicaid and had not requested coverage for him/herself on the last application filed.
- An application was previously correctly denied due to failure to provide required verification. Applicant wants to reapply in a subsequent month for ongoing benefits. Although the application date of the first application is protected, the applicant should sign another application unless there is good cause for not initially providing the verification.
- An application was previously correctly denied for not meeting a basic or financial eligibility criteria. A/R now meets the criteria and wants to reapply for ongoing benefits. Have the applicant complete and sign another application.
- An applicant applied for him/herself and children, but the case trickled to a lower COA. A change then occurs that would make him/her eligible.

A new application is NOT required in the following situations:

- If the system denies the application because the worker has not acted timely on the case.
- If the applicant is already a Medicaid recipient and is changing to another COA, or a continuing Medicaid determination (CMD) is being completed.
- Adding a Newborn Medicaid case
- If a BG member is being added.

- When removing the Reasonable Opportunity Period (ROP) penalty, or adding a child back, to the active Medicaid AU effective the first day of the month that citizenship/immigration status/identity verification was provided.
- MAGI Medicaid cases (except for P4HB) that close for failing to return verification will be reinstated if all the verification is returned within 90 days of closure; an application will not be required. Refer to Section 2706 - Medicaid Renewals.

> Homeless AUs are **NOT** required to provide a physical address but must provide sufficient information to establish Georgia residency. The applicant's statement is acceptable unless conflicting information is known to the agency.

Procedures

Application Screening

Screen the application in Gateway and Georgia Medicaid Management Information System (GAMMIS) to determine the following:

- current receipt of the benefits for which the AU is applying
- current receipt of other benefits.

Interview Requirements

A face-to-face (FTF) interview is **not** required for any Medicaid COA. At the eligibility worker's (EW) discretion or the request of the applicant or PR, a FTF interview may be scheduled, however an application may **not** be denied for failure to appear for an interview.

The A/R is considered to be the primary source of information. The A/R may authorize an Authorized Representative (AREP) to apply and provide information on his/her behalf. An elected AREP may have verbal or written designation. If the designation is written, the applicant's signature is required. However, because the A/R is considered the best source of information, s/he must be contacted to confirm that the information obtained is correct. If information provided by a AREP is questionable or unclear, attempt to contact the A/R for clarification, unless contact with the A/R is precluded by physical or mental limitations. This can be accomplished either by telephone, mail, fax or in-person.

Information necessary to complete an eligibility determination may be obtained by any of the following methods:

- FTF interview

  > A FTF interview may **not** be required of the applicant or AREP and an application may **not** be denied solely for failure to complete a FTF interview.

- telephone call
- mail
- home visit
- facsimile

- secure email
- Gateway

Orally or in writing, inform the A/R about the Medicaid program(s) for which s/he may be entitled. Provide relevant information pamphlets or other printed material. Explain the following information to the applicant/member or AREP:

- services provided by DFCS and how to obtain those services
- requirements of eligibility and the A/R's responsibility to provide correct information to establish eligibility
- HIPAA and confidentiality
- basic and financial eligibility requirements
- Clearinghouse requirements for any AU/BG member
- potential Medicaid COAs
- potential coverage for three months prior to the month of application
- periodic renewals (12-month renewals and renewals competed during an interim change)
- timely reporting of changes and how/where changes are to be reported
- assignment of Third-Party Liability (TPL)
- the role of the Division of Child Support Services (DCSS), assignment of medical support rights to the State, and Good Cause for non-compliance
- Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Referrals to anyone in the AU under the age of 21. Information regarding EPSDT and contact information is included on the GA Gateway approval notice. Refer to Section 2930 - Early and Periodic Screening, Diagnostic, and Treatment (EPSDT).
- Woman Infant and Children (WIC) Referrals to anyone in the AU that is pregnant; breastfeeding; postpartum women; or has a child under the age of 5 years, Section 2985 - Women, Infant and Children (WIC) Services.
- the applicant's right to the following:
  - a fair hearing (Refer to Appendix B for details),
  - a decision within standard of promptness (SOP),
  - confidentiality,
  - non-discrimination in the processing of the application,
  - their rights and responsibilities in the Medicaid program, included in the single streamlined application or Form 297A Rights and Responsibilities.

In addition, explain the following to an AU that includes a pregnant woman:

- the right to apply and how to apply for TANF 45 days prior to the expected date of delivery
- continuous financial eligibility for the pregnant woman
- presumptive eligibility (PE) Medicaid process and how to apply at a public health facility or other qualified provider if the Medicaid eligibility determination for the pregnant woman can-

not be made the same day that the application is filed. Accept the Medicaid application even if the applicant applies for PE Medicaid.

Mandatory Forms

Refer the A/R to other appropriate services such as family planning.

Complete the mandatory forms below when processing a Family Medicaid application:

- Application for Assistance
- Form 297-A (**only** if Form 297 is used to apply).
- Form 216 - Declaration of Citizenship (conditionally mandatory, please see Note below)

> This form is not required if the single streamlined application, Form 94 (Rev. 5/10 or later), Form 94A, 297, 508 (Rev. 5/12 or later), 700 (Rev. 11/09 or later), Gateway Medicaid Online application, or FFM application are used as they contain the required language to meet the needs of the declaration.

- Form 5460 - Notice of Privacy Practices (HIPAA)

> Notice of Privacy Practices and Form 297-A may be mailed to the applicant. The applicant is **NOT** required to sign and return either form, provided the case record is documented that the forms were sent.

- Form DMA 285, Third Party Liability Health Insurance Questionnaire, when the person has other health insurance coverage. See Section 2230 - Third Party Liability for when a DMA285 can be waived, and for other TPL requirements.

> A DMA 285 is not required for children in placement. For MAGI Family Medicaid COAs a separate DMA 285 is not required if the Form 94A Medicaid streamlined application, 297M, or pre-populated renewal form 508M has the TPL information included, and the form is signed.

- Form 138 - Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Services (if a DCSS referral is required)

> Form 138 may be mailed to the applicant. The applicant is **NOT** required to sign and return the form provided the case record is documented that the form was sent. If the application or renewal is completed using Gateway Medical Assistance Application, Gateway Medical Assistance Renewal, or Form 94A Medical Assistance Streamlined Application, then Form 138 is not required as the 138's language is included.

When the Form 94A Medicaid streamlined application is used it also incorporates the Declaration of Citizenship/Immigration Status and TPL; separate forms are not required.

Complete any other forms as necessary depending on the COA and the A/R's circumstances.

Other Required Actions

Determine if the A/R meets all points of eligibility.

Complete mandatory clearinghouse requirements.

Follow appropriate documentation standards for Family Medicaid.

Explore Medicaid eligibility for the three prior months.

Obtain required verification.

Refer to Chart 2065.1 - Family Medicaid Forms in this section.

Standard of Promptness

The eligibility determination for Family Medicaid COAs should be completed with real time determinations or as soon as all verification is received. This should take no longer than the following time frames:

- 10 days from the date of application for pregnant women, regardless of COA
- 45 days for EMA-PgW
- 10 days from the date of report for newborns, regardless of COA

> This pertains to a child born to a woman who was eligible for and receiving Medicaid on the day the child was born who most commonly is approved for Newborn COA but could be approved/dual eligible for another COA, such as Parent/Caretaker.

- 45 days from the date of application for all other Family Medicaid COAs

Calculate the SOP beginning with the date of application. Document the reason for any delays in the case record.

If the SOP date falls on a weekend or holiday, complete the application by the last workday **prior to** the weekend or holiday.

Application Processing Standards

Observe the following standards in processing Family Medicaid applications.

- Accept the signed application on the day the application is received by the agency.
- Register the application using the date the application was received by the agency. The application must be registered within **24 hours** of receipt by the agency.
- If the applicant or AREP is not interviewed on the same day an application is filed and additional information is required, contact the applicant or AREP within a reasonable timeframe to obtain the information necessary to complete the application.
- If verification or additional information is required, complete a verification checklist and mail or give to the applicant or AREP. Establish a reasonable deadline for returning requested verification. Refer to Section 2051 - Verification.
- If incomplete verification is returned, send another checklist specifying what is required; establish a new reasonable deadline for returning requested verification.
- If the applicant or AREP fails to meet the deadline for providing additional information, attempt

to contact the applicant or AREP to assess the need for an extension of the deadline or the possibility of assisting in obtaining required verification.

> Do **not** deny an application for failure to provide verification if the verification can be obtained by the Case Worker.

- Deny an application at the first point ineligibility is established. Do **not** leave a case pending in anticipation of the applicant becoming eligible at a future date beyond the ongoing benefit month.
- Do **not** deny an application solely because the SOP has been reached and eligibility cannot yet be determined.
- Deny an application before the SOP if the applicant or AREP fails to cooperate in the application process or fails to supply necessary information that s/he is capable of obtaining and DFCS has no direct means of obtaining.

Disposition of Application

Determine if the AU meets all points of eligibility.

Process applications in chronological order, with the exception of Medicaid coverage for pregnant women, based on the following:

- date of application
- whether all information is available to determine eligibility

If eligible, approve the application, within 45 days, for all eligible months including retroactive and ongoing months. Process applications for pregnant women within 10 days to ensure early prenatal care.

Notification

Provide the applicant adequate written notification of the eligibility determination. Adequate notification includes the reason(s) for any action taken.

A duplicate notice may be provided to the AREP upon request by the applicant. The applicant, however, must receive all notices regarding his/her case(s).

Notification must explain the following:

- the basis for the approval/denial/termination
- the period of eligibility
- the reason for the action
- the AU's right to request a fair hearing (Refer to Appendix B for details)
- the telephone number of the DFCS Call Center
- the telephone number of legal services.

Generic denial reasons may be used as a secondary or tertiary denial/termination reason, but never

as the sole reason for denial/termination.

Periods of Eligibility

Approve Medicaid and continue eligibility as long as the AU continues to meet the requirements of the COA under which eligibility was approved. A Continuing Medicaid Determination (CMD) must be completed prior to denial or termination of any Medicaid COA. Refer to Section 2052 - Continuing Medicaid Determination.

Certain COAs are time limited. Refer to Chapter 2100, Classes of Assistance.

Chart 2065.1 - Family Medicaid Forms

		FAMILY MEDCAID CLASS OF ASSISTANCE														
	FORMS	Parent/Caretaker with Child(ren) (PCT)	Transitional Medical Assistance (TMA)	Four-month Extended (4MEX)	Newborn (NB)	Pregnant Woman (PGW)	Children Under 19 (CU19)	PeachCare for Kids® (PCK)	Family Medically Needy (FM-MN)	Women's Health Medicaid (WHM)	Pathways	Planning for Healthy Babies (P4HB)	IV-E Foster Care (IV-E FC)	IV-E Adoption Assistance (IV-E AA)	IV-B Foster Care (Child Welfare Foster Care-CWFC)	IV-B Adoption Assistance (State Adoption Assistance-SAA)	Former Foster Care
MANDATORY	Application	Y				Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MANDATORY	*216 - Declaration of Citizenship/ Immigration																
MANDATORY	285 - TPL	Y	Y	Y		Y	Y		Y	Y	Y	Y	Y	Y	Y	Y	Y
MANDATORY	3460 - Notice of Privacy Practices (HIPAA)	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MANDATORY	Pathways Contract (Per each A/R evaluated)										Y						
CONDITIONAL	122 - Child Support Services Foster Care Referral												Y		Y		
CONDITIONAL	**138 - Notice of Cooperation with Child Support Services	Y															
CONDITIONAL	297A - Rights / Responsibilities (if application submitted via Form 297)	Y				Y	Y		Y		Y						Y

***Form 216 - Declaration of Citizenship/Immigration status is not required if the A/R has declared their citizenship or immigrations status on the eligibility application (94, 94A, 297, 508, 700, or via Gateway Customer Portal application) and signed application under penalty of perjury. Also, declaration of citizenship/immigration status/identity is not required if the A/R is determined under EMA procedures. Refer to Section 2215 - Citizenship/Immigration/Identity. *https://gadhs.gitlab.io/pamms/dfcs/medicaid/appendix-f/form-138/[*Form 138, Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in Child Support Services] is not required if the application or renewal is via Gateway or 94A as the 138's language is included in both. Refer to Section 2250 - Cooperation with Division of Child Support Services.**

2066 Placement Outside The Home

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Placement Outside The Home		
	Effective Date:	December 2019		
	Chapter:	2050	**Policy Number:**	2066
	Previous Policy Number(s):	MT 51	**Updated or Reviewed in MT:**	MT-57

Requirements

An individual living in a placement outside the home may, under certain circumstances, be eligible for Family or ABD Medicaid.

Basic Considerations

Who May be Eligible

An individual is potentially eligible for Medicaid if any one of the following situations exist:

- an individual admitted to a medical institution to receive medical care

> An individual incarcerated or placed in a detention facility who is admitted to a medical treatment facility is considered a resident of the detention facility and is therefore ineligible for Medicaid.

- an individual in a private community facility such as a homeless shelter or a shelter for victims of domestic violence
- a child in a private child care institution that provides 24-hour non-secure custodial care, such as a children's home
- a child in a family licensed home supervised by the Department of Juvenile Justice (DJJ)
- an child in a private licensed group home
- a child in a family foster home approved by one of the following agencies:
  - DFCS
  - Child Services and Family Counseling
  - The United Methodist Children's Home
  - The Georgia Baptist Children's Home (Palmetto Campus)
  - DJJ (as contract home or attention home)

> Social Services verifies that a placement has been made in an approved facility.

- an individual in a licensed emergency shelter
- a child placed in any other public or private agency, which DFCS approves for placement.

Public Institution

For Medicaid eligibility purposes, the following placement facilities are *not* considered public institutions:

- public educational or vocational training institution
- publicly operated general hospital
- publicly operated nursing home
- publicly operated community residence or group home that serves no more than 16 individuals
- public child care institution that accommodates no more than 25 children and the child is approved to receive Title IV-E foster care payments
- an intermediate care facility for the mentally disabled (nursing home unit), even if located on the premises of a public institution

Normally Medicaid is not approved for individuals residing in public institutions, such as Georgia Regional Hospital. However, some of these institutions have Medicaid participating nursing homes associated with them. If a level of care instrument is received from one of these facilities, proceed with the Medicaid eligibility determination.

Who is Ineligible

An individual is **ineligible** for Medicaid if any of the following situations exist:

- the individual is incarcerated in a jail, prison or other facility operated primarily for detention
- a child is placed in a detention facility, such as a Youth Development Campus (YDC)

  A child placed temporarily in a Regional Youth Detention Center (RYDC) or YDC while awaiting transfer to a private facility may be eligible for Medicaid.

- the individual is placed in a public institution

  If the placement in the public institution is temporary while awaiting a private placement more appropriate to the needs of the individual, the individual is potentially eligible for Medicaid. (See **NOTE** above.)

- the individual is legally committed to an institution, whether public or private
- the individual is placed in an institution operated for the treatment of tuberculosis

Individual Placed Out-of-State

An individual placed by a state agency in an out-of-state institution or licensed foster care facility is considered a legal resident of the state making the placement.

The state of origin is responsible for the medical expenses of the child.

If the individual is a IV-E eligible child and IV-E payments are made, the child can be approved for Medicaid in the state where the child is placed. Refer to Chapter 2800 for IV-E Foster Care/Adoption Assistance policy.

The placement facility may locate a local doctor, dentist or other medical provider who will enroll as a Medicaid provider in the state of origin.

If no providers are willing to enroll for the other state's Medicaid, notify the state office Medicaid Policy Unit.

Private Placement of a Child

A child placed by a parent or other responsible adult in a private placement facility or LA-D may be eligible for Family or ABD Medicaid.

For Family Medicaid, the child placed in a private childcare (residential) institution is considered as an AU of one (1) and no longer in the home of the family. A child placed in a psychiatric hospital by a parent or other caretaker relative would be considered absent from the home for treatment or training and would not be considered as an AU of one (1).

Refer to Chapter 2600, Family Medicaid AUs and BGs.

For FM, budget any money received by the facility for the child. If the parents provide money, it is considered child support and the $50 child support deduction is allowed. If another responsible adult provides money, it is considered a contribution.

For ABD Medicaid, see Section 2225, Residency for determining state of residence.

Use the following chart of situations to determine if an individual is potentially eligible for Medicaid based on current living arrangement outside the home:

CHART 2066.1 INDIVIDUALS IN PLACEMENT OUTSIDE THE HOME

Situation	Medicaid Eligibility
If the individual is placed in:	**Then s/he is Medicaid**
a public institution	ineligible
Temporary arrangement awaiting a more appropriate placement for his/her needs in a private facility	eligible
a public childcare institution that accommodates no more than 25 children and the child is receiving Title IV-E foster care payments	eligible
a publicly operated community residence or group living home that serves no more than 16 individuals (example: residential drug treatment center operated by the Mental Health Division of DHS)	eligible
a public educational or vocational training institution	eligible
a publicly operated general hospital	eligible
a publicly operated nursing home or hospice provider	eligible
a Regional Youth Detention Center operated by DJJ	eligible
a prison, jail or other incarceration facility operated primarily for detention	ineligible

Situation	Medicaid Eligibility
a Youth Development Campus  Temporary arrangement awaiting a more appropriate placement for his/her needs in a private facility	ineligible eligible
a public or private placement of legal commitment through court proceedings	ineligible
an institution operated for the treatment of mental diseases or tuberculosis	ineligible
a medical institution to receive medical care, such as a hospital	eligible
a private community facility such as a battered women's or homeless shelter	eligible
an intermediate care facility for the mentally retarded (nursing home unit) even if located on the premises of a public institution	eligible
a private licensed group home or personal care home licensed as a CCSP provider	eligible
a private child care institution that provides 24-hour non-secure custodial care, such as a children's home  Consider the child an AU of one. Budget any money received by the facility for the child as income to the child. If the parents provide money, allow the $50 child support deduction.	eligible
an attention home operated by the DJJ	eligible
a contract home operated by the DJJ	eligible
a family foster home approved by DFCS or DJJ, Families First, Inc., United Methodist Children's Home, Georgia Baptist Children's Home (Palmetto) can use any other public or private agency which DFCS may approve for placement	eligible
a licensed private emergency shelter	eligible
an institution or foster care home in the state of Georgia placed by another state's agency  The child is IV-E eligible and receiving IV-E per diem in placement in Georgia.	ineligible eligible
Outdoor therapeutic program/outdoor therapeutic residential wilderness program.	eligible

2067 Presumptive Eligibility Medical Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Presumptive Eligibility Medical Assistance		
	Effective Date:	July 2024		
	Chapter:	2050	**Policy Number:**	2067
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-72

Requirements

Presumptive Eligibility (PE) Medical Assistance allows Qualified Providers (QP) and Qualified Hospitals (QH) authorized by the Department of Community Health (DCH), to make temporary determinations of Medical Assistance eligibility for applicants whose statement of net BG income is less than the appropriate FPL for the Class of Assistance (COA) requested. PE continues while a formal determination of eligibility for ongoing and/or retroactive Medical Assistance is pending with the Division of Family and Children Services (DFCS) office.

Basic Considerations

PE Medical Assistance provides outpatient prenatal care to pregnant women during the period that a formal Medical Assistance application pends with DFCS. All Medical Assistance services given by any participating Medical Assistance provider are covered during the presumptive period with **exceptions of inpatient hospital and delivery services.**

Hospital Presumptive Eligibility (HPE) covers all Medical Assistance related services that are covered by the specific COA requested.

Emergency Medical Assistance (EMA) cannot be completed in the Presumptive Eligibility process.

Hospital Presumptive Eligibility may be determined for the following groups:

- Pregnant Women
- Parent/Caretaker with Child(ren) under age 19
- Child(ren) under 19
- Former Foster Care Children
- Women in treatment for Breast or Cervical Cancer (WHM)

The PE Medical Assistance eligibility period begins on the date the PE application is approved and ends when DFCS determines eligibility or ineligibility, but no later than at the end of the month following the month of the PE approval. (Ex. PE application approved 4/5/24 which begins coverage 4/5/24 through 5/31/24.)

The QP or QH issues temporary Medical Assistance certificates and Notice of Action (Approval/Denial) to applicants. If the applicant is approved for PE Medical Assistance, a plastic

card is sent. The applicant should receive this within 7 to 10 business days. If the plastic card is not received, lost or stolen, the member must contact the Member Contact Center at 1-866-211-0950.

DFCS cannot process applications for PE or issue eligibility forms for PE.

Potential Qualified Providers include the Department of Public Health, federally funded health centers, primary care centers receiving migrant funding and/or homeless funding, hospital outpatient clinics and hospital-based special prenatal clinics.

As of July 1, 2011, Public Health became the Department of Public Health and is now a Qualified Provider.

Procedures

Responsibilities of a Qualified Provider or Qualified Hospital

The QP or QH determines eligibility for PE Medical Assistance based on the applicant's pregnancy statement (Pregnant Women), certificate of diagnosis (Women's Health), the net income of the budget group (BG), citizenship or immigrations status and residency. The QP or QH conducts a face-to-face (FTF) interview with the applicant and performs the following functions:

- Screens the applicant in GAMMIS to see if he/she is already active on Medical Assistance. If a woman is already active on Medical Assistance (except Planning for Health Babies®(P4HB)) **DO NOT** complete a PE application. (See Note below.)
- Accepts the applicant's statement of net income and obtains adequate information from the applicant to complete the following forms: (See Note below.)
  - Form 632, Pregnant Women Presumptive Eligibility application
  - Form 632H Qualified Hospital Presumptive Eligibility application
  - Form 632W, Women's Health Presumptive Eligibility application
  - Form 216, Declaration of Citizenship/Immigration Status
  - Form 5460, HIPPA Notice of Privacy Practices
  - Form 94A, Single Streamlined Medical Assistance application
  - Form 94, Medical Assistance application (Women's Health only)
- Determines if the applicant meets eligibility criteria for PE Medicaid.
- QP forwards the PE Packet to DFCS within five business days of the PE application date.
- QH forward the PE Packet to DCH within five business days of the PE application date.

If the QP or QH determines that the applicant is **eligible** for PE Medicaid, the QP or QH completes the determination process as follows:

- provides the applicant with a Temporary Medical Assistance Certificate and form 634, 634H, 634W – Notice of Action (Approval)
- provides the applicant with the *Quick Guide on Presumptive Eligibility Medical Assistance, Quick Guide on Presumptive Eligibility for Pregnant Women or Quick Guide on Women's Health Medical Assistance*

- informs the applicant of the PE Medical Assistance period and covered services
- informs the applicant about P4HB
- QP forwards the PE Packet to DFCS within five business days of the PE application date
- QH forwards the PE Packet to DCH within five business days of the PE application date

If the QP or QH determines that the applicant is **ineligible** for PE Medical Assistance, the QP or QH completes the determination process as follows:

- informs the applicant that he/she is not eligible and provides him/her with the form 634, 634H or 634W – Notice of Action (Denial)
- advises the applicant that if his/her circumstances change, he/she may have another determination of PE Medical Assistance completed by a QP or QH
- informs the applicant that his/her application for ongoing and/or retroactive Medical Assistance will be forwarded to DFCS for a formal determination of eligibility

A PE application cannot be completed on an already active Medical Assistance member. Qualified Providers and Qualified Hospitals are unable to update pregnancy information in GAMMIS on active Medical Assistance members. If the applicant is pregnant and actively receiving Women's Health, inform member to report pregnancy to their caseworker. If the applicant is actively SSI, QH/QP should complete *the SSI Pregnant Women Update* form and send to DCH by email at pecorrections@dch.ga.gov . All other active members need to contact DFCS at 1-877-423-4746 or submit a Change Report via Gateway "Report My Change" to report their pregnancy.

Form 216 is not required when Forms 632, 632H, or 632W are used as the language is included.

For Women's Health, a certificate of diagnosis is required at the time of application.

The Temporary Medical Assistance Certificate and the Notice of Action-Approval will serve as proof of eligibility.

The PE Packet being sent to DFCS consists of the following:

- PE Application (Form 632, 632H, or 632W)
- Notice of Action (Form 634, 634H or 634W) and Temporary Medical Assistance Certificate
- Third Party Liability Questionnaire (DMA 285)
- Single Streamlined Medical Assistance application (94A) or Medical Assistance application (94 - Women's Health Only)
- Certificate of Diagnosis (Women's Health only)
- Any documentation the applicant provides

To ensure that applications for pregnant women are processed within the 10-day standard of promptness, the local QP(s) should contact DFCS to discuss procedure for forwarding PE Pack-

ets to DFCS daily. All other COAs processed as Hospital Presumptive are subject to a 45-day standard of promptness.

Responsibilities of DFCS

Upon receipt of the PE Medicaid packet, complete a formal determination for Medical Assistance eligibility for the applicant and any other individuals for whom Medical Assistance is requested.

The application date is the date the applicant applies for benefits with the QP or QH and signs the 94 or 94a. Process the 94 or 94A application using the appropriate COA. Refer to Section 2162 Parent/Caretaker with Child(ren), Section 2182 Children Under 19, 2184 Pregnant Women, Section 2198 Women's Health and Section 2819 Former Foster Care.

2068 Special Considerations

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Special Considerations		
	Effective Date:	December 2019		
	Chapter:	2050	**Policy Number:**	2068
	Previous Policy Number(s):	MT 06	**Updated or Reviewed in MT:**	MT-57

Applications at a Non-DFCS Site

DFCS workers are outstationed at certain public health centers, disproportionate share or public hospitals and federally funded health centers to expedite the processing of applications for Medicaid. These workers process the Medicaid applications as if taken at the DFCS office.

Medicaid applications are taken at sites other than DFCS by the facility's personnel. The facility workers are trained by DFCS to accept applications and conduct interviews.

During the interview at a non-DFCS site, the facility interviewer documents the information, signs and dates the form and forwards it to DFCS.

The DFCS worker reviews the application and interview information and conducts follow-up contact with the applicant, if necessary, either by telephone or mail.

Procedures

Follow the steps below for applications received at approved facilities:

Step 1 Review the application for all points of eligibility. If additional information is required, contact the A/R by telephone or mail.

> Follow-up is generally not required for Presumptive Eligibility applications, which contain all information required to determine eligibility.

Step 2 Mail required Forms DMA-285, 297A and 138.

Step 3 Determine eligibility and notify the A/R of the decision. The application date is the date the non-DFCS facility received the signed application from the A/R.

> The application date for applications received from private medical facilities is the date the application is received by DFCS.

Application Received for an Individual Currently Receiving Medicaid in Another State

An individual who is currently receiving Medicaid in another state but has moved to Georgia may file an application. Notify the previous state that the applicant has moved to Georgia, and determine eligibility for Medicaid. Do not delay the disposition of the Medicaid application while waiting for the previous state to terminate benefits.

An individual may receive Medicaid in both states the month that s/he moves to Georgia.

Out-of-State Application for Three months Prior Medicaid for a Former Georgia Resident

An application may be filed for medical services received as a Georgia resident even if the individual subsequently moved out of state.

Complete all necessary forms. Forms can be mailed to the applicant.

Determine eligibility using the appropriate Class of Assistance (COA). Refer to 2053 Retroactive Medicaid.

If eligible, send notification of the decision and certification of Medicaid eligibility.

Current Georgia Resident Requests Three Months Prior Medicaid from Another State

Refer the A/R to the previous state for application and eligibility processing.

Offer assistance in contacting the other state's agency if the A/R is unable to do so.

Application for a Deceased Individual

Accept an application on behalf of a deceased individual by a relative or other responsible party who can provide sufficient information for an eligibility determination.

Determine eligibility based on circumstances that existed in the month(s) prior to the individual's death that Medicaid coverage is requested. Refer to 2053 Retroactive Medicaid.

The months are limited to the application month and three months prior to the application.

Application for a Pregnant Woman After Termination of the Pregnancy

Accept an application and determine eligibility if the A/R meets all eligibility requirements.

The eligibility determination is based on actual circumstances of the month of pregnancy termination and any of the three months prior to the application month. Determine eligibility under Family Medicaid Medically Needy if the BG is over the RSM income level.

If eligibility is determined for any month of the pregnancy, eligibility continues through the remainder of the pregnancy and through the 60-day postpartum transition period. Refer to 2184 Pregnant Women.

Out-of-State Application

Accept applications from individuals outside the state who express the intent to move to Georgia. Deny the application because the state residency is not met. Instruct the applicant to re-apply when s/he moves to Georgia.

A/R Moves to Another County While in Application Atatus

Complete the application process in the county in which the application was received if an applicant moves to another county prior to approval or denial of the application.

Transfer an approved case to the appropriate county after eligibility is determined and the A/R is notified of the decision.

A/R Is Not a Resident of the County in Which S/he Is Filing an Application

Inform the applicant of his/her right to file the application and explain that the application will be faxed or mailed to the county of residence

AND

Inform the applicant of his/her option to take the application to the county of residence him/herself.

The application must be faxed or mailed by the agency the same day if the applicant requests the agency send the application. The date of application is the date the application was first filed by the applicant in any county.

If the applicant chooses to take the application to the county of residence, the date of application is the date the applicant presents the application to the county of residence.

Applicant Mails an Application to a County in Which S/he Is Not a Resident

Forward the application to the county of residence.

The date of application is the date the application is first received by any county in the state.

Changes While in Applicant Status

Inform the applicant that s/he is required to report within 10 days any change that occurs during the application process.

Take action on the reported change during the application process, allowing the applicant sufficient time to provide any information and/or verification that may be required.

2069 Express Lane Eligibility

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Express Lane Eligibility		
	Effective Date:	October 2022		
	Chapter:	2050	**Policy Number:**	2069
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-67

Requirements

Express Lane Eligibility (ELE) is an enrollment strategy which begins with consent to an ELE determination for a child(ren)'s potential Medicaid eligibility and ends with notification to the Assistance Unit (AU) of its eligibility status.

Basic Considerations

The Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3 includes many provisions designed to give states some tools which may be used to effectively enroll eligible children in Medicaid and PeachCare for Kids® (PCK). Section 203 of CHIPRA allows states to rely on the findings from an entity designated by the state as an "Express Lane agency" to determine whether a child satisfies one or more factors of eligibility for Medicaid or PCK. Such agencies are identified by the state Medicaid agency as being capable of making a finding regarding one or more programmatic eligibility requirements using information the agencies are already collecting. "Express Lane agencies" are public agencies which would include the following:

- Agencies that determine eligibility for assistance for any of the following programs or under any of the following authorities:
  - The Temporary Assistance for Needy Families (TANF) program funded under part A of title IV of the Social Security Act (the Act)
  - A State program funded under title IV-D of the Act (Child Support Enforcement)
  - **The State Medicaid or PCK program**
  - The Supplemental Nutrition Assistance Program (SNAP) (formerly Food Stamps)
  - The Richard B. Russell National School Lunch Act (School Lunch programs)
  - The Child Nutrition Act of 1966 (the Special Supplemental Nutrition Program for Women, Infants, and Children, or "WIC")
  - The United States Housing Act of 1937
  - Head Start
  - Child Care under the Child Care and Development Block Grant Act of 1990
  - Homeless Assistance under the Stewart B. McKinney Homeless Assistance Act
  - The Native American Housing Assistance and Self-Determination Act of 1996

- Another State-specified governmental agency that has fiscal liability or legal responsibility for the accuracy of the eligibility determination findings relied on by the State.
- A public agency that is subject to an interagency agreement limiting the disclosure and use of your information disclosed for purposes of determining eligibility for Medicaid or PCK.

The State Medicaid/PCK agency remains responsible for making the ultimate determination of eligibility. The Medicaid and PCK programs may apply the ELE option to children up to age 19.

Initial ELE Determinations

Children (newborn through the month a child turns 19) who are active and receiving benefits on a SNAP or TANF case can have Medicaid or PCK eligibility determined according to ELE criteria as set forth in the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. The Division of Family and Children Services (DFCS) agency will utilize information collected when an application/renewal/change (including ELE opt in statement) is completed by SNAP or TANF eligibility workers for services to determine eligibility. This data includes, but is not limited to all demographic data, proof of income, and household size.

If a SNAP or TANF application/renewal/change is received for a child younger than 19 years old, information provided by the family on that application/renewal/change or otherwise collected for the SNAP or TANF eligibility determination is used by the DFCS agency to determine most factors of Medicaid/PCK eligibility. During eligibility determinations, the DFCS agency will advise SNAP or TANF applicants/recipients that the information provided for the SNAP or TANF application/renewal/change will be shared with the DFCS agency for determining the children's Medicaid/PCK eligibility, unless the individual chooses to opt-out on the initial application/renewal/change document or verbally during the SNAP or TANF interview. A separate Medicaid or PCK application is **not** required.

DFCS must obtain consent from the child's parent, guardian, or custodial relative agreeing to the ELE determination for the children's potential Medical Assistance eligibility. The consent can be obtained verbally, electronically, or written (consent received from application).

DFCS should ensure that the child is not already enrolled in Medicaid (including SSI), PCK, or Medicare prior to an ELE determination. If a child(ren) under 19 Medical Assistance application is received and there is no active SNAP or TANF case, then an ELE determination cannot be completed.

The DFCS agency will use the SNAP or TANF income findings, calculated based on the specific program's eligibility policies (income exclusions, disregards, household composition, deeming, etc.) to determine income eligibility for Medicaid/PCK. DFCS will use other information collected by the SNAP or TANF program on the application/renewal or through its verification processes to determine most other factors of Medicaid/PCK eligibility (e.g., verification of citizenship, State residency). Any SNAP or TANF eligible children that meet the specific program's citizenship requirements, must also meet Medicaid/PCK citizenship requirements. A Reasonable Opportunity Period (ROP) for citizenship is allowed for ELE determinations. Refer to Section 2215-Citizenship/Immigration/Identity.

For Medicaid/PCK ELE determinations, DFCS should compare household income to the highest Medicaid income applicable to a child (0-19) which will be equal to 235% FPL. If household income is

over 235% FPL but at or below 247% FPL, the child should be evaluated for ELE-PCK.

If a child is found eligible for PCK from the ELE determination, DFCS must provide notice that the child may qualify for Medicaid and/or lower premiums if evaluated using the regular eligibility determination and provide an avenue on how to request a full eligibility determination. A separate application is not required. Refer to 2194 PeachCare for Kids® for ELE PCK premium amounts.

Children with third-party liability (TPL) are not eligible for PCK.

If the child's Medicaid or PCK eligibility cannot be determined based on the processes used for ELE (e.g., the child is over income for PCK using the "Express Lane" agency's income finding), a full eligibility determination must be conducted using the regular Medicaid/PCK processes. The income findings from the "Express Lane agency" should not be used, and additional information or verification should be requested from the family as necessary.

If a full determination is conducted based on a request or denial for any potential ELE applicant, the application is no longer considered ELE.

For ELE applications, retroactive months requested should follow the regular eligibility determination process.

It is the expectation that the ELE determination will be completed at the same time as the SNAP or TANF application/renewal but no longer than 45 days from the date ELE was requested.

If there is an already active SNAP or TANF case with a child younger than 19 years old and the client would like to opt in the ELE process to have Medicaid or PCK eligibility determined according to ELE criteria, the client can complete the opt-in statement and drop off at their local DFCS office or upload online at www.gateway.ga.gov at any time.

If the client has an approved ELE determination and would like to opt out of the ELE process and have a full Medical Assistance determination made, the client can call the DFCS call center at 1-877-423-4746 or complete the opt-out statement and drop off at their local DFCS office or upload online at www.gateway.ga.gov at any time.

Procedures

Follow the steps below to determine Medical Assistance using the ELE application process:

Step 1 Accept SNAP or TANF application/renewal/change request (including ELE opt in statement for already active SNAP or TANF cases) for children under 19 years of age submitted through Gateway Customer Portal or other acceptable application/renewal forms.

Step 2 Ensure client has provided ELE consent.

Step 3 Determine ELE eligibility for CU19 or PCK based on the information collected at SNAP or TANF application/renewal/change including household size, residency, income, and citizenship. Children must meet Medicaid/PCK citizenship requirements

Step 4 Approve the case using the appropriate COA (CU19/PCK) if the applicant meets all eligibility criteria.

If the child's Medicaid or PCK eligibility **cannot be determined** based on the processes used for ELE (e.g., the child is over income for PCK using the express lane agency's income finding), a full eligibility determination must be conducted using the regular Medicaid/PCK processes. The income findings from the express lane agency should not be used, and income eligibility should be determined using Medical Assistance policies and procedures.

A full determination follows the regular MAGI eligibility determination process.

Step 5 Notify the AU of the eligibility determination.

Special Considerations

Reasonable Opportunity Period (ROP) is allowed for ELE determinations.

Child(ren) eligible for PeachCare for Kids® may be subject to a premium. Send a determination notice to advise client to report any changes and the ability to opt out of ELE at any time.

If SNAP or TANF closes due to information not provided from VCL, the ELE case will remain active until the end of the ELE POE.

If retroactive months are requested and case is approved for ELE, the retroactive months need to follow the regular MAGI eligibility determination process.

If SNAP or TANF is active with at least one ongoing month at the end of the ELE renewal POE, the ELE case will be automatically renewed using the ELE process.

If SNAP or TANF is not active at the end of the ELE renewal POE, the ELE case would no longer be considered ELE, and renewal must follow the regular MAGI eligibility determination process.

Administrative renewals should not be completed for Medicaid cases whose Medicaid eligibility has been determined using Express Lane Eligibility (ELE).

Gateway should not allow an ELE determination if an individual member is currently receiving Medical Assistance including:

- SSI or Medicare for ELE-CU19
- SSI, Medicare or TPL for ELE-PCK.

ELE determinations do not apply to:

- Expedited SNAP applications that are not approved for a full period of eligibility (POE)
- Transitional SNAP recipients
- Disaster Supplemental Nutrition Assistance Program (DSNAP) recipients
- Disaster Temporary Assistance for Needy Families (DTANF) recipients

2100 Classes of Assistance

2101 ABD Medicaid Classes of Assistance Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Medicaid Classes of Assistance Overview		
	Effective Date:	November 2023		
	Chapter:	2100	**Policy Number:**	2101
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-71

Requirements

An individual must meet the requirements specified under a particular class of assistance (COA) in order to be determined eligible for ABD Medicaid.

Basic Considerations

ABD Medicaid COAs are divided into the following two types:

- FBR (Federal Benefit Rate) – COAs that use the SSI FBR to determine income eligibility.
- Non FBR – COAs that use an income limit other than the FBR to determine income eligibility.

The FBR COAs consist of the following:

- SSI Medicaid
- Pickle (PL 94-566)
- Disabled Adult Child (PL 99-643)
- Disabled Widow(er) Age 50-64
- Widow(er) 60-64 (PL 100-203)
- Widow(er) 1983 (PL 99-272) (**No longer approve these COAs**)
- Protected Medicaid 1972 (PL 92-603) (**No longer approve these COAs**)
- Former SSI Disabled Child

The Non-FBR COAs consist of the following:

- Elderly and Disabled Waiver Program (EDWP) formerly known as Community Care Services Program (CCSP)
- New Options Waiver (NOW)
- Comprehensive Supports Waiver Program (COMP)
- TEFRA/Katie Beckett
- Hospice
- Hospital
- Independent Care Waiver Program (ICWP)

- Nursing Home (NH)
- ABD Medically Needy (AMN)
- Qualified Disabled Working Individuals (QDWI)
- Q Track:
  - Qualified Medicare Beneficiary (QMB)
  - Specified Low-Income Medicare Beneficiary (SLMB)
  - Qualifying Individual 1 (QI-1)

> QMB eligibility for persons receiving SSI is discussed in 2143 Qualified Medicare Beneficiaries.

Refer to Chapter 2050, Application Processing, for a discussion of other Medicaid coverage, including the following:

- 2054 Emergency Medical Assistance
- Retroactive Medicaid, including three months prior and intervening months, Section 2053
- 2055 Sponsored Aliens

Refer to Chapter 2900, Referrals, for other sources of medical assistance.

Procedures

Follow the steps below to determine ABD Medicaid eligibility under a specific COA.

Step 1 Accept the individual's ABD Medicaid application and register the application on the system.

Step 2 Screen each A/R to determine potential SSI eligibility, Family Medicaid, PeachCare for Kids® and/or TANF eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine which SSI trial budget to complete (Individual, Couple or Spouse to Spouse Deeming).
- Use the FBR as the income limit when completing the SSI trial budget.

Step 3 Refer the A/R to the appropriate worker if the A/R appears to be eligible for Family Medicaid and/or TANF and wishes to file an application for either.

> The A/R's application for assistance is protected indefinitely.

Refer the A/R to SSA to file an SSI application if his/her Federal Countable Income (FCI) is less than the appropriate Federal Benefit Rate (FBR) unless one of the following situations exist:

- The A/R requests coverage for any of the 3 months prior to the SSI or ABD Medicaid Application Month.
- The A/R is ineligible due to the deemed income or resources of his/her spouse or parents.
- The A/R dies prior to applying for SSI.
- The A/R is ineligible for Family Medicaid/SSI due to excess resources.
- The A/R has Medicare or other insurance that is expected to pay (or pays) more than 50% of medical expenses, and the A/R is in a public or private hospital or nursing home.

Step 4 Obtain information necessary to process application. Request verification, if necessary.

Step 5 Determine the COA most advantageous to the A/R.

> Explain the advantages of each COA if the A/R is potentially eligible under more than one COA and allow the A/R to choose the COA.

Step 6 Determine basic eligibility. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 7 Determine financial eligibility. Refer to PROCEDURES under the specific section on each COA.

Step 8 If the A/R is eligible under the COA currently being used to determine eligibility, approve ABD Medicaid on the system.

If the A/R is ineligible under the COA currently being used to determine eligibility, complete a CMD. Refer to 2052 Continuing Medicaid Determination.

2111 Supplemental Security Income (SSI) Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Supplemental Security Income (SSI) Medicaid		
	Effective Date:	November 2023		
	Chapter:	2100	**Policy Number:**	2111
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-71

Requirements

Supplemental Security Income (SSI) is a direct monetary payment program administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act. SSI Medicaid is used by DFCS as a class of assistance (COA) for determining sponsored alien and retroactive Medicaid eligibility.

Basic Considerations

Georgia SSI recipients are automatically eligible for Medicaid for any month in which they receive a check except when they refuse to assign TPR. Refer to 2230 Third Party Liability.

To be eligible under the SSI Medicaid COA, the A/R must meet the following conditions:

- The A/R has applied for SSI or ABD Medicaid.
- The A/R requests ABD Medicaid coverage for a month(s) for which s/he is not eligible to receive an SSI payment, such as the following:
  - two months prior to an SSI approval (for the third prior month refer to 2053 Retroactive Medicaid)
  - three months prior to an SSI denial
  - three months prior to an ABD Medicaid application
  - the months related to an SSI application for which the applicant is not financially eligible for an SSI payment
  - the months in which the income of a sponsor renders an alien ineligible for SSI.
- The A/R meets all basic and financial eligibility criteria.

Length of Stay (LOS) and Level of Care (LOC) are **not** requirements for this COA.

Do **not** determine eligibility under the SSI COA for any month covered by an SSI application (the three prior months, the month of SSI application and ongoing) while the SSI application is pending. Refer to 2053 Retroactive Medicaid.

Effective for SSI applications filed on or after August 22, 1996, the first month of SSI payment is the first month following the date the application is filed, or the first month following the month the individual becomes eligible for SSI, whichever is later. For approved or denied SSI applications, the

three prior months are the three months preceding the month of SSI application.

> Do **not** use the SSI Medicaid COA to determine eligibility for the **third month** prior to an SSI approval. Refer to 2053 Retroactive Medicaid for instructions on processing eligibility for SSI prior months.

SSI Terminations

See 2579 SSI 1619 Individuals for SSI Terminations of SSI 1619 Individuals.

Procedures

Follow the steps below to determine Medicaid eligibility under the SSI Medicaid COA.

Step 1 Accept the A/R's request for retroactive Medicaid. A signed application is not required for this COA since an application has been filed with the Social Security Administration (SSA).

Step 2 Obtain information necessary to process the requested months of eligibility.

Step 3 Determine basic eligibility criteria. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 4 Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider
- Which SSI income/resource limits (individual or couple) to use
- Which eligibility budget to complete.

Step 5 Approve Medicaid using the SSI Medicaid COA for any retroactive month in which the A/R meets all eligibility criteria.

> Do not approve SSI COA for the third month prior to an SSI approval. Refer to 2053 Retroactive Medicaid for the appropriate COA and procedures on completing prior months for SSI applications.

2113 PICKLE (Public Law 94-566)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	PICKLE (Public Law 94-566)		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2113
	Previous Policy Number(s):	MT 10	**Updated or Reviewed in MT:**	MT-58

Requirements

Pickle (PL 94-566) is a class of assistance (COA) that provides for an individual or couple who correctly received RSDI and SSI or a Mandatory State Supplement (MSS) concurrently and became ineligible for SSI or MSS for any reason but is currently ineligible for SSI because of RSDI COLAs.

Basic Considerations

To be eligible under the Pickle COA, the A/R must meet the following conditions:

- The A/R previously and correctly received RSDI and SSI or MSS concurrently.
- The A/R's SSI or MSS was terminated after 4/77 for any reason.
- The A/R is eligible for SSI or MSS if the RSDI COLAs received by the A/R and/or his/her spouse since the A/R last received SSI or MSS are disregarded.
- The A/R meets all basic and financial eligibility criteria.

In couple situations, only one spouse needs to have received RSDI and SSI or MSS concurrently. However, each individual must have previously received SSI or MSS in order to establish eligibility under this COA. In order for one member of the couple to be exempt from the requirement of having received SSI and RSDI concurrently, the couple must have been married at the time of the loss of SSI eligibility.

Length of Stay (LOS) and Level of Care (LOC) are **not** requirements for this COA.

Individuals who receive an SSI and RSDI payment in the last month of the waiting period on initial entitlement to RSDI disability benefits are **not** considered to have received SSI and RSDI concurrently.

Procedures

Follow the steps below to determine Medicaid eligibility under the Pickle COA.

Step 1 Accept the A/R's Medicaid Application.

Step 2 Obtain verification from SSA to verify the following:

- The date SSI benefits were terminated.
- The current amount of the A/R's and/or his/her spouse's RSDI.
- The amounts of all RSDI COLAs the A/R and/or his/her spouse have received since SSI was terminated.

Step 3 Determine all basic eligibility criteria except LOS and LOC. Refer to Section 2200, Basic Eligibility Criteria.

Step 4 Determine all basic eligibility using the current SSI income and resource limits. Refer to Section 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider.
- Which SSI income and resource limit (individual or couple) to use
- Which eligibility budget to complete.

Step 5 Determine the A/R's countable income by disregarding the following amounts of RSDI income.

- The COLA that caused SSI termination

  OR

- The first COLA received after SSI was terminated for a reason other than receipt of a COLA, such as a resource ineligibility

  AND

- All subsequent COLAs.

> The COLAs of the A/R (individual or couple) and the A/R's ineligible spouse can be disregarded in determining eligibility under the Pickle COA.

Step 6 Approve Medicaid on the system using the Pickle COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

> Do not approve Medicaid using the Pickle COA for any month for which the A/R was eligible for and received an SSI payment.

2115 Disabled Adult Child (Public Law 99-643)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Disabled Adult Child (Public Law 99-643)		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2115
	Previous Policy Number(s):	MT 15	**Updated or Reviewed in MT:**	MT-58

Requirements

Disabled Adult Child (PL 99-643) is a class of assistance (COA) that provides Medicaid for an individual age 18 or over who had his/her SSI terminated on or after 7/1/87 because of entitlement to or an increase in RSDI income received as a disabled adult child.

Basic Considerations

To be eligible under the Disabled Adult Child COA, the A/R must meet the following conditions:

- The A/R is currently receiving RSDI as a disabled adult child.
- The A/R previously received SSI that was terminated on or after 7/1/87 because of an increase in or initial entitlement to RSDI as a disabled adult child. The increase or initial entitlement must have been on RSDI (Title II) income, not RRR or other income
- The A/R is eligible for SSI if the initial entitlement to RSDI, any increase(s) in RSDI and/or RSDI COLAs received since the A/R last received SSI are disregarded.
- The A/R meets all basic and financial eligibility criteria.

Length of Stay (LOS) and Level of Care (LOC) are not requirements for this COA.

The RSDI claim number will end with a beneficiary identification code (BIC) that includes C if the A/R receives RSDI as a disabled adult child.

Approve Medicaid on the system using the Disabled Adult child COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

Do not approve Medicaid using the Disabled Adult Child COA for any month for which the A/R was eligible for and received an SSI payment.

Procedures

Follow the steps below to determine Medicaid eligibility under the Disabled Adult Child COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct an interview.

Step 3 Obtain verification from SSA to verify the following:

- The date SSI benefits were terminated.
- The current amount of the A/R's RSDI disabled adult child benefit.
- The amounts of the RSDI initial entitlement, increase or COLA that caused SSI termination and all RSDI increases received since SSI was terminated.

Step 4 Determine all basic eligibility criteria except LOS and LOC. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following:

- Whose income and resources to consider
- Which SSI income and resource limit (individual or couple) to use
- Which eligibility budget to complete.

Step 6 Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The initial entitlement to or increase in RSDI as a disabled adult child or an increase in RSDI income that caused SSI termination

  OR

- The RSDI disabled adult child COLA that caused SSI termination

  AND

- All subsequent increases in RSDI. This would include COLAs as well as RSDI increases due to a change in the parents' circumstances, such as retirement and/or death. The only RSDI increase that would not be subject to disregard would be an increase due to the DAC's own work record.

Step 7

> The RSDI claim number will end with a beneficiary identification code (BIC) that includes C if the A/R receives RSDI as a disabled adult child.

Approve Medicaid on the system using the Disabled Adult child COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

> Do not approve Medicaid using the Disabled Adult Child COA for any month for which the A/R was eligible for and received an SSI payment.

2116 Former SSI-Disabled Child

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Former SSI-Disabled Child		
	Effective Date:	December 2022		
	Chapter:	2100	**Policy Number:**	2116
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-68

Requirements

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 changed the definition of disability for children. As a result, a number of children were terminated from SSI. The Balanced budget Act of 1997 mandated that for any child who became ineligible for SSI due to the new definition of disability, the State must redetermine Medicaid eligibility using the previous definition of disability. The Act further specified that the disability status of the child must be protected as long as the child remains eligible for SSI but for the change in definition of disability.

Basic Considerations

To be eligible under the Former SSI-Disabled Child COA, the A/R must meet the following conditions:

- The A/R was receiving SSI as a disabled child on August 22, 1996, and was terminated as a result of SSA's new definition of disability. This includes those SSI A/R's who, as of August 22, 1996: The A/R was receiving SSI as a disabled child on August 22, 1996, and was terminated as a result of SSA's new definition of disability. This includes those SSI A/R's who, as of August 22, 1996:
  - were in current pay status; or
  - received a favorable or partially favorable administrative decision from SSA; or
  - were terminated due to non-cooperation with the disability redetermination process of SSA; or
  - had a Zebley appeal pending.
- The A/R would be eligible for SSI but for the passage of the new disability decision.
- The A/R continues to meet all basic and financial eligibility criteria for SSI.

Length of Stay (LOS) and Level of Care (LOC) are not requirements for this COA.

Procedures

Applications are no longer reviewed under this COA.

Follow the steps below to determine Medicaid eligibility under the Former SSI-Disabled Child COA:

Step 1 Use the DMA generated report entitled SSI to Disabled Children (Section 4913) or accept an application from any A/R contacting DFCS whose name did not appear on said report. Refer to Section 2752, Continuing Medicaid Determination Reports, for instructions on processing the report.

Step 2 Screen the A/R in the system to determine if they have an active Medicaid case with DFCS.

Step 3 For A/R's not appearing on the SSI to Disabled Children (Section 4913) Report, verify that the child was receiving SSI on August 22, 1996, and that the SSI was terminated due to the new definition of disability. For children whose names do appear on the report, accept the report as verification for this step.

Step 4 Using SDX, BENDEX and any other available information, register the case on the system. Prior receipt of SSI is prima facie evidence of disability until the first annual review for all A/R's who were terminated SSI as a result of the new disability decision.

Step 5 Approve Medicaid, including retroactive months if requested, on the system within 10 days of receipt of the list or application unless available information determines the A/R to be ineligible. If the A/R is ineligible, see Special Considerations below. Notify DMA via the form on the GoMail bulletin board entitled Medicaid Forms if the A/R is ineligible for any COA.

Ongoing Eligibility

The county must complete a full review of eligibility within 12 months of approval or when a change is reported, whichever is earlier.

At the first review of eligibility, submit a disability request to SMEU, specifying that the A/R is a Former SSI-Disabled Child. Redetermine all other points of eligibility using current SSI eligibility criteria in order to establish continued ongoing eligibility.

Special Considerations

If the A/R was terminated from SSI for any reason other than disability, the A/R is NOT eligible for Medicaid under this COA. Complete a CMD. Refer for TANF or Family Medicaid if appropriate. Only request a SMEU decision for another ABD COA if the SSI has been terminated for more than 12 months.

If an A/R is approved for but later becomes ineligible for Medicaid under the Former SSI-Disabled child COA for any reason other than disability, the child's disability status remains protected. The child can become eligible again under this COA.

There is not an aid category for this COA in GAMMIS.

2117 Disabled Widow(er)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Disabled Widow(er)		
	Effective Date:	December 2022		
	Chapter:	2100	**Policy Number:**	2117
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

The Disabled Widow(er) class of assistance (COA) provides Medicaid for an individual whose SSI was terminated because of his/her entitlement to an RSDI disabled widow(er) benefit.

Basic Considerations

To be eligible under the Disabled Widow(er) COA the A/R must meet the following conditions:

- The A/R is a disabled widow(er) or a disabled surviving divorced spouse between the ages of 50-59
- The A/R is currently receiving RSDI as a disabled widow(er)/disabled surviving divorced spouse.
- The A/R is currently ineligible for Medicare Part A coverage.
- The A/R previously received SSI or a Mandatory State Supplement (MSS) that was terminated on or after 1/1/91 because of his/her initial entitlement to RSDI as a disabled widow(er)/disabled surviving divorced spouse.
- The A/R is eligible for SSI or MSS if the initial entitlement to RSDI as a disabled widow(er) and all subsequent COLAs are disregarded.
- The A/R meets all basic and financial eligibility criteria.

Length of Stay (LOS) and Level of Care (LOC) are **NOT** requirements for this COA.

A disabled Widow(er) is an individual who applies for RSDI between the ages of 50-59 and is determined to meet RSDI disability criteria.

A widow(er) who applies for RSDI at age 60 or older can receive RSDI without meeting disability requirements. SSA will accept a disability application on these individuals after age 60 only for the purpose of establishing Medicare entitlement. These individuals are not eligible for Medicaid under the Disabled Widow(er) COA. Consider eligibility under all other COAs, including Widow(er) Age 60 to 64 COA.

Disabled widow(er)s whose SSI was terminated on or after 1/1/91 are allowed to count previous months of SSI eligibility toward the 24-month waiting period for Medicare entitlement.

Procedures

Follow the steps below to determine Medicaid eligibility under the Disabled Widow(er) COA:

Step 1 Accept the A/R's Medicaid application.

Step 2 Obtain information required to complete the eligibility determination.

Step 3 Obtain the following verification from the Social Security Administration:

- The date SSI/MSS benefits were terminated
- The current amount of the A/R's RSDI Disabled Widow(er) benefit
- The amounts of the RSDI initial entitlement that caused SSI/MSS termination and all COLAs received since SSI/MSS was terminated
- The A/R's current ineligibility for Medicare Part A coverage

Step 4 Determine all basic eligibility criteria except LOS and LOC. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider
- Which SSI income and resource limit (individual or couple) to use
- Which eligibility budget to complete

Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The initial entitlement to RSDI as a disabled widow(er) that caused SSI termination

  AND

- All subsequent COLAs

The RSDI claim number will end with a beneficiary identification code (BIC) that includes "W" if the A/R receives RSDI as a disabled widow(er) or surviving divorced spouse.

Step 6 Approve Medicaid under the Disabled Widow(er) COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

Do NOT approve Medicaid using the Disabled Widow(er) COA for any month for which the A/R was eligible for and received an SSI payment.

Step 7 Terminate Medicaid under this COA as soon as the A/R becomes entitled to Medicare Part A. Complete a CMD. Refer to 2052 Continuing Medicaid Determination.

2119 Disabled Widow(er) Age 60-64 (Public Law 100-203)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Disabled Widow(er) Age 60-64 (Public Law 100-203)		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2119
	Previous Policy Number(s):	MT 10	**Updated or Reviewed in MT:**	MT-58

Requirements

Widow(er) Age 60 – 64 (PL 100-203) is a class of assistance (COA) that provides Medicaid for a widow(er) who applies for an RSDI widow(er) benefit at age 60 or older and subsequently has his/her SSI terminated because of his/her entitlement to an RSDI widow(er) benefit.

Basic Considerations

To be eligible under the Widow(er) Age 60 – 64 COA the A/R must meet the following conditions:

- The A/R is a disabled or blind widow(er) aged 60 – 64.
- The A/R is currently receiving an RSDI widow(er)/surviving divorced spouse benefit.
- The A/R is currently ineligible for Medicare Part A coverage.
- The A/R previously received SSI that was terminated because of his/her initial entitlement to RSDI as a widow(er)/surviving divorced spouse.
- The A/R is eligible for SSI if the initial entitlement to RSDI as a widow(er)/surviving divorced spouse and all subsequent COLAs are disregarded.
- The A/R meets all basic and financial eligibility criteria.

Length of Stay (LOS) and Level of Care (LOC) are **NOT** requirements for this COA.

When the A/R becomes Medicare eligible at age 65 or after 24 months as disabled, s/he is NO longer eligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

Refer to Section 2117, Disabled Widow(er), for information on Medicare entitlement based on disability for an individual receiving an RSDI widow(er) benefit.

Procedures

Follow the steps below to determine Medicaid eligibility under the Widow(er) Age 60 – 64 COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Obtain information required to complete the eligibility determination.

Step 3 Verify that the A/R is age 60 – 64.

Step 4 Obtain the following verification from the Social Security Administration:

- The date SSI benefits were terminated.
- The current amount of the A/R's RSDI Widow(er) benefit.
- The amounts of the RSDI initial entitlement that caused SSI termination and all COLAs received since SSI was terminated
- The A/R's current ineligibility for Medicare Part A coverage.

Step 5 Determine all basic eligibility criteria except LOS and LOC. Refer to Chapter 2200, Basic Eligibility Criteria.

> Verify blindness or disability if the A/R does not have prima facie evidence of blindness or disability, such as receipt of an RSDI disability benefit. Refer to Section 2205, ABD Requirement.

Step 6 Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider.
- Which SSI income and resource limit (individual or couple) to use.
- Which eligibility budget to complete.

Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The initial entitlement to RSDI as a widow(er) that caused SSI termination

  AND

- All subsequent COLAs

> The RSDI claim number will end with a beneficiary identification code (BIC) that includes "D" if the A/R receives RSDI as a widow(er)/surviving divorced spouse.

Step 7 Approve Medicaid, including prior months if needed, under the Widow(er) Age 60 - 64 COA if the A/R meets all the above eligibility criteria.

> Do NOT approve Medicaid using the Widow(er) Age 60-64 COA for any month for which the A/R was eligible for and received a SSI payment.

Step 8 Terminate Medicaid under this COA as soon as the A/R becomes entitled to Medicare Part A. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

2121 Widow(er) 1984 (Public Law 99-272)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Widow(er) 1984 (Public Law 99-272)		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2121
	Previous Policy Number(s):	MT 10	**Updated or Reviewed in MT:**	MT-58

Requirements

Widow(er) 1984 (PL 99-272) is a class of assistance (COA) for an individual who received RSDI and SSI concurrently and became ineligible for SSI due to an adjustment in his/her RSDI disabled widow(er)'s benefit effective 1/84.

Basic Considerations

Do NOT determine initial ABD Medicaid eligibility under the Widow(er) 1984 COA on any application filed on or after 7/1/88. Complete annual reviews for continued eligibility on established cases as for any other COA.

To be eligible under the Widow(er) 1984 COA the A/R must meet the following conditions:

- The A/R received RSDI and SSI in 12/83.
- The A/R became entitled to and received an adjustment in his/her RSDI disabled widow(er)'s benefit effective 1/84 that caused SSI termination in the month the increased benefit was actually received.
- The A/R was continuously entitled to the increased RSDI benefit from 1/84 until the increase was actually received.
- The A/R is eligible for SSI if the 1/84 increase in the RSDI disabled widow(er) benefit and any subsequent COLAs are disregarded.
- The A/R meets all basic and financial eligibility criteria.

Length of Stay (LOS) and Level of Care (LOC) are NOT requirements for this COA.

Applications are no longer approved under this COA.

Procedures

Complete an annual review of eligibility for individuals currently eligible under the Widower 1984 COA. Refer to Section 2705, Reviews.

Use the following guidelines for completing the review:

Step 1 Obtain verification from the SSA to verify the following:

- The A/R's receipt of RSDI and SSI in 12/83.
- The A/R's receipt of an increased RSDI disabled widow(er)'s benefit effective 1/84.
- The A/R's ineligibility for SSI the month increased benefit was actually received.
- The A/R's continuous receipt of an RSDI disabled widow(er)'s benefit.
- The current amount of the RSDI widow(er)'s benefit and all subsequent COLAs.

Step 2 Determine financial eligibility using the current SSI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following

- Whose income and resources to consider.
- Which SSI income and resource limit (individual or couple) to use.
- Which eligibility budget to complete.

Step 3 Determine the A/R's countable income by disregarding the following amounts of RSDI income:

- The 1/84 increase in the RSDI disabled widow(er)'s benefit.
- All subsequent COLAs.

> The RSDI claim number will end with a beneficiary identification code (BIC) that includes "W" if the A/R receives RSDI as a disabled widow(er)/disabled surviving divorced spouse.

Do NOT approve Medicaid using the Widow(er) 1984 COA for any month for which the A/R was eligible for and received a SSI payment.

2123 Protected Medicaid 1972 (Public Law 92-603)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Protected Medicaid 1972 (Public Law 92-603)		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2123
	Previous Policy Number(s):	MT 10	**Updated or Reviewed in MT:**	MT-58

Requirements

Protected Medicaid 1972 (PL 92-603) is a class of assistance (COA) that provides Medicaid for an individual/couple who received AABD or AFDC and RSDI concurrently in 1972 and became ineligible for AABD or AFDC because of the 20% 1972 COLA increase in RSDI.

Basic Considerations

To be eligible under the Protected Medicaid 1972 COA an A/R must meet the following conditions:

- The A/R is currently receiving RSDI.
- The A/R received AABD or AFDC and RSDI in 8/72.
- The A/R is currently eligible for SSI if the 1972 RSDI COLA is disregarded.
- The A/R meets all basic and financial eligibility criteria.

Length of Stay (LOS) and Level of Care (LOC) are **NOT** requirements for this COA.

Prior receipt of SSI is **NOT** a requirement for this COA.

Applications are no longer approved under this COA.

Procedures

Follow the steps below to determine Medicaid eligibility under the Protected Medicaid 1972 COA:

Step 1 Accept the A/R's Medicaid application.

Step 2 Obtain information required to complete the eligibility determination.

Step 3 Using county and state records, determine whether the A/R received AABD or AFDC in 8/72.

Step 4 Obtain the following verification from the Social Security Administration:

- The current amount of the A/R's RSDI benefit.
- The amount of the A/R's 8/72 RSDI COLA.

Step 5 Determine all basic eligibility criteria except LOS and LOC. Refer to the Chapter 2200, Basic Eligibility Criteria.

Step 6 Determine financial eligibility using the current SSI income and resource limits. Refer to the Chapter 2500, ABD Financial Responsibility and Budgeting, to determine the following:

- Whose income and resources to consider
- Which SSI income and resource limit (individual or couple) to use
- Which eligibility budget to complete

Step 7 Approved Medicaid under the Protected Medicaid 1972 COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

Do not approve Medicaid under the Protected Medicaid 1972 COA for any month for which the A/R was eligible for and received an SSI payment.

2131 Elderly Disabled Waiver Program

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Elderly Disabled Waiver Program		
	Effective Date:	December 2022		
	Chapter:	2100	**Policy Number:**	2131
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-68

Requirements

Elderly Disabled Waiver Program (EDWP) formerly known as Community Care Services Program (CCSP) is a Class of Assistance (COA) designed to provide in home and community-based services to individuals. These individuals meet the criteria for nursing home placement but choose to remain in a residential home situation.

Basic Considerations

To be eligible under the EDWP COA, an A/R must meet the following conditions:

- The A/R is admitted to EDWP and receiving a waivered service(s).
- The A/R resides in a residential home situation, such as his/her own home, another person's home or a personal care home.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

There is no age requirement for participation in EDWP. A client is not required to be homebound to receive EDWP services.

EDWP Medicaid recipients receive certain *waivered* services not normally covered by Medicaid, including the following:

- Adult Day Health
- Alternate Living Services (personal care home placement)
- Emergency Response System
- Home Health Services/Home Delivered Services
- Personal Support Services
- Respite Care

To maintain continuous eligibility for EDWP Medicaid, a client must receive waivered services each calendar month.

Individuals who express an interest in Elderly Disabled Waiver services are to be referred to the Area Agency on Aging for assessment. The telephone screening specialist assesses the individual's

suitability for community-based care in lieu of nursing home placement. If the individual meets the EDWP eligibility criteria, the A/R's name is placed on the EDWP waiting list. When funds become available, the individual is referred to the Care Coordination Agency for a face-to-face assessment.

- If the individual is determined eligible at the face-to-face assessment, s/he is admitted to EDWP.
- The care coordinator arranges for the provision of the EDWP waivered services to the recipient.
- EDWP is a budgeted program, therefore, it is limited to a certain number of clients statewide

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the EDWP COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Conduct an interview.

Step 3 Verify that the A/R is under EDWP care coordinator and receiving waivered service(s) by receipt of the Elderly and Disabled Waiver Communicator (CCC). The CCC should indicate the beginning date of care coordination and the service date.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to the Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility.

- See Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to the 2510 Medicaid Cap Budgeting. If client's income exceeds the Medicaid CAP, then client must establish a QIT in order to be determined eligible.

Step 6 Determine the A/R's cost share for EDWP services. Refer to 2559 Patient Liability / Cost Share Budgeting and 2553 Protection of Income.

Step 7 Approve EDWP Medicaid if the A/R meets all the above eligibility criteria.

DO NOT approve Medicaid under the EDWP class of assistance for any month earlier than the month of the service date.

Step 8 Notify the A/R of case disposition and cost share.

Step 9 Notify the care coordinator of the disposition and cost share by entering the care coordinator's name and address in the system as the Authorized Representative. This will enable the care coordinator to receive system generated notices giving dates of eligibility and cost share information.

Step 10 Complete a review of the case in the month in which the EDWP LOC expires as indicated in Field 45, L.O.S, of the LOC form.

- If a new LOC form extending the stay is received from the EDWP care coordinator, continue Medicaid eligibility under the EDWP COA.
- If the new LOC form stating that the LOC has NOT been extended is received from the care coordinator OR a new LOC form is not received from the EDWP care coordinator by the end of the month the LOC expires, complete a CMD. Refer to the 2052 Continuing Medicaid Determination. Notify the EDWP care coordinator of the outcome of the CMD and any change in cost share.

If LOC form or CCC is not received within two weeks from the end of the approved EDWP stay, send a CCC to the care coordinator requesting information on whether the stay has been extended.

If Medicaid eligibility is terminated as a result of the CMD and a new LOC form is subsequently received within 30 days of the termination date on the system, reopen the case as closed in error. If a new LOC form is received more than 30 days after the system termination date, process a new application. The month the new LOC form is signed is the earliest month for which the case can be reopened under the EDWP COA.

EDWP Temporarily in a NH

If an EDWP A/R temporarily enters a NH (30 days or less), they may continue as EDWP if the NH is enrolled as an EDWP provider. The NH stay would be billed as respite care. The MES would not make any changes in the system based on the temporary NH stay. Change to NH COA if the A/R remains for more than 30 days.

Joint EDWP and Hospice Eligibility

An EDWP recipient may elect to receive Hospice services along with EDWP. Hospice is paid directly by DCH without any Hospice information entered into DFCS' computer system. A/R should remain in EDWP COA. If A/R was in Hospice COA, switch to EDWP.

Special Considerations

A disabled child may be eligible for a $30 SSI personal needs allowance from SSA if s/he meets the following criteria:

- Is disabled
- Received SSI benefits (limited to PNA) while in a medical treatment facility
- Is ineligible for SSI solely because of deemed income or resources of the parents
- Is currently eligible for Medicaid under one of the following COAs:
  - TEFRA/Katie Beckett (Section 2133)
  - EDWP (Section 2131)
  - Is receiving services under GAPP (Section 2933)

If the child meets the above criteria, refer the parent(s) to SSA to continue the SSI $30 PNA payment and Medicaid. Continue to maintain the child under the COA above unless the child no longer meets the criteria for that program.

2132 New Option Waiver and Comprehensive Supports Waiver Program

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	New Option Waiver and Comprehensive Supports Waiver Program		
	Effective Date:	July 2024		
	Chapter:	2100	**Policy Number:**	2132
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-72

Requirements

New Options Waiver (NOW) and Comprehensive Supports Waiver Program (COMP) are classes of assistance (COA) designed to provide in-home and community-based services to Medicaid eligible intellectually disabled and developmentally disabled individuals who do not receive Medicaid benefits under a cash assistance program.

Basic Considerations

To be eligible under the NOW/COMP COA, an A/R must meet the following conditions:

- The A/R is assessed for waivered services by an DBHDD Regional Office.
- The A/R is approved by the DCH Medical Management contractor, Alliant Healthcare Solutions, evidenced by a completed DMA-7.
- The DMA-7 (only used for NOW/COMP) may be approved by the DBHDD Regional Office.
- The A/R is placed in a NOW/COMP slot and is receiving NOW/COMP waivered services.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

NOW/COMP Medicaid recipients receive certain *waivered* services.

The individual determined suitable through a level of care determination for NOW/COMP is placed under support coordination (case management).

The Support Coordinator arranges for the provision of waivered services to the recipient.

> The beginning date of Support Coordination (case management) is the same as the **enrollment date** for an A/R leaving an institution, and the same as the **date services begin** for an A/R already residing in the community.

A/Rs who are coming out of an institution may receive Support Coordination for up to six months prior to placement in NOW/COMP and while they are still living in the facility.

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the NOW/COMP COA.

Step 1 Accept the A/R's application, the Form 1008, NOW/COMP Communicator, and approved LOC instrument

> After April 1, 2003, DMA-6s will no longer be completed by GMCF/Alliant but by private vendors contracting with Mental Health. Instead of an actual DMA-6, it will be a mailer containing pertinent information. A new LOC instrument is required upon entry into NOW/COMP

Step 2 If the A/Rs income includes SSI, STOP, deny application. SSI NOW/COMP A/Rs' claims are directly billed to DCH through the NOW/COMP agency.

Step 3 If the A/R is institutionalized or resides in the community, and is ABD Medicaid eligible, schedule a review when information is received from the Support Coordinator or provider. Proceed to Step 6.

Step 4 If the A/R is institutionalized or resides in the community, and is not currently eligible for Medicaid, schedule an initial interview when information is received from the Support Coordinator or provider.

Step 5 Determine basic eligibility. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 6 Determine financial eligibility.

- Refer to 2500 ABD Financial Responsibility and Budgeting Overview.
- Complete a Medicaid Cap Budget to determine income eligibility. Refer to 2510 Medicaid Cap Budgeting.

Step 7 Determine if the Length of Stay criteria is met. Refer to 2235 Length of Stay for ABD Medicaid.

Step 8 The system will determine the A/R's Cost Share for NOW/COMP services. Refer to 2559 Patient Liability / Cost Share Budgetinge. **The PNA is the same amount as the Medicaid Cap.**

Step 9 Approve if the A/R meets all eligibility criteria.

> Do not approve Medicaid under the NOW/COMP COA for any month prior to the month of either the NOW/COMP Enrollment Date or Date Services Begin listed on Form 1008, NOW/COMP Communicator, or prior to 2/1/94, the effective date of the NOW, or 10/1/97, the effective date of the COMP amendment.

Step 10 Complete Section III of Form 1008, NOW/COMP Communicator. Enter the Medicaid number at the top of the form. Send to the originating I & E Team with a copy to the Regional Office (as noted on Form 1008). A list of Regional Office addresses and the counties they serve is found at the end of Section 2132. The I & E Team will complete the return address for the I & E Team and the Regional Office. File a copy in the case record.

> The NOW/COMP Communicator is used to provide required information to the NOW/COMP agency. If the NOW/COMP agency is listed as AREP in Gateway to receive the required notices, it is not necessary for the DFCS case worker to also complete and return the NOW/COMP Communicator.

Step 11 Notify the A/R and any authorized representative of case disposition.

Annual Reviews and Specials

Effective March 1, 2002, all DMA-7 forms processed by the I & E Teams for continued LOC will be completed on or before the birth date of the recipient. It will be valid until the following birth date, but not for longer than 365 days.

A new LOC instrument will not be required at annual review unless the review month coincides with the recipient's birth month. Otherwise, a LOC instrument received in the birth month of a recipient is to be treated as a special review.

Special Considerations

The NOW/COMP COA requires one specifically designated form, a Form 1008, NOW/COMP Communicator. The Communicator is maintained by DBHDD.

The NOW/COMP Communicator functions much like the Community Care Communicator (CCC). The form is initiated by the I & E Team completing the following sections:

- The top section, with all identifying information except the Medicaid number, unless the A/R is already a Medicaid recipient.
- Section I
- Section II
- Section IV
- Section V should include the I & E Team's address.

Division of Mental Health, Developmental Disabilities and Addictive Diseases

Contact Information for Division of Mental Health, Developmental Disabilities and Addictive Diseases can be found on the DBHDD website.

Entity	Contact Information
General Information	dbhdd.georgia.gov/
Regional Field Offices	dbhdd.georgia.gov/regional-field-offices

Entity	Contact Information
Regional Hospitals	dbhdd.georgia.gov/be-caring Georgia Crisis & Access Line at 1-800-715-4225

2133 TEFRA/Katie Beckett

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	TEFRA/Katie Beckett		
	Effective Date:	July 2024		
	Chapter:	2100	**Policy Number:**	2133
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-72

Requirements

Katie Beckett is a class of assistance (COA) available to children under age 18.

These individuals are determined to be in need of institutionalized care but have chosen to remain at home because they can be cared for at a lower cost. Katie Beckett allows the deeming of the income and resources of the child's parents to be waived when determining ABD Medicaid eligibility.

Basic Considerations

To be eligible under the Katie Beckett COA, an A/R must meet the following conditions:

- The A/R's age does not extend past the month s/he turns age 18.
- The A/R is chronically impaired to the extent of being a suitable candidate for institutionalized care (nursing facility, hospital or intermediate care facility for the intellectually disabled).
- The A/R is financially ineligible for SSI in a private living arrangement (LA-A, B or C) due to his/her own income and/or resources or income/resources deemed from his/her parent(s).
- The A/R meets the Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

Length of Stay (LOS) is not a requirement for this COA.

In some situations, a child may be eligible for either EDWP/CCSP, NOW/COMP, or Katie Beckett. The benefits of each COA should be explained to the parent(s) or other authorized representative (AREP). Also, the availability of CCSP and NOW/COMP services should be considered.

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the Katie Beckett COA.

Applications

Step 1 Accept the A/R's Medicaid application.

Additionally, for new applications, add the parents' income to the case, add Parents to the applicant group, and list the parents as the Authorized Representatives in Gateway.

Step 2 Screen for SSI financial eligibility:

- Complete an SSI trial budget, deeming the income and/or resources of the child's parent(s). Refer to Section 2508, Deeming. Allow a one third deduction to the child's own income if it is Child Support from a non-custodial parent.
  - If the child is financially eligible for SSI refer the child to SSA for an SSI determination and proceed with the Katie Beckett application.
  - If the child is financially ineligible for SSI, proceed with the Katie Beckett application.

> Review any reduction in the income or resources that might make the child eligible for SSI. Schedule interim reviews if changes are anticipated and terminate Katie Beckett Medicaid if the child becomes eligible for SSI.

Step 3 Give the family (or foster care worker if A/R is foster child) a packet of information regarding Katie Beckett COA. Go over forms/instructions with them so that they thoroughly understand how to complete. This packet should include:

- Katie Beckett Cover Letter
- Pediatric DMA-6(A) and instructions for completion
- TEFRA/Katie Beckett Medical Necessity/Level of Care Statement (DMA-706)
- Cost-Effectiveness Form (DMA-704)

The A/R's family (or foster care worker), the attending physician and Medicaid Eligibility Specialist (MES) have roles in completing a DMA-6(A) on the A/R.

- The **A/R's physician** completes the Medical Necessity/Level of Care Statement that outlines how the child's needs are met and the desired outcomes.
- The **caregiver (parent or guardian)** must sign and date.
- Foster Care members must have the signature of the **DFCS representative.**
- The A/R's physician completes the Cost-Effectiveness Form.

> Refer to Appendix F – Forms for instructions in completing DMA-6(A) and the Medical Necessity/Level of Care Statement.

Step 4 When the family (foster care worker) returns the DMA-6(A), the Cost-Effectiveness Form and the Medical Necessity/Level of Care Statement check the forms to make sure that **EVERY** question has been addressed, even if completed with N/A (not applicable). The forms must be signed with original signatures by the physician, parent(s), foster care worker as indicated. Stamped signatures are not acceptable. The doctor's signature date on the DMA-6(A) is valid for 90 days.

Return to the family for completion if lacking any of the requirements. Give them a reasonable time frame in which to return information.

Step 5 Have the family (foster care worker) obtain a signed psychological evaluation if any of the following is indicated on the DMA-6(A):

- Section B, item number 13, has a diagnosis of either mental illness, intellectually disabled, autism, or Asperger's syndrome

  OR

- Section C, item number 33, Behavioral Status has ANY of the boxes checked OTHER THAN "Cooperative" and/or "Alert".

The psychological evaluation must be completed by a licensed professional and is required every three (3) years. Licensed professionals approved to do this testing include Developmental Pediatricians and Ph.D. Psychologists. Psychological evaluations completed by school psychologists, preschool diagnosticians, and education diagnosticians with M.Ed., Ed.S., M.A., M.S., CAS, CAGS, Psy.S, Psy.D, SSP, or Ed.D degrees are also accepted. Developmental Evaluations done by Early Interventionist with Babies Can't Wait are accepted for children with an Individualized Family Service Plan (IFSP). The evaluation must be completed within the last 3 years of the evaluation date whether it is an initial application or review.

Give the family a reasonable time in which to return the psychological evaluation.

Step 6 When the Medical Necessity/Level of Care Statement, Form DMA-706, is received from the family (foster care worker), make sure copies of therapy notes are attached if indicated. The signature date on the Medical Necessity/Level of Care Statement is valid for 90 days.

Step 7 When the Medical Necessity/Level of Care Statement, Form DMA-706, is received from the family (foster care worker), make sure copies of Individualized Family Service Plan (IFSP) or Individualized Education Plan (IEP) are attached if indicated.

Step 8 Once the MES has received all the necessary information/forms, the MES becomes the "gatekeeper" of the material. As such, copies should be made of any data sent to Alliant Health Solutions (AHS).

Step 9 The LOC determination is obtained by mailing the following completed items to AHS.

- Level-of-Care determination routing form/checklist (DMA-705)
- DMA-6(A)
- Medical Necessity/Level of Care Statement (DMA-706)
- Psychological (if indicated)
- Therapy Notes (if indicated)
- Skilled Nursing Notes (if indicated)
- IFSP (if indicated)
- IEP (if indicated)

Send ALL items together at one time. Please check all forms and make sure they are complete. Mail packet to:

Alliant Health Solutions
Attention: TEFRA/Katie Beckett
P.O. Box 105406
Atlanta, GA 30348

If at any time the mailing address of the parents of a KB child changes during the LOC determination process please notify AHS via the TEFRA/Katie Beckett routing form/checklist (DMA 705).

Step 10 AHS reviews the information submitted and does the following:

- If packet is **incomplete**, AHS will issue an initial denial letter which includes what items are missing.
  - Letter is sent to Katie Beckett Specialized Team and family. The Family will have 30 days to return the missing information to AHS. The address for the family to mail information to is printed on the letter. If the family mistakenly sends the information to DFCS, forward immediately to AHS to the address on the letter.

If additional information is not received by the 30th day then the initial denial letter will become final.

- If packet is **complete**, AHS makes the LOC determination.
  - If LOC approval letter is received from AHS, continue with eligibility determination process, Step 15.
  - If LOC is initially denied by AHS, the family and DFCS will receive an “Initial Denial of Admission” letter. Proceed to Step 11.

Step 11 If AHS denies LOC or family fails to appeal and/or provide additional clinical information within the 30 days after the LOC denial, "the initial denial becomes a final denial. If AHS denies LOC after reviewing additional information", the eligibility worker and household will receive a Final Determination Denial of Admission. The family will have an additional 30 days in which to appeal (remove and/or provide medical information) as currently outlined in the section. When counting days, day one is the first day following the date on the letter, regardless of whether that day is a weekend or a holiday. However, if the 30th day falls on a weekend or a holiday, the next full business day is the 30th day. The address for the family to respond to is printed on the letter.

If the family mistakenly sends the information to DFCS, forward immediately to AHS to the address on the letter.

AHS will make a LOC determination and a disability determination, and the MES will proceed as follows:

- If approved, continue with eligibility determination process, Step 15.

For applications, MES will deny the case for no LOC. DO NOT SUPPRESS notice. For reviews, see REVIEW in this section.

If the family challenges the LOC denial, the family will send the appeal directly to DCH's Legal Services at:

Georgia Department of Community Health
Legal Services Section
2 Martin Luther King Jr. Drive SE East Tower
Atlanta, Georgia 30334

The appeal to DCH must be made within 30 days of the date of the LOC denial letter. When counting days, day one is the first day after the date on the letter, regardless of whether that day is a weekend or holiday. However, if the thirtieth falls on a weekend or holiday, the next full business day is the thirtieth day.

Should the family send the appeal to DFCS, forward the appeal to DCH's Legal Services. The state office Medicaid Unit will notify the county if an appeal has been filed. There are no benefits to continue with a denied application.

An Administrative Law Judge (ALJ) conducts the hearings for both LOC hearings and hearings for other reasons. However, requests for LOC hearings are routed through DCH Legal Services, not through OSAH. Follow the OSAH procedures (Appendix B – Hearings) for any hearing requests other than LOC.

Step 12 The MES will do the following based on the outcome of the final LOC hearing:

- If the ALJ upholds the LOC denial, the case remains closed. No further action is required. However, if the family wants to appeal the ALJ decision, see Step 13.
- If the ALJ overturns the LOC denial and provides a letter to that affect, the MES will register the Katie Beckett case again using the original application date and complete the eligibility determination process. It is not necessary to have the family sign a new application. Proceed to Step 15 or any other step not completed.

Step 13 To appeal the ALJ decision, the family should file a written request for an agency review within 30 days of receipt of the decision to:

Department of Community Health
Commissioner Frank W. Berry
Office of the General Counsel
2 Martin Luther King Jr. Drive SE East Tower
Atlanta, Georgia 30334

A copy must also be sent to DCH Legal at the same address in Step 11, or they may fax copy to 404-657-9711.

Step 14 Determine the child's suitability for care under a home care plan in lieu of institutionalized placement using the Cost-Effectiveness Form and the Katie Beckett Worksheet. Refer to Appendix F – Forms for the Worksheet.

Complete a Katie Beckett Worksheet as follows:

- Based on the approved LOC as determined by AHS, select the Medicaid cost of the appropriate institution using DCH's provided amounts. Refer to Appendix A1 for amounts. Base the type of institution chosen by the LOC reflected on the LOC approval letter.
- Subtract the physician's estimated monthly cost of home care on the Cost- Effectiveness Form from the monthly Medicaid billing rate of the institution.
- If in-home care is more costly, deny the Katie Beckett application.
- If in-home care is less costly or equal to, proceed with the Katie Beckett application.

Take into consideration in the cost comparison process any health or LTC insurance coverage. Do not use GAPP services/costs in the cost effectiveness determination. This includes skilled nursing care.

The MES should never complete the Cost-Effectiveness Form for the family. If the doctor leaves blanks on the form, it is up to the family to get it completed. Other medical entities may complete and initial the parts of the form that pertain to services they render to the A/R.

Step 15 Proceed with the eligibility determination process, completing financial and other Basic Eligibility Criteria, if not already completed.

> Medicaid eligibility under the Katie Beckett COA is not held to the pay date shown on the LOC approval letter for new applications or LOC expirations. For new applications, the three months prior may be approved even if those months pre-date the pay date on the LOC letter. For LOC expirations, the LOC is approved from the end date of the previous LOC approval even if those dates pre-date the pay date on the LOC approval letter. The end date of the LOC is one year from the date that the LOC determination was completed by AHS, unless the LOC letter indicates otherwise.

Step 16 If the A/R meets all eligibility criteria, approve Medicaid in Gateway by entering all pertinent data including any retroactive months. The system will determine financial eligibility using the Medicaid Cap and issue notification letter(s). There is no patient liability for this COA.

Renewals

Complete a review of eligibility annually and document any anticipated change in resources, income or potential SSI eligibility.

At renewal if not already present in case, add the parents' income to the case, add parents to the applicant group, and list the parents as the authorized representatives on the authorized representative page.

Complete Steps 3, 4 – 9, and 14 - 16. If the DMA-6(A) indicates that a psychological evaluation is required, see Step 5 for procedures. A psychological is only valid for 3 years from the date of the evaluation. If the Care Plan indicates the A/R receives therapy, follow procedures in Step 6. If the Care Plan indicates IFSP and/or IEP, follow procedures in Step 7.

Children currently eligible for Katie Beckett but Do Not have a Disability Determination:

- To ensure that a disability decision has been made on previously approved cases, when a Katie Beckett comes up for eligibility renewal and it has an approved LOC but no disability Decision, please request an updated letter from AHS to include disability.

Complete the following if the LOC is denied:

- If the family receives a letter of “Initial Denial of Admission” and submits additional clinical information timely to AHS, leave case open pending “Final Determination Denial of Admission” or LOC approval.
- If family receives the “Final Determination Denial of Admission” from AHS, the family has 30 days in which to appeal. The MES should close the case effective the end of the month in which the 30-day appeal time falls. DO NOT waive notice.
- The state office Medicaid Unit will notify the county if the family has requested an appeal of the LOC. If the family appeals and requests that the case remains open pending the appeal or provides additional medical information to AHS, the MES should reinstate the case. Add the following text to the reinstatement notice: “Case is reopened pending the outcome of the appeal or

reconsideration based on additional medical information."

- If the family appeals the denial and the LOC denial is overturned, reinstate the case, if not already reinstated.
- If the family appeals the denial and the hearing upholds the LOC denial, close the case, if reinstated, and waive the notice. If the family wishes to appeal the upheld LOC denial, they should make this appeal in writing to the DCH Commissioner. See Step 13.
- If the family does not appeal, the case remains closed

> The end date of the LOC is two years from the date that the LOC determination was completed by AHS, unless the LOC letter indicates otherwise. Never allow the LOC to expire before a new one is obtained. Best practice is to send the Katie Beckett packet with the DMA-6(A) to the family at least a month prior to the expiration of the LOC.

Anytime the A/R becomes ineligible for Katie Beckett Medicaid, terminate the case and complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

Procedures for Child Turning Eighteen

In the month the A/R turns 18 years of age, allow the Katie Beckett COA to close for the ongoing or following month. Then register and approve the A/R under AMN De Facto COA beginning the first month the Katie Beckett COA is closed. Send a verification checklist to the A/R or AREP requesting verification of application for SSI benefits. If the A/R fails to apply for SSI, close the existing case for failure to make application for other benefits. If the A/R provides verification of application for SSI, allow the AMN De Facto COA to remain open until the month after the month the child turns 19 years of age or until the SSI application is approved. If SSA makes a determination of not disabled, close the AMN De Facto COA providing timely notice.

> Eligibility must be reviewed under all Medicaid COA's (Waivers, etc.) before closing the (AMN De Facto) COA.

Special Considerations

A disabled child may be eligible for a $30 SSI personal needs allowance from SSA if s/he meets the following criteria:

- Is disabled
- Received SSI benefits (limited to PNA) while in a medical treatment facility
- Is ineligible for SSI solely because of deemed income or resources of the parents
- Is currently eligible for Medicaid under one of the following COAs:
  - Katie Beckett (Section 2133)
  - EDWP/CCSP (Section 2131)
  - Services under GAPP (Section 2933)

If the child meets the above criteria, refer the parent(s) to SSA to continue the SSI $30 PNA payment and Medicaid. Continue to maintain the child under the COA above unless the child no longer meets the criteria for that program.

2135 Hospice Care

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Hospice Care		
	Effective Date:	November 2023		
	Chapter:	2100	**Policy Number:**	2135
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-71

Requirements

Hospice Care is a class of assistance (COA) that provides Medicaid to cover care for terminally ill individuals.

Basic Considerations

To be eligible under the Hospice Care class of assistance an A/R must meet the following conditions:

- The A/R has a medical prognosis of six months or less life expectancy.
- The A/R is receiving hospice care services from an approved hospice care provider.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria

Hospice care services are provided to the A/R by a Medicaid hospice agency. The A/R may reside at home or in a nursing home.

Hospice care services include but are not limited to the following:

- nursing home
- medical social services
- physician services
- counseling services
- respite care
- home health aide services

> DMA only reimburses for medical services provided by the hospice care agency. These recipients receive a Medicaid card that identifies them as hospice care recipients, with a notation to medical service providers that all claims must be submitted through the hospice agency. If the A/R has prescription needs which are not covered through the Hospice provider and are not related to the Hospice diagnosis, the authorizing physician must submit to DCH a statement containing the Hospice diagnosis, what the unrelated drug is and why it is necessary. This statement should be sent for approval to:
>
> DCH Pharmacy Services Unit

2 Martin Luther King Jr. Drive SE
East Tower, 19th Floor
Atlanta, Georgia 30303

All SSI recipients receiving Institutionalized Hospice must be entered and processed in Gateway. These cases should be consistent with case management for SSI only nursing home cases. See 2578 SSI Recipients.

There is no patient liability or cost share for A/Rs in a home setting. However, for Hospice A/Rs in a NH setting, a PL/CS is determined the same as for NH A/Rs. See 2136 Institutionalized Hospice.

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the Hospice Care COA.

Step 1 Accept the A/R's Medicaid application

Step 2 Verify the following through receipt of a Hospice Care Communicator (HCC) from the hospice agency:

- A/R's medical prognosis (life expectancy)
- A/R's (or PR's) election of hospice services
- Date hospice care services began

Step 3 If the A/Rs income includes SSI and not Institutionalized, STOP, deny application. SSI Hospice At Home A/R's claims are directly billed to DCH through the Hospice agency.

Step 4 Conduct an interview.

Step 5 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 6 Determine financial eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to 2510 Medicaid Cap Budgeting. If A/R has income over the Medicaid Cap, refer to 2407 Qualified Income Trust.

Step 7 Approve Medicaid on the system using the Hospice Care COA if the A/R meets all the above eligibility criteria.

For an A/R receiving hospice care services in a nursing home, determine Institutionalized Hospice eligibility. See 2136 Institutionalized Hospice.

Step 8 Notify the A/R of the case disposition via the system. Notify the hospice provider of the case disposition using the Hospice Care Communicator (HCC) and enter the hospice agency as an Authorized Representative in the system.

Step 9 Verify at the following intervals through receipt of an HCC that the hospice care provider has received a signed statement from the A/R electing to continue hospice care services:

- by the end of the first 90-day period of hospice care
- by the end of the second 90-day period of hospice care
- every 60 days thereafter

> Do not approve Medicaid under the Hospice Care COA for any month in which the A/R will not receive hospice services from an approved hospice agency. If the A/R does not elect to continue hospice services at the intervals specified above, complete a CMD. Refer to the 2052 Continuing Medicaid Determination.

Special Considerations

For any month in which an A/R is in Hospice care and another COA such as Hospital or Nursing Home, approve the case on the system under the other COA. Use Hospice COA when the A/R is in Hospice and not eligible under any other COA for a specific month.

A/Rs may receive Hospice services while receiving Medicaid through EDWP/CCSP. It is not necessary to terminate the existing EDWP/CCSP case and switch to Hospice. If A/R was eligible under the Hospice COA, switch to EDWP/CCSP. The Hospice and EDWP/CCSP eligibility may occur simultaneously in MHN.

2136 Institutionalized Hospice

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Institutionalized Hospice		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2136
	Previous Policy Number(s):	MT 54	**Updated or Reviewed in MT:**	MT-58

Requirements

Institutionalized Hospice is an ABD Medicaid Class of Assistance (COA) that provides Medicaid to terminally ill individuals who receive hospice care services while residing in a Medicaid participating nursing home.

Basic Considerations

To be eligible under the Institutionalized Hospice COA, an A/R must meet the following conditions:

- The A/R is receiving or elects to receive Hospice Care services while residing in a Medicaid participating nursing home.
- The A/R has a medical prognosis of six months or less life expectancy.
- The A/R is receiving Hospice Care services from an approved hospice care provider.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria required for the Hospice Care COA.

A DMA-59 is not required unless the A/R leaves hospice care and remains in the nursing home under Medicaid.

Hospice care services are provided to the A/R by a DMA certified hospice agency. Effective April 1, 2003, Medicaid eligible persons who receive or elect hospice care services while residing in a nursing home must pay a monthly patient liability amount to the hospice care provider. The hospice care provider will pay to the nursing home the patient liability amount.

DMA reimburses only those medical services provided by the hospice care agency. These recipients receive a Medicaid card that identifies them as Hospice recipients, with a notice to medical service providers that all claims must be submitted through the hospice agency.

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the Institutionalized Hospice COA.

Step 1 Accept the A/R's Medicaid application

Step 2 Verify the following through receipt of a Hospice Care Communicator (HCC) from the hospice agency:

- A/R's medical prognosis (life expectancy)
- A/R's (or PR's) election of hospice services
- The date hospice services began

Step 3 Conduct an interview.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, for determining whose resources to consider and the resource limit to use.

Step 6 If the A/R meets all the above eligibility criteria, approve Medicaid on the system.

Step 7 Notify the A/R of the case disposition via the system. Notify the hospice provider of the case disposition and Patient Liability using the Hospice Care Communicator (HCC) and enter the hospice provider as an Authorized Representative in the system.

Step 8 Verify at the following intervals through receipt of an HCC that the hospice care provider has received a signed statement from the A/R electing to continue Institutionalized Hospice services:

- by the end of the first 90-day period of Institutionalized Hospice
- by the end of the second 90-day period of Institutionalized Hospice
- every 60 days thereafter

Do not approve Medicaid under the Institutionalized Hospice COA for any month in which the A/R will not receive hospice services from an approved hospice agency. If the A/R does not elect to continue hospice services at the intervals specified above, complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

Special Considerations

Effective September 1, 2004, the AMN IH COA will be eliminated due to a change in the State Plan. Complete a CMD to determine if the A/R is eligible under another COA such as regular AMN.

If the A/R was Medicaid eligible under the NH COA prior to IH or no longer elects IH but remains in the NH, enter the appropriate information on the ABD screen(s) in the current eligibility system.

All SSI only recipients receiving Institutionalized Hospice must be entered and processed in Gateway. These cases should be consistent with case management for SSI only nursing home cases. See SSI Recipients, Section 2578.

Sanctions

If the NH is under a Medicaid sanction resulting in a "ban on admissions", no Hospice Care Communicator (HCC) should be sent to DFCS until such time as the ban is lifted. Until the "ban on admissions" is lifted, no A/R should be approved for the IH COA if the A/R is admitted to IH on or after the effective date of the ban on admissions. A ban on admissions has no effect on A/Rs who are already Medicaid recipients in IH or who were admitted to IH prior to the imposition of the ban.

If an application is received on an A/R who was admitted during the time the "ban on admissions" is in place, hold the case until either the ban is lifted and the case can be approved under the IH COA or the standard of promptness (SOP) is reached. If the case cannot be approved under the IH COA by the SOP date, determine eligibility under another COA such as regular AMN. Do not determine eligibility under any LA-D COA. If the "ban on admissions" is subsequently lifted, historically close the other Medicaid case and approve under the IH COA back to the first month of eligibility.

The county DFCS will be copied on the facilities notification of "Denial of Payment" from DCH/Aging and Community Health Services. The county DFCS will also be copied when the Denial of Payment ban is lifted.

2137 Hospital

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Hospital		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2137
	Previous Policy Number(s):	MT 10	**Updated or Reviewed in MT:**	MT-58

Requirements

The Hospital Class of Assistance (COA) provides Medicaid for individuals who are hospitalized for at least 30 consecutive days. The period of confinement may include a combination of days in either a Medicaid participating or non-Medicaid participating institution.

Basic Considerations

To be eligible under Hospital COA, the A/R must meet the following conditions:

- The A/R requests Medicaid due to a stay in a Medicaid participating hospital.
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the Hospital COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Obtain information required to complete the eligibility determination.

Step 3 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 4 Determine financial eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to Section 2510 Medicaid Cap Budgeting.

There is no patient liability or cost share under this COA.

Step 5 Approve Medicaid under the Hospital COA if the A/R meets all the above eligibility criteria.

Do **not** approve Medicaid under the Hospital COA for any month in which the A/R was not hospitalized for at least one day of the month.

2139 Independent Care Waiver Program

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Independent Care Waiver Program		
	Effective Date:	July 2024		
	Chapter:	2100	**Policy Number:**	2139
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-72

Requirements

The Independent Care Waiver Program (ICWP) is a class of assistance (COA) that provides in home care to individuals who are Severely Physically Disabled (SPD) or who have Traumatic Brain Injuries (TBI). SPD individuals are those who cannot physically care for themselves and require assistance from another for daily functioning. These individuals need more care than can be provided by EDWP. ICWP A/Rs must meet the criteria for nursing home placement although they remain at home.

Basic Considerations

To be eligible under this COA, an A/R must meet the following conditions:

- The A/R is between 21 through 64 years of age. Applicants approved prior to age 65 may continue to be eligible after attaining age 65 if they continue to meet all other eligibility criteria.
- The A/R is receiving case management services through a DMA approved ICWP case management provider.
- The A/R is residing in a residential home situation, such as his/her own home.
- The A/R meets the length of stay (LOS) and the level of care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

ICWP Medicaid recipients receive certain waivered services not normally covered by Medicaid, including the following:

- case management
- companion services
- counseling
- emergency response system (ERS)
- environmental modification
- homemaker services
- occupational therapy
- personal care services
- skilled nursing

- specialized medical equipment and supplies
- transportation

Refer any individuals interested in receiving services under ICWP to:

Alliant Health Solutions
P.O. Box 105406
Atlanta, Georgia 30348

(678) 527-3632, (678) 527-3619 or 1-800-982-0411
Local Fax Line: 678-527-3001
Toll Free Fax Line: 1-800-716-5358

The case management provider (case manager) submits the LOC information to Alliant Health Solutions (AHS) and initiates the ICWP services approval process.

- The case manager obtains the LOC instrument and sends to DFCS. Receipt of the LOC instrument verifies the LOC for ICWP. A DMA-6 is still a valid LOC instrument for some of the older cases.
- The case manager submits an Individual Plan of Care and a Recipient Application form to the DMA Waivered Services Unit for approval of ICWP services. The Waivered Services Unit notifies the case manager of approval or denial of the A/R for ICWP services.
- If DMA approves the A/R, the case manager submits an Independent Care Waiver Communicator to DFCS, specifying the date case management began, which is used for LOS, and the date of the first waivered service, which serves as the slot date for eligibility purposes in the same manner as it is used under EDWP.

The beginning date of case management and the slot date should be the same in most cases since case management is a waivered service under ICWP.

If ICWP services are approved by DMA, the case manager and the A/R decide on service providers.

The A/R may apply for ICWP Medicaid while residing at home, in a hospital or in a nursing home.

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the ICWP class of assistance.

Step 1 Accept the A/R's ABD Medicaid application.

Step 2 Obtain information necessary to process application.

Step 3 Verify that the A/R is receiving ICWP services through receipt of an ICWP Communicator from the case manager. The ICWP Communicator should indicate the beginning date of case management and the slot date.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility. Consider the A/R to be in LA-D.

- See Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on whose resources to consider and the resource limit used in determining resource eligibility.
- Complete a Medicaid Cap budget to determine income eligibility. See Medicaid CAP Budgeting in Chapter 2510. If client's income exceeds the Medicaid CAP, then client must establish a QIT in order to be determined eligible.

> If the A/Rs income includes SSI, STOP, deny application. SSI ICWP claims are directly billed to DCH through ICWP.

Step 6 Determine the A/R's cost share using the Community Spouse Maintenance Need Standard (CSMNS) as the personal needs allowance (PNA) and all other policies applicable to patient liability/cost share budgeting.

> If AR is over the Medicaid CAP and has a QIT please remember that there is the potential of a cost share with these cases.

Step 7 Notify the A/R of eligibility/cost share.

> Do not approve Medicaid under the ICWP class of assistance for any month prior to the month of the slot date. Do not approve Medicaid under the ICWP COA if the A/R is under age 21 or age 65 or older.

Step 8 Notify the ICWP Case manager by:

- Entering the Case Manager's name and address in the system as an Authorized Representative. The Case Manager will then receive information concerning dates of eligibility and cost share.

  OR

- Completing Section II of the ICWP Communicator. Enter the Medicaid number on the top of the form. Send one copy to the Case Manager and scan the other into the document imaging system.

Special Considerations

ICWP Communicator (ICWPC)

The ICWP class of assistance requires the Independent Care Waiver Communicator (ICWC) form as a means for the ICWP Case Manager to communicate with the DFCS Eligibility Worker. The Eligibility Worker may use this form or the system as a means of relaying ICWP approval, denial, or termination information to the Case Manager. Make copies of this form, found at the end of this section, as needed.

The ICWC functions much like the Community Care Communicator (CCC). The form is initiated by the case manager and forwarded to DFCS after the A/R is approved for ICWP services. The case

manager completes the following sections of the ICWC:

- The top section, with all identifying information except the Medicaid number unless the A/R is already a Medicaid recipient.
- Section I, giving the date case management began, the slot date, and a request for a determination of Medicaid eligibility (if needed) and cost share amount.

2141 Nursing Home

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Nursing Home		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2141
	Previous Policy Number(s):	MT 49	**Updated or Reviewed in MT:**	MT-58

Requirements

Nursing Home is a class of assistance (COA) that provides Medicaid to individuals residing in a Medicaid participating nursing home.

Basic Considerations

To be eligible under nursing home COA, an A/R must meet the following conditions:

- The A/R is in a Medicaid participating nursing home, swing bed, facility for mentally retarded or Tertiary Care Unit (TCU) (See Section 2581 for Swing Bed.)
- The A/R meets the Length of Stay (LOS) and Level of Care (LOC) basic eligibility criteria.
- The A/R meets all other basic and financial eligibility criteria.

Please see Section 2143 regarding Medicare Skilled Nursing Facility (SNF) for QMB

Procedures

Follow the steps below to determine ABD Medicaid eligibility under the Nursing Home COA.

Step 1 Accept the A/R's Medicaid application.

Step 2 Verify from the receipt of a Form DMA-59 from the nursing home that the A/R resides in a nursing home or TCU. Verify from the receipt of an approved LOC instrument that the A/R resides in a swing bed or that the A/R is in a facility for the mentally retarded (may be a NH).

Step 3 Conduct an interview. A telephone interview is acceptable.

Step 4 Determine basic eligibility, including Length of Stay (LOS) and Level of Care (LOC). LOC verification may vary depending on whether A/R is in NH, TCU, swing bed or has a LOC of IC-MR. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 5 Determine financial eligibility.

- Refer to Chapter 2500, ABD Financial Responsibility and Budgeting for procedures on whose resources to consider and the resource limit to use in determining resource eligibility.
- Complete a Medicaid CAP budget to determine income eligibility. Refer to Section 2510, Medicaid CAP Budgeting

Step 6 Approve Medicaid using the Nursing home COA if the A/R meets all the above eligibility criteria. The system will determine the A/R's patient liability based on information entered.

Do not approve Medicaid under the Nursing Home COA for any month in which the A/R was not confined to a nursing home for at least one day of the month.

Step 7 Notify the A/R and/or PR and the nursing home of the case disposition and patient liability.

Special Considerations

Effective September 1, 2004, AMN-NH will be eliminated due to a change in the State Plan. Complete a CMD to another COA, such as AMN (Section 2150).

Sanctions

If the NH is under a Medicaid sanction resulting in a "ban on admissions", no DMA-59 should be sent to DFCS until such time as the ban is lifted. Until the "ban on admissions" is lifted, no A/R should be approved for the NH COA if the A/R is admitted to the NH on or after the effective date of the ban on admissions. A ban on admissions has no effect on A/Rs who are already Medicaid recipients in the NH or who were admitted to the NH prior to the imposition of the ban.

If an application is received on an A/R who was admitted during the time the "ban on admissions" is in place, hold the case until either the ban is lifted and the case can be approved under the NH COA or the standard of promptness (SOP) is reached. If the case cannot be approved under the NH COA by the SOP date, determine eligibility under another COA such as regular AMN. Do not determine eligibility under any LA-D COA. If the "ban on admissions" is subsequently lifted, historically close the other Medicaid case and approve under the NH COA back to the first month of eligibility.

The "Denial of Payment" notification letters will come to the Medicaid Policy Unit from DCH's Member Services. The Medicaid Policy Unit will forward the letters to the appropriate Field Program Specialist who will then forward to the county DFCS office. When the Denial of Payment ban is lifted this same process will take place.

2143 Qualified Medicare Beneficiaries

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Qualified Medicare Beneficiaries		
	Effective Date:	November 2023		
	Chapter:	2100	**Policy Number:**	2143
	Previous Policy Number(s):	MT 68	**Updated or Reviewed in MT:**	MT-71

Requirements

Qualified Medicare Beneficiaries (QMB) is a Q Track class of assistance (COA) that provides a Medicare supplement to individuals who meet financial criteria based on the Federal Poverty Level (FPL).

Basic Considerations

To be eligible under this COA an A/R must meet the following conditions:

- The A/R is enrolled in Medicare Part A, Parts A and Part B, or Part B only.
- The A/R meets all basic eligibility criteria.

> Applicants/Recipients who are entitled to or enrolled in Medicare are exempt from the citizenship verification requirement. Citizenship was verified by SSA prior to awarding Medicare. A Declaration of U.S. Citizenship is still required. Individuals who attest to satisfactory immigration status must have their immigration status verified through SAVE as there are some differences in the immigrant eligibility between Medicare and Medicaid.

> Application for Other Benefits, Length of Stay (LOS) and Level of Care (LOC) are not requirements under this COA.

- The A/R has countable resources of less than or equal to the current QMB/SLMB/QI-1 resource limit.
- The A/R has countable net income of less than or equal to the QMB income limit.

QMB pays the following for the QMB eligible individual:

- the monthly premium for Part A Medicare for those individuals who must pay a premium
- the monthly premium for Part B Medicare
- all Medicare co-insurance payments (the 20% of covered charges that Medicare will not pay)
- all Medicare deductibles, such as the in-patient hospital deductible

> Effective for dates of service on or after May 11, 2012, payments for Medicare coinsurance, copayments, and deductibles for dual Medicare/Medicaid members, including QMB, will be limited to the Medicaid maximum allowable amount. If the Medicare payment on a claim is equal to or greater than the Medicaid maximum allowable amount, Medicaid will not pay

anything on the claim. All Medicare providers are prohibited from billing QMB recipients for Medicare cost-sharing. This includes Medicare coinsurance, copayments, and deductibles. (See Special Considerations at the end of this section.)

QMB will **not** cover any medical service that is not covered by Medicare.

Applicants for QMB must meet all eligibility criteria for this COA in the month of approval and the following month in order to be approved.

No property search is required for this class of assistance.

There is no retroactive coverage under this COA. QMB eligibility begins the first day of the month following the month the eligibility determination is completed.

If the individual is enrolled in Part B, but not Part A, determine them eligible for QMB if they otherwise meet the eligibility criteria.

If an individual is age 65 or older and neither enrolled in Part A nor Part B, direct the individual to file a conditional Part A application at SSA for the purposes of applying for QMB. Individuals can conditionally enroll in Part A at SSA at any time of the year, without regard to Medicare enrollment periods.

The conditional enrollment process allows an individual to apply for premium Part A at SSA on the condition that they will only be enrolled in Part A if the individual then applies for Medicaid at DFCS and is determined eligible for QMB. If DFCS determines the individual ineligible for QMB, SSA will not establish Part A entitlement.

As part of the conditional Part A application, SSA will enroll an individual in Part B.

SSA will process applications for Part B Medicare without regard to QMB eligibility.

An individual who has income less than the FBR may be eligible for QMB and not eligible for SSI because of excess resources.

In-kind Support and Maintenance (ISM) is not considered in determining QMB eligibility.

The QMB income limit is based on the FPL. The FPL/QMB income limit is subject to change between February and April of each year. Therefore, the annual January RSDI COLAs are disregarded in determining QMB eligibility until the effective month of the new QMB income limit.

Refer to Special Considerations in this section for procedures on processing the QMB application for **SSI** individuals.

THE STANDARD OF PROMPTNESS FOR QMB APPLICATIONS IS 10 WORKING DAYS FROM RECEIPT OF THE APPLICATION.

The 1999 Government Performance Results Act simplified the policy and procedures for this class of assistance and has changed the application process. In addition to applying at the county office, an A/R may apply with the local Community Health Center or with GeorgiaCares on a simplified application form DCH 700, Medicare Savings for Individuals. (County DFCS shall also use this application form which is available from Central Supply.)

Special Considerations

Any applications that are sent to DCH will be forwarded to the appropriate County Departments. The application date is the date stamped as received by DCH.

Procedures

Follow the steps below to determine QMB eligibility.

Step 1 Accept the A/R's QMB application.

> A face-to-face contact and office interview is not required at initial application or annual redetermination.

Step 2 Contact the A/R by telephone only if information provided on the application is not sufficient to process the case.

Step 3 Verify Part A Medicare entitlement by one of the following:

- client statement, if copy of card or other written verification is not provided or available
- a RSDI Award Letter
- BENDEX, SOLQ under Interfaces in Gateway
- an MBR Query Card
- notification from a local SSA office

Step 4 Determine all basic eligibility criteria except LOS, LOC and Application for Other Benefits. Accept A/R's statement regarding residency. Refer to Chapter 2200, Basic Eligibility Criteria.

> To fulfill the TPR requirement on a QMB applicant who reports a TPR, copy the application and send to the DCH TPL Unit. Attach a copy of the insurance card if available.

Step 5 Determine financial eligibility. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following:

- whose income and resources to consider
- which QMB income and resource limit (individual or couple) to use
- which eligibility budget to complete

> For all applications and annual redeterminations: The A/R's statement of income and resources provided on the application/review form is acceptable verification.

No further verification is required unless questionable. Call, if needed, to confirm TPR status. If BENDEX/SDX/SOLQ or other information known to the agency indicates an amount different from the A/R's statement and is determined to be current, use this amount over the A/R's statement.

> If a Medicare eligible couple both apply for a Q Track COA and they are income ineligible as a couple for all Q track COA, calculate their eligibility as individuals for income but jointly for resources and approve each under whichever Q track COA they are eligible.

The Social Security number of a spouse who is not applying for benefits is not required unless eligibility cannot be established without it.

Step 6 Approve QMB on the system to begin the month **following** the month of case disposition if the A/R meets all the above eligibility requirements. However, if approval of the case is not completed within the standard of promptness due to agency or other agency delay, use the QMB override feature to not penalize the A/R for any month(s) in which the individual meets all of the eligibility requirements in that month, as long as it is for a month after the month of application.

Step 7 Notify the A/R of the case disposition via the system generated notice.

Special Considerations

Processing a QMB Application on an SSI Recipient

Effective August 1991, SSI Only recipients must apply for and be approved for QMB before DCH will pay the Part A Medicare premium through the buy-in process.

The following SSI recipients **must** apply for QMB at DFCS in order to have the premium paid by DCH:

- **Aged SSI Only recipients who are enrolled in Part B only. These individuals are eligible for Part A Medicare with a monthly premium.** SSI Only (without RSDI or RR income) recipients who are age 65 or older are eligible for Part A Medicare with a monthly premium. The member will not receive Part A until the QMB application is approved.
- **SSI recipients (SSI only) whose claim number ends with an "M". This information can be confirmed by viewing electronic sources such as (SDX, Bendex and SOLQ).**

The following SSI Only recipients will receive a letter from DCH informing them of the need to apply for QMB:

- SSI applicants aged 65 or older who are newly approved by SSA to receive SSI
- SSI recipients who reach age 65

The SSI Only recipient must submit an application for QMB through DFCS.

> In October 2017, DCH issued a memorandum regarding SSI recipients eligible for Part B only (eligible for Medicare premium Part A). DFCS eligibility workers should accept and make an eligibility determination on an MSP application from **any SSI-eligible individual**, provided the individual is enrolled in Part A, Parts A and B, or Part B only. Although DCH pays the Medicare Part B premium for SSI-related Medicaid members when they become entitled, they must file an application with DFCS for QMB if they have a Medicare claim number that ends with “M" and wish to have the Part A Medicare premium paid by DCH.

Current SSI eligibility is prima facie evidence of financial eligibility for QMB. The SDX record showing current SSI pay status is acceptable verification. Document the case that the SDX screen has been viewed.

DFCS eligibility workers must enroll individuals in **Medicare Part A** buy-in after the QMB eligibility determination. Workers should not refer individuals to SSA to apply for Part A. Part B enrollment indicates they are eligible for Part A with a monthly premium.

Follow the steps below to establish QMB eligibility for an SSI Only and/or combo recipient.

Step 1 Register the applicant on the system.

Step 2 Obtain information necessary to process the application. An interview is not required. Additional information may be obtained by contacting the applicant by telephone or mail.

Step 3 Document QMB financial eligibility based on receipt of SSI.

> An SSI certification letter is acceptable verification if SDX is not available.

Step 4 Scan a copy of the letter referring the recipient to DFCS to apply for QMB Into current document imaging system.

Step 5 Verify potential Part A Medicare eligibility by one of the following:

- the DCH letter to the A/R regarding QMB and Buy-In
- the A/R's DOB on SDX showing current age as 65 or older
- "AI" at the end of the SSI claim letter
- an SSI certification letter
- SOLQ

If none of these methods of certification is available, request the A/R obtain a letter from SSA verifying potential eligibility for Part A Medicare entitlement.

Step 6 Approve QMB to begin the month following the month of case disposition if the A/R meets all above eligibility requirements.

Step 7 Notify the A/R of the case disposition via the system.

Reviews for SSI Recipients

Redetermine eligibility in the month due by means of a telephone contact with the client and review of SDX to show that the client remains in current SSI pay status. Since A/R is SSI eligible, no further forms or contact is required.

QMB Recipient under Medicare SNF Care

If the QMB recipient qualifies for Medicare Skilled Nursing Facility (SNF) care, Medicaid is required to pay the copayments even if that amount is zero. QMB individuals are not required to apply for Nursing Home Medicaid if they do not desire to do so. (Note: after the first 100 days in a benefit period QMB recipients will be responsible for all cost.)

When a QMB recipient is admitted to a nursing facility under Medicare SNF care, the nursing facility will complete a Form DMA-59, Sections I, II, and III and email form to dma-59.forms@dch.ga.gov. The nursing facility will notify DCH when the individual is discharged from Medicare SNF care by completing Section IV of the same Form DMA-59 and emailing the form to dma-59.forms@dch.ga.gov.

If an individual is already eligible for QMB or SLMB and later applies for, and is eligible for, a full Medicaid aid category, such as SSI, Nursing Home or Waivered Services, the MSP program should remain open. The individual is dually eligible.

2144 Specified Low-Income Medicare Beneficiaries

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Specified Low-Income Medicare Beneficiaries		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2144
	Previous Policy Number(s):	MT 55	**Updated or Reviewed in MT:**	MT-58

Requirements

Specified Low-Income Medicare Beneficiaries (SLMB) is a Q Track class of assistance (COA) that pays the monthly premium for Medicare Supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal poverty level (FPL).

Basic Considerations

To be eligible under this COA, an A/R must meet the following conditions:

- The A/R is entitled to Part A Medicare coverage.
- The A/R meets all basic eligibility criteria.

> Since SLMB recipients receive Medicare, they are exempt from the citizenship verification requirement. Citizenship was verified by SSA prior to awarding Medicare. The Declaration of Citizenship form is still required.

> Application for Other Benefits, Third Party assignment, Length of Stay (LOS) and Level of Care (LOC) are not requirements under this COA.

- The A/R has countable resources of less than or equal to the current QMB/SLMB/QI-1 resource limit.
- The A/R has countable net income of less than the SLMB income limit but greater than the QMB income limit.

SLMB pays only the monthly premium for Part B Medicare for the SLMB eligible individual.

Retroactive coverage (three months prior and intervening months) is allowed under this COA. SLMB eligibility cannot pre-date January 1993.

The SLMB income limit is based on the federal Poverty level (FPL). The FPL/SLMB income limit is subject to change between February and April of each year. Therefore, the annual January RSDI COLAs are disregarded in determining SLMB eligibility until the effective month of the new SLMB income limit.

In-kind support and maintenance (ISM) is NOT considered in determining SLMB eligibility.

> THE STANDARD OF PROMPTNESS FOR PROCESSING A SLMB APPLICATION IS 10 WORKING

DAYS FROM THE DATE OF RECEIPT OF THE APPLICATION.

Special Considerations

The 1999 Government Performance Results Act simplified the policy and procedures for this class of assistance and has changed the application process. In addition to applying at the county office, an A/R may apply with the local Community Health Center or with HICARE on a simplified application form, DCH 700, Medicare Savings for Individuals. (County DFCS shall also use Form 700 for initial applications and annual reviews. It is available from Central Supply.)

The local Community Health Center and HICARE will forward all applications to DMA, who will forward the applications to the appropriate County Departments. The application date is the date stamped as received by DMA.

Procedures

Follow the steps below to determine SLMB eligibility.

Step 1 Accept the A/R's SLMB application.

Step 2 Contact the A/R by telephone only if information provided on the application is not sufficient to process the case.

> A face-to-face contact and office interview is not required at initial **application or annual redetermination.**

Step 3 Verify Part A Medicare entitlement by one of the following:

- client statement, if copy of card or other written verification is not provided or available
- a RSDI Award Letter
- a Medicare card
- BENDEX under Clearinghouse on the system
- an MBR Query Card
- notification from a local SSA office

> If the A/R has not been approved for Part A Medicare, but is entitled to free Part A, obtain notification from SSA, scan into document imaging system and process SLMB as though the A/R is currently covered by Part A Medicare. (If an A/R is required to pay a premium to receive Part A Medicare, he/she is not considered entitled for purposes of eligibility for SLMB.)

Step 4 Determine all basic eligibility criteria except LOS, LOC and Application for Other Benefits. Accept the A/R's statement regarding residency. Refer to Chapter 2200, Basic Eligibility Criteria.

> To fulfill the TPR requirement on a SLMB applicant who has a TPR, copy the application and send to DMA only if the SLMB applicant becomes Medicaid eligible under another COA. Attach a copy of the insurance card, if available.

Step 5 Determine financial eligibility using SLMB income and resource limits. Refer to the **Chapter 2500, ABD Financial Responsibility and Budgeting** to determine the following:

- whose income and resources to consider
- which SLMB income and resource limit (individual or couple) to use
- which eligibility budget to complete

> For all applications and annual redeterminations: The A/R's **statement of income and resources provided on the application/review form is acceptable verification**. No further verification is required unless questionable. If BENDEX/SDX or other information known to the agency indicates a different amount from the A/R's statement and is determined to be current, use this amount over the A/R's statement.

> If a Medicare eligible couple both apply for a Q Track COA and they are income ineligible as a couple for all Q Track COA, calculate their eligibility as individuals for income but jointly for resources and approve each under whichever Q Track COA they are eligible.

No property search is required for this class of assistance.

The Social Security number of a spouse who is **not** applying for benefits is not required unless eligibility cannot be established without it.

Step 6 If the A/R meets all the above eligibility requirements, approve SLMB by entering the information in the current eligibility system and approve the case for SLMB.

Step 7 Notify the A/R of the case disposition via the system generated notice.

2145 Qualifying Individuals – 1

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Qualifying Individuals – 1		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2145
	Previous Policy Number(s):	MT 51	**Updated or Reviewed in MT:**	MT-58

Requirements

Qualifying Individuals – 1 (QI-1) is a Q Track class of assistance (COA) that pays the monthly premium for Medicare supplemental Medical Insurance (Part B) for individuals who meet financial criteria based on a percentage of the Federal Poverty Level (FPL). Eligibility criteria are identical to SLMB except that the coverage is time limited depending on available State funds and the income limit is higher than the SLMB limit.

Basic Considerations

To be eligible under this COA, an A/R must meet the following conditions:

- The A/R is entitled to Part A Medicare coverage.
- The A/R meets all basic eligibility criteria.

> Since QI-1 recipients receive Medicare, they are exempt from the citizenship verification requirement. Citizenship was verified by SSA prior to awarding Medicare. The Declaration of Citizenship form is still required.

> Application for Other Benefits, Third Party assignment, Length of Stay (LOS) and Level of Care (LOC) are not requirements under this COA.

- The A/R has countable resources of less than or equal to the current QMB/SLMB/QI-1 resource limit.
- The A/R has countable net income of less than the QI-1 income limit but greater than the SLMB income limit.

QI-1 pays only the monthly premium for Part B Medicare for the QI1 eligible individual.

Retroactive coverage (three months prior and intervening months) is allowed under this COA. QI-1 eligibility cannot pre-date January 1998.

The QI-1 income limit is based on the federal Poverty level (FPL). The FPL/QI-1 income limit is subject to change between February and April of each year. Therefore, the annual January RSDI COLAs are disregarded in determining QI-1 eligibility until the effective month of the new QI-1 income limit.

In-kind support and maintenance (ISM) is NOT considered in determining QI-1 eligibility.

THE STANDARD OF PROMPTNESS FOR PROCESSING A SLMB APPLICATION IS 10 WORKING DAYS FROM THE DATE OF RECEIPT OF THE APPLICATION.

Special Considerations

The 1999 Government Performance Results Act simplified the policy and procedures for this class of assistance and has changed the application process. In addition to applying at the county office, an A/R may apply with the local Community Health Center or with HICARE on a simplified application form, DCH 700, Medicare Savings for Individuals. (County DFCS shall also use Form 700 for initial applications and annual reviews. It is available from Central Supply.)

The local Community Health Center and HICARE will forward all applications to DMA, who will forward the applications to the appropriate County Departments. The application date is the date stamped as received by DMA.

Procedures

Follow the steps below to determine QI-1 eligibility.

Step 1 Accept the A/R's QI-1 application. Since this is a time limited program, it is important to take and process applications in chronological order.

Step 2 Contact the A/R by telephone only if information provided on the application is not sufficient to process the case.

A face-to-face contact and office interview is not required at initial **application or annual redetermination.**

Step 3 Verify Part A Medicare entitlement by one of the following:

- client statement, if copy of card or other written verification is not provided or available
- a RSDI Award Letter
- a Medicare card
- BENDEX under Clearinghouse on the system
- an MBR Query Card
- notification from a local SSA office

If the A/R has not been approved for Part A Medicare, but is entitled to free Part A obtain notification from SSA, scan into document imaging system and process QI-1 as though the A/R is currently covered by Part A Medicare. (If an A/R is required to pay a premium to receive Part A Medicare, they are not considered entitled for purposes of eligibility for QI-1.)

Step 4 Determine all basic eligibility criteria except LOS, LOC and Application for Other Benefits. Accept the A/R's statement regarding residency. Refer to Chapter 2200, Basic Eligibility Criteria.

> To fulfill the TPR requirement on a QI-1 applicant who has a TPR, copy the application and send to DMA only if the QI-1 applicant becomes Medicaid eligible under another COA.

Step 5 Determine financial eligibility using QI-1 income and resource limits. Refer to the 2500 ABD Financial Responsibility and Budgeting Overview to determine the following:

- whose income and resources to consider
- which QI-1 income and resource limit (individual or couple) to use
- which eligibility budget to complete

> Effective July 1, 2016, the DCH adopted SSA's Low Income Subsidy definition for "family of the size involved" for the **QI1 Class of Assistance only**. This means we will use the couple income and resource limit for the individual and the individual's spouse, whether or not the spouse is applying (Medicare Eligible) for the QI1 MSP. We will continue to follow the approach of the SSI program under which either the standard for an individual or the standard for a couple will be used for the QMB and SLMB Medicare Savings Programs.

> For all applications and annual redeterminations: The A/R's **statement of income and resources provided on the application/review form is acceptable verification**. No further verification is required unless questionable. If BENDEX/SDX or other information known to the agency indicates a different amount from the A/R's statement and is determined to be current, use this amount over the A/R's statement.

> If a Medicare eligible couple both apply for a Q Track COA and they are income ineligible as a couple for all Q Track COA, calculate their eligibility as individuals for income but jointly for resources and approve each under whichever Q Track COA they are eligible.

No property search is required for this class of assistance.

The Social Security number of a spouse who is not applying for benefits is not required unless eligibility cannot be established without it.

Except for AMN, an individual cannot be dually eligible for QI-1 and another Medicaid COA for ongoing eligibility. If an active QI-1 A/R applies for and is approved ongoing under another COA, close the QI-1 case.

Step 6 Approve QI-1 on the system if the A/R meets all the above eligibility Requirements.

Step 7 Notify the A/R of the case disposition via the system generated notice.

2146 Low Income Subsidy (Extra Help for Medicare Part D)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Low Income Subsidy (Extra Help for Medicare Part D)		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2146
	Previous Policy Number(s):	MT 55	**Updated or Reviewed in MT:**	MT-59

Requirements

Certain Medicare recipients may be eligible to receive a Low-Income Subsidy (LIS) to help pay for the expenses incurred under Medicare Part D.

Basic Considerations

Anyone may apply for the LIS. However, to be eligible to receive the LIS or Extra Help, an A/R must meet the following conditions:

- Be eligible for or enrolled in Medicare Parts A and B **AND**
- Be a recipient for full Medicaid benefits,
- **OR** Q Track,
- **OR** have limited income and resources (Refer to Appendix A1 for current limits.)

If the Medicare recipient is determined eligible for the LIS, s/he will not be reimbursed for any out of pocket Medicare Part D expenses incurred. Once that information is updated in Social Security's and/or Centers for Medicaid and Medicare Services' system, then the premiums and deductibles should be covered.

Procedures

DFCS staff may be requested to assist in helping Medicare recipients apply for the LIS. The LIS application (LISA) is completed on a Form SSA -1020B – OCR-SM. Applications may be accepted as early as May 2005. If the Medicare recipient insists on having the State determine the eligibility for the LIS, contact your Medicaid Program Specialist.

Also see Sections 2751 and 2931 for more information.

Follow the steps below in **completing the LISA**:

Step 1 The LISA MUST be completed on an original Form SSA-1020B. Photocopies should only be made for filing purposes and/or to determine eligibility for Medicaid COAs. Recipients may come with their own LISA application on which some information may be preprinted. If not, provide the recipient with the LISA and complete needed information.

Step 2 Refer recipients to GeorgiaCares (1-800-669-8387) for the Prescription Plan explanations and help in enrolling in the Medicare Part D. Refer to Section 2931, Medicare Part D.

Step 3 Complete one application for legally married couples living together. For others complete an individual application.

Step 4 Complete application using **ONLY black ink or # 2 pencil**. Any block which must be "checked" should be done using an **X**.

Step 5 Even though there is not a "field" provided, write the date the application was taken in the upper right-hand corner of the LISA in the MMDDYYYY format. This date must be handwritten as a date stamp will void the form.

Step 6 In the State code blocks, enter GA. Do not mark "WBDOC Exception" Official Use in Wilkes-Barre Only.

Step 7 Print the recipient's name and SSN in the blocks provided in number 1 of the LISA, beginning with the Last Name. Make sure it matches the Medicare card.

Step 8 If recipient is legally married, print the spouse's name and SSN in the blocks provided in number 2, beginning with the Last Name. Make sure it matches the Medicare card. Be sure to check whether the application is for one spouse or both.

Step 9 When completing numbers 3 - 7, remember resource exclusions for FBR COAs, such as $1500 burial exclusion per person, $3000 per couple ($5000/$10,000 non FBR), homeplace, vehicle, etc. Accept the recipient's statement as to the value of assets. It is not necessary to verify unless this application is also used for a Medicaid COA which requires verification.

Step 10 Question number 8 address household size. Make sure, for purposes of the LISA, the recipient understands that s/he will have a higher income limit based as the household size increases. Include any relative (related by blood, marriage or adoption) in the household size for which the recipient provides at least one-half of the financial support. Refer to Appendix A1 for Federal Poverty Level Tables.

Step 11 Number 9 refers to unearned income. Do not enter RSDI or SSI income. However, if the application will be used for a Medicaid application, ask and accept the recipient's statement regarding RSDI/SSI income. **Annotate on the copy only.**

Enter the gross amounts of any other unearned income based on what the recipient tells you. It is not necessary to verify unless this application is also used for a Medicaid COA, which requires verification.

Step 12 In number 11, enter the amount the recipient reports as being provided.

Step 13 Numbers 12 – 16 refer to earned income. Accept the recipient's statement as to the amount of earnings. It is not necessary to verify unless this application is also used for a Medicaid COA which requires verification.

Step 14 Page 6 is the signature page. Both the recipient and spouse should sign in Section A, if available. If one or both are not available, a representative may sign for them. The MES should sign in Section B. Enter an X in "Other" and "Georgia DFCS" in the space provided.

Step 15 Make 2 copies of the form. Give one copy to the recipient or the person acting on their behalf. Use the other to screen for Medicaid and FS eligibility the **same day** the LISA is completed. If the A/R appears to be potentially eligible for FS provide him/her with a Form 297 to apply for the FS using the current date as the application date. If the recipient appears eligible for a Medicaid COA, follow regular application processing standards. Another Medicaid application form is not required although additional information and verifications may be required.

If the A/R is ineligible for ANY Medicaid COA, then register and deny on Georgia Gateway

Step 16 If the A/R is Medicaid eligible, do not send the 1020 to SSA. If the A/R is NOT Medicaid eligible, mail the **ORIGINAL** LISA the same day as completed in the postage paid envelope to:

Social Security Administration
Wilkes Barre Data Operations Center
P.O. Box 1020
Wilkes Barre, Pennsylvania 18767-1020

Additional LISAs may be obtained from your local SSA.

2147 Qualified Disabled Working Individuals

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Qualified Disabled Working Individuals		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2147
	Previous Policy Number(s):	MT 13	**Updated or Reviewed in MT:**	MT-58

Requirements

Qualified Disabled Working Individuals (QDWI) is a class of assistance (COA) that provides payment of the monthly Part A Medicare premium for disabled working individuals.

Basic Considerations

To be eligible for QDWI coverage, an A/R must meet the following conditions:

- The A/R is under the age of 65.
- The A/R is entitled to but not receiving RSDI disability benefits because s/he has earnings that exceed the substantial gainful activity (SGA) limits.
- The A/R is eligible for Part A Medicare coverage with a monthly premium.
- The A/R meets all basic and financial eligibility criteria.

> Length of Stay (LOS), Level of Care (LOC) and TPR assignment are **not** requirements of this COA.

In-kind support and maintenance (ISM) is not considered in determining QDWI eligibility.

The only coverage this COA provides is payment of the monthly Part A Medicare premium by Medicaid. No other medical expenses incurred by the QDWI recipient are paid by Medicaid.

A Medicaid card is not issued to QDWI recipients and Form 962 is not issued to the recipient or providers.

QDWI eligibility cannot begin prior to the A/R's eligibility for Part A Medicare.

Procedures

Follow the steps below to determine QDWI eligibility.

Step 1 Accept the A/R's Medicaid application.

Step 2 Obtain information required to complete the eligibility determination.

Step 3 Determine that the A/R is ineligible for full Medicaid coverage under all other COAs.

Step 4 Obtain the following verification from the Social Security Administration:

- The termination of the A/R's RSDI disability payment due to excessive earned income.
- The A/R's eligibility for Part A Medicare coverage with a monthly premium.

Step 5 Determine all basic eligibility criteria except LOS, LOC and TPR. Refer to Chapter 2200, Basic Eligibility Criteria.

Step 6 Determine financial eligibility using the current QDWI income and resource limits. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting to determine the following:

- whose income and resources to consider
- which SSI income and resource limit (individual or couple) to use
- which eligibility budget to complete.

Step 7 Approve under QDWI COA if the A/R meets all the above eligibility criteria, including retroactive months if needed.

2149 Georgia Medicaid for Workers with Disabilities

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Georgia Medicaid for Workers with Disabilities		
	Effective Date:	July 2024		
	Chapter:	2100	**Policy Number:**	2149
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-72

Requirements

Georgia Medicaid for Workers with Disabilities (GMWD) offers people with disabilities, who are working, the opportunity to buy health care coverage through the Georgia Medicaid Program. This Program became effective March 2008.

Basic Considerations

The "Ticket to Work and Work Incentives Improvement Act of 1999" (TWWIIA) enacted on December 17, 1999, provided states with new options for making it possible for people with disabilities to join, or remain in, the workplace without fear of losing their Medicare and Medicaid coverage. Georgia elected to provide Medicaid coverage in the "Basic Coverage Group" of TWWIIA. Under this group, Medicaid can cover individuals at least 16, but less than 65 years of age, who except for earned income would be eligible to receive SSI.

This program provides Medicaid coverage to workers with disabilities who are employed but are no longer eligible for SSI due to increased earnings. There is no requirement other than an individual must have at one time been a recipient of SSI or SSA disability. However, if an individual was not a recipient of SSI or SSA disability, a disability determination must be completed. Other GMWD non-financial and financial eligibility criteria are based on similar ABD Medicaid Categories.

Eligibility Requirements

To qualify for GMWD, an individual must meet all of the following criteria:

- Have a disability that meets Social Security Administration's standards
- Have disability income between $600.00-$699.00/month
- Be employed and receiving compensation
- Be a Georgia resident
- Be at least 16 years of age, but less than the age of 65
- Have countable income less than the Medicaid Cap (300 percent of the FPL)
- Have countable resources less than $4000.00 for an individual, $6000.00 for couple

Premium Costs

GMWD participants may be required to pay a monthly premium. Premium amount is based on the individual's age and total countable income.

Applying for GMWD

Application may be submitted in the following ways:

- Online at www.gateway.ga.gov
- Telephonically by calling 1-877-423-4746
- Paper application by mail, fax, or in person at the local DFCS office. www.dfcs.georgia.gov/

Individuals approved for GMWD may be required to pay a monthly premium. GMWD premiums are paid to PSI, Inc., and are due one month prior to the month of coverage. The address for payment of a GMWD premium is P.O. Box 162348 Atlanta, Ga. 30348-2348.

2150 ABD Medically Needy

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Medically Needy		
	Effective Date:	July 2024		
	Chapter:	2100	**Policy Number:**	2150
	Previous Policy Number(s):	MT 71	**Updated or Reviewed in MT:**	MT-72

Requirements

ABD Medically Needy (AMN) is a class of assistance (COA) that provides Medicaid coverage for aged, blind, or disabled individuals whose income and/or resources exceed income and resource limits for all other ABD Medicaid COAs.

There are two types of Medically Needy cases.

- **De Facto eligible** occurs when the A/R's net countable income is less than or equal to the ABD Medically Needy Income Level (AMNIL) and resources are less than or equal to the AMN resource limit.
- **Spenddown eligible** occurs when the A/R's net countable income is greater than the AMNIL. The amount of income greater than the AMNIL, called the spenddown, is offset by incurred medical expenses. Resources must also be less than or equal to the AMN resource limit.

Basic Considerations

AMN coverage is potentially available to aged, blind, or disabled individuals who have been determined to be financially ineligible under all other ABD Medicaid COAs. Eligibility for all other ABD Medicaid COAs except Q track and SSI must be ruled out before determining eligibility under AMN.

Resource Limits

The resource limit used for an AMN individual is the SSI Individual resource limit.

The resource limit used for an AMN couple or an AMN individual with an ineligible spouse is twice the SSI Individual resource limit.

Review Period

In AMN, the review period is for six months. Each month of the six-month review period is a separate budget period. Eligibility is determined for each month individually. The review period begins on the first day of the month in which the application is filed and runs through the last day of the sixth consecutive month.

For three months prior, each month is also a separate budget period.

De Facto Eligible

If the A/R's monthly countable income is equal to or less than the AMNIL, the A/R is De Facto eligible for Medicaid. Eligibility begins on the first day of the month.

Spenddown Eligible

If the A/R's monthly countable income is greater than the AMNIL, the excess amount is called the spenddown.

This spenddown must be met before the A/R can be approved for Medicaid under AMN.

The spenddown is met by subtracting allowable medical expenses from the spenddown amount until the spenddown reaches zero.

When the spenddown is met, the A/R is considered spenddown eligible, and the A/R is approved for Medicaid effective the day spenddown is met through the end of the month.

The following individuals' medical expenses can be used in meeting the spenddown:

- the A/R
- the A/R's **legal** ineligible spouse
- the A/R's **non-legal** ineligible spouse only if the second potential spenddown is used as the AMN spenddown
- the A/R's ineligible child
- the A/R's ineligible parent if the A/R is a child
- the deceased spouse or child of the A/R if the A/R remains liable for payment of the bill
- the child of the A/R who has reached 18 years of age if the child was under 18 at the time the medical expense was incurred, and the A/R remains liable for the bill.

> The child does not have to be currently living in the home with the A/R.

Medical expenses are used to meet the spenddown if they meet all of the following conditions:

- The bill is unpaid as of the first day of the month or is incurred or paid during the budget period.
- The A/R or deemor is legally obligated to pay the expenses of the people listed on page 2150-2.
- There is no third-party liability (TPL) that is liable for payment of the expense. Refer to Special Considerations in this section and Chart 2150.1 – Allowable Medical Expenses for AMN.

> VA Aid and Attendance is **NOT** a TPL.

- The bill is medically necessary. Any expense ordered or prescribed in writing by a medical practitioner recognized under state law is medically necessary. Doctor and hospital services are considered medically necessary.

The spenddown may be met using medical expenses incurred prior to the month. If this occurs, the A/R is eligible from the first day of the month.

If the spenddown is not met by previously incurred bills, the case is placed in suspense until enough bills are incurred to meet the spenddown or until the end of the month, whichever occurs first.

If the spenddown is met during the month, a first day liability (FDL) is computed for the day the spenddown is met. The A/R is responsible for paying this FDL. Form 400, Medically Needy First Day Liability, is used to inform the provider that the A/R is responsible for the FDL.

If an A/R submits a medical expense after the expiration of the budget period, the bill can be used to meet or adjust the SD for the expired budget period only if it is submitted within three months of the expired period, unless Good Cause exists.

If an A/R becomes eligible under another COA during a month while the case is in suspense, change the COA and begin eligibility effective the first day of that month.

Begin Authorization Date

Medicaid eligibility begins on a specific day in the month. This day is called the Begin Authorization Date (BAD).

Medical expenses incurred prior to the BAD in a month will not be paid by Medicaid. The BAD can be any one of the following dates:

- the first day of the month if De Facto eligibility is established
- the first day of the month if the spenddown is met using only unpaid medical bills incurred prior to the month
- the day in the month in which the spenddown is met using bills incurred during the month or a combination of bills incurred during and prior to the month. (This day could also be the first day of the month.)

Procedures

Screen for eligibility for SSI and all other classes of ABD Medicaid.

AMN may be processed if the A/R is financially eligible for SSI and has an approved SMEU decision.

Follow the steps below to establish eligibility for ABD Medicaid under AMN.

Step 1 Accept the Medicaid application from the A/R and establish the six-month review period. Obtain a written statement of choice when a bill that could potentially be paid by Medicaid is used to meet SD for an ongoing month.

Step 2 Conduct an interview. A phone interview is required for AMN applications.

Determine all basic eligibility criteria except length of stay (LOS) and level of care (LOC).

> Complete Form DMA-285, Third Party Liability (TPL), if a resource exists that will pay for all or a portion of the A/R's medical expenses.

Step 3 Establish financial responsibility. Refer to 2500 ABD Financial Responsibility and Budgeting Overview Chapter 2500 ABD Financial Responsibility and Budgeting, to determine the following:

- whose income and resources to consider
- which AMNIL and AMN resource limit (individual or couple) to use
- which eligibility budget to complete.

Step 4 Determine the countable resources of the A/R and/or deemor for the first month of the review period and all requested prior months and compare to the appropriate resource limit to determine resource eligibility.

Step 5 Determine the income for the A/R and/or deemor.

Step 6 De Facto Eligibility.

If the A/R's net countable income is less than or equal to the appropriate AMNIL, the A/R is De Facto eligible. Approve the A/R for Medicaid effective the first day of the month.

If the case is not De Facto eligible, proceed to Step 7.

Step 7 Spenddown Eligibility.

If the A/R's net countable income exceeds the appropriate AMNIL, the amount of the excess is the spenddown. Explain the spenddown concept to the A/R.

Step 8 Determine whose expenses may be allowed as a deduction from the spenddown. Refer to Basic Considerations in this section.

Step 9 Obtain copies of any unpaid medical expenses and those paid during the month for the individuals determined in Step 8. The A/R has the option to use the unpaid medical bill for the month incurred or in a subsequent month. If the A/R submits unpaid medical bills and wants them used in a spenddown budget other than the month in which it was incurred, have them complete and sign the Medically Needy Option Statement, which may be found in Appendix F - Forms. A large unpaid bill may be used as a rollover bill for consecutive or non-consecutive months.

If a TPL exists, determine how much the TPL will pay on these bills and subtract this amount from the bill. Deduct only the remaining amount from the spenddown. Do not delay an eligibility determination simply because TPL cannot be ascertained or payment of the third party has not yet been received. This includes pending lawsuits/legal issues as long as the legal proceedings are reported to the TPL unit. Once verification of the TPL is received, reconcile the SD budget, and make adjustments if it is to the advantage of the A/R.

Refer to Special Considerations and to Chart 2150.1 – Allowable Medical Expenses for AMN.

If the A/R is a self-payer for the Medicare premium, allow the premium as the first deduction for each month of the review period.

> This is an exception to the policy of deducting bills in chronological order. The Medicare premium can be deducted the first of each month even if the A/R has other deductible bills incurred prior to the first of the month.

Keep copies in the document imaging system of all medical bills used in the SD budget to prevent reuse of bills in subsequent SD budgets.

Step 10 Arrange the allowable medical expenses in chronological order by date incurred, oldest to most recent.

Deduct from the spenddown allowable medical expenses incurred prior to the month in chronological order.

If the spenddown is met using prior medical expenses, approve Medicaid for the A/R from the first day of the budget period.

Notify the A/R, PR, and DCH via the system of eligibility dates and first day liability. Do not send a Form 400 to DCH.

If the spenddown is **not** met, proceed to Step 11.

Step 11 Deduct from the spenddown allowable medical expenses incurred during the month in chronological order.

Rank medical expenses incurred on the **same day** as follows:

1. expenses incurred by an ineligible spouse or ineligible child
2. expenses incurred by the A/R but not covered by Medicaid (non-covered items such as over-the-counter drugs or bills payable to non-Medicaid providers)
3. remaining expenses, low to high, incurred by the A/R that are payable to a Medicaid provider.

If the spenddown is met, proceed to Step 12.

If the spenddown is **not** met, proceed to Step 14.

Step 12 If the spenddown is met by bills in ranking order 1 or 2, Form 400 is not required. Complete the following actions:

- Approve the A/R for Medicaid to begin on the day in which the bill that brought the spenddown to zero (the break-even bill) was incurred.
- Send notice to the A/R. Include the BAD, the ending date of eligibility and the A/R's Medicaid number.
- Complete Form 962 for any months you are unable to enter in the system. Enter $0 as the First Day Liability Amount.

If the spenddown is met by bills in ranking order 3, Form 400 is required. Complete the following actions:

- Issue a Form 400 for the break-even bill showing the amount of the bill that was applied to the spenddown as the client liability.

  > The Form 400 can be issued to either the A/R or to a provider. Discuss with the A/R and determine to whom the Form 400 should be issued.

- Issue Form 400 with a client liability of zero for any other Medicaid covered bills incurred on the BAD that were not used to meet the spenddown.

The Form 962 must contain the following:

- "Form 400 Required"- "Y"
- The amount of the First Day Liability (FDL)
- Pharmacy is Break-even bill – "Y" or "N"
- "Eff Date" and "End Date" are the month, day, and year of the beginning and ending dates of eligibility.

  > For group practices, indicate the specific individual who performed the medical service on Form 400, not the group name.

> Hospitals often submit a consolidated bill to the A/R. If requested to do so, issue Form(s) 400 to any individual provider whose bill was included in the consolidated bill. Include the FDL on the Form 400 for the hospital, but not on the Form 400 for the individual provider.

- Send notice to the A/R, including the BAD, FDL and the A/R's Medicaid number.

Step 13 If the spenddown is not met, place the case in suspense until enough medical expenses are incurred to meet the spenddown.

Step 14 Subtract verified allowable medical expenses from the spenddown as they are presented by the A/R using Step 11 ranking order.

Step 15 Deduct any medical expenses incurred during the month as they are provided by the A/R.

Step 16 If the spenddown is met during the month, approve Medicaid as of the day spenddown is met.

If the spenddown is not met during the month, begin the spenddown determination for the next month.

Special Considerations

Allowable Medical Expenses

The following expenses can be used to meet the AMN spenddown:

- Services provided by the following:
  - Chiropractors
  - Dentists
  - Hospitals
  - LPNs
  - Medical Clinics
  - Mental Health Clinics
  - MR Group Homes (daily rate for treatment and training)
  - Nursing Assistants
  - Opticians
  - Optometrists
  - Osteopaths
  - Oculists
  - Personal Attendants (sitters) – obtain doctor's statement that a personal attendant/sitter is necessary for A/R's medical condition
  - Physicians
  - Psychiatrists
  - RNs
- Medical care purchases, such as the following:
  - medical tests
  - hearing aids
  - eyeglasses
  - contact lens
  - dentures
  - prescription drugs
  - over-the-counter medical needs
  - transportation costs to obtain medical services – the lesser of actual cost or maximum allow-

able amount. (See Appendix A-1 for maximum allowable mileage costs)
    - prosthetic devices
    - immunizations
    - Guide Dog or other animal trained to assist a physically disabled person (include the cost of securing and maintaining animal)
- Elective surgery
- Medically necessary ambulance service
- Health and/or dental insurance premium. If a fee or premium is paid by an entity other than the A/R, such as the Federal or state government, it is NOT treated as a medical expense for AMN.
- A prescription drug that is NOT covered on an A/R's Medicare Part D plan may only be allowed as a medical expense for AMN if the A/R provides verification that s/he has gone through the appeals process with their plan's carrier and has received an unfavorable decision.
- The following medical expenses may be projected (rather than used as a daily expense) as billed/paid for applying to the AMN spenddown:
    - personal care home (with doctor's statement - medical expense portion only, room and board expenses are not allowable)
    - NH bill
    - Personal sitter (with doctor's statement only)

      The projected medical bills of personal care home, NH, and personal sitter will not be paid by DCH.

> These lists are not all inclusive. Explore TPL coverage before applying any medical expense as a deduction from the spenddown. If the medical bill is questionable as to whether or not it is allowable, follow the procedures outlined in Section 2555-3 to submit IMEs for approval.

Verification of Medical Expenses

Verify incurred medical expenses by one of the following:

- Medical bills or statements
- Receipts for payment of medical expenses
- Medical Explanation of Benefits (EOB) which shows covered/non-covered and paid/unpaid medical expenses
- Health insurance statements showing amount paid
- Odometer readings for mileage costs
- Other appropriate means

> A doctor's statement (written or verbal) indicating anticipated Medicare TPL may be used as verification until such time as the Medicare EOB is received.

If a previously "written off" bill is submitted again as owed, do not allow this bill to be used in the spenddown budget. Writing a bill off gives the provider of service a tax benefit and makes them eli-

gible for Indigent Trust funds.

Use the following chart to determine which medical expenses can be deducted to meet the spend-down in an AMN case:

Chart 2150.1 – Allowable Medical Expenses for AMN

ALLOWABLE	NOT ALLOWABLE
• Medical bills belonging to individuals who are or could have been included in the BG when the expenses were incurred. • Unpaid bills that the A/R or deemor remains liable for paying. • If there is a deductible or co-payment amount to be paid by the A/R, this can be allowed. However, if a decision is pending as to who is liable, do **not** allow the deduction until the decision on liability is made. If a bill is paid in full or in part to a provider or as a reimbursement to the A/R or deemor by a public program funded by the state or programs of political subdivisions of the state, allow this as a deduction in the month incurred or paid, as long as **no federal funds** are used. Verify the source of the funding to ensure that there are no federal funds. Allow a **reimbursement** for this third party only **if** the bill was paid by the A/R and reimbursed in the same month. Do not allow the bill as a deduction if the A/R paid the incurred expenses prior to the current month and was reimbursed in the current month. • Unpaid bills incurred **prior** to the month which were not used to meet a spenddown for another month. • Bills incurred during the month, whether paid or unpaid. • Bills applied to an earlier spenddown that was never met if the bills are still owed and the individual who incurred them is still a deemor or A/R's minor child. • Medical bills used in ARM AMN budgets in the spenddown process. • Bills not presented to the worker during the month provided the A/R or deemor remains liable for payment as of the first day of the next month under consideration. • The remainder of unpaid bills incurred prior to the month that have been turned over to a collection agency. If these medical bills are consolidated with other bills, only the portion that can be verified as unpaid medical expenses can be deducted. Monthly payments to a collection agency cannot be deducted. • Medical expenses related to pregnancy, including prepayment of delivery fees or admission fees by the hospital when billed.	• Medical bills past or present which are/were subject to payment by a third-party liability (TPL), including Medicare. Exception: See Step 9 regarding legal issues. VA Aid and Attendance is **not** a TPL. • Medical bills incurred in a month in which the A/R was Medicaid eligible that were not submitted to DMA or not submitted timely for payment, or which were submitted and rejected for errors in filing the claim. • For ongoing AMN, past medical debts which were forgiven or written off by the provider prior to the first day of the month or prior to the date the case is brought to final disposition. • Medical expenses paid by Medicaid under three months prior coverage. • Medical bills applied in another month in which spenddown is met. • Long term care medical bills incurred by A/R who is not found eligible for Medicaid under an LA-D COA due to a transfer penalty, may not use those bills as an expense for AMN.

ALLOWABLE	NOT ALLOWABLE
• **Emergency Medical Assistance COA:** Bills from any time period can be used as long as the A/R or deemor still has a legal obligation to pay the bill. The incurred bills are not limited to the time of the emergency service. • Medical bills that have been paid with the proceeds of a loan if the loan has not been fully repaid. If other expenses were also paid by the loan, consider any and all payments made on the loan to be for the medical bills. • Medicare premiums for an A/R who is a self-payer are deductible the first day of each month, even if A/R is eligible as of the first day of the month using bills from previous months. • Medical bills that may potentially be paid as the result of a pending lawsuit/legal issue are allowable in the month the bill is incurred. However, complete and send a Form DMA 285 regarding the pending lawsuit. • A prescription drug that is NOT covered on an A/R's Medicare Part D if the A/R provides verification that s/he has received an unfavorable decision from the carrier that it will not be covered. • Medicare Part D premiums and co-pays until such time as they are picked up by Medicaid. This should occur annually within two months after the first month of AMN approval.	• Any prescription that is covered under Medicare Part D (excluding co-pay). • Once the A/R has met SD, do not allow any prescription payments or co-pays from that point to the end of the month. These should be covered by Medicaid.

Processing the AMN

Since AMN eligibility is determined for a time limited review period, the AMN case must be reviewed at the beginning of each new review period.

- Complete a full eligibility determination with the A/R's first application, including a signed application, other basic eligibility criteria and full verification as required for an initial application under any other ABD Medicaid COA.
- For each successive review period on a case that has continued in an active or suspense status, complete a review of eligibility using the procedures in 2706 Medicaid Renewals. It is not necessary to complete another application unless the case has been closed for an entire month or more.

> If a SMEU decision is used to verify disability at the point of an initial AMN application, the SMEU decision is verification of disability for all successive AMN applications unless SMEU requests a review of disability.

Standard of Promptness

The SOP for an AMN application is met when all basic and financial eligibility criteria are met, and the A/R is either notified in writing of the amount of the spenddown, or the A/R is approved if spenddown is already met.

Q-Track Recipient Applies for AMN

An individual who is eligible for ongoing QMB, SLMB or QI-1 does not have to file a separate application for AMN. The A/R must make his/her intentions known by requesting AMN verbally or by a written statement. Document the case record accordingly. If the A/R submits medical bills not covered by Q Track, consider it a request for AMN.

Determine AMN eligibility for:

- the month the bill is received by the case worker

  OR

- any of the three prior months

  OR

- the ongoing month.

The medical bill has to meet all criteria for being an allowable deduction for the month under consideration.

A Q Track application filed on a DCH Form 700 may also be used as an application for full Medicaid benefits. However, additional information and verification may be required for full Medicaid.

TYPE OF CASE	BAD	FDL	400s REQUIRED	TRANSMIT ELIGIBILITY VIA	962 to A/R
De Facto	First Day of BP	$0	NONE	System	See note
SD: Unpaid break-even bill incurred prior to BP	First Day of BP	$0	None	System	See note
SD: Unpaid Medicaid covered, break-even bill incurred by A/R during the BP	Date of break-even bill	Amount of break-even bill applied to SD	Break-even bill and any other of A/R's Medicaid covered bills incurred on BAD, but not needed to meet SD	System	See note
SD: Break-even bill not covered by Medicaid and incurred during BP	Date of break-even bill	$0	NONE	System	See note

The system generated notice, which includes Medicaid eligibility information, replaces Form 962. Complete a Form 962 **only** if eligibility cannot be entered in the system, such as a three-month prior application that is greater than thirteen months old.

2160 Family Medicaid Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Overview		
	Effective Date:	July 2023		
	Chapter:	2100	**Policy Number:**	2160
	Previous Policy Number(s):	MT 68	**Updated or Reviewed in MT:**	MT-70

Requirements

Family Medicaid provides Medicaid benefits for low-income families and individuals who are not receiving SSI and may or may not be receiving TANF. Benefits are provided through a variety of classes of assistance (COA's), each with its own specific eligibility criteria.

Effective January 1, 2014, Family Medicaid will be comprised of two groups; the Modified Adjusted Gross Income (MAGI) COAs and the Non-MAGI COAs.

Basic Considerations

Family Medicaid Non-MAGI Assistance Units (AUs) include:

- Newborn
- Family Medically Needy
- Pregnant Medically Needy
- Refugee
- Foster Care
- Adoption
- CHAFEE
- Women's Health Medicaid

Family Medicaid MAGI AUs include:

- Parent/Caretaker of child(ren)
- TMA/4Mex
- Pregnant Women
- Children Under 19 years of age
- Pathways
- Planning for Healthy Babies® (P4HB)
- Former Foster Care Medicaid

Family Medicaid AUs must meet specific Basic Eligibility Criteria:

- age
- application for other benefits
- citizenship/immigration status
- cooperation with DCSS
- enumeration
- identity
- residency
- third party liability
- specified relative relationship/tax filer/non-filer status

Each COA has different exceptions to the Basic Eligibility Criteria. Refer to Section 2200, Basic Eligibility Criteria and to each COA in this chapter.

A pregnant woman who is eligible for and receiving Medicaid under any Medicaid COA (except Q-track, P4HB or a suspended spend down) or SSI on the date the pregnancy terminates is eligible to continue to receive the 12-month extended postpartum period. The 12-month extended postpartum period count begins the month after the termination of pregnancy. Medicaid continues through the last day of the 12th month.

Medicaid coverage under any Medicaid COA (except Q-track, P4HB or a suspended spend down) or SSI is continued for a pregnant woman who, after approval becomes financially ineligible solely because of new income or a change in income of any BG member. The pregnant woman remains eligible for Medicaid for the remainder of the pregnancy, including the 12-month extended postpartum period. Refer to 2720 Continuous Coverage For Pregnant Women.

If a pregnant woman meets spend down for at least one month during their pregnancy or in the pregnancy termination month, the pregnant woman is eligible for the 12-month extended postpartum period. Eligibility for any Family Medicaid COA can begin with the month of application and can include up to three months prior to the month of application. All points of eligibility for that COA must be met in each of the three prior months. Refer to 2053 Retroactive Medicaid.

Pathways does not allow for retroactive coverage.

Three months retroactive Medicaid does not pertain to January 2014 applications for MAGI COAs.

Under certain conditions, Medicaid may cover services rendered to Medicaid-eligible Georgia residents who are out of state when medical services are provided. Procedures for qualifying for out-of-state coverage are found on the back of the Medicaid card.

Financial Eligibility Criteria

All Family Non-MAGI Medicaid cases are budgeted using prospective income and expenses.

All Family MAGI Medicaid cases are budgeted using prospective income.

> Eligibility for three months prior Family Medicaid is determined using actual income and expenses. If available, actual income may be used for intervening months. Data sources and/or related active programs verification must be accessed for all MAGI Medicaid COAs prior to requesting verification.

For Family Non-MAGI Medicaid COA's, if resources of the BG are within the applicable resource limit at any time during a month, the AU is resource-eligible for that month.

> There are no resource requirements for MAGI Medicaid COAs.

A Family Medicaid case that is ineligible because of financial reasons for one month only is suspended, not terminated. Refer to 2700 Case Management Overview, 2712 Family Medicaid Changes Overview, 2714 Family Medicaid AU/BG Composition Changes, 2715 Family Medicaid Changes In Income and 2716 Family Medicaid Miscellaneous Changes.

MAGI COAs use the MAGI based income methodology.

Other Considerations

Family Medicaid applications are accepted at the following sites:

- Federally Facilitated Marketplace (FFM)
- County DFCS offices
- DFCS Project outreach locations
- Department of Public Health offices
- Public medical facilities
- Federally funded health care centers
- Disproportionate-share hospitals
- Gateway

Refer to 2050 Application Processing Overview.

Presumptive Eligibility

Presumptive Eligibility (PE) is determined by Qualified Providers (QPs) and Qualified Hospitals (QHs) certified by the Department of Community Health (DCH). PE is a temporary eligibility determination and is available to pregnant women, parent/caretakers with children under age 19, children under age 19, former foster care children and women in treatment for breast or cervical cancer. If an individual is determined eligible for PE, a temporary Medicaid Certification is issued by the QP/QH. A PE Packet is completed concurrently and routed to DFCS for processing. Refer to 2050 Application Processing Overview, 2065 Family Medicaid Application Processing, 2067 Presumptive Eligibility Medical Assistance for additional information regarding PE.

Procedures

The Medicaid application process begins with a request for assistance and ends with notification to the AU of the eligibility decision. Refer to 2050 Application Processing Overview for additional information.

A **Continuing Medicaid Determination** (CMD) is required before denying a Medicaid application or terminating Medicaid under the current COA. A CMD is the determination of Medicaid eligibility under all COA's. Refer to 2050 Application Processing Overview and 2700 Case Management Overview for additional information.

At application and renewal, contact the A/R to inquire if any AU member is pregnant. If an AU member is pregnant, Gateway will send a follow-up contact with the pregnant woman during the month prior to the Estimated Delivery Date (EDD).

Referrals

Health check services information for all Medicaid recipients under age 21 is referenced on Gateway notices. Refer to 2930 EPSDT Services for additional information.

Refer the following to the Department of Public Health for services under the **Women, Infant and Children (WIC) Program**:

- pregnant women
- women who are breast feeding through the first twelve months after the birth of a child
- children under age five
- post-partum women for six months from the termination of pregnancy Refer to 2985 Women, Infant and Children (WIC) Services for additional information.

2162 Parent/Caretaker with Children

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Parent/Caretaker with Children		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2162
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-58

Requirements

Parent/Caretaker with Child(ren) provides Medicaid benefits for eligible children under the age of 19, and the eligible adult(s), who meet the tax filer or non tax filer status for the child(ren).

Basic Considerations

Basic Eligibility Criteria

Assistance Unit (AU) members must meet the following basic eligibility requirements:

- **Age** – A child must be under the age of 19 to be eligible. There is no age requirement for adult AU members. Refer to 2255 Age (Family Medicaid).
- **Application for Other Benefits** - The A/R must apply, or agree to apply for and accept other benefits to which s/he or other AU members may be entitled.

The A/R is not required to apply for non taxable income benefits for MAGI COAs; they should be notified of the potential benefit. These include, but are not limited to:

- Child Support
- Supplemental Security Income (SSI)
- Veterans Affairs (VA) benefits
- Worker's Compensation

An adult who does not meet this requirement, and the child(ren) included in the AU, are excluded from the AU. Refer to 2210 Application for Other Benefits.

- **Citizenship/Immigration Status/Identity** - Each AU member must be a U.S. citizen or meet immigration eligibility requirements. Refer to Section 2215, Citizenship/ Immigration Status.
- **Enumeration** - The A/R must furnish, apply for, or agree to apply for a Social Security Number (SSN) for each AU member, unless Good Cause is established.

An adult who does not meet this requirement, without Good Cause, is penalized. The child(ren) in the AU that do not meet this requirement, without Good Cause, are excluded from the AU. Refer to 2220 Enumeration.

- **Child Support Services (DCSS)** - The AU must cooperate with DCSS in the attempt to obtain

medical support from the absent parent (AP), unless Good Cause is established. A referral to, and cooperation with Child Support Services (DCSS) is, however **NOT** a requirement for child-only Medicaid cases.

A child-only Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid. An AU which contains a penalized adult is **NOT** considered a child-only case.

The AP of a child included in a Parent/Caretaker with child(ren) AU is not referred to DCSS if the AP provides health insurance for the child, unless the A/R wishes to pursue collection of child support monies.

An adult who does not cooperate with DCSS, without Good Cause, is penalized. Refer to 2250 Cooperation With Division of Child Support Services.

- **Tax Filer and Non-Tax Filer Status** - Individuals expected to be included on the next tax return filed are potentially eligible to receive MAGI Medicaid. Individuals that meet non tax filer criteria are potentially eligible to receive MAGI Medicaid. Refer to 2245 Living With A Specified Relative / Tax Filer / Non-Filer Status.
- **Residency** - AU members must be residents of Georgia. Refer to 2225 Residency.
- **Third Party Liability Requirements** - The A/R is required to provide information regarding any Third Party Liability (TPL) available to any AU member. The A/R must assign his/her TPL rights to DCH, unless Good Cause exists.

An adult who does not meet this requirement, without Good Cause, is penalized. Refer to 2230 Third Party Liability.

Financial Eligibility Criteria

AU's must have income within the following limit:

- **Modified Adjusted Gross Income (MAGI)** - The total taxable net income of the AU must be equal to or less than the MAGI income limit of the AU size. Refer to Appendix A2, Financial Limits for Family Medicaid.

Prospective budgeting is used in determining eligibility for the application month and the ongoing benefit period. If available, actual income may be used for intervening months. Data sources and/or active related programs verification is used prior to requesting verification.

Actual income is used to determine eligibility for retroactive three (3) months prior Medicaid. Refer to 2053 Retroactive Medicaid.

Modified Adjusted Gross Income (MAGI) financial methodologies are used to calculate the monthly MAGI income used for the BG. Pre-tax deductions and 1040 deductions are given. Refer to 2663 Non-Modified Adjusted Gross Income (MAGI) Budgeting.

MAGI income deduction is 5% of the 100% Federal Poverty Level (FPL) of the AU size. Refer to 2663 Non-Modified Adjusted Gross Income (MAGI) Budgeting.

2166 Transitional Medical Assistance (TMA)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Transitional Medical Assistance (TMA)		
	Effective Date:	September 2024		
	Chapter:	2100	**Policy Number:**	2166
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-73

Requirements

Transitional Medical Assistance (TMA) provides continued Medicaid coverage for up to 12 months for Parent/Caretaker with Child(ren) AUs that become ineligible because of changes related to earned income.

Basic Considerations

To be eligible for continued Medicaid coverage under TMA, the AU must have correctly received Parent/Caretaker with Child(ren) in three of the six months preceding the first month of Parent/Caretaker with Child(ren) ineligibility. An AU is potentially eligible to receive TMA for 12 months beginning with the first month following the last month of Parent/Caretaker with Child(ren) Medicaid.

To be eligible for continued Medicaid coverage under TMA, Medicaid ineligibility must result exclusively from new or increased Modified Adjusted Gross Income (MAGI) earnings of an adult AU member or child AU Member with earnings above the allowable IRS dependent exemption, referred herein as a "TMA-qualifying event."

TMA-qualifying event includes any of the following:

- new employment
- increase in earnings as a result of an increase in hours worked
- increase in salary or hourly wage
- earnings of an eligible member added to the AU
- decrease in pre-tax or 1040 deductions

Ineligibility may be caused by new or increased earnings **and** a **concurrent** change. If the concurrent change **alone** caused ineligibility, the AU is **ineligible** for TMA.

Cooperation with Third Party Liability (TPL) is required at approval for TMA as well as during both 6-month review periods. Refer to Section 2230 - Third Party Liability.

Referral to Child Support Services is not required.

Effective 5/17/2024, the first month of Parent/Caretaker ineligibility and the first month of the TMA period will **No Longer Be The Same Month**. The first month of Parent/Caretaker ineligibility is

based on when the AU's income actually exceeds Parent/Caretaker FPL. The first month of TMA period is the month after the case worker (CW) takes action based on the change or renewal (including administrative renewals) that an AU member has experienced a TMA-qualifying event and the expiration of timely notice.

The AU still must report a TMA-qualifying event within 10 days of the change. If the AU fails to report the change within 10 days, the CW will no longer be required to look back to determine the effective date of change for TMA. Rather, the effective date now will only be prospective (after expiration of timely notice).

Any individual who moves into the home during the TMA eligibility period is ineligible for TMA, however s/he may qualify for another Medical Assistance COA.

If the individual was previously a member of the TMA AU, the individual may be added.

Eligibility Period

The TMA period of eligibility consists of the following:

- the initial 6-month extension
- an additional 6-month extension

Each of the 6-month periods has specific and distinct eligibility requirements.

Financial Eligibility

There is no MAGI income requirement for the first 6 months of TMA. To remain eligible for the second 6 months of TMA, the AU's MAGI income must be below 205% of the Federal Poverty Level (FPL).

There is no resource requirement for TMA.

Reporting

To remain eligible for TMA, the AU must report MAGI income on a quarterly basis. The Form 328 - Quarterly Report Form (QRF) is mailed by the agency to the AU.

All MAGI income reported on the QRF must be verified. Refer to Section 2051 - Verification.

Summary of TMA Quarterly Reporting Requirements

Quarterly Report	Reporting Period	Due Date
1st Quarterly Report	Months 1-3 of the initial TMA period	21st day of Month 4
2nd Quarterly Report	Months 4-6 of the initial TMA period	21st day of Month 7
3rd Quarterly Report	Months 7-9 of the second TMA period	21st day of Month 10

During the initial 6-month TMA eligibility period, if the AU does not comply with QRF reporting requirements for the QRF due in the 4th month, TMA eligibility terminates effective the first month after the initial extension (7th month).

If the AU does not comply with QRF requirements for the QRF due in the 7th month, eligibility terminates effective the 8th month.

If the AU does not comply with QRF requirements for the QRF due in the 10th month of TMA, eligibility terminates effective the 11th month.

Initial Six Months Extension

To be eligible to **begin** the **initial** six months of TMA, the AU must meet **ALL** of the following requirements:

- must be financially ineligible for Medicaid based exclusively from new or increased Modified Adjusted Gross Income (MAGI)
- earnings of an AU member must have correctly received Medicaid during three of the six months preceding the first month of Medicaid ineligibility
- must include a child under 19 years of age

Additional Six Months Extension

To be eligible to **begin** the **additional** six-month extension the AU must meet **ALL** of the following requirements:

- must have received TMA for each month of the initial six-month extension
- must have met the QRF reporting requirement in the 4th month of TMA
- must include a child under 19 years of age

To **remain** TMA eligible for the additional six-month extension, the AU must meet **ALL** of the following requirements:

- must comply with the 7th and 10th month QRF reporting requirements by the 5th day of the 7th and 10th months of TMA
- must meet TMA income eligibility requirements
- must include the caretaker or other eligible adult who was employed for at least part of each of the months included in the 7th and 10th months QRFs.

> Any eligible member in the AU can meet the employment criteria, even if s/he was not employed when the AU became eligible for TMA. Employment, for TMA purposes, is defined as working during the month. Receipt of a remaining paycheck from previous employment does not meet this criterion.

- must include a child under 19 years of age

> If the only child in the TMA AU becomes eligible for SSI, the other AU members may continue to receive TMA until the child is 19 years of age, or until the end of the TMA period if all of the above is met, whichever occurs first.

> If the income in the 7th or 10th month QRF exceeds the TMA FPL limit but is less than the PCK FPL limit, then the child will remain TMA eligible and **NOT** cascade to PCK due to continuous

> eligibility. However, if the income in the 7th or 10th month QRF exceeds the TMA and PCK FPL limits, then the child would terminate from TMA and not cascade to another COA.

Good Cause may be claimed for unemployment during one or more of the specified months. Refer to Special Considerations in this section.

If the TMA case is terminated because of unemployment of the caretaker or other eligible adult, without Good Cause, TMA cannot be reinstated, even if employment is subsequently obtained.

Procedures

Initial Six-Month Extension

Follow the steps below to establish the initial six-month TMA extension.

Step 1 Establish that the AU is financially ineligible for Medicaid based exclusively from a TMA-qualifying event. All income must be verified. Refer to Section 2051 - Verification.

Step 2 Establish that the AU correctly received Medicaid in three of the six months preceding the first month of Medicaid ineligibility. Refer to Section 2162 - Parent/Caretaker with Child(ren) Medicaid.

Step 3 Determine the last month of Parent/Caretaker with Child(ren) Medicaid, based on the date of the change, date the caseworker took action and the expiration of timely notice. All MAGI income must be verified. Refer to Section 2051 - Verification.

Step 4 Notify the AU of the following:

- termination of Parent/Caretaker with Child(ren) Medicaid eligibility
- approval of the initial six months of TMA
- reporting requirements of continued TMA eligibility

Step 5 Mail Form 328 - Quarterly Report Form (QRF) by the 15th of the third month of TMA. The QRF must request the AU's actual MAGI income for the first three months of TMA. Refer to Section 2051 - Verification.

Step 6 Use Chart 2166.1, Processing QRF Due in the Fourth Month of TMA, to process the QRF or information received, or to determine the appropriate action to be taken if QRF reporting requirements are not met.

All MAGI income reported on the QRF must be verified. Refer to Section 2051 - Verification.

Additional Six-Month Extension

Follow the steps below to continue eligibility for the additional six-month extension of TMA.

Step 1 Mail Form 328 - Quarterly Report Form (QRF) by the 15th day of the sixth month of TMA if the recipient complied with fourth month reporting and received all six months of TMA during the initial extension. Request MAGI income for the fourth, fifth and sixth months of TMA.

> All MAGI income reported on the QRF must be verified. Refer to Section 2051 - Verification. The QRF is due by the 5th day of the seventh month.

Step 2 Complete TMA budgeting procedures in the seventh month after the QRF is returned by the AU. Refer to Section 2667 - Transitional Medical Assistance Budgeting and Chart 2166-2, TMA QRF Processing Procedures for the Seventh and Tenth Months.

If the AU remains eligible based on the TMA budget, continue TMA.

If the AU is TMA ineligible because of MAGI income reported on the QRF, or if ineligible for any other reason, complete a Continuing Medicaid Determination (CMD) prior to termination of TMA and notify the AU. Refer to Section 2052 - Continuing Medicaid Determination.

Step 3 Mail Form 328 - Quarterly Report Form (QRF) by the 15th day of the ninth month of TMA if the recipient complied with the seventh month QRF. Request MAGI income for the seventh, eighth and ninth months of TMA. Refer to Section 2051 - Verification.

> All MAGI income reported on the QRF must be verified. Refer to Section 2051 - Verification. The QRF is due by the 5th day of the tenth month.

Step 4 Complete a TMA budget in the tenth month after the QRF is returned by the AU. Refer to Section 2667 - Transitional Medical Assistance Budgeting and Chart 2166.2 - TMA QRF Processing for the Seventh and Tenth Months.

If the AU remains eligible based on the TMA budget, continue TMA.

If the AU is TMA ineligible because of MAGI income reported on the QRF, or if ineligible for any other reason, complete a CMD prior to termination of TMA and notify the AU. Refer to Section 2052 - Continuing Medicaid Determination.

Step 5 Complete a CMD during the 12th (final) month of TMA eligibility and notify the AU prior to termination of TMA. Refer to Section 2052 - Continuing Medicaid Determination.

TMA Special Considerations

Procedures to Determine if a QRF is Complete

Use the following criteria to determine if a QRF is complete:

- The QRF is signed by the recipient and dated on or after the last day of the last month for which information is being reported.
- All items (except Question No. 3) are completed. All **yes/no** blocks are checked.

Question No. 3 is used only for CMD purposes if the family is ineligible for TMA. Refer to Section 2052 - Continuing Medicaid Determination.

All MAGI income reported on the QRF, due in the fourth, seventh and tenth months, must be verified. Refer to Section 2051 - Verification.

If the QRF is incomplete, request the information in writing. The A/R is not required to send back the actual QRF form. A written statement of the total MAGI income for the months listed on the QRF along with the appropriate verification is sufficient. Refer to Section 2051 - Verification.

Procedures to Determine Good Cause for Failure to Meet Work Requirements

Use the following information to determine if Good Cause exists for failure to meet the work requirements because of the termination of employment of a caretaker or other eligible adult:

- Explore the reason for termination of employment with the A/R.
- Use the following list as examples in determining if Good Cause exists. This list is not inclusive.
  - involuntary loss of employment, e.g., layoff
  - illness of the recipient or an immediate family member
  - family emergency
  - childcare not available
  - transportation not available

If Good Cause exists, the reporting requirement is met. Obtain the information needed to determine continued eligibility.

Document the case decision.

Procedures to Determine Good Cause for Failure to Comply with QRF Requirements

Good Cause for untimely or incomplete submission of QRF or QRF information may be granted.

The following are examples of Good Cause. This list is not all inclusive:

- The recipient did not receive the QRF or received it untimely.
- The recipient or an immediate family member was ill or in the hospital.
- The recipient is illiterate.
- There was a serious family crisis such as death.
- There was a natural disaster.
- The recipient was out of town.
- The return envelope was postmarked in time to reach the county department but did not. The QRF is considered timely if postmarked at least one day prior to the deadline.
- The AU was ineligible for TMA when the report was due but the reason for ineligibility no longer exists. This is applicable only to AUs who were ineligible for TMA because of any of the following reasons:

- the AU moved out of state
- the only child cease to live with the family
- the individual who qualified the AU for TMA ceased to live with AU.

If Good Cause exists, the reporting requirement is met. Obtain the information needed to determine continued eligibility.

Document the decision.

Use the following chart to process the QRFs due in the fourth month of TMA.

CHART 2166.1 - PROCESSING QRF DUE IN FOURTH MONTH OF TMA

IF	THEN
The completed QRF or QRF information is received by the 5th calendar day of the report month	Begin the additional six-month extension of TMA in the 7th month.
The QRF or QRF information is not received by the 5th calendar day of the 4th month of TMA (or by the following workday if the 5th is a weekend or holiday)	Send TMA Quarterly Report Follow-up Notice (GA Gateway sends this automatically), giving the AU until the 21st to provide the completed QRF or QRF information.
The completed QRF or QRF information is received by the 21st	Begin the additional six-month extension of TMA in the 7th month.
The QRF or QRF information is not received by the 21st	Determine if Good Cause exists. Refer to TMA Special Considerations in this Section.
The completed QRF or QRF information is not received by the 21st and Good Cause does not exist	Complete a CMD and terminate TMA effective the 7th month of eligibility. Provide adequate notice. Refer to Section 2052 - CMD.
The QRF or QRF information is received by the 21st but is not complete.	Send a verification checklist requesting the missing information within 5 calendar days. Allow an additional 10 days or until the 21st, whichever is later, to provide the information. Refer to Section 2051 - Verification.
The completed QRF or QRF information is received by the second deadline.	Begin the additional six-month extension of TMA in the 7th month.
The QRF or QRF information is not received by the second deadline.	Complete a CMD and terminate TMA effective the 7th month of eligibility. Allow adequate notice. Refer to Section 2052 - CMD.
The QRF or QRF information is received by the second deadline but is not complete.	Send another verification checklist. Allow an additional 10 days for response. • If the completed QRF or QRF information is received by the extended deadline, the report requirement is met. • If the completed QRF or QRF information is not received by the extended deadline, complete a CMD and terminate TMA effective the 7th month. Allow adequate notice. Refer to Section 2052 - CMD.

Use the following chart to process the QRFs due in the seventh and tenth months of TMA.

CHART 2166.2 - TMA QRF PROCESSING PROCEDURES FOR THE SEVENTH AND TENTH MONTHS

IF	THEN
The completed QRF or QRF information is received by the 5th calendar day of the report month	Continue TMA eligibility.
The QRF or QRF information is not received by the 5th calendar day of the report month (or by the following workday if the 5th is a weekend or holiday	Send TMA Quarterly Report Follow-up Notice (GA Gateway does this automatically), giving the AU until the 21st to provide the completed QRF or QRF information.
The completed QRF or QRF information is received by the 21st	Continue TMA eligibility.
The QRF or QRF information is not received by the 21st	Determine if Good Cause exists. Refer to TMA Special Considerations in this Section.
The completed QRF or QRF information is not received by the 21st and Good Cause does not exist	Complete a CMD and terminate TMA effective the 8th or 11th month of TMA. Provide adequate notice. Refer to Section 2052 - Continuing Medicaid Determination.
The QRF or QRF information is received by the 21st but is not complete.	Send a verification checklist requesting the missing information. Allow an additional 10 days or until the 21st, whichever is later, for the AU to provide the information. Refer to Section 2051 - Verification.
The completed QRF or QRF information is received by the second deadline.	Continue TMA eligibility.
The QRF or QRF information is not received by the second deadline.	Complete a CMD and terminate TMA effective the 8th or 11th month. Provide adequate notice. Refer to Section 2052 - Continuing Medicaid Determination.
The QRF or QRF information is received by the second deadline but is not complete.	Send another verification checklist. Allow an additional 10 days for response. • If the completed QRF is received by the extended deadline, the reporting requirement is met. Continue TMA eligibility. • If the completed QRF is not received by the extended deadline, complete a CMD and terminate TMA effective the 8th or 11th month. Provide adequate notice. Refer to Section 2052 - Continuing Medicaid Determination.

Refer to TMA Special Considerations for information on determining if a QRF is complete and determining good cause for not complying with reporting requirements.

2170 Four Months Extended Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Four Months Extended Medicaid		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2170
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-58

Requirements

Four Months Extended Medicaid (4MEx) provides 4 months of Medicaid coverage for a Parent/Caretaker with Child(ren) AU that becomes ineligible due to the receipt of spousal support.

Basic Considerations

4MEx is available to an AU that becomes ineligible for Parent/Caretaker with Child(ren) because of new or increased spousal support income OR new or increased spousal support income concurrent with changes, other than earned Modified Adjusted Gross Income (MAGI) income, that cause Parent/Caretaker with Child(ren) ineligibility.

Due to the Tax Cuts and Jobs Act of 2017, alimony is no longer considered a deduction or income as of 01/01/2019. Divorces and separations finalized before 01/01/2019, alimony is included as income and can be allowed as a deduction.

An AU with earned MAGI income that becomes ineligible for Parent/Caretaker with Child(ren) because of concurrent increases of spousal support and earned MAGI income should receive TMA. In this instance, the months of TMA and 4MEx would run concurrently.

The AU must have correctly received Parent/Caretaker with Child(ren) in three of the six months preceding the first month of Parent/Caretaker with Child(ren) ineligibility. Refer to 2162 Parent/Caretaker with Children for criteria for correctly receiving Parent/Caretaker with Child(ren). 4MEx would begin the month following the expiration of timely notice.

Parent/Caretaker with Child(ren) ineligibility may be a result of an increase in spousal support and a concurrent change. If the concurrent change alone caused Parent/Caretaker with Child(ren) ineligibility, the AU is ineligible for 4MEx.

“Spousal Support” is court-ordered payment from an estranged spouse or former spouse to the other spouse for support under the terms of a court order or settlement agreement following a divorce. Payments may be in one lump sum, or in a series of monthly payments. Alimony is also termed “spousal support” or “maintenance”.

Increased spousal support is defined as any of the following:

- the initial receipt of spousal support
- an increase in the amount of spousal support received

- the receipt of an additional spousal support payment.

If the AU receives a back payment of spousal support, the lump sum is budgeted as income in the month of receipt unless the accumulation is because of an administrative procedure or error. Refer to 2051 Verification.

Spousal support may be received directly from the divorced spouse or another source such as Clerk of the Court.

Reporting

The AU must report the increase in spousal support within 10 days of receiving the income. If the AU fails to report the change within 10 days of receipt of the increase, the eligibility worker (EW) must determine when the change should have been effective based on the 10 day reporting requirement.

The EW must make the change as soon as possible, but no later than 10 days after the report. If Parent/Caretaker with Child(ren) ineligibility results from the increase in spousal support income, 4MEx eligibility begins the first month following the expiration of timely notice.

Ongoing Eligibility

Once 4MEx eligibility is established, the AU does not have to continue to receive spousal support in each of the four months to remain eligible.

> If an A/R loses 4MEx because he/she moves out of state, but returns to Georgia within the same 4 month period, he/she may resume 4MEx for any remaining months.

A notice is sent at the beginning of the four month extended period specifying the months of eligibility under 4MEx. Ensure that the months of 4MEx are determined correctly by GA Gateway and the AU receives appropriate notice.

An AU that becomes eligible for Parent/Caretaker with Child(ren) during the 4MEx eligibility period has the option of receiving Parent/Caretaker with Child(ren) or 4MEx. If the AU elects to receive Parent/Caretaker with Child(ren) and subsequently becomes ineligible, Medicaid cannot be reinstated for the remainder of the original 4MEx period. However, if the reason for Parent/Caretaker with Child(ren) ineligibility would again qualify the AU for 4MEx, a new 4MEx eligibility period may be established.

Procedures

Follow the steps below to establish Medicaid eligibility for the AU under 4MEx.

1. Determine the amount of spousal support, the date of first receipt and the date reported by the AU. Refer to 2051 Verification.
2. Determine Parent/Caretaker with Child(ren) ineligibility because of spousal support income; or spousal support income in combination with other MAGI income; or other concurrent change, but not the other MAGI income or concurrent change alone.
3. Establish that the AU correctly received Parent/Caretaker with Child(ren) in three of the six

months preceding the first month of ineligibility for Parent/Caretaker with Child(ren).

4. Terminate Parent/Caretaker with Child(ren) and approve 4MEx for the AU effective the month following the expiration of timely notice by entering the new or increased income in GA Gateway and allowing the case to cascade to Four Months Extended.
5. Notify the A/R of the change, specifying the four months of Medicaid eligibility under 4MEx and the individuals covered. GA Gateway will issue the notice.
6. At the end of the four month eligibility period, complete a Continued Medicaid Determination (CMD) and notify the AU. Refer to 2052 Continuing Medicaid Determination.

Use the following chart to determine the action to be taken because of changes in the AU during the Four Months Extended Medicaid time period.

CHART 2170.1, CHANGES IN AU DURING FOUR MONTHS EXTENDED MEDICAID

IF	THEN discontinue 4MEx for	AND reinstate 4MEx effective
the individual whose MAGI income qualified the AU for 4MEx leaves the home **OR** the only child in the AU leaves the home	the entire AU and complete a CMD. Refer to 2052 Continuing Medicaid Determination. If the only child leaves the home, provide a copy of the Medicaid Certification to the adult with whom the child is now living while a CMD is being completed. Use the existing case number during this time.	the month the individual returns, only if there are months remaining in the original 4MEx time period.
any other AU member leaves the home	the individual leaving the AU	the month the individual returns to the AU, only if there are months remaining in the original 4MEx eligibility period.
the entire AU leaves Georgia	the entire AU	the month the AU returns to the state, only if there are months remaining on the original 4MEx eligibility period.
the only child in the AU reaches age 19	the entire AU and complete a CMD. Refer to 2052 Continuing Medicaid Determination.	N/A

2174 Newborn Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Newborn Medicaid		
	Effective Date:	December 2019		
	Chapter:	2100	**Policy Number:**	2174
	Previous Policy Number(s):	MT 49	**Updated or Reviewed in MT:**	MT-57

Requirements

Newborn (NB) Medicaid provides Medicaid coverage to a child born to a woman who was eligible for and receiving Medicaid on the day the child was born.

Basic Considerations

A child is eligible for Newborn Medicaid for up to 13 months beginning with the month of birth and continuing through the month in which the child reaches age 1. Eligibility begins with the birth month, regardless of when the agency is notified of the birth.

Receiving Medicaid

A child is eligible for Newborn Medicaid if born to a woman eligible for and receiving Medicaid under any class of assistance (COA), including PeachCare for Kids®, Supplemental Security Income or any Aged, Blind and Disabled COA (except Q-track and Spenddown in suspense status), or to a woman receiving Emergency Medical Assistance.

> A child born to a woman who is in Medically Needy suspense status on the day of delivery is ineligible for NB Medicaid. Spenddown must be met on or before the date of delivery for the child to qualify for NB. A newborn would not be eligible for NB Medicaid if born to a mother receiving in a Planning for Healthy Babies® COA until a continuing Medicaid determination is completed and she is eligible for a full Medicaid class of assistance. A child born to a woman who only received Presumptive Eligibility Medicaid and was not approved for Pregnant Woman (PGW) Medicaid is not eligible for Newborn Medicaid as presumptive does not cover labor and delivery.

Eligible for and receiving Medicaid is defined as follows:

- The woman's Medicaid application was filed and approved prior to the birth of the child.

  OR

- The woman's application for Medicaid was filed prior to the birth of the child, approved after the birth of the child, and the approval covered the date the child was born.

  OR

- The woman's application for Medicaid was filed and approved after the birth of the child and

the approval covered the date the child was born.

Living Arrangements

Any child born to a woman receiving Medicaid at the time of birth will remain Newborn eligible regardless of whether or not s/he continues to live with the mother. If the child enters foster care, is adopted, or ceases to live with the mother for any other reason, the existing Newborn case would need to be closed, and a separate Newborn case would need to be registered with the new guardian's name and address. A new application is not required.

Request for Newborn Medicaid Coverage

The request for Newborn Medicaid may be made by the parent or guardian or certain Medicaid participating providers. The request may be made by contacting DFCS in person, by telephone or in writing. Certain Medicaid providers may also request Newborn Medicaid online through GAMMIS, or by contacting a DFCS Call Center.

If the request for Newborn Medicaid is made by the parent or guardian or the provider, coverage is approved effective the month of birth. The mother's or guardian's statement of the child's living arrangements is acceptable, unless questionable.

If the provider contacts DCH directly to request Newborn Medicaid for a child, DCH establishes the child's eligibility on their system. DCH provides DFCS with a monthly listing of children that have been added to their system.

Neither an application nor an interview is required to approve a child for Newborn Medicaid.

Dual Eligibility

A child who is dually eligible for Newborn Medicaid and another Medicaid COA may be approved for either COA.

The agency must evaluate the family's circumstances to determine which Medicaid COA provides coverage to the maximum number of family members for the maximum length of time.

If a Newborn Medicaid eligible child receives Medicaid under another COA and becomes ineligible during any month up to and including the month the child turns 1, NB coverage can be approved for the remainder of the thirteen months, provided NB requirements have been met continuously since birth.

Ongoing Eligibility

The child does not have to meet any financial or non-financial eligibility requirements other than to live in Georgia in order to continue to receive Newborn Medicaid after the month of birth.

The **only** circumstance under which a child may become ineligible for Newborn Medicaid is as follows:

- the child no longer lives in Georgia.

If a child moves out of state and then returns to live in Georgia prior to age 1, Newborn Medicaid

can be reinstated until the child reaches age 1.

The parent or guardian is required to report within 10 calendar days any changes, which may affect the child's eligibility for Newborn Medicaid.

Periodic renewals are not required.

Child Support Services

The noncustodial parent of a child receiving Newborn Medicaid is not referred to the Division of Child Support Services (DCSS). However, the parent or guardian must be advised that DCSS services are available to them. If the parent or guardian is interested in receiving these services, they must be provided with written information on how to contact the local DCSS office. Refer to 2250 Cooperation With Division of Child Support Services.

Third Party Liability

The parent or guardian of a child receiving newborn Medicaid is not required to provide information on third party liability available to the newborn. However, the agency must inquire about third party resources and submit any information obtained to DCH. Refer to 2230 Third Party Liability.

Continuing Medicaid Determination

A Continuing Medicaid Determination (CMD) must be completed in the last month of Newborn Medicaid eligibility.

Requirements for completion of the CMD are dependent on the information already known to the agency because of concurrent Medicaid, TANF or Food Stamp eligibility of other family members.

The CMD may require a complete review of eligibility, including a face-to-face contact, or may require only a telephone contact. The worker must evaluate the available information to determine the extent of the contact required. Refer to 2052 Continuing Medicaid Determination.

If the child is not eligible for Medicaid under any COA (including PeachCare for Kids®) please refer family to FFM.

Procedures

Follow the procedures below when notified of the birth of a child.

- Establish that the mother was eligible for and receiving Medicaid on the day the child was born.
- Approve Newborn Medicaid for the child on the system back to the month of birth. The child's date of birth should be used as the application date.
- If the child enters foster care, is adopted, or ceases to live with the mother for any other reason, close the existing Newborn case and register a case with the new guardian's name and address. A new application is not required.
- Screen in GAMMIS to determine if child was previously receiving as a presumptive Newborn (aid category 835) If so, link Gateway client ID numbers to GAMMIS member ID numbers.

- Terminate Newborn Medicaid following timely notice at any time the child ceases to live in Georgia.

Establish the mother's Medicaid eligibility for the month of the child's birth by agency records or by the State Data Exchange for a SSI recipient.

Accept the parent's or guardian's or the Medicaid provider's statement of the child's date of birth, unless questionable.

Documentation and Verification

Document the following information in case notes:

- the child's name and date of birth,
- the Medicaid eligibility status of the mother,
- the date, how (telephone, mail, facsimile, etc.) and by whom the above information was reported.

2182 Children Under 19 Years of Age

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Children Under 19 Years of Age		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2182
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-58

Requirements

Provides Medicaid to children from birth through the last day of the month in which the child turns nineteen (19) years of age.

Basic Considerations

The following basic eligibility requirements must be met to qualify:

- Age. The applicant's statement of the child's date of birth may be acceptable. Refer to 2255 Age (Family Medicaid).
- Application for Other Benefits

  Application for Supplemental Security Income (SSI) or Temporary Assistance to Needy Families (TANF) are not required.

- Enumeration

  Enumeration is not a requirement for Emergency Medical assistance (EMA). Refer to 2054 Emergency Medical Assistance.

  Refer to 2215 Citizenship / Immigration / Identity.

- Residency Refer to Section 2225, Residency.
- Third Party Liability (TPL)

  This includes TPL information on the reputed or legal father of an existing child.

  Refer to 2230 Third Party Liability.

- Cooperation with the Division of Child Support Services (DCSS)

  A referral to and cooperation with DCSS is **NOT** a requirement for child-only Medicaid cases. A child-only Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid under the child's case or under any related case. An AU that contains a penalized adult is **NOT** considered a child-only case.

  Refer to 2250 Cooperation With Division of Child Support Services.

Resources are not considered in determining eligibility.

Financial Eligibility Criteria

Modified Adjusted Gross Income (MAGI) Income limits vary based on the age of the child(ren) in accordance of the Federal Poverty Level (FPL) for the BG size. Refer to Appendix A2, Financial Limits for Family Medicaid.

Verification

Verification of MAGI income is obtained in the following order:

- Agency Data Sources available and/or verified information from related active cases
- The A/R should provide verification from the payment source
- If the A/R cannot obtain the verification, the agency must request it directly from the payment source
- Verification can be obtained from a collateral source if verification cannot be provided by the payment source.

Other Considerations

The statement of the A/R may be accepted if all other attempts to verify MAGI income are unsuccessful and the A/R has cooperated with previous attempts to obtain verification. Refer to 2051 Verification.

Procedures

Screen for Parent/Caretaker with Child(ren) Medicaid. If the applicant is eligible, approve. If not, proceed with the Children Under 19 Years of Age Medicaid.

Follow the steps below to determine eligibility for a child:

Step 1 Review the application and contact the applicant by telephone or mail if additional information is needed that is not included in the application. If no additional information is needed, proceed with the application processing.

Step 2 Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

Step 3 Establish all points of eligibility. Accept the A/R's statement unless information known to the agency conflicts with the A/R's statement or is otherwise questionable.

Step 4 Based on tax filer or non tax filer status, apply the appropriate FPL depending on the BG size, to determine eligibility for the child(ren). Refer to 2245 Living With A Specified Relative / Tax Filer / Non-Filer Status. Refer to Appendix A2, Financial Limits for Family Medicaid.

Step 5 Verify all MAGI income of the BG. Refer to 2051 Verification.

Step 6 Complete the budgeting process. Refer to 2669 MAGI Budgeting.

Step 7 Refer any AU with a child under the age of 5 to WIC. Section 2985 Women, Infant and Children (WIC) Services.

Step 8 If eligible, approve.

If any child is ineligible, complete and document the results of a Continued Medicaid Determination (CMD) for the ineligible child(ren) prior to denial. Refer to Section 2052, CMD.

When eligibility is denied/closed because the MAGI income is above the Medicaid income limit, but at or below the PeachCare for Kids® income limit, a system CMD will be completed to PeachCare for Kids®.

When the MAGI income limit is above the PeachCare for Kids® income limit a system CMD will be completed to the Federally Facilitated Marketplace (FFM).

Renewal

Assistance may continue through the last day of the month the child reaches age 19. A renewal is completed yearly to determine continued eligibility. Refer to 2706 Medicaid Renewals.

Complete and document the results of a CMD for the ineligible child(ren) prior to termination of Medicaid. Refer to 2052 Continuing Medicaid Determination.

Special Considerations

Inpatient Services

If a child is receiving inpatient services when the age limit for an income level is reached or when the child turns 19 years of age, eligibility continues if **all** of the following requirements are met:

- reaching age 19 or the age limit for an income level is the sole reason for ineligibility;
- inpatient services are received in a Medicaid participating hospital or nursing facility on the last day of the month in which the age or income limit is reached and the first day of the next month;
- the child remains eligible under all Children Under 19 Years of Age criteria except for age or income limit through the month in which the inpatient stay terminates.

If the child is transferred directly from one medical facility to another, the extended eligibility can continue if all other requirements are met.

> Upon discharge or if there is a break in stay in a medical facility, the lower income level must be used if the child is under 19 years of age. If the child has reached 19 years of age, s/he is ineligible upon discharge or if there is a break in stay in a medical facility. Complete and document the results of a CMD prior to termination of Children Under 19 Years of Age.

This coverage can be established in the three months prior to an application, even if the child reaches the age limit in one of the prior months, provided the above criteria are met.

Step 1 Verify the inpatient stay that continues beyond the date the child would become Children Under 19 Years of Age ineligible. Continue Children Under 19 Years of Age eligibility through the month following the date of ineligibility and for each month until the child is discharged.

Step 2 Complete and document results of a CMD on the child upon discharge from the medical facility and discontinue Children Under 19 Years of Age.

If Children Under 19 Years of Age is terminated before the agency is notified of the inpatient services, verify that the inpatient services were received and reopen the Children Under 19 Years of Age case. Continue Children Under 19 Years of Age until the patient is discharged. Complete and document the results of a CMD prior to terminating Children Under 19 Years of Age when the child is discharged from the medical facility.

2184 Pregnant Women

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Pregnant Women		
	Effective Date:	May 2023		
	Chapter:	2100	**Policy Number:**	2184
	Previous Policy Number(s):	MT 68	**Updated or Reviewed in MT:**	MT-69

Requirements

Pregnant Women provides Medicaid to pregnant women who have Budget Group (BG) income at or below 220% of the Federal Poverty Level (FPL) and who meet all other eligibility requirements.

Basic Considerations

For eligibility purposes effective November 1, 2022, pregnancy begins with the month of conception and continues through the 12th month following the termination of pregnancy. Eligibility terminates at the end of the month in which the 12th month falls. Begin the 12 month count the month after the termination of pregnancy.

Pregnancy termination includes live birth, still birth, spontaneous abortion (miscarriage), therapeutic abortion and elective abortion.

Pregnant Women Medicaid considers a woman as pregnant during the 12-month extended postpartum period. A pregnant woman who is not receiving Medicaid or is not eligible as a pregnant woman prior to and/or including the month of pregnancy termination is not eligible for Pregnant Women Medicaid during the 12-month extended postpartum period even if she meets eligibility requirements during the 12- month period.

A pregnant woman who is correctly determined Medicaid eligible remains financially eligible from the effective month of approval through the end of the 12-month pregnancy transition period, regardless of changes in the BG income. Refer to 2720 Continuous Coverage For Pregnant Women.

A pregnant woman must continue to meet all non-financial eligibility requirements.

12-Month Extended Postpartum Coverage

Individuals may be eligible for the 12-Month Extended Postpartum coverage if:

- While pregnant were eligible for and received coverage under Medicaid or PCK in Georgia. The 12-month extended postpartum coverage will not be extended to individuals who were not enrolled in Medicaid or PCK in the Georgia at some point during pregnancy.
- Applying for Medicaid benefits were pregnant and received Medicaid-covered services in Georgia while pregnant or terminated during a period of retroactive eligibility.

  No retroactive coverage in PCK.

Pregnant individuals (including Individuals in their postpartum period) should remain eligible through the last day of the month in which the 12-month extended postpartum period ends regardless of any changes in circumstances that may affect eligibility (ex. income, household composition, gaining SSI or aging out). For PCK individuals in their extended postpartum period, this also includes becoming Medicaid eligible or non-payment of premiums. This list is not all inclusive.

If an individual voluntarily requests closure of their PCK case during their extended postpartum period, the individual would not be eligible for the remainder of the 12-month postpartum period if later approved for a Medicaid COA.

EXCEPTIONS:

- Individuals who receive Pregnant Women Medicaid as Emergency Medical Assistance (EMA) are not required to meet the citizenship/identity or enumeration requirements. Refer to 2054 Emergency Medical Assistance.
- Individuals who receive Pregnant Women Medicaid are not required to cooperate with DCSS and are not required to apply for other benefits.

A pregnant woman can be determined eligible for continuous Medicaid coverage based on Pregnant Women Medicaid eligibility in any of the three months prior to the application month. The pregnant woman must meet all financial and non-financial requirements and must be pregnant in the prior month in which eligibility is being determined.

A pregnant woman is budgeted at minimum as two individuals (the pregnant woman and the unborn child). Increase the BG to include the number of fetuses per client statement. If the pregnant woman is included in any Family Medicaid category, ensure the fetus(es) are counted in the BG for the family according to the tax-filer/non-filer rules.

Other Considerations

Presumptive Eligibility

Certain medical facilities including the Department of Public Health (DPH) are approved by the Department of Community Health (DCH) and provide an on-site Presumptive Eligibility (PE) Medicaid certification to pregnant women who apply for and are presumed eligible for Pregnant Women Medicaid.

A Presumptive Eligibility Medicaid application is completed by certified Qualified Providers (QP's) at these facilities. The purpose of the PE is to provide Medicaid coverage for pregnant women to receive immediate prenatal care. After certification, the PE packet is forwarded to the local DFCS or RSM Outreach Project worker for a full Medicaid determination, as the PE decision is temporary and only covers services performed on an outpatient basis.

Qualified Providers do not verify citizenship and identity for PE applications. This must be done by the DFCS or RSM Project worker when completing the regular Medicaid determination.

Refer to 2067 Presumptive Eligibility Medical Assistance.

Procedures

Follow the steps below to determine Medicaid eligibility for Pregnant Woman Medicaid:

Step 1 Review the application and contact the applicant if additional information is needed that is not included in the application.

Step 2 Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

> If an applicant applies for Pregnant Woman Medicaid after her pregnancy has terminated, accept her statement of pregnancy, fetus number, and termination date of pregnancy.

Step 3 Obtain the number of fetuses and estimated date of delivery (EDD) from a medical provider or from the applicant. Written verification of the pregnancy is not required.

Step 4 Establish all points of basic eligibility. Verify applicant's citizenship/qualified immigrant status and identity. Accept the applicant's statement for all other points of basic eligibility unless the statement conflicts with information known to the agency or is deemed questionable. Refer to 2215 Citizenship / Immigration / Identity.

Document in the case record the conflict of information or reason questioned and the verification that is subsequently requested.

> Citizenship/Immigration Status/Identity are not a requirement for Emergency Medical Assistance (EMA). Refer to 2054 Emergency Medical Assistance.

Step 5 Based on tax filer or non-tax filer status, apply the appropriate FPL depending on the BG size, to determine eligibility for the Pregnant Women. Refer to 2245 Living With A Specified Relative / Tax Filer / Non-Filer Status. Refer to Appendix A2, Financial Limits for Family Medicaid.

Step 6 Verify Modified Adjusted Gross Income (MAGI) income using available electronic data sources. Refer to 2051 Verification.

Step 7 Complete the budgeting process. Refer to 2669 MAGI Budgeting.

Step 8 If eligible, approve Pregnant Women Medicaid. If ineligible, allow case to cascade to Pregnancy Spend Down Medicaid (or PCK, depending on age of Pregnant Woman and amount of income), complete and document the results of a Continued Medicaid Determination (CMD). Refer to 2052 Continuing Medicaid Determination.

When the MAGI income limit is above the PeachCare for Kids® income limit, or the applicant is 19 years of age or older, a system CMD will be completed to the Federally Facilitated Marketplace (FFM).

Step 9 If the application originated as a Presumptive Medicaid, screen in GAMMIS to determine if applicant is actively receiving as a Presumptive Medicaid pregnant woman (aid category 865). If so, link GA Gateway client ID numbers to GAMMIS member ID numbers. This must be done the same day the application is approved.

Step 10 Refer pregnant women to WIC and document the case. Refer to 2985 Women, Infant and Children (WIC) Services.

Step 11 Initiate contact with the member in the month prior to the month in which the EDD falls. Continue these monthly contacts to establish that the pregnancy continues.

If the pregnancy terminates with a live birth, the child meets the Deemed Newborn requirement and Medicaid must be established for the newborn. Refer to 2174 Newborn Medicaid.

Continue Pregnant Women Medicaid eligibility 12 months following termination of pregnancy. Terminate eligibility at the end of the month in which the 12th month falls. Begin a CMD for the pregnant woman in the month prior to the last month of Pregnant Women Medicaid eligibility.

2186 Planning For Health Babies®

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Planning For Health Babies®		
	Effective Date:	November 2023		
	Chapter:	2100	**Policy Number:**	2186
	Previous Policy Number(s):	MT 63	**Updated or Reviewed in MT:**	MT-71

Requirements

The Center for Medicare and Medicaid Services (CMS) approved a 10-year extension in August 2019 to the Planning for Healthy Babies® (P4HB) 1115 Demonstration Wavier. This wavier expands the provision of family planning services to women who are Georgia residents, women between the ages of 18 and 44, who do not qualify for other Medicaid benefits and any other insurance coverage with the exception of vision or dental insurance, including Medicare Part A or Part B of Title XVIII of the Social Security Act or CHIP which is known as Peach Care for Kids®. P4HB is not recognized as Minimum Essential Coverage (MEC) as outlined in section 5000A(f)(1)(A)(ii) of the Internal Revenue Code of 1986. This program became effective on January 1, 2011.

Basic Considerations

Family Planning (FP) 181

Uninsured women, ages 18 through 44, who have family income up to and including 211 percent of the FPL, who are not otherwise eligible for Medicaid or CHIP, including women losing Medicaid pregnancy coverage at the conclusion of the 12th month extended postpartum period. Individuals must enroll in a managed care plan to receive family planning and family planning-related services.

Inter-Pregnancy Care (IPC) 180

Uninsured women ages 18 through 44, within three years of delivery of a VLBW baby, who have income up to and including 211 percent of the FPL, who are not otherwise eligible for Medicaid or CHIP. Women in the IPC component must enroll in a managed care plan to receive Family Planning and IPC services.

Resource Mothers (RM) 182 & 183

Women, ages 18 through 44, who have income at or below 211 percent of the FPL, within three years of delivery of a VLBW baby, and who qualify under Medicaid State plan. Women who qualify under the Low-Income Medicaid, “Parent Caretaker” Medical Assistance, or the Aged Blind and Disabled Classes of Medical Assistance.

Primary Goals

The primary goals of the P4HB program are to reduce Georgia’s low birth weight (less than 2500

grams or 5 lbs. 8 oz) and very low birth weight (less than 1500 grams or 3 lbs. 5 oz) rates; reduce the number of unintended and high-risk pregnancies in Georgia, and to reduce Medicaid costs by reducing the number of unintended pregnancies. To provide access to IPC health services for eligible women who have previously delivered a VLBW baby and to increase child spacing intervals through effective contraceptive use.

CMO Enrollment

Members approved for Family Planning services are auto assigned or passively enrolled into a CMO automatically through an algorithm. The member will have the opportunity to participate in a choice change period immediately after being auto assigned. if she does not want the health plan that is chosen for her, she can change to another health plan. The member will have 90 days from the start date of her health plan to change to a new health plan.

Services will not begin until the member is enrolled in a CMO.

Family Planning Services

Family planning services include medically necessary services and supplies described in section 1905(a)(4)(C) of the Act related to the following:

- FDA-approved methods of contraception
- Sexually transmitted infection (STI)/sexually transmitted disease (STD) testing,
- Pap smears and pelvic exams.
- The laboratory tests done during an initial family planning visit for contraception include a Pap smear, screening tests for STIs/STDs, blood count, and a pregnancy test.
- Additional screening tests may be performed depending on the method of contraception desired and the protocol established by the clinic, program, or provider. Additional laboratory tests may be needed to address a family planning problem or need during an inter-periodic family planning visit for contraception
- Drugs, supplies, or devices related to women's health services described above
- Contraceptive management, patient education, and counseling.

Family planning-related services and supplies are defined as those services provided as part of, or as follow-up to, a family planning visit. Such services are provided because a "family planning-related" problem was identified and/or diagnosed during a routine or periodic family planning visit. The following are examples of the family-planning-related services:

- Colposcopy (and procedures are done with/during a colposcopy) or repeat Pap smear performed as a follow-up to an abnormal Pap smear which is done as part of a routine/periodic family planning visit.
- Drugs for the treatment of STIs, except for HIV/AIDS and hepatitis, follow-up visit/encounter for the treatment/drugs, and subsequent follow-up visits to rescreen for STIs based on the Centers for Disease Control and Prevention (CDC) guidelines may be covered.
- Drugs for vaginal infections/disorders, other lower genital tract and genital skin infections/disorders, and urinary tract infections, where these conditions are identified/diagnosed during a

routine/periodic family planning visit. A follow-up visit/encounter for the treatment/ drugs may be covered.

- Other medical diagnoses, treatment, and preventive services that are routinely provided pursuant to family planning services in a family planning setting.

Treatment of major complications arising from a family planning procedure such as:

- Treatment of a perforated uterus due to an intrauterine device insertion
- Treatment of severe menstrual bleeding caused by a Depo-Provera injection requiring dilation and curettage
- or Treatment of surgical or anesthesia-related complications during a sterilization procedure.

Inter-Pregnancy Care Services

In addition to the family planning and family planning-related services described above, women who are enrolled in the IPC component are also eligible for the benefits described in the table below.

Services	Notes / Limitations
Primary care	Limited to 5 office/outpatient visits per year
Management and treatment of chronic diseases	
Substance use disorder treatment (detoxification and intensive outpatient rehabilitation)	
Limited Dental	Services are limited to exams and cleanings every six months; x-rays every 12 months; and simple extractions; and emergency dental services.
Prescription Drugs (non-family planning)	Prescription drug coverage is limited to the IPC formulary.
Non-emergency medical transportation	Only available for beneficiaries eligible under the IPC component.
Case management/Resource Mother Outreach	

Resource Mother Services

Women served under the IPC and Resource Mother components will have access to Resource Mother Outreach. The purpose of the Resource Mother Outreach is to provide peer services in coordination with a nurse case manager. The Resource Mother provides a broad range of paraprofessional services to P4HB participants in the Interpregnancy Care component of the Planning for Healthy Babies Program and their families. The Resource Mother performs certain aspects of case management including the provision of assistance in dealing with personal and social problems and may provide supportive counseling to P4HB participants and their families and/or serve as a liaison for social services.

Card

PH4B recipients will receive specific color CMO cards for each category and will have specific Aid Categories listed in GAMMIS as follows:

- Family Planning-181, pink CMO card

- Inter-Pregnancy Care-180, purple CMO card
- Resource Mother Parent/Caretaker Medicaid-182, yellow CMO card
- Resource Mother ABD/SSI Medicaid-183, yellow CMO card

Policy Requirements

Applicants for P4HB must meet the following eligibility requirements:

- Age – women ages 18 (month of 18th birthday) through 44 (month of 45th birthday)
- Must be able to become pregnant
- Georgia resident
- Citizenship/Immigration Status/Identity
  - Reasonable opportunity policy applies (refer to Section 2215)
  - The signed Streamline application meets the declaration of citizenship requirement, so a separate declaration is not required.
- Third-Party Liability (TPL), DMA285 is not required if there is no TPL.
- Income up to and including 211 percent of the FPL based on MAGI Rules. Individuals that meet on tax filer criteria are potentially eligible to receive coverage based on the MAGI Medical Assistance policy. Refer to Section 2245, Filer Status/Specified Relative Relationship and Section 2610 - Magi Budget Groups/Assistance Units
- Limited to 24 months for (180-IPC and 181 and 182-RM services) for each reported VLBW baby and will be disenrolled after 2 years of participation.
- No retroactive (three months prior) coverage
- No Emergency Medical Assistance (EMA) coverage
- Must report changes within 10 days
- A woman enrolled in P4HB who becomes pregnant can apply for Presumptive Eligibility (PE) Pregnant Women Medical Assistance. Her P4HB services will be terminated the same day of her pregnancy eligibility.
- Post-partum women who were on Medicaid coverage and enrolled in a Georgia Families Care Management Organization (CMO) at delivery will be automatically cascaded to the appropriate aid category and enrolled in the plan with which they were affiliated. These women will be afforded the opportunity to choose a new CMO if desired.
- If a member has an active P4HB case 180 or 181 but does not apply for PE Pregnant Women Medical Assistance until after she delivers her baby. There must be a “Continuing Medicaid Determination” (CMD) for the member to cascade from P4HB to Pregnant Women Medicaid. Refer to 2052 Continuing Medicaid Determination.
- All P4HB services, FP-181, IPC-180, and RM-182 & 183 are subject to annual renewals.
- All women between the ages of 18 through 44 must receive notification their application for P4HB has been approved, denied or their P4HB eligibility has been terminated.
- All pregnant women receiving Medical Assistance under any class of assistance (COA) will be sent a letter in their eighth month of pregnancy from their CMO informing them of the P4HB

program. Pregnant women whose Medical Assistance cases are closing and who are not eligible for another COA may be eligible for P4HB Family Planning services.

P4HB Disenrollment

Women who no longer meet the eligibility criteria outlined for the P4HB program will be disenrolled from the P4HB program. These include women who:

- If a woman becomes pregnant while enrolled, she may be determined eligible for Medicaid in the pregnant woman eligibility group in accordance with 42 CFR 435.916.
- Women who choose to receive a sterilization procedure and complete all necessary follow-up procedures will be disenrolled.
- Women receiving IPC services will be disenrolled from the IPC component and enrolled in the family planning-only component after 2 years of participation. Additional deliveries of subsequent VLBW babies will grant an additional two-year enrollment period in the IPC component.
- Before disenrollment of any beneficiary eligible, there must be an administrative renewals for all affected beneficiaries in order to determine if they qualify for Medicaid eligibility under a different eligibility category prior to termination, required under 42 C.F.R. 435.916(f)(1).
- Move out of the state
- Become incarcerated
- Become unable to become pregnant
- Women who have aged out

Redeterminations

Redeterminations of eligibility are conducted not more frequently than every 12 months in accordance with 42 CFR 435.916(a).

Enrollment to IPC-180 and RM-181 &182 limited to 24 months

Women applying for IPC 180 and RM 182 & 183 must have delivered a very low birth weight (VLBW) baby within three years. If the member delivers multiple births on the same day or a different day, the birth of the last child delivered is used to count toward the 24 months.

Prior to Exhausting the 24 Months

If an IPC 180 or RM 183 member leaves the program prior to exhausting their 24 months of services; she can reenter the program and reclaim the remaining months. If she delivers and reports another VLBW baby within her remaining 24 months, the clock will reset in Gateway, even if she did not complete her 24 months in a previous case. Any remaining months will be voided after verification of new reported VLBW baby and a new 24 months restarts. An IPC 180 and RM 182 & 183 member cannot exceed 24 months at any given period.

P4HB Required Verification for IPC/RM

What verification is required?

- Physician's Statement for P4HB Inter-Pregnancy Care and Resource Mother

  OR

- Hospital Confirmation of Birth Record that includes birth weight

  OR

- Care Management Organizations (CMO) Report

> The Care Management Organizations (CMO) report is manually entered in Gateway by the Department of Family Children Services RSM Alma group validating the VLBW baby or disenrollment.

HIPAA

Health Portability and Accountability Act (HIPAA) notification must be mailed to the adult who makes an application for P4HB. If there are additional adults in the household for whom Medical Assistance is being requested a separate HIPAA notice must be sent by the agency determining eligibility.

Hearing Process

Appeals for the P4HB program should follow the Appendix B process for hearings.

Applications

There are several ways an applicant can apply for P4HB:

- The applicant can apply through the Georgia Gateway Customer Portal at www.gateway.ga.gov/.
- The applicant can print a streamline application from the website at medicaid.georgia.gov/programs/all-programs/planning-healthy-babies by notating P4HB on the application
- The applicant can apply by calling 1-877-427-3224 or request an application be mailed to them
- The application can be returned by fax to 1-912-632-0389
- The application can be returned to:

  Planning for Healthy Babies®
  PO Box 786
  Alma, GA 31510

  Or

  Division of Family and Children Services
  Customer Contact Center
  PO Box 4190
  Albany, GA 31706

An applicant can obtain an application from their local DFCS or apply at one of the following:

- Qualified Provider (QP)

- Qualified Hospital (QH)
- Department of Public Health (DPH)
- Federally Qualified Health Centers (FQHC)
- Rural Health Centers (RHC)

2194 PeachCare for Kids®

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	PeachCare for Kids®		
	Effective Date:	September 2024		
	Chapter:	2100	**Policy Number:**	2194
	Previous Policy Number(s):	MT 67	**Updated or Reviewed in MT:**	MT-73

Requirements

PeachCare for Kids® (PCK) provides health insurance for uninsured children under the age of 19 living in Georgia. These children are in families with incomes between 134 to 247 percent of the federal poverty limit. Eligibility is determined based on the Modified Adjusted Gross Income (MAGI).

Basic Considerations

PCK health coverage is available to children from birth through the last day of the month of a child's 19th birthday.

PCK uses Modified Adjusted Gross Income (MAGI) rules to determine eligibility. Refer to Section 2610 - MAGI Budget Groups / Assistance Units and Section 2245 - Living with a Specified Relative/Tax Filer/Non-Filer Status.

Countable income must be less than or equal to 247% fo the FPL. Refer to Appendix A2, Financial Limits for Family Medical Assistance.

All income received by the applicant must be verified electronically or manually.

PCK recipients must meet the Medical Assistance citizenship/immigration criteria. Citizenship/immigration status must be verified. Refer to Section 2215 - Citizenship/Immigration/Identity.

Referral of the non-custodial parent (NCP) to DCSS does not apply.

Enrollment in PCK begins the first day of the month in which a complete application or renewal, including all applicable verifications and initial premium payment have been received.

PCK does **NOT** provide prior month coverage. If prior month medical bills are owed, the child may be potentially eligible for Family Medicaid Medically Needy.

Exceptions

- Children who are eligible for Medicaid are ineligible for PeachCare for Kids®.
- Children who are eligible for Newborn Medicaid are ineligible for PeachCare for Kids®.
- Children covered by other public or private health insurance (except vision or dental insurance) are ineligible for PeachCare for Kids®. Refer to Section 2230 - Third Party Liability.

PCK enrollees may only be denied/terminated for TPL or income exceeding FPL at application and renewal due to continuous eligibility restrictions.

- PeachCare for Kids® enrollees are ineligible to receive Georgia Pediatric Program (GAPP) services.
- PeachCare for Kids® is not an EMA eligible class of assistance.

Procedures

Gateway will automatically screen each application or renewal for all Medicaid Classes of Assistance (COA).

A PeachCare for Kids® enrollee who becomes pregnant can apply for Pregnant Woman Medicaid. If the pregnant PCK enrollee is determined Pregnant Woman Medicaid eligible, then the PCK enrollee is no longer eligible to receive PCK.

If the PeachCare for Kids® enrollee's pregnancy has ended by delivery or termination and the individual is in their 12-month postpartum period, then the PCK enrollee will remain PCK eligible through the last day of the month of their 12-month postpartum period regardless of any changes in circumstances that may affect eligibility (e.g. income, household composition, aging out, nonpayment of premiums or becoming Medicaid/SSI eligible).

If the PeachCare for Kids® enrollee voluntarily request closure of their PCK case during their 12-month postpartum period, the PCK enrollee would not be eligible for the remainder of their 12-month postpartum period if later approved for a Medicaid class of assistance.

Other Considerations

A Care Maintenance Organization (CMO) and a primary care physician must be selected for children eligible for PCK. This may be done after approval through Georgia Families®. If no CMO and primary care physician are selected, a CMO and physician will be assigned according to the area in which the child lives.

Any physician, medical practice, clinic or hospital that accepts Medicaid also accepts PCK.

PCK health benefits will not start until after the initial premium payment is received. A 45-day initial premium payment period will be given to new PCK applicants. A 30-day initial premium period will be given to PCK enrollees at renewal.

PCK enrollees will no longer lose coverage for non-payment of premiums after the initial premium payment is received for each new enrollment period, which includes the initial eligibility determination at application and annual renewals, due to continuous eligibility restrictions.

Monthly premium payments will still be accrued, and a quarterly statement will be sent to the customer. Premium payments are due 30 days before the first day of the month that enrollees receive PCK health benefits.

Premiums are calculated on a sliding scale based on household income, ranging from $11 to a family maximum of $72. The premium schedule for PCK is shown in the chart below.

Premium Scheduled by FPL

FPL	One Child	Family Cap
134 - 158%	$11.00	$16.00
159 - 170%	$22.00	$44.00
171 - 190%	$24.00	$49.00
191 - 210%	$29.00	$58.00
211 - 231%	$32.00	$64.00
232 - 247%	$36.00	$72.00

No premium or co-payment is charged for children under age six (6), children in Foster Care or American Indians and Alaskan Natives (AI/AN).

ELE PCK premium(s) is as follows:

- 236%-247%, $36.00 for 1 child; $72.00 for 2 or more children.

Refer to Section 2069 - Express Lane Eligibility (ELE).

PCK customers are required to pay co-payments for their child(ren). These co-payments are paid to medical care providers on the date medical services are received. However, children under the age of six (6), in Foster Care, American Indian or Alaskan Native are exempt from these co-payments and will not have to pay any fees for services received.

Applicants may apply for PCK the following ways:

- Online at www.gateway.ga.gov
- By phone at 1-877-427-3224 or 1-877-423-4745 and follow the prompts
- Submit an application in person at a local DFCS or RSM Office by requesting an application for Medical Assistance or by downloading, printing, and completing an application found online at dch.georgia.gov/applications-0 and submitting it in person.
- A completed and signed application can be mailed to:

  RSM
  P.O. Box 786
  Alma, Georgia 31510

How to submit PeachCare for Kids® premium payments.

- By internet: www.gateway.ga.gov
- By phone: 1-877 GA PEACH (427-3224) to make a payment anytime.
- By mail:

  PeachCare for Kids® Payment
  P.O. Box 44031
  Jacksonville, FL 32231

Important: The case number should be included on the check or money order.

Initial Premium Payments mailed to another address or not received on time may delay receiving health benefits.

A single **Coupon Slip** will be sent to the client when their child(ren) becomes PeachCare for Kids® eligible. After that, coupons are sent based upon the client's request and can be requested through Gateway on the CHIP Triage Center Case Information Search/Summary page. Also, if the client mails in premium payments consistently in a year, they will automatically receive a coupon book for the next year.

2195 Pathways

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Pathways		
	Effective Date:	July 2023		
	Chapter:	2100	**Policy Number:**	2195
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-70

Requirements

Georgia designed and submitted its Pathways Section 1115 Demonstration waiver to CMS on December 23, 2019. The goal of this class of assistance (COA) is to create an opportunity for Georgians ages 19 through 64 with household incomes up to 95% of the FPL after 5% income disregard, who are not otherwise eligible for Medicaid, to gain access to affordable, quality healthcare until their income meets or exceeds 100% of the FPL, and they have access to affordable health insurance through the individual market or employer-sponsored insurance. Pathways will go into effect on July 1, 2023, and is a MAGI COA.

Basic Considerations

Basic Eligibility Criteria

A/Rs must meet the following basic eligibility requirements:

- **Age** – Must be an adult age 19 through 64. Refer to 2255 Age (Family Medicaid).
- **Citizenship/Immigration Status/Identity** – A/R must be a U.S. citizen or meet immigration eligibility requirements. Refer to 2215 Citizenship / Immigration / Identity.
- **Enumeration** – A/R must furnish, apply for, or agree to apply for a Social Security Number (SSN) for each member, unless Good Cause for SSN is established, is penalized. Refer to 2220 Enumeration.
- **Tax Filer and Non-Tax Filer Status** – A/Rs expected to be included on the next tax return filed are potentially eligible to receive MAGI Medicaid. A/Rs that meet non-tax filer criteria are potentially eligible to receive MAGI Medicaid. Refer to 2245 Living With A Specified Relative / Tax Filer / Non-Filer Status.
- **Residency** - AU members must be residents of Georgia and not incarcerated in a public institution. Refer to 2225 Residency.
- **Third Party Liability Requirements** – The A/R is required to provide information regarding any Third-Party Liability (TPL) available to any Potential Pathways member. The A/R must assign his/her TPL rights to DCH, unless Good Cause for TPL exists. Refer to 2230 Third Party Liability.
- Potential Pathways Member is not eligible for any other Medicaid class of assistance (Family or ABD).

For Pathways COA, Application for Other Benefits is not a requirement. A/R should be notified of potential benefits if applicable.

Prospective Eligibility

Coverage in Pathways is prospective only and begins with the first day of enrollment in either a Medicaid Care Management Organization (CMO) or the Pathways Health Insurance Premium Payment (HIPP) program. A/Rs subject to premium payments must make their initial premium payment before they are enrolled in Pathways. A/Rs not subject to premium payments will begin coverage on the first of the month following the A/R's eligibility determination.

There are **no** retroactive months or Hospital Presumptive Eligibility (HPE) for this COA. There is also **no** Emergency Medical Assistance (EMA) eligibility for Pathways.

Financial Eligibility Criteria

A/R must have income within the following limit:

- **Modified Adjusted Gross Income (MAGI)** - The total taxable net income of the AU must be equal to or less than the MAGI income limit of the AU size. For Pathways the household income can be up to 100% of the FPL, which includes a 5% of the FPL income disregard. After the 5% disregard and all applicable 1040 and Pre-tax deductions the A/R income must be equal to or less than 95% of the FPL. Refer to Appendix A2, Financial Limits for Family Medicaid.

Prospective budgeting is used in determining eligibility for the application month and the ongoing benefit period. Data sources and/or active related programs verification is used prior to requesting verification.

Modified Adjusted Gross Income (MAGI) financial methodologies are used to calculate the monthly MAGI income used for the BG. Pre-Tax deductions and 1040 deductions are given. Refer to 2669 MAGI Budgeting.

Non-Financial Eligibility Criteria

- **Qualifying Activities** - In order to be eligible for Pathways at application, an A/R must demonstrate that they are currently engaged in at least 80 hours per month of a qualifying activity or combination of activities.

  Qualifying activities include:

  - Unsubsidized employment, including self-employment
  - Subsidized private sector employment
  - Subsidized public sector employment
  - On-the-job training
  - Job readiness
  - Community service
  - Vocational educational training
  - Enrollment in an institution of higher education

    - Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program

- **Maintaining Eligibility** – To remain eligible for Medicaid coverage through Pathways, an A/R must report their hours monthly. Reporting of hours will include an A/R's self- attestation of activity hours, accompanied by supporting documentation for verification. If an A/R fails to report their monthly hours, they will be suspended from the program unless they have a Good Cause Exception.

An A/R with evidence of meeting the hours and activities threshold for six consecutive months will be exempt from the reporting requirement, except that they will have a responsibility to report any changes in circumstance. An A/R who can provide evidence of meeting the hours and activities threshold for the six months prior to applying for Medical Assistance will also be exempt from the monthly reporting requirement, except that they will have an affirmative responsibility to inform the State of any changes in circumstance.

For more information regarding reporting requirements - Refer to 2256 Pathways Qualifying Activities Reporting.

Pathways Health Insurance Premium Payment (HIPP) Program

A/Rs with access to Employer Sponsored Insurance (ESI) must enroll in the Pathways HIPP program if it is determined to be cost-effective for the State.

- **Cost-effectiveness** is defined as a savings of $1.00 or more per year for the State. It takes into account the cost to the State paying the A/R's cost-sharing obligations, including premiums, for the employer's insurance compared to the cost of paying Medicaid capitation rates. Cost-effectiveness will be determined by the Third-Party Liability (TPL) vendor using their proprietary formulas and processes.

If the A/R is determined eligible for Pathways but is determined not to be cost-effective to enroll in ESI, the A/R will receive an approval notice from Gateway for Pathways and be enrolled into a CMO.

- **HIPP Referral Process** - An A/R who reports having access to or reports being currently enrolled in ESI at application will be referred to the TPL vendor Health Management Systems (HMS) for an ESI cost-effectiveness determination if they are identified as potentially eligible for Pathways. The A/R will receive a notice informing them of this referral.

  The eligibility determinations for Pathways and for ESI cost-effectiveness will occur concurrently in order to remain within the 45-day standard of promptness requirement for eligibility determination. Gateway will determine eligibility for Pathways while the TPL vendor will determine cost-effectiveness for ESI.

  If the A/R is determined eligible for Pathways and is determined cost-effective to enroll in ESI, the A/R will receive an approval notice from Gateway outlining requirements for ongoing participation and next steps for enrollment with the TPL vendor.

> A/Rs enrolled in the Pathways HIPP program will have their ESI premium payments and cost-sharing obligations (including copayments & deductibles) made on their behalf by the State. **The Pathways HIPP program is not effective until Phase 2 implementation,**

scheduled January 1, 2024.

Member Rewards Account

All A/Rs enrolled in Pathways, except those participating in the Pathways HIPP program, will have access to a Member Rewards Account (MRA or account). Premium payments will be deposited into the account. Additionally, A/Rs will have the opportunity to earn dollars by engaging in healthy behaviors. Funds in the account will be available to pay copayments as well as to pay for additional services not covered by Medicaid, such as vision or dental services.

MRA program will not be effective until Phase 3 implementation, scheduled July 1, 2024.

Premium Payment and Tobacco Use Surcharges

A/Rs with income between 50% and 100% of the FPL and not enrolled in the Pathways HIPP program will be required to pay monthly premiums. Monthly premium payments are due by the 3rd of the month in order to maintain eligibility. The final deadline for a late premium payment is the 17th of the month. The monthly amount for A/Rs with income from 50% up to 85% is $7.00 and the monthly amount for A/Rs with income from 85% up to 100% is $11.00. A/Rs that currently consume tobacco or tobacco products on a regular basis will be subject to a tobacco surcharge.

A/Rs who have income less than 50% FPL or are enrolled in the Pathways HIPP program are exempt from the premium requirement. A/Rs enrolled in and for 2 months after graduation from the Technical College System of Georgia High Demand Career Initiative/HOPE Career Grant program are waived from the premium requirement.

Premiums will be deposited monthly into the Members Rewards Account (MRA).

Premium Payments at Renewal - If a member is required to pay premiums in their current certification period, their premium is due on the 3rd of the last calendar month of their certification period (with a final deadline of the 17th of the month) in order to be eligible for the following month.

Members who are newly required to pay premiums as a result of a change in income determined at the renewal process will have a one-month waiver from premium payment.

During redetermination, A/R's income will be verified in order to determine eligibility for a new certification year. If at redetermination the member's income has increased or decreased, the State will evaluate whether the member's premium contribution amount should be adjusted for the following certification year.

If the A/R's income at redetermination is between 50% and up to 100% of the FPL, the member must pay the premium for the first month of the new certification period as a condition of eligibility. If the A/R was not required to pay premiums in the prior certification year, but now has an income between 50% and up to 100% of the FPL, then they will be required to pay premiums in the new certification year. They will be notified of this change in the Redetermination Approval Notice.

For these members, a one-month waiver for premium payment will be given to provide the member with sufficient time to receive information about the new obligation and allow for continuous coverage.

The timeline for payment of the new premium amount depends on whether the change is negative or positive for the member.

- If positive (decrease or elimination of premium), the new premium amount is owed starting in the first month of the new certification period.
- If negative (increase of new requirement to pay premium), the new premium amount is owed starting in the first of the month following expiration of timely notice or at the start of the second month, whichever is later. This will provide the member with sufficient time to receive information about the new amount and adjust payment accordingly.

Premium Payments will not be required until Phase 3 implementation, scheduled July 1, 2024.

Copayments

Copayments will be required for all A/Rs enrolled in Pathways regardless of their income, except for A/Rs enrolled in the Pathways HIPP program.

Pathways copayments will not be required until Phase 3 implementation, scheduled July 1, 2024.

Pathways Contract

In order to be enrolled in Pathways, an A/R identified as potentially eligible must sign a contract with the State indicating their awareness of the terms of coverage, agreeing to comply with the premium payment (if applicable) and qualifying activities reporting requirement, that they may be subject to random and periodic audits, and awareness that their employer may be contacted to gather additional information on their ESI plan (if applicable).

Pathways contract must be signed by the A/R for whom it is intended or an authorized representative they have given permission to act on their behalf. A Pathways contract must be received for each A/R who would like to be evaluated for Pathways COA.

Pathways Renewal

If the renewal is completed and submitted timely, the member will continue to be covered under Pathways until the renewal is processed, as long as they continue to meet their monthly qualifying activities requirement and premium payment (if applicable). For more information regarding the renewal process for Pathways please refer to 2706 Medicaid Renewals.

Pathways renewal process will be implemented in Phase 2, scheduled for January 2024.

Changes

All Pathways members are required to report a change in circumstance to the State which may impact their continued eligibility for the program within 10 days. During all reported changes, Pathways members will be evaluated to determine potential eligibility for all Medicaid classes of assistance other than Pathways.

In addition to reporting changes required by MAGI-Medicaid classes of assistance, Pathways members are required to report changes in:

- Participation in qualifying activities that would impact their eligibility for the program (e.g., reduction of hours engaged below 80-hour threshold, withdrawal from full-time enrollment in an institution of higher education, etc.)
- Employer access to ESI (e.g., gain of access to ESI that was not indicated in the Medical Assistance application)

  For Changes in Qualifying Hours and Activities refer to 2256 Pathways Qualifying Activities Reporting.

- **Failure to Report a Change** - If the State is made aware that a member failed to report a change that makes them ineligible for Pathways or any other COA, the member will be terminated effective the first day following the month timely notice expires.

A/Rs who are terminated for failure to report a change in circumstance will receive a notice that their coverage will be terminated along with information on appeals.

If it is discovered that a member has intentionally defrauded the State, the current process for referral, investigation and fraud resolution will be followed.

- **Transition from Another COA to Pathways at Change** - Existing Medicaid A/Rs age 18 or older will have the opportunity to be evaluated for Pathways when reporting a change and signing the Pathways Contract. If eligible and approved for Pathways, coverage will begin prospectively on the first of the month following authorization of the approval. A/Rs will receive a one-month waiver for premium payment (if premium payment is required) to allow for continuous coverage.
- **Targeted Advance Notice** - Gateway will identify A/Rs currently enrolled in other classes of assistance who are coming to a known termination date (due to age) and who are under 120% of the FPL and include a Targeted Advance Notice with their Change/Termination Notice. The Targeted Advance Notice will include information such as the Pathways program overview, and information on submitting a change or new application and reporting qualifying activities for consideration of coverage through Pathways.

Other Considerations

Pathways and Care Management Organizations – A/Rs enrolled in Pathways will be automatically assigned into a Care Management Organization (CMO), except A/Rs who are enrolled in ESI and determined to be cost-effective. A/Rs will have 90 days after auto-assignments to change CMOs.

Pathways Manual Audit Process - As part of ongoing operations for Pathways, auditing of enrolled members will be conducted to verify compliance with the qualifying hours and activities requirement. All Pathways members assigned to a CMO or enrolled in ESI claimed through a spouse or family member will be subject to program audits. Upon approval in Pathways, the eligibility approval notice is generated which contains language to inform the A/R of the requirement to comply with random and periodic audits to maintain coverage under Pathways.

Enrolled Pathways members within the following three categories are subject to audit:

1. Members who are required to report monthly and who have reported hours and activities.

2. Members who have completed six months of consecutive reporting and who are exempt or waived from reporting hours and activities.
3. Members who have submitted Good Cause Exception request.

> Pathways members who are enrolled in the Pathways Health Insurance Premium Payment (HIPP) program are not required to report qualifying hours and activities monthly unless the Pathways member Employer-Sponsored Insurance (ESI) is claimed through a spouse or family member. As such, they are not subject to the qualifying hours and activities compliance audit.

The Pathways Program eligibility audit process will consist of third party and/or collateral verification of the qualifying hours and activity documents submitted by the member for the most recent month available within the case. Third party verification may be obtained via work number or computer matches. Collateral contact may be made verbally by telephone or, in writing. Additionally, members who are exempt from monthly reporting are expected to have certain forms of documentation available to show their continued engagement in qualifying activity or activities. If audited, the member will need to provide documents to verify compliance with qualifying hours and activities.

Applying for Pathways – A/Rs can apply for Pathways through the following methods:

- Online through the Customer Portal at www.gateway.ga.gov/
- By calling 1-877-423-4746
- In-person at a Division of Family and Children Services (DFCS) office
- By paper application

2196 Family Medicaid Medically Needy

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Medically Needy		
	Effective Date:	February 2020		
	Chapter:	2100	**Policy Number:**	2196
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-58

Requirements

Family Medicaid Medically Needy (FM-MN) provides Medicaid coverage for children under 19 years of age and for pregnant women whose BG income exceeds limits for all Family Medicaid COAs and PeachCare for Kids®.

Basic Considerations

FM-MN is available to pregnant women who meet any of the following conditions:

- The budget group (BG) income exceeds the Pregnant Woman Medicaid net taxable income limit.
- The pregnant woman would be eligible for Parent/Caretaker with Child(ren) Medicaid upon the birth of the child except the BG net taxable income exceeds the Parent/Caretaker with Child(ren) Medicaid limits.

FM-MN is available to children under 19 years of age who meet any of the following conditions:

- The child's BG income exceeds Children Under19 Years of Age Medicaid and PeachCare for Kids® net taxable income limits.
- The child would be eligible for Parent/Caretaker with Child(ren) Medicaid except for excessive net taxable income.
- The child is in foster care with income exceeding Parent/Caretaker with Child(ren) Medicaid, CWFC, Children Under 19 Years of Age Medicaid, and PeachCare for Kids® net taxable income limits.

Eligibility for all Family Medicaid COAs (including Children Under 19 Years of Age Medicaid) and PeachCare for Kids® must be ruled out prior to determining eligibility under FM-MN.

Children Under 19 Years of Age Medicaid net taxable income limits vary based on a child's age. Because of this, it is possible that a younger child may be Children Under 19 Years of Age Medicaid eligible and a sibling may be FM-MN eligible because of Children Under 19 Years of Age Medicaid ineligibility.

All basic eligibility criteria must be met with the exception of living with a relative within the specified degree of relationship and cooperating with DCSS for child only cases. Refer to Chapter 2200, Basic Eligibility Criteria.

Resource Limit

FM-MN resource limits are based on SSI resource limits.

If resources are less than or equal to the applicable resource limit at any time during a month, the BG is resource eligible for the entire month.

Use the chart below to determine the resource limit for a BG.

EFFECTIVE	NUMBER IN BUDGET GROUP							
	1	2	3	4	5	6	7	8
7/1/98 through the present	$2000	4000	4100	4200	4300	4400	4500	4600
Add $100.00 for each BG member above eight.								

Renewal Period

The FM-MN renewal period is 6 months. Each month of the 6-month FM-MN renewal period is a separate budget period and eligibility is determined for each month individually. The first budget period begins on the first day of the month in which the application is filed and ends with the last day of the application month. The second through sixth budget periods begin on the first day and end on the last day of each of the months 2 through 6. The renewal period begins on the first day of the month in which the application is filed and continues through the last day of the sixth consecutive month.

Prior Months

FM-MN is available for the three months prior to the application month. Each of the three prior months is budgeted separately using actual income and expenses for each of those months.

Income and expenses are budgeted prospectively for each one-month budget period in the six-month renewal period. Refer to 2653 Prospective Budgeting.

Spenddown FM-MN

Spenddown (SD) eligibility is determined when the BG's net countable income is greater than the MNIL for the BG size and is offset by the incurred medical expenses of the BG. Resources must be less than or equal to the FM-MN resource limit.

If the BG's net countable income for the budget period exceeds the MNIL for the BG size, the excess amount is the SD.

The SD must be met before the AU is approved for FM-MN.

The SD is met by subtracting allowable medical expenses of the BG members from the SD until the SD is zero.

When the SD is met, the case is considered FM-MN SD eligible and the AU members are approved for Medicaid effective the day the SD is met. Eligibility continues through the end of the month.

Individuals Whose Medical Expense May Be Used

The following individuals' medical expenses may be used to meet an AU's SD:

- any BG member
- a deceased spouse or child of a BG member if s/he could have been included in the BG at the time the medical expense was incurred

  Enumeration is not required for a deceased individual.

- the child of a BG member who has reached 19 years of age if that child could have been included in the BG at the time the medical expense was incurred.

  The child does not have to be currently living in the home with the BG and does not have to be enumerated.

- the parent of a minor parent.

Allowable Medical Expenses

Medical expenses are used to meet the SD if they meet all of the following conditions:

- the bill is unpaid

  Medical bills paid during the budget period are allowed.

- a BG member is legally obligated to pay the expense
- there is no TPL coverage to pay the expense. Refer to Special Considerations and Chart 2196.1 – Allowable Medical Expenses for FM-MN in this section.

The SD may be met using medical expenses incurred prior to the budget period. If this situation occurs, the AU is eligible from the first day of the one-month budget period. Any remaining portion of the unpaid expense not used to meet SD in a month may be used to meet SD in subsequent months, provided the bill remains unpaid during those months.

If the SD is not met by previously incurred bills, the case is held in suspense status until bills are incurred that meet the SD for any month in the renewal period.

SD that remains in suspense status should be closed with the correct closure codes to refer to the Federally Facilitated Marketplace (FFM).

If the SD is met during a budget period, a first day liability (FDL) is calculated for the day the SD is met. The BG is responsible for paying the FDL. Form 400, MN First Day Liability, is used to inform the member or the provider of the FDL amount for which the member is responsible.

If a member submits a medical expense after the expiration of the budget period, the bill can be used to meet or adjust the SD for the expired budget period only if it is submitted within three months of the expired period, unless Good Cause exists.

If the bill is submitted in the fourth month after an expired FM-MN budget period and Good Cause does not exist, the bill can be used to meet a current or future SD if a BG member con-

tinues to be legally obligated to pay it and there is no TPR for that bill.

If an AU member becomes eligible for another Medicaid COA while the FM-MN case is in suspense status, terminate the FM-MN case and approve the AU member for the other COA.

A woman whose medical bills meet SD the day **after** the day the pregnancy terminates is **not** eligible for Medicaid as a pregnant woman.

The Newborn does not qualify for NB Medicaid.

A pregnant woman who applies for FM-MN and whose medical bills meet SD on or before the day of the termination of pregnancy can be eligible for Medicaid through the month in which the 60th day from pregnancy termination occurs. Refer to 2720 Continuous Coverage For Pregnant Women.

FM-MN Medicaid begins on the Begin Authorization Date (BAD), a specific day during the budget period.

Medical expenses incurred prior to the BAD in a budget period are not paid by DCH.

Begin Authorization Date

The BAD is any of the following dates:

- the first day of the budget period if SD is met using only unpaid medical bills incurred prior to the budget period
- the day in the budget period in which the SD is met using bills incurred during the budget period or a combination of bills incurred during and prior to the budget period. This day can also be the first day of the budget period.

Procedures

Screen for eligibility for all classes of Family Medicaid and for PeachCare for Kids®.

If the AU is ineligible for all Family Medicaid COAs and PeachCare for Kids® based on income or resources, proceed with FM-MN.

Follow the steps below to establish FM-MN eligibility:

Step 1 Accept the Medicaid application from the A/R and establish the six-month renewal period. Obtain a written statement of choice when a bill that could potentially be paid by Medicaid is used to meet SD for an ongoing month. Medically Needy Option Statement.

Step 2 Determine the AU and BG. Refer to Chapter 2600, Family Medicaid Assistance Units and Budget Groups.

Step 3 Establish each budget month of the renewal period.

Step 4 Determine the countable resources of the BG for the budget period and compare to the FM-MN resource limit for the BG size to determine resource eligibility.

Step 5 Determine if a TPL resource exists that will pay for all or any portion of the medical expenses.

Step 6 Complete a FM-MN budget using the prospectively budgeted income and expenses of the BG. Refer to Section 2671, Family Medicaid Medically Needy Budgeting.

Step 7 If the net countable income of the BG exceeds the MNIL for the BG size, the amount of the excess is the SD. Explain to the applicant/member the SD process.

Step 8 Determine whose expenses are allowed as deductions from the SD.

Step 9 Obtain itemized copies of bills for unpaid medical expenses and those paid during the budget period for the individuals determined in Step 8.

Step 10 Determine which medical bills may be applied to the SD.

Step 11 If a TPL exists, determine how much the TPL has paid or will pay toward these bills and subtract the TPL payment(s) from the bill(s). Use only the remaining amount toward meeting the SD.

Step 12 Sort medical bills in ascending (oldest to most recent) chronological order.

Step 13 Deduct from the SD the allowable prior medical bills (bills that were incurred prior to the budget period).

If the SD is met using prior medical expenses, approve FM-MN Medicaid for the AU members on the first day of the budget period. Complete the following actions:

- Approve FM-MN Medicaid for the AU members beginning the first day of the budget period.
- Notify the AU. Notification includes the BAD, the ending date of eligibility and the Medicaid numbers for each AU member.
- Provide to the AU a Form 962 for any/all approved months that can not be entered in the system. Fax form 962 to HP to be manually updated.

If the SD is **not** met using prior medical expenses, proceed to Step 14.

Step 14 Deduct allowable medical expenses incurred during the budget period in ascending (oldest to most recent) chronological order.

Rank bills incurred the same day as follows:

1. incurred by BG members not included in the AU;
2. incurred by AU members but not covered by Medicaid (noncovered expenses such as over-the-counter medications or bills payable to non-Medicaid providers);
3. incurred by AU members payable to a Medicaid provider, the lowest dollar amounts first.

If the SD is met, proceed to Step 15.

If the SD is **not** met, skip to Step 16.

Step 15 If the SD is met by bills ranking order 1 or 2 (as described in Step 14), **Form 400, First Day Liability** is not required, as the AU has no FDL.

Complete the following actions:

- Approve the AU members for Medicaid to begin on the day in which the bill that brought the SD to zero (the **break-even** bill) was incurred.
- Notify the AU of the BAD and the ending date of eligibility and the Medicaid numbers for each AU member.
- Provide to the AU a Form 962 for any/all approved months that can not be entered into the system. Fax form 962 to HP to be manually updated.

If the SD is met by bills in ranking order 3 (as described in Step 12), **Form 400, First Day Liability is necessary.**

Complete the following actions:

- Issue a Form 400 for the break-even bill showing the dollar amount of the FDL as the client liability
- Issue Form 400 with a client liability of zero for all other bills incurred on the BAD that were not used to meet the SD.

> Do not issue Form 400 for bills incurred on the BAD that were applied to the SD prior to the break-even bill as no portion of these bills is payable or reimbursable by DCH and are the total responsibility of the client.

- Report to the client and DCH the amount of the break-even bill used to meet the SD as the FDL. If a manual Form 962 is used, indicate the BAD as the “Eff Date” and the last day of the budget period as the “End Date”. Complete the “First Day Liability” field, indicate Form 400 is required (Y) and whether the breakeven bill was for a pharmacy (Y or N).

> For group medical practices, clinics, or other provider names that do not include the name of a specific physician or clinician who performed the medical service, include the name of the individual in addition to the group name.

- Notify the AU of the BAD, FDL, the ending date of eligibility and the Medicaid numbers for each AU member.
- Provide the AU a Form 962 for any/all approved months that cannot be entered into the system. Fax form 962 to HP to be manually updated.

Step 16 If the SD is not met, place the case in suspense status until medical expenses adequate to meet the SD are incurred.

Step 17 Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred.

When medical expenses equal the SD for cases in suspense status, complete the following actions:

- Determine actual income already received during the budget period.
- Recalculate the SD using the actual income and any income anticipated to be received in the remainder of the budget period.

Step 18 If the recalculated SD is met, approve the AU for FM-MN, completing actions outlined in Step 13.

Step 19 If the recalculated SD (see Step 15) is not met, place the case in suspense status and notify the AU of the amount of the SD for each budget period month remaining in the renewal period.

Step 20 Subtract from the SD any medical expenses incurred during the budget period as they are provided by the AU, according to the date incurred. If there is a question as to whether or not the medical expense can be used, mail or fax to DCH at:

P.O. Box 38420
Atlanta, Georgia 30303

or

Fax: 404-656-4913

If the SD is met, approve FM-MN according to procedures outlined in Step 15.

Step 21 If the SD is not met during the one-month budget period, continue the case in suspense until enough bills are incurred to meet the SD in another budget period. A renewal of the case must be completed every six months for continued eligibility.

SD that remains in suspense status should be closed with the correct closure codes to refer to the Federally Facilitated Marketplace (FFM).

Special Considerations

Applicants may apply for PCK the following ways:

The following types of medical expenses of a BG member who has the legal obligation to pay the expenses can be used to meet the FMMN SD.

Medical Expenses

- Services provided by the following:
  - hospital
  - registered nurse

    - medical clinic
    - licensed practical nurse
    - physician
    - dentist
    - psychiatrist
    - osteopath
    - mental health clinic
    - oculist
    - personal attendant (sitter)
    - nursing assistant
    - optician
    - optometrist
    - hospice
    - chiropractor
- Medical care purchases, such as the following:
    - medical tests
    - eye glasses
    - hearing aids
    - contact lens
    - prescription drugs
    - medical supplies (bandages, tape, syringes, etc.)
    - dentures
    - other-the-counter drugs
    - prosthetic devices
    - immunizations
    - transportation costs to medical services (allow current mileage reimbursement rate, or actual cost, whichever is less) Refer to Appendix A2.
- Elective surgery
- Health insurance premiums
- Medically necessary ambulance service

These lists are not all inclusive.

Verification of Medical Expenses

Explore TPL coverage before applying any medical expenses as deductions from the SD.

Verify incurred medical expenses by any one of the following:

- itemized medical bill or statement
- receipts for payment of medical expenses
- medical Explanation of Benefits (EOB) listing covered/ non-covered and paid/unpaid medical expenses
- health insurance statement listing amount paid
- odometer reading for mileage expense
- other sources deemed appropriate.

A doctor's statement (written or verbal) indicating anticipated Medicare TPL may be used as verification until such time as the Medicare Explanation of Benefits (EOB) is received.

Use the following chart to determine which medical expenses can be deducted to meet the spend-down in a MN case:

Chart 2196.1 – Allowable Medical Expenses for FM-MN

Allowable	Not Allowable
• Medical bills belonging to individuals who are or could have been included in the BG when the expenses were incurred. • Unpaid bills that a BG member remains liable for paying. • Unpaid bills incurred **prior** to the budget period and not used in a prior month(s) determination of eligibility nor used to meet a prior spenddown. • Bills that a BG member incurred during the budget period, whether paid or unpaid. • Bills applied to an earlier spenddown that was never met can be deducted in a current spenddown if the bills are still owed and the individual who incurred them is still a BG member. • Medical bills NOT used in Aged, Blind, Disabled MN budgets in the spenddown process. • Bills not presented to the worker during the budget period provided the BG member remains liable for payment as of the first day of the new budget period. • For prior months MN budget period only: past medical debts, which have been written off subsequent to the budget period. ℹ If the bill was forgiven or written off prior to the end of the budget period, it is not allowed. • the remainder of unpaid bills incurred prior to the budget period that has been turned over to a collection agency. If these medical bills are consolidated with other bills, only the portion that can be verified as unpaid medical expenses can be deducted. ℹ Monthly payments to a collection agency cannot be deducted. • Medical expenses related to pregnancy: ◦ allow when BG becomes obligated for payment of the expense ◦ include prepayment of delivery fees or admission fees by the hospital. ◦ Bills from any time period can be used as long as a BG member still has a legal obligation to pay the bill. The incurred bills are not limited to the time of the emergency service.	• Medical bills past or present, which will be paid by a liable third party. **EXCEPTIONS:** Deductibles and co-pays to be paid by the BG are allowed. If a decision is pending as to who is liable, allow the deduction with the understanding that the eligibility is revoked if the decision is reversed. If a bill is paid in full or in part to a provider, or as a reimbursement to a BG member by a public program funded by the state or programs or political subdivisions of the state, allow this as a deduction as long as **no federal funds** are used and the bill was paid during the budget period. Verify the source of the funding to ensure there are no federal funds used. ℹ Allow a reimbursement for this third party only **if** the bill was paid by the BG member and reimbursed in the same budget period. Do not allow the bill as a deduction if the BG member paid the incurred expenses prior to the budget period and was reimbursed in the budget period. • For ongoing MN budget periods, past medical debts, which were forgiven or written off by the provider prior to the first day of a budget period, or prior to the date the case is brought to final disposition. • Medical expenses paid by Medicaid under three months-prior coverage. • Medical bills applied in another budget period in which spenddown is met.

Use the following chart to determine procedures for the use of Form 400 and 962 in MN.

Chart 2196.2 – MN Instructions on Forms 400 and 962

IF	THEN ISSUE ACTION / REQUEST / CERTIFICATION FORM 962	THEN ISSUE DMA FORM 400	THEN ISSUE MEMBER NOTIFICATION
There was spenddown at the time of application but it was met with bills incurred prior to the budget period.	To member for providers if unable to enter in system. Fax form 962 to HP to manually update on GAMMIS. Put an “N” for no on the form DMA400 being required in the Medically Needy Information section. Retain a copy for the case record.	Not required.	No first day liability is put on the form if system notice not used.
Spenddown is met by a BG member who is potentially Medicaid eligible and the bill is issued by a Medicaid provider for a Medicaid-covered expense. Also, spenddown is met with bills incurred during the budget period.	To member for providers if unable to enter in system. Fax form 962 to HP to be manually updated on GAMMIS. Note in the Medically Needy Information section regarding the DMA400 being required. Retain a copy for the case record.	To provider, whose bill meets spenddown (i.e., the break-even claim). Show the actual dollar amount to be paid by the member for that bill. To every Medicaid provider with a subsequent bill on the BAD, show the amount to be paid by the member as zero. In both of the above situations, keep a copy of each form DMA 400 in the case record.	If system notice not used, enter the first day liability amount (column 5, Form 238 on the line immediately preceding the first line of the BAD).
Spenddown is met with bills incurred by a BG member who is not Medicaid eligible or with a bill from a non-Medicaid provider or with an expense that is not covered by Medicaid.	To A/R for providers if unable to enter in system. Put an “N” for no on the form DMA400 being required in the Medically Needy Information section. Retain a copy for the case record.	Not required.	No first day liability is put on the form if system notice not used.

2198 Women's Health Medical Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Women's Health Medical Assistance		
	Effective Date:	January 2021		
	Chapter:	2100	**Policy Number:**	2198
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-63

Requirements

The Breast and Cervical Cancer Prevention and Treatment Act of 2000 provide Medical Assistance coverage to women diagnosed and who need treatment for breast or cervical cancer and/or precancerous conditions of the breast or cervix. This coverage is provided under the Women's Health Medical Assistance (WHM) class of assistance.

Presumptive WHM is a determination performed by a Qualified Provider (QP)/Qualified Hospital (QH) which includes the Department of Public Health (DPH), Federally Qualified Health Centers (FQHC), and Rural Health Centers (RHC). Coverage is available prior to the Division of Family Children Services (DFCS).

Basic Considerations

Effective July 1, 2001 the Department of Community Health (DCH) began implementation of the Women's Health Medical Assistance (WHM) class of assistance (COA) for women who have been screened under the Centers for Disease Control and Prevention (CDC) breast and cervical cancer early detection program (BCCEDP), established in accordance with the requirements of section 1504 of the Public Health Service Act, and found to need treatment for breast or cervical cancer; section 1504 of the Public Health Service Act, including pre-cancerous conditions and early stage cancer. This is a Non-MAGI Class of Assistance. Refer to 2663 Non-Modified Adjusted Gross Income (MAGI) Budgeting.

Public Health or one of its partner affiliates completes the breast and/or cervical cancer screening in accordance with the Center for Disease Control (CDC) guidelines established under Title XV.

To be eligible under the WHM COA an A/R must meet the following conditions:

- Screened for breast or cervical cancer under the CDC Breast and Cervical Cancer Early Detection Program in accordance with Title XV guidelines and diagnosed and found to need treatment for breast or cervical cancer or a precancerous condition of the breast or cervix.
- Have no creditable health coverage as defined in section 2704(c) of the Public Health Service Act, for treatment of the individual's breast or cervical cancer, including health insurance, Medicare Part A or Part B of Title XVIII of the Social Security Act and Medicaid.

> There may be limited circumstances where the member has creditable coverage but is in a period of exclusion such as a pre-existing condition or where lifetime limits have been exhausted. In these situations, the member is considered uninsured.

- Is under age 65
- Must be a Georgia resident.
- U.S. citizen or a lawfully admitted immigrant in the U.S.

> An A/R who does not meet the citizenship requirement may qualify for this COA using EMA criteria. EMA is not completed as part of the PE process. Refer to 2054 Emergency Medical Assistance for clarification on this policy.

- Biologically born a woman or Qualified Transgender

Definition-Qualified Transgender

Transgender men (female-to-male) may still receive cancer screenings if they have not had a bilateral mastectomy or total hysterectomy.

Transgender women (male-to-female) are only eligible if on female hormones for transition and should be in the process and/or completed treatment.

Income

In order to be considered for the WHM COA, the A/R's income must be at or below 200% of the Federal Poverty Level, as required by the Title XV program. This screening of income is completed during the Presumptive Eligibility process by the local public health department or qualified providers.

Full Medicaid Determination

Applicant/Recipient approved for this COA is entitled to the full range of Medical Assistance covered services. Eligibility for coverage ends when the A/R's course of treatment is completed or the member no longer meets eligibility requirements (for example, the member has attained the age of 65 or obtained creditable health coverage or the member becomes eligible under another Medical Assistance COA or over the 200% FPL).

Full eligibility determination begins the month of application if the member meets all eligibility criteria. Retroactive Medical Assistance is available provided the A/R has an affirmative diagnosis of breast or cervical cancer or precancer and meets all other eligibility criteria in the prior month(s) requested.

Breast Reconstructions and Prostheses after Mastectomy RHA News Update – December 16, 2016

Women who have had a Mastectomy can receive reconstruction and prosthetic treatment. Eligibility is based on clinical justification and medical necessity documentation by a physician, surgeon, or licensed medical professional. The woman can decide at any time after her mastectomy to have reconstruction; there is no time limit to when she can have this done. She is approved for a one-year post-surgery and will be subject to a yearly redetermination to continue eligibility. A woman who is no longer in treatment, but later experience complications can reapply. Eligibility will be determined by a second-level review completed by the State Office Department of Public Health and its designated staff.

Procedures

Process/Implementation

This program involves the Department of Community Health, Division of Public Health, and the Division of Family and Children Services. The eligibility determination is a two-pronged process consisting of a presumptive eligibility determination and a determination of eligibility for regular categories of Medical Assistance.

Presumptive Eligibility Process

Women who have received a diagnosis or suspect they have breast or cervical cancer must apply initially through the local Public Health Department or one of its partner affiliates such as Grady Hospital, Federally Qualified Health Centers (FQHC), and Rural Health Centers (RHC) will complete the breast and/or cervical cancer screening procedures in accordance with CDC guidelines established under Title XV.

If the woman meets all of the guidelines set forth by Title XV, Public Health will take a Presumptive Eligibility application. This consists of completing an application, interviewing the woman, and determining eligibility in accordance with the basic eligibility criteria.

The PE period begins on the approved application date and ends when the woman is determined eligible or ineligible for regular Medical Assistance by DFCS; however, no later than the end of the second month of presumptive. The PE application date is the date that the application was entered into GAMMIS. Once the application is determined for full medical assistance and is approved, the date will revert to the first date of the month. If the applicant is denied, the case should closed in GAMMIS the same date the determination is made in Gateway.

As part of the Presumptive Eligibility determination process, health department personnel are required to complete the following forms which complete the application package:

- DMA-632W
- Certificate of Diagnosis
- Form 94 Medical Assistance Application
- Form 216 Citizenship Affidavit,
- DMA-285, Health Insurance Questionnaire on all applicants, if applicable
- DMA-634W, Notice of Action.

Encrypted Email

The application package is emailed and encrypted to womenshealth@dhs.ga.gov or fax 912-377-1134. DFCS will send confirmation of receipt of all WHM packages received.

DMA 285

The DMA-285 is required on all applicants that have third-party liability coverage by the health department as part of the PE application. Any coverage that pays the cost of cancer treatment would make her ineligible. Limited scope coverage such as vision or dental coverage would not

make her ineligible. Note: The DMA-634W is completed if the application is denied.

Notice of Action

If the A/R is determined eligible, she will be given temporary Medical Assistance certification forms. The member will have immediate access to health care and the full range of Medical Assistance covered services until the plastic Medical Assistance card is received. The A/R is given a Notice of Action form DMA-634W when the temporary Medical Assistance Certificate does not print for approved PE WHM members advising of approval and a list of cancer specialists in her area.

Medicaid Card-CMO Assignment

If the application is approved, Public Health or its affiliate partners will enter the eligibility information directly into the Georgia Medicaid Management Information System (GAMMIS). The A/R will receive a temporary Medical Assistance card until her ongoing eligibility is determined for full Medical Assistance. She will receive a plastic Medical Assistance card within seven to ten days. A/Rs that are eligible under this COA are assigned through passive enrollment to one of the Care Management Organizations (CMOs) serving their area. The A/R has 90 days to change her CMO after the approval of her application. If the member requires an immediate CMO change for emergency purposes. The qualified provider or caseworker must submit a written request to DCH at pecorrections@dch.ga.gov. The member must be within her 90 days choice period for the change to take effect. There are no co-payments in the WHM program.

If the A/R is determined to be ineligible for the program, Public Health gives a Notice of Action advising of ineligibility, an application for the State Cancer Aid Program, and a list of cancer specialists in their area.

Eligibility Determination

Public Health will forward to DFCS staff copies of all applications, approved or denied for review. DFCS will determine the A/R's ongoing eligibility under the WHM COA or any other potential Medical Assistance COA such as Child Under 19 or Parent/Caretaker Medicaid. If the A/R appears to be potentially eligible for another COA as listed above.

Parent/Caretaker and WHM

Women who apply for WHM COA and are approved may sometimes cascade to Parent Caretaker. The AU must cooperate with DCSS in the attempt to obtain medical support from the absent parent (AP) unless Good Cause is established. Refer to Policy 2162 – Parent/Caretaker with Child(ren). An adult who does not cooperate with DCSS, without Good Cause, is penalized. Refer to Section 2250, Cooperation with Division of Child Support Services. In this case, when the woman is penalized, she can apply for WHM COA as long as she meets the criteria for eligibility; there is no penalization for the non-cooperation of DCSS for WHM.

Review Process

WHM cases are reviewed for continuing eligibility one year after approval by the date of application. Gateway sends the A/R a cover letter informing the member of her review. Since there are some manual components to the WHM review, DFCS sends a review that includes the Physician's Statement of Treatment form and Form 173 for Proof of Income. The member is given 30 days to

return her information to DFCS. Once the information is returned, DFCS completes the eligibility review.

Reassessment

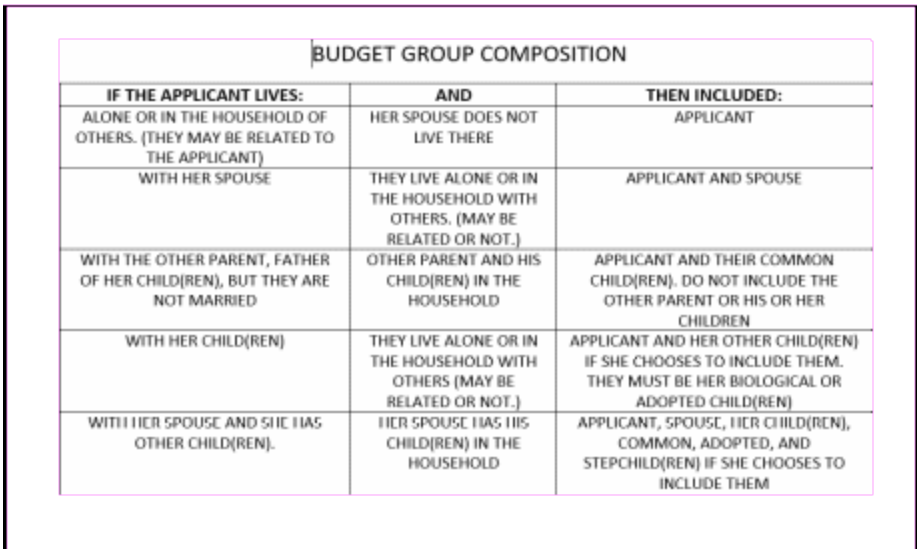
During the WHM review, the Physician's Statement of Treatment form is completed for continued coverage. However, some members' coverage ends when the doctor states the member is no longer in treatment. There are times the doctor will indicate on the Physician's Statement of Treatment form that the member is in treatment, but writes on the form that the member is being treated for follow-ups or may have another type of cancer that is not considered as coverage under the Breast and Cervical Cancer Program. When the doctor writes on the form this will require a second-level review by Public Health to determine if the member is eligible or ineligible. DFCS must receive a written response from Public Health before action can be taken. Once there is a decision made, the casework will act on case and document in Gateway of the decision made by Public Health.

Denial and Reapplication

If a WHM case has been denied less than 90 days or haven't received presumptive within the last two years, the A/R can reapply with DFCS using the form 94. In addition to the form 94, the A/R must submit a Physician's Statement of Treatment form or a Certificate of Diagnosis. Either of these forms must be less than 30 days old. The RSM worker will screen in GAMMIS or Gateway to verify previous eligibility of WHM. If the member does not show in GAMMIS or Gateway, a copy of the original presumptive WHM application must be obtained before the reapplication can be completed.

Budget Group Composition

In a WHM's budget group the spouse is always included and his or her income (exception: SSI spouse and children, which includes legally adopted and stepchildren living in the home are excluded and their income). The member can choose to include or exclude her child (ren) from the budget group if income belonging to a child will affect the applicant eligibility. If she includes her child(ren) or stepchild(ren) living in the home, she must include their income. If she decides to remove the child(ren) from her BG in an attempt to become eligible; she will be reducing the size of her BG. The child(ren) must be the biological, stepchild, or a legally adopted child of the member. No other specified relative meets this budget group description for WHM.



BUDGET GROUP COMPOSITION

IF THE APPLICANT LIVES:	AND	THEN INCLUDED:
ALONE OR IN THE HOUSEHOLD OF OTHERS. (THEY MAY BE RELATED TO THE APPLICANT)	HER SPOUSE DOES NOT LIVE THERE	APPLICANT
WITH HER SPOUSE	THEY LIVE ALONE OR IN THE HOUSEHOLD WITH OTHERS. (MAY BE RELATED OR NOT.)	APPLICANT AND SPOUSE
WITH THE OTHER PARENT, FATHER OF HER CHILD(REN), BUT THEY ARE NOT MARRIED	OTHER PARENT AND HIS CHILD(REN) IN THE HOUSEHOLD	APPLICANT AND THEIR COMMON CHILD(REN). DO NOT INCLUDE THE OTHER PARENT OR HIS OR HER CHILDREN
WITH HER CHILD(REN)	THEY LIVE ALONE OR IN THE HOUSEHOLD WITH OTHERS (MAY BE RELATED OR NOT.)	APPLICANT AND HER OTHER CHILD(REN) IF SHE CHOOSES TO INCLUDE THEM. THEY MUST BE HER BIOLOGICAL OR ADOPTED CHILD(REN)
WITH HER SPOUSE AND SHE HAS OTHER CHILD(REN).	HER SPOUSE HAS HIS CHILD(REN) IN THE HOUSEHOLD	APPLICANT, SPOUSE, HER CHILD(REN), COMMON, ADOPTED, AND STEPCHILD(REN) IF SHE CHOOSES TO INCLUDE THEM

Determining who not to include in the WHM budget group:

- Other Parent's Children
- Other relatives living in the home
  - Parents, siblings, nieces, cousins, etc.
  - Specified Relative Relationship
- Child (ren) 19 years of age or older
- Child and/or spouse, living in the home who are receiving SSI (Supplemental Security Income).

Gateway will determine if a child(ren) should be included or excluded based on the information provided. The goal is to try and make the woman eligible at the end of the exclusion or inclusion.

Treatment of Income

Please refer to ODIS Policy 2499. Treatment of Income in Medical Assistance when determining what income should be considered and how it is counted in the case.

Hearing Rights

When a A/R is found to be ineligible for Women's Health Medical Assistance, the A/R is sent an appropriate notification. Appeal rights are applicable when eligibility for continued Medical Assistance is denied. Appeals and all inquiries pertaining to Women's Health Medical Assistance cases should be filed according to Appendix B-Hearings. The Department of Community Health (DCH) must be notified of all WHM hearing requests and dispositions at pecorrections@dch.ga.gov. Department of Public Health (DPH) must be notified in writing of all second-level hearing requests upon receipt of hearing being scheduled. When there is legal counsel or legal representation of the opposing opponent, DCH legal personnel must be notified to determine if the state will require legal representation.

Reports

Presumptive WHM reports are available at www.mmis.georgia.gov.

2200 Basic Eligibility Criteria

2201 Basic Eligibility Criteria Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Basic Eligibility Criteria Overview		
	Effective Date:	July 2023		
	Chapter:	2200	**Policy Number:**	2201
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-70

Requirements

Basic Eligibility Criteria are non-financial requirements the Assistance Unit (AU) members must meet in order to qualify for Medicaid.

Basic Considerations

ABD Medicaid

The following Basic Eligibility Criteria are required when determining eligibility under any ABD Medicaid Class of Assistance (COA).

- Aged, Blind or Disabled
- Application for Other Benefits
- Citizenship/Immigration Status/Identity
- Enumeration
- Residency
- Third Party Liability (TPL) assignment

EXCEPTION:

- Application for Other Benefits is NOT a requirement for Q Track COAs.
- Citizenship/Immigration/Identity and Enumeration are NOT requirements for Emergency Medical Assistance (EMA).
- Third Party assignment is NOT a requirement for SLMB and QI-1 COAs.

The following Basic Eligibility Criteria are requirements when determining eligibility under any Medicaid CAP COA:

- Length of Stay
- Level of Care

Length of Stay is **NOT** required for Deeming Waiver. Refer to Section 2101, ABD COA Overview.

Family Medicaid

The following Basic Eligibility Criteria are requirements when determining eligibility under a Family Medicaid COA. Refer to the specific COA to determine if the criterion applies.

- Age
- Application for Other Benefits
- Citizenship/Immigration Status/Identity
- Cooperation with the Division of Child Support Services (DCSS)
- Deprivation
- Enumeration
- Residency
- Third Party Liability (TPL)
- Living with a Specified Relative/Tax Filer/Non Tax Filer Status

Citizenship/Immigration/Identity and Enumeration are **NOT** requirements for Emergency Medical Assistance (EMA).

Procedures

Establish and verify, if required, that the A/R meets all Basic Eligibility Criteria required for the COA under which Medicaid eligibility is being determined or continued.

If all Basic Eligibility Criteria requirements are met, proceed with the financial eligibility determination.

Failure to Comply with Basic Eligibility Criteria

If a member of the AU fails to comply with one or more of the required Basic Eligibility Criteria, deny or terminate Medicaid or apply a penalty, depending on the COA under which Medicaid is being determined.

If the Basic Eligibility Criterion the AU member has failed to meet is not required under another COA, complete a CMD to determine eligibility under the other COA before denying or terminating Medicaid.

Failure to Comply - ABD Medicaid

If the A/R fails to meet one or more of the Basic Eligibility Criteria, deny or terminate ABD Medicaid.

Failure to Comply - Family Medicaid

Do not include an adult in the AU if s/he fails to comply with Basic Eligibility Requirements. A non-compliant adult **is** included in the BG if s/he is a parent or spouse of an AU member.

If an adult fails to apply for potential benefits, exclude the parent and everyone for whom s/he is financially responsible, unless the adult is included in a Pregnant Woman AU.

Remove from the Family Medicaid AU, but not the BG the adult who fails to comply with any of the following requirements:

- cooperation with his/her own Enumeration
- when Reasonable Opportunity Period (ROP) has expired
- when the AU contains at least one qualifying child
- identification and provision of information regarding any TPL available to the AU
- referral to and cooperation with DCSS

EXCEPTION:

- Pregnant women in any COA are not referred to and are not required to cooperate with DCSS for an unborn child.
- Pregnant women are not referred to, and are not required to cooperate with DCSS for an existing child
- A referral to DCSS is not required for a Medicaid-eligible individual age 19 years or older.
- A referral to DCSS is **NOT** made for child-only Medicaid cases.
- A child-only Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid under the same case as the child or under any related case. An AU which contains a penalized adult is **NOT** considered a child-only case.

Refer to specific Basic Eligibility Requirements in this Chapter.

Remove the child from the AU if the responsible adult in the AU or BG fails to enumerate the child; and/or fails to apply for benefits to which the child may be entitled; and/or ROP has expired for the child. For FM-MN, the child may be included or excluded in the BG at the request of the A/R.

These requirements do not apply to NB Medicaid, or Medicaid applications for deceased individuals. For EMA only, citizenship/immigration status/identity and enumeration do not apply.

Verification

ABD Medicaid

Basic Eligibility Criteria must be established when determining eligibility under all ABD COAs.

It is not necessary to verify Enumeration or Residency, unless questionable.

Family Medicaid

The statement of the A/R may be accepted as verification for all Basic Eligibility Criteria unless there is information known to the agency that conflicts with the statement of the A/R or if the statement is otherwise questionable.

EXCEPTION:

- Citizenship/Immigration Status/Identity

- Any information that conflicts with information known to the agency, or that is otherwise questionable must be verified.

The following charts list Basic Eligibility Criteria and the COAs to which each applies.

CHART 2201.1 ABD MEDICAID BASIC ELIGIBILITY CRITERIA

ABD MEDICAID CLASS OF ASSISTANCE	AGED / BLIND / DISABLED	APPLICATION FOR OTHER BENEFITS	CITIZENSHIP / IMMIGRATION STATUS / IDENTITY	ENUMERATION	LENGTH OF STAY	LEVEL OF CARE	RESIDENCY	THIRD PARTY LIABILITY
SSI Medicaid (SSI)	X	X	X	X			X	X
Pickle (PL 94-566)	X	X	X	X			X	X
Disabled Adult Child (PL 99-643)	X	X	X	X			X	X
Former SSI-Disabled Child	X	X	X	X			X	X
Disabled Widow(er)	X	X	X	X			X	X
Widow(er) Age 60-64 (PL 100-203)	X	X	X	X			X	X
1984 Widow(er) (PL 99-272)	X	X	X	X			X	X
1972 COLA (PL 92-603)	X	X	X	X			X	X
Community Care Services Program	X	X	X	X	X	X	X	X
NOW/COMP	X	X	X	X	X	X	X	X
Deeming Waiver	X	X	X	X		X	X	X
Hospice (at home or institutionalized)	X	X	X	X	X	X	X	X
30 Day Hospital	X	X	X	X	X	X	X	X
Independent Care Waiver Program	X	X	X	X	X	X	X	X
Nursing Home	X	X	X	X	X	X	X	X
QMB	X		X	X			X	X
SLMB	X		X	X			X	
QI-1	X		X	X			X	
QDWI	X	X	X	X			X	X
ABD Medically Needy (AMN)	X	X	X	X			X	X

CHART 2201.2 FAMILY MEDICAID BASIC ELIGIBILITY CRITERIA

FAMILY MEDICAID CLASS OF ASSISTANCE	AGE	APPLICATION FOR OTHER BENEFITS	CITIZENSHIP / IMMIGRATION STATUS / IDENTITY	COOPERATION WITH DIVISION OF CHILD SUPPORT SERVICES *	ENUMERATION	LIVING WITH A SPECIFIED RELATIVE / TAX FILER / NON TAX FILER	RESIDENCY	THIRD PARTY LIABILITY
Parent/Caretaker with Child(ren) Medicaid	X	X	X	X	X	X	X	X
Transitional Medical Assistance (TMA)	X		X		X	X	X	X
Four Months Extended (4MEx)	X		X		X	X	X	X
Newborn	X		X				X	X
Children Under 19 Years of Age	X	X	X	*	X	X	X	X
Pregnant Woman (PgW)			X		X		X	X
State Adoption Assistance (SAA) Medicaid	X	X	X	X	X	X	X	X
Child Welfare Foster Care (CWFC) Medicaid	X	X	X	X	X		X	X
Former FosterCare Medicaid	X		X		X		X	X
Women's Health Medicaid	X	X	X		X		X	X
Pathways	X		X		X	X	X	X
Planning For Healthy Babies (P4HB)	X	X	X		X		X	X
PeachCare for Kids®	X		X		X	X	X	X
Family Medicaid Medically Needy	X	X	X	X	X	X	X	X

*No referral to Child Support Services is made for child-only Medicaid cases. Refer to 2250 Cooperation With Division of Child Support Services for definition of a child-only Medicaid AU.

2205 Aged, Blind, Disabled Requirement for ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Aged, Blind, Disabled Requirement for ABD Medicaid		
	Effective Date:	November 2023		
	Chapter:	2200	**Policy Number:**	2205
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-71

Requirements

To be eligible for ABD Medicaid, the applicant/recipient (A/R) must be determined to be aged, blind or disabled.

Basic Considerations

Verify that the A/R is aged if the A/R alleges to be 65 or older. Verify blindness or disability in all other situations.

Aged

Verify that the A/R is aged by use of one of the following:

- birth certificate
- baptismal record
- SSA record that shows date of birth, e.g.
  - BENDEX/SDX
  - Medicare card issued prior to 1/74
  - Any written verification from SSA
- any State issued ID card or Driver's License

  OR

- Two documents over 5 years old which record the same month and year

  OR

- Three reliable documents indicating the same year of birth.

If the A/R turns 65 during a month, approve as aged for that month, but process the case on or after the A/R's 65th birthday.

If the A/R is not aged, verify whether the A/R is blind or disabled.

Blindness or Disability

Verify blindness or disability using one of the following sources:

- Prima facie evidence
- Disability Adjudication Section (DAS) **(Form 71 no longer in use as of 09/2013, please use SSA Form 831)**
- State Medicaid Eligibility Unit (SMEU)

Form DMA-6 or other LOC instrument is not verification of disability.

Prima Facie Verification

- RSDI disability benefits
- Railroad Retirement disability benefits
- Medicare (See exception below)
- For SSI approvals only, the SDX disability/blind date verifies when disability began.

If no prima facie evidence exists, verify disability or blindness by means of a disability decision from DAS or SMEU.

Receipt of Medicare as a result of a kidney transplant, renal failure or dialysis is **not** prima facie evidence of disability. The Medicare number will have a **T** as the Beneficiary Identification Code (BIC).

Procedures

When to Request DAS Verification

Form 71 no longer in use as of 09/2013, please use SSA Form 831.

Request the results of a disability determination from DAS when no prima facie evidence exists for any of the applicable months prior to an approved SSI application.

DAS usually determines the disability onset date, including months prior to an **approved** SSI application. If available, check SDX on approved SSI recipients to verify the disability onset date. If the verified disability onset date covers the prior months, this onset date is prima facie evidence of disability and **no** SMEU decision is required. If current SDX information is not available, send a Form 71 to DAS for any months prior to an approved SSI application and only use SMEU procedures in situations where DAS indicates that they did not establish disability for those months. DAS does not complete disability determinations for months prior to denied applications. Use SMEU procedures for these situations.

How to Request DAS Verification

Send Form 71 to DAS via U.S. mail at:

P.O. Box 57
Stone Mountain, GA 30086-9902

Review the decision when Form 71 is returned by DAS.

Use the following chart to determine how to use a DAS decision to verify blindness/disability.

Chart 2205.1 – Verifying Blindness or Disability with a DAS Decision

IF DAS	THEN
determines the A/R is disabled or blind in any of the months requested	disability requirement is met for these months. Proceed to other eligibility criteria.
determines the A/R is not blind or disabled in any of the months requested	deny the application for these months.
indicates a determination has not been made for any of the months requested	obtain a SMEU decision for these months.

When to Request SMEU Verification

Request a decision from SMEU when there is no prima facie evidence of blindness or disability, an individual alleges a disability, or a determination was not rendered by DAS for the prior months (**Form 71 no longer in use as of 09/2013, please use SSA Form 831**).

SMEU Request for Stroke, Heart Attack, or By-Pass Patients

Follow SMEU procedures to verify disability. Document circumstances explaining delay, awaiting SMEU decision on stroke, heart attack, or by-pass patient. Three months after the incident has occurred, submit current medical verification detailing what, if any, permanent or long-lasting damage has occurred.

How to Request SMEU Verification

Follow the steps below to request a SMEU disability decision to verify blindness or disability.

Step 1 The DFCS Case Manager completes Form 184 SMEU Data Report in detail. Form 188 is obsolete effective 12/1/22.

SMEU Data Report (Form 184) must be completed by DFCS Case Manager.

Step 2 Obtain any of the following medical information applicable to the A/R:

- Form 115, Report of Eye examination (Dr. supplies this form)
- Hospital records, including discharge summary, if available
- Physician's medical records
- Psychiatric and/or psychological examination reports
- Current therapy notes (speech, occupational or physical)
- X-ray and laboratory reports
- Death Certificate

> The above list is not all-inclusive. If medical information is not available and/or is incomplete, the A/R will need to obtain additional information from an examining physician or risk denial of disability based on insufficient medical reports.

Step 3 **Effective 10/11/22, the SMEU submission process has changed due to SMEU Automation.** DFCS Case Manager gathers all necessary documents:

- Medical records
- SMEU Data Report (Form 184)
- SMEU Cover Letter (Form 245)
- Any other relevant documents to substantiate disability

> If SMEU requests additional information after original submission, send a checklist to the AR requesting the new information. If the AR fails to return the additional information, close the case for failure to verify and **notify SMEU of the closure.**

DFCS Case Manager will submit SMEU request by email to smeu@dhs.ga.gov. The DFCS Case Manager who submitted the request, and their supervisor will receive automated email communications throughout the process, including:

- If initial submission has been accepted or returned for correction
- If additional information is needed, i.e., 90-day follow-up
- When decision has been made

Step 4 DFCS Case Manager will receive a task when SMEU decision letter has been uploaded.

Step 5 If paper medical records were received, after the Approval/Denial has been received from SMEU (for active cases at review), check with the A/R or authorized representative to see if the medical information used to determine disability should be returned to them or shredded. Shred the SMEU Data report. Do not retain or upload paper medical records.

A re-evaluation by SMEU may be required when an approval decision is rendered for only a specified timeframe per SSA guidelines.

Use the following chart to determine how to use a SMEU decision to verify disability or blindness:

Chart 2205.2 – Verifying Blindness or Disability with a SMEU Decision

IF SMEU determines the A/R is	THEN
disabled or blind for any of the months requested	the ABD requirement is met for these months. Proceed to other eligibility criteria.
not disabled or blind for any of the months requested	the ABD requirement is **not** met for these months. Deny the application for these months.

Use the following chart to determine when to begin verification of blindness or disability with the DAS procedures and when to begin with the SMEU procedure:

Form 71 no longer in use as of 09/2013, please use SSA Form 831.

Chart 2205.3 – When to Use DAS Vs. SMEU Procedures

IF the AR	THEN
has an approved SSI application **AND** applies for Medicaid for any of the months immediately prior to the month of the SSI application	follow the DAS procedures, if onset date is not available from current SDX information.
has a pending SSI application **AND** applies for Medicaid for any of the months immediately prior to the SSI application	follow the SMEU procedures. If potentially eligible for RSDI, refer to SSA to apply. Abide by SSA disability determination if it differs from SMEU determination.
is potentially eligible for SSI and RSDI and has not applied **AND** requests Medicaid at DFCS for any of the months immediately prior to the current month	follow the SMEU procedures. If potentially eligible for RSDI, refer to SSA to apply. Abide by SSA disability determination if it differs from SMEU determination.
is financially ineligible for SSI for all of the months for which Medicaid is requested **AND** has a RSDI application pending or is potentially RSDI eligible,	follow the SMEU procedures. If potentially eligible for RSDI, refer to SSA to apply. Abide by SSA disability determination if it differs from SMEU determination.

IF the AR	THEN
is deceased **AND** has never filed an application for SSI **AND** the surviving spouse or another individual requests Medicaid to cover unpaid medical bills	follow the SMEU procedures.
has a pending SSI application **AND** dies prior to SSA's approval of the SSI **AND** the surviving spouse requests Medicaid to cover any unpaid medical bills	follow the SMEU procedures. Abide by SSA disability determination if it differs from SMEU determination.
has a pending SSI application **AND** dies prior to SSA's approval of the SSI with no surviving spouse **AND** the A/R's personal representative requests Medicaid to cover unpaid medical bills	follow SMEU procedures.
has a denied SSI application **AND** requests Medicaid for any of the 3 months prior to the SSI application	follow SMEU procedures.
SSI application is denied due to failure to meet the disability criteria **AND** the A/R requests Medicaid ongoing through DFCS	If the SSI denial is within 12 months of the DFCS application for ongoing Medicaid, deny the application and refer the applicant to SSA to reapply for SSI or request a reconsideration of the SSI decision (unless A/R reports a worsening of condition or a new condition, then follow SMEU procedures).

Verification

File the disability verification obtained through prima facie evidence or from DAS or SMEU in the case record. Do NOT retain copies of medical information in the case record. Return to the A/R or authorized representative or shred.

Documentation

Document the method of verification.

Special Considerations

When SSA makes a determination of **not disabled** for either RSDI or SSI, this ruling is in effect for 12 months. However, if the A/R alleges a worsening of his/her condition or if a different disabling condition has occurred, DFCS must accept a new Medicaid application upon expiration of the 12 months disability determination from SSA.

- Follow SMEU procedures to verify disability.
- It is important to submit medical evidence that substantiates the worsening and/or different condition alleged.
- Document the applicant's allegation of the change in his/her condition on the Form 184, SMEU Data Report, completed as part of the SMEU procedures.

If an A/R's SSI has been terminated for a financial or non-financial reason other than failure to meet the disability requirement and s/he has applied for Medicaid through DFCS, the prior receipt of SSI is prima facie evidence of disability for twelve months following the last month of receipt of SSI. At the expiration of the twelve-month period, obtain a disability decision from SMEU.

2210 Application for Other Benefits

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Application for Other Benefits		
	Effective Date:	November 2023		
	Chapter:	2200	**Policy Number:**	2210
	Previous Policy Number(s):	MT 70	**Updated or Reviewed in MT:**	MT-71

Requirements

An Applicant/Recipient (A/R) for Medicaid must apply for and accept all other monetary benefits, payments or allotments to which s/he or any member of the Assistance Unit (AU) or Budget Group (BG) may be entitled in order to be eligible for Medicaid.

Basic Considerations

Application for other benefits must be made prior to the approval of the Medicaid application based on the applicant's or beneficiary's statement they will apply. For Family Medicaid, do not delay benefits for proof of the application for other potential benefits.

EXCEPTIONS:

- Application for other benefits is not required for the following COAs:
  - Newborn Medicaid
  - TMA
  - Four Months Extended (4MEx)
  - Pregnant Woman Medicaid
  - Q Track
  - PeachCare for Kids® (PCK)
  - Pathways
  - Planning for Healthy Babies® (P4HB)
- Family Medicaid COAs do not require application for SSI or TANF.
- MAGI Family Medicaid COAs do not require an application for non-taxable income benefits; however, they should be informed of the potential benefits. Non-taxable benefits include, but are not limited to:
  - Child Support
  - Supplemental Security Income (SSI)
  - Veterans Affairs (VA) benefits
  - Worker's Compensation
- Applications for other benefits that would result in an overall reduction of current income are

not required.

Advise the applicant of potential benefits, even if application is not required.

Failure or refusal to apply for and accept other benefits results in the following actions for Family Medicaid COAs:

- If the potential benefit is for a parent, exclude the parent and everyone for whom s/he is financially responsible.
- If the potential benefit is for a child, exclude only the child.

An individual in a Family Medicaid COA who fails to apply for other benefits may be eligible for another Family Medicaid COA in which the application for other benefits is not required. Complete a CMD prior to denial or termination of Medicaid and document the results of the CMD.

Failure or refusal to apply for and accept other benefits (excluding RSDI Disability/SSI) results in ineligibility for ABD Medicaid COAs.

The A/R must apply for the highest possible benefit for which s/he is eligible and must accept a benefit for the earliest month it is available. In addition, the A/R must comply with all requirements set forth by the agencies issuing the other benefits. These agencies include, but are not limited to: Department of Labor, Social Security Administration, and Veteran's Administration.

AU members are required to apply for Unemployment Compensation Benefits (UCB) only if Clearinghouse indicates potential eligibility.

ABD Application for VA Compensation or VA Pension must be made by individuals who may be eligible for either benefit. VA Pension applicants may choose either to project estimated medical expenses (prospective) or claim medical expenses for the past year (retrospective).

A/Rs who are currently receiving a VA Pension do not have to file a special application for the New Improved Pension.

Benefits and income are not synonymous terms. Benefits include, but are not limited to the following:

- UCB
- annuities
- disability payments and Worker's Compensation
- pension
- unprobated estates

Benefits do **NOT** include the following:

- alimony
- child support
- Medicare
- payments on loans or promissory notes

- rent

The A/R is **NOT** required to apply for the following benefits:

- TANF
- benefits from a trust over which the A/R has no control
- Earned Income Credit (EIC)
- non-receipt of court ordered child support/alimony
- Prouty (Special Age 72) RSDI benefits
- Veterans Aid and Attendance
- Veterans Household Allowance
- Widow(er)'s Year's Support
- RSDI Disability, SSI

> If A/R appears eligible for RSDI Disability or financially eligible for SSI, refer A/R to apply. However, failure to apply will not affect eligibility.

Refer to Chapter 2400, Income, for more detailed information about specific types of income.

Procedures

Determine those benefits to which the A/R may be entitled by asking the A/R about employment history, military service, etc., of the applicant, AU members and any person through whom the applicant or AU members may be entitled (i.e., spouse or parent).

Advise the A/R or PR of other benefits to which the AU may be entitled and refer the A/R to the appropriate agency to apply. Do not refer A/R to apply for SSI if you know s/he will not be eligible (example: Katie Beckett child whose parents' income/resources exceed the SSI limit or aliens who don't meet the criteria for SSI eligibility).

Assign a reasonable deadline for the A/R to apply for the other benefits and to provide verification that the application was made.

Verify with one of the following:

- approval or denial letter
- documentation verifying proof of application
- contact with the agency where the application was filed.

For Family Medicaid COAs, the A/R's verbal or written statement that s/he will apply or has applied for other benefits is sufficient to meet this requirement. This is applicable at application, renewal, or interim change.

If the applicant is eligible on all other points of eligibility, do not delay approval of an application awaiting the approval/denial of the application for other benefits.

Schedule an interim review to verify the status of the application for other benefits if the applica-

tion is still pending at time of approval. For Family Medicaid COAs, follow-up is required in the third month following the month that potential eligibility is indicated. Verification of the application for other benefits must be obtained at this time. Check data sources and/or active related programs prior to obtaining verification.

No follow-up is required for ABD COAs as verification of application for other benefits must be obtained at application or renewal.

Document the case file to show:

- Type(s) of other benefit(s) for which A/R must apply
- Deadline date by which A/R must provide proof of application of other benefits
- Date of A/R's verbal statement that s/he will apply for other benefits and when follow-up is due
- Reason an AU was not required to apply for any potential other benefits and the benefit type (e.g., UCB)

2215 Citizenship / Immigration / Identity

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Citizenship / Immigration / Identity		
	Effective Date:	November 2023		
	Chapter:	2200	**Policy Number:**	2215
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-71

Requirements

An individual must be a U.S. citizen or establish Department of Homeland Security (DHS) status as a lawfully admitted qualified immigrant to be eligible for Medical Assistance.

An individual determined ineligible for Medicaid solely because s/he does not meet the citizenship/immigration requirement is potentially eligible for Emergency Medical Assistance. Refer to 2054 Emergency Medical Assistance.

Basic Considerations

Citizenship/immigration status determines the benefits to which a person may be entitled.

Definition of Citizenship

A U.S. citizen is an individual who is one of the following:

- born in one of the 50 states, District of Columbia, Puerto Rico, Guam, U.S. Virgin Islands (St. Thomas, St. Croix, and St. John), Northern Mariana Islands (Saipan, Rota, and Tinian), American Samoa, or Swains Island.
- a child adopted by a U.S. citizen (Refer to the Child Citizenship Act).
- a minor child born in another country to a non-U.S. citizen becomes a citizen when the parent resides in the U.S. for the required period of time and becomes a naturalized citizen.
- born in another country to a U.S. citizen.
- has fulfilled the requirements and completed the process of naturalization.

The Child Citizenship Act, which became effective February 27, 2001, amended the Immigration and Nationality Act (INA) to provide U.S. citizenship automatically to adopted or biological children born out of the United States when all required criteria are satisfied:

- At least one parent is a U.S. citizen by either birth or naturalization,
- The child is under 18 years of age,
- The child is residing in the United States in the legal and physical custody of the U.S. citizen parent,
- The child is admitted to the United States as an immigrant, and

- If the child is adopted, a full and final adoption of the child.

Verification of U.S. Citizenship

Verification of citizenship/immigration is **not** a requirement for an individual who is **not** a recipient in the Medical Assistance AU, but who is included in the Medical Assistance budget group (BG) only.

Citizenship and identity must be verified at the following:

- at initial application
- when an individual is added to an AU
- when the agency becomes aware of a discrepancy
- at renewal if not previously verified

Citizenship status does not have to be verified for an individual to receive EMA.

Deemed Newborns

Children born to a mother eligible for Medicaid or PeachCare for Kids® (PCK) at the time of the child's birth are considered "deemed newborns". No additional verification of Citizenship (including identity) is required.

A child who is deemed Newborn is considered to have provided satisfactory proof of citizenship and is not required to provide any additional verification at CMD or future application for another Medical Assistance COA. If a child is determined to meet "deemed newborn" status then document Client level case notes, "child deemed newborn" and include the Case ID of the Medical Assistance case in which the child's mother was enrolled at the time of birth.

Verification of Citizenship may be submitted in person, by mail, by guardian, by authorized representative, or by an authorized agency. See 2215-10 below for a list of authorized agencies.

Copies of citizenship documents must be maintained in the case record or State eligibility system and must be made available for compliance audits (DCH MEQC, PERM, etc.). Documentation in Gateway should clearly state what documentary evidence was used; including, but not limited to, the documents assigned number and the information on the document.

A hierarchical approach should be used in verifying citizenship. At application provide each head of household or authorized representative with a copy of "Providing Verification of Citizenship for Medicaid". Use Form 218, "Citizenship/Identity Verification Checklist" to give to the applicant/member or representative when actual verifications are requested. Both forms are found in Appendix F, Forms.

When requesting verification, do not indicate the specific types of documents for applicants/recipients to provide, e.g., do not request "Birth Certificate". Request any missing citizenship verification with the Form 173 and include Form 218 Citizenship/Identity Verification Checklist.

If an applicant or recipient presents evidence from the listing of primary documents, no other information will be required. When such evidence cannot be obtained, the next tier of

acceptable forms of verification should be used. An attempt to obtain primary documentation should be made before continuing to secondary or tertiary lists. The second, third, and fourth level documentation also require verification of identity.

Primary Documents

- Current or expired U.S. passport (not limited passports)
- Certificate of Naturalization (N-550 or N-570)
- Certificate of Citizenship (N-560 or N-561)

Secondary Documents (also requires verification of identity)

- U.S. public birth record showing birth in one of the U.S. states, District of Columbia, American Samoa, Swain's Island, Puerto Rico if born on or after January 13, 1941, Virgin Islands of the U.S. if born on or after January 17, 1917, Northern Mariana Islands if born after November 4, 1986, or Guam if born on or after April 10, 1899
- A U.S. birth certificate or data match with a State Vital Statistics Agency (refer to 2215-15 for instructions for accessing GA Vital Records)
- Certification of Report of Birth (DS-1350) issued by the Dept. of State.
- Consular Report of Birth Abroad of a Citizen of the United States of America (FS- 240) Certification of Birth Abroad (FS-545)
- United States Citizen Identification Card (I-197 or I-179)
- American Indian Card (I-872) issued by the Department of Homeland Security with the classification code "KIC". (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border).
- Northern Mariana Identification Card (I-873) or Collective Naturalization for those who lived in the Northern Mariana Islands
- Final Adoption Decree
- Evidence of civil service employment by the U.S. government before June 1, 1976
- Official military record showing a U.S. place of birth
- SAVE-Systematic Alien Verification Entitlements Program for Naturalized Citizens (See WEB1).
- The Child Citizenship Act (2215-1) must obtain documentary evidence that verifies on or after February 27, 2001, the conditions were met.

Third Level Documents (also requires verification of identity)

- Extract of hospital record on hospital letterhead indicating a U.S. place of birth established at the time of the person's birth and was created at least 5 years before the initial application date (for children under 16, the document must have been created near the time of birth or 5 years before the date of application)

  Do not accept a souvenir birth certificate issued by the hospital.

- Life or health or other insurance record showing a U.S. place of birth and was created at least 5

years before the initial application date

- Religious record recorded in the U.S. within 3 months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. (Entries in a family Bible are not considered religious records.)
- Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, and name(s) and place(s) of birth of the applicant's parents.

Fourth Level Documents (also requires verification of identity)

This level of documents should only be used in extremely rare of circumstances when either Primary, Secondary, or Third Level documents are unavailable; document the situation in Gateway.

- Federal or State census record showing U.S citizenship or U.S. place of birth (generally for persons born 1900 through 1950). The census record must also show the applicant's age. To secure this information the applicant, member or worker should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested". Also add that the purpose is for Medicaid eligibility. This form requires a fee. The BC-600 is also available online at: www.census.gov/history/pdf/bc-600-2013.pdf
- Institutional admission papers from a nursing home, skilled nursing care facility or other institution indicating a U.S. place of birth and was created at least 5 years before the initial application date
- Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth and was created at least 5 years before the initial application date

The Form 3231 immunization from the Department of Public Health (DPH) is acceptable if an immunization date on the form was documented before the individual's 16th birthday.

- Other document that shows a U.S. place of birth and that was created at least five years before the application for Medical Assistance (or for children under 16 near the time of birth). These documents are a Seneca Indian tribal census record, Bureau of Indian Affairs tribal census records of the Navajo Indians, a U.S. State Vital Statistics official notification of birth registration, a delayed U.S. public birth record that was recorded more than 5 years after the person's birth, a statement signed by the physician or midwife who was in attendance at the time of birth, and the Bureau of Indian Affairs Roll of Alaska Natives.
- Form 219 Citizenship or Identity Affidavit (only used in rare circumstances as a last resort) by two individuals of whom one is not related to the applicant/recipient and who have personal knowledge of the event(s) establishing the applicants or recipient's claim of citizenship. The person(s) making the affidavit must be able to provide verification of his/her own citizenship and identity for the affidavit to be accepted. (A copy of the verification should be maintained in the case record.) A third affidavit from the applicant/recipient or other knowledgeable individual must also be obtained explaining why documentary evidence does not exist or cannot be obtained.

An affidavit may be used to verify citizenship of anyone or identity of a child, but not both.

Verification of Identity (when required)

Evidence of Identity (Any form of identity verification listed below is acceptable. The hierarchical approach is not required.)

Proof of identity is not required for qualified or undocumented immigrants.

- A state driver's license, Georgia Identification card or the Georgia Identification Card for Voting Purposes issued by the Department of Driver's Services
- Certificate of Indian Blood or other U.S. American Indian/Alaska Native tribal document
- U.S. military card or draft record (must contain photo or other identifying information
- Identification card issued by federal, state, or local government agencies or entities either containing a picture or identifying information such as name, date of birth, sex, height, color of eyes, and address (includes the Georgia Identification card issued by the County Voter Registrar's office). Military dependent's identification card if it contains a photograph or other identifying information
- United States Coast Guard Merchant Mariner Card
- School identification card with a photograph
- U.S. passport issued with limitations
- Data matches or documents from law enforcement or corrections agencies, such as police departments, sheriff's departments, parole office, DJJ and Youth Detention Centers. Information such as height, race, date of birth, weight, eye color and/or other identifying information should be included. A print-out from their data system with identifying information would verify identity. Identifying information for former inmates can be accessed through the Georgia Department of Corrections at gdc.ga.gov/GDC/Offender/Query.
- Form 3231 Immunization Record if an immunization date on the form was documented before the individual's 16th birthday. Refer to Appendix J for procedures for accessing the Georgia Registry of immunization Transactions and Services (GRITS) system.
- 3 or more documents that together reasonably corroborate the identity of an individual provided such documents have not been used to establish the individual's citizenship and the individual submitted second or third tier evidence of citizenship. The worker must first ensure that no other evidence of identity is available to the individual prior to accepting such documents and document situation. Such documents must at a minimum contain the individual's name, plus any additional information establishing the individual's identity. All documents used must contain consistent identifying information, i.e., if a document is accepted that contains the name, DOB and address of the applicant/member, the other documents should contain the name, DOB and address of the applicant/recipient; or contain either the name and DOB; or the name and address. Identifying information includes full name, height, weight, eye color, DOB, current residential address, and photo identification. These documents include employer identification cards, high school and college diplomas from accredited institutions (including general education and high school equivalency diplomas), marriage certificates, divorce decrees and property deeds/titles. Data matches with the marriage, divorce, or death records of the state vital records index are also acceptable.
- Disabled individuals in residential care facilities may have their identity attested to by the facility director or administrator when the individual does not have or cannot get any document on

the preceding lists. Again, the affidavit is signed under penalty, but need not be notarized.

For individuals under age 16 who are unable to produce a document listed above, the following documents are acceptable to establish identity:

- School record including report card, daycare, or nursery school record. (Must verify record with issuing school).
- Clinic, doctor, or hospital record showing date of birth,
- Form DMA-550 (Newborn certification) if it was created within 3 months of the child's birth and is signed by a provider.
- Form 219 Citizenship or Identity Affidavit (only used in rare circumstances as a last resort). Affidavit signed under penalty of perjury by a parent or guardian, stating the date and place of birth of the child and attesting to the identity of the child.

A signed Form 216 "Declaration of Citizenship" that includes the above information can be accepted to verify the child's identity if he/she is under the age of 16. The identity remains verified even after the age of sixteen (16) and the applicant/recipient should not be asked to verify identity again if the Form 216 is in the current case record and documented.

An individual cannot use an affidavit for identity if he or she also submitted an affidavit for proof of birth or nationality.

Verification of identity is not required for deemed Newborns and is not required for EMA. A child who is deemed newborn is considered to have provided satisfactory proof of identity and is not required to provide any additional verification at CMD or future application for another Medical Assistance COA.

Verification of identity for adults and children can be verified by the following interfaces:

- FDSH
- SOLQ
- SDX
- BENDEX
- DDS

State Verification Exchange System (SVES)

The 2009 Children's Health Insurance Program Reauthorization Act (CHIPRA) amended the Social Security Act to provide an optional process for verifying the citizenship/ID or nationality of Medicaid or CHIP applicants declaring to be U.S. citizens or nationals using the State Verification Exchange System (SVES). A State may submit to the Social Security Administration (SSA) an applicant's name, Social Security Number (SSN), and date of birth (DOB) for comparison with information that SSA has in its Master File of SSN Holders ("Numident"). A response from SSA that confirms the data submitted by the State is consistent with SSA data, including citizenship or nationality, meets the citizenship/ID verification requirements. **No further action is required for the State or individual and no additional verification of either citizenship or identity is required.**

A SVES match is submitted in nightly batch for all newly active or pending A/Rs. SSA will return a results file in 48 to 72 hours. Gateway will automatically update valid values for citizenship, identity and original for A/Rs for whom SSA returns a citizenship match. If the SVES match does not return a citizen match, the existing valid values will not be overwritten.

The following valid values will be entered automatically upon verification of citizenship via SVES:

- Citizenship field - "U.S. Citizen/National" for citizenship; Verification – "Electronically verified by SVES" for "verified SSA interface"

Since SVES is tied to federally verified SSNs, if the SSN is changed a new SVES match will take place. Individuals for whom SVES does not return a match will be submitted for the match again if their demographic information (e.g., name, DOB or SSN) is updated in GA Gateway.

SVES verification constitutes the highest level of citizenship/ID verification.

SVES at Application

Complete the following on applications for Medical Assistance:

Step 1 Screen the applicant(s) in Gateway to ensure his/her SSN has been federally verified electronically verified by SVES– if NOT, use the SSN correction process to resolve any discrepancies (verification of citizenship through SVES is directly tied to federal verification of the SSN)

Step 2 Check if the A/R has previously verified citizenship/ID,

a. if yes, do not request again (SVES match will be submitted)
b. if no, was the A/R ever eligible for Medicaid as a "deemed newborn"?
    i. if yes, do not request citizenship/ID again (SVES match will be submitted)
    ii. if no, go to the next step

Step 3 For an AU that will be interviewed or ready for a determination prior to a SVES match being returned, request verification of Citizenship/ID following Reasonable Opportunity policy below.

Step 4 If an SVES citizenship match is returned, no additional action is needed, and the A/R will not appear on the ROP report.

Step 5 If the SVES citizenship match is **not** returned, follow ROP policy below.

If the A/R has verified citizenship through paper documentation, review the SSN Discrepancy report ENR-018-WLY and resolve any discrepancies.

An applicant/recipient is not required to provide documentation of citizenship/identity again unless documentation previously submitted is questionable.

Reasonable Opportunity to Provide Verification

Individuals who declare they are U.S. citizens, under penalty of perjury, must be given a reasonable opportunity to provide required proof of citizenship/identity without Medical Assistance benefits being denied, delayed, or terminated. If an applicant/recipient provides all other verification necessary to determine eligibility, but does not provide proof of citizenship/identity, the case should be approved. The applicant/recipient will be given until the end of the third month following the month of approval to provide verification.

Prior months are not considered part of the reasonable opportunity period. Prior month coverage should be approved with the application month and any intervening months.

Each applicant will be allowed one reasonable opportunity period (ROP) per year. This year will run twelve (12) consecutive calendar months beginning the first day of the month following the end of the ROP and will continue regardless of whether the Medicaid case remains active or not.

Verification is NOT Returned

Reasonable opportunity applies to each individual AU member rather than the entire AU. If an applicant/recipient does **not** return verification of citizenship/identity by the beginning of the third month following the month of approval, the individual for whom citizenship/identity has not been verified should be penalized (an adult) or excluded (a child) from the Medical Assistance AU at the end of the ROP. Refer to 2657 Penalized Individuals. The change must be completed in time for timely notice to expire no later than the end of the third month.

If verification for the penalized or excluded applicant/recipient is returned after the closure but before the end of the third month, the individual should be reinstated. Citizenship/identity verification for a penalized or excluded AU member who received an ROP can be provided at any time during the 12-month period following the expiration of the ROP. No new application is required when removing the penalty or adding the child back to the original Medical Assistance AU. The previously penalized or excluded A/R should be added back to the Medical Assistance AU effective the first day of the month that verification is provided.

In the following situations, a new application is required if verification of citizenship/identity is provided during the 12-month period following the ROP.

- A Medical Assistance case in which there is only one AU member
- A Parent/Caretaker case that contains only one eligible child and the child's verification of citizenship/identity is not provided. In this situation, the case would have closed as there would be no qualifying child in the AU under 19.

Definition of Immigrant

An immigrant is an individual who is not a U.S. citizen but resides in the U.S. or its territories. Visitors, tourists, foreign students, and diplomats are not eligible for benefits.

Immigrant status determines the benefits to which an immigrant may be entitled.

Date of Entry

The recognized date of entry into the U.S. is the date recognized by DHS as opposed to the actual, physical date of entry.

An immigrant who entered the U.S. on or after August 22, 1996, is not eligible for Medical Assistance, except under EMA procedures, for a period of five years from the date of entry into the U.S., unless s/he is a Qualified immigrant and meets one of the criteria in Chart 2215.1.

An immigrant who entered the U.S. for permanent lawful residence prior to August 22, 1996, meets the citizenship/immigration criteria for any Family or ABD Medical Assistance COA.

An immigrant who entered the U.S. for permanent lawful residence prior to August 22, 1996, and who is not potentially eligible for SSI based on the criteria in Chart 2215.1, meets the citizenship/immigration criteria for any ABD Medical Assistance COA.

An immigrant who entered the U.S. for permanent lawful residence after August 22, 1996, and who has lived in the U.S. for at least 5 years meets the citizenship/immigration criteria for any Family or ABD Medical Assistance COA.

All pregnant women and children under the age of 19 with a valid immigration status that are lawfully residing in the U.S. will not be subjected to meet any specified time period (5-year bar) to be considered a qualified immigrant and will meet the citizenship/immigration criteria for any Family or ABD Medical Assistance COA. Also, qualified immigrant children who are eligible for title IV-E retain their categorical eligibility for Medicaid under title XIX, regardless of how long they have been in the United States.

According to the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 and subsequent legislation, a Qualified Immigrant is an immigrant who, at the time of Medical Assistance application or approval, is one of the following:

- Immigrants lawfully admitted for permanent residence under the Immigration and Nationality Act (INA), 8 USC 1101 et seq.; This includes Special Immigrant Juvenile Status (SIJS) granted to an undocumented foster child that has petitioned U.S. Citizenship and Immigration Services and been granted SIJ status and is classified as a lawful permanent resident.
- Refugees admitted under Section 207 of the INA
- Immigrants granted asylum under Section 208 of the INA
- Cuban and Haitian entrants (as defined in section 501(e) of the Refugee Education Assistance Act of 1980),
- Immigrants granted parole for at least one year under Section 212(d)(5) of the INA
- Immigrants whose deportation is being withheld under (1) Section 243(h) of the INA as in effect prior to April 1, 1997: or (2) Section 241(b)(3) of the INA as amended
- Immigrants granted conditional entry under Section 203(a)(7) of the INA in effect before April 1, 1980
- Battered immigrants, who meet the conditions set forth in Section 431(c) of PRWORA, as added by Section 501 of the Illegal Immigration Reform and Immigration Responsibility Act of 1996, P.L. 104-208 (IIRIRA), and amended by Section 5571 of the Balanced Budget Act of 1997, P.L. 105-

33 (BBA), and Section 1508 of the Violence Against Women Act of 2000, P.L. 106-386. Section 431 (c) of PRWORA, as amended, is codified at 8 USC 1641 (c)

- Victims of a severe form of trafficking, in accordance with Section107(b)(1) of the Trafficking Victims Protection Act of 2000, P.L. 106-386. The Office of Refugee Resettlement (ORR) provides victims of trafficking with a "Certification Letter" if 18 or over or an "Eligibility Letter" if under 18.
  - Accept the ORR letter.
  - Call the ORR trafficking verification line (1-866-401-5510) to confirm the validity of the letter and to notify ORR that the individual has applied for benefits.
  - Instruct the individual to apply for a Social Security Number (SSN) if not already obtained. Assist the applicant, if necessary, in obtaining a number. Do not delay, deny or discontinue benefits for not having a SSN
  - At each renewal, call the ORR trafficking verification line (1-866-401-5510) to verify that the member continues to be certified as a victim of trafficking to remain eligible for Medical Assistance

Non-Immigrants (temporary residents)

Non-immigrants may be legally admitted to the U.S., but only for a temporary or specified period of time. These immigrants are INELIGIBLE for full Medical Assistance or emergency medical services because they do not meet the Georgia residency requirement.

An immigrant admitted for a limited period of time who does not leave the U.S. when the period of time expires becomes an undocumented immigrant. If he/she then establishes Georgia residency, he/she may be eligible for Emergency Medical Assistance only.

Examples of legal non-immigrants include:

1. Foreign government representatives on official business and their families and servants.
2. Visitors for business or pleasure, including exchange visitors.
3. Immigrants in travel status while traveling directly through the U.S.
4. Ship crewmen on shore leave
5. Treaty traders and investors and their families
6. Foreign students
7. International organization representatives and personnel and their families and servants,
8. Temporary workers including agricultural contract workers
9. Members of foreign press, radio, film, or other information media and their families.

Medical Assistance applicants must declare, under penalty of perjury, their citizenship or immigration status at the following times:

- at initial application
- when an individual is added to an AU

- when the agency becomes aware of a discrepancy

Declaration of Citizenship/Immigrant Status

A separate declaration is not required if the application/renewal form was completed and signed under penalty of perjury by an adult assistance unit (AU) member or Authorized Representative (AREP). Applications cannot be denied, and renewals cannot be terminated for failure to provide the Declaration of Citizenship form 216 when these conditions have been met. The Declaration of Citizenship form 216 can be used, when necessary, as a standalone form if citizenship of an applicant/recipient cannot be verified by electronic data sources and was not declared previously by an adult AU member or AREP who can attest to the individual's citizenship.

A parent or guardian applying for Medical Assistance may declare citizenship or immigration status on behalf of a child or ward 18 years of age or younger.

Effective November 30, 2016, any other individual 18 years of age or older included in the application for Medical Assistance does not have to sign the application or a separate declaration of citizenship (Form 216) unless the applicant does not have knowledge of the person's citizenship or immigration status.

Examples of individuals who might have knowledge of another person's citizenship or immigration status and can make declaration on another person's behalf include:

- Parent
- Spouse
- Friend
- An Adult Family Member
- Acquaintance who can attest to knowing the person's status.

This list is not inclusive.

Declaration of Citizenship/Immigration status/Identity Form 216 is not required if the A/R has declared their citizenship or immigrations status on the eligibility application (94, 94A, 297, 508, 700, or via Gateway Customer Portal application) and signed application under penalty of perjury. Also, declaration of citizenship/immigration status/identity is not required if the A/R is determined under EMA procedures.

EXCEPTIONS:

- Children who meet "deemed newborn" status do not have to have a written declaration of citizenship until the next redetermination of eligibility or change in Class of Assistance (COA).
- Do not require a written declaration of citizenship/immigrant status for a foster care or adoption assistance child.
- Do not require a written declaration of citizenship/immigrant status for any applicant who indicates inability or unwillingness to do so. Failure to complete a declaration of citizenship will result in a citizen being ineligible for Medical Assistance. Classify a qualified immigrant as a non-qualified immigrant and consider eligibility only for EMA. Refer to 2054 Emergency Medical Assistance.

- EMA applicants/recipients are not required to declare citizenship/immigration status.

Procedures

Verification of Citizenship and Identity

Review the applicants in Gateway. If the A/R was previously known to Gateway:

1. Ensure his/her SSN has been federally verified– if it has NOT been federally verified, use the SSN correction process to resolve any discrepancies; verification of citizenship through SVES is directly tied to federal verification of the SSN
2. If the A/R has previously verified citizenship/ID, do not request again (SVES match will be submitted)
3. If the A/R has not previously verified citizenship/ID, check to see if the A/R was ever eligible for Medicaid as a “deemed newborn”,
    a. If so, do not request citizenship/ID again (SVES match will be submitted)
    b. If not, go to next step
4. For A/Rs not found in EMPI or the A/R was never eligible for Medicaid as a “deemed newborn” and not previously verified citizenship/ID, request verification of Citizenship – follow Reasonable Opportunity policy for Medical Assistance and Good Cause policy for Food Stamps and TANF. If a SVES citizenship match is returned, the A/R will not appear on the ROP report, no additional action is needed.

When there is no SVES match, additional documentary evidence for citizenship or identity must be requested.

Effective May 1, 2016, original documentation of citizenship or identity is no longer required for Medicaid or PeachCare for Kids® eligibility determinations. When documents are provided, file the copy of the document in the case record or Document Imaging System (DIS). For DIS, the document should be tagged with both the Client ID of the client for whom it is for and the AU ID(s) of the case(s) impacted. Document GATEWAY where the verification is located, either in the case record or DIS.

Although some documents contain a statement, DO NOT COPY, authorizing agencies may copy and file these documents in the case file for the official purpose of establishing Medical Assistance eligibility.

The following agencies are authorized to make copy of citizenship/identity documents:

- Department of Community Health (DCH)
- Division of Family and Children Services (DFCS)
- Right from the Start Medicaid (RSM)
- Department of Public Health (DPH) including Women, Infants and Children (WIC)
- Qualified Provider (QP). QPs include Federally Qualified Health Centers and Rural Health Centers.

- MAXIMUS
- Georgia Cares
- CHIPRA Grantees

Authorized agencies are not limited to the State of Georgia; other state and federal agencies, outside of Georgia, which are reasonably equivalent to those noted above, are considered authorized.

Authorized agencies do not include cost recovery agencies; schools; nonprofit agencies such as March of Dimes or American Lung Association; faith-based organizations such as a church; Healthy Mothers/Healthy Babies, etc.

If DFCS staff has any doubts about the copy, they should request that the individual send in or bring in the original documents for verification.

If an individual receives Medical Assistance, and it is determined that documents are inconsistent with pre-existing information, are counterfeit or altered, the Division of Family and Children Services shall investigate for potential fraud and abuse and refer to Special Investigations Unit with Office of Inspector General; in Metro Atlanta (404) 463-7590, and statewide at (1-800-533-0686). However, if the case is denied because the citizenship criteria was not met or income discrepancies could not be resolved, then no referral is required. If an applicant or recipient tries to present documentation but is unable to do so because the documents are not available, the eligibility worker should assist the individual in securing evidence of citizenship.

The following groups are exempt from further citizenship/identity verification requirements:

- Persons entitled to or enrolled in Medicare
- Persons currently receiving, or have received, SSI cash benefits as long as the citizenship indicator on SDX states they are a citizen or qualified immigrant
- Individuals on Social Security disability, including a disabled child, widow, or widower receiving disability benefits on the account of a worker
- Children receiving Title IV-B Foster Care benefits
- Children receiving Title IV-E Foster Care benefits
- Children receiving Title IV-E Subsidized Adoption benefits
- Children who meet deemed newborn status

Any assistance unit (AU) member who fails or refuses to cooperate in determining his/her own citizenship/immigration/identity status is ineligible for any ABD or Family Medical Assistance COA.

Situations where individuals provide documents verifying citizenship and identity but for whom SVES does not return a match should be investigated to ensure that the SSN, first and last names, and date of birth have been entered correctly in Gateway.

Verifying Immigrant Status

Qualified Immigrants must provide satisfactory documentary evidence to verify the declaration of immigration status and identity.

Data verification with the Systematic Alien Verification for Entitlements (SAVE) Program must be used to verify qualified immigration status through WEB1.

Non-Qualified Immigrants are not required to declare immigration status, cooperate with the enumeration process nor provide any immigration status and/or identity verification. These individuals are potentially eligible for Emergency Medical Assistance (EMA) services only.

Verify immigrant status for all AU members who are not U.S. citizens. Use DHS documents and Chart 2215.1 to determine immigrant status and potential eligibility for Medical Assistance.

Reasonable Opportunity Period for Qualified Immigrants

Individuals who declare they are Qualified Immigrants, under penalty of perjury, must be given a reasonable opportunity to provide required proof of Qualified Immigration status without Medical Assistance benefits being denied, delayed, or terminated. Apply the same procedures for ROP for Citizens found beginning on page 10 above when providing ROP for Qualified Immigrants.

Qualified Immigrants, that have an expired ROP period, are entitled to fair hearing rights if they request a fair hearing in writing within thirty (30) days from the adverse action notification.

Refugees may not have identity documentation at application but should have identity documentation within 30 days of resettlement.

Verifying Qualified Immigrant Status

Do not require verification of immigrant status for an immigrant that meets all of these criteria:

- Immigrant is unable or unwilling to provide verification
- Immigrant has a date of entry less than 5 years prior to application date
- Immigrant does not meet any of the exemptions from the 5-year rule.

An immigrant that meets all of the above criteria should be classified as an undocumented immigrant and would only be eligible for EMA.

A qualified immigrant who meets the 5-year requirement but does not provide proof of his/her immigrant status is not eligible for Medical Assistance. This includes EMA.

Additional documents may be requested from DHS only with the immigrant's written permission. Reconsider an immigrant for inclusion in the AU if DHS immigrant status verification is later received. Refer to Chapters 2500, ABD Responsibility Budgeting, 2600, Family Medicaid AUs/BGs and 2650, Family Medicaid Budgeting.

Document the following:

- AU's statement of immigrant status
- source of verification
- WEB-1 verification

WEB-1 VIS/CPS Immigrant Verification

The Verification Information System (VIS), Customer Processing System (CPS) is provided by DHS to verify the immigration status of non-citizens who are applying for benefits. The WEB-1 Access Method is designed to assist government agencies with eligibility determinations for federal, state and/or local public benefits.

WEB-1 establishes the legitimacy of immigrant documentation and provides verification of the status under which an immigrant has been admitted to the U.S. WEB-1 access is available at: save.uscis.gov/save/app/client/ui/home?JS=YES.

A tutorial for the system is available from the main screen once the login is completed. Complete WEB-1 procedures in the following situations:

- To establish the immigration status of ALL non-citizens

> Do not verify immigration status for EMA determinations. Refer to 2054 Emergency Medical Assistance for additional information.

- To verify the legitimacy of an immigrant's documentation
- To determine the status of an immigrant whose documentation has been lost or has expired
- To determine if DHS has assigned a new immigration status

If secondary verification is required, send a copy of the G-845 and copies of DHS documents to USCIS at: USCIS, 2150 Parklake Drive NE, Atlanta, GA 30345. Continue with the eligibility determination while awaiting secondary verification. Allow timely notice and deny Medical Assistance case if secondary verification indicates the immigrant is unqualified. If WEB-1 does not show the applicant's documents as legitimate, or if the system does not give a response and does not require secondary verification for the documents in question, the immigrant should be considered unqualified. Consider EMA.

Determining 40 Qualifying Quarters

Lawful permanent residents who can be credited with 40 qualifying quarters of employment meet the citizenship/immigration requirement. No five (5) year waiting period is required.

To establish 40 qualifying quarters, complete the following process:

Step 1 Obtain the name, SSN, date of birth and gender of each wage earner whose quarters are being used to establish eligibility.

The wage earner may be:

- the immigrant (self)

  Not an undocumented immigrant.

- a current spouse (consider only quarters worked during the marriage)
- a deceased spouse whose credited quarters were worked during the marriage
- A parent (deceased or divorced) whose children (biological or adopted) are/were under age 18 at the time the credited quarters are/were worked.

  Quarters earned prior to birth of the child may be used.

- A stepparent, if at the time the credited quarters were worked the child was under age 18, unmarried and there was a marital relationship with the child's parent.

  - If the marital relationship ends for reasons other than death, credited quarters of a stepparent may not be used
  - A child's quarters of employment cannot be used by a parent to meet this requirement.

Step 2 Accept the applicant/member's or wage earner's statement of quarters worked if:

- Alone or in combination with parents and/or spouse the immigrant has sufficient time in the U.S. to have acquired 40 quarters.
- DHS documents verify that the dates of entry are consistent with 40 credited quarters or more.
- The immigrant, spouse, parent, or a combination of both have sufficient quarters to meet the requirement. The same quarters may be used to meet the requirement for more than one immigrant.

Step 3 Use the WEB-1 system interface with SSA to obtain verification needed to establish credit quarters.

Have each wage earner whose quarters are being used to establish eligibility complete and sign Form SSA-3288, SSA Consent for Release Information, and to provide a statement if his/her work history as outlined in Step 2.

The wage earner may be an immigrant or U.S. citizen by birth or naturalization. The wage earner does not have to have paid Social Security taxes or have earned quarters under the SSA.

Step 4 Exclude as a credit quarter any quarter in which the wage earner received federal public assistance on or after January 1, 1997. The result is the total qualifying quarters and must equal or exceed 40 for the lawful permanent resident to be eligible for Medicaid.

Public assistance is defined as Food Stamp benefits, housing, TANF, employment services, support services, childcare subsidy, federal energy assistance, subsidized utilities, SSI or Medicaid (other than EMA). This list is not inclusive.

Public assistance does not include EMA, public health assistance, foster care, adoption assistance, soup kitchen meals, crisis counseling, short term shelter, educational assistance, WIA, disaster relief, or Head Start. This list is not inclusive.

Step 5 Determine the number of credited quarters, as follows and document calculations in the case record.

- Prior to 1978: If earnings totaled at least $50 per quarter (January through March, April through June, July through September, or October through December), a quarter was credited to the wage earner.
- On or after January 1, 1978: Credited quarters are based on the total yearly earnings. To determine the number of credited quarters, divide the total yearly earnings by the figures listed below for that year. The result (up to 4), minus the number of quarters public assistance was received, is the number of credit quarters.

1978	$250	1987	$460	1996	$640	2005	$920	2014	$1200	2023 $1640
1979	$260	1988	$470	1997	$670	2006	$970	2015	$1220	
1980	$290	1989	$500	1998	$700	2007	$1000	2016	$1260	
1981	$310	1990	$520	1999	$740	2008	$1050	2017	$1300	
1982	$340	1991	$540	2000	$780	2009	$1090	2018	$1320	
1983	$370	1992	$570	2001	$830	2010	$1120	2019	$1360	
1984	$390	1993	$590	2002	$870	2011	$1120	2020	$1410	
1985	$410	1994	$620	2003	$890	2012	$1130	2021	$1470	
1986	$440	1995	$630	2004	$900	2013	$1160	2022	$1510	

Step 6 Document calculations in the case record. The chart below provides each DHS status, which is routinely applicable to eligibility determinations. This chart is not all-inclusive. DHS has the discretion to change documents or codes to allow any immigrant or group of immigrants to stay in the U.S. for an indefinite period. Service agencies may not be aware of these changes prior to implementation.

Additionally, documents issued by the DHS vary by local DHS office. For example, two immigrants with the same immigration status may not have the same document to verify the same status. Letters of decision from immigration judges may identify DHS status, also. Direct questions regarding documents to the appropriate policy help desk.

Chart 2215.1 – Determination of Immigrant Status

IF the applicant/recipient's Immigration DHS status is:	THEN the applicant / recipient meets the Citizenship / Immigration eligibility criteria for the following COAs:	Verify with one of the following DHS documents:
Lawful Permanent Resident with 40 qualifying quarters of coverage who enters the U.S. • prior to 8/22/96	SSI, Any Family or ABD COA.	Resident Alien Card Passport, Visa, I-94, I-181, DHS AR-3a or other DHS documentation stating the "Processed for I-551, Temporary Evidence of Lawful Residence"
• on or after 8/22/96	Any Family or ABD COA, beginning from the date of entry. No waiting period applies.	
Lawful Permanent Resident **without** 40 qualifying quarters of coverage who entered the U.S. • Prior to 8/22/96	SSI, Any Family or ABD COA.	
• On or after 8/22/96	Any Family or ABD COA, beginning 5 years after the date of entry. Pregnant women through the end of their postpartum period or children under the age of 19, no waiting period applies. For all other individuals EMA, beginning from the date of entry.	
Lawful Permanent Resident who was lawfully residing in U.S. on or prior to 8/22/96 and who is, or becomes disabled or blind	SSI, any Family or ABD COA.	Resident Alien Card Passport, Visa, I-94, I-181, DHS AR-3a or other DHS documentation bearing the endorsement "Processed for I- 551, Temporary Evidence of Lawful Residence"
Lawful Permanent Resident who was lawfully residing in U.S. on or prior to 8/22/96 and was 65 years or older at that time	Ineligible for SSI, unless disabled or having 40 qualifying quarters. Refer to SSA to make application for SSI if appropriate. Eligible for any Family COA or ABD COA based on age.	
Any SSI recipient who applied for SSI before 1979	SSI, Any ABD COA	Any DHS status or any documentation establishing that the immigrant applied for SSI prior to 1979
An immigrant granted asylum status under Section 208 of INA who entered the U.S. • Prior to 8/22/96	Any Family or ABD COA OR SSI for 7 years from date asylee status is granted, regardless of current DHS status	I-94 annotated with Section 208 asylum codes of AS1, AS2, AS3, AS6, AS7, AS8
• On or after 8/22/96	Any Family or ABD COA OR SSI for 7 years from date asylee status is granted, regardless of current DHS status	Other DHS documents with asylum codes of AS1, AS2, AS3, AS6, AS7, AS8

IF the applicant/recipient's Immigration DHS status is:	THEN the applicant / recipient meets the Citizenship / Immigration eligibility criteria for the following COAs:	Verify with one of the following DHS documents:
An American Indian born outside the US, but recognized as a Lawful Permanent Resident if living along the Canadian border	SSI OR Any Family or ABD COA	Same as above or 50% blood is that of an American Indian or is a member of a federally recognized tribe.
An immigrant paroled for at least one year under Section 212(d)(5) who entered the U.S. • prior to 8/22/96	Any Family or ABD COA	I-688B annotated 274a.12(a)(4) or c(11), I-94 annotated with 212(d)(5an), I-512 annotated with Section 212(d)(5)
• on or after 8/22/96	Any Family or ABD COA, beginning 5 years from the entry date Pregnant women through the end of their postpartum period or children under the age of 19, no waiting period applies. For all other individuals EMA for 5 years beginning from the date granted parolee status.	
A Cuban and Haitian entrant admitted under Section 501(3) of Refugee Education Assistance Act of 1980 (as of 11/98)	SSI for 7 years from date of entering into U.S. OR Any Family or ABD COA	I-94 annotated with paroled as refugee, Section 207 or married Cuban, I-551 or I-151 with CH6, CNP, CU6 or 7
An immigrant with Amerasian DHS status who entered the U.S. either prior or on or after 8/22/96.	SSI for 7 years from date of entry into the U.S. regardless of current status OR Any Family or ABD COA	I-95 annotated with AM1, AM2, AM3 I-551 annotated with AM6, AM7, AM8, Vietnamese Exit Visa, Vietnamese Passport, or U.S. Passport stamped AM1, AM2, AM3
Any above listed immigrant and considered a battered spouse or child and who is no longer living with the batterer.	Any Family or ABD COA, beginning 5 years after the date of entry. Pregnant women through the end of their postpartum period or children under the age of 19, no waiting period applies. For all other individuals EMA, beginning from the date of entry.	Any DHS document that established a spouse or child(ren) as lawfully residing in the U.S. and considers them as a battered spouse or child(ren).

IF the applicant/recipient's Immigration DHS status is:	THEN the applicant / recipient meets the Citizenship / Immigration eligibility criteria for the following COAs:	Verify with one of the following DHS documents:
A qualified immigrant with any documented status if the immigrant is: • a veteran who has been honorably discharged for reasons other than immigration, OR • on active military duty (other than active duty for training) AND • a qualified immigrant spouse and unmarried children (natural, adoptive or step) under 18 of the veteran or military personnel on active duty	SSI OR Any Family or ABD COA	Any DHS document that establishes that the immigrant is lawfully residing in the U.S. (Spouse and any unmarried children [natural, adoptive, or step] under 18, must also be documented as lawfully residing in the U.S.
A refugee admitted under Section 207 of Immigration & Naturalization Act (INA)	SSI for 7 years from date of entry into U.S., regardless of current status, Any Family or ABD COA	
Immigrant whose deportation is being withheld under Section 243(h) or 241(b) of the INA	SSI for 7 years from date of withholding deportation OR Any Family or ABD COA	I-94 annotated with Section 243(h) Other DHS documentation from an immigration judge showing that deportation has been withheld
Conditional entrants under Section 203(a)(7) of the INA in effect prior to 4/1/80 who entered the U.S. • Prior to 8/22/96	Any Family or ABD COA	I-94 annotated with Section 203(a)(7)
Conditional entrants under Section 203(a)(7) of the INA in effect prior to 4/1/80 who entered the U.S. • On or After 8/22/96	EMA for 5 years beginning from the date of entry THEN Any Family or ABD COA Pregnant women through the end of their postpartum period or children under the age of 19, no waiting period applies. For all other individuals EMA, beginning from the date of entry.	I-94 annotated with Section 203(a)(7)

IF the applicant/recipient's Immigration DHS status is:	THEN the applicant / recipient meets the Citizenship / Immigration eligibility criteria for the following COAs:	Verify with one of the following DHS documents:
Iraqi and Afghani Special Immigrants (Public Law 110-161)	Any Family or ABD COA beginning the date the A/R is granted the Special Immigrant status. The date the status is granted must be 12/26/07 or later. For dates prior to 12/26/07, these groups would only be eligible for EMA.	Iraqi or Afghani passport with an immigrant visa stamp noting that the individual has been admitted under IV (Immigrant Visa) category SI1, SI2, or SI3, and DHS stamp or notation on passport or I-94 showing date of entry. Iraqi passport with an immigrant visa stamp noting that the individual has been admitted under IV (Immigrant Visa) category SQ1, SQ2, or SQ3, and DHS stamp or notation on passport or I-94 showing date of entry. DHS Form I-551 showing Iraqi or Afghan nationality (or Iraqi or Afghan passport) with an IV (Immigrant Visa) code of SI6, SI7, or SI9. DHS Form I-551 showing Iraqi nationality (or Iraqi passport) with an IV (Immigrant Visa) code of SQ6, SQ7, or SQ9.
Persons from the Compact of Free Association States, which include the Federated States of Micronesia, Republic of the Marshall Islands, and the Republic of Palau.	Citizens of the Compact of Free Association States have a special status with the U.S. that allows them to enter the country, work here and acquire a Social Security number without obtaining an immigration status from the Department of Homeland Security. They are known as Compact of Free Association (COFA) migrants (compact citizens) and are to be considered "qualified non-citizens". Effective 12/27/2020, they are eligible for Medical Assistance (does not extend to PCK) and are not required to meet the 5-year waiting period required of other non-citizen immigrants.	Any documentation stating, they are a citizen of one of the Compact of Free Association States. Immigration status for COFA migrants may be verified by Federal Data Services Hub (FDSH) or other established pathways.

IF the applicant/recipient's Immigration DHS status is:	THEN the applicant / recipient meets the Citizenship / Immigration eligibility criteria for the following COAs:	Verify with one of the following DHS documents:
Ukrainian national who enters between 2/24/2022 and 9/30/2023 as parolee	Medicaid or PCK to the same extent as refugees, without a 5-year waiting period and are considered "qualified non-citizens" for purposes of Medicaid and PCK.	Form I-94 with Ukrainian Humanitarian Parole (UHP) Class of Admission (COA); Foreign passport with parole stamp that includes a UHP COA; or Form I-766 with C11 category
Ukrainian national who are paroled after 9/30/2023 and are the spouse of child or parolee, or the parent, legal guardian, or primary caregiver of parolee described above who is determined to be an unaccompanied minor	Medicaid or PCK to the same extent as refugees	
Ukrainian granted Temporary Protected Status (TPS) or has a pending application for TPS and who has been granted employment authorization	Not eligible for Medicaid or PCK and are not considered as "qualified non-citizens"	
Ukrainian non-citizens	Eligible for EMA if they do not qualify for full Medicaid based on their immigration status	
Deferred Action for Childhood Arrivals (DACA)	Any Medical Assistance COA using EMA procedures except PCK, P4HB, Pathways	N/A
All other immigrants	Any Medical Assistance COA using EMA procedures except PCK, P4HB and Pathways	N/A

Instructions for Vital Records Inquiry

	ACTIVITY	SCREEN DISPLAYS
1	From the GO screen, type DHR and press Enter. (This function is not available from DHR8).	The DFCS Integrated Systems Sign On menu appears. The cursor will appear in the selected field.
2	Type 1 (for $TARS) In the selection field and press Tab. Type your RACF User ID in the RACF ID field and press Tab. Type your RACF password in the password field and press enter.	The following message appears: "DFHCE3549 Sign-on is complete".
3	Clear the screen.	A blank screen appears.
4	Type **SIBI** and press Enter for Birth Index Inquiry OR **SIDT** and press Enter for Death Index Search OR **SIDV** and press Enter for Divorce Index Search OR **SIMI** and press Enter for Marriage Index Search	The Birth Index Inquiry Screen appears. The Death Index Search Screen appears. The Divorce Index Search Screen appears. The Marriage Index Search Screen appears.

	ACTIVITY	SCREEN DISPLAYS
5	Type the year and last name. To narrow the search, type the month and day if known. Press Enter to complete the inquiry. If match appears on the Birth Index, tab down to the line with the match, type an “S” and press Enter. To go from one Vital Record Inquiry to another, clear the screen after the inquiry is completed and type the next index screen desired.	Vital Record information on file (if any) will appear. A screen with the person’s full name, birth date and parent’s names will appear. This screen can be copied and pasted into Gateway. **DO NOT PRINT VITAL RECORD SCREENS.**
6	Clear the screen. Type CESF LOGOFF to exit	The GO screen will appear.

Do not print Vital Record Screens. The information is confidential. Document case files but do not put screen print in case records.

2220 Enumeration

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Enumeration		
	Effective Date:	July 2022		
	Chapter:	2200	**Policy Number:**	2220
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-65

Requirements

Each Assistance Unit (AU) member must provide or apply for a Social Security Number (SSN) in order to receive Medicaid.

Basic Considerations

Enumeration is the process by which an SSN is obtained and validated.

SSNs are used to secure information from other sources to achieve the following:

- complete reviews necessitated by federal benefit changes
- discover unreported income or resources
- prevent duplicate benefits
- verify reported information.

An attempt should be made to obtain the SSNs of non-AU individuals whose income and/or resources are considered in determining eligibility. Clearly state that the provision of the SSN by non-AU members is voluntary and explain what the SSN will be used for, as defined above.

Eligibility is not adversely affected if the applicant fails to furnish the SSN of a non-AU individual unless questionable/conflicting income information can be resolved only with the SSN. This should be a rare occurrence. A case may not be closed solely for the failure to provide the SSN of a non-AU member.

Benefits will not be denied during the application for, or the validation of, an SSN.

Refusal to be enumerated without Good Cause results in denial of Medicaid coverage for the non-enumerated AU member.

Enumeration is not required for Emergency Medical Assistance (EMA) and Newborn Medicaid COAs.

The A/R's verbal or written statement of the SSN, intent to apply or that s/he has applied for the SSN of an AU member meets the enumeration requirement. If the A/R's statement of intent to apply or that s/he has applied for an SSN is accepted (not questionable), follow-up is required in the third month after the month of approval. If the SSN or verification of an application for an SSN is not received within 30 days of the follow-up request, the individual is not eligible for Medicaid unless

Good Cause is established. Refer to Good Cause and Chart 2220.2 in this Section.

TMA/4Mex

A Parent/Caretaker with Child(ren) Medicaid AU member who complied with the enumeration requirement by agreeing to apply for an SSN or by establishing Good Cause is no longer required to comply following approval for TMA or 4MEx.

Newborn Medicaid and EMA

Compliance with the enumeration process is not required for Newborn Medicaid, Family Medicaid EMA and ABD EMA.

Good Cause

Good Cause may be established for failure to meet the enumeration requirement. Refusal to meet the requirement without Good Cause results in an automatic determination of non-compliance.

Good Cause is established when it is determined that the AU member has made every effort to obtain an SSN but has been unsuccessful. The agency must make every effort to assist the AU in obtaining documents needed to complete the enumeration process.

Good Cause includes, but is not limited to the following:

- documentary evidence or collateral information that the AU member has applied for an SSN and has not yet been issued a number
- the inability of the AU to obtain the necessary documents required by the Social Security Administration (SSA). Example: inability to obtain a birth certificate.

Good Cause does NOT include the following:

- lack of transportation
- temporary absence from the home
- age/illness/infirmity

The eligibility worker must provide assistance to the A/R in obtaining information required to meet the enumeration requirement.

Procedures

Use the following chart to determine the procedures for obtaining and validating an SSN in specific situations.

Chart 2220.1 – Enumeration

IF the A/R	THEN
is currently in the system with an SSN	document the SSN. Compare known SSN with the A/R's statement. The SSN will be verified through the validation process.
knows the SSN at the interview or provides the SSN on the application	document the SSN. Enter the SSN into the system. Upload copies of available SSN cards to DIS.
does not know the SSN at the interview or provide the SSN on the application	request that the SSN be provided within 14 days. Issue the verification checklist. Document the SSN when it is provided. Enter the SSN in the system. **If SSN or proof of application for SSN is not provided, do not include non-enumerated individual in AU unless good cause is asserted.**
has multiple SSNs	refer the A/R to the Social Security Administration (SSA) to determine the correct SSN. Document all known SSNs. Inform the A/R of the responsibility to report the correct and primary SSN to the county office upon resolution with SSA. Refer to the chart entitled System Related Enumeration Problems if appropriate and/or 2005 SSN Validation.
is enumerated at birth by a medical facility	accept client statement, unless questionable. Contact the A/R no later than the third month following the month of application for the SSN to determine if the SSN has been received. If the SSN has not been received, contact the A/R monthly thereafter.

IF the A/R	THEN
never had an SSN OR had an SSN but the number is unknown or cannot be located	refer the AU member to SSA to apply for a new or replacement SSN. Follow these steps: 1. Inform the AU of the responsibility to submit original or certified copies of documents that verify age, identity, and citizenship (e.g., birth certificates, driver's licenses, etc.) to SSA with the application for an SSN. 2. Provide the AU with a copy of Form SS-5 to complete and take to the Social Security Administration. This form can be downloaded at: www.socialsecurity.gov/online/ss-5.html, or have the AU call Social Security at 1-800-772-1213 to obtain the form. 3. Obtain the A/R's verbal or written statement that s/he has applied for or will apply for an SSN for the AU member. Document the A/R's statement. 4. Contact the A/R in the third month after the month of approval to obtain the SSN or verification of the application for an SSN. 5. Allow 30 days from the date of request for the A/R to provide the SSN or verification of the application for an SSN. 6. Document the SSN, upload verification of the application in DIS. OR determine if Good Cause exists if the requirement is not met. 7. If Good Cause exists, contact the AU monthly to monitor Good Cause. 8. If Good Cause does not exist, the non-enumerated individual is not included in the AU. 9. Request the SSN at the next review if it has not been provided. If the SSN has not been received by the next review, request the SSN at each review thereafter.

Non-Compliance with Enumeration Process

AU members who fail or refuse, without Good Cause, to complete the enumeration process are not eligible to be included in a Family Medicaid or ABD AU.

Parent/Caretaker with Child(ren) Medicaid

A parent who does not meet the Medicaid enumeration requirement is penalized and his/her needs are not considered in determining Parent/Caretaker with Child(ren) Medicaid eligibility. Refer to Chapter 2650, Family Medicaid Budgeting, for budgeting procedures for a penalized individual.

Child Under 19 Years of Age Medicaid and Family Medicaid Medically Needy

A pregnant woman who does not meet the enumeration requirement is ineligible. If the pregnant woman has a child for whom Children Under 19 Years of Age Medicaid or FM-MN eligibility is being determined, she is included in the BG.

A child who does not meet the enumeration requirement is ineligible. The child may be included in or excluded from the BG at the option of the A/R for any Non-MAGI Medicaid COA.

A parent who does not meet the enumeration requirement is included in the BG with his/her

child(ren) for whom MAGI and Non-MAGI Family Medicaid eligibility is being considered.

A non-parent relative who does not meet the enumeration requirement is excluded from the BG.

CWFC Medicaid

A CWFC child who does not meet the enumeration requirement is ineligible.

Compliance

The individual is added to the AU the month the requirement is met, or Good Cause is established.

Use the following chart to determine required action when Good Cause is established, or the enumeration requirement is met following non-compliance.

Chart 2220.2 - Good Cause in Enumeration

IF	THEN
Good Cause is established at application processing OR Good Cause is established when an individual joins the AU	document the following: • the AU's statement of the reason for non-compliance • the reason for establishing Good Cause • the offer of assistance in obtaining needed verification. Include the individual in the AU and/or BG. Monitor Good Cause assertion on a monthly basis by the following methods: • contact the A/R in writing, in person, or by telephone AND • document the current status of the Good Cause determination.
the non-enumerated individual meets the enumeration requirement OR establishes Good Cause	document that the enumeration requirement has been met. Add the individual to the AU/BG the month in which the requirement is met, or Good Cause is established.
Good Cause assertion is denied at application processing	document the following: • the AU's statement of the reason for non-compliance • the reason for denial of the Good Cause claim • the offer of assistance in applying for an SSN Complete the application. Do not include the non-enumerated individual in the AU. Refer to Chart 2220.1. Issue a notice to the AU. Include the following information in the notice: • the reason for the action • the eligibility of the remaining AU members • the action the individual must take to be added to the AU.

IF	THEN
Good Cause assertion is denied when an individual joins the AU	document the following: • the AU's statement of the reason for non-compliance • the reason for denial of the Good Cause claim • the offer of assistance in applying for an SSN Do not include the non-enumerated individual in the AU. Issue a notice to the AU. Include the following information in the notice: • the reason for the action • the eligibility and benefit level of the remaining AU members • the action the individual must take to be added to the AU.
AU member initially complies with enumeration but refuses to resolve discrepancies identified during the SSA validation process	document the following: • the AU's statement of the reason for non-compliance • the reason for denial of the Good Cause claim • the offer of assistance in applying for an SSN Do not include the non-enumerated individual in the AU. Issue a notice to the AU. Include the following information in the notice: • the reason for the action • the eligibility and benefit level of the remaining AU members • the action the individual must take to be added to the AU.
AU member is currently receiving benefits OR Good Cause for non-compliance no longer exists	document the reason Good Cause no longer exists. Issue a timely notice to the AU. The notice must include the following information: • the reason for the action • the eligibility of the remaining AU members • the action the individual must take to be added to the AU. Remove the non-enumerated individual from the AU effective the month following the month timely notice expires. (Refer to Chart 2220.1.)

Use the following chart to determine the procedures for various situations related to problems with SSNs.

Chart 2220.3 – System Related Enumeration Problems

IF the A/R's SSN	THEN
appears on the system generated SSN discrepancy listing	research the case record to determine if the information regarding the A/R's full name, DOB and SSN matches information on the A/R's official documents. Correct any information that is found to be in error. Refer the client to SSA for corrective action if the SSA information is found to be the source of the error.

IF the A/R's SSN	THEN
matches with another SSN known to the system	screen and research both SSNs to determine which number on the system is correctly assigned. Contact with another DFCS office/county may be necessary. Take action to have any erroneously entered SSNs corrected in the system. OR refer the A/R to SSA for corrective action if multiple individuals are verified to have been assigned the same SSN.
is incorrect and is validated by the system	contact the EMPI Help Desk at empi.helpdesk@dhs.ga.gov.

SSN Validation

Requirements

The system interfaces with the files at the Social Security Administration (SSA) to verify the accuracy of the SSN of an AU member.

Procedures

Follow the procedures in Chart 2220.4 - SSN Validation to complete validation requirements.

Chart 2220.4 - SSN Validation

IF an AU Member's SSN	THEN
is valid	The system will annotate the SSN with "Electronically verified by SVES", "Electronically verified by SOLQ" or "Electronically verified by FDSH" (federally verified). No further action is required.
appears on the system generated enumeration or validation discrepancy lists	determine if the AU member's full name, DOB and SSN matches information on the individual's official documents. Correct any information that is in error. Refer the A/R to SSA for corrective action if the SSA information is the source of the error.
matches with another SSN known to the system	determine which number on the system is correctly assigned. Correct any SSNs erroneously entered in the system OR Refer the AU member to SSA for corrective action if multiple individuals are assigned the same SSN.
is validated by the system but differs from verification (SSN card) obtained from the A/R	follow the steps under How to Change a Validated SSN in this section.

Please note if the SSN is showing "Electronically verified by SOLQ" or "Electronically verified

by FDSH", generated by running the State Online Query or Federal Data Hub Services interfaces respectively, these are also considered federally verified SSNs.

How to Change a Validated SSN

Step 1 Gather the following case identifying information and report it in the order listed:

- worker's name
- worker's telephone number
- county, office, supervisor, user ID
- AU number
- AU name
- AU member's name
- AU member's ID number

Step 2 Contact the EMPI Help Desk at empi.helpdesk@dhs.ga.gov.

Step 3 Correct the SSN when the EMPI Helpdesk provides notification that the validation code has been removed.

2225 Residency

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Residency		
	Effective Date:	February 2020		
	Chapter:	2200	**Policy Number:**	2225
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-58

Requirements

The A/R member(s) must be a resident of Georgia in order to be eligible for Medicaid.

Basic Considerations

The A/R must live or intend to live in Georgia indefinitely.

There is no specific durational requirement but the A/R may not be in Georgia for a visit.

The A/R does not have to live in Georgia on the first day of the month or live in Georgia for any certain number of days during the month in order to be considered a Georgia resident.

An A/R may still be considered a resident of Georgia if s/he is temporarily out of state and intends to return to Georgia once the purpose of the absence has been accomplished. However, if the A/R is receiving Medicaid benefits from another state, s/he is no longer considered a resident of Georgia, and Georgia Medicaid benefits should be terminated until/unless A/R returns.

If the A/R has been out of the country for any period of time, s/he can begin receiving Medicaid benefits immediately upon return if all eligibility criteria are met.

If an A/R receives a Medicaid card in another state for a particular month and applies for Medicaid in Georgia later in the same month, the A/R is considered a Georgia resident that same month if s/he intends to remain in Georgia indefinitely. S/he is potentially eligible for Medicaid in Georgia for that month.

The place of residence need not be a fixed dwelling.

Procedures

Use the following guidelines to determine the state of residence:

For MAGI Family Medicaid COAs, a tax dependent is considered to be a resident of the state in which the tax filer expects to file their tax return.

For Non MAGI Family Medicaid COAs, a child is considered to be a resident of the state in which the parent or caretaker of the child resides. This includes MAGI Family Medicaid COAs that do not expect to file a tax return (non tax filer budget groups).

For ABD Medicaid COAs, a child applicant who is not in LA-D is considered to be a resident of the state in which s/he lives.

If a child applicant is in LA-D, base the child's residency on one of the following:

- the state in which the parent(s) or guardian lives at the time of placement

  OR

- the current state of residence of the parent(s) or guardian if the child resides in LA-D in the same state

  OR

- the residence of the person who makes the application for the child if the child is abandoned (without a guardian) and lives in the same state.

> Use an Interstate Residency Agreement (IRA) if possible to waive residency when it is determined that a LA-D child is a resident of a state other than Georgia. Refer to Special Considerations in this section.

Consider an adult applicant who is mentally capable to be a resident of the state, in which s/he lives and intends to remain indefinitely.

Adult Applicant who Became Mentally Incapable After Age 18

If an adult applicant became mentally incapable after age 18, consider the adult to be a resident of the state in which s/he is physically present.

Adult Applicant who Became Mentally Incapable Before Age 18

If an adult applicant who became mentally incapable before age 18 is **not** in LA-D, consider the adult to be a resident of the state in which s/he lives.

If an adult applicant who became mentally incapable before age 18 is in LA-D, use the rules for a LA-D child applicant to determine the state of residency, including use of an IRA.

> An applicant is never a Georgia resident if s/he is placed in a Georgia institution by an out-of-state state agency.

Verification

Establish Georgia residency at initial application.

Accept and document A/R's statement of residency unless information known to the agency conflicts with the A/R's statement.

Verify when questionable with one of the following:

- lease, rent or utility company receipts
- school records

- written statement of responsible reference
- any other document proving residency

Document the A/R's statement of residency and the source of verification , if required.

For ABD Medicaid, if the A/R is mentally incapable of stating residency, verify and document mental incapability using any of the following:

- personal observation
- documentation on Form DMA-6
- a statement from a physician
- legal documentation of incompetency

For ABD Medicaid, also document a mentally capable adult A/R's statement of intent to remain in Georgia indefinitely.

Special Considerations

Interstate Residency Agreement (IRA) For ABD

Waive the Georgia residency requirement if the A/R who is determined to be a resident of another state meets the following conditions:

- the applicant is placed in LA-D in Georgia

  AND

- the applicant is under age 18

  OR

- the applicant is age 18 or older but became mentally incapable prior to age 18

  AND

- Georgia has an IRA with the individual's state of residence.
  - Georgia has an IRA with the following states: WV AL CA MS FL MD LA TN MN KY NM NJ OH PA WI NC* NY

> Some of the other states with which Georgia has an IRA make the effective dates retroactive. Consequently, some individuals who applied for Medicaid who were determined ineligible due to residency may now be eligible for that period.

*The agreement with North Carolina covers only incapable individuals who reside in non-border institutions. Incapable individuals who enter a border institution which serves communities in both Georgia and North Carolina are the responsibility of the state in which they are determined to be a resident. A border institution is one located within forty miles of the Georgia/North Carolina state line.

2230 Third Party Liability

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Third Party Liability		
	Effective Date:	September 2024		
	Chapter:	2200	**Policy Number:**	2230
	Previous Policy Number(s):	MT 71	**Updated or Reviewed in MT:**	MT-73

Requirements

Medical Assistance applicants and recipients (A/Rs) are required to provide information regarding third party liability (TPLs) available to AU members. Rights to TPLs must be assigned to the Department of Community Health (DCH).

Basic Considerations

TPLs are medical benefits and include, but are not limited to, the following:

- TriCare (formerly known as CHAMPUS) - active-duty insurance
- TriCare (formerly known as CHAMPVA) or TriCare for Life for veterans enrolled in Medicare Part A & Part B - disabled veteran insurance
- Court ordered payments of medical costs by a non-custodial parent (NCP)
- Court awards or trusts which provide for payment of medical expenses
- Commercial Health insurance policies (including a NCP's policy)
    - private
    - indemnity
    - group
    - liability
    - Long Term Care
    - Medicare Supplement Plans
    - Managed Care Plans (i.e., HMO, PPO, etc.)
- Health Reimbursement Accounts
- Medicare (does not have to be reported as a TPL)
- Worker's Compensation
- Any trust
- Any legal document that specifies monies are due to the State (including lawsuit settlements, workers' compensation benefits, etc.)

Casualty Unit Contact numbers: Phone: 678-564-1163; Fax: 855-467-3970 or email gacasualty@gain-

Payments from TPLs are assigned to DCH when the A/R signs the application/renewal forms or the DMA 285 form for Medicaid.

Form DMA 285

If a TPL exists a Form DMA 285, Health Insurance Information Questionnaire, must be signed and placed in the case record or scanned into DIS. A copy of the front and back of the Medical Insurance card, if available, should also be scanned into DIS. The reported TPL must be entered into Gateway on corresponding page as this is electronically transmitted to HMS. Do not submit Form DMA 285 if Medicare is the only TPL.

Form DMA 285 is not needed if the AU reported their TPL while using one of the following:

- Form 94A Medicaid Streamlined application
- Federal Single Streamlined application
- Gateway Online Medicaid application or renewal

The pre-paid dental services do not need a DMA 285 completed. For example: Onsite Dental Services does not require a DMA 285.

If an AU has no TPL, completion of the DMA 285 is **not** required if application for Medicaid is made with the following forms that include the assignment of TPL rights:

- Form 94 (rev. 12/03 or later)
- Form 508
- Form 297M (rev. 11/07 or later) This must be completed with the Form 297 **(Obsolete as of 12/2021)**
- Form 700 (rev. 11/07 or later)
- Gateway Online Medicaid Application and Renewal
- PeachCare for Kids® Application **(Obsolete as of 09/2017)**
- Form 94A Medicaid Streamlined Application
- Form 632 Presumptive Eligible (PE) Pregnancy Medicaid (rev. 4/1/10 or later)
- Form 632W Presumptive Eligible (PE) Women's Health Medicaid (rev. 1/1/13 or later)

Form DMA 285 can be accessed by the below link: www.mmis.georgia.gov/portal/Portals/0/StaticContent/Public/ALL/FORMS/10232006_285_Rev-Jan06_RVSD%2013-02-2012%20212123.pdf

The assignment of TPL rights must be done at each application and renewal. If a renewal is completed by phone, a renewal form must be sent to the A/R for signature, and the form must be returned to prevent penalization/loss of coverage.

For MAGI Family Medicaid COAs a separate DMA 285 is not required if the Form 94A Medicaid streamlined application, or pre-populated renewal (web services) has the TPL information

included, and the form is signed.

For Q-Track applications, a DMA 285 is not required to be completed even when the AU has TPL. A copy of the application may be submitted in lieu of the DMA 285 with a copy of the insurance card attached, if possible.

Mail, fax, or email Form DMA 285 to:

Health Management Systems
100 Crescent Centre Pkwy, Suite 1000
Tucker, Georgia 30084
Phone 678-564-1162, Press 3
Email: gatpl@gainwelltechnologies.com

or

fax # 770-937-0180

It is not necessary to mail or fax Form DMA 285 if the Case Worker was able to input the required information on the assigned Gateway page. Prior to sending form DMA 285 to HMS please consult with your local Medicaid Field Program Specialist.

Trusts and Other Legal Documents

Any trust, such as a Special Needs Trust, Qualified Income Trust (QIT), Pooled Trust or other similar legal document is considered a TPL and is to be reported to DCH. Annotate Form 285 to indicate there is a trust document. Attach a copy of the trust or legal document and mail or email to the TPL Trust Unit.

If mailed, send the trust document (including QITs that adhere to a DCH approved format along with the QIT Certification form) **and** Form DMA 285, Health Insurance Information Questionnaire, to:

Georgia Department of Community Health
ATTN: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30084
Email: gatrustunit@gainwelltechnologies.com
Fax: 678-564-1169

Mail QITs that do not adhere to one of the DCH approved formats to:

Georgia Department of Community Health
ATTN: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30084
Email: gatrustunit@gainwelltechnologies.com
Fax: 678-564-1169

The Georgia Trust Unit is paperless and prefers all documents and information be emailed. For questions, email using the above address or call 678-564-1168.

Include Form 947 - QIT Approved Format Deviation Form, found in Appendix F - TOC; explaining how the trust differs from the DCH approved QIT format and proof that a QIT account has been opened.

When the A/R with a trust/QIT dies or becomes ineligible, send the TPL Unit a copy of the original DMA 285. Annotate in red at the top of the form that the A/R is deceased/ineligible, the date of death/ineligibility, and whether the TPL is a trust or QIT.

Qualified Income Trust
Fax: 678-564-1169
QIT email: gatrustunit@gainwelltechnologies.com

Special Needs Trusts
Contact numbers: 678-564-1168;
Fax: 678-564-1169
Special Needs Trust email: gatrustunit@gainwelltechnologies.com

ABD and SSI Medicaid TPL Requirements

ABD and SSI Medicaid recipients who refuse to cooperate with the TPL process, are ineligible for Medicaid effective the month following the expiration of timely notice. ABD and SSI applicants who refuse to assign TPLs during the SSI application process are ineligible for Medicaid until TPL is assigned at the county DFCS office.

Family Medicaid TPL Requirements

Family Medicaid A/Rs must provide information regarding a TPL held by a non-custodial parent unless good cause is asserted and upheld. Good cause for refusing to cooperate is based on Division of Child Support Services good cause and non-cooperation standards.

Complete Form 138 to document waiver of the TPL requirement because of Good Cause for non-cooperation with DCSS.

An adult A/R is penalized for failure to cooperate with the TPL process. If there are two adults in the AU, both would be penalized if there is no TPL cooperation.

Recipients of Newborn Medicaid are not required to provide information regarding TPLs.

A child is never penalized or excluded from the AU because of an adult's failure to cooperate with TPL.

Refer to Section 2657 - Penalized Individuals for information regarding Family Medicaid failure to comply with TPL requirements.

Children covered by other public or private health insurance (except vision or dental insurance) are ineligible to receive PeachCare for Kids®. PeachCare for Kids® enrollees may only be denied/terminated for TPL at application or renewal due to continuous eligibility restrictions.

For children in DFCS custody, refer to Problem Resolutions with Medicaid Billing and TPL and Children in Placement.

Nursing Home Insurance

For A/Rs who have insurance that pays for care in a nursing facility, determine if the insurance payment can be assigned to the facility. If the payments **can** be assigned, complete Form DMA 285 notifying DCH that the nursing facility will be paid directly from the insurance carrier. If payments **cannot** be assigned to the facility, treat the payments made to the A/R as income in the month received and include in the patient liability budget.

Health Insurance Premium Payment Program

The Form 124 - Health Insurance Premium Payment (HIPP) Referral is used to notify DCH via HMS of the potential purchase of an A/R's health insurance. HIPP referrals may come from DFCS, a hospital, or other medical providers.

When DCH/HMS receives a referral for a "priority" applicant (person has cancer, diabetes, etc.), a decision is normally pended for 30 days awaiting the outcome of the Medicaid determination. If the applicant is not approved for Medicaid within the 30 days, the HIPP request is denied, and the applicant is sent a denial letter.

If the referral is for a "non-priority" applicant, then a survey letter is sent to the applicant requesting the name of the employer, insurance company, etc. The applicant has 30 days from the date of the survey letter to return the letter to HMS. If the applicant is not made eligible for Medicaid by the time the survey letter is received by HMS, the HIPP referral is denied, and a denial letter is mailed to the applicant. If the applicant is made eligible for Medicaid by the time the survey letter is returned, the approval process for HIPP begins. If the applicant fails to return the survey letter within the 30 days from the date on the letter, the HIPP referral is denied, and a denial letter is mailed to the applicant. The earliest HIPP payments will begin is the first month of Medicaid eligibility. Payments are not made for any month(s) in which the A/R is not Medicaid eligible. HIPP payments are not retroactive.

Do **NOT** make HIPP referrals for an A/R:

- with no health insurance or no access to health insurance
- whose only insurance is a Medicare Supplement
- whose only insurance is a per-diem (a policy that reimburses the policyholder a contractual amount per day for specified medical services or procedures) or cancer policy
- who is eligible only for Q-Track
- who does not have ongoing Medicaid coverage (for example, approved for three months prior only)
- who is Medically Needy spenddown eligible, and spenddown is met at or near the end of a budget period

  > A referral **should** be made if the A/R is de facto eligible or spenddown eligible for multiple budget periods.

- whose coverage is through a non-custodial parent
- who is a refugee

- whose employer information is unavailable
- when the name of the policy holder is not known
- when there is no known person to contact for referral.

Refer only the primary policy to HIPP if an A/R has multiple health insurance policies.

Complete a Form 124 - Health Insurance Premium Payment (HIPP) Referral, if appropriate, and forward the original to Health Management Systems or document why a HIPP referral was not made.

Mail or fax the HIPP Referral Form along with Form DMA 285, Health Insurance Information Questionnaire, to:

Health Management Systems
100 Crescent Centre Pkwy, Suite 1000
Tucker, Georgia 30084
Phone 678-564-1162, Press 1
Email: hippga@gainwelltechnologies.com

or

fax # 800-817-1769

If a TPL pays DCH more than the amount DCH paid for all other services, including HIPP expenses, DCH will issue a refund to the A/R and notify the county via the state office of the refund. Refer to Section 2499 - Treatment of Income for Medical Assistance for treatment of refunds from DCH.

Disability Insurance Payments

If the A/R receives payments based on disability from an insurance policy, treat the payments as follows:

- If the payments are designated by the policy owner to cover medical expenses only, consider the payments to be a TPL. Report the payments to Health Management Systems on Form DMA 285.
- If the payments are designated to cover lost wages or to be used at the discretion of the policyholder (A/R), consider the payments to be unearned income if the payments cannot be assigned.

Problem Resolutions with Medicaid Billing and TPL

Pharmacies should never deny filling an A/R's prescription because of an insurance issue. However, follow the instructions below if the insurance continues to be a barrier to getting prescriptions filled or Medicaid claims paid:

1. Worker is notified by A/R, pharmacy, or provider that a claim cannot be processed because of a TPL.
2. Worker checks with A/R to validate if TPL exists. Also check case record/Gateway for information regarding either the existence of TPL or cancellation of TPL.
3. If the TPL is valid, inform A/R that the TPL is the primary payer of prescription. No further action needed.

4. If the TPL is valid, but the benefits have been exhausted for that particular service, that TPL may not be deleted from GAMMIS. The pharmacy provider may process the claim Point of Sale (POS) using an Other Coverage Code = 4 Other coverage exists - payment not collected. If the pharmacy system does not allow for POS processing the pharmacy provider may submit the claim manually on a Universal Claim Form (UCF). The pharmacy provider should also include an explanation of benefits (EOB) from the primary carrier or a pharmacy screen print/profile with primary carrier detail that should include: the primary (copay/deductible), and remaining amount due that is being billed to DCH. The provider must maintain documentation in their records concerning the denial in case of an audit. Mail pharmacy paper claims (Universal Claim Form (UCF)) to:

   OptumRx
   PO Box 968021
   Schaumburg IL 60196-8021

5. If evidence is that the TPL is no longer valid, complete a Form DMA 285 and put a note on the top of the form that the insurance is not valid and attach a copy of the GAMMIS screen showing the invalid TPL. Fax to HMS at 770-937-0180. HMS has 30 days to act on the cancellation.
6. If the TPL was cancelled many months ago or has never been a valid TPL for the A/R, complete a Form DMA 285 and put a note on the top of the form that the insurance is not valid and attach a copy of the GAMMIS screen showing the invalid TPL. Fax to HMS at 770-937-0180.
7. However, if this is an emergency and the prescription needs to be processed immediately, you may need to contact HMS by phone at 678-564-1162 option 3 or by fax at 770-937-0180.
8. The pharmacy should immediately fill the prescription, but in the event that the pharmacist, at the “Point of Sale”, is unsure of what COB override code to use, the table below provides the appropriate designation for their use. If necessary, direct them to the OptumRx Pharmacy Services Helpdesk at 1-866-525-5826.

FIELD	NAME OF FIELD	VALUES/DEFINITIONS OF FIELDS
308-C8	Other Coverage Code	2 = Other coverage exists – payment collected
		3 = Other coverage exists – claim not covered
		4 = Other coverage exists – payment not collected
		8 = Claim is billing for patient financial responsibility only(co-pay/coinsurance)

9. Paper processing is allowed if the pharmacy system does not allow for online processing of Medicaid secondary or tertiary claims. If the carrier returns payment for the claim, the pharmacy provider must include EOB from primary carrier or a pharmacy screen print/profile with primary carrier detail that paid, recipient amount paid (co-pay/deductible), and remaining amount due that is being billed to DCH. If the other carrier denied the claim, attach the denial statement from the other insurance carrier to your claim form for processing. If no response is received from the insurance carrier, attach the coordination of benefits confirmation statement to the back of your claim for payment.

   Please mail pharmacy paper claims (Universal Claim Form (UCF)) to:

   OptumRx

PO Box 968021
Schaumburg IL 60196-8021

Children in Placement

For children in placement, when there are difficulties in verifying a child's insurance coverage or termination of insurance coverage with an insurance carrier due to HIPAA and custody issues, RevMax RMS should submit form DMA 285 with all known information, including: RMS name and contact number; contact date(s) and name for insurance carrier and issue details. Submit form to:

Health Management Systems
100 Crescent Centre Pkwy, Suite 1000
Tucker, Georgia 30084

or fax # 770-937-0180

2235 Length of Stay for ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Length of Stay for ABD Medicaid		
	Effective Date:	October 2022		
	Chapter:	2200	**Policy Number:**	2235
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-67

Requirements

Length of Stay (LOS) is a basic eligibility requirement for the following ABD Medicaid CAP Classes of Assistance (COA):

- Elderly Disabled Waiver Program (EDWP) formerly known as Community Care Services Program (CCSP)
- Hospice Care
- Hospital
- Independent Care Waiver Program (ICWP)
- Nursing Home
- New Options Waiver (NOW)
- Comprehensive Supports Waiver Program (COMP)

An individual must remain in one of the above COAs for 30 continuous days to meet the LOS requirement.

Basic Considerations

Once LOS is met, the Medicaid CAP is used to determine financial eligibility for each month the A/R resides in a Medicaid participating hospital or nursing home, or for each month the A/R receives either hospice services from an approved provider or a NOW/COMP, ICWP or EDWP waivered service. If income exceeds the Medicaid CAP, refer to 2407 Qualified Income Trust.

The LOS requirement is **not** applicable to individuals already receiving Medicaid at the time of admission to one of the institutions or programs listed above.

Individuals receiving only Q Track COAs who enter one of these institutions or programs must meet the LOS requirement in order for the COA to be changed. LOS may be assumed where permissible. Refer to Chart 2235.1, Computing Length of Stay.

The LOS requirement is waived for individuals who die while residing in Living Arrangement D (LA-D). Refer to PROCEDURES in this section for a list of LA-D situations.

The LOS requirement can be assumed to have been met before 30 continuous days of confinement has elapsed in certain situations. Refer to Chart 2235.1, Computing Length of Stay.

Procedures

Compute the LOS by adding the continuous days of confinement in LA-D, including days of confinement from a month in which an individual is ineligible for Medicaid. The LOS requirement is met after 30 continuous days of LA-D confinement.

Consider the following to be LA-D confinement:

- Case management days in EDWP (CCSP) or ICWP
- Confinement in a Medicaid participating hospital or nursing home
- Enrollment in NOW/COMP
- Confinement in a non-Medicaid participating hospital or nursing home
- Confinement in an out-of-state medical institution
- Confinement in a state hospital
- Receipt of hospice services from an approved provider.

Always disregard the day of discharge when computing the LOS.

If the LOS requirement is **not** met, complete a Continuing Medicaid Determination (CMD) to consider Medicaid eligibility under all COAs other than those using the Medicaid CAP.

Use the following chart to determine how to compute and verify the LOS requirement for specific situations:

Chart 2235.1 – Computing Length of Stay

IF the A/R is in	THEN compute the LOS beginning with the day	AND the LOS requirement is
EDWP (CCSP)	of admission to care coordination	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by a Community Care Communicator from the EDWP (CCSP) Care Coordinator.
Hospice care at home or in a nursing home	of admission to hospice services	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by a Hospice Care Communicator (HCC), from the hospice care provider.
a hospital	of admission to a hospital	met after 30 continuous days of hospital confinement. Verify in writing or by a telephone contact with the hospital.

IF the A/R is in	THEN compute the LOS beginning with the day	AND the LOS requirement is
ICWP	of admission to case management services	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by an Independent Care Waiver Communicator from the ICWP case manager.
NOW/COMP	of admission to NOW/COMP (use enrollment date or date services begin)	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by an NOW/COMP Communicator from the CET.
a nursing home or hospital swing bed	of admission to a nursing home	assumed to have been met unless notification of discharge is received prior to approval of the case. Verify by Form DMA-59.
any combination of the above situations	of the first admission to LA-D, as long as the A/R goes directly from one LA-D to the other without interruption	met using the requirement for the COA under which ongoing eligibility is approved. Verify each of the admissions and discharges.

2240 Level of Care

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Level of Care		
	Effective Date:	February 2020		
	Chapter:	2200	**Policy Number:**	2240
	Previous Policy Number(s):	MT 49	**Updated or Reviewed in MT:**	MT-58

Requirements

An approved level of care (LOC) is a basic eligibility requirement for the following ABD Medicaid classes of assistance (COAs):

- Institutionalized Hospice Care
- Community Care Services Program (CCSP)
- TEFRA/Katie Beckett
- Hospice Care
- Hospital
- Independent Care Waiver Program (ICWP)
- Nursing Home
- New Options Waiver (NOW)
- Comprehensive Supports Waiver Program (COMP)
- Swing Beds

Basic Considerations

The Alliant Health Solutions (AHS) or other DMA approved entities determine the LOC for the above mentioned COAs.

For ABD Medicaid eligibility, LOC is defined as nursing facility care and is verified by receipt of an approved instrument indicating that the A/R meets the LOC requirement for that COA. The distinction between different levels of care is not relevant for Medicaid eligibility purposes.

In some instances, a LOC may only be approved for a limited period of time. Refer to 2577 Limited Stays for procedures for a limited stay.

If a LOC is not approved, DMA is notified by the agency responsible for the decision. DMA then notifies DFCS of non-approval by letter. DFCS cannot approve Medicaid under a Medicaid Cap COA but must review eligibility under other COAs.

Procedures

Use the following chart to determine how to obtain verification of LOC for each class of assistance:

Chart 2240.1 – Verifying Level of Care

IF A/R is	THEN verify LOC by
in CCSP	The LOC form, CCSP Level of Care and Placement Instrument, approved by the CCSP RN care coordinator. • The physician and RN care coordinator complete the LOC form. • The RN care coordinator can approve a LOC for a CCSP stay of up to one year. The stay begins on the day the LOC form is signed by the RN care coordinator. • If the RN care coordinator approves a LOC, the approved LOC form is sent to DFCS. • The RN care coordinator redetermines the LOC before the expiration date on the current LOC form. If approved for a new LOC, the care coordination agency sends a copy of the new LOC form to DFCS. If the LOC form is not sent to DFCS within 30 days of the application date, follow up with the Care Coordinator by phone and in writing on the Community Care Communicator.
in hospice care at home or nursing home	receipt of a Hospice Care Communicator stating a prognosis of six months or less life expectancy. Form DMA-6 is **not** required.
in a hospital	written or telephone contact with the hospital. Form DMA-6 is **not** required.
in ICWP	A LOC instrument via AHS obtained from the ICWP case manager.
in NOW/COMP	An approved LOC instrument completed by a vendor approved by Mental Health for approval of any level of nursing facility care. Obtain a copy of the approved LOC instrument from the NOW/COMP CET. If a gap in days occurs between LOC instruments, a “Level of Care Agreement” form signed by a physician is an acceptable LOC instrument for the gap in days.
in NH or hospital with an IC-MR LOC	An approved DMA-6 or DMA-6(A) completed by a vendor authorized by Mental Health for approval of the IC-MR LOC. The county should be mailed a copy of the DMA-6 or 6(A). At a minimum the DMA-6 should show a signature and date in box 37 and a payment date and paid through date just above the signature in box 37. A “stamped” LOC on the 6 is not necessary. Parkwood of Augusta’s LOC will continue to be completed by GMCF.

IF A/R is	THEN verify LOC by
in a nursing home	Form DMA-59, Authorization of Nursing Facility Reimbursement, from the nursing home, signed by administrator. Form DMA-6 is completed by the physician and the Director of Nursing at the nursing home and remains on file at the NH. No copy of Form DMA-6 is sent to DFCS for admissions after 4/1/03. A new Form DMA – 59 should be received at each new readmission, even if from a different COA while in the NH (such as Institutionalized Hospice to NH). If the Form DMA-59 is not received within 30 days of the application date, follow up by phone and in writing on Form 950, Facility Action Request. Prior to 4/1/03, LOC approval requires a Form DMA-6 from GMCF. If the NH is under a Medicaid sanction resulting in a "ban on admissions", refer to Section 2141-2, "Nursing Home".
in a swing bed	An approved LOC instrument from AHS showing a skilled or intermediate LOC approval. For question regarding a pending LOC for a Swing Bed A/R, call the CIC at 800-766-4456, select option 6, then option 1, then option 4.
in Katie Beckett or GAPP COA	Form DMA-6(A) approved by AHS for any level of nursing facility care. If the LOC is approved, AHS issues a LOC approval letter for a specified period of time. LOC approval may range from 90 days or up to a year unless the LOC approval indicates otherwise. For questions regarding a pending LOC contact your Medicaid Program Specialist. See 2133 TEFRA/Katie Beckett for specifics on procedures for obtaining an approved LOC. See 2933 Georgia Pediatric Program for referral to GAPP.

Use the following chart to determine the actions to be taken after a LOC determination has been made.

Chart 2240.2 – Action after a LOC Determination

IF the Approving Agency	THEN
approves a LOC and sends an approved LOC instrument to the county DFCS	approve Medicaid under the appropriate COA upon completion of the eligibility determination. Refer to 2551 Patient Liability/Cost Share Overview and 2576 Vendor Payment Authorization for instructions on the patient liability/cost share determination and vendor payment authorization.

IF the Approving Agency	THEN
approves a LOC for a limited stay and sends an approved LOC instrument to the county DFCS indicating a specified number of days	approve Medicaid under the appropriate COA upon completion of the eligibility determination. Refer to 2551 Patient Liability/Cost Share Overview for instructions on the patient liability/cost share determination. Authorize services only for the period of time indicated on Form DMA-6 or approved LOC instrument. Refer to 2577 Limited Stays. NH residents are no longer approved for Limited Stays effective 4/1/03. All NH stays are considered permanent until notified by the NH or other entity of discharge, ineligibility or death.
does not approve a LOC and DMA notifies the county DFCS by letter	**do not** approve Medicaid under a Medicaid CAP COA. Complete a Continuing Medicaid Determination to review eligibility under all other COAs. Refer to 2052 Continuing Medicaid Determination.

Effective July 1, 2003, the following vendors are authorized to perform Level of Care (LOC) authorization for the IC-MR LOC and for the NOW/COMP COAs.

West Central Region
*Columbus Community Services
1501 13th Street, Suite E
Columbus, Ga. 31901
Phone: 706-494-5929
Fax: 706-494-5931
Emergency: 706-536-1545
ccswcentral@aol.com

East Central Region
*Columbus Community Services
1058 Claussen Road, Suite 108
Augusta, Ga. 30907
Phone: 706-736-0401
Fax: 706-736-0403
Emergency: 706-951-8372 or 678-592-4172
ccsecentral@aol.com

North Region
North Intake and Evaluation Team
475 Tribble Gap Road, Suite 120
Cumming, Ga. 30040
Phone: 770-886-3407
Emergency: 678-852-4302
Fax: 770-886-8540

Southeast Region
Southeast Intake and Evaluation Team
MHDDAD Regional Office

7001 Chatham Center Drive
The Liberty Building, Suite 600
Savannah, Georgia 31405
Phone: 912-651-0964
Fax: 915-651-0968
Toll Free: 800-348-3503

Central Region
Central Intake and Evaluation
Central State Hospital
Yarbrough Building, Room 3068
Milledgeville, Ga. 31062
Phone: 478-445-7735
Fax: 478-445-7121
Emergency: Karla Brown-478-731-4970
KBBROWN8@dhr.state.ga.us

Metro Region
*Columbus Community Services
2300 Henderson Mill Road, Suite 100
Atlanta, Ga. 30345
Phone: 770-938-5310 (24 hrs.)
Fax: 770-938-7815

Southwest Region
*Columbus Community Services
235 Roosevelt Ave., Suite 251
Albany, Ga. 31701-2372
Phone: 229-435-3212
Fax: 229-435-3262
Emergency: 229-291-3587

Parkwood of Augusta's LOC determinations will continue to be done by GMCF.

*All Columbus Community Services offices can be reached through **Toll Free Number: 800-579-7609** or www.columbuscommunityservices.com/ccs/home.jsp

GMCF Address:
GMCF
1455 Lincoln Pkwy, E.
Suite 750
Atlanta, Ga. 30346-2209

or Fax: 678-527-3547

2245 Living With A Specified Relative / Tax Filer / Non-Filer Status

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Living With A Specified Relative / Tax Filer / Non-Filer Status		
	Effective Date:	December 2022		
	Chapter:	2200	**Policy Number:**	2245
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-68

Requirements

Children in Non-Modified Adjusted Gross Income (MAGI) Family Medical Assistance Classes of Assistance (COAs) must be related to and living in the home with a specified relative. Tax filing status, or non-tax filing status, is used to determine household composition for MAGI Family Medical Assistance classes of assistance, with some exceptions.

Basic Considerations

MAGI Family Medicaid COAs-Tax Filer

Tax rules are used for households that expect to file a tax return.

All tax dependents that are expected to be claimed on the tax return are included in the budget group (BG).

MAGI Family Medical Assistance Tax Filer BGs include:

- the filer
- the tax filer's spouse
- any other individual(s) claimed as a dependent(s) on the tax filer's tax return. This includes related and non-related child(ren) and/or adults.
- any pregnant BG member's fetus(es). Refer to 2184 Pregnant Women.

Accept the tax filer's statement on their expectations to file a tax return and the dependent(s) being claimed on the tax return. Document the case record.

The exceptions to this rule are as follows:

- Tax dependents that are not the spouse or child of the tax filer, such as extended relatives like nieces/nephews, grandchild(ren), or unrelated individuals living in the household.
- Children under the age of 19 with unmarried, mutual parents in the household. This includes:
  a. When each parent expects file their own tax return, and one parent expects to claim the child as a dependent. Both parents are still financially responsible for the child and both net taxable incomes must be included in the budget.

b. Unmarried couples with a common child in the home and the mother is pregnant. The net taxable income of the father must be counted in the common child's budget. If there is no common child, his income would not be counted.

- Children under the age of 19 who are expected to be claimed as tax dependents by the non-custodial parent.
  a. The Internal Revenue Service (IRS) allows non-custodial parents to claim a child on their tax return. In these situations, include the child(ren) in the AU of the home they live in even though the child(ren) is being claimed by the other parent who lives in a different home.
- Married couples not filing jointly
  a. The IRS allows for married couples to file a tax return separately. When a married couple lives together, even if they don't expect to file together, both of their net taxable incomes are included in the AU.
  b. This also applies for non-qualified immigrant parents with child(ren) who are U.S. citizens. Count the parent(s) net taxable income.
- Pregnant Women
  a. A pregnant woman and her fetus(es) are included in the BG for any MAGI Medicaid COA, even though the IRS will not allow an unborn child(ren) to be counted on a tax return. Medical verification is required if a pregnant A/R claims she is carrying more than one fetus, and this increase in AU size is needed to make her eligible for any MAGI COA other than Pregnant Woman.

If the AU is eligible without the medical verification of multiple fetuses, process the case counting her and one fetus. Refer to 2184 Pregnant Women.

If a tax filer cannot reasonably establish that another individual is expected to be a tax dependent of the tax filer, include the individual in the household of the tax filer by using non-tax filer rules.

If an A/R refuses to provide tax filer/non-tax filer status, the application should be denied or the existing case terminated for failure to verify.

MAGI Family Medicaid COAs-Non-Tax Filer

For households that do not file a tax return, include in the BG these individuals living in the home:

- the non-tax filer adult
- the non-tax filer's spouse
- their natural, biological, adopted and step-child(ren) under 19 years of age
- the sibling(s), natural, biological, adoptive, half and step, of the child(ren) in the BG that are under 19 years of age.

Non-MAGI Family Medicaid COAs

The following Non-MAGI Family Medical Assistance COA requires that a specified relative relationship is established prior to including the child(ren) in the budget group (BG):

- Family Medically Needy

- Pregnant Medically Needy
- Women's Health Medicaid (see BG chart below):

BUDGET GROUP COMPOSITION

IF THE APPLICANT LIVES:	AND	THEN INCLUDED:
ALONE OR IN THE HOUSEHOLD OF OTHERS. (THEY MAY BE RELATED TO THE APPLICANT)	HER SPOUSE DOES NOT LIVE THERE	APPLICANT
WITH HER SPOUSE	THEY LIVE ALONE OR IN THE HOUSEHOLD WITH OTHERS. (MAY BE RELATED OR NOT.)	APPLICANT AND SPOUSE
WITH THE OTHER PARENT, FATHER OF HER CHILD(REN), BUT THEY ARE NOT MARRIED	OTHER PARENT AND HIS CHILD(REN) IN THE HOUSEHOLD	APPLICANT AND THEIR COMMON CHILD(REN). DO NOT INCLUDE THE OTHER PARENT OR HIS OR HER CHILDREN
WITH HER CHILD(REN)	THEY LIVE ALONE OR IN THE HOUSEHOLD WITH OTHERS (MAY BE RELATED OR NOT.)	APPLICANT AND HER OTHER CHILD(REN) IF SHE CHOOSES TO INCLUDE THEM. THEY MUST BE HER BIOLOGICAL OR ADOPTED CHILD(REN)
WITH HER SPOUSE AND SHE HAS OTHER CHILD(REN).	HER SPOUSE HAS HIS CHILD(REN) IN THE HOUSEHOLD	APPLICANT, SPOUSE, HER CHILD(REN), COMMON, ADOPTED, AND STEPCHILD(REN) IF SHE CHOOSES TO INCLUDE THEM

The following relationships meet the requirements of the specified relative:

- parents (either by birth or legal adoption)
- grandparents (up to great-great-great)
- siblings (whole or half)
- aunts/uncles (up to great-great)
- nieces/nephews (up to great-great)
- first cousin
- first cousin once removed (the child of a first cousin)
- spouses of any person named in the above group, even after the marriage is terminated by death or divorce.

Procedures

MAGI Family Medicaid COA

1. Determine if MAGI or non-MAGI rules should apply for the household. An individual could be included in the BG of a MAGI Family Medical Assistance COA and only be included in their ABD COA. If an individual(s) in the AU are 65 years of age or older, and if they are not a parent or caretaker of a child in the household, and not pregnant, non-MAGI (ABD) rules would apply for determining their AU for ABD Medicaid.
2. Determine individual assistance unit (AU) characteristics. For each individual in the household, determine if the individual is expected to be a tax filer, a tax dependent, or a non-tax filer.

Refer to 2610 MAGI Budget Groups / Assistance Units.

Non-MAGI Family Medicaid COAs

Relationship is established by one of the following:

- birth
- marriage
- legal adoption
- legal guardianship

An individual who has legal custody of a child does **NOT** meet the relationship requirement. Adoption or severance of parental rights does **NOT** terminate blood relationship for the specified relative requirement.

The biological parent of a child who has been adopted continues to meet the relationship requirement but is treated as a non-parent relative. When a child is adopted, the relatives of the adoptive parent(s) assume the new relationships created by the adoption.

If a child is born or adopted after a marriage is terminated, the former spouse is NOT within the degree of relationship UNLESS s/he is the biological parent of the child.

Trace the relationship of the child to the A/R and document the names and relationships of all direct and/or intermediate relatives.

Accept the A/R's statement of relationship unless information known to the agency conflicts with the A/R's statement or is otherwise questionable.

Document the following:

- A/R's statement of relationship and living arrangements
    - Source of verification, if questionable.

If relationship is questionable, document the questionable circumstances and verify relationship with one of the following:

- adoption records
    - affidavits of persons present at the birth
    - baptismal or other church records
    - birth certificate of the child and the relative and any intermediary relative
    - census record
    - court record
    - family Bible
    - insurance record
    - medical record
    - school record
    - Social Security record

- vital statistics record
- wills
- other reliable genealogical record.

2250 Cooperation With Division of Child Support Services

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Cooperation With Division of Child Support Services		
	Effective Date:	July 2023		
	Chapter:	2200	**Policy Number:**	2250
	Previous Policy Number(s):	MT 68	**Updated or Reviewed in MT:**	MT-70

Requirements

The AU must cooperate with the Division of Child Support Services (DCSS) in order for AU members to receive Family Medicaid, unless Good Cause exists, or it is a Child Only case.

Basic Considerations

Eligibility of AU members for Family Medicaid is contingent upon cooperation with DCSS, unless Good Cause exists.

A non-custodial parent (NCP) whose child receives Medicaid under any Family Medicaid COA is required to provide medical insurance for the child.

States are required to establish a program to enforce the NCP's obligation to provide support in the form of medical insurance for his/her child(ren). Child Support Services administers this program in Georgia.

DCSS performs the following functions:

- locating the non-custodial parent(s)
- establishing legal paternity
- establishing child support orders
- collecting and distributing child support payments
- obtaining medical support orders
- participating in hearings regarding Good Cause
- reviewing the agency's Good Cause decisions

A Medicaid AU's rights to medical support are assigned by law to the state upon receipt of Medicaid.

A Family Medicaid AU must cooperate with DCSS in locating the NCP of a dependent child included in the AU, establishing legal paternity, and obtaining medical support from him/her, unless Good Cause exists.

EXCEPTIONS:

A referral to, and cooperation with DCSS is **NOT** a requirement in the following situations:

- TMA / 4Mex
- Pathways
- Any child-only Family Medicaid case.

> A child-only Family Medicaid case is defined as a Medicaid AU in which no adults are receiving Medicaid under a Parent/Caretaker or Parent/Caretaker related case. A case with an adult receiving Pregnant Woman Medicaid or SSI would be considered child only. An AU that contains a penalized adult is **not** considered a child-only case.

- A child receiving Medicaid under Newborn Medicaid COA.
- A Parent/Caretaker case in which a parent is receiving and the only child in the AU receives SSI.
- A Parent/Caretaker case in which both parents are in the home and are the natural parents to all children in the AU.
- Pregnant women receiving Medicaid under any COA are not referred to and are not required to cooperate with DCSS for the unborn child.
- Children Under 19 eligible pregnant women are not referred to and are not required to cooperate with DCSS for an existing or unborn child.
- A minor parent who is included in a Parent/Caretaker AU as a dependent child must cooperate with DCSS if the minor parent's child is included in the AU unless the minor parent chooses to exclude his/her child.
- A minor parent is not referred to DCSS unless he/she is receiving assistance as a dependent child.
- A referral to DCSS is not required for an 18-year- old receiving Medicaid under Children Under 19 and CWFC Medicaid COAs.
- The NCP(s) of a married minor is not legally responsible for the support of a married minor and is therefore not referred to DCSS.
- The NCP of a child included in a Medicaid AU is not referred to DCSS if the NCP provides health insurance for the child.

Cooperation with DCSS includes, but is not limited to the following:

- Providing the following relevant information about the NCP in attempt to locate and obtain support from the NCP:
  - name
  - date of birth
  - Social Security number
  - current and/or former address
  - medical insurance information
  - employment information (current and/or former)
  - any other information that would assist in locating the NCP.

- Attesting to the above information or attesting to the lack of information, under penalty of law.
- Submitting to a paternity test if paternity is in question.

Good Cause

Good Cause for failure to cooperate with DCSS may be claimed for non-cooperation with either the child support process or the medical support process.

Good Cause may be claimed at any time during the application process or following approval.

DCSS will not attempt to establish paternity or collect child and/or medical support if Good Cause is established.

When Good Cause is asserted on an active case, DCSS will suspend activity until the Good Cause determination is made.

The AU has the primary responsibility for establishing Good Cause. The agency, however, must assist the AU in obtaining information to establish Good Cause upon request of the A/R.

Good Cause can be established if one of the following circumstances exists:

- Cooperation with DCSS would result in physical or emotional harm to the child or the A/R.
- The child was conceived as the result of rape or incest.
- Legal proceedings for the adoption of the child are pending
- The A/R is receiving assistance from a public or licensed social service agency to resolve the issue of whether to keep the child or release the child for adoption and the discussions have not pended for more than three months.

Assistance is not delayed, denied or terminated pending a determination of Good Cause if the A/R has cooperated in providing information and/or evidence in support of the Good Cause claim.

CHART 2250.1 – EVIDENCE NEEDED TO SUBSTANTIATE GOOD CAUSE DETERMINATION

GOOD CAUSE CIRCUMSTANCE	PROOF REQUIRED
Physical and/or emotional harm to the child	Child Protective Services (CPS), court, criminal, law enforcement, medical, psychological, or social services records indicating the possibility of physical or emotional harm by the NCP
Physical and/or emotional harm to the grantee relative	Court, criminal, law enforcement, medical, psychological or social services records indicating the possibility of physical or emotional harm by the NCP
Child conceived as a result of rape or incest	Medical or law enforcement records indicating conception resulted from rape or incest
Pending legal adoption proceedings	Court documents or statement from social services indicating that adoption is pending
A public or private social service agency is assisting the A/R in deciding whether to keep the child or release him/her for adoption	Written statement from the public or private social service agency assisting the A/R

GOOD CAUSE CIRCUMSTANCE	PROOF REQUIRED
Any of the above Good Cause circumstances	Sworn statement from individual(s) with knowledge of Good Cause circumstances when the above proof cannot be obtained

Failure to Comply

If a Family Medicaid AU member fails to cooperate with DCSS without Good Cause, the adult who failed to cooperate is penalized.

Procedures

Provide the following information to the A/R at initial application, renewal and when adding a child to the AU:

- explanation of the child support program
- assignment to the state of child support and/or medical support
- the requirement to cooperate with DCSS and the consequences for failing to cooperate
- notice to the A/R of the right to claim Good Cause at any time.

Form 138

Review with the A/R Form 138, Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Cooperate in DCSS and Third Party Resource Requirements.

Obtain the A/R's signature on Form 138 and provide the A/R with a copy at initial, renewal and when adding a child to the AU. File the signed original in the case record or scan into DIS. If the application or renewal is completed using GA Gateway or a 94A, a 138 is not required as the 138's language is included in the GA Gateway, and 94A application and renewal.

Form 138 may be mailed to the applicant. The applicant is **NOT** required to sign and return the form, provided the case record is documented that the form was sent.

Determining Good Cause

Follow the procedures below when an A/R claims Good Cause:

Step 1

Refer to the Chart 2250.1 in this section for types of documentary evidence needed to establish a Good Cause claim.

Step 2

Notify the A/R of the evidence needed to establish Good Cause and establish a deadline for returning the information 20 calendar days from the date Good Cause was claimed.

Reasonable extensions may be granted with supervisor approval. Document the reason for the extension.

Step 3

Notify DCSS immediately when Good Cause is asserted if an NCP had previously been referred.

DCSS will suspend enforcement activities pending the Good Cause determination.

Step 4

Review all information provided by the A/R and any other available evidence.

Step 5

Request additional evidence from the A/R if necessary. Assist the A/R in obtaining information if requested to do so.

Step 6

Conduct an investigation if the evidence submitted by the A/R is insufficient to substantiate the Good Cause claim. Notify the A/R in writing when such an investigation is required.

Do not contact the NCP unless necessary to determine Good Cause. Notify the A/R prior to contacting the NCP.

Step 7

Base the Good Cause determination on the supporting evidence provided by the A/R and/or the information obtained during the investigation.

Step 8

Determine Good Cause within 45 calendar days of the application or 30 calendar days at any other time.

Step 9

Document the Good Cause determination.

Step 10

Notify the A/R of the Good Cause determination.

Good Cause Established

If Good Cause **IS** established, notify the A/R that the NCP will **NOT** be referred to DCSS and that DCSS activities will be terminated if the NCP had been previously referred.

Review the case circumstances at the next renewal if Good Cause is subject to change.

Good Cause Not Established

If Good Cause is **NOT** established, notify the A/R within 2 days of the decision. Notify the A/R of the following options and allow 10 days for the A/R to choose an option:

- cooperate with DCSS
- request termination of Medicaid benefits for non-cooperating adult AU member
- request a hearing

- withdraw the application

Take appropriate action based on the decision of the A/R.

Do not impose a penalty or refer to DCSS if a hearing is requested.

Notify the A/R that Good Cause may be asserted again if circumstances change.

Notice of Non-Cooperation

Follow the steps below when a notice received from DCSS cites substantial evidence of the AU's non-cooperation.

Step 1

Discuss any mitigating circumstances with the DCSS agent.

Step 2

Determine if Good Cause exists.

Step 3

If Good Cause is established, notify DCSS.

Step 4

If Good Cause is not established, impose appropriate penalty, and notify the AU and DCSS. Refer to 2657 Penalized Individuals and 2714 Family Medicaid AU/BG Composition Changes. Inform the AU of the right to request a hearing.

If a hearing is requested, include the name and address of the local DCSS agent on the hearing request.

A penalized recipient whose case is closed and who reapplies will continue to be penalized until s/he cooperates.

Do not penalize a Medicaid A/R who fails to cooperate in obtaining child support. A Medicaid A/R is required to cooperate in obtaining **medical support only**. Penalize only if s/he fails to cooperate in obtaining medical support unless good cause exists.

Adding Penalized Individual back to AU Following Denial/ Termination Due to Non-Cooperation

Follow the steps below when an application for Family Medicaid is made for a penalized adult following denial or termination due to non-cooperation with DCSS:

Step 1

Inform the A/R that cooperation with DCSS, prior to approval of Medicaid, is required.

Step 2

Obtain A/R signature on the DCSS Compliance Agreement. Provide a copy of the Agreement to the A/R and to the DCSS office assigned to the case. File the original Agreement in the case record.

Step 3

Inform the A/R that s/he must contact DCSS and, if deemed necessary by DCSS, schedule an appointment.

Step 4

If DCSS notifies the agency that the A/R has cooperated, approve Medicaid for the penalized adult effective the month of compliance if otherwise eligible. Refer to 2714 Family Medicaid AU/BG Composition Changes.

Step 5

If DCSS notifies the agency that the A/R has failed to cooperate, determine whether Good Cause for non-cooperation exists. If it is determined that Good Cause exists, approve Medicaid for the penalized adult if otherwise eligible.

Step 6

If it is determined that Good Cause for non-cooperation does NOT exist, deny Medicaid for the penalized adult, complete CMD to the appropriate class of assistance and notify the A/R of the decision.

> If the A/R has a non-cooperation penalty applied and the NCP for whom the non-cooperation penalty was applied moves back into the home, the DCSS referral would no longer be required, and the penalty can be lifted. DCSS should be contacted and informed that the NCP is back in the home so they can close their case.

2255 Age (Family Medicaid)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Age (Family Medicaid)		
	Effective Date:	July 2023		
	Chapter:	2200	**Policy Number:**	2255
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-70

Requirements

An individual must be under a specified age to be eligible for Family Medicaid. The age limit depends on the Family Medicaid Class of Assistance (COA) for which eligibility is being considered.

Refer to Section 2205, Age, Blind, Disabled Requirement for ABD Medicaid COAs.

Basic Considerations

An individual must be under the following age limits to be eligible for that Family Medicaid COA.

Age Limit	Class of Assistance
65 years	Pathways
65 years	Women's Health Medicaid
45 years	Planning for Healthy Babies®
21 years	Foster Care Medicaid
21 years	State Adoption Assistance Medicaid
26 years	Former Foster Care Medicaid
19 years	PeachCare for Kids®
19 years	Children Under 19 Years of Age Medicaid
19 years	Parent/Caretaker with Child(ren) Medicaid
19 years	Transitional Medical Assistance (TMA)
19 years	Four Months Extended Medicaid (4MEx)
19 years	Family Medicaid Medically Needy
13 months	Newborn Medicaid

For Parent/Caretaker with Child(ren), TMA and 4MEx there is no age limit for the adults requesting/receiving assistance but there must be a child in the assistance unit under the age of 19 for the Parent, Caretaker or Specified Relative to receive Medicaid in these COAs.

A child's age affects the financial income limit used in determining eligibility for Children Under 19 Years of Age Medicaid. Refer to Appendix A2, Family Medicaid Financial Limits and to 2182 Children Under 19 Years of Age.

There is no age limit associated with Pregnant Women Medicaid (PgW).

Eligibility for a Medicaid COA ends at the end of the month in which the child reaches the age limit for that COA. A Continuing Medicaid Determination (CMD) must be completed and documented prior to denial or termination of any Medicaid COA.

Procedures

Accept and document the A/R's statement of the child(ren)'s age, unless questionable. If age is questionable, document the reason age is questioned.

Verify questionable age at the following times:

- at application
- when a child is added to the Family Medicaid AU
- when the agency becomes aware of a discrepancy.

Verify questionable age by one of the following:

- adoption records
- affidavit of persons present at birth
- baptismal or other church records
- birth certificate
- census record
- court record
- driver's license
- family Bible
- insurance record
- medical record
- school record
- Social Security record
- U.S. passport
- vital statistic records
- any other reliable records indicating age or date of birth.

Document the date and source of verification.

If age is questionable and the A/R fails to provide acceptable verification, document the reason verification was requested, the date verification was requested, the date verification was due, and the A/R's failure to comply prior to denial or termination of Medicaid.

2256 Pathways Qualifying Activities Reporting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Pathways Qualifying Activities Reporting		
	Effective Date:	July 2023		
	Chapter:	2200	**Policy Number:**	2256
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-70

Requirements

Pathways is an 1115 Demonstration Waiver that provides coverage to adults ages 19 through 64 with household incomes up to 95% of the Federal Poverty Level (FPL) plus the 5% income disregard if necessary and who meet all other eligibility requirements.

To be eligible for Pathways, A/Rs must also be Georgia residents, US citizens or lawful permanent immigrants, meet the threshold of 80 hours per month of qualifying activities, not be eligible for any other Medical Assistance COA, and not be incarcerated.

Basic Considerations

Qualifying Activities

To be eligible for Georgia Pathways an A/R must demonstrate that they are currently engaged in at least 80 hours per month of a qualifying activity or combination of activities.

Qualifying Activities include:

- Unsubsidized employment, including self-employment
- Subsidized private sector employment
- Subsidized public sector employment
- On-the-job training
- Job readiness
- Community service
- Vocational education training
- Enrollment in an institution of higher education
- Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program

For definitions and acceptable verification of each QA type, please see Chart 2256.3 - Qualifying Activities.

Qualifying Activity Hours at Application

A/Rs must report at least 80 hours of engagement in a qualifying activity or activities at application and provide documentation for verification that they meet the hours and activities threshold for the most recent four weeks available. The submitted four weeks must be within the eight weeks prior to the application date.

Qualifying Activities Hours Reporting

Once enrolled in Pathways, A/Rs are required to report and verify their hours and activities monthly by the 3rd of the month to maintain eligibility. The final deadline for late reporting is the 17th of the month. Exceptions to this monthly reporting are the following:

- A/Rs enrolled in the Pathways Health Insurance Premium Payment (HIPP) program (monthly reporting will be required if the Pathways HIPP A/R is not the employee that has Employer Sponsored Insurance)
- A/Rs who demonstrate having worked a minimum of 80 hours per month for the six months prior to submitting their application
- A/Rs who successfully complete six consecutive months of reporting
- Members who report and verify that they are enrolled as full-time students in an Institution of Higher Education or a Vocational Education Training program
- A/Rs enrolled and actively engaged in the GVRA VR program. Please refer to Ongoing Pathways Eligibility for GVRA Clients section for more information.

> A/Rs exempt from the monthly reporting requirement will have to report and verify hours and activities for the month prior to their renewal end date to continue coverage in the next certification period.

How to report hours and activities

A/Rs receiving Pathways may report their qualifying hours and activities through multiple channels:

- **Customer Portal (CP):** Members may attest to hours and activities for the past month and upload documentation (pdf, jpg, tiff, bmp, docx) through their CP account.
- **By Phone:** Members may call to attest to their hours and activities but will need to submit supporting documentation via one of the other allowable channels by the 17th of the month of reporting.
- **In-Person:** Members may attest to hours and activities and provide documentation at a local DFCS office. Documentation must be stamped upon receipt by the 17th of the month of reporting.
- **Paper/Mail:** Members may attest to hours and activities using a standard form template with attached documentation and mail it to a local DFCS office. Mail must be post-marked by the 17th of the month of reporting.

Penalties for Failure to Report Qualifying Activities and Hours

If the A/R fails to report and verify their **prior month** qualifying activities and hours or reports

insufficient hours by the 17th of the month without submitting a Good Cause Exception request, they will enter a suspension period for up to three consecutive months starting the calendar month immediately following the month in which reporting was required.

If the A/R reports and verifies their hours from the prior month up until the 17th of the third month of suspension, the member is no longer in suspension starting the first day of the calendar month following reporting.

Example:

A/R failed to report their QA hours for June by July 17th.
A/R is in suspension status starting August 1st.
On October 16th A/R reported 80 QA hours for September.
Starting November 1st, A/R is now in active status.

A/Rs may be reinstated after suspension by submitting a Good Cause Exception request.

Suspension

While in suspension:

- The A/R's claims are not paid, capitation rate is not paid, and the member is not covered.
- The member is not eligible for coverage during the suspension period retroactively.
    a. Retroactive coverage may be allowable in limited circumstances, such as if qualifying activities are sent by mail and received after the 17th of the month, or if a member submits a hearing request and requests a continuation of benefits.
- The member does not have access to the Member Rewards Account (MRA).

Good Cause Exception

A/Rs must attest to the hours and activities completed and submit supporting documentation validating hours and activities. If A/Rs fail to meet the threshold of at least 80 hours in a given month, they can submit a Good Cause Exception request for consideration to continue/reinstate eligibility. Good Cause Exceptions are temporary circumstances that prevent or diminish an A/R's ability to fulfill the hours and activities threshold during the reporting period.

If the Good Cause Exception is submitted timely and approved, the A/R will not enter a suspension period in the month following non-compliance with hours and activities requirements. The A/R may only request a Good Cause Exception for the prior month of activities and hours. The timeline for reporting Good Cause Exceptions is the same as for reporting qualifying hours and activities stated in previous section Qualifying Activities Hours Reporting.

The A/R will be allowed up to 120 hours of Good Cause Exception hours per certification year even if no longer required to report monthly. Refer to Exceptions to Six Consecutive Months of Qualifying Activity Reporting for more information on exceptions to monthly report. The Good Cause Exception hours will reset upon the certification of a new Period of Eligibility (POE).

Acceptable Good Cause Exception reasons are as follows:

- Family emergency or life event
- Birth, adoption, foster placement, or death of an immediate family member
- Temporary illness/short-term injury
- Serious illness or hospitalization of member or immediate family member
- Natural or human-caused disaster
- Temporary homelessness
- COVID-19
- Other (approved by State)

This list is not all-inclusive.

A/Rs must select one of the acceptable reasons for the Good Cause Exceptions, provide written explanations of the circumstances, indicate number of hours requested, and submit supporting documentation. A/Rs may request a maximum of 120 hours per certification period.

How to Request a Good Cause Exception

To make a Good Cause Exception request, the member must complete four requirements:

- Select a reason for the Good Cause Exception from a list of pre-defined options
- Provide a written explanation of the circumstance
- Indicate the number of hours requested for Good Cause
- Submit documentation to support the request

At the time of submitting the request, the member must attest that s/he was unable to fulfill their qualifying hours and activities due to the Good Cause reason that is selected.

The A/R may make a Good Cause Exception request at the same time as reporting their qualifying hours and activities.

If by the **3rd day of the month** a member does not report their hours or reports insufficient hours (i.e., any amount less than 80), and does not submit a Good Cause Exception request by this date, then they will receive instructions on the Good Cause Exception request process in their Monthly Qualifying Activity Incomplete Notice.

The A/R may request a maximum of 120 hours of Good Cause Exceptions per certification year. If the cumulative total of Good Cause hours requested in a single certification year exceeds 120 hours, all subsequent requests will be denied. Members will not be able to request a Good Cause Exception if they have reached the 120-hour maximum. Good Cause Exception cannot be accepted at application.

The A/R may request a Good Cause Exception through the same channels used to report their qualifying hours and activities, as follows:

- **Customer Portal (CP):** If the A/R reports hours below the 80-hour threshold, s/he will be prompted to make an exception request.

- **By Phone:** A/R may request a Good Cause Exception over the phone but will need to submit supporting documentation via one of the other allowable channels mentioned above by the **17th day of the month** of reporting.
- **In-person:** A/R may request a Good Cause Exception in-person and provide documentation at a local DFCS office. Documentation must be stamped upon receipt by the **17th day of the month** of reporting.
- **Paper/Mail:** A/R may attest to Good Cause Exception on the standard form template (Form 996) when s/he report their hours and activities and mail the form to a local DFCS office. Mail must be post-marked by the **17th day of the month** of reporting.

The A/Rs who submit a Good Cause Exception Request will be subject to audit and are informed of this requirement at initial application approval of Pathways.

If the A/R chooses the "Other" category as the reason for the Good Cause Exception request, a task will be created and routed to an eligibility worker to review and approve/deny the request.

- If the exception is denied by the eligibility worker and there are no other qualifying activities reported that meet the minimum of 80 hours for the reported month, the A/R will enter a suspension period in the month following the month of non-compliance with the hours and activities reporting requirement.
- If a Good Cause Exception that requires staff review is not reviewed timely for continued coverage in the following month, the member will maintain coverage for the following month.
    - If the member does not comply with the qualifying activities reporting in the following month, or if the Good Cause Exception request is denied by the eligibility worker, then the member will enter suspension starting from the first of the following month.
- An eligibility worker may grant Good Cause Exceptions for longer than a one-month period based on the unique needs of a member's circumstance.
    - It may be required for a staff member to request permission from a supervisor to exceed the one-month period.

> If the A/R requests Good Cause Exception hours in an amount that exceeds the total number of Good Cause Exception hours remaining in the A/R's certification period, all the requested Good Cause Exception hours will be denied. Example: A/R has 10 Good Cause Exception hours remaining, A/R requests 20 hours for their reporting period. All 20 requested hours will be denied due to insufficient remaining hours.

Good Cause Exception requests received during the renewal month will be determined using the hours remaining in that certification period.

Verification of Good Cause Exceptions

Acceptable documentation for Good Cause Exception requests is defined as follows:

Chart 2256.1 - Good Cause Reasons and Acceptable Verification

Good Cause Reason	Acceptable Verification
Family emergency or life event	• Client statement with collateral contact • Clinician's note • Court papers/Legal papers • Police report/Domestic disturbance report • Jury duty selection notice
Birth, adoption, foster placement, or death of an immediate family member	• Birth certificate • Birth announcement • Adoption papers • Obituary • Death certificate • Caregiver placement passport (for foster placement)
Temporary illness/short-term injury	• Clinician's note • Employer/Supervisor statement
Serious illness or hospitalization of member or immediate family member	• Clinician's note • Employer/Supervisor statement
Natural or human-caused disaster	• Client statement with collateral contact • State-issued executive order • Federally declared disaster • Property loss statement
Temporary homelessness	• Client statement • Landlord letter • Lease document
COVID-19	• Client statement with collateral contact • Clinician's note • Employer/Supervisor statement
Other (approved by State)	• Client statement with collateral contact • TBD (circumstance reviewed and determined acceptable)

Six Consecutive Months of Reporting Compliance

If the A/R is compliant with reporting qualifying hours and activities timely (by the 23rd of each month) for six consecutive months of enrollment in Pathways, s/he will no longer be required to report monthly for the remainder of s/he time in Pathways.

- An A/R with evidence of meeting the hours and activities threshold for six consecutive months will be exempt from the reporting requirement, except that they will have a responsibility to report any changes in circumstance.
- An A/R who can provide evidence of meeting the hours and activities threshold for the six months prior to applying for Medical Assistance will also be exempt from the reporting requirement, except that they will have a responsibility to report any changes in circumstance.

The A/R must report hours and activities from the month prior to submitting a renewal to continue coverage in the next certification year during renewal. Also, member will remain subject to random and period audits.

Reporting Qualifying Activity Hours During Renewal

A/R must complete the hours and qualifying activities reporting requirements (self-attestation and documentation for verification) for the month prior to submitting the renewal to be determined eligible for Pathways.

A/Rs who were exempt from monthly reporting due to successfully completing six months of consecutive reporting are required to report at renewal. They must report and provide documentation for verification of their hours and activities for the month prior to submitting their renewal to be determined eligible for Pathways at redetermination.

Members who successfully completed six months of reporting during a prior certification period will not be required to do ongoing reporting for the new certification period upon eligibility redetermination.

For members who are reporting monthly at the time of redetermination, the month reported within their renewal will count towards their six consecutive months of reporting required to be exempt from ongoing monthly reporting in the future.

The member must continue to report their hours and activities and provide documentation for verification each month until six consecutive months of reporting and verification are met. The six months of consecutive reporting may span across certification periods.

Six Consecutive Months Counter

The qualifying activities 6-month reporting counter will:

- track completion of six consecutive months of reporting for members who are required to complete monthly reporting.
- be set at 0 for initial intake
- be set at 0 following any termination authorized for Pathways. This includes any subsequent reopening, reinstatement, or new application for Pathways.

This will occur regardless of how long the gap in coverage is and regardless of if they had previously met the six months of consecutive reporting.

The qualifying activities and hours submitted prior to the eligibility determination as part of the Medical Assistance application do not count towards the qualifying activities 6-month reporting counter, except:

- If an A/R demonstrates having worked a minimum of 80 hours per month for the six consecutive months prior to submitting their Medical Assistance application.

If A/R is granted a Good Cause Exception, the qualifying activities 6-month reporting counter pauses and continues with the same count after the month in which the Good Cause Exception has been granted.

If A/R enters a suspension period at any time, the qualifying activities 6-month reporting counter resets.

If A/R enters a new certification year but has not submitted hours and activities timely for six consecutive months, the qualifying activities 6-month reporting counter will continue with the same count in the new period.

If A/R is granted a Reasonable Accommodation from their employer/supervisor of a reduction in hours, the qualifying 6-month reporting counter will continue to increment for each month the reduction in hours applies if they are compliant with reporting requirements.

This includes if a member has a reduction in hours equal to or exceeding the 80-hour requirement (i.e., a reduction to zero hours).

Exceptions to Six Consecutive Months of Qualifying Activity Reporting

There are circumstances in which the A/R is not subject to the six consecutive months of qualifying activity reporting requirement. They are not subject to this requirement; they will receive a Change Notice for Reporting Requirements. This notice will be customized according to the below table.

Chart 2256.2 - Change Notice for Reporting Requirements

Qualifying Activity Status	Reporting Status	Change Notice
Member **completes 6 consecutive months** of reporting compliance	Reporting requirement met	Informs member that ongoing monthly reporting is no longer required
Member is **enrolled in an Institution of Higher Education / Vocational Education program full time**	Reporting is not required for duration of full-time enrollment	Informs member that ongoing monthly reporting is not required for their duration of full-time enrollment
Member is **no longer enrolled in an Institution of Higher Education / Vocational Education program full time**	Reporting is required (if 6-month reporting requirement has not been met)	Informs member that they have an ongoing monthly reporting requirement since they are no longer enrolled full-time
Member is **enrolled in GVRA**	Reporting is not required for duration of enrollment	Informs member that the ongoing monthly reporting is not required for their duration of enrollment and active engagement
Member is **no longer enrolled in GVRA**	Reporting is required (if 6-month reporting requirement has not been met)	Informs member that they have an ongoing monthly reporting requirement since they are no longer enrolled full-time
Member is the employee with ESI access and is **enrolled in Pathways HIPP Program (Phase 2)**	Reporting is not required while in Pathways HIPP Program	Informs member that ongoing monthly reporting is not required also long as are in the Pathways HIPP program
Member is the employee with ESI access and is **no longer enrolled in Pathways HIPP Program (Phase 2)**	Reporting is required (if 6-month reporting requirement has not been met)	Informs member that they have an ongoing monthly reporting requirement since they are no longer enrolled in Pathways HIPP

Reporting Exception if Six Consecutive Months of Employment Verified at Application

If the applicant is determined eligible for Pathways and provides verification of completing a minimum of 80 hours total (not on average) of employment during the most recent six consecutive

months prior to application for which verification is available, then the A/R will be exempt from reporting.

> The last four weeks of reporting submitted must fall within the eight weeks preceding the application submission date.

Applicants will have the opportunity to report and provide verification for the most recent six consecutive months of employment prior to application for which verification is available.

- **CP/Paper:** If the applicant indicates in their application that they participated in employment with a start date that is greater than six months from the time of application submission, they will be directed to provide more information on their participation at the time of application.
- **CP/Paper:** If the applicant **does not** provide documentation for verification of six consecutive months of employment at the time of application, they will be reminded of this outstanding verification via a Verification Checklist (VCL) if they are authorized eligible for Pathways.

If the A/R successfully submits six months of documentation at application or after notified via a VCL, they will be notified in their Approval Notice that they are not required to participate in six consecutive months of qualifying hours and activity reporting upon enrollment.

If the A/R fails to submit the six months of documentation within a reasonable timeframe, they are no longer considered for a reporting exception. Failure to submit six months of documentation upfront is optional and not required, so it does not impact their eligibility for Pathways ongoing. They will be notified in their Approval Notice that they are required to participate in six consecutive months of qualifying hours and activity reporting upon enrollment.

> If six consecutive months of employment can be verified for the applicant via Work Number, then they will also be waived from the reporting requirement upon enrollment in Pathways. The Work Number interface should be checked prior to sending a VCL.

Changes in Qualifying Hours and Activities

Fluctuations in the A/R's community engagement, either in number of hours or types of activities, is not considered a change in circumstances. This does not need to be reported if the A/R still meets the requirements of the program of at least 80 hours/month of engagement in qualifying activities.

Normal fluctuations include the following:

- Minor changes in hours worked due to scheduling changes made by the employer
- Vacation/sick leave taken within a calendar month
- Short-term academic breaks (e.g., President's Day, Spring Break) taken within a calendar month

> The above list is not all-inclusive.

In the event the A/R incurs a change in their qualifying activities that results in not meeting the minimum hours threshold of 80 hours/month, the A/R has a responsibility to report this as a change in circumstance. The A/R may submit a Good Cause Exception request (if applicable).

Pathways Reasonable Modification

To qualify for Pathways, A/Rs must report at least 80 hours per month of engagement in a qualifying activity or activities before eligibility can be approved. All applicants must verify they meet the qualifying activities and 80 hours threshold for the most recent four weeks available within the eight weeks prior to an application.

If any Pathways Medical Assistance applicant or member with a disability who is no longer able to perform any work, education, or Qualifying Activity needs assistance to meet the 80-hour Pathways Qualifying Activities requirement in a month, the applicant or member with a disability can make the following Reasonable Modification requests that are specific to Pathways Qualifying Activity:

1. Additional time to meet the reporting requirements at application (applies to Pathways applicants);
2. Additional time for a referral to GVRA (applies to Pathways applicants and members).

Please see Chart 2256.4 - Reasonable Modifications vs. Reasonable Accommodations as a quick reference to understanding Reasonable Modification requests.

Eligibility Workers will process, review, and make decisions on Pathways applicant and member requests for Reasonable Modifications specific to Pathways qualifying hours and activities requirement. See the following examples:

Example 1:

If an eligibility worker grants a Pathways *applicant's* Reasonable Modification request for "additional time to meet reporting requirements at application," this means that the worker would provide the applicant up to 90 additional days to meet the reporting requirements.

Example 2:

If an eligibility worker grants a Pathways *member's* Reasonable Modification request for "additional time for a referral to GVRA" due to a disability, this means that the worker would allow the member to maintain Pathways coverage for up to 90 days while the member engages in GVRA's intake process.

To meet the Pathways Qualifying Activity requirement with this Reasonable Modification, the Pathways member is responsible for complying with the GVRA intake process, enrollment, and participation.

In addition to the Reasonable Modification types listed above, Pathways applicants and members are afforded the same access to Reasonable Modifications that are available for all categories of Medicaid. (For examples, please refer to Medicaid Manual Policy Section 2020 Americans with Disabilities Act (ADA) and Section 504). If an applicant or member needs a Reasonable Modification or Communication Assistance, the applicant or member should contact his or her caseworker or call DFCS at 404-657-3433 or DCH at 678-248-7449. The applicant or member may also make the request online at dfcs.georgia.gov/adasection-504-and-civil-rights. If the applicant or member is deaf, hard-of-hearing, deaf-blind or have difficulty speaking, s/he can call DFCS at the numbers above by dial-

ing 711 (Georgia Relay).

The definition of disability used in Pathways follows the Americans with Disabilities Act (ADA) definition which states that an A/R meet any of the following three criteria:

- the A/R has a physical, mental, or sensory impairment that substantially limits one or more major life activities,
- the A/R has a record of such impairment, or
- the A/R is regarded as having such an impairment.

Please refer to Medicaid Manual Policy Section 2020 Americans with Disabilities Act (ADA) and Section 504. The Pathways definition of disability differs from the ABD definition of disability, which uses the Social Security Administration (SSA) definition of disability.

The eligibility worker will contact the potential Pathways eligible A/R to determine next steps for the applicant's/member's Reasonable Modification request for Pathways qualifying hours and activities. The eligibility worker will:

- Explain the qualifying activities and hours requirements for the Pathways program and collect additional information from the A/R that may be needed.
- Provide information and resources to help the A/R get engaged with an activity.
- Allow for additional time (up to 90 days from request) for the A/R to show compliance before making an eligibility determination, if necessary.
- Provide a referral to GVRA Vocational Rehabilitation Program, if applicable.

Interview for Reasonable Modification for Pathways Qualifying Activity Requests

The eligibility worker will attempt to reach the A/R following the current practice of conducting two unscheduled telephone attempts prior to scheduling an interview with the A/R who is requesting a Reasonable Modification for Pathways qualifying hours and activities due to a disability. If the A/R is not reached after two telephone attempts, the eligibility worker will schedule an interview. The A/R will receive a notice with their scheduled interview time and contact information for the assigned eligibility worker. The notice will indicate that failure to complete the interview will result in a denial for Pathways Medicaid.

If the A/R is not reached after the scheduled interview, the eligibility worker may deny their application.

If a potential Pathways eligible A/R who has attested to having a disability and is not currently meeting the qualifying hours and activities threshold and did not request a Reasonable Modification for qualifying hours and activities, the eligibility worker – during the Pathways interview – is to inquire whether the A/R needs a Reasonable Modification because they are unable to meet qualifying hours and activities required for Pathways due to a disability. If the A/R declines or otherwise fails to indicate the need for a Reasonable Modification because they are unable to meet qualifying hours and activities required for Pathways due to a disability, then the application will be denied and referred to the Federally Facilitated Marketplace (FFM).

Providing Reasonable Modification for Pathways Qualifying Activity Requests at Application

If the A/R reports that they are able to meet the qualifying hours and activities for Pathways eligibility, the eligibility worker will offer information on potential resources available to help the A/R get engaged with employment, education, training, or volunteer activities, if needed.

The A/R's Medical Assistance application will pend for up to 90 days to allow the A/R to demonstrate compliance of four weeks of engagement with the qualifying hours and activities threshold. If the A/R submits verification of compliance with the Pathways hours and activities requirement within the 90 days, the eligibility worker will approve the application for Pathways. If the A/R fails to submit verification of compliance with the Pathways hours and activities requirement within 90 days, the application will be auto denied.

Referral to GVRA

If the A/R reports that they are unable to meet the qualifying hours and activities requirement due to their disability, the eligibility worker will offer a referral to the GVRA Vocational Rehabilitation Program to assist the A/R with coming into compliance. If the A/R accepts the referral, the eligibility worker will make a referral to GVRA. The worker will obtain verbal consent prior to the referral that the individual consents to a referral to GVRA.

The Standard of Promptness (SOP) for processing of Pathways A/Rs who have been referred to GVRA is 90 days from the date of authorization of a referral to GVRA. A Pathways application will remain in "Eligible – Pending GVRA Enrollment Status" until the member's referral to GVRA is dispositioned as enrolled or denied.

If an A/R is determined **eligible** and **enrolled** in services for GVRA, Gateway automatically updates the Medical Assistance application to indicate enrollment in GVRA, which is a qualifying activity for Pathways. If GVRA enrollment status is received manually, a worker will be able to update the case with GVRA enrollment information. The A/R will be enrolled in Pathways effective the first of the month following receipt of the eligibility determination and enrollment from GVRA, or the month following receipt of initial premium payment, if applicable.

If an A/R is currently active on Pathways and reports a change or during renewal state s/he is no longer able to continue to meet the qualifying activity hours due to a disability and is requesting a Pathways Reasonable Modification and accepts a referral to GVRA, the A/R would maintain his/her current Pathways eligibility until an enrollment determination is received from GVRA.

If an A/R is determined **ineligible** and therefore not enrolled for GVRA, upon receipt of this information Gateway will authorize a denial for Pathways and a denial notice will be sent. The denial notice will specify that an A/R is not eligible for Pathways for failure to meet the hours and activities threshold and that the agency has been informed of their denial from GVRA. The denial notice will include information regarding other workforce development resources, which is provided to all applicants who are denied for failure to meet the qualifying activities requirement.

If an A/R has been **pending** for Pathways due to a referral to GVRA, the A/R will continue to pend for Pathways until an enrollment status is received from GVRA.

Ongoing Pathways Eligibility for GVRA Clients

A/Rs who are eligible for Pathways due to being enrolled in GVRA will be considered to be meeting the monthly hours and activities requirements for Pathways if they remain in compliance with the terms of the GVRA program. Enrollment in GVRA is considered a qualifying activity for Pathways. Enrolled A/Rs **will not** be required to report on monthly activities if they remain in compliance with the terms of the GVRA program. GVRA will notify Gateway through an interface (if consent was granted by A/R) when a Pathways program participant is no longer an active client with GVRA, either due to graduation from the program or due to disenrollment.

GVRA will send information to Gateway (if consent was granted by A/R) when a client is disenrolled from the GVRA Vocational Rehabilitation Program, if the A/R has not completed the six consecutive months of reporting requirement, Gateway will issue a notice informing the member that they are no longer an active client of GVRA and will need to come into compliance with the Pathways requirements through engagement in other qualifying activities in order to maintain eligibility.

> The potential Pathways eligible A/R must consent to the release of their personal information to GVRA for the purpose of validating their enrollment in GVRA before Gateway can make any automated updates to the A/R's case received from an interface with GVRA. For A/Rs who do not consent to the release of their information to GVRA, they will be responsible for providing all changes in their GVRA enrollment status to DFCS. A/Rs who are no longer enrolled in GVRA will have a one-month waiver from reporting Pathways qualifying activities and hours, after which, if they fail to report engagement they will be suspended from Pathways.

If the A/R was enrolled in GVRA for at least six months prior to transitioning to Pathways, this fulfills the six consecutive months of reporting requirement. They will be exempt from the requirement to report qualifying hours and activities ongoing. They will not report qualifying activities until Pathways redetermination.

Reasonable Accommodations for Pathways Members

If an A/R is already enrolled in Pathways and develops a condition which is temporary and prohibits their monthly compliance with the qualifying hours and activities, they may request a Good Cause Exception from the qualifying hours and activities. For more information about Good Cause Exception please refer to section located within this chapter labeled Good Cause Exception. However, if the A/R develops a physical or mental impairment that substantially limits one or more major life activity, the A/R may report a **Reasonable Accommodation** from their employer, educational institution, organization, or supervisor to maintain their current activity.

Reasonable Accommodations for Pathways only refers to changes made by an employer/supervisor/institution for an A/R with a disability to allow the person to work or engage in an activity. The A/R must request a Reasonable Accommodations directly from the employer/supervisor/institution or through GVRA. DFCS staff do not collect verification of disabilities for a Reasonable Accommodation nor make determinations on the types of Reasonable Accommodations that area necessary for the Pathways applicant/recipient to be able to engage in a qualifying activity.

The only circumstance in which DFCS needs to be informed about a Reasonable Accommodation made between the employer/supervisor/institution and the Pathways A/R is if the member has reduced work/engagement hours and will be unable to meet the minimum of 80 hours/month required for Pathways eligibility. In this circumstance, the A/R will report and provide verification

of the Reasonable Accommodation granted by his or her employer/supervisor/institution and the eligibility worker will reduce the A/R's monthly minimum qualifying activities and hours requirement to maintain ongoing Pathways eligibility accordingly.

Reporting/Requesting Reasonable Modifications and Reasonable Accommodations

To maintain eligibility, Pathways members must report a change in circumstance and request a Reasonable Modification or report that they were granted a Reasonable Accommodation that allows them to work fewer than 80 hours per month, using the same channels available for submitting Good Cause Exception requests (i.e., phone, mail, in-office, online portal).

Please see Chart 2256.4 - Reasonable Modifications vs. Reasonable Accommodations for an overview of how these terms are used for the Pathways program and as a quick reference to understanding Reasonable Modification requests and Reasonable Accommodations granted by employers/supervisors/institutions.

Chart 2256.3 - Qualifying Activities

Qualifying Activity	Definition	Acceptable Verifications
Employment	Full or part-time employment in the public or private sector that is not subsidized by a public program. Employment in the private sector for which the employer receives a subsidy from public funds to offset some or all of the wages and costs of employing an individual. Employment in the public sector for which the employer receives a subsidy from public funds to offset some or all of the wages and costs of employing an individual.	Work number Pay stubs Written statement from source/employer Gross earnings (if hourly pay is known) Timesheet
Self-Employment	Earnings from an individual's own business or self-employment work, as opposed to wages or salary from an employer. Some examples include but are not limited to owing one's own business, cutting grass, collecting cans for recycling, babysitting, selling food items, taxi/food delivery service, etc.	Signed Standardized Work/Participation Calendar from member indicating hours engaged (Member may fill in a standardized worksheet template indicating total weekly hours worked per client/activity; OR submit a snapshot of their actual work calendar from the reporting month (e.g., Photo of ledger of appointments or Screenshot of calendar with work activities)
On-the-job-training	Training in the public or private sector that is given to a paid employee while he or she is engaged in productive work, and that provides knowledge and skills essential to the full and adequate performance of the job.	Statement from supervisor sponsoring the OJT

Qualifying Activity	Definition	Acceptable Verifications
Job Readiness	Activities directly related to the preparation for employment, including life-skills training, GED course enrollment, resume building, and habilitation or rehabilitation activities, including substance use disorder treatment. Rehabilitation activities must be determined to be necessary and documented by a qualified medical professional. An inpatient hospital stay is considered a habilitation or rehabilitation activity under job readiness only at initial application. For each day of an inpatient hospital stay, an applicant may claim 4 hours towards their monthly Qualifying Activities requirement.	Signed statement from Recognized Agency or Community Resource indicating hours engaged. (Recognized agencies include Georgia Department of Labor Career Center, Workforce Development Board, Georgia Vocational Rehabilitation Agency, Goodwill, and other agencies as authorized by the State) Signed statement from habilitation/rehabilitation institution verifying hours in last four weeks
Community Service	Structures programs and embedded activities in which an individual performs work for the direct benefits of the community under the auspices of public or nonprofit organizations. Approved community service programs are limited to projects that serve a useful community purpose in fields such as health, social service, environmental protection, education, urban and rural development, welfare, recreation, public facilities, public safety, and childcare. Georgia will consider, to the extent possible, the prior training, experience, and skills of an individual in making appropriate community service assignments.	Signed Standardized Work/Participation Calendar Signed statement on organization letterhead from supervisor verifying hours
Vocational Education Training	Organized education programs that are directly related to the preparation of individuals for employment in current or emerging occupations. Course hour requirements for vocational education training shall be determined by the Department of Community Health (DCH).	Official course enrollment for the current semester from the office of the Registrar Copy of class schedule for the current semester
Enrollment in an Institution of Higher Education	Enrolled in and earning course credit at a college, university, or other institution of higher learning. A full-time academic workload, as determined by the Department of Community Health (DCH), will meet the requirements for 80 hours of qualifying activities in the month. For individuals not enrolled full-time, DCH shall determine the associated number of qualifying hours based on the course load when compared to full-time. The student's workload may include any combination of courses, work, research, or special studies that the institution considers contributing to an individual's full-time status.	Official course enrollment for the current semester from the office of the Registrar Copy of class schedule for the current semester

Qualifying Activity	Definition	Acceptable Verifications
Enrollment and active engagement in the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program	Enrolled in and compliant with the requirements of the Georgia Vocational Rehabilitation Agency (GVRA) Vocational Rehabilitation program. Individuals who are accepted in the program whose IEP is under development, or who comply with the terms of their IEP once completed, will satisfy the requirements of 80 hours of qualifying activities in the month.	Signed statement from GVRA, dated within four weeks of submission by the applicant Enrollment letter dated within four weeks of submission by the applicant Active status through agency interface (only if available)

Chart 2256.4 - Reasonable Modifications vs. Reasonable Accommodations

	Reasonable Modifications (All Programs)	Reasonable Modifications (Additional for Pathways)	Reasonable Accommodations
Use in Program	Available for all customers who indicate they have a disability and request a Reasonable Modification to apply for or stay compliant once enrolled for Medical Assistance.	Available for Pathways applicants and members who indicate they have a disability which prevents them from meeting the minimum qualifying hours and activities and request a Reasonable Modification	An agreement made between an employer/institution and a Pathways member that enables them to work or engage in an activity
Who Grants Request	All DFCS OFI Staff	OFI Eligibility Staff	Employer / Institution / Supervisor
Types Available	Examples of the types of Reasonable Modifications available to all Medical Assistance Applicants and Members (not a complete list): • Sign language interpreter • Cued speech interpreter • Oral interpreter • Tactile interpreter • Email • Face to face interview • Electronic communication • Teletypewriter (TTY) • Braille • Large print • Video Relay • Telephonic signature • Telephonic apps/renewals • Telephone call reminder of deadlines	Additional types of Reasonable Modification available for Pathways: • Pending the Pathways application up to an additional 90 days for the applicant to have additional time to report compliance with the qualifying hours and activities prior to determination • Pending the Pathways application up to 90 days while the applicant is referred and going through GVRA intake • Providing continued coverage up to 90 days while an enrolled Pathways member (who can no longer work/engage) is referred and going through GVRA intake.	Several types of Reasonable Accommodations may be made by the employer/institution to enable the A/R with a disability to engage (such as job restricting, low-tech roles, equipment) Only one type of Reasonable Accommodation needs to be reported to the Pathways Medicaid program: • If the Reasonable Accommodation provided by the employer/institution is a reduction in hours the A/R is able to work/engage, which results in them not being able to meet the 80 hours/month required to maintain enrollment in Pathways

2300 Resources

2300 ABD Medicaid Resources Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Medicaid Resources Overview		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2300
	Previous Policy Number(s):	MT 26	**Updated or Reviewed in MT:**	MT-59

Requirements

The value of an A/R's or couple's countable resources cannot exceed the appropriate resource limit in order for the A/R or couple to be eligible for ABD Medicaid.

Basic Considerations

The appropriate resource limit is dependent upon several factors:

- the A/R's class of assistance (COA)
- whether the A/R is living with or has lived with an ineligible spouse or ineligible parent in LA-A, B, or C
- whether an A/R living in LA-D has a spouse living in LA-A or B

To determine an A/R's appropriate resource limit (individual or couple), refer to Chapter 2500, ABD Financial Responsibility and Budgeting. Refer to Appendix A1 for current individual and couple resource limits for each COA.

Resources are assets. Assets, with respect to an A/R, includes all income and resources of the A/R and of the A/R's spouse, including income and resources which the A/R or A/R's spouse is entitled to but does not receive because of some action by one or both of them. Refer to Section 2342 for explanation of those actions.

Resources may include cash, other personal property and real property that the A/R or ineligible spouse or parent owns under the following conditions:

- The owner has the right, authority, or power to convert the asset to cash (if not already cash).
- The owner is not legally restricted from using the asset for his/her support and maintenance.

An asset is usually income in the month of receipt. Any portion of a countable asset that is retained becomes a resource on the first day of the month following the month of receipt. An asset cannot be considered income and a resource in the same month.

EXCEPTIONS:

- Checks dated and received early because the regular date of receipt falls on a weekend or holiday are counted as income, rather than a resource, in the month for which they were intended.

- Any portion of a lump sum SSI or RSDI payment retained after the month of receipt is excluded as a resource for up to nine full calendar months. (These entire lump sum payments are income in the month of receipt.)

The values of some resources may be totally or partially excluded. Refer to Section 2304, Treatment of Resources.

The countable value of a resource that is applied to the resource limit is the resource's equity value as of the first moment of the first day of each calendar month.

Current market value (CMV) is used for automobiles that cannot be totally excluded.

Refer to 2303 Determining the Countable Value of Resources for ABD Medicaid.

If an adult A/R lives with a spouse in LA-A or B, the spouse's resources are considered to be available to the A/R.

If a Medicaid child lives with his/her parent(s) in LA-A, B or C, the parent(s) excess resources are deemed to the child. Refer to 2502 Deeming (ABD).

There are two types of resources.

- Liquid resources are any resources in the form of cash or in any other form that can be converted to cash within 20 workdays.
- Non-liquid resources are any resources which are not in the form of cash and which cannot be converted to cash within 20 workdays.

If an individual is unaware of his/her ownership of an asset, the asset is not a resource during the period for which the individual was unaware of the ownership. The previously unknown asset, including any monies (such as interest) accumulated on it through the month of discovery by the individual, is income only in the month of discovery. For exceptions on interest or dividends as income, refer to 2499 Treatment of Income in Medical Assistance. Thereafter, the previously unknown asset is subject to resource-counting rules.

Conversion of Resources

In the event an excluded resource is converted to a countable resource, including cash, the value of the resource is applied to the appropriate resource limit in the month after the month of conversion.

Proceeds from the sale of capital goods are considered income. Refer to Section 2499.1, Treatment of Income by Type.

2301 Family Medicaid Resources Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Resources Overview		
	Effective Date:	July 2023		
	Chapter:	2300	**Policy Number:**	2301
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-70

Requirements

Resources are assets available to the Assistance Unit (AU) that can be converted to cash to meet daily living expenses. These assets must be taken into consideration in determining eligibility.

Basic Considerations

Resource Limit

Resource limits are set by federal or state law.

The resource limit for the following Family Medicaid Classes of Assistance (COA) is $1000 per AU:

- Child Welfare Foster Care (CWFC)
- State Adoption Assistance (SAA)

Parent/Caretaker Medicaid, Pregnant Woman Medicaid, Child Under 19 Medicaid, Newborn Medicaid, TMA, Four Months Extended Medicaid (4MEx), PeachCare for Kids®, and Pathways have no resource limit.

The Family Medicaid Medically Needy (FM-MN) resource limit increases based on the number of individuals in the Budget Group (BG), as follows:

Number of Individuals in FM-MN BG

1	2	3	4	5	6	7	8
$2000	$4000	$4100	$4200	$4300	$4400	$4500	$4600

The FM-MN resource limit increases by $100 for each additional BG member.

Consideration of Resources

All countable resources available to the AU are applied to the resource limit of the Family Medicaid COA.

If the total countable resources are less than or equal to the resource limit, the AU is eligible based on resources.

If the countable resources exceed the resource limit for a Family Medicaid COA, the AU is ineligible

for that COA.

For Family Medicaid COAs, if resources of the BG are within the applicable limit at any time during a month, the AU is resource eligible for that month.

Eligibility based on resources is determined by resolving the following questions:

- Whose resources are considered?
- Who owns the resource?
- Is the resource available to the AU to meet its needs?
- Is the resource countable?
- What is the value of the resource?
- What is the resource limit in the program for which assistance is requested?

Resources are considered liquid or non-liquid and are described as follows:

- Liquid resources are those such as cash or bank accounts which can be converted to cash and are available for daily living expenses.
- Non-liquid resources are those such as property or vehicles which cannot be easily converted to cash.

Resources available to an AU are used to determine eligibility at the following times:

- application
- review
- when the agency becomes aware of a change.

The countable resources of the following individuals are used to determine eligibility:

- eligible AU members
- ineligible aliens
- penalized individuals
- ineligible parents.

A portion of the resources of the sponsor of a sponsored alien is used to determine eligibility.

Ownership of Resources

It is assumed that a resource belongs to the individual in whose name it is listed unless the AU can prove otherwise.

The burden of proof in establishing that a resource does not belong to an individual rests with the AU.

Convincing evidence such as the following must be provided to rebut ownership:

- statements from other individuals in a position to substantiate the AU member's claim

- legal documents substantiating the claim.

Jointly Owned Resources

A resource that is jointly owned with a non-AU or non-BG member is considered available to the Family Medicaid AU or BG in its entirety if the following conditions apply:

- The AU or BG has the right to dispose of the property.
- The AU or BG can dispose of the property without the consent of the owner.

A resource which is jointly owned with a non-AU or non-BG member is excluded if all of the following apply:

- The resource cannot be practically subdivided.
- Access is dependent on the agreement of the other owner.
- The joint owner states in writing that s/he is unwilling to dispose of the resource.

A portion of a jointly owned resource is included if the AU or BG has access to and may dispose of a portion of the resource.

If a resource is owned by individuals receiving Medicaid in different AUs, the resource is considered available to each owner in equal shares.

The balance of a jointly owned bank account is divided among the individual owners.

> In the event an AU or BG member is named on a joint bank account with a non-AU or non-BG individual solely for convenience or emergency, the joint account is excluded as a resource to the AU or BG member if the other individual, or someone in a position to know verifies that s/he has deposited all the monies in the account and all withdrawals are used for the non-AU or non-BG individual's benefit.

A resource is considered available when the AU or BG has the legal right to liquidate the resource and to use the proceeds.

Accessibility of Resources

Resources that are inaccessible to the AU or BG or which AU or BG cannot legally liquidate are excluded.

Examples of excluded resources include the following:

- security deposits on rental property or utilities
- property in probate
- real estate which the AU or BG is making a good faith effort to sell
- resources jointly owned by women and/or children in shelters for victims of domestic violence and their former AU or BG members if access is dependent on the agreement of the joint owner
- money placed in an account for AUs residing in public housing or receiving Section 8 assistance and participating in the Family Self-Sufficiency Program as long as the AU does not have legal

access to the money.

This list is not all inclusive.

Bankruptcy

Bankruptcy is a condition whereas a debtor, either voluntarily or invoked by a creditor, is judged legally insolvent and the debtor's remaining property is administered and distributed to his/her creditors.

The AU's resources are included or excluded depending on their accessibility and the AU's ability to liquidate the resource and retain the proceeds.

Countable Resources

Refer to 2399 Treatment of Resources by Resource Type Chart.

Excluded income that is retained as a resource the month following the month the income was received is counted as a resource.

Only those resources that are available to the AU at the time that eligibility is determined are counted.

Commingled Resources

Excluded resources may be commingled with countable resources. The excluded resources retain its exclusion for six months from the date the resources were commingled. Beginning in the seventh month following the commingling of funds, the asset's value is counted in its entirety.

Conversion of Resources

In the event an excluded resource is converted to a countable resource, the value of the resource is applied to the appropriate resource limit in the month the resource is converted.

Proceeds from the sale of capital goods are considered income. Refer to Section 2499.1, Treatment of Income by Type.

If a countable resource is converted to cash, the value of the cash is countable toward the appropriate resource limit.

Money Received for the Replacement/Repair of a Resource

Money received from a third party, such as an insurance company that is intended to cover the replacement or repair of a resource is excluded based on the guidelines below:

- The amount that is used for the replacement or repair of the resources is excluded.
- The money must be used or contracted to be used for the repair or replacement of the resource within 6 months of receipt.

Any amount not used for the specific replacement or repair is considered income to the AU. Any unused amount that exceeds the FPL is budgeted as a lump sum in the month received.

Determining the Value of a Resource

The most current available information is used to verify the value of a resource in determining eligibility.

Sources which may be used to determine value include the following:

- bank records
- deeds
- property records
- tax records
- appraisals
- tag receipts
- insurance policies
- stock quotes
- statements from individuals in a position to verify the value of a resource.

This list is not all inclusive.

Determining Appreciation/Depreciation

The appreciation or depreciation of a non-liquid resource is considered in determining the value of the resource.

Appreciation is an increase in the value of a resource due to of any of the following:

- improvements to the property
- normal marketing increases
- interest accrued

Appreciation is determined by obtaining verification from a knowledgeable source. Depreciation is a decrease in the value of a resource due to any of the following:

- normal use of the resource
- destruction of property in a storm, fire or other casualty
- marketing decreases.

Depreciation is determined by obtaining verification from a reliable source.

Resource Value

The value of a resource is determined by using one of the following:

- cash value (CV)
- fair market value (FMV)

- equity value (EV)

Cash Value

Cash value is the amount available to the AU if the resource is converted to U.S. funds. In some cases, a penalty may be applied for early withdrawal of funds. The amount of the penalty is deducted from the value of the resource to determine the cash value available to the AU.

Fair Market Value

Fair market value is the amount that the item can sell for on the open market in the geographic area involved.

Equity Value

Equity value is the FMV less legal debts, liens or other encumbrances.

Proof of this legal debt, lien or encumbrance must be in writing and signed by the property owner. It must specify the location of the property and the amount of the debt.

If the owner has financed the purchase of a resource with a loan, the current payoff of the loan must be verified by the lender to determine indebtedness.

Transfer of Resources

A transfer of resources includes selling, swapping, trading, or giving away a countable resource for less than the FMV.

In Family Medicaid Classes of Assistance (COAs), there is no penalty for transferring resources. Only resources owned by the AU at the time of the eligibility determination are considered.

Procedures

Determining Eligibility on Resources

Follow the steps below to determine whether or not the AU or BG meets the resource limit:

Step 1 Determine whose resources must be considered.

Step 2 Determine if the resource is available to the AU/BG.

Step 3 Determine if the resource must be counted.

Step 4 Calculate the total countable resources.

If the total countable resources are less than or equal to the resource limit, the AU/BG meets the resource criteria for that COA.

If the total countable resources exceed the resource limit, deny or terminate benefits.

Verification

Verify the following resources at application, review, or when a change occurs:

- jointly owned property
- real property (excluding homeplace)
- all resources when the total liquid and non liquid value exceeds 75% of the applicable resource limit
- when interest paid from a resource totals $10.00 or more a month
- vehicles (Refer to 2308 Automobiles / Vehicles.)

For all other countable resources, accept the AU member's statement of type and value unless the information provided conflicts with other information available to the agency.

2302 Ownership of Resources in ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Ownership of Resources in ABD Medicaid		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2302
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

In order for the value of a resource to be applied to the resource limit, the A/R and/or deemor must have an ownership interest in the resource, and the A/R and/or deemor must have the legal right to the use and/or disposal of the resource.

Basic Considerations

Ownership interests in property, whether real or personal, can occur in various types and forms. Since the type and form of ownership may affect the value of property and even its status as a resource, they are significant in determining resource eligibility.

Procedures

Use the following chart to determine the value of an A/R or deemor's ownership interest in a resource.

Chart 2302.1 - Determining the Ownership of a Resource

Resource	Ownership Interest	Value
Real Property	Fee Simple	Count the entire equity value to the A/R or deemor.
Real Property	Tenancy-In-Common	Determine and count the A/R's or deemor's share of the equity value (each owner does not necessarily own equal shares).
Real Property	Joint Tenancy or Tenancy by the Entirety	Divide the equity value by the number of joint owners (each owner owns an equal share).
Real Property	Life Estate	Non-FBR A/R: Exclude total value. FBR A/R: Use Chart 2322.1 - Unisex Life Estate or Remainder Interest Table to determine value. Refer to 2322 Life Estate and Remainder Interests.
Real Property	Remainder Interest	Divide the value of the remainder interest by the number of persons with a remainder interest. Refer to 2322 Life Estate and Remainder Interests.
Unprobated Estate	Heir Interest	Will: Count the value of any resources left to the A/R or deemor until probated. No Will: Use Georgia's Intestate Laws to determine the A/R's or deemor's share. Refer to 2320 Inheritances and Unprobated Estates.

Resource	Ownership Interest	Value
Financial Instrument (savings or checking account, etc.)	Joint	Consider the financial instrument to be owned in equal shares by the Medicaid A/Rs whose names are listed as owners of the instrument. Do not allow a share of the financial instrument to a Non-Medicaid owner. If the A/R rebuts ownership of or unrestricted access to the financial instrument, refer to 2334 Savings and Checking Accounts for rebuttal procedures.

Any ownership interest in homeplace property is excluded.

2303 Determining the Countable Value of Resources for ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Determining the Countable Value of Resources for ABD Medicaid		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2303
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

The countable value of a resource is its equity value as of the first moment of the first day of the month of verification.

Basic Considerations

To determine the value of a specific resource, refer to the specific section in this chapter on the particular resource.

The countable value of a non-liquid resource is its equity value.

Equity Value

Equity value (EV) is the current market value (CMV) less the following encumbrances:

- the amount of principal owed
- any prepayment penalty
- any other debts (liens, loans, etc.).

Current Market Value

The current market value (CMV) 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.

For real property located in Georgia, the CMV is the *assessed tax value* multiplied by 2.5 unless an A/R successfully rebuts this value.

First Day of Month Rule

If the total countable value of an A/R's resources, as of the first moment of the first day of the month, exceeds the resource limit, the A/R is ***ineligible*** based on resources for the entire month, regardless of fluctuations during the month.

If the total countable value of an A/R's resources, as of the first moment of the first day of the month, does not exceed the resource limit, the A/R is eligible for the entire month, regardless of

fluctuations during the month.

Procedures

Use the following chart to determine whether the A/R is eligible for ABD Medicaid based on the countable value of his/her resources.

Chart 2303.1 - Determining Eligibility Based on Countable Resources

IF the countable value of resources	THEN based on resources
does not exceed the resource limit on the first moment of the first day of the month	the A/R is eligible for the month.
exceeds the resource limit on the first moment of the first day of the month	the A/R is ineligible for the month.
does not exceed the resource limit on the first moment of the first day of the month BUT increases in value until it exceeds the resource later in the month	the A/R is eligible for the month AND DFCS must redetermine the value of resources as of the first moment of the first day of the following month.
exceeds the resource limit on the first moment of the first day of the month BUT decreases in value until it does not exceed the resource limit later in the month	the A/R is ineligible for the month AND DFCS must redetermine the value of resources as of the first moment of the first day of the following month.

Resource Eligibility at Application

For applications, verify the countable value of each resource as of the first moment of the first day of the month of application and as of the first moment of the first day of each prior month for which eligibility is being determined.

Resource Eligibility at a Review

At each review, verify the value of ***all*** resources as of the first moment of the first day of the same month.

Rebuttal of CMV of Real Property

If an A/R rebuts the Tax Digest CMV, require the A/R to obtain two estimates from knowledgeable sources, such as a realtor. Use the ***average*** of the two estimates as the CMV.

2304 Treatment of Resources For ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Treatment of Resources For ABD Medicaid		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2304
	Previous Policy Number(s):	MT 24	**Updated or Reviewed in MT:**	MT-59

Requirements

The treatment of resources is dependent upon several variables.

Basic Considerations

Non-FBR COAs vs FBR COAs

The following resources are treated differently for non-FBR and FBR A/Rs:

- burial contracts and burial space items
- cemetery lots (refer to 2311 Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items)
- funds set aside for burial
- life insurance policies
- accrued dividends earned on life insurance policies
- life estate interests
- income producing property
- household goods and personal effects
- promissory notes/loans/mortgages
- Homeplace property

> The above resources may be excluded or treated differently under Non-FBR policy (refer to the Resource Chart in Section 2399): The exclusion only applies IF the resources are owned by the A/R or transferred by the A/R to a spouse or into a trust. IF a resource excluded under Non-FBR policy is transferred to someone or something other than a spouse or a trust, a transfer of assets penalty should be developed. Refer to 2342 Transfer of Assets.

All other resources are treated the same for all classes of assistance.

> Refer to Absence from Homeplace in 2316 Homeplace: ABD Medicaid.

Special Exclusions

Certain non-liquid resources that would normally be counted may be totally or partially excluded if specific conditions are met.

Income Producing Property

Personal or real property which *currently* (or is expected to resume) produces earned income, unearned income, goods, or services may be partially or totally excluded. Refer to 2327 Property Essential to Self-Support.

Undue Hardship Provision

Refer to 2345 Undue Hardship Provision for ABD Medicaid for policy on hardship to A/R or Co-Owner.

Procedures

Bona Fide Effort to Sell

Exclude personal or real property for any month in which the A/R is making a bona fide effort to sell the property.

Evidence of a *bona fide effort* to sell includes any of the following:

- listing the property with a realtor
- a *for sale* sign on the property
- advertisement in a newspaper
- has not refused a reasonable offer (2/3 of CMV).

If the real property for which a bona fide effort to sell is being made is non-homeplace, require the A/R to sign a statement that s/he has tried to sell, is trying to sell, or will try to sell the property within the next 30 days. Require the A/R to market the resource at current market value (CMV).

Verify/document that the A/R has not refused a reasonable offer on the property (2/3 of the CMV).

Verify/Document the A/R's past and continuous efforts to sell the property at the following intervals:

- prior to approval of the application
- 9 months after approval
- every three months thereafter.

The A/R has 30 days to put the property on the market after signing a statement of intent to do so.

Restricted Allotted Indian Lands

Consider restricted allocated land owned by an individual who is of Indian descent from a federally recognized Indian tribe to be an excluded resource if the individual cannot sell, transfer or otherwise dispose of it without permission from other individuals, his or her tribe, or an agency of the Federal Government.

If an individual alleges owning land that meets the criteria above, complete the following procedures:

- obtain a copy of any document or documents that might identify it as such
- verify the allegation with the appropriate Indian agency.
- Document appropriately.

2305 Commingled Funds

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Commingled Funds		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2305
	Previous Policy Number(s):	MT 25	**Updated or Reviewed in MT:**	MT-59

Requirements

Excluded liquid resources may be commingled in various financial instruments, such as a checking account, only if they are clearly identifiable. However, there are some exceptions. Burial funds may not be commingled with non-burial funds for any ABD Medicaid COA.

Basic Considerations

Identifiability does not require that excluded funds be kept physically apart from other funds, such as in a separate bank account.

Procedures

When withdrawals are made from an account with commingled funds, always assume that non-excluded funds are withdrawn first, leaving as much of the excluded funds in the account as possible.

If excluded funds are withdrawn, the excluded funds left in the account can be added to only in one of the following ways:

- deposits of subsequently received funds that are excluded under the same provision
- excluded interest.

Interest earned by funds excluded under this provision may or may not be excluded from resources and income. Refer to Section 2399, Treatment of Income Retained After the Month of Receipt, and Interest in Chart 2399.2, Treatment of Income in ABD Medicaid, for resource and income treatment of interest earned on commingled funds.

2306 Agent Orange

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Agent Orange		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2306
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

Permanently exclude from resources unspent portions of Agent Orange Payments.

Basic Considerations

Agent Orange payments are made to Vietnam veterans exposed to Agent Orange defoliant. Payments may be made to surviving spouses.

Interest earned on unspent portions is a countable resource if left to accrue.

Procedures

Verify the date(s) and amount(s) of payments. If deposited, obtain a copy as to the date(s) and amount(s) of deposits, if available. If not available, obtain a written statement from the A/R or RP. Refer to 2305 Commingled Funds.

2307 Austrian Social Insurance Payments

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Austrian Social Insurance Payments		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2307
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

Permanently exclude from resources unspent Austrian Social Insurance Payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

Basic Considerations

Austrian Social Insurance Payments not based on wage credits granted under Paragraphs 500-506 are not excluded from resources under this provision.

Interest earned on unspent portions is not excluded from income or resources.

Procedures

If the payments were excluded from income on the basis of wage credits, exclude unspent portions as a resource indefinitely.

If the payments are not based on wage credits, obtain a signed statement from the individual as to the date(s) and amount(s) of any deposits corresponding to the Austrian Social Insurance Payments.

2308 Automobiles / Vehicles

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Automobiles / Vehicles		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2308
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

The treatment of an automobile/vehicle as a resource is dependent upon whether eligibility is determined under ABD or Family Medicaid.

Basic Considerations

"Automobile" means **any** vehicle used for **transportation**. These include cars, trucks, motorcycles, golf carts, animal-drawn vehicles and animals.

The value of an automobile may or may not be considered as a resource when determining eligibility, depending upon whether eligibility is determined under ABD or Family Medicaid. All automobiles owned by LA-D A/Rs are subject to estate recovery.

Vehicles Considered Personal Property

The following automobiles are considered personal property and the equity value of each is considered a countable resource:

- permanently **inoperable** (junked) automobiles
- recreational automobiles (boat, RV, dirt bike, etc.)

Ownership of a Vehicle

Ownership of an automobile must be established before it can be considered a resource. Refer to 2301 Family Medicaid Resources Overview and 2302 Ownership of Resources in ABD Medicaid for policy regarding jointly owned resources.

An automobile that is used by a member of the assistance unit (AU) or budget group (BG) but which is registered to and owned by another individual who is not a member of the AU or BG is not considered a countable resource.

Leased Vehicles

Leased vehicles are not considered when determining eligibility, as the AU/BG does not own the vehicle.

Adaptive Equipment

Special equipment to adapt a vehicle for use by a handicapped person is not considered in determining the value of a vehicle.

Current Market Value

The Current Market Value (CMV) of a vehicle is any one of the following:

- the assessed tax value determined by the county tag office, multiplied by 2.5
- the average trade-in value from the most current available NADA Official Used Car Guide, Kelley Blue Book, at www.kbb.com/, or at www.nada.com/
- the statement of a dealer.

If the AU claims the CMV is not representative of the value of the vehicle, the AU must be given the opportunity to provide a value rebuttal from another reliable source, such as a used car/truck dealer, automobile insurance company or classic car appraiser.

Equity Value

The Equity Value (EV) is the CMV less any indebtedness or financial encumbrances.

Verification of Debt or Encumbrances

A/R's statement may be accepted as proof of debt or encumbrances on a vehicle, unless questionable. Their statement should identify the vehicle and the current payoff amount.

ABD Medicaid

Changes in the automobile policy are effective July 1, 2005. However, implement the policy for reviews and for applications (including three prior months) beginning January 1, 2007. Exclude the value of **one** automobile per household if used for the transportation of the eligible individual/couple or a member of the eligible individual's/couple's household. This policy applies regardless of the living arrangement or the COA (even if one or both spouses are institutionalized). Assume the automobile is used for transportation, absent evidence to the contrary.

If the eligible individual/couple owns a second automobile used for transportation of them or a member of their household, the total exclusion applies to the automobile with the greater EV.

The EV of any automobile other than the excluded one is a countable resource when it:

- is owned by an eligible individual/couple and/or deemors; **and**
- cannot be excluded under another provision (e.g., property essential to self-support, plan for achieving self-support, etc.)

Automobiles may **NOT** be designated as burial funds.

Family Medicaid (Non-MAGI only) COAs

The value of a vehicle is excluded if used for either of the following reasons:

- primarily as a dwelling
- over 50% of the time for income-producing purposes.

The EV(s) of all other vehicles must be considered when determining the total countable resources for the AU.

A $4,650 exclusion of one vehicle's EV is given, regardless of the use of the vehicle.

The AU is allowed to choose the vehicle to which the exclusion is applied. Exclusions are applied in the manner most advantageous to the AU.

Procedures

ABD Medicaid

Beginning January 1, 2007, with each new application (including three months prior) and at review, verify and document the ABD A/R's ownership of each automobile. For each automobile owned, accept the individual's statement of sole or joint ownership of an automobile and his/her share of joint ownership, unless questionable. Resolve any questions by examining the title, the current year's registration, the bill of sale or Department of Motor Vehicles (GRATIS).

Verify and document usage of each automobile. Accept the A/R's statement as verification of the use of an automobile unless questionable. Determine the reason if an automobile is owned but not used for transportation. If the automobile is an antique or collectible automobile, develop the collector value.

Unless questionable, accept the A/R's statement regarding factors qualifying an automobile for an exclusion, regardless of the value of the automobile.

For an A/R who owns an automobile and who has no household members using the automobile, consider the following to determine whether the automobile should be excluded:

- is title in A/R's name only
- who uses the auto
- where is the auto parked
- can the A/R or representative provide times and date the automobile was used to transport the A/R
- is it routinely used by someone else
- what is the mileage used compared to the number of miles used to transport the member
- was the automobile purchased while in LA-D or near the time of entering LA-D
- who holds the policy and pays for the auto insurance

If it appears that the automobile is rarely or never used by the A/R or was purchased to shelter assets, count the auto as a resource.

Verify and document the CMV of an automobile from one of the following sources:

- Tag receipt or assessed tax value obtained from the county tag office or GRATIS and multiplied by 2.5
- For vehicles up to 8 years old, the CMV is the average trade-in value listed in the most current available NADA Official Used Car Guide or Kelley Blue Book
- For vehicles 8 to 18 years old, the CMV is the average trade-in value listed in the most current available NADA Older Car Guide or Kelley Blue Book
- For vehicles more than 18 years old, use the value listed for the vehicle at 18 years old.

If the A/R disagrees with the NADA or Kelley Blue Book listed value and eligibility is affected by the value, give him/her the opportunity to rebut the value.

Rebuttal evidence consists of a written appraisal of the automobile's CMV obtained by the A/R, at his/her own cost, from a **disinterested knowledgeable** source such as a used car or truck dealer or an automobile insurance company.

Provide the rebuttal source with a complete description of the automobile including year, make, model, equipment, etc. Assume the automobile to be in average condition unless there is evidence to the contrary.

Inform the rebuttal source that the estimate should show the average retail value for the automobile in the geographic area covered by the local media. If the estimate is obtained by telephone, document the file with all the pertinent facts.

The AU's statement of ownership of an automobile is accepted, unless questionable.

Family Medicaid COAs

Verify and document usage of each automobile. Accept the A/R's statement as verification of the use of an automobile unless questionable. Determine the reason if an automobile is owned but not used for transportation. If the automobile is an antique or collectible automobile, develop the collector value.

Follow the steps below to determine the countable resource value of an automobile for Family Medicaid:

Step 1 Determine what vehicle(s) are owned by the AU and determine the use of each.

Step 2 Determine if the value of any automobile(s) can be totally excluded based on use.

Step 3 Determine the year, make, and model of any remaining automobile(s) owned by the AU.

Step 4 Verify and document the FMV of an automobile from one of the following sources:

- Tag receipt or assessed tax value obtained from the county tag office or GRATIS and multiplied by 2.5
- For vehicles up to 8 years old, the FMV is the average trade-in value listed in the most current available NADA Official Used Car Guide or Kelley Blue Book
- For vehicles 8 to 18 years old, the FMV is the average trade-in value listed in the most current available NADA Older Car Guide or Kelley Blue Book
- For vehicles more than 18 years old, use the value listed for the vehicle at 18 years old.

If the A/R disagrees with the NADA or Kelley Blue Book listed value and eligibility is affected by the value, give him/her the opportunity to rebut the value.

Rebuttal evidence consists of a written appraisal of the automobile's FMV obtained by the A/R, at his/her own cost, from a **disinterested knowledgeable** source such as a used car or truck dealer or an automobile insurance company

Provide the rebuttal source with a complete description of the automobile including year, make, model, equipment, etc. Assume the automobile to be in average condition unless there is evidence to the contrary.

Inform the rebuttal source that the estimate should show the average retail value for the automobile in the geographic area covered by the local media. If the estimate is obtained by telephone, document the file with all the pertinent facts.

Step 5 Determine the EV by subtracting the amount owed from the FMV.

Step 6 Apply a $4,650 exclusion to one automobile's EV.

Total the countable value of all automobiles, add to the value of other countable resources and apply to the resource limit.

2309 Bonds - Municipal, Corporate, Government

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Bonds - Municipal, Corporate, Government		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2309
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

The value of a bond as a resource is its Current Market Value (CMV) as of the first moment of the first day of the month of verification.

Basic Considerations

A bond is a written obligation to pay a sum of money at a specified future date. Bonds are negotiable and transferable.

Municipal

A municipal bond is the obligation of a state or a locality.

Localities include a county, city, town, village, or special purpose authority, such as a school district.

Corporate

A corporate bond is the obligation of a private corporation.

Government

A government bond, as distinct from a U.S. Savings Bond, is a transferable obligation issued or backed by the Federal government. Refer to 2310 Bonds - U.S. Savings.

Procedures

Verify the CMV by contacting the seller of the bond or a securities company, such as a stockbroker.

2310 Bonds - U.S. Savings

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Bonds - U.S. Savings		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2310
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

The resource value of a U.S. Savings Bond is its current market value (CMV).

Basic Considerations

U.S. Savings Bonds are obligations of the federal government. Unlike other bonds, they are not transferable. They can only be sold back to the federal government.

If bonds are owned jointly, co-owners own equal shares of the value of the bond.

A U.S. Savings Bond is not a resource to a co-owner if another co-owner has and will not relinquish possession of it.

Procedures

All saving bonds are a countable resource. Although the minimum retention period for several savings bond series is 12 months (Series EE bonds, Series I bonds and Series HH bonds), the minimum retention period may be waived easily if the owner/family member is experiencing an illness, has need of institutional care, etc. The owner of the Bond would contact the Bureau of Fiscal Service regarding the hardship and the owner will be issued a refund of the Bond. Any A/R or deemor who owns such a Bond is required to request such a waiver. Obtain verification that the request of a refund due to hardship has been made to the Bureau of Fiscal Service. Count the value of the Bond unless proof is provided that the request of the refund was denied. Use the Table of Redemption Values for U.S. Savings Bonds to determine value.

Purchase of the bonds is not considered a transfer of resources, because the buyer is purchasing the bonds at fair market value, and if the bonds are held to maturity, the buyer will get the full return on the investment.

If the table is not available, obtain the value by telephone or in writing from a local bank. The bank will need the series, denomination, and date of purchase and/or issue date.

Document the case.

If the individual alleges that he or she cannot submit a bond because a co-owner has and will not relinquish physical possession of it, obtain a signed statement from the co-owner.

ABD Medicaid

Determine the CMV, if any, as of the first moment of the first day of the month.

Family Medicaid

Accept the A/R's statement of CMV, unless the total of all resources exceeds 75% of the resource limit. If the total resources exceeds 75% of the resource limit, the amount must be verified.

2311 Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2311
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-65

Requirements

The treatment of burial contracts and burial space items is dependent upon whether an A/R's class of assistance (COA) is FBR, Non-FBR or Family Medicaid.

Basic Considerations

Contracts

A prepaid (or pre-need) burial contract is an agreement whereby a buyer pays in advance for a burial that the seller agrees to furnish upon death of the buyer or other designated individual. A burial contract is usually with a funeral home and may include coffin, vault, flowers, embalming, cremation, etc. A cemetery contract is with owners of a cemetery and may include opening/closing of the grave, maintenance of the gravesite, mausoleum, headstone, etc. At times a burial contract may include items pertaining to the gravesite.

All burial contracts purchased in Georgia are, by state law revocable. Assume that all other contracts are revocable unless the A/R provides proof to the contrary. Treat any burial contracts that are irrevocable the same as revocable contracts.

A non-itemized contract does not indicate the cost of each item.

Only one burial contract and one cemetery contract designated on a particular individual may be considered for exclusion from resources.

For Non-FBR ABD Medicaid COAs, treat a life insurance policy that is purchased to fund a prepaid burial contract in the following way:

- if the contract is itemized, treat as a burial contract. See Procedures in this section.
- if the contract is not itemized, treat as a life insurance policy. See 2323 Life Insurance Policies.

In either case, the face value should be equal to the purchase price of the burial contract at the time of purchase. Any appreciation of the excluded funds after the date of designation may also be excluded. If the life insurance policy has not been irrevocably assigned to the funeral home, then the contract is not considered as paid in full. Notice of the irrevocable assignment must be received.

Burial Space Items

Burial space items may be part of a burial contract or owned outright. The following are burial space items:

- burial plot
- grave site
- crypt
- mausoleum
- casket
- urn
- niche
- other repository customarily and traditionally used for the deceased's bodily remains.

The term burial space item also includes necessary and reasonable improvement for additions to such spaces, including but not limited to the following:

- vaults
- headstones, markers, or plaques
- other burial containers for caskets
- arrangements for the opening and closing of the gravesite
- contracts for the care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care.

Only the value of burial space items, which are paid in full, may be exempt from resources and the burial exclusion policy. If the A/R and deemor own burial assets in excess of the burial exclusion allowance, the excess is considered as a countable resource to be applied toward the resource limit of the appropriate COA.

Examples of Non-Burial space items include: Services, Embalming, Cremation, Flowers, Cards, Newspaper, Death Certificates, Service Vehicle, etc. This list is not all inclusive.

Immediate Family

Immediate family includes the Medicaid individual's spouse; minor and adult natural, adopted and stepchildren and their spouses; natural and adoptive parents and their spouses, siblings and their spouses. If the relationship to the A/R is by marriage only, the marriage must be in effect in order for the burial space exclusion to continue to apply. Immediate family does not include members of an ineligible spouse's family unless they are also within the appropriate degree of relationship(s) to the Medicaid individual.

Procedures

Family Medicaid

Exclude up to $1500 of the combined equity value (EV) of all burial contracts and one burial plot per each AU or BG member. Count the EV of any additional plot(s) toward the resource limit. Changes in the burial contract policy are effective July 1, 2005.

Burial Contracts Non-FBR COAs

However, implement the policy for applications (including the three prior months) and reviews beginning January 1, 2007. Non-FBR A/Rs may exclude up to a total of $10,000 for burial purposes. This includes the FV of life insurance policies 2323 Life Insurance Policies, funds set aside for burial 2312 Burial Funds and the purchase price of burial contracts less paid in full burial space items.

Burial Contracts FBR COAs

FBR A/Rs may exclude up to a total of $1500 for burial purposes. This includes the FV of life insurance policies 2323 Life Insurance Policies, funds set aside for burial 2312 Burial Funds and the purchase price of burial contracts less paid in full burial space items.

Burial/Cemetery Contracts and Burial Space Items ABD COAs

Obtain an original copy of each burial/cemetery contract to verify the following:

- for whom the contract is designated
- that the contract is with a business that conducts funeral services or operates a cemetery
- if the contract is itemized
- the value of items at time of purchase
- whether the contract is paid in full at time of purchase

The purchase price of a contract is the amount paid for contract less any sales tax.

Count as a resource burial space items owned by an A/R or deemor if they are designated for anyone other than a member of the A/R's immediate family or they are not designated for use by a specific individual.

Exclude only one burial space item per person that serves the same purpose, such as a casket or an urn.

Treatment of Itemized Burial Contracts

If the contract is paid in full, the value of the contract is the purchase price less any burial space items.

Sales tax is not part of the purchase price.

If the contract is not paid in full, the value of the contract is the amount paid to date less any paid in full burial space items.

If the contract includes no burial space items, the value is the purchase price or the amount paid to date.

Treatment of Non-Itemized Burial Contracts

If the contract is not itemized, the value of the contract is the full purchase price or amount paid to date.

Allow reasonable time for the A/R to have the contract itemized if possible.

Determining the Current Value of a Burial Contract

If the contract is paid in full and includes the cost of burial space items, follow the steps below to determine the current value.

Refer to Appendix F, for the "Burial Exclusion" form **985**.

Step 1

Determine the purchase price of the contract less any sales tax.

Step 2

If the contract is itemized, subtract from the purchase price any burial space items included in the contract.

Step 3

The remainder is the value of the burial contract.

If the contract is not itemized the value is the purchase price less sales tax.

If the contract is not paid in full, follow the steps below to determine the value:

Step 1

Determine the amount paid to date on the contract.

Step 2

If the contract is itemized, subtract from the purchase price only the paid in full burial space items (if any have been paid in full).

Step 3

The remainder is the value of the burial contract.

If the contract is not itemized, the value is the amount paid to date.

The value of the burial contract may be excluded under the burial exclusion allowance or counted as a resource.

Significant Hardship

Consult the Field Program Specialist for instructions if the A/R claims that selling or cashing in of a burial contract will cause significant hardship.

Documentation and Verification of Burial Space Items

If an A/R alleges owning only one of a particular burial space item, or an A/R and spouse allege

owning no more than two, assume that the items are designated for the A/R and spouse. Document the allegation in the case record.

If an A/R or A/R and spouse allege owning more than one (or two for the A/R and spouse) of a particular burial space item, obtain a signed statement Form 987 showing the name and relationship of the person for whose burial each item is designated.

Verify the CMV and EV of all non-excluded burial space items using Form 986, found in Appendix F.

Document the case appropriately.

Burial Plots ABD Medicaid COAs

Exclude from resources only the burial plots owned by an ABD A/R or deemor that are designated for immediate family members. Count as a resource those owned for others.

Document the A/R's statement as to the number of burial plots owned.

Computing Burial Assets

Refer to the "Burial Exclusion" form 985 in Appendix F and compute the $1500/$10,000 burial funds exclusion by the value of any of the following assets owned by the A/R and deemor:

- the face value of burial insurance policies
- the face value of any life insurance policy (whole or term) on the A/R or A/R's spouse. For Non-FBR A/Rs:
  - If the FV was not used to reduce the burial exclusion allowance, then the CSV of the life insurance is a countable resource.
  - All or part of the FV of an A/R's life insurance may not be designated for his/her spouse. See 2323 Life Insurance Policies.
- The current value of a burial contract.
- Funds set aside for burial (less any interest/dividends left to accrue). Funds designated for burial must be owned by the individual or jointly owned between the A/R and spouse. See 2312 Burial Funds.

If the A/R or deemor owns burial assets in excess of the burial exclusion allowance, determine which assets to exclude. Guidelines for this determination:

1. FV of term life insurance must be applied to the burial exclusion allowance first.
2. Other assets should be applied in the most advantageous way for the AR or deemor.
3. Whole life policies may not be partially excluded. If the full FV cannot be excluded, the CSV must be counted as a resource.

If a burial fund or the countable value of a burial contract is included in the burial asset exclusion, the Form 985 **must** be signed to specifically designate those items for burial.

2312 Burial Funds

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Burial Funds		
	Effective Date:	October 2022		
	Chapter:	2300	**Policy Number:**	2312
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-67

Requirements

For ABD Medicaid an A/R or personal representative may designate non-excluded resources as funds set aside for burial for the A/R and/or the A/R's spouse.

There is no burial fund exclusion in Family Medicaid.

Basic Considerations

To designate funds for burial the A/R or personal representative must sign a statement (Form 985) at application or within 30 days of review that includes the following:

- the value and owner of the resource
- for whose burial the resource is set aside
- the form(s) in which the resource is held (burial contract, bank account, etc.)
- the date the individual first considered the funds set aside for the burial of the person specified.

Any amount may be designated for burial. However, only the allowable burial exclusion amount will be exempt from the countable resource determination.

For Q Track applications, accept the A/R's statement regarding designation of burial funds.

If an A/R uses excluded burial funds for a purpose other than the burial arrangements of the A/R or the A/R's spouse for whom the funds were set aside, the amount used will be considered as income in the month following the expiration of timely notice. However, this penalty applies only if the A/R's resources would have exceeded the resource limit for the month in which the excluded funds were used had the exclusion not been given.

Any appreciation in the value of excluded burial funds is excluded from resources and income, if left to accrue. Funds may be considered designated prior to eligibility, and any appreciation of the funds after the date of designation may be excluded.

Additional amounts can be added to the original designation until the excluded amount reaches the maximum allowed. Accumulated interest, if left to accrue, earned on the original exclusion is not included in determining if the maximum exclusion has been reached.

Whether an A/R's class of assistance (COA) is non-FBR or FBR will determine the following:

- the types of resources which may be designated
- the amounts which may be excluded
- whether or not the burial funds may be commingled.

Non-FBR COAs

Non-FBR A/Rs and the community spouse may designate ANY non-excluded resource, liquid or non-liquid.

> Funds designated for burial must be owned by the individual or jointly owned between the A/R and spouse. Contracts (promissory notes, loans, or property agreements), automobiles, and CSV of life insurance may not be designated as burial funds.

The change in Burial Funds policy is effective July 1, 2005. However, it is to be implemented with applications (including three prior months) and reviews beginning January 1, 2007. The maximum burial exclusion is $10,000 for the A/R and $10,000 for the A/R's spouse. Any amount may be designated for burial, but only up to the cumulative amount of $10,000 may be excluded. **This maximum includes the FV of life insurance (2323 Life Insurance Policies), burial contracts (2311 Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items) and burial funds.**

FBR COAs

FBR A/Rs may designate non-excluded, **liquid** resources only as burial funds. Non-liquid resources cannot be designated for burial.

The maximum burial exclusion for FBR A/Rs is $1500 for the A/R and $1500 for the A/R's ineligible spouse. Any amount may be designated up to the limit. This is the maximum including the FV of life insurance (2323 Life Insurance Policies) burial contracts (2311 Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items) and burial funds.

All ABD Medicaid COAs

Designated burial funds **CANNOT** be commingled with **non-burial funds**. If the A/R wishes to designate only a portion of a liquid resource, the A/R must put the designated portion into a separate account/instrument.

Types of designated funds may include the following:

- financial accounts, such as savings, checking accounts, CDs, stocks, bonds, etc.
- (FBR COA'S ONLY) – the CSV of non-excluded life insurance policies
- amounts paid toward installment burial contracts
- non-excluded portions of revocable burial contracts
- cash.

Burial funds may be designated retroactively to 4/1/88 if they are separately identifiable and can be tracked.

In order for the funds to be designated retroactively, the funds must still be available at the time of

application, unless spent on a now deceased A/R's burial.

Non-FBR A/Rs: If the burial funds are commingled with non-burial funds, allow the exclusion, but require that they separate the funds within 30 days. Verify that the separation of funds has occurred. Designated burial funds may be in excess of the burial exclusion limit and not have to be separated (property); however, the excess will be a countable resource.

Once the date that burial funds were considered as set aside for burial has been established **for FBR COAs**, the exclusion may be applied the following month, provided the following month is no earlier than the first month of Medicaid eligibility.

Reduce the $1500/$10,000 burial funds exclusion by the value of any of the following assets owned by the A/R and deemor:

- the face value of burial insurance policies. See 2323 Life Insurance Policies.
- the face value of any life insurance policy (whole or term).
- For Non-FBR A/Rs:
  - All or part of the FV of one spouse's insurance may NOT be applied to the other spouse's burial exclusion. See 2323 Life Insurance Policies.
  - If the FV was not used to reduce the burial exclusion amount, then the CSV of the life insurance is a countable resource.
- the non-excluded portion of any pre-need burial contract. See 2311 Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items.
- funds set aside for burial (less any interest/dividends left to accrue). Funds designated for burial must be owned by the individual or jointly owned between the A/R and spouse.

Use the value of the burial assets in the most advantageous way for the A/R/deemor so that it does not exceed the $1500/$10,000 burial exclusion.

Determining the Resource Value of Burial Funds at Application and Review

For applications and future reviews, when burial funds include both excluded and countable assets, verify the current value of the designated resource. Take the current value of the total designated resource and multiply it by the non-excluded percentage of the resource to determine the current resource value of the non-excluded portion. Determine the ratio of the non-excluded portion of the funds to the excluded portion by dividing the value of the non-excluded portion by the total amount of the commingled funds. Carry the quotient to 3 decimals.

The decimal is also used to project interest income earned on the non-excluded portion.

The same ratio (decimal) may be used every year as long as there are no deposits or withdrawals from the total designated fund. Otherwise, a new ratio calculation is required.

Refer to Appendix F, for "Burial Exclusion" Form 985 form to help complete the value of burial funds.

2313 Contracts: Promissory Notes, Loans, and Property Agreements

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Contracts: Promissory Notes, Loans, and Property Agreements		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2313
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

The resource value of a promissory note, loan or property agreement is determined for all ABD Medicaid COAs. This determination is made effective May 1, 2005, on existing notes, loans or property agreements that were previously excluded and on newly established contracts.

This policy does not apply to Family Medicaid COAs.

Basic Considerations

The context of the instructions in this section assumes that the individual is the creditor (lender of money or seller of property) and therefore the owner of the promissory note, loan or property agreement.

For the owner of the agreement (the seller), a contract is a resource. The property itself is not a resource because the seller cannot legally convert it to cash while it is encumbered by the agreement.

For the buyer of the property (debtor/borrower), the contract is not a resource. However, the property purchased may be a countable resource in the month following the month of the transaction.

Legal Contracts may consist of:

- A promissory note is a **written**, unconditional agreement whereby one party promises to pay a specified sum of money at a specified time (or on demand) to another party. It may be given in return for goods, money loaned, or services rendered. It may NOT be for real estate property; however, it may be used as evidence of a **debt** for the transfer of the property.
- A loan is a transaction whereby one-party advances money to or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral and must be enforceable under state law. A written loan agreement is a form of promissory note. Refer to 2347 Loans (Borrower), for procedures for the Borrower.
- A property agreement is a pledge or security of particular property for the payment of a debt or the performance of some other obligation within a specified period. Property agreements on real estate generally are referred to as mortgages but also may be called land contracts, contracts for deed, deeds of trust, etc. Personal property agreements such as a pledge of crops, fixtures, inventory, etc., are commonly known as chattel mortgages. Property agreements may

NOT be in the form of an oral loan.

Terminology

Actuarially Sound

Actuarially sound means that the average number of years of expected life remaining for the owner of the contract must be equal to or more than the number of years stated in the contract to be paid. Refer to Life Expectancy Table.

Amortized

Amortized means the payments are equal with a reasonable interest rate (at least 1% interest) so that the last payment is the same as the previous payments. For Medicaid purposes, payments must be monthly only. Any other schedule of payments is not considered as amortized.

Negotiable Agreement

A negotiable agreement is an agreement whereby the ownership of the instrument itself and the whole amount of money expressed on its face can be transferred (e.g., sold) from one person to another. If the agreement may be sold, it is negotiable.

Non-Negotiable Agreement

If the contract plainly states that it is not transferable under any circumstance, it is non-negotiable. A non-negotiable contract is considered a transfer of assets for less than the value unless it is:

- Actuarially sound,
- Fully amortized with a reasonable rate of interest,
- Free of any conditional or self-canceling clauses.

Original Principal Balance

The original principal balance is the amount owed to the creditor when the agreement was established.

The outstanding principal balance is the balance in the month for which a determination is being made (amount loaned less amount paid on principal).

Oral Loans

Oral loans are not valid for promissory notes or property agreements. If the **Loan** is an Oral Loan Agreement, obtain a statement from each of the parties involved (Lender and Borrower) acknowledging the borrower's obligation to repay and obtaining the following information:

- The date and amount of the original loan
- Any collateral used
- The schedule and amount of payment if any, or other plan for repayment (e.g., borrower plans to repay the loan when s/he receives expected income)

- The outstanding principal balance
- The interest rate
- Copies of checks or receipts of payments showing principal and interest

If both parties agree that an oral loan exists, consider the oral loan to be a contract. Otherwise, the oral loan agreement is not a contract, and therefore not a resource to the lender. Consider a transfer of resources. Refer to 2342 Transfer of Assets.

Procedures

Follow the steps below to determine the treatment of a contract created prior to 10/1/2006:

Step 1 From the A/R or PR, obtain a copy of the contract for the file, including payment schedule and amounts.

Step 2 Determine the original principal balance using the contract. Cease development, if including the original principal balance, as shown in the contract DOES NOT cause ineligibility in resources. Count the original principal balance as a resource. Count the interest portion of the payment as income.

Proceed to Step 8.

For computing interest portion of payment, outstanding principal balance, etc., refer to “Computations”, page 9, in this section.

If the original principal balance along with the other resources exceeds the resource limit, proceed to Step 3.

Step 3 Determine the outstanding principal balance and if the contract provides for payments to be made monthly. If the contract is not in the form of monthly payments, STOP. If this is a new application, count the outstanding value of the contract as a resource. If this is a review, give the A/R 30 days in which to have the contract converted to monthly payments. If payments **are** made monthly proceed to Step 4.

Step 4 Cease development, if including the outstanding principal balance DOES NOT cause ineligibility in resources. Count the outstanding principal balance as a resource. Count the interest portion of the payment as income. Proceed to Step 8.

If the outstanding principal balance along with other resources is over the resource limit, notify the A/R of closure/denial, possibility of transfer of assets, and the right to rebut the value of the outstanding principal balance. See Appendix F, “Notice of Review of Promissory Note, Loan or Property Agreement”. If this is an initial application, deny the case as over resources pending rebuttal. If this is a review, leave the case open pending receipt of a rebuttal. If a rebuttal is not received, close the case on the 31st day allowing for timely notice. If the contract is rebutted, proceed to Step 5 on rebuttal process.

Step 5 In order to rebut the value of the contract, the A/R or RP must obtain sworn affidavits from two independent and knowledgeable sources that buy notes. One of these sources shall be chosen by DFCS. To effectively rebut the outstanding principal balance, the affidavit must show that the Current Market Value (CMV) of the contract is less than its outstanding principal balance and must include the following information:

- Do you buy contracts?
- What type?
- How long have you been buying contracts?
- How are you knowledgeable about the business?
- Would you be willing to buy this contract?
- If yes, how much would you pay for this contract?
- If not, why wouldn't you buy the contract?
- What factors did you use to arrive at this amount?

The broker does not have to buy the contract. They only need to appraise the contract, provide a value and the other information listed.

Knowledgeable sources include anyone regularly engaged in the business of making such evaluations, such as banks or other financial institutions, private investors or real estate brokers.

Knowledgeable sources may be found in the telephone book, yellow pages or internet. The estimate must indicate the name, title, and address of the source.

Calculating Value After Rebuttal

IF	THEN
Both brokers provide a value of the contract,	count the higher offer as a resource, even if it is higher than the outstanding principal balance.
Only one broker provides a value of the contract,	count that amount as a resource.
both brokers provide a zero value to the contract,	it has a zero-resource value.

If the broker rebutted value along with other resources is above the resource limit, the A/R is ineligible. Close/deny the case as over resources, using the "Notice of Termination of Medicaid Benefits" found in Appendix F. Waive Georgia Gateway generated notice.

If the broker value along with other resources is below the resource limit, use the rebutted amount as the countable resource value of the note in the eligibility determination process. Count the interest portion of the payment as income. Proceed to Step 6.

Step 6 Determine if the contract is amortized, actuarially sound, and negotiable/non-negotiable with exceptions. See Terminology definitions. If the contract is NOT amortized, NOT actuarially sound or non-negotiable, it is considered invalid. Using the chart below, compute a transfer of assets penalty from the date the note was established using the difference between the original principal balance and the rebutted value. Any penalty will begin with the month the contract was established. The look back period would begin from the month of application. If all or part of the contract is returned to the owner of the contract, recompute any penalty using the new value of the contract. Refer to 2342 Transfer of Assets.

Type of Asset in Contract	Contract Is Valid	Contract Is Invalid
Real property	No transfer penalty	Yes transfer penalty
Goods & services	No transfer penalty	Yes transfer penalty
Money	Yes transfer penalty	Yes transfer penalty

Step 7 *Result of the Penalty*

IF the penalty period:	Then the Resource Value is:	And Then the Countable Income is:
Has expired,	the rebutted or outstanding value of the contract, if not rebutted,	only the interest portion of the payment. Proceed to Step 8.
Has NOT expired,	the rebutted or outstanding value of the contract, if not rebutted,	the interest portion of the payment, if the AU remains open. Notify the A/R of the transfer penalty. Proceed to Step 8.

Step 8 Proceed with the eligibility determination process, including basic eligibility criteria, income/resource eligibility and PL/CS as applicable to the COA.

Use the interest payment at the time of application unless it changes significantly from month to month (Refer to 2558 Significant Change in Income or IME.) Then annually change to the interest rate in the month of annual review.

DRA - Contracts Created 10/1/06 or After

Follow the steps below to determine the treatment of a contract created on or after 10/01/2006.

Step 1 From the A/R or PR, obtain a copy of the contract for the file, including payment schedule and amounts.

Step 2 Determine if the contract is secure or unsecure.

Secure Contracts – with collateral
Unsecure Contracts – without collateral

Step 3 Determine if the contract meets all of the following:

- The repayment terms must be actuarially sound;
- Payments must be amortized (made in equal monthly amounts during the term of the loan) with no deferral of payments and no balloon payments;
- Must not contain a prepayment clause; and
- The note, loan, or mortgage must prohibit cancellation of the debt upon death of the lender.

Step 4 If the contract is unsecure and meets **all** of the above criteria, stop and count the monthly payment as unearned income.

If the contract is secure and meets all the above criteria, it is still a countable resource if it has value and can be sold.

If the contract (secure or unsecure) does not meet all of the above criteria, it must be treated as a transfer of assets.

Step 5 Develop a transfer of assets penalty on the entire outstanding balance due as of the month of the individual's application for Medicaid coverage for long-term care. You must verify by cancelled check, bank statement, or other reliable source the repayment terms according to the contract and payment schedule.

If the payor of the note dies prior to paying the debt in full, the Medicaid member must take legal action to recover the remaining balance of the note from the payor's estate and provide documentation of such action. If the member fails to provide documentation of such action, the remaining balance is considered a transfer of assets and penalty should be applied.

Special Considerations

Non-Payment on Contracts: As long as the requirements for the contract are met and payments made directly to the A/R, no transfer has occurred.

- If the A/R should "forgive" payments on the contract, compute a transfer penalty on the outstanding balance, not deducting forgiven payments from the original balance. The penalty start date would be the first month in which a payment was forgiven.
- If the A/R is not actually receiving the payments because the payments are made to a third party, compute a transfer penalty on the outstanding balance not deducting the payments made to the third party.
- If the A/R reduces the outstanding principal balance of the contract by purchasing items for people other than the spouse or by giving away a portion of the outstanding principal balance, then compute a transfer penalty based on the amount of the purchased item or the amount that was given away.

Defaulting on payments: Should the borrower default on payments on contracts that are actuarially sound and fully amortized, including so called "paid ahead contracts", the owner of the contract:

- MUST take legal action to foreclose on the contract within 60 days of the default.
- Must provide verification of the action being taken.
- If no action to foreclose on the contract is taken, the owner of the contract is considered to have transferred assets equal to the remaining value of the contract. The effective date of this transfer is the date the payments stopped.

A contract in which the full interest payment is not made monthly is considered as a default of the payment.

Questionable Contracts: For any questionable contracts, such as real estate property which has been put in a promissory note or oral loan, contact your Medicaid Program Specialist for instructions.

Interest Computations

Step 1 To determine the amount of interest to be paid on a contract, multiply the original contract amount by the interest amount (ex. $50,000 X .03 = $1500 interest amount to be paid.)

a. _____ original contract amount

b. x _____ interest on contract in decimal point

c. = _____ yearly interest to be paid on the loan

Step 2 To obtain the monthly amount that should be paid in interest the first year of the contract, divide the interest amount to be paid by 12 (ex. $1500/12 = $125 monthly amount of interest paid).

a. _____ (1.c) yearly interest due on loan

divided by 12 months

b. = _____ monthly amount of interest to be paid (count as monthly income)

Step 3 To determine the outstanding principal balance, subtract the monthly amount of interest paid from the monthly payment to be made (ex. Monthly payment is $200 - $125 = $75 monthly principal payment).

a. _____ total amount of monthly payment

b. - _____ (2.c) monthly amount of interest to be paid

c. = _____ monthly payment on principal

Step 4 Next multiply the monthly payment amount on the principal by the number of actual payments made to date by the A/R (ex. 10 payment made to A/R X $75 = $750).

a. _____ (3.c) monthly payment on principal

b. x _____ number of monthly payments made to date

c. = _____ amount of principal paid to date

Step 5 The outstanding principal balance, could then be computed by subtracting the actual payments made to date from the original amount of the contract (ex. $50,000 - $750 = $49,250 outstanding principal balance).

a. _____ (1.b) original contract amount

b. - _____ (4.c) amount of principal paid to date

c. = _____ Outstanding Principal Balance.

Annual Review: Each year at review this process will need to be redone. The interest payments should go down each year. The next year, however, instead of using the original amount of the contract, start with the outstanding principal balance obtained in Step 5 the previous year. That will be the amount used beginning with Step 1.

2314 Disaster Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Disaster Assistance		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2314
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

Unspent portions of Federal Disaster Assistance are permanently excluded as a resource.

Basic Considerations

To be excluded as a resource, Disaster Assistance must have met requirements for excluding it as income.

Interest earned on unspent Disaster Assistance is excluded as income and resources.

Procedures

Verify that unspent Disaster Assistance was excluded as income. Verify the dates and amounts of payments.

If payments were deposited into a financial account, obtain a copy of the account statement(s) to determine the dates and amounts of deposits.

Refer to Section 2305, Commingled Funds, for information on how to treat Disaster Assistance payments commingled in a financial account with other non-excluded resources.

2315 Dividends, Accrued

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Dividends, Accrued		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2315
	Previous Policy Number(s):	MT 26	**Updated or Reviewed in MT:**	MT-59

Requirements

Accrued dividends earned on financial investments, such as stocks, are countable resources separate and apart from the investment resource. This applies to all ABD Medicaid classes of assistance (COA). They are excluded in Family Medicaid COAs.

Whether or not accrued dividends on life insurance policies are countable resources is dependent upon whether the life insurance policy is excluded for burial purposes and is for a Non-FBR A/R.

Basic Considerations

A dividend is a share of surplus company earnings paid on some financial investments and life insurance policies.

Accrued dividends are dividends that an A/R has constructively received but left in the custody of the company.

Non-FBR COAs

For Non-FBR COA, dividends left to accrue on Excluded life insurance policies are excluded. Dividends left to accrue on countable life insurance are a resource. Dividends actually received are income in the month received.

FBR COAs

For FBR COAs, dividends left to accrue on all life insurance policies (including excluded policies) are countable resources, separate and apart from any CSVs.

If a policy states non-participating or does not pay dividends no further development of dividends is required. Otherwise, verify from the insurance company whether a policy earns dividends and the amount of accrued dividends as of the first day of the month of verification.

Procedures

Verify from the source the value of any accrued dividends as of the first moment of the first day of the month of verification.

2316 Homeplace: ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Homeplace: ABD Medicaid		
	Effective Date:	September 2024		
	Chapter:	2300	**Policy Number:**	2316
	Previous Policy Number(s):	MT 68	**Updated or Reviewed in MT:**	MT-73

Requirements

A non-institutionalized A/R's homeplace, regardless of value, is excluded from resources in its entirety. An institutionalized A/R's homeplace is a countable resource, but the value will be considered exempt in certain instances.

Basic Considerations

The homeplace is property in which the A/R or a deemor has an ownership interest and that serves as the principal place of residence of the A/R, the A/R's spouse or other dependent relative.

The homeplace consists of the following:

- the shelter in which the A/R lives
- the land on which the shelter is located (home plot)
- all land which adjoins the home plot if the adjoining land is not completely separated from the home plot by land in which neither the A/R nor a deemor has an ownership interest.

  Easements and public rights of way do ***not*** separate the property of the homeplace.

- all other buildings located on the homeplace property.

SSA does not consider a ***vacant*** homeplace to be an excluded resource for purposes of determining SSI eligibility. A vacant homeplace may be an uncounted resource for an ABD Medicaid A/R only if the A/R resides in LA-D, or a dependent relative resides in the homeplace. (See DRA policy change below.) However, the homeplace will be designated as a countable resource if and when the homeplace is no longer in A/R's name.

A **dependent relative** can be a spouse, son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, grandmother, grandfather, aunt, uncle, sister, brother, stepsister, stepbrother, half-sister, half-brother, niece, nephew or cousin.

Dependency may be found where the relative alleges any reasonable degree of reliance on the A/R's homeplace. Reasonable factors of dependency are age, medical reasons, financial circumstances, etc. The degree of dependency is not material. It is not necessary to assign a dollar limitation for determining whether financial dependency exists.

The Deficit Reduction Act (DRA) of 2005, enacted 2/8/06, has made substantial changes in the way

the homeplace is considered for A/Rs in LA-D.

Katie Beckett COA.

As of 10/1/06, but beginning with new and pending applications and reviews in 2/1/07, LA-D A/Rs, who own homeplace property with an equity value in excess of the **yearly updated** excess home equity limit, shall no longer be eligible for payment of nursing facility and other long-term care Medicaid services. Some exceptions apply. See Procedures.

Excess Home Equity Limit

1/1/2016 - 552,000	1/1/2022 - 636,000
1/1/2017 - 560,000	1/1/2023 - 688,000
1/1/2018 - 572,000	1/1/2024 - 713,000
1/1/2019 - 585,000	
1/1/2020 - 595,000	
1/1/2021 - 603,000	

Absences from Homeplace

Absence for A/Rs in LA-A, B, or C

Georgia Homeplace - A/Rs in LA-A, B, or C

If the absent A/R's home is located in Georgia, the homeplace will continue to be excluded from resources if any one of the following conditions is met:

- The A/R or PR states in writing that the A/R plans to return to the homeplace.
- The A/R's spouse or dependent relative continues to live at the homeplace while the A/R is absent.
- Sale of the homeplace would cause undue hardship to a co-owner of the homeplace because of loss of housing.

Out of State Homeplace - A/Rs in LA-A, B, or C

An out-of-state homeplace may be excluded from resources during the A/R's absence only if the A/R's spouse or dependent relative lives in the homeplace or if the A/R goes into LA-D.

Absence from Homeplace for A/Rs in LA-D

The homeplace of an A/R residing in LA-D is a countable resource effective the first full month that the A/R resides in LA-D. However, the value of the homeplace may not be counted in the resource determination, as long as the A/R remains in LA-D, retains ownership interest and, as of 10/1/06, has equity value at or less than the excess home equity limit. See Procedures and Special Consideration in this section.

Procedures

Step 1

Verify and document the A/R's ownership interest in homeplace property. Refer to Section 2060 - ABD Medicaid Application Processing for guidelines on completing a property search.

Step 2

Scan copies of any legal documents obtained via the property search or in the possession of the A/R or Form 991 - Property Search Record into the document imaging system and document GA Gateway.

Step 3

For LA-D A/Rs or FBR A/Rs whose home is not excluded, determine the equity value by obtaining the current market value (CMV) minus any encumbrances (mortgage, legitimate and/or bona fide home equity loan or reverse mortgage). Refer to Section 2303 - Determining the Countable Value of Resources for ABD Medicaid.

To determine if the loan is bona fide, obtain the following at a minimum:

- Copy of the note
- Verify balance
- Verify rate schedule
- Verify payments

If the A/R cannot verify the loan is bona fide, do not use the loan to offset the equity value of the home.

Step 4

If an A/R residing in LA-A, B, or C intends to return to a homeplace, obtain the A/R's or PR's **written** statement for the case record.

If the spouse or dependent relative lives in a Georgia or out-of-state homeplace, document the A/R's or PR's statement. If questionable, develop further by verifying with a home visit, collateral contact, etc.

Accept and document the A/R's or PR's statement as to the degree of relationship and dependency unless questionable.

Step 5

For LA-D A/Rs:

Beginning 2/1/07 with new applications, applications pending since 10/1/06 and at each review, do the following:

- If the homeplace is valued at excess home equity limit or less, do not count the value of the homeplace in the resource determination as long as the A/R remains in LA-D and retains ownership of the homeplace.
- If the homeplace is valued greater than the excess home equity limit, the A/R is not eligible for

payment of nursing facility and other long-term care Medicaid services, unless the following is residing the in A/R's home:

- the A/R's spouse
- the A/R's child who is under age 21 or is blind or permanently disabled as defined by section 1614 of the DRA.

> If one or more of the above exceptions are not met, for NH and institutionalized hospice, do not authorize a vendor payment. For all home and community based waivered COAs, deny/close the case.

See Special Considerations below.

Special Considerations

Transfer of Homeplace

Effective with OBRA '93, the homeplace is a countable resource for A/Rs in LA-D, even though the value may not be considered in the resource determination. For any homeplace transferred on or after 8-11-93 (OBRA '93), presume that the transfer was made for the A/R to avoid estate recovery, qualify for or to continue to qualify for Medicaid under OBRA '93. Homeplace transfers done on or after 2/8/06 for less than the FMV by either the A/R or spouse will result in a transfer of assets penalty. See exceptions in Section 2342 - Transfer of Assets.

Determine if the individual received FMV for the transferred homeplace property. If the individual received FMV for the property, a transfer of asset for less than the FMV does not apply. However, if the individual did not receive FMV for the property, compute a transfer of assets penalty. This policy applies even after the individual has established Medicaid eligibility. For reviews or specials, consider a transfer penalty on any transfer of homeplace property done 6/1/05 or after. For applications, consider a transfer penalty on any transfer of homeplace within the 36-month look back period or 60-month look back period effective 2/8/06. Undue hardship policy may apply. Refer to Section 2345 - Undue Hardship Provision for ABD Medicaid and Section 2342 - Transfer of Assets.

Co-Ownership of Homeplace

If the overall equity interest in the home is shared by co-owners, equity interest is determined by dividing the total equity interest by the number of shared owners proportional to their interest in the property.

Other Medicaid COAs

A/Rs determined ineligible for payment of nursing facility or long-term care Medicaid services due to substantial home equity are eligible for other Medicaid services if otherwise eligible for Medicaid.

Undue Hardship Waiver

A/Rs may request the home equity provisions be waived in the case of a **demonstrated undue hardship**. Refer to 2345 - Undue Hardship Provision for ABD Medicaid.

Rental of Homeplace Property

Rental of Homeplace property is not subject to the Rental Property policy (6000/6% rule), as long as A/R retains ownership interest in the property. Count rental income as unearned income in the month of receipt.

2317 Homeplace: Family Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Homeplace: Family Medicaid		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2317
	Previous Policy Number(s):	MT 3	**Updated or Reviewed in MT:**	MT-59

Requirements

A Family Medicaid applicant/recipient's (A/R's) homeplace, regardless of value, is an excluded resource in its entirety.

Basic Considerations

A homeplace is property in which an A/R has an ownership interest and that serves as the principal place of residence of the A/R.

Only one homeplace per AU is exempt. The homeplace includes the following:

- the house, building or other shelter in which the A/R lives
- the land on which the homeplace is located (home plot)
- all land contiguous to the home plot

> If the A/R owns a homeplace and s/he and another individual jointly own land contiguous to the homeplace property, the jointly owned contiguous property is not considered part of the homeplace and is therefore not excluded.

> Easements and public rights of way, including roads do not separate the property of the homeplace. Surrounding property separated by property owned by individuals other than the A/R is not considered part of the homeplace and is therefore not excluded.

- All other outbuildings located on the homeplace property.

> Buildings on the homeplace such as other houses or businesses, which are clearly not part of the home and its outbuildings, are not excluded. Only one home and its outbuildings are exempt.

The original homeplace may have been expanded by purchase of property contiguous to the homeplace, therefore, more than one deed may exist for the homeplace. These multiple deeds are considered a single homeplace provided all deeds are in the name of the A/R and/or the A/R's spouse.

The homeplace may continue to be excluded from resources when the A/R is absent from the home for any of the following reasons:

- illness

- vacation
- uninhabitability caused by natural disaster or other casualty
- employment
- training

Land or a lot purchased with the intent to build a home is excluded only if the AU currently does not own a home.

A partially built home is excluded only if the AU currently does not own a home.

Money derived from the sale of a homeplace must be reinvested in another homeplace within six months. If a new homeplace is not purchased, the proceeds from the sale are considered a resource and are counted in the eligibility determination. If a new homeplace is purchased, but the purchased price is less than the proceeds from the sale of the previous homeplace, the unspent proceeds are considered a resource and are counted in the eligibility determination.

2318 Home Replacement Funds

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Home Replacement Funds		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2318
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

When an individual sells an excluded home, the proceeds of the sale are excluded as a resource if the individual plans to use the proceeds to buy another home that can be excluded and does so within the appropriate time frame of receiving the proceeds.

Basic Considerations

Family Medicaid

If a Family Medicaid AU sells an excluded homeplace, the proceeds derived from the sale must be reinvested in another homeplace within six (6) months. If not, the proceeds from the sale are considered a resource and counted in the eligibility determination.

ABD Medicaid

If an ABD Medicaid A/R sells an excluded homeplace, the proceeds from the sale are excluded as a resource if the individual reinvests the proceeds in another homeplace which can be excluded within three (3) full calendar months of receiving the proceeds.

It is permissible for the ABD Medicaid A/R to reinvest the proceeds into a homeplace that will be jointly owned by the A/R and others.

If the ABD Medicaid A/R receives the proceeds from the sale of their homeplace under an installment contract, the contract is an excluded resource for as long as the following conditions are met:

- The individual plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home.
- The home is purchased within three (3) full calendar months of receiving such down payment or installment payment.

If an ABD Medicaid A/R receives the proceeds from the sale of their homeplace in a lump sum, the proceeds are the net amount the seller receives at settlement.

If paid in installments, the proceeds consist of the following:

- any down payment
- any portion of any subsequent payment that is not interest.

Use of proceeds to buy another excluded home includes payment of any costs that stem from the purchase. These include, but are not necessarily limited to, the following:

- down payment
- settlement costs
- loan processing fees and points
- moving expenses
- necessary repairs to or replacements of the new home's structure or fixtures, such as roof, furnace, plumbing, built-in appliances, that are identified and documented prior to occupancy
- mortgage payments.

Use of proceeds to pay other costs will warrant their exclusion if such costs are identified and documented prior to occupancy and stem directly from the purchase or occupancy of the new home.

Within three (3) full calendar months means by the end of the last day of the third month after the month in which the proceeds are received.

Using the proceeds includes obligating them by contract as well as actually paying them out.

Lump Sum Proceeds Received by ABD Medicaid A/R's

If lump sum proceeds are not used within 3 months, the exclusion of unused funds will be revoked retroactively to the date of their receipt.

Installment Payments Received by ABD Medicaid A/R's

If installment payment proceeds are not used within 3 months, the exclusion of the installment contract itself, and of the unused portion of any installment payments, will be revoked retroactively to the date the unused proceeds were received.

The exclusion of an installment contract, once revoked, will be reinstated if the individual intends to and does use the entire principal portion of a subsequent installment payment toward the purchase of another excluded home within 3 full calendar months of receiving such installment payment.

Procedures

ABD Medicaid

Explain the home replacement exclusion to any individual who has sold an excluded home (if it is not too late to exclude any of the proceeds) or who plans to do so. Include the date, if known, by which the proceeds must be used in order to qualify for the resource exclusion.

Obtain a signed statement from the individual as to whether s/he intends to use the proceeds to buy another home by the date specified. If so, the statement must also reflect his or her understanding that the exclusion of any funds not used by the date specified will be revoked retroactively.

Installment Contracts

When the proceeds are being paid in installments, the individual's statement of intent must reflect his/her understanding that, if the non-interest portion of any payment is not used within 3 months of its receipt, the exclusion of the unused portion of such payment and the contract itself will be revoked retroactively to the date of receipt of such payment.

Review at End of Exclusion Period

Create a task to contact the individual in the last month of the exclusion period to determine if the proceeds have been committed to the purchase of a new home.

If the amount paid at settlement on the new home equals or exceeds the lump sum received for the old home, cease development of the lump sum proceeds as a resource.

Documentation

Document the case and upload a copy of the settlement sheet, contract for sale and/or evidence that shows the net proceeds of the sale and how paid or payable, such as paid in full at settlement, dates and amounts of the down payment and installment payments, interest, etc.
Document with the same type of evidence used to document the proceeds of the sale of the prior home and, if necessary, with bills, receipts, or other evidence of related allowable expenses.

Installment Payments

Unless there is a question of unstated income or previously undetected resources, cease current development if both the following conditions are met:

- The down payment on the new home equals or exceeds the down payment received from the sale of the prior home.
- Monthly payments on the new home equal or exceed the non-interest portion of the installment payments being received on the prior home.

Lump-Sum Proceeds of Down Payment

Document use of the proceeds for related allowable expenses if either of the following occurs:

- The amount paid at settlement for the new home is less than the lump-sum proceeds of the sale of the prior home.
- The down payment on the new home is less than the down payment received from the sale of the prior home.

If all of the proceeds will NOT be used within 3 months, redetermine the value of countable resources for the months after the proceeds were received. Include the following as a countable resource:

- The unused portion of the lump-sum proceeds or down payment.
- The value of an installment contract.

2319 Household Goods and Personal Effects

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Household Goods and Personal Effects		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2319
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

The countable value of household goods and personal effects is dependent on whether the items are for personal use or are for investment purposes.

All household goods and personal effects are excluded in Family Medicaid.

Basic Considerations

Household Goods

Household goods are items of personal property customarily found in the home and used in connection with the maintenance, use, and occupancy of the premises as a home. They include furniture, appliances, television sets, carpets, cooking and eating utensils, dishes, etc.

Personal Effects

Personal effects are items of personal property that are worn or carried by an individual or that have an intimate relation to him/her. They include clothing, jewelry, personal care items, prosthetic devices, and educational or recreational items such as books, musical instruments or hobby materials.

Investment Property

All household goods and personal effects owned by non-FBR A/Rs and deemors are excluded as resources, regardless of value.

Effective October 1, 2006, but beginning 2/1/07 for all new applications (including three months prior and pending) and reviews, personal property that an A/R or deemor acquires or holds because of its value or as an investment is treated as follows:

- As a countable resource and
- Is NOT considered to be household goods or personal effects for the purposes of that exclusion.

Such items include, but are not limited to, gems acquired or held because of their value or as an investment, jewelry that is not worn or held for family significance, and collectibles acquired or held because of their value or as an investment.

Procedures

All ABD COAs

Household Goods and Personal Effects

Assume, absent evidence to the contrary, that all household goods and personal effects an A/R or deemor owns are excluded under this provision. No further development is required.

Follow the procedures below if the A/R alleges ownership of other personal property that is not excludable as household goods or personal effects;

Step 1 Verify the CMV of the item(s) using any reliable evidence the A/R may have when s/he alleges or the MES otherwise discovers ownership of property that is considered investment property. Acceptable evidence could include a recent sales slip, an appraisal of the item(s), or insurance coverage. If this information is not available, obtain an estimate from a knowledgeable source such as a local merchant.

> Insurance appraisals and amounts of insurance coverage often reflect replacement value (the amount it would cost to purchase a similar item new) rather than CMV. Do not use replacement value in lieu of CMV.

Step 2 Determine the equity value (EV) of any item on which the A/R or deemor alleges there is an encumbrance to determine the amount of countable resources.

Step 3 Deny the case if the value of the resource puts the A/R over the resource limit.

Step 4 Send appropriate notice to the A/R authorized representative and any other required entities.

2320 Inheritances and Unprobated Estates

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Inheritances and Unprobated Estates		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2320
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

An ownership interest in an unprobated estate may be a resource if any one of the following conditions is met:

- The individual is an heir or relative of the deceased
- The individual receives any income from the property
- The individual has acquired rights in the property due to the death of the deceased under state intestacy laws

Basic Considerations

There is an ownership interest in an unprobated estate if one of the following conditions is met:

- Documents such as a will or court record indicate an individual is an heir to property of a deceased individual.
- An individual has use of a deceased's property or receives income from it.
- Documents establish or the individual alleges a relationship between himself and the deceased that awards the individual a share in the distribution of the deceased's property under state intestacy laws and the inheritance, use of income and distribution are uncontested.

Any inheritance becomes a resource the month after the month of receipt. Refer to 2405 Treatment of Income to determine if an inheritance is income in the month of receipt.

Procedures

When a relative of an A/R dies intestate, use Georgia intestate laws to determine the A/R's share until the estate goes to probate court.

Exclude an interest in an unprobated estate (will or no will) from the date the estate goes to probate court. While in probate, check monthly to determine the status of the case until the case is settled; then determine CMV of A/R's share of the estate.

Document the case as applicable with the copy of the following:

- an inheritance or relationship document or signed statement alleging a relationship

- evidence of income from the property
- the individual's signed statement concerning his/her use of the property and whether any factor is contested.

Georgia Intestacy Laws

WILLS, TRUST, AND ESTATES

ARTICLE 4
ACKNOWLEDGEMENTS OF SERVICE

Effective date - This article became effective July 1, 1986.

Editor's notes - Ga. L. 1986, P.436, Sec. 2, not codified by the General Assembly, provided: "This Act shall become effective July 1, 1986, and shall apply to acknowledgements filed for record on or after its effective date."

53-3-80. Acknowledgement of service to be attested.

No acknowledgement of service in any proceeding relating to the probate of wills shall be valid unless it is attested by a notary public or the clerk of the probate court. (Code 1981, Sec. 53-3-80, enacted by Ga. L. 1986, p.436.Sec. 1)

CHAPTER 4: DESCENT AND DISTRIBUTION

ARTICLE 1
GENERAL PROVISION

Sec. 53-4-2. Rules on inheritance generally.

Sec. 53-4-3. Inheritance by husband, children, and descendants of intestate (Repealed).

Sec. 53-4-4. Inheritance by illegitimates and their offspring.

Research References

ALR. - Statutory or constitutional provision allowing widow but not widower to take against will and receive dower interests, allowances, homestead rights, or the like as denial of equal protection of law, 18 ALR 4th 910

53-4-2. Rules of inheritance generally.

The following rules shall determine who are the heirs at law of a deceased person:

1. Upon the death of the husband or wife without lineal descendants, the surviving spouse is the sole heir and upon payment of that deceased spouse's debts, if any, may take possession of the estate without administration;
2. If, upon the death of the husband or wife, there are children or representatives of deceased children, the surviving spouse shall have a child's part, unless the shares exceed four in number in which case, the surviving spouse shall have one-fourth part of the estate and the children shall have three-fourths' part of the estate; and the surviving spouse and children shall take per

capita but the descendants of the children shall take per stirpes. In any case in which a surviving spouse is entitled to the year's support and maintenance under Chapter 5 of title 53, the amount of such support and maintenance shall not be includable in computing the amount to which that surviving spouse is entitled under this paragraph. No election by the surviving spouse shall be necessary to entitle that spouse to the portion of the estate allowed by this paragraph, but that surviving spouse shall be entitled thereto as a matter of law unless that spouse renounces such portion, in whole or in part, within nine months after death of the other spouse;

If a spouse died prior to 7/85, the surviving spouse is entitled to a minimum of 1/5 of the estate.

The 1985 amendment effective July 1, 1985, rewrote paragraph (1) and (2) formerly relating to heirs upon death of the husband, would apply to all cases in which a person dies intestate on or after July 1, 1985.

3. Whenever the husband or wife of a deceased person is under the age of 18 years and entitled to a share in the estate of the deceased husband or wife, he or she shall be entitled to take and hold such share without the intervention of a guardian or other trustee.
4. Children shall stand in the first degree from the intestate and inherit equally all property of every description accounting for advancements as provided in Article 3 of this chapter. Posthumous children shall stand upon the same footing with children in being upon all questions of inheritance. The lineal descendants of children shall stand in the place of their deceased parents, but in all cases of inheritance from a lineal ancestor the distribution is per stirpes and not per capita;
5. Brothers and sisters of the intestate shall stand in the second degree and shall inherit if there is no surviving spouse, child, or representative of a child. The half-blood, both on the paternal and maternal side, shall inherit equally with the whole blood. Brothers and sisters of the whole blood, brothers and sisters of the half blood and brothers and sisters adopted by a mutual parent of the intestate shall stand in the same degree and inherit equally from each other. The children or grandchildren of deceased brothers and sisters shall request and stand in the place of their deceased parents but there shall be no representation further than this among collaterals. If all the brothers and sisters are dead at the time of death of the intestate, then the distribution shall be between the nephews and nieces per capita; and if any of the nephews and nieces are dead, leaving children, distribution shall be made as though the nephews and nieces were alive, the children of the deceased nephew or niece standing in the place of the parent;
6. The father and mother inherit equally with brothers and sisters and stand in the same degree;
7. In all degrees more remote than those specified in the paragraphs (1) through (6) of this code section, the paternal and maternal next of kin shall stand on an equal footing;
8. The grandfathers and grandmothers of the intestate shall stand next in degree;
9. Uncles and aunts shall stand next in degree with the children of any deceased uncle or aunt inheriting in the place of their parent;
10. First cousins shall stand next in degree; and
11. The more remote degrees of kindship shall be determined by counting the steps from the claimant to the closest common ancestor and from the ancestor to the intestate. The sum of the two shall be the degree of kinship.

Term uncle as used in this section is limited to those persons who have a common ancestor with the niece or nephew.

2321 Japanese American and Aleutian Restitution Payments

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Japanese American and Aleutian Restitution Payments		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2321
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

Permanently exclude from resources unspent portions of Japanese American and Aleutian Restitution Payments.

Basic Considerations

These payments are restitution payments made by the U.S. Government to Japanese Americans and Aleutians or their survivors who were interned or relocated during World War II.

Interest earned on unspent portions is treated as countable income for the month available and as a resource if retained in subsequent months.

Procedures

If an individual alleges that his or her resources include restitution payments, obtain a statement as to the following:

- The date(s) and amount(s) of such payment(s)
- The date(s) and amount(s) of any corresponding account deposits.

Accept the individual's allegation in the absence of evidence to the contrary.

2322 Life Estate and Remainder Interests

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Life Estate and Remainder Interests		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2322
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-65

Requirements

The value of a life estate interest may or may not be a countable resource. The value of a remainder interest is a countable resource for all ABD COAs.

For Family Medicaid COAs, life estate interest that an individual has a right to use, but not dispose of during his/her life, is excluded as a countable non-liquid resource. However, consider any income received from the property.

Basic Considerations

Life Estate

Under a life estate, an individual who owns property transfers ownership of that property to another individual while retaining, for the rest of his or her life (or the life of another person), certain rights to that property.

The owner of a life estate can sell the life estate but does not have full title to the property. The life estate owner cannot sell the property or pass it on as an inheritance.

However, some states allow life estates with powers, wherein the owner of the property creates a life estate for himself or herself retaining the power to sell the property, with a remainder interest to someone else, such as a child.

NON-FBR and FBR COAs

If an A/R owns a life estate with powers, its resource value is its full equity value.

If an A/R owns a life estate with no powers, use the table on the following page to determine the resource value.

If the property for which an A/R owns a life estate is the A/R's principal place of residence, apply the homeplace exclusion.

When the owner of the property gives it to one party in the form of a life estate and designates a second party to inherit it upon the death of the life estate holder, the second party has a remainder interest in the property.

If an A/R purchases a life estate interest in another individual's home the purchase price will be

considered a transfer of resource, unless the purchaser resides in the home for at least one year (12 months) from the date of purchase (12 months must be consecutive).

When making the determination of whether the 12-month residency requirement was met look at factors like was the person's mail delivered there, did they pay property taxes etc. Brief rehabilitation stays or vacations do not necessarily negate the residency, but this is a factual inquiry that must be conducted on the particular case. If the A/R who purchased the life estate moves out prior to the end of the12 month period, a transfer of assets penalty must be imposed. The uncompensated value is the full amount paid for the life estate as if the individual never moved into the home.

If purchase price was not for fair market value, then a transfer penalty must be applied. If the purchaser's life expectancy is less than the value of the life estate or they make a gift of the life estate impose a transfer penalty.

Remainder Interest

The value of a remainder interest in non-homeplace property is a countable resource for all A/Rs.

If an A/R transfers ownership of real property and retains life interest, he/she has transferred remainder interest. Consider a transfer of resources penalty on the value of the remainder interest.

Transfer of Assets Penalty

If an A/R transfers life estate interest, consider a transfer of assets penalty on the value of the life estate interest. See 2342 Transfer of Assets.

Procedures

Step 1 Obtain copies of legal documents which convey the life estate or remainder interest.

Step 2 Determine if this has been the primary or only residence of the A/R and that it is not the purchase of a life estate in another person's property. If the life estate meets this criteria, exclude the life estate interest value from countable resources. If not, proceed to Step 3. Determine if a transfer of resource penalty should be applied for a remainder interest.

Step 3 If the A/R has purchased a life estate interest in another's home, the following conditions must be met for the value of the life estate interest to be excluded from resources:

- The A/R must have resided in the home for a minimum of twelve months after the date of purchase. If the A/R moves out of the home prior to the expiration of the twelve-month period, it is the same as if the A/R had never moved into the home.
- Determine if the purchase price of the life estate was for the fair market value.
- Determine if the person's life expectancy is equal to or greater than the value of the life estate purchased.
- The life estate must not be gifted to anyone.

If the life estate did not meet all of these criteria, impose a transfer of assets penalty. Refer to 2342 Transfer of Assets.

Step 4 Verify the CMV, minus any encumbrances, of any property in which an A/R owns a life estate interest, or any liquid asset in which an A/R owns a life estate interest, or in which an A/R owns a remainder interest. Evaluate as a potential countable asset or transfer of asset.

Step 5 If the life estate or remainder interest has a countable resource value that puts the A/R over the resource limit, close/deny the case. If the life estate results in the imposition of a penalty, the penalty may result in denial/closure or in non-payment of the long-term care Medicaid services. Refer to 2342 Transfer of Assets.

Use the following chart to determine the resource value of a life estate or remainder interest. Multiply the CMV, minus any encumbrances, of the property by the life estate or remainder interest decimal that corresponds to the life estate interest holder's age. Always use the life estater's age to determine the value of a life estate or remainder interest.

Chart 2322.1 - Unisex Life Estate or Remainder Interest Table

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

AGE	LIFE ESTATE	REMAINDER
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
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422

AGE	LIFE ESTATE	REMAINDER
50	.84743	.15257
51	.83674	.16126
52	.82969	.10731
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
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141

AGE	LIFE ESTATE	REMAINDER
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

2323 Life Insurance Policies

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Life Insurance Policies		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2323
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

A life insurance policy is a resource if it has a cash surrender value (CSV). Its value as a resource is the amount of the CSV. The CSV of some policies may be excluded in ABD Medicaid. Accidental Death and Dismemberment policies are not considered as Life insurance policies for purposes of burial assets.

This is an excluded resource for Family Medicaid.

Basic Considerations

Cash Surrender Value

The CSV is a form of equity value that the policy acquires over time. The owner of a policy can obtain its CSV only by turning the policy in for cancellation before it matures or before the insured dies. A loan against a policy reduces its CSV. In some cases, penalties may be applied for early access of funds. These penalties are deducted from the value of the resource to determine the cash value available.

Term insurance policies that do not generate a CSV are not resources. However, they are considered first as part of the burial exclusion allowance.

A burial insurance policy is a contract with terms that preclude the use of its proceeds for anything other than payment of the insured's burial expense. Burial insurance policies are not resources if the owner does not have access to the CSV. However, they will be included as part of the burial exclusion allowance or considered as a transfer of assets, if the A/R exceeds the burial exclusion allowance. Refer to 2342 Transfer of Assets.

If a burial policy has a CSV to which the owner has access, the policy is considered to be a life insurance policy, and not a burial policy.

A supplementary contract is not a life insurance policy. Supplementary contracts normally provide for an annuity. Treat such contracts in accordance with the instructions on filing for other benefits, just as an IRA or other type of retirement fund. Refer to 2332 Retirement Funds and/or 2339 Annuities.

Face Value (FV)

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, the amount of this policy, the sum insured, etc.

A policy's FV does not include the following:

- the FV of any dividend addition that is added after the policy is issued
- additional sums payable in the event of accidental death or because of other special provision
- the amount(s) of term insurance when a policy provides whole life coverage for one family member and term coverage for the other(s).

Dividend additions are amounts of insurance purchased with dividends and added to the policy, increasing its death benefit and CSV. The table of CSVs that comes with the policy does not reflect the added CSV of any dividend additions.

Dividend additions are not included in the face value amount used to determine whether a life insurance policy is an excluded resource. Refer to PROCEDURES in this section for more information on dividends paid on life insurance policies.

Procedures

Exclusions

How whole or term life insurance is considered depends upon whether the policy is used as part of the burial exclusion allowance. Funds set aside for burial, burial contracts and the FV of all life insurance policies are considered in the computation of the burial exclusion allowance.

To be exempted from resources, an A/R and/or deemor may own up to the total burial exclusion allowance on each individual (A/R or deemor). A life insurance policy on an A/R or spouse that is owned by another person is not counted as part of the burial exclusion or as a resource. However, explore whose money funded the policy for potential transfer penalty.

ABD Medicaid Non-FBR COAs

Life insurance policies with a Face Value of 10,000 or less may be considered for burial exclusion. Life insurance policies with a Face Value greater than 10,000 must have the cash surrender value counted toward the resource limit. Only the Face Value, not the Cash Surrender Value may be applied toward the burial exclusion allowance.

Compute a transfer of assets penalty in the following situations:

- If the A/R transfers the policy to another, compute a transfer penalty on the FV.
- If the A/R cashes in all or part of the life insurance and transfers that amount, compute the transfer penalty on the actual dollar amount transferred. Any amount retained is a countable resource.
- If the A/R uses his/her funds to purchase a life insurance policy that is owned by another person.

Begin the penalty for applicants the month of the transfer or the 1st month in which A/R is otherwise Medicaid eligible, whichever is later; or for recipients the 1st month in which timely notice may be given. Refer to 2342 Transfer of Assets.

If the A/R or deemor has a term policy which has a FV of $10,000 or more, that policy will make up the entire burial exclusion allowance. **Term policies should always be considered first in the burial exclusion allowance.** Any amount in excess of the $10,000 will be subject to Estate Recovery.

This change in policy is effective July 1, 2005. However, implement beginning January 1, 2007, for any applications (including three month's prior) and reviews completed after this date.

Exclusion for ABD Medicaid FBR COAs

For FBR A/R's, exclude from resources the accessible CSV of life insurance policies owned by the A/R if its face value (FV) and the value of all other burial exclusion assets owned by the A/R on the same individual is a total of $1500 or less.

An FBR A/R may own up to a total of $1500 FV life insurance on **each** individual (A/R and deemor) and still be entitled to the exclusion.

Verification and Documentation for ABD Medicaid

Require the A/R to submit all life insurance policies owned by the A/R and deemors.

Q Track A/Rs do not need to submit policies unless questionable or if it is necessary to determine the CSV.

Document all policies on the system.

Verify the following items on all life insurance policies:

- the owner
- the insured
- the FV
- whether the policy pays dividends and, if it does, what option the individual selected for their disposition, such as accumulation, dividend additions, applied to premiums or paid directly to the A/R by check.
- the CSV of any dividend additions
- the current amount and interest earned on any dividend accumulations.
- for Non-FBR COAs, policies with a FV greater than $10,000 verify the following: whether the policy generates a CSV and, if it does, the current CSV (do not count the CSV of any dividend additions). It is not necessary to verify the CSV of life insurance policies with a cumulative FV of $10,000 or less if used as part of the burial exclusion allowance. Verify the CSV of any policies not included in the burial exclusion allowance
- for FBR COAs, policies with a FV greater than $1500 verify the following: whether the policy generates a CSV and, if it does, the current CSV (do not count the CSV of any dividend additions).

It is not necessary to verify the CSV of life insurance policies with a cumulative FV of $1500 or less.

Dividends

Make copies of pages from insurance policies which show the above information. If a policy does not reveal any item, contact the insurance agent or company by telephone, letter or Form 106.

Refer to Appendix F for Form 106 and Record of Life Insurance form.

Unless there is evidence to the contrary, assume the following to be true:

- A policy issued by a non-participating or stock company does not pay dividends.
- A policy issued by a participating or mutual company pays dividends.

Identification of the kind of company usually follows its name on the face page of the policy.

If the examination of a policy does not reveal this information, obtain the information by telephone, letter or Form 106 from the insurance agency or company.

Refer to 2315 Dividends, Accrued for information on the resource treatment of dividends paid on life insurance policies.

Computing Burial Assets

Refer to Appendix F for **Burial Exclusion Form 985 to compute the $1500/$10,000 burial funds exclusion** by the value of any of the following assets owned by the A/R or deemor:

- The FV of burial insurance policies.
- The FV of any life insurance policy (whole or term) on the A/R or A/R's spouse. For Non- FBR A/Rs:
  - If the FV was not used to reduce the burial exclusion amount, then the CSV of the life insurance is a countable resource.
  - All or part of the FV of one spouse's insurance may NOT be applied to the other spouse's burial exclusion.
- The non-excluded portion of any pre-need burial contract. See 2311 Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items.
- Funds set aside for burial (less any interest/dividends left to accrue). Funds designated for burial must be owned by the individual or jointly owned between the A/R and spouse. See 2312 Burial Funds.

Use the value of the burial assets **in the most advantageous way** for the A/R or deemor so that it does not exceed the $1500/$10,000 burial exclusion.

2324 Lump Sums

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Lump Sums		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2324
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-65

Requirements

Money received in the form of a lump sum that is not expected to recur, i.e., rebates, retroactive or corrective payments for prior months, insurance settlements, federal or state tax refunds.

Basic Considerations

Lump Sums are counted as income the month of receipt. Any remainder counts as a resource beginning the month after the month of receipt.

Unspent RSDI or SSI lump sums are excluded resources for 9 full calendar months after receipt. Federal and State tax refunds do not count as income, but any remaining amount is counted as a resource in months following the month of receipt.

Interest earned on unspent RSDI or SSI lump sums is not excluded as income. See 2499 Treatment of Income in Medical Assistance for exceptions.

Refer to 2305 Commingled Funds if unspent RSDI or SSI lump sums are commingled with other funds.

Refer to 2405 Treatment of Income for instructions on how to treat lottery and gambling lump sum winnings which are received in a single payment.

Procedures

For all lump sums, verify the amount and date of receipt from the source of the payment.

2325 Patient Fund Account (NH)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Patient Fund Account (NH)		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2325
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

A nursing home patient fund account is treated as any other financial account. The balance of the account as of the first moment of the first day of the month is a countable resource. This is not applicable to Family Medicaid with the exception of a Parent/Caretaker with Child(ren) individual in a nursing home.

Basic Considerations

A nursing home patient fund account is a bank account set up by the nursing home for the convenience of the patient.

A nursing home holding a patient fund account with a balance of $50 or less is not required to pay interest on the account. Individual patient fund accounts may not be pooled with other resident's patient fund accounts. Any interest earned on the account belongs to the resident.

Refer to Interest in Section 2499, Chart 2499.1, Treatment of Income in ABD Medicaid, for the income treatment of any interest earned on a patient fund account containing more than $50.

Procedures

On every application and at redetermination (except for SSI A/Rs), verify first moment of the first day of month balance by telephone, printed patient fund account statement, or Form 958 whether a NH A/R has an account and the account balance and interest earned as of the first moment of the first day of the month of application or review.

2326 Prepayments and Deposits (NH)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Prepayments and Deposits (NH)		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2326
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

If a nursing home refunds a prepayment or deposit to an A/R, the amount of the refund is a countable resource at application and is treated as a savings account.

This is not applicable to Family Medicaid with the exception of a Parent/Caretaker with Child(ren) individual in a nursing home.

Basic Considerations

Prepayments or deposits are collected by NHs in the event an applicant's ABD Medicaid application is denied. These prepayments/deposits are usually refunded if the application is approved.

If a prepayment/deposit was made by someone other than the A/R and will be refunded to the other individual, the refund has no effect on the A/R's eligibility.

Procedures

On every applicant in a NH, verify whether a prepayment or deposit was made to the NH, to whom a refund will be made and the amount of the expected refund. Verify by telephone or Form 958. Document the system appropriately.

2327 Property Essential to Self-Support

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Property Essential to Self-Support		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2327
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

Personal or non-homeplace real property that produces income, goods or services may be partially or totally excluded.

Basic Considerations

Current Use Requirements

Property, including property used by an individual as an employee, must be in current use in the type of activity that qualifies it as essential to be excluded as essential to self-support. Current use is evaluated on a monthly basis. Property not in current use can be excluded as essential to self-support only if the following conditions are met:

- It has been in use
- There is a reasonable expectation that the use will resume.

Resumption of use must be expected within 12 months of last use. For example, if property was last used in October, resumption of use must reasonably be expected to occur before the end of the following October.

The 12-month period can be extended for an additional 12 months if non-use is due to a disabling condition.

Categories of Property Essential to Self-Support

There are three categories of property essential to self-support:

- Business Property, such as the following:
  - property used in a trade or business, such as farmland, barber shop, etc.
  - property that represents government authority to engage in an income producing activity, such as commercial fishing permits, tobacco crop allotments
  - property used by an individual as an employee for work, such as the tools of an employed mechanic.
- Non-business property used to produce goods or services for home consumption, such as land or equipment used to produce vegetables or livestock solely for home consumption.

- Non-business income producing property such as rental property that produces a net annual return, this does not include homeplace property. Please refer to 2316 Homeplace: ABD Medicaid for treatment of homeplace rental property.

Procedures

Business Property

Totally exclude business property as a resource, regardless of its value or rate of return.

FBR and Non-FBR COAs

When an individual alleges owning trade or business property not already being excluded, consider if a valid trade or business exists and whether the property is in current use. Obtain a statement giving the information below:

- a description of the trade or business
- a description of the assets of the trade or business
- the number of years it has been operating
- the identity of any co-owners.

Obtain a copy of the business tax return (Form 1040 and the appropriate schedules) for the tax year prior to the application or redetermination. Use the return to determine the net earnings from self-employment and validity of the trade or business. The following can be particularly helpful:

- Schedule C, Profit or Loss from Business or Profession
- Schedule SE, Computation of Social Security Self-employment
- Schedule F, Farm Income and Expenses
- Form 4562, Depreciation and Amortization
- Form 1065, U.S. Partnership Return of Income.

If the current tax return is not available, obtain a copy of the latest tax return available.

Property that Produces Goods/Services for Home Consumption FBR and Non-FBR COAs

Exclude as a resource up to $6000 of the equity value of non-business property used to produce goods or services for home consumption, regardless of the rate of return. Any portion of the equity value in excess of $6000 is a countable resource.

> While this category of property may encompass a vehicle used solely in a non-business self-support activity, such as a garden tractor or boat used for subsistence fishing, it does not include any vehicle that qualifies as an automobile.

When an individual alleges owning property that he or she uses to produce goods or services necessary for daily activities, obtain his or her statement on the following:

- a description of the property

- how it is used
- an estimate of its CMV and any encumbrances.

If evidence to the contrary is absence, accept their statement.

Determine the CMV of real property and, if necessary, the EV of real property.

Have the individual obtain a CMV estimate of personal property from a knowledgeable source. The estimate must include the following:

- the identity of the source of the statement
- a description of the item whose CMV is being estimated
- the basis for the estimate.

If a knowledgeable source provides a value range, use the lower end of the range.

Non-Business Income Producing Property

When an individual alleges owning non-business real property that produces income such as land or a house for rent, obtain his or her signed statement on the following:

- the number of years s/he has owned the property
- any co-owners of the property
- a description of the property
- the estimated CMV of the property and any encumbrances on it
- the estimated net and gross income from the property for the current year.

If evidence to the contrary is absent, accept the individual's statement with respect to years of ownership, identity of owners and description of the property.

Effective October 1, 2006, but implemented February 1, 2007, on all applications (new or pending, including three months prior) and reviews/specials, exclude up to $6000 of the equity value of non-business income producing property as a resource only if the property produces a net annual return of at least 6% of the excluded portion. Any portion in excess of $6000 is a countable resource.

If an individual owns more than one piece of non-business income producing property, apply the following rules:

- The 6% return requirement applies individually to each
- The $6000 EV limit applies to the total EV of all properties meeting the 6% return requirement

If all properties meet the 6% test but the total EV exceeds $6000, that portion of the total EV in excess of $6000 is not excluded under this provision.

Determine the rate of return based on income and value figures shown on the individual's Schedule E (Supplemental Income Schedule) of Form 1040 for the year prior to filing of the application. If no tax return is available, obtain other appropriate evidence from the individual, such as a copy of

the lease agreement for the period in question.

When redetermining the status of property already excluded under this provision, only the value and income need to be redeveloped.

Also reference 2410 Rental Income if needed.

Special Considerations

Business Property Government Permits

If an individual alleges owning a government license, permit, or other property that represents government authority to engage in an income producing activity, and that has value as a resource, obtain his or her signed statement as to the following:

- the type of license, permit, or other property
- the name of the issuing agency, if appropriate
- whether the law requires such license, permit, or property for engaging in the income producing activity at issue
- how the license, permit, or other property is being used, or
- if it is not being used, why not.

Have the individual submit a copy of the license, permit, and/or other pertinent documents. For example, an individual engaged in fishing in Alaska would have a permit. In North Carolina, a person growing flue-cured tobacco would have a marketing sales card to sell it. If the individual cannot submit the necessary evidence, verify his or her allegations with the issuing agency. Do this by telephone if possible.

Tobacco Crop Allotment (TCA)

The TCA is the other most commonly encountered type of property representing government authority to engage in an income producing activity. It is issued by the U.S. Department of Agriculture's Agricultural Stabilization and Conservation Service. It is required for the growing and selling of flue-cured tobacco, which is grown mostly in the southeastern United States. Do not confuse a TCA with a price support or subsidy, or a soil bank program.

Exclude a TCA only when the grower who has it is restricted to growing a certain quantity of the crop.

Item Used for Employment

If an individual alleges owning items that are used in his or her work as an employee, obtain his or her statement on the following:

- the name, address, and telephone number of the employer
- a general description of the items
- a general description of his or her duties

- whether the items are currently being used.

Absent evidence to the contrary, accept the individual's statement.

Liquid Resource Used in Trade or Business

All or a portion of a liquid resource used in the operation of a trade or business, such as a checking account, can be excluded from resources. This applies to all classes of assistance.

- Obtain the A/R's signed allegation that the liquid resource is used in a trade or business.
- Obtain verification of average monthly business expenditures in order to determine what portion of the resource is used in the trade or business.
- Exclude up to three times the average monthly business expenditures as the portion of the liquid resource used in the trade or business.

2328 Property Rights

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Property Rights		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2328
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

Property rights are treated as real property in determining resource eligibility.

Basic Considerations

Property rights can be in any of the following forms.

Mineral Rights

Mineral rights represent an ownership interest in natural resources such as coal, oil, or natural gas, which normally are extracted from the ground.

Timber Rights

Timber rights permit one party to cut and remove free standing trees from the property of another party.

Easements

An easement gives one party the right to use land of another party for a special purpose.

Leaseholds

A leasehold gives one party control over certain property of another party for a specified period. In some states, a lease for life can create a life estate under common law.

Water Rights

Water rights usually confer upon the owner of river front or shore front property the right to access and use the adjacent water.

Procedures

Verify the ownership and equity value of property rights.

If the individual owns the land to which the mineral rights pertain, the CMV of the land can be assumed to include the value of the mineral rights. Additional development is unnecessary.

If the individual does not own the land to which the mineral rights pertain, obtain a CMV estimate from a knowledgeable source.

Such sources include the following:

- the Bureau of Land Management
- the U.S. Geological Survey
- any mining company that holds leases.

Refer any *lease for life* agreement to the Medicaid Unit for a determination of whether it creates a life estate.

2329 Real Property: Non-Homeplace

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Real Property: Non-Homeplace		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2329
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

The equity value of the applicant/recipient's (A/R's) interest in non-homeplace real property is a countable resource for all ABD and Family Medicaid Classes of Assistance (COAs).

Basic Considerations

Non-homeplace real property includes the following:

- land
- lots
- trees on land
- buildings on non-homeplace property which would transfer to a buyer if/when the land or lot were sold
- houses and mobile homes, whether occupied or unoccupied

Equity value (fair market value less any indebtedness) is the countable value of non- homeplace property.

Indebtedness is the total amount of debt that remains to be paid, including principal, interest, and any liens and/or encumbrances.

Non-homeplace real property may be totally or partially excluded if it meets one of the following conditions:

- the property is jointly owned, and the sale of the property would cause undue hardship to a co-owner(s). Refer to 2345 Undue Hardship Provision for ABD Medicaid.
- the A/R is making a bona-fide or good faith effort to sell the property. Refer to 2304 Treatment of Resources For ABD Medicaid.
- the property is restricted allotted Indian land. Refer to 2304 Treatment of Resources For ABD Medicaid.
- the property meets undue hardship provisions. Refer to 2345 Undue Hardship Provision for ABD Medicaid.
- the property is essential to self-support (this applies only to ABD COAs). Refer to 2327 Property Essential to Self-Support.

- the property is declared unmarketable by a competent authority
- the A/R owns a life estate interest in the property (ABD Non-FBR COAs only). Refer to 2322 Life Estate and Remainder Interests.

Sale of Non-Homeplace Real Property

The proceeds from the sale of excluded non-homeplace real property are excluded during the month of sale. Any proceeds remaining the month following the sale are a countable resource.

Bona-fide or Good Faith Effort to Sell

A bona-fide or good faith effort to sell is defined as follows:

- actual sale attempt at a price not more than current market value
- listing with a realtor OR
- appropriate advertising such as in newspapers, radio, etc.
- acceptance of any reasonable offer.

Refer to 2304 Treatment of Resources For ABD Medicaid. See 2304-2 Bona Fide Effort to Sale.

Income Producing Property: ABD Medicaid

Refer to 2327 Property Essential to Self-Support.

Income Producing Property: Family Medicaid

Income producing property is considered a countable resource when determining eligibility for Family Medicaid COAs.

Income producing property is defined as follows:

- property which produces income, even if used only on a seasonal basis
- property essential to the employment or self-employment of a household member (rental homes, farmland, etc.)
- rental property which is used for vacation purposes at some time during the year and which produces income
- installment contracts for the sale of land or buildings if the contract or agreement produces income.

Refer to 2410 Rental Income.

Procedures

Verify ownership interest and Current Market Value (CMV) of non-homeplace real property using one of the following documents:

- property search (Form 991)

- legal documents indicating value of the property.

Determine the equity value of the property.

If the A/R rebuts the CMV indicated in the Tax Digest, the A/R may obtain written appraisals or estimates from two reliable sources, such as realtors or appraisers, as to the accurate CMV. Average the two appraisals or estimates to determine CMV.

2330 Relocation Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Relocation Assistance		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2330
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

Effective for resource determinations made for the month of May 1991 and subsequent months through April 1994, unspent relocation assistance payments from a state or local government which are received through April 1994 are excluded from resources for 9 months. The last month for which this resource exclusion may apply is April 1994.

This is an excluded resource for Family Medicaid.

Basic Considerations

To be excluded from the resources under this provision, the payments must be of the type described under *Federal Programs, Miscellaneous,* in Section 2499, Chart 2499.1, Treatment of Income in ABD Medicaid.

Payments received after July 1993 cannot be excluded under this provision for the full 9-month period but only through April 1994.

Interest earned on unspent relocation assistance payments is not excluded from income or resources by this provision.

Procedures

If an individual alleges that his or her resources included unspent relocation assistance payments from a state or local government, complete the following procedures:

- Document the date(s) and amount(s) of such payment(s).
- Obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the payments.

Refer to 2305 Commingled Funds.

2331 Repair/Replacement Funds

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Repair/Replacement Funds		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2331
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-65

Requirements

Cash and in-kind items received for the repair or replacement of lost, damaged, or stolen excluded resources may be excluded from resources for up to 18 calendar months.

This is an excluded resource for Family Medicaid.

Basic Considerations

Cash and in-kind items received for the repair or replacement of lost, damaged or stolen excluded resources may come from any source, such as an insurance company, a federal or state agency, a public or private organization or an individual.

These funds include ISM or funds for the purchase of temporary housing but do not include funds received for personal injury.

These funds do not include Federal Disaster Assistance. Refer to 2314 Disaster Assistance.

The above unspent funds are excluded resources for 9 months from the date of their receipt. To be excluded from resources under this provision, the funds must be excluded from countable income.

Unspent cash receipts for the repair or replacement of excluded resources can be excluded from resources for up to an additional 9 months if, for the first 9 months, circumstances beyond the individual's control hinder the following actions:

- repair or replacement of the damaged or destroyed property
- contracting for such repair or replacement.

What the individual intends to do with the funds does not affect their exclusion for the first 9 months.

An individual cannot qualify for an extension of the original 9-month exclusion unless he or she intends to use the funds for their designated purpose.

The extension will terminate as of the date of the change of intent. The previously excluded funds will be taken into account in determining resources for the following month.

Interest earned by funds excluded under this provision is excluded from income and from resources for as long as the funds themselves are excluded.

Procedures

Obtain a copy of any evidence the individual has which verifies the following:

- The evidence must show the source, value, date(s), and intended purpose of the item received, including whether any cash received is for a purpose other than the replacement or repair of the lost, damaged, or stolen (and excluded) resource.
- Evidence that establishes the ability of funds to be excluded from income also establishes their ability to be excluded from resources. Refer to 2405 Treatment of Income and 2504 Determining Countable Income.
- If the individual cannot provide evidence sufficient for a determination, obtain the necessary information from the source of the payment(s).

Summarize the basis for the exclusion. Show the amount excluded and the first and last day of the exclusion period.

Schedule an alert to contact the A/R at least 30 days before the exclusion expires. Obtain evidence of the amount of excluded assistance still unspent.

If assistance remains unspent but the individual alleges good cause and plans to use the funds for their intended repairs or replacement, obtain his or her signed statement. Have the individual submit evidence to substantiate the allegation of good cause.

If the evidence does not establish good cause, include the unspent assistance in determining countable resources as of the first moment of the first day of the month after the month in which the exclusion period expires.

If the evidence shows good cause, discuss with the individual how much additional time is needed and why. On the basis of that discussion, extend the exclusion period for up to an additional 9 months, repeating the development steps above.

2332 Retirement Funds

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Retirement Funds		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2332
	Previous Policy Number(s):	MT 39	**Updated or Reviewed in MT:**	MT-59

Requirements

A retirement fund owned by an eligible individual is a countable resource if s/he has the option of withdrawing the fund as a lump sum, even if s/he is not eligible for periodic payments.

Basic Considerations

Retirement funds are work-related plans for providing income when employment ends, such as a pension, disability, or retirement plans administered by an employer or union. Other examples are funds held in an individual retirement account (IRA), Roth or Traditional and plans for self-employed individuals, sometimes referred to as Keogh plans. Also, depending on the requirements established by the employer, some profit-sharing plans may qualify as retirement funds.

Periodic retirement benefits are payments made to an individual at some regular interval (e.g., monthly) and which result from entitlement under a retirement fund. Payments which consist of interest or dividends only do not meet the definition of entitlement under a retirement. The payments must include a portion of the principal.

The value of a retirement fund is the amount of money that an individual can currently withdraw from the fund. If there is a penalty for early withdrawal, the fund's value is the amount available to an individual after the penalty deduction. Any income taxes incurred by the withdrawal are not deductible in determining the fund's value. However, if the individual is eligible for and receives periodic payments which include a portion of the principal, the retirement fund is excluded as a countable resource.

To be eligible for ABD Medicaid, an individual must apply for periodic benefits. If s/he has a choice between periodic payments and a lump sum, they must choose the periodic payments.

A retirement fund is not a countable resource if an individual must terminate employment in order to obtain any payment from the fund.

A previously unavailable retirement fund is not income to its recipient when the fund becomes available. The fund is subject to resource counting rules in the month following the month in which it first becomes available.

A resource determination for the month following that in which a retirement fund becomes available for withdrawal must include the fund's value. A delay in payment for reasons beyond the individual's control, such as an organization's processing time, does not mean that the fund is not a

resource since the individual is legally able to obtain the money. It is a non-liquid resource.

If an individual receives a denial on a claim for periodic retirement payments but can withdraw the funds in a lump sum, include the fund's lump sum value in the resource determination for the month following that in which the individual receives the denial notice.

If an ineligible spouse, parent or spouse of parent owns a retirement fund, the value is excluded as a countable resource.

Procedures

If an individual has a retirement fund, determine and document whether he/she is eligible for periodic payments. If not, determine and document whether he/she can make a lump-sum withdrawal.

If an individual is eligible for and receiving periodic payments from a retirement fund, which include a portion of the principal, budget the payments as income.

If an individual is eligible for periodic payments but refuses to accept them, count the value of the retirement fund as a resource.

2333 Safe Deposit Box

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Safe Deposit Box		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2333
	Previous Policy Number(s):	MT 16	**Updated or Reviewed in MT:**	MT-59

Requirements

The contents of a safe deposit box may include undisclosed countable resources and/or legal documents necessary for resource verification.

Basic Considerations

A safe deposit box is a strong metal container for storing valuable papers, jewels, or keepsakes, in a bank.

If an A/R alleges not having a safe deposit box, no further development is required unless it is necessary to send a Form 957 to a financial institution for verification of checking or savings accounts. Always check the entry, “Does the person have a safe deposit box…?”, when a Form 957 is required.

Procedures

ABD Medicaid Non-FBR COAs

If a non-FBR A/R alleges having a safe deposit box, ask the A/R or PR to itemize the contents of the box. If necessary, require the A/R or PR to submit any document(s) for verification purposes. Exclude any household goods and personal effects kept in the box. *If the A/R or PR’s statement of contents is questionable,* follow the procedures below for FBR A/Rs.

ABD Medicaid FBR COAs

If an FBR A/R alleges to have a safe deposit box, the contents must be inventoried. Complete a physical inventory or get a sworn statement from a bank official.

Family Medicaid

Accept the A/R’s sworn statement as to the contents of a safe deposit box.

2334 Savings and Checking Accounts

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Savings and Checking Accounts		
	Effective Date:	December 2019		
	Chapter:	2300	**Policy Number:**	2334
	Previous Policy Number(s):	MT 54	**Updated or Reviewed in MT:**	MT-57

Requirements

The resource value of a savings instrument with a financial institution or NH is the balance of the account, less any early withdrawal penalty.

Basic Considerations

The term savings encompasses the following:

- cash savings on hand
- checking and savings accounts
- certificates of deposit (CDs)
- credit union accounts
- time deposits
- NH patient fund accounts
- NH prepayments/deposits if to be returned to A/R
- individual retirement accounts (IRAs)
- Keoghs.

Any cash on hand received in a prior month and retained after the month of receipt is a resource.

For the treatment of retirement funds, including IRAs and Keoghs, see Section 2332, Retirement Funds

Verification and Documentation Family Medicaid

Accept the A/R's statement of account balance(s) unless questionable. If the total of all liquid and non-liquid resources exceeds 75% of the resource limit, the account balances must be verified. Refer to Section 2301, Family Medicaid Resources Overview.

Verification and Documentation ABD Medicaid

At application obtain financial statements that will verify account balance(s) as of the first moment of the first day of each month Medicaid eligibility is requested. For A/Rs alleging to have accounts with financial institutions, obtain copies of statements and/or updated passbooks.

If the A/R's past financial history is questionable, it is reasonable at initial application to request financial statements for a minimum of three months prior to the first month that Medicaid eligibility is requested in order to establish a history of financial transactions.

A/R's with a **Direct Express Debit card** do not receive monthly statements. The resource type is cash [on hand] as Direct Express debit card is not a savings or checking instrument with a financial institution. This is not a checking account, the only monies that can be direct deposited are Social Security, Supplemental Security Income (SSI), VA Compensation or Pension, RRB Annuity and OPM (Federal Retirement). Count Direct Express deposits as income in the month received. The balance is considered a resource the first day of the following month.

For NH A/Rs, verify ownership and balance of patient fund accounts by telephone or Form 958 on every application and redetermination, regardless of whether the A/R alleges having a patient fund account.

If the above records are available, and if they appear accurate and complete, calculate the balance(s) as of the first moment of the first day of the verification month. Take into consideration any deposits, withdrawals or checks that have been written that are reflected on check stubs/passbooks that are not reflected on the account statement.

If the accuracy, reliability or completeness of the account statement and the A/R's personal records is questionable, a Form 957, MAO Resource Clearance Form, must be completed by the institution. Form 957 must indicate the balance as of the first moment of the first day of the month.

Inquire as to the disposition of previously owned accounts and develop as necessary. Check available IEVS IRS matches on each review for unreported accounts.

Special Considerations

Joint Accounts Family Medicaid

When an AU of Family Medicaid Budget Group member is named on a joint bank account with a non-AU or BG individual solely for the convenience or emergency, exclude the joint account as a resource to the Family Medicaid AU or BG member if the other individual, or someone who is in a position to know, verifies that s/he has deposited all the money in the account and all withdrawals are used for the non-AU or non-BG individual's benefit.

Joint Accounts ABD Medicaid

If an A/R's or deemor' s name appears on any checking or savings account, including an account under several names, assume that the A/R is an owner of the account unless the A/R verifies otherwise through the rebuttal process. Refer to *Joint Account Ownership Rebuttal* in this section for rebuttal procedures.

If an account is owned jointly by one or more Medicaid A/Rs and one or more non-Medicaid individuals, count all of the funds in the account as a resource to the Medicaid A/Rs in equal shares. Do *not* allow a share of the funds to the non-Medicaid individuals.

Assume that an A/R with ownership interest in a checking or savings account has unrestricted access to the account unless the A/R verifies restricted access through the rebuttal process. Refer to

Unrestricted Access Rebuttal in this section for rebuttal procedures.

Joint Account Ownership Rebuttal

If an individual wishes to rebut the applicable ownership assumption, obtain his or her statement regarding the following:

- who owns the funds
- why there is a joint account
- who has made deposits to and withdrawals from the account
- how withdrawals have been spent.

In addition, inform the individual that he or she must submit the following evidence within 30 days:

- a corroborating statement from each other account holder

> If the only other account holder is incompetent or a minor, have the individual submit a corroborating statement from anyone aware of the circumstances surrounding establishment of the account.

- account records showing a history of deposits, withdrawals and interest payments.
- if the individual owns none of the funds, evidence showing that he or she can no longer withdraw funds from the account, such as removal of the individual's name from the account.
- if the individual owns only a portion of the funds, evidence showing removal from the account of such funds, or removal of the funds owned by the other account of such funds, or removal of the funds owned by the other account holder(s) and re-designation of the account.

Exclude from the A/R's resources any funds that the evidence establishes were owned by the other account holder(s) and can no longer be withdrawn from the account by the A/R.

> Such funds are a countable resource in determining the A/R's resource eligibility if the account holder to whom they belong is a deemor.

Withdrawals by other Account Holder(s)

Develop a transfer of resources penalty for any withdrawals made on or after 8-11-93 by the other account holder if the A/R has not successfully rebutted ownership. Refer to Section 2342, Transfer of Resources.

> In Family Medicaid there is no penalty for transferring resources. Consider only resources owned by the AU at the time of the eligibility determination.

Unrestricted Access Rebuttal

If an A/R verifies through the financial institution that s/he cannot withdraw funds from a checking or savings account without the signature of the other joint owner(s), consider the A/R to have restricted access to the account, and exclude the account from the A/R's countable resources.

If a *restricted* account is owned jointly by an A/R and deemor only, the account is a countable resource.

Georgia STABLE Account

The Achieving Better Life Experiences Act (ABLE) was passed by the United States Congress in December 2014. The ABLE Act amends Section 529 of the Internal Revenue Code to create tax advantaged savings accounts for individuals with disabilities. This federal legislation allows eligible individuals with disabilities the opportunity save and fund a variety of qualified disability expenses without impacting their ability to receive Supplemental Security Income (SSI), Medicaid, and other federal programs. The Georgia ABLE program is named Georgia STABLE.

The purpose of the ABLE Act is to permit people with disabilities and their families to save money in and withdraw funds from their ABLE accounts which can be used to help maintain health, independence, and quality of life.

Individuals with disabilities and their families can save up to a maximum amount annually in a tax-advantaged account for disability-related expenses. The maximum amount may change yearly.

Maximum amount:

2017 14,000.00
2018 15,000.00

Effective January 1, 2019, the designated beneficiary of an ABLE account is temporarily allowed to contribute additional monies above the maximum annual limit towards savings. The balance within a single ABLE account for an individual, including contributions and earnings, is an excluded resource.

An ABLE account is an account established and owned by an eligible individual and maintained under a qualified ABLE program. The eligible individual is the designated beneficiary of the ABLE account. An individual is permitted to have only one ABLE account. The individual may open the account in their state of residence, or in another state's ABLE program.

A parent, legal guardian, or the holder of a Power of Attorney can also open, set up, and manage an ABLE account for their loved one.

Whenever a Medicaid applicant or recipient reports they are the owner of an ABLE account, obtain verification of documentation of the following:

- The name of the designated beneficiary or owner of the account
- The state ABLE program administering the account
- The name of the person who has signature authority (if different from the owner)
- The unique account number assigned by the state to the ABLE account
- The date the account was opened
- The first of the month account balance

Treatment of Funds in an ABLE Account

All funds in an ABLE account are disregarded including earning on the account (e.g. interest) when determining eligibility of Medicaid applicants and beneficiaries who are subject to a resource test. The balance within a single ABLE account for an individual, including contributions and earnings, is excluded as a resource.

Qualified Disability Expenses

The funds in an ABLE account are intended to cover an individual's Qualified Disability Expenses (QDEs) related to his or her blindness or disability. QDEs include, but are not limited to education, housing and basic living expenses, transportation, employment training and support, assistive technology and personal support services, health, prevention and wellness, financial management, and administrative services, legal fees, and funeral and burial expenses.

Treatment of Distributions

Distributions from ABLE accounts are excluded if used or intended to be used for QDEs as long as the distributions are identifiable.

- Distributions from an ABLE account are excluded if used or intended to be used for QDEs
- Distributions from an ABLE account used for non-qualified expenses are excluded if spent in the month of receipt

Distributions from an ABLE account are countable when:

- Distributions are retained past the month of receipt and are used for or intended to be used for non-QDE or
- Distributions are retained past the month of receipt and were previously excluded because it was intended for a QDE but was used for a non-qualified expense. Count the amount of funds used as a resource the first of the month in which funds were spent; or
- Distributions are retained past the month of receipt, have not been spent, and the intent to use funds as a QDE has changed. Count the retained funds as a resource the first of the following month.

Estate Recovery

Estate Recovery applies to funds in an ABLE account that have become part of an estate subject to recovery.

2335 Stocks and Mutual Fund Shares

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Stocks and Mutual Fund Shares		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2335
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

The value of shares of stock and mutual funds is a countable resource.

Shares of stock in an Alaskan native regional or village corporation are excluded as resources.

Basic Considerations

Shares of stock represent ownership in a business corporation. Their value shifts with demand and may fluctuate widely. The following guidelines apply to all types of stock, including preferred stock, warrants and rights, and options to purchase stock.

A *mutual fund* is a company whose primary business is buying and selling securities and other investments. Shares in a mutual fund represent ownership in the investment held by the fund.

Procedures

Verify and document the following:

- Ownership Interest: If the shares are owned jointly, assume that each owner owns an equal share.
- Number of Shares Owned: Ask the individual to submit the stock certificate or most recent statement of account (including dividend account) from the firm that issued or is holding the stock. Document the system and case with a photocopy. If the individual does not have this documentation, have him/her obtain a statement from the firm. Provide assistance as needed.

Determine the countable resource value of shares of stock or mutual funds by multiplying the number of shares owned by the CMV of each share.

- Current Market Value (CMV) of Each Share: The CMV of a stock as of the first moment of a given month is its closing price on the last business day of the preceding month. The value of over-the counter stock is shown on a bid and asked basis. Use the bid price as the CMV. The par value or stated value shown on some stock certificates is not the market value of the stock.
- Consider the CMV of a mutual fund share to be the selling price (sell).

The closing price of a stock on a given day can usually be found in the next day's newspaper.

If the value of a stock does not appear in a newspaper, contact a local securities firm. Provide the

firm with the following information:

- name of stock, bond, or mutual fund
- type of stock, such as preferred or common
- months for which values are needed.

2336 Trust Property, Medicaid Qualifying (Prior to OBRA ’93)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Trust Property, Medicaid Qualifying (Prior to OBRA ’93)		
	Effective Date:	September 2024		
	Chapter:	2300	**Policy Number:**	2336
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-73

Requirements

Effective January 1, 1988, a trust which meets the definition of a Medicaid Qualifying Trust (MQT) is a countable asset.

This policy applies ONLY to trusts created prior to 8-11-93 (OBRA '93). Refer to Section 2337 - Trust Property – OBRA '93 for trusts created on or after 8-11-93. Also refer to Section 2338 - Trust Property for trusts created by a will.

Not applicable in Family Medicaid.

Basic Considerations

An MQT is a trust or similar legal device established by an individual (or his/her spouse) under which (a) the individual is the beneficiary of all or part of the payments from the trust, **and** (b) the amount of such distribution is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed to the individual. The distributable amount from an MQT has no *use* limitation, and MQTs include trusts that are irrevocable or revocable or which are for purposes other than to enable the individual to qualify for Medicaid.

Because there are no *use* limits on the trust funds in an MQT, trusts such as irrevocable burial trusts, education trusts, and medical trusts could be MQTs, provided they meet the criteria as specified in the definition. For example, the terms of the trust may be written so that the trustee may make payments directly to the health care provider for medical services. Thus, although the payments from the trust are not directly paid to the beneficiary, s/he is in fact receiving benefits from payments.

The *individual* is the person who both establishes the trust (or whose spouse establishes the trust) and is beneficiary of the trust. A trust that is established by an individual’s guardian or legal representative, acting on the individual’s behalf, falls under the definition of a MQT. If an individual is not legally competent, for example, a trust established by their legal guardian (including a parent) using the individual’s assets can be treated as having been established by the individual, since the individual could not establish the trust for himself.

A trust meeting the definition of an MQT established prior to April 7, 1986 for an individual residing in an intermediate care facility (ICF) for the mentally retarded is not considered an

> MQT. A trust established by a will is never treated as an MQT.

The distributable amount of the trust is the maximum amount considered available to be distributed to the beneficiary under the terms of the trust if the trustee exercises his full discretion.

Any portion of the available amount, principal or interest, that is distributed to the A/R for any purpose is income to the A/R for the month received and is a resource in the following month if retained.

Any portion of the available amount, principal or interest, that is not distributed to the A/R is a resource to the A/R.

Any portion of the trust assets, principal or interest not considered available to the A/R under the terms of the trust is to be reviewed under the transfer of assets policy. Refer to Section 2342 - Transfer of Resources. Also, refer to Section 2345 - Undue Hardship Provision for ABD Medicaid.

Definitions

Definitions of common terms used in describing trusts:

Similar Legal Devices – any arrangements, instruments or devices which are established by the A/R or their spouse which are not called trusts, or which do not qualify as trusts under state law, but which have all of the characteristics described in the definition of an MQT.

Trustee – a trustee is any individual, individuals, or entity (such as an insurance company or bank) that manages a trust or similar device and has fiduciary responsibilities.

Disbursements – Any money generated by the trust.

Grantor – an individual who creates a trust. The term grantor includes:

- the individual
- the individual's spouse
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse
- a person, including a court or administrative body acting at the direction or upon the request of the individual, or the individual's spouse.

Beneficiary or grantee – the person on whom the money in the trust is to be spent, the person specified in the trust whose needs are to be met. In an MQT, the grantor and beneficiary are the same person (the A/R or a deemor).

Corpus or principal – the assets that make up the trust.

Encroach upon, or encroachment – the ability to access and use the assets in the trust. The trust document might say the trustee shall have the right to encroach upon the corpus of the trust as deemed necessary for the benefit of the grantee.

Proceeds – the money earned on the corpus, usually interest, dividends or rent.

Procedures

Follow the steps below to determine the treatment of an MQT:

Step 1 Obtain a copy of the trust document and any supporting information detailing any investments and a history of distributions made by the trustee.

Step 2 Determine if the trust meets the definition of an MQT, such as who set up the trust and who is the beneficiary of the trust. Proceed to Step 3, if the trust is determined to be an MQT.

Step 3 Determine the total amount considered available to the A/R, if any. Determine the amount(s) actually distributed to the A/R and at what interval(s).

Step 4 Treat the amount the A/R actually receives as income in the month received and as a resource if retained in any month past the month of receipt. Treat any portion of the amount available to be distributed that is not actually distributed to the A/R as a resource to the A/R.

Step 5 Develop a transfer of assets penalty if a portion of the trust assets is not available to the A/R.

Step 6 If AU is approved, attach a copy of the trust document to a completed Form DMA-285 and forward to: (signature of A/R or RP not required)

Georgia Department of Community Health
ATTN: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30084
Email: gatrustunit@gainwelltechnologies.com
Fax: 678-564-1169

The Georgia Trust Unit is paperless and prefers all documents and information be emailed. For questions, email using the above address or call 678-564-1168.

2337 Trust Property – OBRA ‘93

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Trust Property – OBRA ‘93		
	Effective Date:	September 2024		
	Chapter:	2300	**Policy Number:**	2337
	Previous Policy Number(s):	MT 71	**Updated or Reviewed in MT:**	MT-73

Requirements

Effective with all trusts created on or after 8-11-93 by the A/R or someone acting on behalf of the A/R, the corpus of a trust is either (1) a resource available to the A/R; or, (2) is subject to the transfer of resources penalty. Disbursements from the trust are countable income.

Basic Considerations

The Omnibus Budget Reconciliation Act of 1993 (OBRA '93) applies to all trusts into which an A/R has placed his/her resources. The A/R may have established the trust for his/her own benefit, or the benefit of another person.

Refer to Section 2338 - Trust Property for definitions pertaining to trusts and for policy on trusts created by a will. Refer to Section 2336 - Trust Property - Medicaid Qualifying for trusts created prior to 8-11-93.

Consider all trusts created by the following individuals:

- the A/R
- the A/R’s spouse
- any person, including a court or administrative body, acting at the request or direction of the A/R or spouse
- any person, including a court or administrative body, with the legal authority to act on behalf of the A/R or spouse.

Consider all trusts, except those created by a will, which were created as follows:

- with the A/R’s resources

  AND/OR

- with the A/R as beneficiary

Burial Trusts

A burial trust is a trust established by the A/R to pay for the funeral expenses of the A/R. Beginning January 1, 2007, burial exclusions may be up to a maximum of $10,000 for Non- FBR A/Rs and deemors. This includes the total of the face value of life insurance policies (Section 2323 - Life Insur-

ance Policies), burial funds (Section 2312 - Burial Funds) and burial trusts/pre-need contracts (Section 2311 - Burial Contracts and Burial Space Items).

The following trusts will NOT be counted as a resource or considered a transfer of assets as long as it is considered a valid document by DCH Legal:

- For guidelines on a *Special Needs Trust* (SNT) refer to Section 2346 - Special Needs Trust. DCH Legal determines the validity of any SNTs.
- A Qualified Income Trust (QIT), also known as a Miller Trust, established in the state for the benefit of an individual if:
  - the trust is composed only of pension, Social Security, and other income to the individual (and accumulated income in the trust),
  - the trust is irrevocable,
  - the state will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total medical assistance paid on behalf of the individual, and
  - Income placed in the QIT is not counted in the eligibility determination. However, the patient liability/cost share budget incorporates the A/R's income in the QIT, and income not put in the QIT. See Section 2407 - Qualified Income Trust for more complete information.
- A trust, generally referred to as a *Pooled Trust*, contains the assets of an individual who is disabled that meet the following conditions:
  - The definition of disabled for purposes of a Pooled Trust is that the A/R was under age 65 and disabled according to the SSA definition of disability when the trust was established.

    Please include documentation of AR's disability when sending the trust to DCH.

  - The trust is established and managed by a non-profit organization.
  - Separate accounts are maintained for each beneficiary, even if pooled for purposes of investment and management.
  - The trust was established by the disabled individual, their parents, grandparents, legal guardian or the court.
  - All trusts funded with the proceeds of a settlement must submit a certified copy of the court order and the Settlement Agreement to DCH. The joinder agreement must specifically identify in an attached schedule the initial source of the funding of the beneficiary's account.
  - The trustee must notify DCH within five days of the death of the beneficiary. Amounts remaining upon the beneficiary's death are paid to the State by the trust in an amount equal to the total amount of medical assistance paid on his/her behalf. The following expenses and payments are NOT permitted prior to reimbursement of the State for medical assistance:
    - Payment of debts owed to third parties,
    - Funeral expenses, and
    - Payments to residual beneficiaries.
  - A pooled trust established by or for the benefit of an aged individual (age 65 or older) on or after May 1, 2006, should be treated as a transfer of resources and a transfer penalty applied.

- DCH determines the validity of all Pooled Trusts. If DCH Legal does not approve an irrevocable trust, compute a transfer of resource penalty; if it was revocable, count as a resource. Refer to Section 2342. - Transfer of Assets. Submit a copy of a Pooled Trust for approval prior to completion of an application or review (if not previously approved by DCH).
- Send all SNT, QIT's that deviate from one of the approved templates, and Pooled Trust to:

  Georgia Department of Community Health
  ATTN: Trust Unit
  100 Crescent Centre Pkwy, Suite 1000
  Tucker, GA 30084
  Email: gatrustunit@gainwelltechnologies.com
  Fax: 678-564-1169

The Georgia Trust Unit is paperless and prefers all documents and information be emailed. For questions, email using the above address or call 678-564-1168.

All trusts are considered a TPL and must be sent to the Third-Party Liability Unit. Refer to Section 2230 - Third Party Liability for more information.

Revocable Trusts

Any disbursements from the trust given directly to the A/R or disbursements paid to a third party for the purpose of food, clothing or shelter are considered income to the A/R in the month of disbursement.

Count the corpus or principal of a revocable trust as a resource available to the A/R.

Irrevocable Trusts

Count any money generated by the trust as income to the A/R, whether or not received by the A/R.

Count any portion of the corpus or principal of an irrevocable trust from which it is possible to make a disbursement to the A/R as a resource available to the A/R.

Count any portion of the corpus or principal of the trust from which it is NOT possible to make a disbursement to the A/R as a transfer of resources.

Count any disbursements from the trust as income to the A/R, whether or not received by the A/R.

Transfer of Resources Penalty

Consider the transfer of resources penalty, if appropriate, for any resource placed into a trust within the 60 month look back period.

The transfer of resources penalty does not apply to resources that are excluded under Non- FBR policy if transferred into a trust.

If a resource can be considered under both the OBRA '93 trust provision OR the transfer of resource penalty provision, treat the resource under OBRA '93 trust provisions.

Refer to Section 2342 - Transfer of Resources and Section 2345 - Undue Hardship Provision for ABD

Medicaid.

Procedures

Follow the steps below to determine the treatment of a trust:

Step 1 Obtain a copy of the trust document and any supporting documentation detailing any investments and distributions made by the trust. For QITs refer to Section 2407 - Qualified Income Trust; for SNTs refer to Section 2346 - Special Needs Trust (SNT).

Step 2 Determine the date that the trust was established.

- If established on or after 8-11-93, continue to step 3.
- If established prior to 8-11-93, see Section 2336 - Trust Property Medicaid Qualifying and Section 2338 - Trust Property.

Step 3 Determine if the trust is revocable or irrevocable.

Step 4 For an irrevocable trust, based on the conditions of the trust document, determine the following:

- the total amount of the corpus or principal considered available to the A/R. Count as a resource available to the A/R.
- the total amount to the corpus or principal considered NOT available to the A/R. Consider the transfer of resources penalty.
- the total amount of income generated by the trust. Count as income to the A/R, whether or not received by the A/R.
- any disbursements that have been made from the trust. Count as income to the A/R, whether or not received by the A/R.

Step 5 For a revocable trust, count the total value of the corpus or principal as a resource available to the A/R. Count any disbursements that have been made from the trust as income to the A/R, whether or not received by the A/R.

Step 6 If AU is approved, attach a copy of the trust document to a completed Form DMA-285 and forward to: (signature of A/R or RP not required)

Georgia Department of Community Health
ATTN: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30084
Email: gatrustunit@gainwelltechnologies.com
Fax: 678-564-1169

The Georgia Trust Unit is paperless and prefers all documents and information be emailed. For questions, email using the above address or call 678-564-1168.

2338 Trust Property

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Trust Property		
	Effective Date:	September 2024		
	Chapter:	2300	**Policy Number:**	2338
	Previous Policy Number(s):	MT 59	**Updated or Reviewed in MT:**	MT-73

Requirements

The trust principal is a resource to an individual who is legally empowered to revoke the trust and use the principal for his/her own support and maintenance.

Basic Considerations

A trust is a legal arrangement by which one person holds property for the benefit of another. The person who makes the arrangement is the trustor/grantor/settlor. The person who holds the property is the trustee. The person for whom the property is held is the beneficiary.

Totten Trust

A Totten Trust is a trust in which an individual makes himself/herself trustee of his/her own funds for the benefit of another. The trustor/trustee can revoke a Totten Trust at any time. Should the trustor/trustee die without revoking the trust, the principal of the trust reverts to the beneficiary.

If the A/R is the trustor of a Totten Trust, the principal of the trust is a resource to the A/R, and any income generated by the principal is income to the A/R.

If the A/R is the beneficiary of a Totten Trust, the principal of the trust is **not** a resource to the A/R **unless** the trust itself gives the A/R access to the property without the intervention of the trustee. When the beneficiary has no control over the trust, count as income only trust distributions actually received by the beneficiary, regardless of what the trust specifies the beneficiary should receive.

MQT

A Medicaid Qualifying Trust (MQT) is a trust created prior to 8-11-93 by an individual, spouse, or someone acting on his/her behalf, with his/her own funds, and with him/her named as the beneficiary of the trust. Refer to Section 2336 - Trust Property Medicaid Qualifying.

OBRA ‘93

An OBRA'93 trust is a trust created on or after 8-11-93 by an individual, spouse, or someone acting on his/her behalf, with his/her own funds, and with his/her named as the beneficiary of the trust. Refer to Section 2337 - Trust Property-OBRA '93.

Other Trusts

Trust property which is neither an MQT nor a Totten Trust, such as a trust created by a will, will be treated as follows:

- The trust principal is not a resource to an individual who is not legally empowered to revoke the trust and use the principal for his/her own support and maintenance.
- Revocability of a trust depends on the terms of the trust agreement and/or on state law. If a trust is irrevocable, the trust principal is not anyone's resource.
- Trust earnings and disbursements are not income to the trustor or trustee unless designated as belonging to the trustor or trustee under the terms of the trust, such as fees payable to a trustee or interest payable to a trustor rather than feeding into the trust itself.
- Additions to the trust principal are not income to a trustor or trustee. However, they may be income to a trustor or trustee prior to becoming part of the trust principal. For example, if the trustor or trustee is a deemor who receives RSDI benefits and adds to the trust principal, consider the RSDI as income for deeming purposes.
- Trust earnings are not income to the beneficiary unless the trust dictates, or the trustee allows, payment to a beneficiary.
- Trust distributions are income to the beneficiary if paid to him/her in cash. They may result in income to the beneficiary if used to make certain third-party vendor payments on his/her behalf.

The transfer of assets policy can be applied whenever a trustor who is an A/R establishes a trust fund for the benefit of another person.

Procedures

Review the trust document and determine whether any of the following conditions applies to the trust:

- The individual (A/R or deemor) is the trustor, trustee or beneficiary.
- The trust is revocable and, if so, whether the individual has the authority to revoke and to use the principal for his/her own support and maintenance.
- The individual has unrestricted access to the trust principal.
- The trust provides for payments to the individual or on his/her behalf.
- The trust principal generates income and, if so, whether the individual has the right to any of that income.

If the A/R is the beneficiary of a non-MQT trust, contact the trustee to verify the actual income from the trust received by the A/R.

When trust property is a resource and its value is material to eligibility, determine the type of the property and establish its value by one of the following means:

- Contact the holder of the funds if they are in cash.
- Develop the resource value of the property as outlined in the applicable section in this chapter

dealing with the specific type of property.

- Record all information used in determining whether the trust is a resource or creates income. Record your conclusions and include a copy of the trust document, if any.

Forward a copy of the trust attached to a completed Form DMA-285 to: (signature of A/R or RP not required)

Georgia Department of Community Health
ATTN: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30084
Email: gatrustunit@gainwelltechnologies.com
Fax: 678-564-1169

The Georgia Trust Unit is paperless and prefers all documents and information be emailed. For questions, email using the above address or call 678-564-1168.

2339 Annuities

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Annuities		
	Effective Date:	June 2021		
	Chapter:	2300	**Policy Number:**	2339
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-64

Requirements

Annuities are considered trust property. Trust, for purposes of asset transfers and the look-back period, includes annuities purchased by or on behalf of an individual who has applied for Medicaid covered nursing facility or other long-term care services (LA-D COAs). An annuity purchased prior to 2/8/06, that **is** *actuarially sound* is treated as a retirement fund. An annuity purchased prior to 2/8/06, that **is not** *actuarially sound* is subject to the appropriate trust provisions. Any annuity purchased on or after 2/8/06 is subject to the changes outlined in the Deficit Reduction Act (DRA) of 2005

Basic Considerations

An annuity is a financial entity that provides to the purchaser the right to receive periodic payments, either for life or for a specified period of time.

The annuity must be amortized. This means that the regular payments are equal so that the last payment is the same as the previous payment. For Medicaid purposes, payments must be monthly only.

The Deficit Reduction Act of 2005 (DRA)

The DRA of 2005, enacted 2/8/06, has changed the way some annuities are to be treated. These policy changes will be implemented beginning 2/1/07 for all applications (pending or new, including three months prior) and all new and pending reviews/specials.

State Remainder Beneficiary (DRA)

Effective with annuities **purchased** on or after 2/8/06, for A/Rs applying for or already receiving LA-D Medicaid, the State of Georgia must be named as the remainder beneficiary of the annuity in the **first position** for the total amount of medical assistance paid on behalf of the individual receiving LA-D Medicaid.

> If there is a community spouse and/or minor or disabled child(ren), the State may be named in the next position after those individuals. If that is the case and any of those individuals or their representatives dispose of any of the remainder of the annuity for less than the FMV, the State must then be named in the first position.

The MES is required to notify the issuer of the annuity(s) of the State's rights as a preferred remain-

der beneficiary. The A/R, spouse or representative must notify DFCS of any changes in disbursement of income or principal from the annuity. The issuer of the annuity may disclose information about the State's position as remainder beneficiary to others who have a remainder interest in the annuity. Failure to name the State as the remainder beneficiary will result in a transfer of asset penalty. See 2342 Transfer of Assets. This policy applies to annuities purchased by a spouse or to transactions made by the A/R or spouse, as well as annuities purchased by or on behalf of the A/R.

Full Disclosure (DRA)

The DRA requires a full disclosure and description of any interest the applicant or the community spouse may have in any and all annuities owned by the A/R and/or spouse. This disclosure is a condition for Medicaid eligibility for LA-D COAs:

- Nursing facility services (NH and institutional hospice).
- A level of care in any institution equivalent to that of nursing services (ex. Mental health/retardation hospitals); and
- Home and community-based services furnished under a waiver COA (Katie Beckett, NOW, COMP, EDWP, ICWP, Hospice).

If the A/R, spouse or representative refuses to disclose sufficient information to determine eligibility, computation of resources, income, or PL/CS the Medicaid case will be denied or terminated.

If an unreported annuity is discovered after eligibility has been favorably established and after payment for long term care services has been made, the MES will take appropriate steps to terminate the Medicaid case as discussed above, including appropriate notice to the A/R of adverse action.

The MES will also refer the case to DCH to consider whether other steps should be taken, including, if appropriate, possible civil and criminal charges, liens, and potential recovery of benefits which were incorrectly paid.

Annuity as a Countable Asset (DRA)

An annuity is considered in determining eligibility, including spousal income and resources, and in the PL/CS determination. The MES will treat an **irrevocable, non-assignable actuarially sound annuity that provides payments in approximately equal amounts, with no deferred or balloon payments** as income to the AR or spouse. Annuities that have a qualified tax status according to the Internal Revenue Code (IRC) are exempt from the above criteria, **but the income is still counted** toward the AR or spouse. These include annuities purchased with proceeds from 401k, pension, 403b or a qualified retirement plan or annuities considered as:

- An IRA according to section 408(b) of the IRC of 1986.
- A deemed IRA under a qualified employer plan according to section 408(q) of the IRC
- Purchased with proceeds from a traditional IRA according to section 408(a) of the IRC
- Purchased with proceeds from certain accounts or trusts which are treated as traditional IRAs according to section 408(c) of the IRC
- Purchased with proceeds from a simplified retirement account according to section 408(p) of

the IRC

- Purchased with proceeds from a simplified employee pension according to section 408(k) of the IRC
- Purchased with proceeds from a Roth IRA according to section 408(a) of the IRC

SSA Life Expectancy Table

Using the Social Security Administration's Life Expectancy Actuarial Tables for the age and sex of the purchaser in this section, determine if the expected return from the annuity is equal to the purchase price.

- If the expected return is equal to or greater than the purchase price, the annuity is actuarially sound. Treat as a retirement fund, if purchased prior to 2/8/06. Refer to 2332 Retirement Funds to determine how to treat retirement funds. If purchased on or after this date, treat under DRA'05 policy as outlined in this section.
- If the expected return is less than the purchase price, the annuity is not actuarially sound. The difference between the expected return and the purchase price is a trust. Treat under the appropriate trust provision. Refer to 2336 Trust Property, Medicaid Qualifying (Prior to OBRA '93); 2337 Trust Property – OBRA '93; 2338 Trust Property to determine how to treat these trusts. If purchased on or after 2/8/06, treat under DRA '05 policy as outlined in this section.

Annuity-Related Transactions Other than Purchases

Certain transactions which are made to an annuity purchased prior to 2/8/06, may make that annuity subject to the DRA rules. These transactions include any action taken by the A/R or spouse that changes the course of payments to be made by the annuity or the treatment of the income or principal of the annuity. Examples of this type of transactions are:

- Additions of principal,
- Elective withdrawals,
- Requests to change the distribution of the annuity,
- Elections to annuitize the contract
- Similar actions taken after 2/8/06.

Routine changes and automatic events that do not require any action or decision after 2/8/06, are not considered transactions that would subject the annuity to treatment under these provisions of the DRA. Routine changes could be notification of an address change or death or divorce of a remainder beneficiary, and other similar circumstances. Changes which occur based on the terms of the annuity which existed prior to 2/8/06, and which do not require a decision, election or action to take effect are not subject to the DRA. Changes which are beyond the control of the individual, such as a change in law, a change in the policies of the issuer, or a change in the terms based on other factors, such as the issuer's economic conditions, are not considered transactions that cause the annuity to be subject to the terms under the DRA.

Procedures

Follow the steps below to determine how to treat an annuity **purchased on or after 2/8/06**:

Step 1 Obtain a copy of the annuity and determine if the A/R, spouse or representative has given a full disclosure of the annuity. If the parties refuse to cooperate in the disclosure process or an unreported annuity is discovered after eligibility has been established and after payment for LA-D services have been made – **Stop** – Deny/terminate the Medicaid case allowing recipients adverse action.

For A/Rs who have not previously disclosed information regarding an annuity, report to Medicaid Fraud.

If there has been a full disclosure regarding the annuity, proceed to Step 2.

Step 2 Verify that the State of Georgia is named as the remainder beneficiary for any annuity owned by the A/R or spouse, or the next beneficiary if there is a spouse, minor/disabled child(ren) in the home.

If No, proceed to step 3.

If Yes, the MES :

- will notify the issuer of the annuity that the State is named as beneficiary in the first position. Use Annuity Issuer Form found in Appendix F.
- inform the A/R or representative to notify the state when there is any change in the amount of the income or principal being withdrawn, and
- Proceed to step 4

Step 3 If the State is not named as the appropriate beneficiary – **Stop** – develop a transfer of assets penalty on the full value remaining on the annuity as follows:

- For NH/IH the penalty will result in no vendor payment made to the facility and an increase in PL for any partial month penalty. Refer to 2342 Transfer of Assets.
- For home and community-based waiver cases, deny/terminate the case allowing for adverse action. Refer to 2342 Transfer of Assets.

For recipients in either situation, allow the A/R or representative 30 days in which to have the annuity changed to name the State in the proper position. If they fail to comply, close the case or impose the transfer penalty as appropriate.

Step 4 Determine if the annuity is one which is exempt from the transfer of assets penalty as outline by the Internal Revenue Code of 1986. See page 3 of this section.

Determine if the annuity is irrevocable, non-assignable, actuarially sound and provides equal monthly payments. See Step 2 through 9 following this set of Procedures.

- If the annuity meets all these requirements – **Stop** – count the income received from the annuity toward the income eligibility and PL/CS determination.
- If the **annuity is one exempt under the IRC rules**, count the income received from the annuity toward the income eligibility and PL/CS determination.
- If it does not meet these criteria, impose the transfer of assets penalty as follows:
  - for NH/institutionalized hospice A/Rs, the penalty will result in no vendor payment made to the facility and an increase in PL for any partial month penalty. 2342 Transfer of Assets.
  - for home and community-based waiver cases, deny/terminate the case allowing for adverse action. 2342 Transfer of Assets

Step 5 If the AU is approved and the annuity is NOT actuarially sound or not amortized, attach a copy of the document to a completed Form DMA-285 and forward to: (signature of A/R or RP not required)

Third Party Liability Unit
P.O. Box 1984
Atlanta, Georgia 30301-1984

Follow the steps below to determine if an annuity is actuarially sound **for annuities purchased prior to 2/8/06 or Steps 2 – 8 for DRA '05 annuities:**

Step 1 Determine the date on which the annuity was purchased. Use the appropriate trust provisions (based on the date of purchase and whose funds were used) to determine how to treat the annuity. The appropriate trust provisions are found in 2336 Trust Property, Medicaid Qualifying (Prior to OBRA '93); 2337 Trust Property – OBRA '93; and 2338 Trust Property.

Step 2 Determine the age and sex of the purchaser at the time of purchase.

Step 3 Verify the purchase price of the annuity.

Step 4 Determine the amount and the frequency of the payments. If the payment frequency is other than monthly, require that the payments be converted to monthly. If the payments are not converted to monthly, compute a transfer of assets penalty on the purchase price of the annuity.

Step 5 Determine the length of time that the individual will receive periodic payments from the annuity.

Step 6 Determine if the annuity is amortized.

- If the annuity is not amortized, consider a transfer of assets penalty on the purchase price of the annuity. Refer to 2342 Transfer of Assets. Proceed to Step 10.
- If the annuity is amortized, proceed to Step 8.

Step 7 Using the Social Security Life Expectancy Actuarial Table, determine the life expectancy of the purchaser from the date of the purchase of the annuity.

Step 8 Based on the individual's life expectancy, the amount, frequency, and duration of the payments, calculate the total dollar amount of the payment the purchaser is expected to receive from the annuity.

If the total dollar amount of the payment from the annuity is expected to equal or exceed the purchase price, the annuity is considered to be actuarially sound. Treat the annuity as retirement funds if purchased prior to 2/8/06. See 2332 Retirement Funds to determine the correct treatment of retirement funds. For DRA '05 annuities, return to page 6 step 4.

Step 9 If the total dollar amount of payment from the annuity is expected to be less than the purchase price, the annuity is not considered to be actuarially sound. For DRA '05 annuities, return to page 6 step 4. For those purchased prior to 2/8/06 proceed to Step 10.

Calculate the difference between the purchase price and the expected total payment from the annuity.

- The amount of the purchase price that the A/R is expected to receive is considered retirement funds
- The amount of the purchase price the A/R is not expected to receive should be counted as a trust under the correct trust provisions.

Step 10 If the AU is approved and the annuity is **NOT** actuarially sound or not amortized, attach a copy of the document to a completed Form DMA-285 and forward to: (signature of A/R or RP not required)

Third Party Liability Unit
P.O. Box 38439
Atlanta, Georgia 30334

Annual Review

At each annual review, for A/R and spouse, reverify income received, ask about any changes made to the annuity and that the annuity and/or income from it has not been transferred. In addition, for DRA annuities, reverify that the State is still the remainder beneficiary.

Family Medicaid

Refer to 2301 Family Medicaid Resources Overview and to 2399 Treatment of Resources by

Resource Type Chart.

Life Expectancy Table

Use the Period Life Table (from SSA.gov) located at www.ssa.gov/oact/STATS/table4c6.html to determine the value of compensation for annuities and contracts. Refer to the formula below to compute if an annuity or contract is actuarially sound.

Formula:

Age at time of purchase + yrs. of life remaining (from chart) = expected age for life.

Then (Expected age for life) – (age at time of purchase - 1 yr.) = remaining yrs.

remaining yrs. X 12 (if payments are monthly) = # of monthly payments.

# of monthly payments X monthly payment amount = Total $ amount received in payment.

If this $ amount is equal to or greater than purchase price, then the annuity is actuarially sound.

2340 Uniform Gifts to Minors

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Uniform Gifts to Minors		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2340
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

If an A/R is the donor of a uniform gift to a minor (UGM), the transfer of resources provision may apply.

If an A/R is the recipient of a UGM, the UGM is not a countable resource until the month after the A/R's 21st birthday.

Basic Considerations

A UGM involves the following:

- The donor, who makes an irrevocable gift of money or other property (assets) to a minor.
- The recipient, who automatically receives control of the assets upon attainment of majority (age 21).
- The gift, plus any earnings it generates, which is under the control of a custodian until the recipient reaches the age of majority established by state law.
- The custodian, who has full discretion to spend for the minor's support, maintenance, benefit or education as much of the assets as s/he deems necessary.

Since a custodian of UGM assets cannot legally use any of the funds for his or her own personal benefit, the UGM assets are not a resource to the custodian.

Additions to or earnings on the UGM principal are not income to the custodian since s/he has no right to use them for his/her own support and maintenance. Additions to the principal may be income to the donor prior to becoming part of the UGM principal.

The custodian's UGM disbursements to the minor, including third party vendor payments for food, clothing, or shelter, are income to the minor.

When the recipient reaches majority age, all UGM property becomes subject to evaluation as income in the month of attainment of majority.

Procedures

Verify all allegations of the existence of a UGM by obtaining a copy of the document of ownership, such as a deed, certificate of deposit, savings passbook or other written document from the issuing

source (donor) designating a gift under UGM. Unless there is evidence to the contrary, accept any such document as proof of a valid gift.

If there is no document designating a UGM, do not develop further. Deal with the property as if there had been no allegation of a UGM.

Contact the State Medicaid Unit for further assistance.

2341 Victims’ Compensation

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Victims’ Compensation		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2341
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

Unspent portions of Victims' Compensation are excluded as resources for nine full calendar months after the month of receipt.

This is an excluded resource for Family Medicaid.

Basic Considerations

Victims' Compensation (VC) is payments from a fund established by a state for expenses incurred or losses suffered as a result of a crime.

Interest earned on unspent VC is *not* excluded from income or resources.

Procedures

If an individual alleges that his or her resources include unspent VC, ask the individual to submit evidence that establishes the following:

- the source, date(s), and amount(s) of VC payments(s)
- the VC was paid as compensation for expenses incurred or losses suffered as the result of a crime.

Obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the VC payment(s). Assist the individual as necessary.

Accept the following as evidence establishing that the payment was a VC payment:

- a letter or check stub from the payment indicating the payment is VC
- a subsequent letter requested by the claimant/recipient to clarify that the reason for the payment is VC.
- Any other document indicating the reason for the payments as VC.

If the individual is unable to submit acceptable evidence, attempt to obtain the needed information over the phone through a contact with the agency that issued the VC.

2342 Transfer of Assets

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Transfer of Assets		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2342
	Previous Policy Number(s):	MT 42	**Updated or Reviewed in MT:**	MT-59

Requirements

Assets, with respect to an A/R, includes all income and resources of the A/R and of the A/R's spouse, including income and resources which the A/R or A/R's spouse is entitled to but does not receive because of action by:

- the A/R or spouse
- a person, including a court or administrative body, with legal authority to act in place of or on behalf of the A/R or spouse
- any person, including any court or administrative body, acting at the direction or upon the request of the A/R or spouse

If an A/R, anyone acting legally on an A/R's behalf, anyone holding an asset in common with an A/R, or the A/R's spouse, gives away or sells assets for less than current market value (CMV) during the look-back period, the A/R may be subject to a transfer of assets penalty.

The transfer of assets policy does not apply to Family Medicaid.

Basic Considerations

OBRA '93

Omnibus Budget Reconciliation Act of 1993 - the legislative basis for the transfer of resource penalty, effective 10/1/93, for all assets transferred on or after 8/11/93.

DRA '05

The Deficit Reduction Act of 2005 is the legislative basis for the transfer of assets penalty, enacted 2/8/2006. The DRA transfer of assets policy and partial month transfer of assets policy is to be implemented 2/1/07 with all applications (including three months prior) and reviews taken on or after October 1, 2006, for transfers which were done on or after 02/8/06.

Fair Market Value

Fair market value (FMV) is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred. Value is based on criteria you use in appraising the value of assets for the purpose of determining Medicaid eligibility. For an asset to be considered transferred for FMV, the compensation received for the asset must be in a tangible form with intrinsic value.

Uncompensated Value

The difference between the FMV of the asset at the time of the transfer and compensation received for the resource.

Look Back Period

A specified number of months immediately preceding the application or request for assistance for which the worker must determine if an asset has been transferred. The look back period is different depending on when each law was enacted:

OBRA '93

- 60 months for assets transferred into a trust, beginning with the first month for which Medicaid eligibility is requested. Refer to Special Considerations of this Section.
- 36 months for other transferred assets beginning with the first month for which Medicaid eligibility is requested. Refer to Special Considerations of this Section.

DRA '05

- 60 months prior to the application date for ALL transfers of assets done on or after 2/8/06.

All Transfers

A transfer of assets **penalty does not apply** if any one of the following conditions is met:

- An asset is used to pay a valid debt.
- An asset is a valid loan.
- An A/R transfers an asset to his/her community spouse, or to another individual for the sole benefit of the spouse. See Chart 2502.1, for a definition of sole benefit of.
- An A/R can provide a satisfactory showing that he/she intended to dispose of the asset for fair market value, or for other valuable considerations. This would include situations where an individual is defrauded or executes a transfer as a result of misrepresentation.
- All of the transferred resources/assets have been returned to the individual.
- Denial of eligibility would cause an undue hardship. Undue hardship must be considered in every case. Refer to 2345 Undue Hardship Provision for ABD Medicaid.
- An asset was transferred **exclusively** for a purpose other than to qualify for Medicaid.

  This policy does not apply to transfer of homeplace property.

- An asset owned by the community spouse of an institutionalized A/R is transferred by the community spouse after eligibility is established.

  Annuities and homeplace property.

- An asset was transferred to a blind or disabled child (minor or adult) as established under title XVI or defined in section 1614 of the Social Security Act.

Transfers Made On or After 8/11/93 (OBRA '93 and DRA '05)

A transfer of assets **penalty does not apply** if any one of the following conditions is met:

- The homeplace was transferred (1) to the community spouse of the A/R or (2) child of the A/R if the child is under the age of 21 or is blind or is permanently and totally disabled.
- The homeplace was transferred to a sibling of a LA-D A/R if the sibling has an equity interest in the home and has been residing in the home for at least one year immediately prior to the A/R entering LA-D.
- The homeplace was transferred to a son or daughter of the A/R who has been residing in the home for at least two years immediately prior to the A/R entering LA-D, and the son or daughter was providing such care to the A/R as to permit the A/R to continue to reside at home rather than enter LA-D.
- The assets were transferred to a trust established for the sole benefit of (1) the A/R's disabled child or (2) a disabled individual who is under 65 years of age. Use the same definition of sole benefit of as for transfer to a spouse. See Chart 2502.1.
- The transferred asset was any resource other than a homeplace that can be excluded under FBR policy.
- The resource was excluded under Non-FBR policy and was transferred into a trust.

Transfers Made On or After 8/11/93 (OBRA '93)

A transfer penalty does apply and is developed if:

- The community spouse of an A/R transfers an asset to anyone for purposes other than the sole benefit of him/herself during the 36 month look back period. Refer to Chart 2502.1, for definition of sole benefit of.
- An A/R gives away or sells an asset for less than CMV, or refuses an inheritance, during the 36 month look back period or anytime thereafter.
- An A/R transfers non-excluded assets into a trust during the 60 month look back period or anytime thereafter.
- An A/R transfers homeplace property to anyone other than those individuals listed in the above exceptions.
- An asset held by an A/R in common with another individual or individuals in a joint tenancy, tenancy in common or similar arrangement, shall be considered to be transferred by the A/R when any action is taken, either by the A/R or the other owner(s), to reduce or eliminate the A/R's ownership or control.

  It does not matter if the A/R had knowledge or gave consent. This includes withdrawals from joint accounts by the other account holder.

- If an A/R's asset is given to someone (other than spouse) who has provided care to the A/R who at the time provided the care for free, presume that the services were intended to be provided without compensation. Thus, a transfer to a relative or others for care provided for free in the past is a transfer of assets for less than FMV. However, an individual can rebut this presumption with tangible evidence that is acceptable.

Transfers Made On or After 2/8/06 (DRA '05)

A transfer **penalty does apply** and is developed if:

- The community spouse of an A/R transfers an asset (including income) to anyone during the application process for purposes other than the sole benefit of him/herself during the 60 month look back period. Refer to Chart 2502.1, for definition of *sole benefit of*.
- The community spouse of an A/R transfers an annuity or homeplace to anyone for purposes other than the sole benefit of him/herself during the 60 month look back period or any time thereafter.
- An A/R gives away or sells an asset for less than CMV, or refuses an inheritance, during the 60 month look back period or anytime thereafter.
- The A/R or community spouse purchases a life estate interest in another individual's home without having lived in the home for at least 12 consecutive months from the date of purchase. Refer to 2322 Life Estate and Remainder Interests.
- An A/R transfers non-excluded assets into a trust during the 60 month look back period or anytime thereafter.
- An A/R transfers homeplace property to anyone other than those individuals listed in the above exceptions. (See OBRA '93.)
- An asset held by an A/R in common with another individual or individuals in a joint tenancy, tenancy in common or similar arrangement, shall be considered to be transferred by the A/R when any action is taken, either by the A/R or the other owner(s), to reduce or eliminate the A/R's ownership or control.

  It does not matter if the A/R had knowledge or gave consent. This includes withdrawals from joint accounts by the other account holder.

- If an A/R's asset is given to someone (other than spouse) who has provided care to the A/R who at the time provided the care for free, presume that the services were intended to be provided without compensation. Thus, a transfer to a relative or others for care provided for free in the past is a transfer of assets for less than FMV. However, an individual can rebut this presumption with tangible evidence that is acceptable.

Procedures

Developing the Possibility of a Transfer of Assets

The possibility of a transfer of assets must be documented on every application and review on A/R and community spouse for ABD Medicaid, with detailed development at the time of application for a LA-D COA.

Indications that a transfer of ownership may have occurred include, but are not limited to the following:

- an individual alleges a resource transfer
- an individual's resources exceed the statutory limit for one or more months of the review period and decline in subsequent months

- other evidence, such as an IRS alert indicating the sale of land or stock.

Obtain the individual's signed statement on the following:

- the nature of the transfer-whether the asset was sold, given away, exchanged for goods or services, etc.
- the method of transfer-whether the property was listed with an agent and sold, transferred without financial considerations, disposed of through purchase(s), etc.
- the date of transfer
- a description of the transferred property
- the market value of the transfer - the amount of cash transferred or the estimated current market value (CMV) minus encumbrances of the property the month of transfer
- the amount of compensation received, if any, whether there were proceeds, their value and whether additional consideration is expected and when
- any remaining ownership interest, such as a partial interest.

Obtain a copy of available evidence of the alleged transaction. This would include items such as bills of sale, statements of purchase, receipts from landlords for prepayment of rent or corroborating statements from recipients of gifts.

When an AR or an AR's spouse transfers a piece of property, we look at the date the legal title is accepted and delivered not at the date the deed was recorded.

Recognize that an individual may not be able to provide an exact to the penny accounting for purchases incurred more than a month or two in the past. Additionally, an individual may allege a purchase or that money was spent in a way, which cannot be corroborated, such as gambling. Exercise great care in resolving the issue of transfer by spending. Any reasonable accounting can be accepted.

Limit development when an individual alleges having transferred excess countable assets through spending, such as making one or more purchases. Such allegations must always be documented by the individual's statement, but no other evidence need be developed except in either of the following situations:

- The individual cannot provide enough information about the alleged purchases to establish his/her resource eligibility status as of the first moment of each relevant month.
- Information in the files makes the allegations questionable

If an A/R is found to have incurred a transfer of assets penalty, complete the following procedures:

- Compute and document the correct penalty.
- Notify the A/R that the penalty is being imposed, and that the undue hardship provision was considered and determined not to be applicable.
- For all cases involving a penalty of more than five years, document the case in Case Notes and scan all verification and supporting documents into the document imaging system.

OBRA '93 Transfer of Assets Penalty

Develop an OBRA '93 transfer of assets penalty on every A/R effective October 1, 1993. Develop a penalty on all assets transferred within the 36 month look back period or anytime thereafter. Impose an OBRA '93 penalty only on those assets transferred on or after 8/11/93.

Determine the number of months of the penalty by dividing the total uncompensated value (UV) of the transferred resource by the average Georgia private pay rate (See Appendix A.1). Drop all fractions.

Begin the penalty the month that the asset was transferred. Do not apply a penalty for a fraction of a month. There is no limit to the number of months a penalty may last.

Impose the penalty on A/R's in LA-D as follows:

- A/R's requesting nursing home service or Institutionalized Hospice in the nursing home will not be eligible for a vendor payment. Determine eligibility as usual. Do not authorize a vendor payment. The A/R is responsible for paying the Medicaid rate to the NH/Hospice provider.
- A/R's requesting services under a home and community-based waiver (CCSP, ICWP, NOW/COMP, non-institutionalized Hospice, Katie Beckett) will be ineligible for home and community-based services (not receiving waivered services). Do not determine eligibility under the Medicaid CAP. Complete a CMD. Hospital is not included in the above.

DRA '05 Transfer of Assets Penalty

Develop a DRA '05 transfer of assets penalty and a "partial month" transfer of assets penalty on every application (including three prior months) and reviews beginning February 1, 2007. This would include applications or reviews pending since 10/1/06. Develop a penalty on all assets transferred within the 60 month look back period or anytime thereafter. Impose a DRA '05 penalty only on those resources transferred on or after 2/8/06. If a penalty has already been computed under OBRA, do not recompute the penalty. For any asset transferred prior to 2/8/06, apply the OBRA penalty as appropriate.

If the community spouse transfers an asset during the 60 month look back period or during the application process for less than the FMV, the transfer penalty is imposed on the A/R. If the community spouse transfers an annuity or homeplace during the 60 month look back period or at any time thereafter for less than the FMV, the transfer penalty is imposed on the A/R. If the community spouse, subsequently goes into LA-D, the penalty may be shared between the spouses in the most advantageous way. Should one-member die or otherwise lose Medicaid eligibility, the remaining eligible spouse will complete the remainder of the penalty period for the now ineligible spouse.

Determine the number of months of the penalty by dividing the total uncompensated value (UV) of the transferred resource by the average Georgia private pay rate (See Appendix A.1). **DO NOT** drop fractions. Determine a penalty even if the penalty does not result in a full month of penalty. A penalty is not imposed until the A/R is determined Medicaid eligible in every aspect **except for the transfer**.

If an A/R has a penalty imposed and subsequently leaves LA-D, the penalty continues to run even if the A/R is not continuing to receive any kind of Medicaid.

For applicants, begin the penalty when the A/R is in LA-D beginning with the later of:

- the month that the resource was transferred, or
- the month that the A/R is otherwise Medicaid eligible

For recipients, begin the penalty, when the A/R is in LA-D beginning with the later of:

- the month after the month of discovery if timely notice can be given,
- The second month after the month of discovery if timely notice cannot be given for the month after discovery.

See the DRA '05 Penalty Computation Form on page 12 to determine how to compute whole and partial months' penalty. There is no limit to the number of months a penalty may last.

If an A/R has a penalty imposed the A/R may NOT subsequently use those incurred long-term care bills as an IME in the PL/CS or for AMN.

Impose the penalty on A/R's in LA-D as follows:

- A/R's requesting nursing home service or Institutionalized Hospice in the nursing home will be Medicaid eligible but not eligible for a vendor payment. Determine eligibility as usual. Do not authorize a vendor payment for whole months of the penalty. The A/R is responsible for paying the private pay rate to the NH/Hospice provider for the full months of the penalty. For the month in which a fraction of a penalty is applied, the A/R will have the vendor payment paid, but the patient liability amount will be increased according to a dollar value of the partial penalty, even if income has otherwise been protected in that month. See the DRA '05 Penalty Computation Form on page 12 for how to compute whole and partial months' penalty and the partial month dollar amount.
- A/R's requesting services under a home and community-based waiver (CCSP, ICWP, NOW/COMP, non-institutionalized Hospice) will be ineligible for home and community-based services (not receiving waivered services). Deny/terminate the HCBW case. Do not determine eligibility under the Medicaid CAP. Complete a CMD. For the month in which a fraction of a penalty is applied, the A/R will be eligible and will have the vendor payment paid, but the cost share amount will be increased according to a dollar value of the partial penalty, even if income has otherwise been protected in that month.

All Transfers

When it is determined that an asset transfer will result in a penalty period, notify the A/R, PR, nursing home and/or the HCB Waiver agency. The notice should include a statement that the hardship provision was determined not to be applicable. For penalties under DRA '05, send a letter, Undue Hardship Waiver Letter and form for Undue Hardship Waiver Application. See Appendix F, Forms.

Special Considerations

If an individual makes more than one application for Medicaid (whether approved or denied), the look back period is based on the first date that the individual enters LA-D and requests Medicaid to pay for those services.

If an A/R is not in a nursing home under the Nursing Home or Institutionalized Hospice class of assistance or receiving community waivered services at the time the transfer penalty is computed, the penalty has no immediate effect. However, if the A/R enters a NH, Institutionalized Hospice or begins receiving community waivered services before the penalty expires (OBRA '93), impose the remainder of the penalty. If the transfer was made on or after 2/8/06, impose the penalty beginning with the first day of the month in which the asset(s) was transferred, or the date on which the individual is otherwise eligible for LA-D Medicaid, whichever is later.

If an asset is transferred back to the A/R, void the penalty. Determine eligibility for all requested months as if no transfer had ever occurred.

An A/R may not exchange non-excluded assets for services received prior to the transfer unless there was a written contract at the time the services were provided.

Multiple Transfers On or After 8/11/93 (OBRA '93)

For an A/R who transfers more than one asset between 8/11/93 and 2/7/06, develop a transfer of assets penalty on each separate transfer. However, treat multiple transfers in the same month as one transfer. Impose all penalties consecutively.

- Begin the penalty with the first transfer.
- Impose the penalty for the second transfer to begin the month following the expiration of the first penalty.
- Impose the penalty for the third transfer to begin the month following the expiration of the second penalty.
- Continue the process as necessary for additional transfers.

> If an A/R or spouse makes multiple transfers in which some or all of each transfer is under the average NH private pay billing rate, compute a penalty beginning with the transfer that causes ineligibility. In other words, if the first transfer penalty does not result in the imposition of a penalty and a subsequent transfer(s) would result in a penalty if added to the amount of the first transfer, then compute the penalty of the combined amount(s) with the penalty to begin the month of the subsequent transfer.

Multiple Transfers On or After 2/8/06 (DRA '05)

Effective with new or pending applications/reviews taken on or after February 1, 2007, assets transferred on or after the 60 month look back period (but not earlier than 2/8/06) by an A/R or the A/R's spouse in more than one month for less than the fair market value, will have the penalty determined by:

- Treating the total cumulative uncompensated value of all assets transferred by the A/R or spouse (if applicable) during all months on or after the 60 month look back period as one transfer; and
- The start date of the penalty for applicants is the first day of a month in which the asset(s) was transferred or the first month in which the A/R is otherwise eligible for LA-D Medicaid, whichever is later. For recipients, the penalty begins the month after month of discovery (allowing for timely notice) and the A/R is in LA-D.

Treatment of Income as an Asset

When it is determined that an A/R disposes of income that would be an asset the next month (e.g., a lump sum payment) for reasons other than ordinary and legitimate expenses, develop a transfer of assets penalty beginning in the month in which the money was given away. If the A/R gives away or assigns the right to receive recurring income, develop a transfer of assets penalty. All the policies and procedures for DRA '05, transfer of assets, apply to a transfer of income.

- If the income is a lump sum, determine a penalty based on the value of the lump sum minus ordinary and legitimate expenses.
- If the A/R assigns or gives away a stream of income or the right to a stream of income, base the penalty period on the combined actuarial value of all payments transferred. Obtain this figure from the payment source, if possible. See Multiple Transfers above.
- For transfers of individual income payments that are less than the private pay rate, impose partial month penalty periods.

Purchase of Life Estates in Another's Home (DRA '05)

If an A/R or A/R's spouse purchases a life estate interest in another's home, impose a transfer of assets penalty:

- If the A/R or spouse does not reside in the home for a minimum of 12 consecutive months following the date of purchase. Brief rehab stays or vacations do not necessarily negate residency but should involve investigation. To regard a house as a residence, take into consideration:
  - Whether the person's mail is delivered there,
  - Whether they pay property taxes, etc.
- If the individual who purchases a life estate moves out of the home prior to the end of the 12-month period. The date of transfer is the date of purchase of the life estate, and the uncompensated value is the full amount paid for the life estate as if the individual never moves into the home.
- If the life estate was not purchased for the FMV.
- If the person's life expectancy is less than the value of the life estate purchased.
- If the person makes a gift of the life estate.

DRA '05 Transfer Policy for Applicants/Recipients

Effective 2/8/06

Step 1 Subtract the compensation received from the FMV of the transferred resource.

a. _____ FMV of transferred asset

b. - _____ Compensation received

c. = _____ Uncompensated value

Step 2 Divide the uncompensated value by the NH Private Pay Billing Rate (NH PP BR)*.

a. _____ (1.c)

Divided by

b. _____ (NH PP BR)

c. = _____ months of penalty including partial months**

Step 3 Multiply the NH PP BR by the number of FULL months' penalty found in 2.c.

a. _____ (NH PP BR)

b. x _____ (2.c) # of FULL months' penalty without the fraction

c. = _____ dollar value of the full months' penalty

Step 4 Subtract the value of the full months' penalty from the uncompensated value of the Transferred asset.

a. _____ (1.c) uncompensated value of the transferred asset

b. - _____ (3.c) value of full months' penalty

c. = _____ partial month penalty amount

Step 5 Include the partial month penalty amount (4.c) as unearned income in the AU for the benefit month in which the partial month penalty falls.

*NH PP BR (Nursing Home private pay billing rate): the average Georgia private pay rate. Refer to Appendix A.1.

The number of months the A/R is ineligible for a nursing home/institutionalized hospice vendor payment. Medicaid eligibility is not affected for NH or Institutionalized Hospice A/Rs. However, do **not approve eligibility for CCSP, ICWP, NOW/COMP, non-institutionalized Hospice or Katie Beckett COAs until the **full** months' penalty period expires.

The penalty normally begins the first day of a month in which the asset(s) was transferred, or the date on which the individual is otherwise eligible for LA-D Medicaid, whichever is later.

There is NO limit to the number of months a penalty may last.

OBRA '93 Transfer Policy for Applicants/Recipients

Effective 8/11/93

Step 1 Subtract the compensation received from the CMV of the transferred resource.

a. _____ value of transferred resource

b. - _____ compensation received

c. = _____ uncompensated value (enter on line 2.a)

Step 2 Compute penalty.

a. _____ (1.c)

Divided by

b. _____ (NH PP BR*)

c. = _____ months penalty**

*NH PP BR (Nursing Home private pay billing rate): the average Georgia private pay rate. Refer to Appendix A.1.

The number of months the A/R is ineligible for a nursing home/institutionalized hospice vendor payment. Medicaid eligibility is not affected for NH or Institutionalized Hospice A/Rs. However, do **not approve eligibility for CCSP, ICWP, NOW/COMP, non- institutionalized Hospice or Deeming Waiver COAs until the penalty period expires.

The penalty normally begins the month in which the transfer occurred. There is **NO** limit to the number of months a penalty may last.

2343 German Reparation Payments

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	German Reparation Payments		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2343
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-59

Requirements

Unspent German Reparation Payments are permanently excluded resources.

Basic Considerations

Interest earned by German Reparations Payments conserved in a financial account is not excluded from income by this provision.

Procedures

If an individual alleges that his or her resources include German reparations payments, obtain a statement from the individual on the following:

- the date(s) and amount(s) of such payment(s)
- the date(s) and amount(s) of any corresponding account deposit(s) Accept the allegation absent evidence to the contrary.

2344 Qualified Tuition Savings Program (529 Plans)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Qualified Tuition Savings Program (529 Plans)		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2344
	Previous Policy Number(s):	MT 9	**Updated or Reviewed in MT:**	MT-59

Requirements

The resource value of a Qualified Tuition Savings Program (529 Plan) is determined by whether an A/R is the donor of the plan or the beneficiary of the plan.

Basic Considerations

A Qualified Tuition Savings Program (529 Plan) was enacted to allow a tax-advantage to individuals who wish to save for future education. There are two types of 529 Plans:

- The College Savings Plan is a state-sponsored plan that helps families/individuals save for higher education. It provides tax-free withdrawals for certain expenses, tax deferral on earnings, professional money management and the flexibility to use the money at any source of higher education.
- The Prepaid Tuition Plan allows the donor to pre-select a higher education institution in advance at today's prices. These plans usually cover tuition only, not room and board, etc.

With either of the 529 Plans, the donor maintains control over the plan and may cancel or change it. A change in the investment options for a 529 Plan may be made annually.

Procedures

The person who is named on the plan as the owner/account holder is considered the donor(s). If the A/R is the donor of the 529 Plan, consider the plan as a resource to the donor. Do not count as a resource to the beneficiary.

If the A/R is the beneficiary of the 529 Plan, totally exclude the value of the plan and any disbursements made from the plan.

Verification and Documentation

Obtain a copy of the 529 Plan for the file.

If the A/R is the donor, for resource purposes, obtain verification from the source regarding mandatory fees, taxes and/or penalties that would be incurred if the 529 Plan were to be liquidated. Count the remainder as a resource to the donor.

2345 Undue Hardship Provision for ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Undue Hardship Provision for ABD Medicaid		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2345
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-59

Requirements

Every case should be evaluated for the potential of the undue hardship exclusion prior to denial or computing a transfer penalty.

Basic Considerations

Undue hardship is defined as a situation wherein an individual would be deprived of medical care such that his/her health or life would be endangered; or would be deprived of food, clothing, shelter, or other necessities of life.

For purposes of this policy, the following definitions apply:

- “Health or life would be endangered” means: A medical doctor with knowledge of the A/R’s medical condition at the time of the application of the penalty period, certifies in writing that in his or her professional opinion, the A/R will be in substantial danger of death or the A/R’s health will suffer substantial and irreparable harm.
- “Other necessities of life” means: Basic, life sustaining utilities, including water, heat, electricity, phone, and other items or activities that without which the individual’s health or life would be endangered.

With the Deficit Reduction Act (DRA) of '05, enacted 2/8/06 to be effective 2/1/07 on all transfers of assets computed on or after that date, the community spouse is not protected by the undue hardship waiver on assets transferred by the community spouse unless the spouse is also applying for LA-D Medicaid. Undue hardship only applies to the Applicant or Recipients, not community spouses.

Undue hardship does NOT exist when:

- the application of a transfer of assets penalty merely inconveniences or restricts the lifestyle of the A/R
- the institutionalized spouse has transferred his/her assets to the community spouse and the community spouse refuses to cooperate in making the assets available to the institutionalized spouse
- the A/R’s total available income and assets (or if a couple, the total combined available income and assets of the A/R and the A/R’s spouse, or if under age 18, the combined available assets and income of the A/R and the A/R’s parents), including all countable and excluded income and

assets, are sufficient to provide the A/R medical care and food.

- Clothing, shelter, and other necessities of life such that the A/R's health or life would NOT be endangered

There are three conditions for use of the undue hardship provision, only one of which needs to be met:

- An institutionalized spouse who has excess resources will not be found ineligible for Medicaid where it is determined that denial of eligibility on the basis of having excess assets would create undue hardship.
- An individual for whom receipt of distribution from a Medicaid qualifying trust would cause ineligibility will not be found ineligible for Medicaid where it is determined that such denial would create undue hardship to the A/R.
- An individual having transferred assets for less than the fair market value, or having transferred assets into a trust, will not be found ineligible for Medicaid nursing facility services or home and community-based services where it is determined that such denial would create undue hardship to the A/R.

Procedures

Determine the value of countable assets. Make a decision based on the facts present in the case.

Undue hardship must be considered in each of the above situations. However, with applications and reviews processed on or after February 1, 2007, for transfers made on or after 2/8/06, the applicant or representative must have taken legal action and equitable remedies to recover the asset before undue hardship can be considered. Documentation of such action must be attached to the undue hardship request. The A/R, his/her representative or the facility (with consent of the A/R or representative) has to request undue hardship, using the Undue Hardship Waiver Application. Refer to Appendix F, Forms, for a copy of the form.

The A/R has the burden of proof that his/her health and age did not indicate a need for long-term care services at the time the asset was transferred.

If the application/ongoing case is subsequently penalized or denied/closed due to a transfer of assets made on or after 2/8/06, the MES must take the following actions:

- Generate a system notice (timely if review) and a separate Undue Hardship Waiver letter, found in Appendix F,
  - that an undue hardship waiver exists
  - that the undue hardship waiver must be requested within 12 days of the date on the notice
  - to contact the county MES to obtain the necessary form within that 12 days
  - if the undue hardship waiver is denied that decision may be appealed to the Administrative Law Judge. However, if benefits are continued, the state will recoup Medicaid funds expended on the A/R's behalf during the appeal period
- within that initial 12 days, DFCS provides, in writing, the "Undue Hardship Waiver Application" form and information to apply for undue hardship

- if an additional 12 days is needed to obtain information, the A/R, representative or facility must request prior to the end of the initial 12 days
- once the undue hardship waiver is decided, the MES has 12 days in which to notify the A/R, representative and facility of the outcome.
- If the undue hardship waiver is approved, reopen the case if it was denied/closed, waiving the penalty, beginning with the month of the application for the waiver or the month in which all information and documentation is provided to make the waiver determination, whichever is later. Do not waive notice.
- If the undue hardship waiver is denied or if at the end of the allotted time periods, the undue hardship waiver has not been submitted by the A/R, representative or facility, another denial/closure notice must be sent. Close or activate transfer if case has been left open. If the case was already closed/denied, notify the AR in writing of the denial. The notice of the penalty to the A/R must include a statement that undue hardship was considered and determined not to be applicable. The A/R may still request a hearing under the normal hearing process (either via system or manual letter). These hearings will be handled by the Department of Human Resources Legal Services Office. Refer to Appendix B OSAH Responsibilities.

The regional Medicaid Program Specialist will make the determination of whether or not to approve the Undue Hardship Waiver request. For ongoing cases, leave the case open pending the outcome of the hardship waiver request.

Thoroughly and completely document the case record to support applying the undue hardship provision.

- document which of the three conditions is met.
- document how the condition is met including why the individual will suffer irrevocable harm if denied Medicaid.
- Document date request received, date when MES responded and whether the request was written or oral.

Undue Hardship to Co-Owner

Exclude jointly owned real property if the sale would cause undue hardship to the co-owner.

Consider that sale of the property would cause undue hardship to a co-owner if one of the following situations exist:

- The co-owner uses the property as his/her principal place of residence.
- The co-owner would have to move if the property were sold.
- The co-owner has no other readily available housing.

If the A/R alleges that the sale of certain real property would force a co-owner living on it to move, obtain the following documentation and verification:

- The individual's signed statement to that effect
- Evidence of joint ownership

Obtain a statement from the co-owner regarding whether he or she:

- Uses the property as his or her principal place of residence
- Would have to move if the property were sold
- Would have other living quarters readily available.

Accept any reasonable allegation from the co-owner that there is no readily available housing, no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual.

If undue hardship to the co-owner does not apply, follow the same procedures found on pages 1 through 3.

2346 Special Needs Trust

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Special Needs Trust		
	Effective Date:	September 2024		
	Chapter:	2300	**Policy Number:**	2346
	Previous Policy Number(s):	MT 67	**Updated or Reviewed in MT:**	MT-73

Requirements

A Special Needs Trust (SNT) is a trust that contains the assets of certain individuals for his/her benefit. It also limits the trustee's discretion as to the purpose of the distributions.

Basic Considerations

A Special Needs Trust (SNT) must meet the following specific guidelines:

- Be established for the sole benefit of the individual by a parent, grandparent, legal guardian of the individual, or a court. Refer to Section 2502 - Deeming ABD, Chart 2502.1 - Resource Transfers by an A/R with a Community Spouse for definition of "sole benefit of".
- Provide that the State will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total medical assistance paid on behalf of the individual
- May contain the assets of individuals other than the disabled individual.
- Must be established by a disabled individual under 65 and contain only their assets (income and resources).
- Must have had no additions to or augmentation of since member turned 65.

A SNT is set up to provide for extra needs of a disabled person, over and above the basic care provided by government programs. There are different SNT. SNT such as a Third Party SNT is created with money of someone else other than the beneficiary. Testamentary SNT is a trust created by a Will. Both the Third Party SNT and the Testamentary SNT do not require a Medicaid payback.

Other types of SNT could be called Luxury, Discretionary or Supplementary Trust(s). These trusts provide only what is not provided by Medicaid and adds to what Medicaid provides. At times, they are called "payback trusts" because federal law requires reimbursement to the State Medicaid Agency when the trust ends. Typically, they are set up to help the beneficiary become or remain eligible for SSI and/or Medicaid.

Certain payments are not assignable by law and, therefore, are income to the individual entitled to receive payment under regular income rules. They may not be paid directly into a trust, but individuals may attempt to structure trusts so that it appears that they are so paid.

Important examples of non-assignable payments include:

- TANF

- Railroad Retirement Board - administered pensions
- Veterans' pensions and assistance
- Federal employee retirement payments administered by the Office of Personnel Management
- Social Security title II and SSI payments
- Private pensions under the Employee Retirement Income Security Act

Effective April 1, 2005, DCH Legal Services will determine the validity of all SNTs.

To be a valid SNT, attorneys drawing up the SNT should adhere to the following guidelines:

Step 1 The attorney should send the SNT to DCH Legal Services two months prior to execution and/or judicial approval. Use the Form 956 - Special Needs Trust Review Routing Form found in Appendix F - TOC of the Medicaid Manual.

Step 2 If the trust is to be funded with the proceeds of a settlement, a certified copy of the settlement and the court order must be submitted with the trust.

Step 3 Notice of the time and place of any hearing regarding a Court approval of the settlement and SNT should be served upon DCH at least 15 business days before the hearing.

Step 4 DCH will not recognize the validity of any SNT until all liens in favor of DCH shall be first satisfied in full.

Step 5 All SNTs are subject to a yearly audit by DCH or its agents. DCH may also audit prior years of the trust.

Step 6 No payment can be made from the trust except for the benefit of the beneficiary and may not exceed the amount that can be determined to reasonably meet the special needs of the beneficiary. Refer to Section 2502 - Deeming ABD, Chart 2502.1 - Resource Transfers by an A/R with a Community Spouse for definition of "sole benefit of."

Step 7 The SNT shall specifically identify, in an attached schedule, the initial source of the trust, all assets of the trust, all assets purchased with trust funds and all wages or payment for caregiver or other services. The trustee must update the schedule yearly. Schedules must be submitted to DFCS and to DCH Legal Services.

Step 8 The SNT shall specifically state the age of the trust beneficiary and affirm that the trust beneficiary is disabled within the definition of 42 U.S. C. Section 1382c(a)(3), and whether the trust beneficiary is competent or incompetent at the time the trust is established.

Step 9 The SNT shall specifically state that its purpose is to permit the use of SNT assets to supplement, and not to supplant, impair or diminish benefits or assistance of any Federal, State or other governmental entity for which the beneficiary may otherwise be eligible or for which the beneficiary is competent at the time the trust is established.

Step 10 DCH shall be given a minimum of 30 days' notice if there is a change in the trustee.

Step 11 DCH must be given notice within 5 days of the death of the beneficiary.

Step 12 Beneficiaries are required to comply with SSI income rules. See 20 CFR 416.

Step 13 Failure to comply with policy will result in the SNT being counted as an asset or transfer of resources.

Procedures

Follow the procedures below for processing applications/reviews containing SNTs:

Step 1 For applications pending on or after April 1, 2005, send a copy of the SNT to DCH Legal Services Section, along with proof of disability, prior to approval of the case. Use the routing form in Appendix F - TOC, entitled Form 956 - Special Needs Trust Review Routing Form. Some attorneys may submit SNTs to DCH prior to the application at DFCS. Obtain copies of the submission to DCH and its determination. If not, submit SNT upon receipt during application process. Submit the same documents that are required above. If a Notice of Approval of a SNT is submitted with a Medicaid application, the SNT does not have to be sent back to the Trust Unit for review. As agreed with DCH Legal, if a Notice of Draft Approval is submitted with the application, it is verification that the SNT will be approved once the applicant is approved for Medicaid, and the SNT is excluded as a resource for application and eligibility purposes. The Trust Unit will provide the final Approval once the Medicaid application has been approved.

For **active cases where a previously unknown SNT** is discovered, send a copy of the SNT to DCH Legal Services Section, along with proof of disability, prior to completion of the annual review or special review. Submit two months prior to review if possible. Use the routing form in Appendix F - TOC, entitled Form 956 - Special Needs Trust Review Routing Form.

Step 2 Do not finalize the application or review until DCH Legal has either approved or denied the validity of the trust.

Step 3 If the trust is irrevocable and cannot be used by the A/R for his/her support and maintenance, it is not a resource. If the A/R does not have the legal authority to revoke the trust or direct the use of the trust assets, the trust principal is not the A/R's resource.

Step 4 Treat disbursements from the trust as follows:

- Cash paid directly to the A/R is unearned income.
- Food, clothing, or shelter received as a result of a disbursement from the trust is income in the form of in-kind support and maintenance. Use the presumed maximum value (PMV) rule. See Section 2430 - Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid.
- Disbursements by the trustee to a third party that result in the A/R receiving items that are NOT food, clothing or shelter are not considered income (example personal sitters, handicapped van, etc.).
- If the trust principal is a countable resource to the A/R, disbursements from the trust principal received by the A/R are not income, but a conversion of a resource. However, the trust earnings (interest) are counted as unearned income.

Step 5 If you find there have been additions to or augmentations of the trust since the member reached age 65, then count as an asset or transfer of asset.

Step 6 Should you discover during an annual or special review that the requirements of the trust are not being followed, consult your Medicaid Program Specialist for instructions.

Contact if there is a question as to:

- If the SNT has been reviewed and approved
- If a SNT has been received and not reviewed by the Trust Unit
- Is a questionable trust.

SNT contact information:

Georgia Department of Community Health
ATTN: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30084
Email: gatrustunit@gainwelltechnologies.com
Phone: 678-564-1168
Fax: 678-564-1169

The Georgia Trust Unit is paperless and prefers all documents and information be emailed.

2347 Loans (Borrower)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Loans (Borrower)		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2347
	Previous Policy Number(s):	MT 17	**Updated or Reviewed in MT:**	MT-59

Requirements

Treatment of a loan or loan agreement as a resource or income depends on whether the A/R is the lender or the borrower and upon whether the loan is bona fide and negotiable.

Basic Considerations

The context of the instructions in this section assumes that the individual (A/R) is the Borrower of the loan and is therefore the recipient of the asset (cash) and the person making payments to the Lender. Reference Section 2313, Contracts, for regulations and procedures for the Lender of the loan.

Terminology Loan

A loan is a transaction whereby one-party advances money to, or on behalf of another party, who promises to repay the lender in full, with or without interest. The loan agreement may be written or oral and must be enforceable under State law.

Informal Loan

An informal loan is one between entities who are not in the business of lending money or extending credit. It may be oral or written.

Formal Loan

Formal loans are commercial loans with an entity that is in the business of making loans.

Negotiable Agreement

A negotiable loan agreement is one in which the ownership of the loan instrument itself and the amount of money stated in the agreement may be transferred from one entity to another.

Bona Fide Agreement

A “bona fide” loan agreement is one that is legally binding and made in good faith.

Procedures

Determination of Loan Value

The resource value of the loan is different for the Borrower and the Lender. For the **Borrower**:

If the loan is a **Bona Fide** agreement, then:

- The loan agreement itself is **NOT** a resource.
- The cash received from the lender is **NOT** counted as income when received.
- The cash received from the lender is a **countable resource** if retained in the month following the month or receipt.

If the loan is not a **Bona Fide** agreement, then:

- The loan agreement itself is **NOT** a resource.
- Cash received from the lender **IS income** in the month received.
- The cash received from the lender **is a countable resource** if retained in the month following the month or receipt.

For the **Lender**, refer to Section 2313, Contracts.

Determining if an Informal Loan is Bona Fide

An Informal Loan is Bona Fide if it meets the following requirements:

- It must be enforceable under State Law.
- The loan agreement must be in effect at the time the asset (cash) is given to the borrower. The loan cannot be established after the fact.
- The obligation to repay the loan MUST be acknowledged by both lender and borrower to be a bona fide loan. The borrower feeling an obligation to repay a friend or relative does not make it a legal obligation, nor does stating a loan should only be repaid if the borrower becomes able to pay because of a change in financial circumstances.
- The loan must have a plan for repayment and state the collateral used to back the loan.
- The repayment plan must be reasonable considering the borrower's financial circumstances including anticipated income and living expenses.

Follow the steps below to determine the treatment of a Loan for the **Borrower**:

Step 1 Obtain a copy of the loan agreement for a formal loan or informal written loan.

Step 2 Assume a formal loan is bona fide and negotiable unless A/R presents convincing evidence of a legal bar to a transfer of ownership.

Step 3 If the loan is informal, obtain signed statements from the lender(s) and borrower(s) addressing the requirements for a bona fide informal loan. See page 2. Use this information to determine if the informal loan is bona fide.

Step 4 Determine the countable income using the criteria on page 1 of this section.

Step 5 Determine the resource value of the loan proceeds based on the criteria on pages 1 and 2 of this section. It may be necessary to verify if the loan proceeds are retained into the month(s) after receipt via a bank statement, etc.

Step 6 If the loan proceeds along with other countable resources puts the A/R over the resource limit deny/close the case. If the loan proceeds along with other countable income does NOT put the A/R over the resource limit, proceed to Step 7.

Step 7 Continue the application process with the remaining eligibility criteria.

2348 Long-Term Care Insurance Partnership

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Long-Term Care Insurance Partnership		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2348
	Previous Policy Number(s):	MT 32	**Updated or Reviewed in MT:**	MT-59

Requirements

The Deficit Reduction Act amended Section 1917(b) of the Social Security Act (the Act) to permit States to develop Long-Term Care Partnership Programs to increase the role of private long-term care insurance in financing long-term services. The Georgia Qualified Long-Term Care Partnership program will be implemented effective January 1, 2007.

Basic Considerations

The Georgia Long-Term Care Partnership (Partnership) program is a public-private initiative administered by the Department of Community Health, with the assistance of the Office of the Commissioner of Insurance, the Department of Human Resources, and Division of Aging Services (DAS).

Each agency is responsible for different parts of the LTCP. The Division of Medical Assistance is responsible for administering the Partnership program. The Office of the Commissioner of Insurance is primarily responsible for ensuring that insurers follow the federal regulations. The Division of Aging Services is responsible for counseling services to individuals in planning their long-term care needs, as well as marketing and outreach for the Partnership program. The Department of Human Services is responsible for determining a Medicaid eligible person has the correct amount of resource dollars disregarded based on the payout of their Long- Term Care Partnership policy.

The Partnership is designed to reward Georgians who plan ahead for their future long-term care needs. The Georgia LTC Partnership and non-Partnership LTC insurance policies are similar. However, the Partnership policies have the added benefit of allowing policyholders to protect a portion of their assets if they choose to apply for Medicaid.

Dollar for dollar asset protection

Dollar-for-dollar asset protection means that for every dollar the Partnership policy pays out in benefits, a dollar of assets can be protected from the long-term care Medicaid asset limit. When determining long-term care Medicaid eligibility, any assets up to the amount the Partnership insurance policy **paid in benefits** will be disregarded. The individual's Partnership insurance policy benefits **do not have to be exhausted** before the asset protection is allowed. The protected assets will also be exempted from Estate Recovery in an amount equal to the **benefits paid** by the long-term care insurance policy. An individual is not required to designate a specific asset to be protected (disregarded). The disregarded amount of resources will be equal to the amount of benefits paid out.

Reciprocity

Georgia **is a Participating state.** A Participating state is one that did **NOT** elect to be exempt from reciprocity standards. Each participating state agrees as follows:

- Any individual who has purchased a qualified Partnership long-term care policy in any Participating state; who has received benefits under the policy; and who applies for Medicaid in a Participating State other than the one in which the policy was issued, will receive an asset disregard in an amount equal (dollar for dollar) to the benefits received under the policy;
- The asset disregard procedure and calculation will be the same for every individual with a Partnership policy that applies for Medicaid in the Participating State, without regard to whether the policy was purchased in another state, or the date the policy was purchased (all states did not start selling these policies at the same time);
- An amount equal to the benefits received under the policy will be exempt from Medicaid Estate Recovery provisions; and,
- If a person moves from the state in which their Partnership policy was issued, and later applies for Medicaid in another Participating state; and is determined to be eligible using a Partnership asset disregard, the Partnership asset disregard will not be revoked upon eligibility re-determination should the state subsequently decide to become exempt from the reciprocity agreement.

A list of participating states will be provided as soon as it becomes available. For now please contact your Medicaid Field Program Specialist to verify if the state is a participating state or not.

Procedures

Policies purchased prior to January 1, 2007, are not Partnership policies. LTC policies issued on or after January 1, 2007, may or may not be Partnership Policies.

For a policy to be considered a Partnership Policy, it must meet the following requirements:

- Be issued to an individual on or after January 1, 2007;
- Cover an individual who was a State of Georgia resident when coverage first becomes effective under the policy;
- Meet stringent consumer protection standards;
- Contain a disclosure statement indicating that it meets the requirements under § 7702B(b) of the Internal Revenue Service Code of 1986; and
- Provide the following inflation protections:
  - if the individual was under 61 years of age when policy was issued, must provide annual-compound inflation protection;
  - if the individual was age 61 to 76 when the policy was issued, must provide some level of inflation protection; and
  - if age 76 or older, inflation protection may be offered but is not required.

The case manager must verify the amount of long-term care benefits paid on behalf of the policyholder. Although written verification is preferred (i.e. statement from insurance company, or a

copy of the Explanation of Benefits statements), verbal verification is acceptable from the insurer with detailed documentation (i.e. who the case manager spoke with, date, etc.).

When an individual applies for long-term care Medicaid benefits and request asset protection, the case manager must obtain a copy of the Partnership Disclosure Notice (LTCP 200-B) and the LTC Partnership Certification Form (LTCP 200-C) for verification of the requirements above. These forms are from the Insurance Commissioner's office. The AR should have these documents in their possession because these documents are a part of all Partnership policies. Verification and documentation regarding a Partnership Policy must be kept with other permanent verification in the case record.

If policy is purchased outside the state of Georgia you will have to obtain the equivalent of the LTCP 200-B and the LTCP 200-C from the state where the policy was sold.

2349 Personal Care Contracts

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Personal Care Contracts		
	Effective Date:	April 2020		
	Chapter:	2300	**Policy Number:**	2349
	Previous Policy Number(s):	MT 34	**Updated or Reviewed in MT:**	MT-59

Requirements

Personal Care Contracts provide a way for an elder individual to share assets with a family member while also spending down their estate. Payments made under personal care contracts may be considered an uncompensated transfer of assets in the eligibility determination process.

Basic Considerations

Services contracts, sometimes referred to as a personal care contracts, care agreement, etc. will be referred to as personal care contracts in this section. Personal care contracts allow an individual to pay another person to provide personal care. Examples of personal care include, but are not limited to, grocery shopping, housekeeping, cooking and financial management, that an individual is no longer able to perform for him/herself.

Procedures

When a personal care contract is presented as the basis for a transfer of assets you must first, determine if a valid agreement exists. Secondly, if a valid agreement exists, you must determine whether adequate compensation in the form of services was provided.

A Personal Care Contract is valid only if ALL of the following are met:

- The personal care contract must be executed prior to the provision of services. The contract cannot be applied retroactively to pay for services that were provided prior to the agreement.
- The personal care contract must be in writing, signed, and dated by each party. The contract must be notarized.
- The personal care contract must have been made by the applicant/recipient or a legally authorized representative such as an agent under a power of attorney, guardian or conservator. If a representative signs the contract on behalf of the applicant/recipient of the services, that representative **may not** also be a beneficiary of the agreement.
- The personal care contract must specify the type, frequency, and number of hours spent for each service or assistance to be provided in exchange for the payment. The terms must be specific and verifiable.
- These services must be provided at market rate.
- The personal care contract must provide for payment upon rendering the services or assistance,

or within thirty (30) days thereafter and; must be supported by evidence that payments were made in accordance with the agreement.

    - Any payment(s) made prior to the date the contract was signed by all parties is considered an uncompensated transfer.

- The caregiver cannot be the spouse or parent of the applicant/recipient.
- The applicant/recipient or a legally authorized representative must have the power to modify, revoke or terminate the agreement.

A Personal Care Contract that fails to contain any of the mandatory provisions is considered to be invalid for Medicaid eligibility purposes. Payments that are not made in accordance with a valid personal care contract are considered a transfer without compensation.

If a valid personal care contract exists, determine whether or not adequate compensation in the form of services or assistance was provided.

- Adequate compensation shall be measured against rates paid in the open market for the services or assistance actually provided. If the services or assistance require extraordinary skill, the caregiver must possess the required skill, experience or expertise and licensing. These services or assistance will be valued in accordance with similar services in the community.
- Adequate compensation shall not be met if the service(s) or assistance duplicates services that another party is being paid to provide or which another party is legally responsible to provide (i.e. the nursing facility, case manager).
- Adequate compensation shall not be met when the service(s) is a type of service or assistance that is not commonly paid for, including services that a relative would normally provide out of love and affection, like visiting the individual and updating other relatives on the individual's condition.

If payments are made for compensated services or assistance but the payments exceed the allowed market value of similar services or assistance, then the amount of the payment is a transfer without compensation.

The contracted service(s) or assistance must be provided within thirty (30) days from the date of payment. Any payment for services that have not been performed within thirty (30) days is considered an uncompensated transfer of assets.

The Personal Care Contract ceases upon the death of the applicant/recipient or upon admission to a nursing facility.

2398 Estate Recovery for ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Estate Recovery for ABD Medicaid		
	Effective Date:	July 2022		
	Chapter:	2300	**Policy Number:**	2398
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-65

Requirements

Estate Recovery is part of a federal program that was established with the Omnibus Budget Reconciliation Act of 1993, OBRA '93. Beginning May 3, 2006, Georgia is implementing Estate Recovery (ER) to be in compliance with this mandate.

Basic Considerations

Georgia will limit its ER to Medicaid monies that paid for an A/R's medical care beginning May 3, 2006, or the first month of Medicaid eligibility, whichever is later.

ER will be pursued under the following conditions:

- A/R's total estate is valued at $25,000 or more. Effective July 1, 2018, the State will waive estate recovery of the first $25,000 of estates valued over $25,000 for any estate subject to an Estate Recovery claim for the deceased Medicaid Member with a date of death on or after July 1, 2018.
- Medicaid members who, at any age, are in a nursing facility, intermediate care facility for the mentally retarded, or other mental institution that have their medical care paid by Medicaid.
- Medicaid members who are 55 years of age or older and who receive home and community-based services or are enrolled in and receive services through a waiver program.
- Currently active A/Rs (including SSI recipients) who are not disenrolled from institutionalized Medicaid for NH, EDWP/Source, NOW/COMP, ICWP, Hospice, Institutionalized Hospice by May 3, 2006.
- An A/R who disenrolls to avoid ER and subsequently reapplies for Medicaid under one of the above COAs, will have ER pursued back to date of first Medicaid eligibility or May 03, 2006, whichever is later.

> Effective July 1, 2018, each member and/or authorized representative MUST receive notification of Estate Recovery at application and each renewal via first class mail or electronic means.

The A/R's assets that may be subject to ER are:

- All real estate property, including homeplace property

> A Life Estate does not exempt the estate or home from ER

- All personal property, whether held individually or jointly
- If a transfer penalty period was not completed due to the A/R's death, the value of the remaining penalty period may be recovered.

If the A/R or spouse transfers assets to avoid ER, a transfer penalty may be applied. Refer to 2342 Transfer of Assets.

When the Medicaid A/R dies, the authorized representative, executor or heirs will be notified by DCH or their agent before any recovery is attempted on the A/R's estate. Upon notification, the heirs of the estate will be given an opportunity to show if they meet one of the exceptions in the law that will delay ER, then they will be told by DCH how to request an undue hardship waiver.

Recovery may be delayed if the deceased A/R has:

- a surviving spouse,
- child(ren) under 21 years of age (for the delay to continue past age 21, the child must have become disabled prior to reaching age 21),
- child(ren) who are blind or permanently and totally disabled according to Social Security guidelines,
- a sibling of the A/R who was residing in the A/R's home for a least one year immediately prior to the A/R's date of institutionalization, and who was providing such care to the A/R that institutionalization was delayed or
- a child of the A/R who was residing in the A/R's home at least two years immediately prior to the A/R's date of institutionalization, and who was providing such care to the A/R that institutionalization was delayed

If ER is delayed under one of the above deferments, that delay is valid until one of the below things occur:

- the surviving spouse is deceased or divorced
- the child(ren) turns 21 years of age or decease, whichever occurs first
- the blind or totally disabled child(ren) decease
- the sibling/child deceases or no longer resides in the home

Chart 2398.1 - ABD Medicaid Estate Recovery

Who is Affected:		**Delay of Recovery Criteria:**	**What will be Recovered:**
Age	**COAs**		
Any age & institutional facility	• L01(NH) • L01(NH) with IC-MR LOC	• Surviving spouse • Child(ren) under 21 • Child(ren): blind/disabled	• Homeplace • Any other assets including joint tenancy & life estate
Age 55 or older	• W01(IH), W02(Hospice), W03(EDWP), W04(NOW), W05(ICWP), W07(COMP) • L01(NH)		

Procedures

Follow the steps below for Estate Recovery:

Step 1 Be prepared to answer questions regarding Medicaid eligibility/transfer penalty and make proper referrals, especially lien related questions, to Estate Recovery Office at 770-916-0328.

Step 2 New applicants of L01(including Swing Bed),W01-W05, W07 Medicaid who have submitted their application via Form 700 (10-2021 or later) or via Provider Portal or Gateway Customer Portal (12/2021 or later) are considered to have met the ER acknowledgment requirement. New applicants who have submitted an application using other means than what is listed above will require Form 315, Official Notice of Georgia Medicaid Estate Recovery Program, to be mailed via first class mail or via electronic means. If requested, the DCH Estate Recovery informational brochure can be mailed to the client. You can download the brochure at dch.georgia.gov or you can order by calling Health Management Systems (HMS) at 770-916-0328. Refer to Appendix F (Forms), for a copy of DMA 315. It is preferable to get the form returned and housed in the document imaging system. However, if the A/R or representative does not return the document, document in Georgia Gateway that the 315 was sent and the date. If Form 315 is not acknowledged at application, Form 315 will be system generated every 90 days until the form has been signed and returned by client/AREP.

Step 3 A/Rs or AREPs who receive the DMA 315 and have notified the Eligibility Specialists of A/R's death should be closed due to death. However, fax/email Form DMA 327, Estate Recovery Notification Form to Estate Recovery. Refer to Appendix F, Forms for a copy of DMA 327. Check that the closure is due to death.

Step 4 Applicants who notify DCFS of their desire to withdraw from L01/W01-W05, W07 Medicaid, based on their intent to avoid Estate Recovery:

- Should have their case denied, but not earlier than 5/3/06.
- WAIVE Timely Notice Period.
- Close case in Georgia Gateway using Voluntary Closure.
- On Program Request Details, enter a termination date of the effective date of closure, but not earlier than 5/3/06. Enter a discharge date on the appropriate ABD Medicaid screen if A/R physically leaves the facility or home and community-based waiver programs.
- Enter additional text on the closure notice stating, "AU closed at your request to avoid estate recovery." Add this text to each case denied.
- Email/fax Form DMA 327, Estate Recovery Notification Form, only if the AU was approved for any months, within 5 days of receipt/notification, to Estate Recovery at the address/fax on the form. Document in case notes date sent and why and reason for termination of vendor payment.
- Maintain a copy of the DMA 327 in the document imaging system.

Step 5 When any recipient who meets or at one time did meet (on/after 5/3/06) the criteria for estate recovery dies or his/her Medicaid terminates, send in a Form DMA 327 to the Estate Recovery email address/fax. Maintain a copy of the 327 in the document imaging system and retain for three years.

When communicating upon death of AR, withdrawal, or termination of Medicaid, email or fax Form 327 to Gainwell Technologies.

Email address: gaestaterecoverydept@gainwelltechnologies.com
Phone 770-916-0328
Fax 678-569-0066

2399 Treatment of Resources by Resource Type Chart

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Treatment of Resources by Resource Type Chart		
	Effective Date:	June 2024		
	Chapter:	2300	**Policy Number:**	2399
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-72

Requirements

The chart below lists resources alphabetically and provides the following information

- description of the resource
- the value to consider - cash value (CV), equity value (EV) or fair market value (FMV)
- whether the resource is included (I) or excluded (E) in the eligibility determination.

Chart 2399.1 - Types of Resources

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
ABLE Account (Achieving Better Life Experiences)	Tax-advantaged savings account for individuals with disabilities.	E	FBR - E NON-FBR - E Treatment of Distributions, refer to 2334 Savings and Checking Accounts
ACTION / DOMESTIC VOLUNTEER PROGRAMS (Unspent)	Refer to Chart 2399.3 in this section.	E	FBR - E NON-FBR - E
AGENT ORANGE PAYMENTS	Payments made to Vietnam Veterans who were exposed to Agent Orange and to surviving spouses and children of deceased Vietnam Veterans who were exposed to Agent Orange. Refer to Chart 2399.2 in this section.	E	FBR - E NON-FBR - E

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
ANNUITIES (Supplemental Retirement Plans)	An investment plan. It can be established as a supplemental retirement plan through an insurance company or other investment source. Exclude if termination of employment or retirement is required for access and employment continues. If recurring payments are made from the annuity, refer to Chart 2499.1, Types of Income in Medicaid, and Section 2339 - Annuities.	I	FBR AND NON-FBR Treat as Retirement Funds if actuarially sound. Refer to Sections 2332 Retirement Funds and Section 2339 Annuities Treat as a Trust if not Actuarially sound. Some annuities may be a resource regardless of being actuarially sound. Refer to sections 2336 Trust Property, Medicaid Qualifying (Prior to OBRA '93), 2337 Trust Property – OBRA '93, 2338 Trust Property, and 2339 Annuities
AUSTRIAN SOCIAL INSURANCE (unspent)	Refer to Chart 2399.2 in this section.	E	FBR - Exclude If Based on Wage Credits. Refer to Chart 2399.2. NON-FBR - SAME
BONDS	Government-issued interest-bearing Certificates redeemable on a specific date, such as U.S. savings bonds, municipal, corporate, government bonds, etc. CMV is a countable resource. Refer to Section 2310 Bonds - U.S. Savings.	I	FBR - I NON-FBR -I
BURIAL CONTRACTS / BURIAL SPACE ITEMS	Prepaid contracts to cover funeral expenses For ABD Medicaid, refer to Section 2311 Burial Contracts (Pre-Paid or Pre-Need) and Burial Space Items. *For Family Medicaid, exclude up to $1500 of the combined EV of all burial contracts and burial insurance for each AU or BG member Only one burial contract per A/R, spouse or deemor may be excluded for ABD Medicaid.	*	FBR & Non-FBR Exclude burial space items owned outright or if itemized in a paid up burial contract designated for the A/R or an immediate family member.

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
BURIAL FUNDS	Funds that have been set aside for burial. For ABD refer to Section 2312 Burial Funds.	There is no burial exclusion in Family Medicaid.	FBR & Non-FBR Exclude up to $1500 for FBR and $10,000 for Non-FBR each for A/R and their spouse minus CMV of irrevocable burial contracts and FV of excluded life (term and whole) and burial insurance policies. Refer to Section 2312, Burial Funds
BURIAL PLOTS	One burial plot per AU or BG member Use EV for each additional plot and count toward the resource limit.	E	FBR & NON-FBR Exclude only the plots owned by A/R or deemor that are designated for Immediate Family Members. Refer to Section 2311.
CASH	Money held by an AU or BG member that has not been considered as income for that month. Use CV.	I	FBR - I NON-FBR - I
CERTIFICATE OF DEPOSIT	Certificate that states that the named person(s) has a specific sum on deposit which accrues interest over a set period of time less any penalties for early withdrawal. Use CV.	I	FBR - I NON-FBR - I
CHECKING ACCOUNTS	An account on which checks may be written against amounts on deposit. Use CV less any money considered income in that month. Refer to the section on Jointly Owned Bank Accounts if a resource is jointly owned or ownership is disputed.	I	FBR - I NON-FBR - I
COIN COLLECTIONS	A collection of coins, regardless of age. Use the face value of the coin collection as the cash value.	I	FBR - I NON-FBR - I

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
COMMINGLED FUNDS	Excluded resources commingled with countable resources The portion of the commingled funds that can be identified as excluded resources retain the exclusion. Funds that cannot be identified as excluded resources must be counted in their entirety.	I	FBR - I NON-FBR - I
CONTINUING CARE RETIREMENT COMMUNITY (CCRC) OR LIFE CARE COMMUNITY FACILITY ENTRANCE FEES	Continuing Care Retirement Community (CCRC) / Life Care Community (LCC) – An organization which offers a contract to provide an individual of retirement status, other than an individual related by consanguinity or affinity to the provider furnishing the care, with board and lodging, licensed nursing facility care and medical or other health related services, or both upon payment of an entrance fee. The CCRC/LCC provides multiple residential options in one location like independent living, assisted living, and skilled nursing care.	N/A	FBR - I NON FBR - I Include only if all three conditions are met. 1. The Entrance fee can be used to pay for the care, under the terms of the entrance care contract, should other resources of the individual be insufficient: and 2. The Entrance fee (or remaining portion) is refundable when the individual dies or terminates the contract & leaves the CCRC or LCC: and 3. The Entrance fee does not confer an ownership interest in the community.
CREDIT UNION ACCOUNTS	Money on deposit with a Cooperative organization with the functions of a bank (loans, money, provides checking & savings account services, etc.). Use CV less any money considered income in that month.	I	FBR - I NON-FBR - I
DEFERRED COMPENSATION PLANS	Tax deferred income in a fund available only upon termination of employment, hardship or retirement Use CV of any withdrawals from plan. Withdrawals would be counted in both ABD and Family Medicaid as income.	E	FBR - E NON-FBR - E

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
DEATH BENEFITS (unspent)	Money in excess of last illness and funeral expenses.	E	FBR - May be able to exclude temporarily. Refer to Chart 2399.2. NON-FBR - SAME
DISASTER RELIEF ACT OF 1974 AND EMERGENCY ASSISTANCE ACT OF 1988	Any governmental (federal, state, local) payments, which are designated for the restoration of a home, damaged in a major disaster or natural catastrophe. This includes governmental payments to save lives, protect property and public health and safety or to lessen or avert the threat of a catastrophe or major disaster. Includes loans and grants from the Federal Emergency Management Assistance (FEMA). Includes payments made by the Department of Housing and Urban Development, disaster loans, family grant programs and grants made by the Small Business Administration as a result of disasters.	E	FBR - Exclude Permanently NON-FBR - SAME
DIVIDENDS LEFT TO ACCRUE ON: INVESTMENTS LIFE INSURANCE	Accrued dividends earned on financial investments, such as stocks, are resources separate and apart from the investment source.	E E	FBR - I NON-FBR - I FBR - Countable resources on all policies, including term and excluded policies separate and apart from CSV. NON-FBR – Exclude on excluded policies. Count on non-excluded policies.
EARNED INCOME TAX CREDIT (EITC)	Tax credit that is received in one of the following ways: • Advance payments - tax credits received as part of the regular pay check	E	FBR - N/A NON-FBR - SAME
	• Non-recurring lump sum-tax credits received in the form of an income tax refund	E	FBR - N/A NON-FBR - SAME
EDUCATION ASSISTANCE (unspent)	Unspent portion of payments for education assistance which is excluded as a resource.	E	FBR – Exclude portions for tuition fees and other necessary expenses NON-FBR - SAME

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
	Payments or allowances made under any federal, state, or local law for the purpose of energy assistance.	E	FBR - E
ENERGY ASSISTANCE OTHER THAN LIHEAA	Federal or State one-time assistance for weatherization or emergency repair or replacement of heating or cooling devices. Energy Assistance payments made under state law.	E	NON-FBR - E
EQUIPMENT	Tools, machinery, stock, and inventory essential to the production of goods or services, even during temporary periods of unemployment or inactivity. Annually produces income consistent with FMV, even if only used on a seasonal basis. Contact local realtors, local tax assessors, small business administration, etc. to determine prevailing rate of return.	E	FBR - E NON-FBR - E
ESCROW ACCOUNT	Money set aside for a particular purpose that cannot be used otherwise, usually held by a third party. *For ABD, treat escrow accounts other than those set up as part of a homeplace mortgage as a trust. Any remaining funds will be subject to Estate Recovery.	E	*
GERMAN REPARATION (unspent)	Unspent German Reparation payments are permanently resources.	E	E
HEALTH REIMBURSEMENT ACCOUNT	An account through an employer which may only be used to reimburse individuals for certain medical services. *Do not count as a resource in month of receipt or for one calendar month following month of receipt.	*	*

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
HOMEPLACE	The home and surrounding land occupied by the AU or A/R, if not separated by intervening property owned by others. *Refer to Section 2316 - Homeplace: ABD Medicaid if the A/R is absent from a homeplace located in another state or LA-D A/R owns a home valued at over $500,000.	E Refer to Section 2317 - Family Medicaid Homeplace.	*FBR - E *NON-FBR - E
HOME REPLACEMENT FUNDS (unspent)	Proceeds from the sale of a home.	E* *Exclude for up to 6 months.	FBR and NON-FBR - Exclude for up to 3 months if A/R signs a statement of intent to buy a new homeplace. Refer to Chart 2399.2.
HOUSEHOLD / PERSONAL GOODS	Household and personal effects or other belongings such as furniture, appliances, clothing, personal items or items required because of a disability	E	E For investment property or items that do not meet the definition of “personal property of HH effects”, see Section 2319 - Household Goods and Personal Effects.
HOUSEHOLD ITEMS OF UNUSUAL VALUE	Items such as expensive silver, jewelry, stamps, guns, or other such collections.	E	See Household/Personal Goods and Refer to Section 2319 - Household Goods and Personal Effects
INCOME TAX REFUND	Monetary refunds paid to taxpayers from the state or federal government Count the total amount of the refund if the refund is for a single individual. If the refund is a joint check for a jointly filed tax return, see Jointly Owned Resources in Section 2301 - Family Medicaid Resources Overview for Family Medicaid and 2300 - ABD Medicaid Resources Overview for ABD Medicaid. If any portion of the refund includes EITC, refer to Earned Income Tax Credit (EITC) in this section.	I	FBR - E NON-FBR - E

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
INDIAN / ALASKAN NATIVE PAYMENTS	Payments to Native Americans based on federal statutes. Examples of these statutes include, but are not limited to, the following: • Alaska Native Claims Settlement Act • Sac and Fox Indian claims • Indian Tribal Payments under PL 94-114, Section 6. • Grand River Band of Ottawa Tribal payments under PL 94-540 • Public Law to the Confederated Tribes and Bands of the Yakima Indian and Apache Tribe of the Mescalero • Payments made under the Maine Indian Claims Settlement Act of l980 • Navajo or Hopi Indian pursuant to PL 93-531 • Indian Child Welfare, Public Law 95- 608	E	FBR - E NON-FBR - E
INDIAN GAMBLING ACT	Tribal distribution to individuals on a per capita basis from tribally managed gaming revenues. *Exclude only if held in trust by the Sec. of the Interior prior to distribution.	*	*
INDIVIDUAL DEVELOPMENT ACCOUNT (IDA)	An account established by or on behalf of a TANF A/R for post-secondary educational expenses, first purchase of a home or to start a new business. Exclude funds up to $5000, including funds withdrawn and used for the stated purpose.	E	FBR - E NON-FBR - E
	At the point, the owner of the IDA is no longer a TANF recipient, the IDA becomes a countable resource in the FS and Medicaid programs.	I	
INHERITANCES AND UNPROBATED ESTATES AND WILLS	An ownership interest in an unprobated estate may be a resource.	Refer to Section 2320.	FBR - Refer to Section 2320. NON-FBR - SAME

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
INSTALLMENT CONTRACTS / AGREEMENTS (for sale of land or buildings)	A written agreement with specific stipulations for the sale of land or buildings and the contract/agreement produces income consistent with its FMV. The property sold under the contract or held as security in exchange for a purchase price consistent with the FMV of the property is also excluded.	E	FBR - E NON-FBR - E
JAPANESE/ALEUTIAN RESTITUTION	Restitution payments made by the U.S. Government to Japanese Americans and Aleutians or their survivors who were interned or relocated during WWII.	E	FBR - Exclude Permanently NON-FBR - SAME
KEOGH PLAN (owned by individual)	A retirement plan Consider the total CV of the funds in the retirement plan, minus the early withdrawal penalty. If the plan is owned by more than one person, refer to Jointly Owned Resources in 2301 Family Medicaid Resources Overview for Family Medicaid and 2302 Ownership of Resources in ABD Medicaid.	I	FBR - I NON-FBR - I
KEOGH PLAN (owned with others)	If the plan contains a contractual agreement with an individual whose resources will not be considered in determining eligibility, the funds are considered inaccessible to the AU.	E	Refer to Sections 2332 and 2334

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
LIFE INSURANCE	Insurance policy which pays a beneficiary on the death of an individual. Refer to 2323 Life Insurance Policies.	E	FBR - Exclude CSV only if combined FV's of all policies is $1500 or less & is part of a burial exclusion. Count accrued dividends on all policies. NON-FBR - Exclude CSV only if combined FVs of all policies (whole & term) is $10,000 or less & is part of a burial exclusion. Exclude accrued dividends on exempt policies as long as dividends are left to accrue. Count as income dividends paid out.
LIFE INTEREST / LIFE ESTATE AND REMAINDER INTEREST	Property that an individual has a right to use but not dispose of during his/her life. Consider any income received from the property. * Refer to 2322 Life Estate and Remainder Interests for purchasing life estate in another's property.	E	FBR - I * NON-FBR - Exclude life estates, treat remainder interests as transfers.
LIVESTOCK/PETS	Animals owned for the following purposes: • For purposes of feeding AU members • Producing income at its FMV • Used to assist a disabled individual.	E	FBR - E NON-FBR - E
	• Not producing income consistent with FMV • Used for recreational purposes and no income is derived. Count EV.	I	FBR - I NON-FBR - E
LOANS FROM OTHERS - BORROWER	Money received by the AU or A/R that the AU or A/R has an obligation to repay. *Considered as a resource month after receipt, if retained; may be counted as income.	E	* I * Refer to 2347 Loans (Borrower)

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
LOANS TO OTHERS - LENDER (NOTES RECEIVABLE)	Monies loaned to persons outside the AU where a repayment agreement exists. Count CV of any money owed to the AU. *Refer to 2313 Contracts: Promissory Notes, Loans, and Property Agreements for resource treatment. May be counted as income.	I	*
LOW INCOME HOME ENERGY ASSISTANCE ACT LIHEAA	Payments for home energy provided to, or indirectly on behalf, of an AU.	E	E
LUMP SUMS	Money received in the form of a lump sum that is not expected to recur, i.e. rebates, retroactive or corrective payments for prior months, insurance settlements, federal or state tax refunds. *Count as income in the month of Receipt (refer to Income Chart 2499.1, Lump Sums). Any remainder is counted as a resource beginning the month after receipt. Tax refunds do not count as income, at all. Any remainder is counted as a resource beginning the month after receipt.	*	*
LUMP SUM / SSI BACK PAYMENTS	Payments for previous SSI benefits owed and paid to an individual who is currently receiving SSI. Payment for previous SSI benefits owed and paid to an individual who is no longer receiving SSI. *Family Medicaid: Disregard as income/resource in the month of receipt and any remainder in the month after receipt. Any remainder after these two months is counted as a resource.	*	Refer to Section 2324 for ABD Medicaid.

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
NON-HOMEPLACE, REAL PROPERTY	Buildings and lands which are owned by the AU and not considered part of the homeplace. *Count Equity value unless successfully rebutted or partially or totally excluded due to the following: • Essential to self-support • Undue hardship to co-owner • Bona fide effort to sell • Undue Hardship provision	I	*FBR - I *NON-FBR - I
NON-LIQUID RESOURCES FOR WHICH A BONA FIDE EFFORT TO SELL IS BEING MADE		E	FBR - E NON-FBR - E
PASS ACCOUNT (Plan to Achieve Self- Sufficiency)	Money deposited in a bank account to be used for an SSI individual in a plan for self-sufficiency approved by the SSA. The interest earned from a PASS account is disregarded as income.	E	FBR - E NON-FBR - E
PATIENT FUND ACCOUNTS	Funds held by a nursing home for their residents	N/A	FBR - N/A NON-FBR - I
PENSION PLAN (including 401K plans)	A retirement plan provided by an employer Exclude as inaccessible if still Employed under the plan. For ABD Medicaid, exclude if termination of employment is required in order to receive benefits.	E	FBR & NON-FBR - Exclude if receiving periodic payments. Otherwise, count as a resource. Exclude accounts owned by a ineligible spouse, parent or spouse of parent. Refer to Section 2332.
	If funds are withdrawn, consider the cash value.	I	N/A

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
	If annually produces income consistent with FMV, even if only used on seasonal basis. Contact local tax assessors, small business administration, etc. to determine prevailing rate of return.	E	E
PERSONAL PROPERTY - equipment, tools, machinery, stock and inventory essential to the production of goods or services, even during temporary periods of unemployment or inactivity	If essential to employment or self-employment of an AU member Value retains exclusion for one year from date the AU member terminates self-employment from farming.	E	E
	Does not produce income consistent with FMV or is not essential to employment or self-employment. Consider the equity value.	I	I
PREPAYMENTS AND DEPOSITS (NH)	Made on behalf of a person who enters a nursing home and refunded when approved for Medicaid.	N/A	FBR - N/A NON-FBR - I (unless refund is made to someone other than the A/R)
PROPERTY ESSENTIAL TO SELF-SUPPORT	• Business • Goods/Service for Home Consumption • Non-Business Income Producing	E	FBR and Non-FBR - Exclude up to $6000 of EV if net earnings are at least 6% of the amount being excluded as a resource
PUBLIC LAW 103-286	Payments to individuals received as a result of their status as victims of Nazi persecution	E	E
Qualified Tuition Savings Programs (529 Plans)	A savings plan for higher education. Refer to 2344 Qualified Tuition Savings Program (529 Plans). * E - if A/R is beneficiary * I - if A/R is donor	*	*
Qualified Income Trust (QIT)	Income placed in a QIT is not considered in the income eligibility determination process for LA-D COAs. See Section 2407 for any exceptions.	N/A	LA-D - Exclude Other COAs use OBRA '93 Trust provisions.

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
RELOCATION ASSISTANCE (unspent)	Refer to 2330 Relocation Assistance.	E	FBR - Exclude up to 9 months (exclusion ends 5/94) NON-FBR - SAME
REPAIR/REPLACEMENT FUNDS	Refer to 2331 Repair/Replacement Funds.	E	FBR - Exclude up to 18 months. Refer to Chart 2399.2 and 2399.3. NON-FBR - SAME
RESOURCES OF AN SSI RECIPIENT	AN SSI recipient is a person who: • Has been approved to receive benefits • Receives benefits • Is approved for/or receiving benefits but the benefits are suspended, being recouped because of an overpayment or not paid because the amount is less than the maximum issuance amount	E	N/A Include resources of the SSI spouse in the couple eligibility budget when one member of the couple is an ABD Medicaid A/R and the other receives SSI.
RETAINED CASH AND INKIND PAYMENTS	If used by the AU for vacation purposes during the year annually produces income consistent with FMV or produces income consistent with FMV. Refer to 2410 Rental Income, for treatment of income from rental property for ABD Medicaid.	E	FBR - E NON-FBR - E
	Does not annually produce income consistent with FMV. Consider EV.	I	FBR - I NON-FBR - I
RETIREMENT FUNDS	*Refer to Pension Plan on page 2399-12 of this chart, 2332 Retirement Funds and 2334 Savings and Checking Accounts.	*	FBR - * NON-FBR - *
RETIREMENT ACCOUNTS (including IRAs/Keoghs)	*Refer to Pension Plan on page 2399-12 of this chart and 2332 Retirement Funds.	*	FBR - * NON-FBR - *
REVERSE MORTGAGE	Allows a homeowner to borrow, via a mortgage contract, some percentage of the appraised value of their home. A periodic payment or line of credit is received and does not have to be repaid as long as the borrower resides in the home. Often referred to as a Reverse Annuity Mortgage (RAM).	E	FBR - Treat as a loan and count if retained in the month following the month of receipt. Refer to Section 2405. NON-FBR - SAME

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
SAFE DEPOSIT BOX	Secure storage in a bank or other institution where money and other valuables may be deposited. Obtain a list of items that are in the box from the A/R. Count cash value of the items unless otherwise excluded. Refer to 2333 Safe Deposit Box.	I	FBR - Inventory required NON-FBR - Inventory required only if statement of contents is questionable.
SALE-LEASEBACK	When a homeowner transfers title of the home to a buyer (e.g. an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn, allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. Under this arrangement, the buyer is responsible for the payment of real estate taxes, major maintenance, and casualty insurance.	N/A	FBR - Treat as the conversion of a resource and count if retained into the month following the month of receipt. If the buyer pays taxes, insurance or for repairs on the home the value of these items is not ISM to the former homeowner. Refer to Section 2405.
SAVINGS ACCOUNTS	Monies held in an interest-bearing account. Count CV. Refer to 2334 Savings and Checking Accounts.	I	FBR - I NON-FBR - I
SECURITY DEPOSIT ON RENTAL PROPERTY OR UTILITIES	Cash held by the provider and not accessible to the AU.	E	FBR - E NON-FBR - E
	Cash returned to the AU. Resource in month received.	I	FBR - I NON-FBR - I
SPENDING ACCOUNT	Funds which are held in an account to pay certain expenses such as child care or medical expenses	E	E
SSA DIRECT EXPRESS ACCOUNT	Direct Express is a debit card one can use to access their SSA benefits. *Any balance carried over into the next month. Refer to NOTE in 2334 Savings and Checking Accounts.	I*	FBR - I* NON FBR - I*
STABLE ACCOUNT (Georgia STABLE account, ABLE account)	Refer to ABLE account		

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
STOCKS AND MUTUAL FUNDS	A certificate which verifies ownership of shares in a company Consider CV. Verify the value of stock via the internet, the newspaper, or a broker. Refer to 2335 Stocks and Mutual Fund Shares.	I	FBR - I (Refer to retirement funds in this chart for special instructions) NON-FBR - I
SUSAN WALKER V. BAYER CORPORATION SETTLEMENT PAYMENTS	Cash settlement from a lawsuit	E	FBR - E NON FBR - SAME
TRUSTS	Any funds in a trust or transferred to a trust and the income produced by that trust. If the: • Trust arrangement can be revoked by an AU member	I	Refer to 2335 Stocks and Mutual Fund Shares, 2337 Trust Property – OBRA '93, 2338 Trust Property, and 2339 Annuities.
	• Beneficiary's name can be Changed during the POE	N/A	
	• Trust arrangement can cease during the POE	N/A	
	• Trustee administering the fund is a court, an institution, corporation or organization which is not under the direction or ownership of any AU member	E	
	• Trustee appointed by the court has court imposed limitations placed on the funds	E	
	• Trust investments made on behalf of the trust do not directly involve or assist any business or corporation under the control, direction, or influence of an AU member.	E	
TRUST PROPERTY MEDICAID QUALIFYING Prior to OBRA '93	For description, refer to 2336 Trust Property, Medicaid Qualifying (Prior to OBRA '93).	N/A	FBR - Count as a resource any portion available to but not received by the A/R. Develop a transfer of resources for any portion unavailable to the A/R. Undue hardship may be considered. NON-FBR - SAME

SOURCE/TYPE	DESCRIPTION/VALUE TO CONSIDER	FAMILY MEDICAID	ABD MEDICAID FBR/NON-FBR
TRUST PROPERTY NON-MEDICAID QUALIFYING	For description, refer to 2337 Trust Property – OBRA '93.	N/A	FBR - Exclude unless the A/R is legally empowered to revoke and use the funds. NON-FBR - SAME
UNIFORM GIFTS TO MINORS	For description, refer to 2340 Uniform Gifts to Minors.	N/A	FBR - Exclude until age 21. If the A/R is a donor develop for a transfer of resources. NON-FBR - SAME
UNIFORM LOCATION ASSISTANCE AND REAL PROPERTY ACQUISITION	Reimbursements received under PL 91-646, Section 210	E	E
UNITED STATES AUTOMOBILE ASSN. SUBSCRIBER'S SAVINGS ACCOUNT (USAA)	Considered a reciprocal Interinsurance exchange. May be in the form of a homeowner's insurance policy.	I	I
VEHICLES	For description, refer to 2308 Automobiles / Vehicles.	Refer to 2308 Automobiles / Vehicles.	Refer to 2308 Automobiles / Vehicles for how to count in FBR and Non- FBR
VICTIMS COMPENSATION (unspent)	For description, refer to 2341 Victims' Compensation.	E	FBR - Exclude up to 9 months. Refer to chart 2. NON-FBR - SAME
WIC (Women Infants & Children Special Supplemental Food Program)	Vouchers which are redeemable for food items received by certain women and children considered to be nutritionally high risk.	E	E

Use the following chart to determine the resource treatment of income retained after the month of receipt

Chart 2399.2 - Resource Treatment of Income Retained After the Month of Receipt

Type of Income	Treatment for Month of Receipt	Month Any Portion Retained Becomes a Resource	Treatment of Any Interest Earned
Agent Orange	Exclude as income.	Never	Count as income and resource.
Austrian Social Insurance	Exclude as income.	Never	Count as income and resource.
Cash or In-Kind Payment to Replace or Repair Excluded Resources	Exclude as income.	10th month after month of receipt (exclude 9 calendar months). Exclude an additional 9 months if reason for retention is beyond A/R's control.	Exclude as income and resource during exclusion period.

Type of Income	Treatment for Month of Receipt	Month Any Portion Retained Becomes a Resource	Treatment of Any Interest Earned
Death Benefits	Count payments in excess of last illness and funeral expenses as income for the month of receipt.	2nd month after month of receipt if last illness and burial expenses are unpaid at receipt. 1st month after month of receipt if last illness and burial expenses paid before receipt.	Count as income and resource.
Disaster Assistance	Exclude as income.	Never	Exclude as income and resource.
Earned Income Tax Credit (EITC)	Exclude as income.	10th month after month of receipt (exclude 9 calendar months after month of receipt)	Count as income and resource.
German Reparation	Exclude as income.	Never	Count as income and resource
Home Replacement	Exclude as income.	ABD: 4th month after sale of home if A/R signs a statement of intent to buy a new home within 3 months. Family Medicaid: 7th month after sale of home.	Count as income and resource.
Japanese or Aleutian Restitution	Exclude as income.	Never	Count as income and resource.
Relocation Assistance	Exclude as income.	10th month after month of receipt or until May 1994 (exclude 9 calendar months)	Count as income and resource.
SSI and RSDI Lump Sums	Unearned Income.	ABD Medicaid - 10th month after month of receipt (exclude 9 calendar Months after month of receipt) Family Medicaid - 7th month after month of receipt (exclude 6 calendar months after month of receipt)	Count as income and resource
Victims Compensation	Exclude as income.	10th month after month of receipt or until May 1994 (exclude 9 calendar months)	Count as income and resource.

Except for SSI and RSDI lump sums, the above unspent resources must have met the exclusion from income requirements in order to be excluded from resources.

Refer to 2305 Commingled Funds.

Use the following chart to determine if a benefit can be excluded from income and resources under Federal statutes other than Title XVI:

Chart 2399-3 - BENEFITS EXCLUDED FROM BOTH INCOME AND RESOURCES BY A FEDERAL STATUTE OTHER THAN TITLE XVI

Unspent funds or assets from the following sources are excluded resources:

- Action programs and domestic volunteer services
  - Volunteers in Service to America (VISTA)
  - University Year for Action (UYA)
  - special and demonstration programs
  - retired senior volunteer programs
  - foster grandparent programs
  - senior companion program
- Low income energy assistance - Any assistance in any form, if provided under the federal Low-Income Home Energy Assistance Program (LIHEAP), such as cash, vouchers, in-kind.
- Federal housing assistance - Any assistance in which the Department of Housing and Urban Development (HUD) or the Farmers Home Administration (FHA) is involved, such as cash for utilities, rental subsidies, etc.
- Food programs with federal involvement
  - USDA Food Stamps and USDA commodities
  - School lunches and breakfasts
  - WIC
  - Nutrition and other programs for older Americans under Chapter 35 of Title 42 of the US code
  - Meals furnished at senior citizens centers
  - Meals on wheels
  - Anything other than wages and salaries
- Educational assistance.

2400 Income

2401 Medicaid Income Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicaid Income Overview		
	Effective Date:	February 2020		
	Chapter:	2400	**Policy Number:**	2401
	Previous Policy Number(s):	MT 4	**Updated or Reviewed in MT:**	MT-58

Requirements

All money, earned or unearned, received from any source by the Assistance Unit (AU) or the Medicaid Budget Group (BG) is considered in determining financial eligibility and benefit level.

Medically Needy uses an income level to determine the A/R's excess income, or spenddown.

Basic Considerations

Income is anything an A/R receives in cash or in-kind that can be used to meet basic needs for food, clothing or shelter.

Income is considered on a monthly basis.

Income is considered the month it is received by the A/R or becomes available without encumbrances to the A/R.

An asset can never be considered as both income and a resource in the same month.

Any income retained after the month of receipt becomes a resource on the first day of the month following the month of receipt.

All lump sum payments are income in the month of receipt.

Any portion of a lump sum payment retained after the month of receipt is a resource. Refer to Chart 2399.2, Resource Treatment of Income Retained after the Month of Receipt, for instructions on how to treat any portion of an RSDI or SSI lump sum payment retained after the month of receipt.

Income is considered to be one of the following:

- earned
- unearned

Specific deductions apply to income based on whether it is earned or unearned. For ABD Medicaid refer to Section 2505, Income Deductions. For Family Medicaid, refer to Section 2655, Family Medicaid Deductions.

Procedures

Follow the steps below to determine whether to consider a particular source of income in determining financial eligibility:

Step 1 Determine who owns the income. Refer to 2403 Ownership of Income.

Step 2 Determine if the income is included or excluded in the Medicaid eligibility budget and in the ABD Medicaid patient liability/cost share budget if appropriate. Refer to 2405 Treatment of Income.

If the income being considered is earned income, in-kind support and maintenance (ISM), rental income or self-employment income, refer to the special sections on these types of income in this chapter.

2403 Ownership of Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Ownership of Income		
	Effective Date:	February 2020		
	Chapter:	2400	**Policy Number:**	2403
	Previous Policy Number(s):	MT 17	**Updated or Reviewed in MT:**	MT-58

Requirements

Income received by the Assistance Unit (AU) or Budget Group (BG) is considered in determining Medicaid eligibility.

Basic Considerations

Income can be owned solely or jointly. An agent or organization acting on behalf of an A/R can also receive the income.

The source of income must be identified to determine if the income is included or excluded. Refer to 2499 Treatment of Income in Medical Assistance.

All countable income of the AU or BG is applied to the income limits for the class of assistance being applied for. Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, and 2650 Family Medicaid Budgeting Overview for budgeting procedures.

Children in Placement

The benefits/support (Child Support, RSDI, SSI) of a child in care that are diverted to the county of custody as designated payee for the child's benefit and care are considered the child's. Refer to individual sources of income in Chart 2499.1, Types of Income in Medicaid, as to whether the benefit/support is included (I) or excluded (E) in the Medicaid eligibility budget.

Procedures

Include all income owned solely by the A/R in determining eligibility if it is accessible to the AU or BG for daily use because the AU or BG has the legal ability to use it.

Jointly Received Income in Family Medicaid

If an AU or BG member receives income jointly with another person or a group of persons, the portion that belongs to the AU or BG member is determined as follows:

- If there is an agreement between the parties that specifies how they will divide the income, this agreement is used to determine the amount of income to consider.
- If there is no agreement, a pro rata share of the income is counted to the member whose income is being considered.

Jointly Owned Income in ABD Medicaid

When a financial instrument, such as a bank account, is owned jointly by the A/R and another individual, determine what portion of any deposit or interest represents income to the A/R.

The A/R may rebut ownership of income. For the rebuttal process, refer to Chapter 2300, Resources.

For ABD Medicaid, use the following chart to determine the amount of income generated by a joint financial account to consider as income to the A/R:

Chart 2403.1 - Determining Income from a Joint Financial Account

IF the account is	THEN
jointly owned by the A/R and an ineligible individual(s)	consider the amount of any interest posted as income to the A/R **AND** include the full amount of any deposit made by the A/R, the ineligible bank account holder or a third party as income to the A/R. Income that clearly is owned by another account holder, e.g. direct deposit RSDI, is income to the owner of said income.
jointly owned by two or more A/Rs	allocate any interest posted equally among the joint owners **AND** do not consider deposits made by joint holder as income to the other joint holder.

For ABD Medicaid, use the following chart to determine the treatment of income from a jointly held account after the A/R successfully rebuts ownership of the account:

Chart 2403.2 - Determining Income from a Joint Account after the A/R Rebuts Ownership

IF	THEN
the A/R successfully rebuts ownership of a portion of funds in a joint account	do not consider deposits made by the other account holder as income to the A/R. Charge interest to the A/R in proportions to the percentage of funds that are a resource to the A/R.
the A/R successfully rebuts ownership of all funds in a joint account	do not consider deposits made by the other account holder(s) OR interest posted to the account as income to the A/R.

Special Considerations

For ABD Medicaid

A/R Has an Agent

Treat income received by an agent acting on behalf of an A/R as if the A/R received the income

directly.

A/R Is the Agent

Do not consider income received by an A/R in his/her capacity as an agent as income to the A/R.

Consider fees, commissions or contributions for services rendered as unearned income to an A/R acting as an agent.

2405 Treatment of Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Treatment of Income		
	Effective Date:	December 2022		
	Chapter:	2400	**Policy Number:**	2405
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

Money received is considered to be either earned or unearned. Different rules apply to each type. Either type may be cash or in-kind.

Basic Considerations

Earned income consists of, but is not limited to the following types of payments:

- wages
- net earnings from self-employment (NESE)
- payments for services performed in a sheltered workshop or work activities center
- royalties and honoraria
- sick pay received within six months after work stopped.

Wages include but are not limited to the following:

- salaries
- bonuses
- severance pay
- other special payments received because of employment
- the value of food or shelter in lieu of wages (in-kind earned income). In-kind earned income is counted in ABD Medicaid COAs only.

Unearned income is all income that is not earned. The following are types of unearned income:

- alimony
- annuities, pensions, and other periodic payments
- benefits received as the result of another's death to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the recipient
- dividends, interest, and royalties
- in-kind support and maintenance (ISM)
- prizes and awards

> For MAGI COAs, Lottery and Gambling lump sum winnings which are received in a single payment are counted as income (if less than $80,000 only count in month received, if $80,000 or more count equal amount over a period of time).

- rent.

Income Not Included in Determining Financial Eligibility

The following are not considered income, and are disregarded when determining Medicaid eligibility:

- bills paid by a third party (vendor payment) for an item other than food, shelter, or clothing
- conversion of a resource, such as selling a car to get cash.

> The cash received from conversion of a resource is not counted as income in the month of conversion. Any cash remaining on the first day of the month following the month of the conversion is a resource.

- credit life or credit disability insurance payments
- earned income tax credits (EITC)
- income tax refunds
- non-cash items which will be excluded or partially excluded as resource after the month of receipt, such as a vehicle excluded because it is used for medical treatment.

> Food and shelter are always assigned a value as ISM and included in the eligibility budget as unearned income for ABD Medicaid A/Rs in LA-A, B or C.

- medical or social services provided as cash or in-kind
- proceeds of a loan
- rebates and refunds
- replacement of income which is lost, stolen, or destroyed after receipt (e.g., replacement government checks)
- return of erroneous payments
- value of personal services (e.g., mowing the lawn)
- Veteran's Aid and Attendance
- Veteran's Household Allowance
- Veteran's Unusual Medical Expense (UME) reimbursement
- weatherization assistance (storm doors, windows, insulation, etc.)

Sick Pay

Consider a payment made to or on behalf of an employee by an employer or a private third party because of sickness or accident disability to be Sick Pay.

Consider any Sick Pay received through the six full months after the month work stopped because

of sickness or accident to be earned income. Thereafter, consider as unearned income.

In-Kind Items

For ABD Medicaid, develop the value of food and shelter or other items provided in lieu of wages for the possibility of earned income.

Include the value of the food and/or shelter as ISM (unearned income) using the presumed maximum value (PMV) rule if both the following conditions are met:

- the food and/or shelter is furnished for the employer's convenience and on his/her premises
- the shelter is provided as a condition of employment

If either of the above conditions is not met, include the current market value (CMV) of the food and/or shelter as wages. Consider as earned income payments that an individual receives for services performed in a sheltered workshop or work activities center while participating in a program designed to help him/her become self-supporting.

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

Consider a work environment to be a sheltered workshop if it is a nonprofit organization or institution whose purpose is the following:

- to carry out a recognized program of rehabilitation for handicapped workers
- to provide such individuals with remunerative employment or other occupational activity of an educational or therapeutic nature.

Consider a work environment to be a work activity center if it is planned and designed exclusively to provide therapeutic activities for handicapped workers whose physical or mental impairment is severe as to make their productive capacity inconsequential.

Income from a Terminated Source

If an A/R reports a terminated source of income, the facts regarding the termination, the date on which the final payment of income was received must be verified **only** if questionable (ABD only). For Family Medicaid, the termination of an income source within 30 days of the application must be verified. This includes the last day employed and date last pay was received.

For reviews, any terminated income that has not been reported since the last application or review should be verified. This includes the last day employed and date last pay was received.

The Work Number can be used to verify terminated income from a specific employer. Clearinghouse must still be checked for other employment and for any other discrepancies.

Procedures

Determine whether the specific type(s) of income received by the A/R is included or excluded in the eligibility and patient liability/cost share budgets by referring to Chart 2499.1 - Treatment of Income in Medicaid.

Include income in the budget at the earliest of the following points:

- when it is received
- when it is credited to the individual's account
- when it is set aside for the individual's use.

If the income is to be included in the budget, determine how much of the income is included. Refer to 2504 Determining Countable Income.

Apply the appropriate income deductions, based on whether the income is earned or unearned, when the income is included in the eligibility and patient liability/cost share budgets. For ABD Medicaid, refer to 2505 Income Deductions and 2552 Patient Liability/Cost Share Deductions. For Family Medicaid refer to 2655 Family Medicaid Deductions.

Income Considerations

Eligibility based on income is determined by resolving the following series of questions:

- What is the income limit for type of assistance requested?
- Whose income is considered?
- What is the source of the income?
- Is the income available to the AU to meet its needs?
- Is the income included or excluded?
- How often is the income received?

Income of the following individuals may be considered when determining eligibility:

- AU or BG members
- Persons whose income must be deemed to the AU
- Deemed income of sponsors of aliens
- Ineligible aliens
- Ineligible parents
- Penalized individuals

Refer to Chapter 2500, ABD Financial Responsibility and Budgeting, and Chapter 2650, Family Medicaid Budgeting.

Lottery and Gambling Winnings For MAGI COAs:

- Winnings of $80,000 but less than $90,000 are counted as income over two months.
- For every additional $10,000 one month is added to the period.
- Total winnings are divided in equal installments.
- Winnings counted over multiple months apply only to the individuals who received the winnings.

- Winnings at $1,260,000 or higher will be divided by 120 months for equal installments.
- The winnings are only counted in the subsequent months for the individual that received the winnings. The month of receipt is counted for the entire household budget group.
- A notice must be sent to the affected individuals with the date on which qualified winnings will no longer be counted.

For **Non-MAGI COAs**, Lottery and Gambling Winnings should be treated as income in the month of receipt and any remainder counted as a resource starting the month after receipt.

Documentation

For each type of income received, the following must be documented:

- Source of income
- Individual(s) receiving income
- Frequency (monthly, weekly, bi-weekly, etc.) of payment
- Day of week income is received
- Gross amount
- Source of verification.

If the date of receipt of income or the amount of income cannot be reasonably anticipated, the income is not counted. The decision must be documented.

In addition, the following information must be documented if the income is earned:

- Beginning/ending date of employment (if applicable)
- Employer's name, address, and telephone number
- Date on which new or increased earnings are received.

Verification

For Pregnant Women and Newborn COAs, the A/R's statement of the source and amount of income, earned or unearned may be accepted unless questionable. For all other Family Medicaid COAs, all income must be verified.

For Family Medicaid, client statement is acceptable verification for excluded income.

For ABD Medicaid, the A/R's statement is only acceptable for Q Track COAs. Verification is required when information available to the agency contradicts the A/R's statement or the statement is otherwise questionable.

Verification of income, if required by policy, is obtained in the following order:

- The A/R should provide verification from the payment source.
- If the A/R cannot obtain the verification, the agency must request it directly from the payment source.

- Verification can be obtained from a collateral source, a person who has knowledge of the income, if verification cannot be provided by the payment source.
- The statement of the A/R may be accepted if all other attempts to verify income are unsuccessful and the A/R has cooperated with previous attempts to obtain verification.

Means of Verification - all Medicaid COAs

Verification of income can be provided in a variety of ways, including:

- Work Number
- Pay stubs
- Award letter
- Written statement from source
- Computer match
- Copy of check reflecting gross income
- Form 809 - Wage Verification Form

> Whenever a job is reported, the Work Number should **always** be the **first** source of verification checked. When requesting other forms of verification, the case should be documented that the information was not found in the Work Number.

2407 Qualified Income Trust

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Qualified Income Trust		
	Effective Date:	September 2024		
	Chapter:	2400	**Policy Number:**	2407
	Previous Policy Number(s):	MT 71	**Updated or Reviewed in MT:**	MT-73

Requirements

Effective September 1, 2004, Qualified Income Trusts (QIT) become a viable means in Georgia by which an LA-D A/R may remove income from the Medicaid eligibility determination process.

Basic Considerations

As of September 1, 2004, LA-D A/Rs whose income is equal to or greater than the Medicaid Cap may establish a QIT as an alternative by which they may receive Medicaid benefits by sheltering all or a portion of their income from the eligibility income limit test.

Money entered into an LA-D case to increase the amount of the PL/CS due to a partial month penalty is not considered as income for purposes of a QIT.

To Qualify as a QIT

The trust must be established for the benefit of the A/R and must meet the following requirements:

- Be composed only of income of the A/R, such as pension, RSDI, VA, accumulated interest, etc.
- Be irrevocable. A revocable QIT does not meet the criteria of a QIT and will be treated as a resource and other rules pertaining to OBRA '93 trusts. Refer to Section 2337 - Trust Property - OBRA '93.
- Contain no resources.
  - Money from an existing account cannot be placed in the trust or
  - A non-liquid resource may not be placed in the trust or
  - A non-liquid resource may not be converted to a liquid resource and placed in the trust
- Provide that at the A/R's death, the remainder of the trust will go to the Department of Community Health (DCH), up to the amount that was spent for the A/R's cost of care by Medicaid.
- The QIT may NOT be backdated. It is effective beginning the month in which it is completed and signed by all required parties, not before.
- An A/R must establish a QIT in Georgia. A QIT established in another state cannot be used to qualify for Georgia Medicaid.

Who May Establish a QIT?

The following people may establish a QIT:

- The A/R
- His/her court appointed guardian or court appointed conservator
- Attorney-in-fact if Power of Attorney gives that authority

Anyone other than the A/R who establishes the QIT must present evidence of a POA, court appointed Guardianship or Conservator.

The NH may serve as trustee but cannot establish a trust.

A QIT may not be established for a couple, only for an individual. Therefore, for couples in the same LA-D, if one or both members of the couple are over the individual Cap **and** also together, they are over the Couple Cap, a QIT must be done on the member(s) whose income exceeds the Individual Cap.

Treatment of Income

- Income placed in a QIT is NOT counted in determining income eligibility.
- The income cannot be placed into the QIT by direct deposit from the source of income, i.e., Social Security, etc. However, the current month's income may be transferred from another bank account to the QIT account.
- Income placed in a QIT AND income not placed in the QIT is counted in determining the A/R's patient liability/cost share.
- All of the A/R's income may be placed in the QIT or just the excess over the Medicaid Cap. It is recommended that all of the A/R's income be placed in the trust, if possible.
- Failure to properly and timely fund the QIT will result in a loss of eligibility for that month or the first month in which timely notice may be given. Properly funded simply means that you have deposited, at minimum, the difference between the specified state income cap (minus a dollar) and the applicant's total income.
- Payment for the A/R's medical care (i.e., PL/CS) must be paid by the end of the month following the month, the income is received. If payments are not made, the A/R is not following the provisions of the trust and is not eligible for Medicaid benefits. Take action to close the Medicaid case for the first month that timely notice permits. If payment is subsequently made prior to the expiration of the timely notice, Medicaid eligibility may continue without interruption.
- Other payments from the QIT (i.e., PNA, diversion) must be paid by the end of the month following the month in which it is received.
- Income retained by the A/R and not placed in the QIT is income to the A/R and is counted in determining income eligibility and PL/CS determination.
- Income may be diverted from the QIT or from retained income to the community spouse and/or to dependent child(ren) according to spousal impoverishment and diversion rules. Refer to Section 2554 - Diversion of Income.
- All the rules pertaining to allowable deductions from the PL/CS determination still apply. Refer

to Section 2552 - Patient Liability/Cost Share Deductions. If A/R has self-employment income only the net earnings from self-employment (NESE) should be placed in the QIT since expenses for operating a business are not acceptable disbursements from the QIT. Refer to Section 2415 - Self-Employment. The only income removed from the QIT should be for payment of the PL/CS to the facility, the Personal Needs Allowance (PNA), diversion to the community spouse/dependent child(ren), medical expenses of the community spouse or other medical expenses of the A/R not covered by Medicaid. See "Rules for Funds Entering, Leaving and Remaining in a QIT" below.

- Any other payments made from the QIT may count as income to the A/R. Payments made from the QIT for medical purposes are acceptable disbursements as long as such payments do not negatively impact the PL/CS payment. However, if such income was already used for the PL/CS, it will not be considered income a second time.

Rules for Funds Entering, Leaving and Remaining in a QIT

Income placed in a QIT is exempt in determining income eligibility for Medicaid. However, funds entering and leaving the QIT are not necessarily exempt from treatment for Medicaid.

- Transfer of assets penalties do not apply to income placed in a QIT to the extent that the trust instrument provides that income placed in the trust will be paid out of the trust for medical care provided to the A/R, including nursing home care, CCSP care and institutionalized hospice care, etc. When such payments are made, the individual is considered to have received fair market value for the income placed in the trust, up to the amount of the PL/CS.
- When income remains in the QIT after the amount paid out of the trust for medical services or other items or services which benefit the A/R, the excess income is subject to the transfer of assets penalty (i.e., remaining income exceeds the Medicaid monthly billing rate of the facility). Refer to Section 2342 - Transfer of Assets and Appendix A1.
- Any income remaining in the trust that is not paid out for the A/R's medical care is held there to be recouped by DCH at the A/R's death. The remainder income is not counted as a resource.
- Excess income (income above the PL/CS, diversion, and PNA) placed in a QIT may be transferred for the sole benefit of a spouse without incurring a penalty. Refer to Section 2502 - Deeming (ABD), Chart 2502.1, for a definition of "sole benefit of". This may include payments by the QIT for medical care for the community spouse. There is no transfer of assets penalty for assets transferred to a spouse or to a third party for the sole benefit of the spouse. To be exempt, the QIT instrument must be drafted to require that this particular property can be used only for the benefit of the A/R's spouse while the QIT exists and that the QIT cannot be terminated and distributed to any other individual or entities for any other purpose.
- Inappropriate payments made from the trust (i.e., lawyer fees, mortgage payments, costs of doing business, etc.) will invalidate the trust. Consider such payments as income to the A/R. The A/R thus becomes ineligible because the guidelines of the trust are not being followed. Such payments could only be made from non-QIT income if any remains after required payments.
- The amount of income deposited into the QIT may change as long as the amount of monthly income that does not go into the QIT does not equal or exceed the Medicaid Cap.

Who May/May Not Be the Trustee?

- Spouse may serve as trustee.

- Anyone named by the QIT who is willing and capable to act in that position may serve as trustee.
- NH may serve as trustee.
- The A/R may NOT act as his/her own trustee.

QIT Account

The QIT account should be a banking instrument from which funds can be paid out by the trustee, this could include:

- Checking accounts, money market accounts, etc. (preferably non-interest bearing and no fees attached)
- NH patient fund account if such account meets the guidelines of the QIT (composed only of income, irrevocable, no resources and remainder to go to DCH), or
- Banking account specifically for purpose of QIT (no commingled funds).

Procedures

Follow the steps below to determine the treatment of a QIT:

Step 1 Give every A/R or authorized representative of an A/R whose income exceeds the Medicaid Cap the following handouts found in Appendix F - TOC:

- Form 328 - Qualified Income Trust (QIT) – A Guide for Trustees
- Form 412 - Qualified Income Trust (QIT) Worksheet
- Form 936 - Certification of Department of Community Health Approved Qualified Income Trust
- Copy of the QIT template

> It is not a requirement for an attorney to set up or certify a QIT. But if an attorney sets up the QIT the attorney should certify the QIT with their State Bar Number.

Step 2 If a QIT is established, obtain a copy of the QIT document, and compare to the QIT template.

- If the QIT is identical to the template, has signature of two witnesses and includes the Form 936 - Certification of DCH Approved QIT, proceed to Step 3.
- If the QIT is identical to the template but does not include the certification form proceed to Step 4.
- If the QIT differs from the template, proceed to Step 5.

Step 3 For QITs which are identical to the template QIT and include the certification form, attach a Form 285, include the POA paperwork and submit to:

Georgia Department of Community Health
ATTN: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30384
Email: gatrustunit@gainwelltechnologies.com
Fax: 678-564-1169

> The Georgia Trust Unit is paperless and prefers all documents and information to be emailed. For questions, email using the above address or call 678-564-1168.

Upload a copy into Document Management. Proceed to Step 6.

Step 4 For QITs which are identical to the template QIT but do NOT include the certification form contact the A/R or PR to obtain one. Once received, follow instructions in Step 3.

Step 5 For QITs that differ from the template, attach a copy of the Form 947 - QIT Approved Format Deviation Form from Appendix F - TOC explaining how the QIT differs from the template, include the POA paperwork and send to:

Georgia Department of Community Health
Attn: Trust Unit
100 Crescent Centre Pkwy, Suite 1000
Tucker, GA 30384
Email: gatrustunit@gainwelltechnologies.com
Fax: 678-564-1169

> NOTE: The Georgia Trust Unit is paperless and prefers all documents and information to be emailed. For questions, email using the above address or call 678-564-1168.

Include return mailing instructions. Upload copy of QIT into Document Management. Do not approve case until approval has been received from DCH Legal.

Step 6 Verify how much of the A/R's income is going into the QIT and that the income not put into the QIT is under the Medicaid Cap.

Step 7 Deny the application due to excess income for any benefit month after August 2004 in which a QIT was not established **AND** funded prior to the end of the benefit month and the A/R has income equal to or above the Medicaid Cap.

Step 8 Proceed with the eligibility determination process, including basic eligibility criteria, income/resource eligibility and PL/CS as applicable to the COA.

Step 9 Review QIT every six months. Refer to Appendix F - TOC for a copy of the Form 937 - QIT Review Letter. One of the reviews may coincide with the annual review.

Step 10 The six-month review will be an accounting to the Case Worker by the trustee or AREP of the activity of the QIT during this time period. Obtain bank statements, receipts from nursing facilities or medical providers, documentation of payments to nursing facilities or medical providers etc. of all activity in the account.

Step 11 At any point (at the six-month review or any other time) that the Case Worker becomes aware that the trustee is not following the guidelines of the trust, the Case Worker should begin action to terminate the case. However, the Case Worker or supervisor should contact their Medicaid Program Specialist before taking any such action.

Step 12 The QIT terminates only upon the death of the applicant, or upon the express written authorization and approval of DCH TPL unit. When the A/R dies, leaves LA-D permanently or becomes ineligible (no COA to CMD) resulting in closure of any LA-D COA in which there is a QIT, the QIT trustee should take the following actions:

- Stop the deposit of funds into the QIT.
- Notify the county DFCS office and DCH for the reason for termination. Write a check for the balance of the trust fund made payable to "Georgia Department of Community Health." A copy of the bank statement should be enclosed to confirm that balance. A cover letter or memo must include a brief explanation that the enclosed check is from a QIT. The cover letter and check should clearly identify the A/R by name, SSN and/or Medicaid number.
- The above information should be sent to:

  Georgia Department of Community Health
  Attn: Trust Unit
  100 Crescent Centre Pkwy, Suite 1000
  Tucker, GA 30384
  Email: gatrustunit@gainwelltechnologies.com
  Fax: 678-564-1169

The Georgia Trust Unit is paperless and prefers all documents and information to be emailed. For questions, email using the above address or call 678-564-1168.

- No other checks should be written from the QIT account after the individual's death.

The Case Worker should complete the following:

- Close the case allowing timely notice and/or accurate notice. (Timely notice is not required if the closure is due to death.)
- Notify DCH's TPL Unit via a Form 285 of the event. Print in red ink at the top of the form "QIT". Explain on the form the date and reason for the termination.

Change in Trustee

The provisions of the QIT should be followed to execute a change in the trustee. The QIT should have provisions for a successor trustee. The current trustee must do the following:

- Give 30-day written notice of resignation to the Grantor, each beneficiary and DCH Legal Services. Such notice should clearly identify the A/R/s name, SSN and Medicaid number.
- The resignation may not be effective until 30 days from the date such notice was given.
- The resignation of the old trustee and the appointment of a new trustee must be in writing, witnessed (notarized) and attached to the QIT.
- Depending on the provisions of the trust, it may be necessary to have the old trustee, new trustee and the grantor or their guardian/POA sign the resignation and new appointment document.
- Attach a copy of the new trustee document with signatures, etc. to the existing QIT and send to the Case Worker.

The Case Worker will complete a new Form DMA 285 to the above documents and send to DCH TPR. See Step 3 for address. Upload a copy into Document Management.

Income Now Under the Medicaid Cap

If an A/R who has had a QIT in place now has income under the Medicaid Cap, complete the following:

- The trustee should cease funding the QIT account.
- The trustee should close the QIT account if no funds remain in the account. If funds remain in the QIT and the A/R or PR wants the account closed, then follow instructions in Step 12.
- The MES should document the case regarding the change in income, etc. and change the necessary info in the system to reflect the changes.

2410 Rental Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Rental Income		
	Effective Date:	February 2020		
	Chapter:	2400	**Policy Number:**	2410
	Previous Policy Number(s):	MT 38	**Updated or Reviewed in MT:**	MT-58

Requirements

Any rental payment which an A/R receives for the use of real or personal property, such as land, housing or machinery is included as income to the A/R in the Medicaid financial eligibility and patient liability/cost share budget.

Basic Considerations

Net rental income is gross rent less the ordinary and necessary expenses paid in the same federal/state income tax year.

Ordinary and necessary expenses are those necessary for the production or collection of rental income. These expenses include the following:

- interest on debts
- state and local taxes on real and personal property and on motor fuel
- general sales taxes
- expenses of managing or maintaining property.

Net rental income is unearned income unless it is earned income from the self-employment of someone who is in the business of renting properties.

Procedures

Deductible Expenses

Deduct the following ordinary and necessary expenses as expenses for the month they are paid:

- the interest and escrow portions of a mortgage payment at the point the payment is made to the mortgage holder
- repairs such as minor corrections to an existing structure
- property taxes
- fire and hazard insurance
- lawn care
- snow removal

- advertising for tenants.

Nondeductible Expenses

Do not deduct the following expenses from rental income:

- the principal portion of a mortgage payment
- a capital expenditure, which is an expense for an addition to or increase in the value of the property
- the property depreciation amount claimed as a federal income tax deduction.

Determining Net Rental Income

Follow the steps below to determine net rental income to include in the eligibility and patient liability/cost share budgets.

Step 1 Determine the gross rent received.

Step 2 Obtain statements from two reliable sources, such as realtors, as to the Current Market Value (CMV) for the rental of a comparable property. Use the higher of the two amounts.

Step 3 If the property is leased to an individual/business and is subsequently sub-leased for a higher amount, count the higher amount of the lease payment as income to the A/R.

Step 4 Determine the deductible expenses paid each month.

Step 5 Subtract the deductible expenses from the gross rent to determine the net rental income.

If the expenses exceed the gross rent for a month, deduct the excess expenses as follows:

- Subtract the excess expenses from the next month's gross rent.
- Continue to subtract the excess expenses from each month's gross rent through the end of the tax year.

If excess expenses remain after subtracting expenses through the end of the tax year, deduct the remaining excess expenses as follows:

- Subtract the excess expenses from the gross rent received in the month prior to the month the expenses were paid.
- Continue subtracting the excess expenses from each month's gross rent as necessary back to the beginning of the tax year until they are exhausted.

Verification

Use documents in the individual's possession such as bills, receipts, etc., to verify the gross rent and the dates received, and the expenses and the dates paid.

The individual's most recent federal tax return including Schedule E is helpful in identifying past expenses and in estimating future rental income.

If documents are not available, obtain a signed statement from the A/R. Include an allegation of the gross rent and expenses paid for the period involved.

Do not contact the tenants to verify the allegations.

Contact the local Internal Revenue Service (IRS) or refer to IRS Publication 527 if you are uncertain whether an expense is allowable, such as whether it is an incidental repair or a capital expenditure. Document the information obtained from the IRS.

Special Considerations

Apportion net rental income equally when there is more than one owner.

- Split the gross rent between two joint owners before expenses are paid.
- Deduct expenses paid by the A/R from his/her portion of the gross rent.
- Accept a signed statement from the A/R if it explains why apportionment should not be equal.

Use evidence from the retroactive period to estimate net rental income for the next 12 months. Deduct only predictable expenses, such as utilities, interest payments, taxes, etc.

Deduct an unpredictable expense if reported in the month paid. If the expense exceeds the rent for that month, recalculate the rest of the estimated period as necessary using the steps in Determining Net Rental Income under Procedures in this section.

Use an individual's amortization schedule to determine the mortgage interest expense. If a schedule is not available, divide the yearly interest by twelve to determine monthly interest.

2415 Self-Employment

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Self-Employment		
	Effective Date:	September 2024		
	Chapter:	2400	**Policy Number:**	2415
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-73

Requirements

Earnings from an applicant/recipient's (A/R) own business or self-employment, as opposed to wages or a salary from an employer, are included as earned income when determining eligibility for any Medicaid Class of Assistance (COA) and when determining ABD patient liability/cost share budgets.

Basic Considerations

Net Earnings

The net earnings from self-employment (NESE) is the gross income from any trade or business, plus capital gains, less allowable business expenses, including depreciation.

NESE also includes any distributive share (whether or not distributed) of income or loss from a trade or business operated as a partnership.

Appreciation

Appreciation, or capital gain, is an increase in the value of a business resource, and is a result of any of the following:

- improvement in the property
- normal market increases
- interest accrued

Determine appreciation by obtaining verification of the value of the resources from a reliable source.

Depreciation

Depreciation occurs when a business resource loses value because of either of the following:

- destruction of property in a storm, fire or other disaster
- long term use of the resource reduces its value (e.g., vehicles, machinery)

Determine depreciation by obtaining verification of the value of the resource from a reliable source.

Procedures

ABD Medicaid

Develop NESE in the following situations:

- the A/R was self-employed in the prior tax year
- the A/R is currently self-employed
- the A/R has been self-employed during the current tax year

Calculate NESE on a tax year basis.

- Subtract all allowable IRS business deductions claimed on the self-employed individual's federal tax return from the gross self-employment earnings for the year to determine the NESE.
- Divide the NESE equally among the 12 months in the tax year to determine monthly earnings.

Divide net losses from self-employment over the tax year in the same way as net earnings. Deduct each month's net loss from other earned income for that month.

Divide the entire taxable year's NESE equally among 12 months in the taxable year, even if the business is seasonal, starts late in the year, ceases operation before the end of the tax year or ceases operation prior to the initial application for ABD Medicaid.

When a Medicaid individual, a member of a Medicaid couple, a Medicaid individual's ineligible spouse, or one of two ineligible parents incurs a verified net loss, deduct the loss from other earnings for the tax year in which the loss was incurred, regardless of which individual incurred the loss.

In the event cash or in-kind items are withdrawn from a business for personal use, determine whether the withdrawals were properly accounted for in determining NESE.

Accept the individual's allegation that withdrawals were deducted on his/her tax return in determining the cost of goods sold or that they were deducted on his business records.

If a withdrawal(s) was deducted, then it was properly accounted for.

Family Medicaid

Capital Gains

Consider the total proceeds from the sale of capital goods or equipment, less depreciation, as capital gains income.

Add capital gains income to the gross self-employment income.

Business Expense

Deduct from the gross self-employment wages all allowable IRS business deductions claimed on the self-employed individual's federal tax return. For information on business expenses, refer to www.irs.gov/forms-pubs/guide-to-business-expense-resources#d0e3422 .

The following expenses are not allowable deductions for self-employed individuals:

- Payment on the principal of the purchase price of income-producing real estate, equipment, machinery, etc.
- Federal **income** taxes

> A corporation or partnership can deduct state and local income taxes imposed on the corporation or partnership as business expenses. Various federal, state, local, and foreign taxes directly attributable to a trade or business can be deducted as business expenses. For more information on this, refer to www.irs.gov/publications/p535/ch05.html#d0e3422.

- Portions of self-employment taxes. Refer to Form 1040 Schedule 1 for portion that is allowable.
- Personal expenses (transportation to and from work, living expenses)

Boarder Income

Deduct actual cost of doing business from the boarder income.

Rental Income

Rental income is budgeted as earned or unearned, depending on the number of hours an individual is engaged in property management. Consider self-employment income from rental property as follows:

- If the individual is actively involved in property management at least 20 hours per week, count the gross income, less the cost of doing business, as **earned** income
- If the individual is not actively involved in property management at least 20 hours per week count the gross income, less the cost of doing business, as **unearned** income.

Annualized Income

Annualize self-employment income if the following occurs:

- the self-employment income represents a year's support, even if the income is received in a short time period
- the self-employment income accurately reflects the AU's current circumstances.

> Annualize the self-employment income, even if the AU receives additional income from other sources.

Do not annualize self-employment income if the following occurs:

- the self-employment income is not an accurate reflection of the AU's current circumstances because income has recently increased or decreased
- the self-employment income represents support for only part of the year
- the self-employment income is from a new business in operation for less than one year

To annualize self-employment income, total the gross annual receipts, subtract the cost of doing business and divide by 12.

Non-Annualized Income

Refer to Chart 2415.1, Calculation of Non-Annualized Income.

Self-Employment Income Budgeting Procedures

Follow the steps below to determine self-employment income for inclusion in the budget. Refer to Chapter 2650, Family Medicaid Budgeting.

Step 1 Add all gross self-employment income.

Step 2 Add any capital gains, less depreciation.

Step 3 Subtract the cost of doing business.

> For MAGI Medicaid, the salary the client pays themselves out of the business is not considered a business expense and should be included in the income budget.

Step 4

Consider the result as the adjusted gross self-employment income.

Step 5

Calculate other deductions. Refer to Section 2655 - Family Medicaid Deductions.

Self-Employment Losses Budgeting Procedure

Divide net losses from self-employment over the tax year in the same way as net earnings. Deduct each month's net loss from other **earned** income for that month.

Verification

ABD and Family Medicaid

Verify gross self-employment earnings and allowable IRS deductions through the use of any of the following:

- federal income tax return (including 1040, Schedule 1 and all other applicable Schedules)
- business records including receipts, bills and invoices
- the A/R's signed statement if neither of the above are available.

> Assume that any deductions taken on a tax return or business record is allowable by the Internal Revenue Service.

Document the case record as to why federal income tax returns or business records were not used if the A/R's statement was accepted as verification.

> The A/R's statement of self-employment earnings and allowable deductions is accepted as verification for Pregnant Woman and Newborn COAs unless questionable.

Use Chart 2415.1 to determine treatment of income that is not annualized:

Chart 2415.1 - Calculation of Non-Annualized Income - Family Medicaid

IF THE INCOME	THEN
does not reflect current circumstances (recent increase or decrease in income)	determine the best estimate of current gross income less cost of doing business to be used as the monthly amount budgeted.
is from a new business, i.e., in operation less than one year	average gross income less cost of doing business over the period of operation to determine projected monthly income.
represents support for only part of the year	average gross income less cost of doing business over the number of months the income is intended to cover.
is received monthly	count total gross monthly income less cost of doing business.

2418 VA Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	VA Income		
	Effective Date:	February 2020		
	Chapter:	2400	**Policy Number:**	2418
	Previous Policy Number(s):	MT 42	**Updated or Reviewed in MT:**	MT-58

Requirements

The Veteran's Administration (VA) may provide financial benefits to many veterans and/or their spouses/dependents.

Basic Considerations

Individuals potentially eligible for VA benefits include:

- Any veteran
- Child or spouse of a disabled or deceased veteran
- Unmarried widow(er) of a deceased veteran
- Parents of a veteran who died before 1/1/57 from a service-connected cause.

These benefits may consist of:

- VA pension which is a benefit paid to an aged, blind or disabled veteran and/or dependents who are in need (not military retirement).
- VA Compensation, which is a benefit, paid to veterans/dependents who have a military related injury/disability or death. This also includes Dependency and Indemnity Compensation (DIC), also referred to as Happy Widow(er)'s Pension. The DIC paid to the veteran's widow(er) may continue even if the widow(er) subsequently remarries and is now widowed again.
- VA Aid and Attendance (A&A) which is a payment made to veterans and certain dependents for medical and remedial care in their own home or a nursing home (NH).
- Housebound allowance which is a payment made to veterans and certain dependents who do not require the aid and attendance of another person but who are permanently housebound due to disability.
- Unusual Medical Expense (UME) which is a reimbursement paid to some veterans for high medical costs. VA takes into account Medicaid payments and reduces UME payments accordingly.
- Continuing Medical Expenses (CME) which is a monthly prospective payment for out-of-pocket medical expenses for veterans and their spouse who are in a personal care home or nursing facility. It is considered as a reimbursement.
- Clothing Allowance which is a benefit paid to some veterans with a service connected disability who use prosthetic or orthopedic appliances.

- Augmented VA Benefits which are an increase, or augmentation, of VA benefits to meet the needs of the veteran's dependents.
- VA Educational Benefits which may include benefits paid under/from:
  - A program of vocational rehabilitation
  - Veteran's own contributions
  - Augmentation for dependents.

Procedures

Budgeting Requirements

Budget VA income in the eligibility and PL/CS process as follows: Also refer to Section 2499, VA Benefits.

UME/CME reimbursements and A&A are not considered in determining patient liability and cost share and are never considered as income for determining Medicaid eligibility. A&A is not considered for protection or diversion purposes in the patient liability budget.

Any portion of a VA lump sum check that is not VA A & A, UME/CME reimbursement or is not augmented for a dependent is counted as unearned income for the month of receipt in both the eligibility and PL/CS budgets.

Consider any remaining portion of the A & A lump sum as a resource beginning with the first month following the month of receipt.

A & A lump sums or UME/CME reimbursements are not reported to the DMA Third Party Liability Unit.

- If the A/R is the beneficiary (payee) of an augmented VA check, exclude as income to the A/R any portion augmented for dependents. If the A/R is a dependent of a beneficiary and the beneficiary's check include an augmentation for the A/R, count the augmented portion as income to the A/R if the A/R lives in the same household as the beneficiary. If the A/R lives apart from the beneficiary and the beneficiary does not give the A/R his/her augmented portion, use the following procedures:
- Count the augmented portion of the beneficiary's check as income to the A/R for eligibility.
- Require the A/R to apply for an apportionment (his/her own check).
- Continue to count the augmentation as in(his/her own check).
- Continue to count the augmentation as in come for eligibility until VA denies apportionment.
- If VA approves apportionment, include the apportionment as unearned income.

If the A/R is in a NH and the beneficiary refuses to give the A/R his/her augmented portion of the VA benefit, require the A/R to apply for an apportionment. If the A/R is not receiving his/her augmented portion, do not include the augmented portion in the PL/CS budget until such time as the apportionment is approved. However, continue to include the augmented portion in the eligibility budget until VA approves or denies the apportionment.

The maximum pension benefit for a veteran in a NH with no dependents is the same as the personal needs allowance (PNA) allowed in the PL budget. If the only VA income received is up to $90 that is the A/R's PNA. Do not allow this PNA until the VA income has decreased to $90. If an A/R is receiving the DIC and elects to receive the $90 while in the NH, the DIC will not resume if the A/R then leaves the NH. The veteran does not receive an additional $50 PNA. Refer to Appendix I, "To Have a $90 PNA for a NH A/R with VA Income".

If an A/R who has **countable** income in excess of the monthly Medicaid billing rate for the NH in which s/he resides, enter PL income in the system which will equal the Medicaid billing rate after all pertinent PL deductions are allowed.

Verifications

Verify the amount of monthly VA by submitting the Form 970, VA Communicator, to the address shown on the form.

Be sure the Form 970 includes the veteran's file number.

Appropriately enter the verified amount of VA in the system.

A/R's can call VA to get verification of their benefit amounts by calling one of the following numbers:

VA Telephone Assistance Service -1-800-827-1000

VA National Pension Hotline- 1-877-294-6380

2420 Military Pay

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Military Pay		
	Effective Date:	February 2020		
	Chapter:	2400	**Policy Number:**	2420
	Previous Policy Number(s):	MT 29	**Updated or Reviewed in MT:**	MT-58

Requirements

Military pay, housing allowance, subsistence allowance and other entitlements as shown on the Leave and Earnings Statement (LES) are considered when determining eligibility or assistance.

Basic Considerations

Military pay is treated as earned income when the person in the military is an AU member.

When a person in the military is not in the AU but gives money to the AU or authorizes money to be sent to the AU, that money is counted as unearned income.

The Clothing Maintenance Allowance (CMA) is treated as a reimbursement.

Military pay is counted in the month for which it is intended.

Advance Pay, Casual Pay and Family Subsistence Supplemental Allowances are counted in the month received.

Procedures

Chart 2420.1 provides information on the treatment of military pay.

Determine if there are any debt repayments listed on the LES and treat as follows:

- if a debt repayment is for Advance Pay, then deduct the repayment from the gross income
- if a debt repayment listed as FININ or Debt Repayment on LES is for a personal loan (e.g., for a car loan), count the repayment as part of the gross income.

Do not allow the following deductions or exclusions from income:

- allotments withheld for dependents

  Allow as an exclusion if it is for an ineligible child or for a voluntarily excluded child in Family Medicaid.

- federal tax, FICA, SGLI, Soldiers Home, Insurance.

Use the chart below to determine treatment of military pay.

Chart 2420.1 - Treatment of Military Pay

BENEFIT	TREATMENT OF INCOME
Amount Brought Forward	Disregard amounts brought forward from a previous month.
Advance Pay/Casual Pay	Count the gross amount as earned income in the month received.
Base Pay	Count the gross amount as earned income in the month received.
Basic Allowance for Housing (BAH)	Count the gross amount as earned income in the month for which is it intended. The BAH is one monthly payment, replacing the Variable Housing Allowance (VAA) and Basic Allowance for Quarters (BAQ).
Basic Allowance for Subsistence (BAS)	Count the gross amount as earned income in the month for which it is intended.
Career Sea Pay	Count the gross amount as earned income in the month for which it is intended.
Clothing Maintenance Allowance (CMA)	Do not count as income. Consider it as a reimbursement. Deduct the CMA from the total gross earned income.
Combat Pay	Exclude additional or special payments received by a member of the US Armed Forces due to deployment to a designated combat zone for the duration of the member's deployment to or service in a combat zone. The additional or special pay may be identified on the LES as "incentive pay for hazardous duty" or "special pay for duty subject to hostile fire or imminent danger".
Cost-of-Living Allowance (COLA) or HOUSE	Count the gross amount as earned income in the month for which it is intended.
Fly Pay/Fly Pay-non	Count the gross amount as earned income in the month for which it is intended.
FSSA	Count the gross amount as earned in the month received. Family Subsistence Supplemental Allowances are given to assist low-income military families.
Jump Pay	Count the gross amount as earned income in the month for which it is intended.
Leave or Separate Rations	Count the gross amount as earned income in the month for which it is intended.
National Guard Pay	Count the gross amount as earned income in the month for which it is intended.
Pro-Di	Count the gross amount as earned income in the month for which it is intended.
Reenlistment Bonus	Treat the gross amount as a non-recurring lump sum payment. If paid in installments, count as unearned income in the month received.
Regular Sea Pay	Count the gross amount as earned income in the month for which it is intended.

2430 Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid		
	Effective Date:	February 2020		
	Chapter:	2400	**Policy Number:**	2430
	Previous Policy Number(s):	MT 38	**Updated or Reviewed in MT:**	MT-58

Requirements

In-kind support and maintenance (ISM) is considered as unearned income when establishing financial eligibility for ABD Medicaid. This policy does not apply to Family Medicaid.

Basic Considerations

ISM is unearned income in the form of food or shelter provided to the Medicaid individual/couple or Medicaid child.

The value of ISM received by the Medicaid individual/couple is determined by subtracting the individual/couple's financial contribution toward household operating expenses from the value of food or shelter provided to the individual/couple by another individual.

The following two rules are used to value the ISM an individual/couple receives:

- the presumed maximum value (PMV) rule
- the value of the one-third reduction (VTR) rule.

Presumed Maximum Value (PMV) Rule

The PMV is one-third of the full FBR plus $20.00.

The PMV rule is used to value ISM received by a Medicaid individual / couple residing in Living Arrangement A or C (LA-A or C).

Under PMV, the value of ISM is determined as follows:

- The actual value (AV) of all food and shelter received by the household is determined.
- The ISM is included in the eligibility budget as unearned income using the AV or PMV, whichever is less.

Value of the One-Third Reduction (VTR) Rule

The VTR is one-third of the full SSI Federal Benefit Rate (FBR).

The VTR rule is used to value ISM received by a Medicaid individual/ couple residing in Living Arrangement B (LA-B).

The VTR is used if the Medicaid individual/couple meets both the following criteria:

- The individual lives throughout a month in another person's household.
- The individual receives both food and shelter from others living in that household.

Refer to Living Arrangement B (LA-B under PROCEDURES in this section) for more information on applying the VTR rule.

The two rules for valuing ISM are mutually exclusive. When the VTR rule is applied to ISM received in a month, the PMV rule cannot be applied to the same month.

Living Arrangement Codes

The Medicaid individual/couple's living arrangement is determined in order to select the appropriate means for placing a value on ISM (PMV or VTR).

There are four Living Arrangements: A, B, C and D.

The living arrangement is developed in the following order:

- D
- B
- A or C

Always consider Q Track and AMN individuals/couples to be residing in LA-A. **DO NOT** develop ISM for Q Track and LA-D individuals/couples. ISM must be developed for AMN A/Rs.

Procedures

Follow the steps below to determine the amount of ISM to consider in the eligibility budget:

Step 1 Determine the Medicaid individual/couple's living arrangement (LA).

Step 2 Value ISM based on the LA determined in Step 1.

- If the individual resides in LA-D, do not develop ISM.
- If the individual resides in LA-A or LA-C, develop the AV of ISM. Include ISM not to exceed the PMV in the Medicaid eligibility budget.
- If the individual resides in LA-B, value ISM using the VTR.

Living Arrangement D (LA-D)

Consider a Medicaid individual whose income is under the Medicaid Cap and who resides in any of the following situations to be in LA-D:

- hospital confinement that meets LOS

- nursing home (NH) confinement
- receipt of CCSP, MRWP/CHSS or ICWP services at home
- receipt of hospice care
- receipt of GAPP services at home
- receipt of SSI or ABD Medicaid at home under a Deeming Waiver
- MRWP/CHSS

DO NOT develop ISM for individuals residing in LA-D.

Living Arrangement A (LA-A)

Consider the Medicaid individual/couple to be residing in LA-A if any one of the following situations exists:

- The individual lives alone or with no adults other than his/her spouse.
- The individual has an ownership interest in his/her home.
- The individual has rental liability for his/her home.
- The individual lives in a Public Assistance (PA) household.
- The individual is a transient.
- The individual can show separate consumption of food.
- The individual can show separate purchase of food.
- The individual is sharing household expenses.
- The individual is earmarking his/her share of household expenses, known as earmarked sharing

Home Ownership

Consider the Medicaid individual/couple to have home ownership interest if s/he or his/her spouse has ownership interest of any of the following types:

- life estate interest
- partial ownership, such as a ½ undivided interest
- title or deed (full ownership)
- trust beneficiary
- unprobated estate interest
- warranty deed (the property is mortgaged).

Home Ownership Verification

Accept the individual's statement unless questionable.

Rental Liability

Consider the Medicaid individual/couple to have rental liability if the individual or his/her spouse has agreed to pay the landlord a specified amount periodically (monthly, weekly, etc.).

> Rental liability exists whether rent is actually being paid or if rent paid is less than the current market rental value as long as the agreement is still in effect.

Rental Liability Verification

Accept the individual's statement of rental liability if s/he lives alone or with his/her spouse and/or dependent child. Verify rental liability for all other living situations.

Public Assistance Household

Consider the Medicaid individual/couple to live in a public assistance household (PA household) if each household member receives one of the following types of income:

- Temporary Assistance for Needy Families (TANF)
- Bureau of Indian Affairs general assistance programs
- Payments based on need which are provided under state or local government income maintenance programs
- Payments under the Disaster Relief Act of 1974
- Payments under the Refugee Assistance Act of 1980
- Supplemental Security Income (SSI)
- Veteran's Administration (VA) benefits that are based on need.

> Effective November 1, 1981, when a VA pension or compensation based on need includes an augmentation for a dependent, the dependent's portion of the VA payment is counted as income to him/her. Such dependents are considered public assistance recipients.

Public Assistance Household Verification

Verify that all household members receive public assistance.

Transient

Consider a Medicaid individual to be a transient if s/he has no permanent living arrangement.

Transient Verification

Accept the individual's statement as verification.

Separate Consumption of Food

Consider separate consumption of food to exist when all the following conditions are met:

- The Medicaid individual/couple lives in a household with at least one other person other than a spouse, child, or person whose income is deemed to the individual.

- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or at least one member of a couple, alleges eating no meals in the household during the month.

Separate Consumption of Food Verification

Obtain the individual's signed statement regarding separate consumption and verify the allegation with a knowledgeable adult member of the household other than the individual's spouse.

Separate Purchase of Food

Consider a separate purchase of food exists when all of the following conditions are met:

- The Medicaid individual/couple lives in a household with at least one person other than a spouse, child, or person whose income is deemed to the individual.
- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or both members of a couple, eats meals in the household during a month.
- The individual, or at least one member of a couple, alleges buying his/her food apart from the food of other household members.

Separate Purchase of Food Verification

Obtain the individual's signed statement regarding separate purchase of food and verify the allegation with a knowledgeable adult member of the household other than the individual's spouse.

Sharing

Consider the Medicaid individual/couple to be sharing when all the following conditions are met:

- The individual lives in a household with at least one person other than a spouse, child, or person whose income is deemed to the individual.
- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or both members of a couple, does not separately consume his/her food.
- The individual, or both members of a couple, does not separately purchase his/her food.
- The individual with ownership interest or rental liability makes a contribution toward the household operating expenses.

  OR

  the individual without ownership interest or rental liability makes a contribution toward any expense of the person with ownership interest or rental liability, such as household operating expenses, credit card payments, telephone bill or furniture bill.

Allowable household operating expenses include the following:

- food
- mortgage (including property insurance required by the mortgage holder)
- rent
- real property taxes
- heating fuel
- gas
- electricity
- water
- sewage
- garbage removal

The use of land alone is not a shelter cost. This means that an item such as a trailer space rental fee that does not include water, sewage, etc., is not a household operating expense for purposes of determining sharing.

Follow the steps below to perform a sharing computation:

Step 1 Determine the average household operating expenses.

Step 2 Determine the household composition.

Step 3 Determine the individual's pro rata share of household expenses by dividing the household operating expenses by the number of household members.

Assume all other members of the household share in the food expense unless information is obtained to the contrary. If another member of the household does not share in the food, determine separate pro rata shares for food and shelter and add them together to determine the individual's pro rata share.

Step 4 Determine the individual's average monthly contribution toward household expenses.

Step 5 Compare the contribution to the pro rata share.

If the contribution is within $5 less than or greater than the pro rata share of expenses, consider the contribution and the pro rata share to be equal, and consider the individual to be sharing.

When computing sharing for a Medicaid couple, subtract the couple's contribution from the pro rata share of household expenses multiplied by 2 to determine if sharing exists.

Sharing Verification

Obtain signed statement(s) of household expenses and contributions to establish that an individual

is sharing.

Earmarked Sharing

Consider the Medicaid individual/couple to be earmarked sharing when all the following conditions are met:

- The individual lives in a household with at least one person other than his spouse, child, or a person whose income is deemed to the individual.
- The individual does not have ownership interest or rental liability in the home.
- The individual does not live in a PA household.
- The individual, or both members of an eligible couple, does not separately consume his/her food.
- The individual, or both members of a couple, does not separately purchase his/her food.
- The individual does not contribute within $5 of his/her pro rata share of household operating expenses for food and shelter.
- The individual, or at least one member of a couple, alleges earmarking part or all of his/her contribution toward the household food or shelter expense.

Earmarked Sharing Computation

Verify household expenses and compute earmarked sharing in the same manner as sharing, comparing the individual's contribution toward the earmarked expense to his/her pro rata share of the expense. However, do not allow a $5 tolerance for earmarked sharing.

Earmarked Sharing Verification

Use the verification procedures for sharing.

Double Earmarking

When an individual earmarks a specific portion of his/her contribution for food and another specific portion for shelter, it is called double earmarking.

Compute the individual's pro rata share of food expenses and compare it to the portion of the contribution earmarked for food.

Compute the individual's pro rata share for shelter expenses and compare it to the portion of the contribution earmarked for shelter.

If either earmarked contribution equals or exceeds a pro rata share of the item for which it is earmarked, consider earmarked sharing to exist. The individual is receiving ISM in the form of the item for which s/he is not earmarking. Value this ISM under the PMV rule.

Double Earmarking Verification

If the individual makes a contribution, verify the contribution as follows:

- Obtain the individual's statement regarding earmarking.

- Obtain an additional signed statement from a knowledgeable adult member of the household other than the individual's spouse. This statement should confirm the amount of the earmarked contribution and the household operating expenses for food or shelter, or both if these expenses were not obtained for a sharing determination.

> If evidence of household operating expenses and the earmarked contributions cannot be obtained, consider the individual to be residing in LA-B.

Living Arrangement C (LA-C)

Consider a Medicaid individual to be residing in LA-C if all of the following conditions exist:

- The individual is a disabled child under age 18.
- The individual lives with his/her parent(s).
- The individual's parents have ownership interest or rental liability in the home.

> A disabled child residing at home under the Deeming Waiver or Model Waiver class of ABD Medicaid is considered to be residing in LA-D.

ISM for an Individual Couple in LA-A or C

If a Medicaid individual or couple in LA-A or LA-C receives an item(s) of food or shelter during the month from an individual(s) other than:

- spouse or dependent children for LA-A
- parents or minor siblings for LA-C, place a value on this item(s) and include the value in the eligibility budget as ISM for the month of receipt.

PMV Rule

Use the PMV rule when an individual in LA-A or C receives ISM.

Rebuttal of the PMV Rule

Use of the PMV rule differs from use of the VTR in that an individual may rebut the value assigned to the PMV. If the individual produces evidence that establishes the AV of the ISM is lower than the PMV, use the AV as the value of the ISM.

Eligible Expense for Computing ISM

To compute ISM for a Medicaid individual/couple in LA-A or C, use the household operating expenses listed under Sharing in this section.

> The use of land alone is not a shelter cost. This means that an item such as a trailer space rental fee which does not include water, sewage, etc., is not a household operating expense for purpose of determining inside ISM, nor is it an item of outside ISM if someone outside the household pays the fee. If the fee is not for use of land alone, that part of the fee for water, sewage, etc., is part of the household operating expenses.

Eligible Expense for Computing ISM Verification

Obtain a signed statement(s) of household expenses.

Types of ISM

Consider the following two types of ISM for a Medicaid individual/ couple in LA-A or LA-C:

- Inside ISM is ISM received from other members of the household in which the individual resides.
- Outside ISM is ISM received from someone outside of the household.

Do not develop Inside or Outside ISM for Q Track individuals/couples.

Inside ISM

Develop Inside ISM for a Medicaid individual/couple in LA-A only if the basis for residing in LA-A is one of the following:

- ownership
- rental liability
- separate consumption of food
- separate purchase of food
- earmarked sharing

Develop Inside ISM for a Medicaid individual in LA-C only when there are persons residing in the home other than the individual and his/her parents and other minor children.

Compute Inside ISM in the following manner:

- Determine the total household operating expenses.
- Divide the total household operating expenses by the number of household members to determine the individual's pro rata share of household expenses.
- Deduct the individual's or couple's contribution from the individual's or couple's (individual share multiplied by 2) pro rata share to determine AV of the Inside ISM.

Outside ISM

Develop Outside ISM for all Medicaid individuals/couples residing in LA-A or LA-C.

Compute Outside ISM in the following manner:

- Use the current market value (CMV) of the shelter or food paid by someone outside of the household.
- Deduct from the CMV any payment made by household members toward that item.
- Divide the balance by the number of household members to obtain the AV of the ISM to the individual.

Total Inside and Outside ISM

Total the AVs of the Inside and Outside ISM. Use the total AV or the PMV, whichever is less, as the value of ISM to the Medicaid individual/ couple.

Living Arrangement B (LA-B)

Consider the Medicaid individual/couple to be residing in LA-B if both of the following conditions exist:

- The individual lives in the household of another.
- The individual is not residing in LA-A or C (because they are not paying their fair share of household expenses) or D.

VTR

If the individual is determined to be in LA-B, value ISM using the VTR. The VTR is equal to one third of the individual or couple FBR for LA-A.

FBR for LA-B

Use the FBR for LA-B in order to account for the VTR.

Rebuttal of the VTR

Use of the FBR for valuing ISM cannot be rebutted by the A/R.

Special Considerations

ISM to a Child in LA-C

When computing ISM for a child in LA-C, apply the parent(s)' contributions to their own pro rata share(s) of household operating expenses first. Apply any amount of their contributions exceeding their pro rata share(s) of household operating expenses to their child's pro rata share of household operating expenses.

If the child lives with only his/her parent(s) and other minor children, develop Outside ISM only.

If the child lives with other adults in addition to his/her parent(s), develop Inside and Outside ISM.

Do not deem ISM received by the parent(s) to the child in the Parent to Child Deeming budget.

ISM is a Result of a Third-Party Vendor Payment

When a third-party payment from outside the household is made directly to a vendor for an item of food or shelter, it results in ISM to the Medicaid individual/couple.

Include ISM received as the result of a third-party vendor payment as income for the month the food or shelter is available to the individual to use.

If a vendor extends credit to the individual and the third party pays for (or makes a payment on)

food or shelter, include the value of the ISM as income for the month the payment is made.

Include the ISM only in the month when the third party actually makes the payment, even though the individual may have received the food or shelter in a previous month.

Rent Free Shelter

Rent free shelter is a type of ISM in the form of shelter provided by someone outside the household to a Medicaid individual/couple residing in LA-A.

Shelter that is income in return for services is not rent-free shelter.

Consider rent-free shelter to exist when no household member has ownership interest or rental liability for the dwelling in which the individual/couple lives.

If there is an agreement to pay rent, consider rental liability to exist, even if the individual is not currently making rental payments.

The use of land alone is not rent-free shelter.

Rental Subsidy

A rental subsidy is a type of ISM in the form of subsidized shelter provided by someone outside the household to a Medicaid individual/ couple residing in LA-A.

Develop rental subsidy only when any household member has rental liability and a household member is the parent or child of the landlord.

Determine the amount of rental subsidy as follows:

- Compare the current market rental value (CMRV) of the dwelling to the actual amount of rent paid under the rental agreement.
- If the rent paid is less than the CMRV of the dwelling, consider all household members to be receiving a rental subsidy.
- Pro rate the value of the rental subsidy (CMRV minus rent paid) among all members of the household, including members who are ineligible or temporarily absent.
- Include the Medicaid individual's pro rata share of the rental subsidy as ISM not to exceed the PMV.

Do NOT consider the following as a rental subsidy:

- public housing assistance which is supplied by a state agency based on need
- public housing assistance excluded by federal statute, such as a HUD subsidy
- rental subsidies excluded under a plan for achieving self-sufficiency (PASS)
- rent/mortgage payments made under the terms of a credit life or credit disability policy.

No ISM Charged

Do not charge ISM if a Medicaid individual/couple receives food or shelter that meets any of the fol-

lowing criteria:

- It is specifically excluded by federal law, such as the Disaster Relief Act of 1974.
- It meets the criteria for exclusion of infrequent or irregular unearned income.
- It has no CMV.
- It is provided under a government (federal, state or local) medical or social service program.
- It is ABON from a state or one of its political subdivisions.
- It is food or shelter received at school by a child under age 22 who receives food or shelter only at school while temporarily absent from his/her parent's household.
- It is food or shelter received during a temporary absence.
- It is a replacement of a lost, damaged or stolen resource in the form of food or shelter, including temporary housing.
- It is provided by someone living in the same household whose income is subject to deeming to the individual.

ISM received by a deemor is not deemed to the Medicaid individual.

Food, Clothing, Shelter which is Remuneration for Work

Refer to Section 2405, Treatment of Income, for a discussion of the treatment of food, clothing, or shelter which is remuneration for work.

Documentation

Document the ISM details in the system.

2499 Treatment of Income in Medical Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Treatment of Income in Medical Assistance		
	Effective Date:	December 2019		
	Chapter:	2400	**Policy Number:**	2499
	Previous Policy Number(s):	MT 54	**Updated or Reviewed in MT:**	MT-57

Requirements

Use the chart below to determine the following treatment for a specific type of income:

- Whether the income is included (I) or excluded (E) in the Medical Assistance eligibility budgets for ABD and Family Medical Assistance and patient liability/cost share budgets
- Whether the income is earned or unearned
- Specific verification requirements, if any.

> If specific verification requirements are not listed, verify the income from the source.

KEY:

ABD

Aged, Blind and Disabled COAs only

Non-MAGI FM

Non-MAGI Family Medicaid COAs only

MAGI

MAGI COAs only

> For a list of all MAGI and Non-MAGI COAs refer to 2160 Family Medicaid Overview.

CHART 2499.1 – TYPES OF INCOME IN MEDICAL ASSISTANCE

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
ACCIDENT OR HEALTH PLAN	Unearned - the value of accident or health plan coverage provided by an employer.	E	
	Long Term Care Coverage - contributions by an employer to provide coverage for long-term services. This includes Archer MSA contributions.	E	
	Health Flexible Spending Arrangement (health FSA) - employer provided health FSA which will result in a reduction of salary and reimbursements of medical care.	E	
	Health Savings Accounts (HSA) - contributions made by the individual are deductions for tax returns.	E	
	Distributions from HSA that are used to pay medical expenses.	E	
	Distribution from HSA that are not used to pay medical expenses.	E	
	Contributions to HSA made by employers	I	
	Qualified HSA funding distribution-a onetime distribution from an individual retirement account (IRS) to an HAS.	E	
ADOPTION ASSISTANCE	Unearned – Payment received for the adoption of certain children. IV-E - Exclude as income.	E	E
	IV-B - Exclude as income.	E	E
ADVANCE	Unearned – Money for future expenses that does not represent a gain to the AU.	E	E
	Earned – A prepayment of wages or salaries.	I	I
AGENT ORANGE PAYMENTS	Unearned – A payment made to a Vietnam Veteran who was exposed to Agent Orange defoliant. The payment is made to the surviving spouse and children.	E	I
ALASKA NATIVE CLAIM	Unearned – Payments made under Alaska Native Claims Settlement Act.	E	I
	Alaska Permanent Fund Dividend-payment from Alaska's mineral income fund.	I	I
ALIMONY / SPOUSAL SUPPORT	Unearned – A court-ordered payment from an estranged spouse or former spouse to the other spouse for support under the terms of a court order or settlement agreement following a divorce. Payments may be in one lump sum, or in a series of monthly payments. Alimony is also termed "spousal support" or "maintenance".	I (ABD and Non MAGI FM) E* (MAGI) *Divorces and separations finalized before 01/01/2019 consider Alimony as income for MAGI.	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
AMERICORPS	Income from Americorps Network of programs which encompasses: Americorps USA Americorps VISTA Americorps NCCC Are handled as specified below:		
	Living Allowance Stipend – Earned Income	E (ABD and Non MAGI FM) I (MAGI)	E
	On-the Job Training – Earned Income	E (ABD and Non MAGI FM) I (MAGI)	E
ANNUITY	Unearned – Recurring payment received from an investment. Refer to 2339 Annuities.	I	I
ASSISTANCE BASED ON NEED (ABON)	Unearned – assistance provided under a program which uses income as a factor of eligibility and is funded wholly by a state or local government.	E	E
BLACK LUNG BENEFITS	Unearned – benefits paid to miners and their survivors under the provisions of the Federal Mine Safety and Health Act. Phone number for United Mine Workers is 1-800-654-9763.	I (ABD and Non MAGI FM) E (MAGI)	I
BLOOD, sale of	Earned – Money received from the sale of blood including blood products.	I	I
BOARDER INCOME	Earned – Direct payments for food and related shelter expenses, less the cost of doing business.	I	I
BONUS	Earned – Wages paid in addition to the usual or expected wages. Refer to Wages in this chart.	I	I
CAPITAL GAINS	Earned or Unearned – profits from the sale of capital goods or equipment. Capital assets are resources such as stock, securities, real estate and equipment that are typically held as an investment for a period of time. A capital gain is realized when the item(s) sold have appreciated in value from the original purchase price.	I	I
CENSUS INCOME	Earned - All wages paid by the Census Bureau for temporary employment related to Census activities.	E (ABD and Non MAGI FM) I* (MAGI) *As of 01/01/2019	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CHARITABLE DONATION FROM PRIVATE NON-PROFIT ORGANIZATION NOT STATE / FEDERALLY FUNDED	Unearned – Charitable donation paid to the AU or BG.	E	E
CHARITABLE DONATION FROM FEDERALLY OR STATE FUNDED ORGANIZATION	Unearned – Charitable donation paid to the AU or BG from organizations receiving state or federal funds. For example: Salvation Army, United Way, Catholic Charities, and Lutheran Social Service Agencies.	I	I
CHILD CARE ATTENDENT (wages earned by)	Earned – income received for providing child care services. Consider the income as follows: • Self-employment if the attendant provides child care services in his/her home • As wages if the attendant provides services in the home of the child.	I	I
CHILD CARE PAYMENTS	Unearned – Payments made under Title IV of the Social Security Act to a child care provider on behalf of the AU. These payments include Transitional Child Care, and At Risk block grant child care payments made under P.L 101-508, Section 5801 of the Social Security Act.	E	E
CHILD NUTRITION PAYMENTS	Unearned – The value of meals provided to a child in day care through the Child Nutrition Amendment of 1978. *If the payment is for a child of the attendant, budget the entire amount as unearned income. If the payment is for any other child, treat as self-employment income. Refer to the Section 2415, Self Employment.	*I	I
CHILD SUPPORT	Unearned – Income received for the support of child (ren) from the non-custodial parent of the child. Child support paid for a child by a non-custodial parent is always income to the child and never to a parent/ relative/ guardian. *If an ABD child (including LA-D A/Rs) receives child support from a non-custodial parent exclude from the eligibility budget 1/3 of the monthly child support received.	I* (ABD) I (Non MAGI FM) E (MAGI)	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CHILD'S EARNINGS Children in Placement	Earned – Income earned by a child, including MAGI Medical Assistance under 19 years old and for CW-FC children to 21 years. *Refer to Section 2610 to determine when Child's Earnings should be counted. Reference Section 2835, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria for children in care.	I (ABD) E* (MAGI and Non MAGI FM)	E
CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM BENEFITS	Unearned – income paid by the U.S. Civil Service and Federal Employee Retirement System (FERS) through the Office of Personnel Management (OPM) because of disability, retirement or death. Certain disability benefits paid within the first 6 months that an employee last worked are earned income. Use notices or other documents in the individual's possession (other than a check) to verify the gross amount of the payment. Notices providing the amount of the annuity and the adjusted amount of the annuity are reliable evidence of the gross amount. If an individual's records are unavailable, complete Form 990, Benefits Verification, and direct the inquiry to the following address: Office of Personnel Management Retirement and Insurance Coverage 1900 E. Street, NW Washington, D.C. 20415	I	I
COMMISSION	Earned – A payment, usually a set fee or percentage, made to an employee for his/her service in facilitating a transaction such as buying or selling goods. A commission may be paid in lieu of or in addition to a regular salary. Refer to Wages in this chart. If the payment is recurring, include it when determining representative pay. If not, do not include the pay. Refer to Section 2653, Prospective Budgeting.	I	I
CONTRACTED EMPLOYMENT INCOME	Earned – Income received from jobs in which there is a contract or payment agreement. Determine the gross monthly amount by dividing the total amount during the life of the contract by the number of months specified in the contract.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
CONTRIBUTION, GIFT, PRIZE, AWARD	Unearned – Money given to the AU as a gift from individuals or organizations. *ABD: If the contribution is in the form of food, clothing or shelter, value the contribution as ISM, including third party vendor payments resulting in food, clothing, or shelter to the A/R. Never include ISM as income for an A/R in LA-D.	*I (ABD) I (Non-MAGI FM) E (MAGI)	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
DEATH BENEFITS	Unearned – a benefit received as the result of another's death, such as the following: • Cash or in-kind gifts given by relatives, friends, or a community group to "help out" with expenses related to the death • Inheritances in cash or in kind • Lump sum death benefits from SSA • Proceeds of life insurance policies received due to the death of the insured • RR Retirement burial benefits • VA burial benefits Recurring survivor benefits such as those received under Title II (RSDI), private pension programs, etc., are not death benefits. *Death benefits provided to an individual are income to the individual to the extent that the total amount exceeds the expenses of the deceased person's last illness and burial paid by the individual. Last illness and burial expenses include related hospital and medical expenses; funeral, burial plot, and interment expenses; and other related expenses. Verify all last illness and burial expenses. If verification (e.g., bills, receipts, contact with provider, etc.) cannot be obtained, accept the individual's signed allegation. If an expense has been incurred but not paid, assume the individual will pay the expense unless you have reason to question the situation. No follow-up is required if the assumption is applied. Use judgment to determine whether an expense is reasonably related to the last illness and burial. It is expected that related expenses may include such items as new clothing to wear to the funeral, food for visiting relatives, taxi fare to and from the hospital and funeral home, etc.	*I	*I
DEEMED INCOME	Unearned – A portion of income of a non-AU or BG member that is applied to the AU. *For ABD, there is no deeming in Patient Liability/Cost Share determinations.	I	*

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
DEFERRED COMPENSATION PLAN	UNEARNED - Money paid regularly from a deferred compensation plan. The money is usually available upon the owner's employment retirement or if the owner attains a certain age.	I	I
DISABILITY	Unearned – Paid by insurance company or a source other than an employer. Refer to Sick Pay in this chart.	E (MAGI) I (ABD and Non-MAGI FM)	I
DISASTER ASSISTANCE (Presidentially Declared)	Unearned – Government payments for restoration of a home damaged by a disaster.	E	E
DISASTER UNEMPLOYMENT ASSISTANCE	UNEARNED - Unemployment benefits paid to an AU member during a major disaster or catastrophe.	E (ABD and Non MAGI FM) I (MAGI)	E
DIVERTED INCOME FOR FAMILY MEDICAL ASSISTANCE Children in Placement	Unearned – Money deducted or diverted by a court order to a third party.	E	N/A
	Unearned – Money that is legally obligated to an AU member by a court order but is diverted at the option of the AU member to a third party.	I	N/A
	Benefits/support (child support, SSI, RSDI, etc.) of a child in care diverted to the county of custody as designated payee for the benefit and care of the child and are considered the child's benefits/support. Refer to specific type of income for treatment of income.		N/A
DIVERTED INCOME FOR ABD MEDICAL ASSISTANCE Spouse or Dependent Family Member A/R	Unearned - Income diverted to a spouse or dependent family member from a NH or CCSP A/R. Include as unearned income to the spouse or dependent family member (DFM) to whom the income is diverted in the eligibility and CCSP/ICWP cost share budgets, if the spouse/DFM is a Medical Assistance A/R. Refer to Section 2554, Diversion of Income.	I	I
	Include as unearned income to the A/R from whom the income is diverted in the eligibility budget. Allow as a patient liability/cost share budget deduction. Verify from the NH, CCSP or A/R's case record. Diverted income is included in PL when a community spouse enters LA-D. Refer to Spousal Impoverishment budgeting.	I	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
DIVIDENDS	Unearned – A share of profits received by a policy holder or shareholder. Any dividends left to accrue are a resource separate from the resource that is earning dividends. • For ABD, any dividends earned on countable resources are not counted as income. • For non-FBR COAs, dividends earned on excluded life insurance policies are excluded as income. *For Family Medically Needy, dividends earned on life insurance policies are a countable resource. Non-participating life insurance policies do not earn/pay dividends. Use Form 106 or other acceptable documents to verify dividends.	*E	*E
DOMESTIC VOLUNTEER SERVICES PAYMENTS	Unearned – Payments to volunteers under the federal government program	E	I
EARNED INCOME TAX CREDIT (EITC)	Unearned – A special tax credit which reduces the federal tax liability of certain low income working taxpayers. This tax credit may or may not result in a payment. EITC payments can be received as an advance from an employer or a refund from IRS. EITC given as a tax credit (no payment) is not income.	E	E
EDUCATIONAL GRANTS, SCHOLARSHIPS AND LOANS (Title IV of Higher Education Act Programs)	UNEARNED - Payments for the educational assistance of an AU member enrolled at a recognized institution of post-secondary education, school for the handicapped, vocational program or a program that provides for completion of a secondary school diploma or GED. These programs include Pell grants, State Student Incentive Scholarships, Work-Study programs, etc. Unearned – payments from educational assistance to the A/R. Exclude, regardless of use.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
EMERGENCY ASSISTANCE (IV-A)	Unearned – payments for children, including families with children, provided by the state and matched with federal funds. Emergency Assistance is used to meet emergency needs and is not IBON or ABON. Georgia does not provide Emergency Assistance payments.	I	I
EMPLOYEE RETIREMENT BENEFITS	Unearned – Individuals/surviving spouse may be eligible for retirement benefits based on previous employment. Explore if the A/R or spouse worked 10 or more years for the same employer.	I	I
ENERGY ASSISTANCE PAYMENTS	Unearned – Payment or allowance received under federal, state, and local law for the purpose of assisting the AU with the cost of heating and cooling its home. These include HUD and FMHA Utility reimbursements.	E	E
FARM ALLOTMENTS	Unearned – Payments from government sponsored programs such as Agricultural Stabilization and Conservation Services which are a gain or a benefit to the AU.	I	I
FARMING	Earned – Income received from agricultural labor. Refer to Section 2415, Self Employment.	I	I
FEDERAL EMERGENCY MANAGEMENT AGENCY (FEMA) EMERGENCY FOOD DISTRIBUTION AND SHELTER PROGRAMS	Unearned – food and shelter assistance provided in cash or in kind in emergency disaster situations. Exclude if the assistance is designated as home energy assistance or support and maintenance assistance. Otherwise, contact the State Medicaid Policy Unit for further instructions.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
FEDERAL PROGRAMS, MISCELLANEOUS	• Federal Housing Assistance • Food Stamps • Food Programs with federal involvement for Older Americans • Refugee Cash Assistance, Cuban and Haitian • Entrant Cash Assistance and federally reimbursed general assistance payments to refugees • Refugee reception and placement grants and refugee matching grants • Relocation Assistance Contact the State Medicaid Policy Unit if there is a payment that is not on this list and it is questionable as to whether it should be excluded or counted.	E	E
FLEXIBLE BENEFITS	Earned – Refer to Wages in this chart.	I	I
FOSTER CARE PAYMENTS (IV-B or Title XX)	Unearned – per diem payments received by the foster parents to provide for the needs of the foster child and foster family.	E	E
FOSTER CARE PAYMENTS (IV-E)	Unearned – per diem payment received to provide for the needs of the foster child. Exclude as income to the foster child.	E	E
FOSTER GRANDPARENTS PROGRAM PAYMENTS	Unearned – payments received for voluntary service under the federal government (ACTION)	E	I
GARNISHMENT	Earned/Unearned – A set amount of wages or monies withheld by an employer/entity to pay a debt owed to a third party.	I	I
GUARDIANSHIP, ENHANCED SUBSIDIZED AND SUBSIDIZED	Financial support for a child who was in the custody of DHR and guardianship is awarded to a relative or non-relative foster parent(s). Income is not attributed to the child. Reference Section 2848 – Relative Care Placement for additional information.	E	E
GENERAL ASSISTANCE (GA) PAYMENTS	Unearned – payments received by the A/R from county funds administered by DFCS. Consider as Assistance Based on Need (ABON).	E	E
GENERAL ASSISTANCE VENDOR PAYMENTS	Unearned – GA paid directly to the provider if paid for housing expenses including GA paid for transitional housing for the homeless and if paid for energy or utilities.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
GRANDPARENTS RAISING GRANDCHILD - REN EMERGENCY / CRISIS INTERVENTION SERVICES	TANF lump sum payment in the amount of three times the eligible grant amount for the AU size. This payment is used to help pay for the cost of emergent needs incurred by the grandparents when the children come to live with them. *For ABD, do not deem GRG income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	I
GRANDPARENTS RAISING GRANDCHILD - REN SUBSIDY PAYMENT	UNEARNED - TANF Subsidy in the amount of $50.00 per child per month used assist low income (fixed income) grandparents (60+) to cover additional expenses associated with rearing their grandchildren. *For ABD, do not deem GRG income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	I
GRANDPARENT PAYEE	*The Grandparent payee's income is not counted in the TANF budget. The children's TANF income is not counted in the Grandparent Payee's ABD budget	*	*
HEALTH REIMBURSEMENT ACCOUNT	An account through an employer which may only be used to reimburse individuals for certain medical services. *Count any income received in excess of the incurred expense(s) as unearned income.	*E	*E
HOME PRODUCE	Unearned – home produce used for personal consumption and not offered for sale.	E	E
HOUSING AND DEVELOPMENT (HUD) RENTAL REFUND	Unearned – Payment received by the AU for rent. Payments are often distributed by the Georgia Residential Financial Authority (GRFA). Payments can be made directly to the AU, by a two-party check or directly to the landlord on behalf of the AU.	E	E
HOUSING AND URBAN DEVELOPMENT (HUD) OR FARMERS HOME ADMINISTRATION (FMHA) UTILITY REIMBURSEMENT	Unearned – Utility reimbursement provided by HUD and FMHA to AUs who receive housing assistance and are responsible for paying their utilities separately from their rent. Payments can be paid directly to the AU, by a two-party check or directly to the utility company on behalf of the AU.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
INCOME BASED ON NEED (IBON)	Unearned – Assistance provided under a program that considers other income as a factor in determining eligibility and is funded wholly or partially by the federal government or a non-governmental agency for the purpose of meeting basic needs (TANF, SSI, VA Pension, etc.). NOTE FOR ABD: Do not allow the $20 general exclusion to IBON. Do not deem IBON received by the A/R's spouse or parent to the A/R.	See specific type of IBON	See specific type of IBON
INCOME TAX REFUND	*Refer to the Chapter 2300, Resources, to determine how to count income tax refunds. For how to count in PL/CS, refer to Section 2552, PL/CS Deductions.	*	*
INDIAN LAND GRANTS	Unearned – Federal distributions to members of Indian Tribes.	E	E
INDIAN GAMBLING ACT PAYMENTS	Tribally managed gaming revenues *If the funds have NOT been held in trust by the Secretary of the Interior, count as unearned income. If held in trust by the Sec. of Interior, exclude.	*	*
INHERITANCE	Unearned – cash, a right or non-cash item(s) received as a result of someone's death. Exclude expenses for the last illness & burial of the deceased if paid by the inheritor. Until an item or right has a value or is accessible, it is neither income nor a resource.	I	I
IN-KIND ITEMS RECEIVED IN LIEU OF WAGES	Earned – Wages may include the value of food, clothing, shelter or other items provided in lieu of cash wages.	I (ABD) E (MAGI and Non MAGI FM)	E
IN-KIND SUPPORT AND MAINTENANCE	Unearned – Any gain or benefit that is not in the form of money payable directly to the AU such as meals, clothing, produce or housing. *Refer to Section 2430, Living Arrangements and In-Kind Support and Maintenance.	*I (ABD) E (MAGI and Non MAGI FM)	E
INSURANCE BENEFITS DUE TO LOSS OF INCOME	Unearned – benefits paid from an insurance policy due to loss of income. *Refer to Section 2230, Third Party Resources, for information on benefits paid to cover medical expenses.	*I	*I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
INTEREST	Unearned – Income paid from bank account deposits, life insurance or other financial instruments/investments. FAMILY: Annualize for prospectively budgeted AUs to determine a monthly amount. *Exclude amounts of $1.00 or less per month. ABD: The following types of interest earned on countable resources are excluded as income in the eligibility and PL/CS budgets: • Interest earned on all countable financial instruments, such as checking/savings accounts, CDs, etc. • Interest earned on countable Patient Fund Accounts. *Exception: Interest portion of payment made on contracts are counted as income. If total interest earned on excluded resources is $20/month or less, exclude in the Medical Assistance eligibility and AMN spenddown budgets. If total interest earned on excluded resources exceeds $20/month, include all the interest in the eligibility and spenddown budgets. See exceptions below.	*I (MAGI and Non MAGI FM) *E (ABD)	E*
INTEREST Burial Contracts Burial Funds	Exclude interest earned on the excluded portion of a burial contract for FBR A/Rs.	E	E
	Exclude all interest earned on a burial contract for non-FBR A/Rs if left to accrue.	E	E
	Exclude interest earned on the excluded portion of funds set aside for burial for FBR A/Rs.	E	E
	Exclude interest earned on the first $5000 of funds set aside for burial for non-FBR A/Rs if left to accrue.	E	E
INTEREST Dividends	Exclude interest earned on the dividend accumulations from excluded life insurance policies for ABD non-FBR A/Rs.	E	E
	For Family, include interest earned on life insurance policies, stocks and mutual funds.	I	I
	For ABD, exclude as income dividends/interest earned on countable resources such as stocks and mutual funds.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
IRREGULAR / INFREQUENT INCOME	Earned and Unearned – Income that is received too infrequently or irregularly to be anticipated, regardless of the amount. Refer to Section 2504 for definition of irregular or infrequent income. Treat such income as the following: Earned income of $30 or more received over a three month period	I	I
	Earned income of less than $30 received over a three month period	E (ABD) I (MAGI and Non MAGI FM)	I
	Unearned income of less than $60 received over a three month period	E (ABD) I (MAGI and Non MAGI FM)	I
	Unearned income of $60 or more received over a three month period	I	I
JAPANESE – AMERICAN AND ALEUTIAN RESTITUTION PAYMENTS (PL 100-383)	Unearned – Restitution payments made by the U.S. Government to Japanese-Americans and Aleutians or their survivors as a consequence of their evacuation, relocation and internment during World War II.	E	E
JURY DUTY	Earned – Compensation received for serving on a jury.	I	I
LOANS FROM OTHERS (PERSONAL OR BUSINESS): A/R is making payments	Unearned – Money received that the borrower has an obligation to repay. Requires a prepayment agreement (written or oral).	E	E
LOANS TO OTHERS (Payment made to A/R)	Unearned - Money loaned to persons outside the AU where a repayment agreement exists. Payments received are considered income. *ABD refer to Section 2313.	I*	I*
LOTTERY WINNINGS	Unearned – A sum of money received as a result of purchasing a winning ticket in a game of chance. *Refer to the appropriate sections on Lump Sum budgeting for Family or ABD Medical Assistance and also refer to note in Section 2405.	*	*

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
LUMP SUM Children in Placement	Unearned – A sum of money that is received at one time. This may be an accumulated amount or a one-time occurrence. *Count as income in month of receipt. Any remainder is counted as a resource beginning the month after receipt (refer to Resources Chart 2399.1, Lump Sums). For all AFDC related categories of Medical Assistance, a lump sum is treated as income in the month received and as a resource in any amounts thereafter.	*	*
MANAGED INCOME	Unearned – Money legally due the AU that is paid to a protective payee even if the payee is not a member of the AU or resides elsewhere.	I (ABD) I (MAGI and Non MAGI FM)	I
	Unearned – Money received by the AU for the care and maintenance of an individual not in the AU. Include as income to the individual entitled to the income. Exclude as income to the protective payee. Exclude as income to the AU if the protective payee is not making payments to or for the AU.	I (ABD) I (MAGI and Non MAGI FM)	I
MILITARY ALLOTMENTS	Unearned – payments received for quarters, rations, and clothing are subject to deeming. In ABD, Furnished on-post housing is subject to the PMV rule as ISM but is not subject to deeming. *In Family, consider the income as child support if for a dependent child. Only base pay is earned income. (This would be excluded for MAGI COAs)	I	I
MILITARY PAY	Military personnel benefits as reported on Leave and Earnings Statement (LES). Refer to Section 2420, Military Pay.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
MILITARY RETIREMENT	Unearned – income received by military retirees and survivors. Beneficiaries who may be entitled to receive military payments include the retiree, his/her surviving spouse and children. Direct inquiries to the Military Finance Centers as shown below: Air Force Parallel FO: 388 AFAFC/XSP Denver, CO 80279 Army USAFAC Director, Retired Operations Indianapolis, IN 46246 ATTN: Management Support Office Marine Corps Parallel FO: D24 Marine Corps Finance Center 1500 E. 95th Street Kansas City, MO 64197 Navy Parallel FO: D24 Retired Pay Department Code 305, Navy Finance Center Anthony J. Celebrezze Building Cleveland, OH 44199	I	I
MILITARY RETIREMENT LUMP SUM	Unearned – Consider as unearned income in the month or receipt. Treat as a resource the month following the month of receipt.	I	I
MONTGOMERY GI BILL PAYMENTS	VA payments for individuals enrolled in Active Duty or the Selected Reserve of the Army, Navy, Air Force, Marine Corps, Coast Guard, or Air National Guard for up to 36 months of education assistance. Any portion of funds that come from the individual's earnings is counted as income.	E	E
NATIONAL EMERGENCY GRANT (DISASTER RELIEF EMPLOYMENT)	UNEARNED - Grants funded by FEMA, used to provide disaster relief employment on projects that provide food, clothing, shelter and other humanitarian assistance for disaster victims.	E	E
NATIONAL FLOOD INSURANCE PAYMENTS	UNEARNED - Payments made for flood mitigation activities under the National Flood Insurance Act of 1968.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
NOISE ABATEMENT PAYMENTS	Unearned – Non-recurring payment designated for noise abatement work on a dwelling.	E	E
OLDER AMERICANS ACT / SENIOR COMMUNITY SERVICE EMPLOYMENT PROGRAM	Earned – Title V income paid for community service employment to individuals 55 or over. This includes Green Thumb income. Anything provided under these programs other than a wage or salary is excluded income.	I (ABD) E (MAGI and Non MAGI FM)	I
OVERTIME PAY	EARNED - Extra income paid to employees who work in excess of 40 hours in a week. Refer to Wages in this chart.	I	I
PENSIONS	Unearned – A payment received regularly as a retirement benefit.	I	I
PUBLIC LAW 103-286 - PAYMENTS to VICTIMS of NAZI PERSECUTION (examples, including but not limited to the following: German Reparation, German Pensions for Work in Ghettos	Unearned – any payments made to individuals because of their status as victims of Nazi persecution under Section 1(a) of the Victims of Nazi Persecution Act of 1994, Public Law 103-286 Such payments are disregarded in determining eligibility for any amount of benefits/services provided under any Federal or federally assisted program based on need.	E	E
Qualified Income Trust (QIT)	Income placed in a QIT allows for income eligibility under ABD LA-D COAs. Refer to Section 2407.	MAGI and Non MAGI FM – N/A ABD LA-D COAs – E All other ABD COAs – N/A	I
Qualified Tuition Savings Programs (529 Plans)	A savings plan for higher education. Refer to Section 2344.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RAILROAD RETIREMENT (RR)	Unearned – retirement, survivors or disability income paid to former railroad employees and/or their dependents. Use gross RR and/or RSDI, including the amount paid as a Medicare premium. *For ABD, refer to Section 2552, Patient Liability/Cost Share Deductions, for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget. Consider a benefit augmented for dependents as income to the beneficiary, not the dependent. If the A/R's SSN begins with a 7, the individual is likely to be eligible for RR. If the A/R's deceased spouse worked for a railway system, the A/R may be eligible, even if remarried. RSDI and RR may be combined in one check. If so, verify RSDI via SSA and RR through the Railroad Retirement Board. To obtain written verification of the benefit amount, complete Form 990 and mail to: [%hardbreaks] Benefits Verification Railroad Retirement Board 401 W. Peachtree Street, Room 1702 Atlanta, GA 30365-2550	I	*I
REFUNDS FROM DCH	Unearned – A refund of excess proceeds from a TPL after Medicaid and the TPL have paid a medical expense claim in full.	I	I
REIMBURSEMENT	Unearned - Payment for an expense that does not represent a gain or benefit to the AU.	E	E
RELATIVE CARE SUBSIDY	Unearned - Financial support for children placed with an approved relative caregiver. A child may or may not be in DFCS custody for relative caregiver to qualify for certain subsidies.	E	E
RELOCATION ASSISTANCE	Unearned – Money paid under Title II of the Uniform Relocation Assistance & Real Property Acquisition Policies Act of l970.	E	E

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RENTAL INCOME	Earned or unearned – Money received on property owned by an AU member and rented to others. Earned – Must be engaged in management of property an average of 20 hours per week. Unearned – If not involved in management more than 20 hours per week.	I Family - May deduct expenses from maintaining and handling of property	I May deduct expenses from maintaining and handling of property
REPAYMENT OF OVERPAYMENT OF BENEFITS THROUGH BENEFIT REDUCTION IN TANF, SSI, RSDI, UCB (or others)	FAMILY: Unearned – Money withheld from the income source to repay a previous overpayment. Do not count the repayment amount. Count the gross minus the repayment amount. *ABD: Refer to RSDI Recoupment Amount and SSI Recoupment Amount in this chart.	E (MAGI and Non MAGIFM) ABD - *	*
RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)	Unearned – A federal volunteer services program.	E	I
RETIREMENT	Unearned – A sum of money paid regularly as a retirement benefit.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RETIREMENT SURVIVORS DISABILITY INSURANCE (RSDI) (Also referred to as TITLE II BENEFITS or Social Security Benefits)	Unearned – Social Security benefits paid to an insured worker or dependent on the basis of the retirement, death or disability of the worker. Use the gross entitlement (before the Medicare Part B premium is deducted) in the eligibility budget. *For ABD, refer to 2552 Patient Liability/Cost Share Deductions for information on allowing the Medicare premium as a deduction in the patient liability/cost share budget. Count the entire RSDI lump sum payment as income for the month of receipt. Refer to Chart 2399.2 – Resource Treatment of Income Retained after the Month of Receipt, for instructions on how to treat any portion of a RSDI lump sum retained after the month of receipt. Do not count refunded Medicare Part B premiums as unearned income. *For MAGI COAs RSDI of a tax dependent/child who has no other source of income AND resides with a parent is **excluded**. RSDI for a tax dependent/child is countable **only** if the tax dependent/child has other income that meets the IRS tax filing threshold **or** if the child does not reside with a parent and is not claimed as a tax dependent by his/her parent. Refer to Section 2610.	I (ABD and Non-MAGI FM) I* (MAGI)	I*
REVERSE MORTGAGE	Unearned – allows a homeowner to borrow, via a mortgage contract, a portion of the appraised value of the home. The homeowner then receives a periodic payment (or a line of credit) which does not have to be repaid as long as the borrower lives in the home. Reverse Annuity Mortgages (RAMs) involve the purchase of an annuity. In most reverse mortgages, the original loan does not need to be repaid until the homeowner dies, sells the home, or moves. The HEC plans connected with HUD through the Federal Housing Authority are reverse mortgages.		
	Treat as loan proceeds	I	
	Annuity payments from a RAM	E	
ROOMER	Earned – Direct payments for room only.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
RSDI RECOUPMENT AMOUNT	Unearned – an amount withheld from an individual's monthly RSDI check by SSA to recover an overpayment of RSDI benefits to the individual *Refer to Repayment of Overpayment of Benefits on Page 2499-22.	I (ABD) E* (MAGI and Non MAGI FM)	E
SALE – LEASEBACK	Unearned – the homeowner transfers title of the home to a buyer (e.g., an individual or financial institution) in exchange for an installment note satisfied by monthly payments. The installment note may bear interest. The buyer, in turn allows the former homeowner to remain in the home for life (or until the arrangement is terminated) in exchange for rent. The difference between payments on the installment note and the rental cost provides the former homeowner with cash. Under this arrangement, the buyer is responsible for the payment or real estate taxes, major maintenance, and casualty insurance. Some sale-leaseback arrangements involve the purchase of an annuity.		
	Treat as the conversion of a resource, not as income.	E	E
	Interest earned from an installment note	I	I
	Annuity payments	I	I
SCHOOL LUNCH PROGRAM	UNEARNED - The cash value of assistance provided to children under the National School Lunch Program, Child Nutrition Act, Special Milk Program, or School Breakfast program.	E	E
SELF EMPLOYMENT EARNINGS (NET)	Earned – income from a self-employed enterprise. Refer to 2415 Self-Employment.	I	I
SENIOR COMPANION PROGRAM	Unearned – payments to volunteers under a federal government program	E	I
SEVERANCE PAY	Earned – Money received from former employer upon termination of employment. Unearned - payments received from a former employer after termination of employment.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
SHARED HOUSEHOLD EXPENSES	Payments made to an AU by a person who shares household expenses, and which do not represent a gain or benefit to the AU. Consider UNEARNED income for Family Medical Assistance. Refer to 2430 Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid.	E	E
SHELTERED WORKSHOP / WORK ACTIVITY CENTER PAYMENTS	Earned – payments received for work performed in a sheltered workshop or work activity center.	I	I
SICK PAY	Sick Pay is a payment made to or on behalf of an employee by an employer or a private third party for sickness or accident disability.	I	I
	Unearned – Any payments for sickness and accident disability paid more than 6 months after work stopped because of sickness or disability or sick payments made from the employee's own contributions are unearned income.	I	
	Earned – If paid from employer's payroll.	I	
	Unearned – Paid by insurance company or a source other than an employer.	E (MAGI) I (ABD and Non-MAGI FM)	
SPECIAL AND DEMONSTRATION VOLUNTEER PROGRAMS	Unearned – Payments to volunteers under a federal government program	E	I
SPENDING ACCOUNT	EARNED - Pre-taxed earnings that are deducted from an employee's gross wages and placed in an account to pay AU expenses such as childcare and medical costs.	I	I
STRIKE BENEFITS	Unearned – Income received by individuals on strike.	I	I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
SUPPLEMENTAL SECURITY INCOME (SSI)	Unearned – monthly payments made to aged, blind or disabled individuals from the federal government. SSI is administered by the Social Security Administration. Consider as Income Based on Need (IBON). SSI recipients also receive Medical Assistance. *For ABD, do not deem the ineligible parent or spouse's SSI income to the A/R. However, include SSI in the Couple eligibility budget when one member of the couple is AMN and the other receives SSI. **Refer to 2578 SSI Recipients for information on including SSI income in nursing home patient liability budgets.	*I (ABD) E (MAGI and Non MAGI FM)	**I
SSI RECOUP-MENT AMOUNT	Unearned – an amount withheld from an individual's monthly SSI or RSDI check by SSA to recover an overpayment of SSI benefits to the individual. *Exclude a SSI recoupment from a SSI check, but include a SSI recoupment from an RSDI check, in the patient liability budget. For Family Medical Assistance, refer to Repay-ment of Overpayment of Benefits through Benefit Reduction in TANF, SSI, RSDI, UCB or others on page 2499-22-23.	I (ABD) E (MAGI and Non MAGI FM)	*I
SUSAN WALKER VS BAYER COR-PORATION SET-TLEMENT PAY-MENTS	A cash settlement as a result of a class action lawsuit. Unearned	E	E
TAX REFUNDS	A refund of taxes paid on food, income or property. It may be considered as earned or unearned.	E	*
	Earned - A refund of federal or state taxes paid on income.	E	*
	Unearned - A refund of taxes paid on food or property, such as real property or automo-biles. Refer to 2405 Treatment of Income. *Refer to 2552 Patient Liability/Cost Share Deductions.	E	*

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
TEMPORARY ASSISTANCE FOR NEEDY FAMILIES (TANF)	Unearned – benefits received from Temporary Assistance to Needy Families, including supplemental payments. TANF benefits received from another state are budgeted for the month of receipt only. *For ABD, do not deem TANF income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	I
TIPS	Earned – Voluntary payments above the stated cost of a product or service given in appreciation for the service rendered. Refer to Wages in this chart.	I	I
TRADE READJUSTMENT ALLOWANCE (TRA)	UNEARNED - Weekly payment available for up to 52 weeks after an individual's UCB is exhausted and during a period in which the individual is participating in a full-time training program approved in accordance with the Trade Act.	I	I
TRAINING ALLOWANCES / STIPENDS (Refer to WIA for treatment of WIA income)	Earned – Payments received from vocational/rehabilitation programs recognized by Federal, State, local governments to the extent they are not a reimbursement or specifically excluded. If the earnings belong to a child, refer to Child's Earnings in this chart.	I	I
TRANSITIONAL SUPPORT SERVICES (TANF)	UNEARNED - TANF support payment used to pay for or reimburse the cost of childcare, transportation, and incidental expenses to an applicant or recipient. TSS is available for a period of six months beginning with the first month of TANF ineligibility. *For ABD, do not deem WSP income of the A/R's parent or spouse to the A/R.	I* (ABD) E (MAGI and Non MAGI FM)	I
TRUST FUND PROCEEDS	Unearned – Money in a trust fund. *If the trust is not a Medicaid Qualifying Trust (MQT), include as income only those trust proceeds actually provided to the A/R by the trustee.	*I	*I
	*If the trust is an MQT, refer to 2336 Trust Property, Medicaid Qualifying (Prior to OBRA '93) for information on how to treat the trust proceeds. Verify by a copy of the trust document and contact with the trustee.	*I	*I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
UNEMPLOYMENT COMPENSATION BENEFITS (UCB)	Unearned – Benefits received from the Department of Labor (DOL) by unemployed individuals. Usually received weekly. Continue to count until notified by the A/R of termination. Use DOL Clearinghouse for verification of the amount and date of weekly benefits.	I	I
UNION FUNDS	Unearned – Refer to Strike Benefits in this chart.	I	I
UNIVERSITY YEAR FOR ACTION (UYA)	Unearned – payments received under a federal volunteer services program.	E	I
UTILITY PAYMENT (HUD SECTION 8/GRFA/FMHA)	Unearned - *Refer to Housing and Development (HUD) in this chart.	*	*
VACATION PAY	Earned – Any amount paid to employees for a regular scheduled period spent away from work or regular duty. It includes amounts paid even if the employee chooses not to take a vacation. Refer to Wages in this chart.	I	I
VENDOR PAYMENT	UNEARNED - Money paid by an outside source to a third party on behalf of the AU for an expense.	E	E
	Personal expenses paid for by another person that does not make up for a loss caused by that person.	E	
	Personal expenses paid for by another person that makes up for a loss caused by that person, and only restores the individual to a position before the loss.	I	
	Housing assistance payments made by a state or local government to a third party on behalf of an AU residing in transitional for the homeless. If the vendor payment is made with GA funds, refer to General Assistance Vendor Payments in this chart. For ABD, consider possibility of ISM. Refer to 2430 Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid.	E	
VETERANS ADMINISTRATION (VA) BENEFITS	Refer to 2418 VA Income for a description of the different types of VA income.		

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
VA PENSION	Unearned VA pensions are IBON and are not entitled to the $20 general exclusion. (Section 2505)	I (ABD) E (MAGI and Non MAGI FM)	I
VA COMPENSATION	Unearned VA compensation is not IBON. Compensation received by parents due to the service connected death of their child is IBON.	I (ABD) E (MAGI and Non MAGI FM)	I
VA EDUCATIONAL BENEFITS	Unearned	I (ABD) E (MAGI and Non MAGI FM)	E
Other VA Benefits Which are NOT Included As Income in the Eligibility Determination	Aid and Attendance	E	E
	Unusual Medical Expense (UME) reimbursement & Continuing Medical Expense (CME)	E	E
	Housebound Allowance	E	E
	Clothing Allowance	E	E
Augmented VA Benefits	Unearned *Refer to 2418 VA Income for specifics on counting Augmented VA income. Any portion of a VA check augmented for dependents is income to the dependent(s).	*I (ABD) E (MAGI and Non MAGI FM)	*I
Augmented VA Benefits To NH/CCSP A/Rs	Unearned *Refer to 2418 VA Income for specifics on counting Augmented VA income for LA-D A/Rs. Augmented VA benefits are treated differently than augmented RR benefits. The entire amount of an augmented RR check is income to the beneficiary.	*I (ABD) E (MAGI and Non MAGI FM)	*I
VA Recoupment	Repayment of VA benefits which are deducted from the VA check.	I Count the gross amount for eligibility determination FM-E	E Count the gross less recoupment
VA Lump Sum	Unearned *Any portion of a VA lump sum that is not VA Aid and Attendance, is not VA UME reimbursement or is not augmented is counted as unearned income for the month of receipt.	*I (ABD) E (MAGI and Non MAGI FM)	*I

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
VICTIM RESTITUTION	Unearned – Money received by a victim of a crime from a crime victim restitution program, usually a reimbursement for financial losses.	E	E
	The value of the payment does not exceed the value of the loss	E	E
	The value of the payment exceeds the value of the loss. Count the excess value as income in the month of receipt.	I	I
	The payment is a set monthly amount based on a court ruling. Count as income in the month of receipt.	I	I
VISTA VOLUNTEER PAYMENT	Earned – Income received by VISTA volunteers under Title I of the Domestic Volunteer Services Act. Included are payments from the Urban Crime Prevention Program	E	E
VOLUNTEER PAYMENT RSVP Foster Grandparent/ VISTA Urban Crime Prevention	Unearned – Title II of Domestic Volunteer Services Act of l973	E	I
	Unearned – Payments from Title I. Exclude only if the A/R was receiving FS or AFDC at the time they joined Title I even if there is a break in participation.	E	I
WAGES (SALARIES) Children in Placement	Earned – Payment given in return for labor, goods, and services rendered. Wages may be paid on an hourly, weekly, or daily basis. Include commissions, tips, overtime, vacation pay, bonus pay, flex benefits, and the employee's share of FICA when paid by the employer. Reference 2835 AFDC Relatedness Budgeting, PROCEDURES, Earnings of an AFDC Child, for exclusion criteria.	I	I
WORKER'S COMPENSATION	Unearned – payments awarded to injured employees or to their survivors. Exclude any portion designated for medical, legal, or related expenses paid or deducted and not controlled by the A/R in connection with claim. Verify from the employer or from the source of the payment.	I (ABD) E (MAGI and Non MAGI FM)	I
WORKFORCE INVESTMENT ACT	Earned – Income received while working as part of a WIA program.	I	I
WORK STUDY PROGRAM (Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	E	N/A

TYPE OF INCOME	DESCRIPTION / SPECIAL INSTRUCTIONS / VERIFICATION	ELIGIBILITY - FAMILY OR ABD	PL/CS FOR ABD
WORK STUDY PROGRAM (Non-Federal)	Earned – A plan operated by a post or secondary school during the school year in which a student works on campus and earns money.	I	N/A
YOUTH BUILD PROGRAM PAYMENTS	EARNED - Payments made through the Youth Build Program. *See WIA for treatment of this income.	I*	I*
YOUTH PROJECT PAYMENTS	Unearned – Payments made through projects developed to assist youth in acquiring work skills including the following: • Youth incentive entitlement pilot project • Youth community conservations and improvement projects • Youth employment *See WIA for treatment of this income.	I*	I*

2500 ABD Financial Responsibility and Budgeting

2500 ABD Financial Responsibility and Budgeting Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Financial Responsibility and Budgeting Overview		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2500
	Previous Policy Number(s):	MT 13	**Updated or Reviewed in MT:**	MT-58

Requirements

Financial responsibility implies that a parent or spouse's income and resources are available to the Medicaid A/R as long as the A/R and the parent or spouse lives together in the same household.

Eligibility budgeting is the process in determining the A/R's income eligibility for ABD Medicaid by applying allowable deductions to the countable income of the A/R and financially responsible person.

Basic Considerations

The following factors must be taken into consideration in order to determine whether to consider the income and resources of persons other than the A/R, the correct budget to be completed and the correct income limit to use:

- the A/R's living arrangement (LA)
- the adult A/R's marital relationship
- the financial responsibility of the A/R's spouse or parent
- the class of assistance under which the ABD Medicaid application will be processed

Procedures

Follow the steps below to determine financial responsibility and income eligibility for ABD Medicaid by completion of the correct eligibility target.

Step 1 Determine the A/R's LA, class of assistance and the financial responsibility of the A/R's spouse or parent(s).

- Refer to Section 2430, Living Arrangements and In-Kind Support and Maintenance, for procedures on determining the A/R's LA.
- Refer to Chapter 2100, Classes of Assistance, for procedures on determining the COA most advantageous to the A/R.
- Refer to the Chapter 2500, ABD Financial Responsibility and Budgeting, for procedures on the following:
  - When to include the income of the A/R's spouse or parent in the budget.
  - The correct budgeting procedures for determining income eligibility.
- If the A/R is an adult, determine if the A/R is currently in a marital relationship. Refer to Section 2501, Marital Relationship.
- If the A/R is a child under age 18 living with his/her parent(s) in LA-C, refer to Section 2502, Deeming, for procedures on considering the income and resources of the parent(s).

Step 2 Determine countable income to be included in the eligibility budget. Refer to Section 2504, Determining Countable Income, Section 2405, "Treatment of Income" and Section 2499, "Treatment of Income in Medicaid Chart".

Step 3 Enter income in the system, allowing the correct deductions and income limit for the A/R's LA and COA to be appropriately applied in the budgeting process.

- Refer to Section 2505, Income Deductions, for information on deductions allowed in the eligibility budget.
- Refer to Appendix A for current income limits.

2501 Marital Relationship

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Marital Relationship		
	Effective Date:	December 2022		
	Chapter:	2500	**Policy Number:**	2501
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

The A/R's marital relationship must be established to determine whether or not to consider the income and resources of a person other than the A/R.

Basic Considerations

Marital Relationship (Prior to 1/1/97)

A marital relationship exists for a man and a woman who are legally married or living together, free to marry and holding out (common-law) to the community as married. The common–law marriage must have existed prior to 1/1/97 to be recognized as a marital relationship.

Marital Relationship (On or after 1/1/97)

A marital relationship exists for a man and a woman who are legally married. A common-law marriage established on or after 1/1/97 is not considered a marital relationship in Georgia.

Marital Relationships Established Prior to 1/1/97 Begins

A marital relationship begins to exist the month following the month two people marry or begin living together and holding out to the community as husband and wife.

Use of the Spousal Impoverishment resource limit is limited to situations where an A/R in LA-D has a legal spouse in the community. See Section 2502 for definitions of legal and non-legal spouses.

Marital Relationship Ends

A marital relationship ceases the month following the month of separation of spouses, regardless of whether or not either or both is Medicaid eligible.

The admission of one or both spouses into LA-D is considered separation.

Admission of one spouse to a hospital is not always considered separation.

Refer to Special Considerations in 2503 Couples.

An A/R is considered an individual only if a marital relationship has ended, by definition above, or

has never existed.

Procedures

A marital relationship has ceased for an individual who is legally married but is living separately from his/her spouse due to estrangement (alienation, loss of affection, indifference). The spouse, including spouse who is incarcerated, is not considered a community spouse for purposes of determining resource eligibility and patient liability.

Identify an adult A/R as one of the following:

- a Medicaid individual
- a Medicaid individual married to and living with a Medicaid individual (Medicaid couple)
- a Medicaid individual living with an ineligible spouse.

Medicaid Individual

Consider an SSI or ABD Medicaid A/R who is not currently in a marital relationship to be a Medicaid individual.

Consider only the income and resources of the Medicaid individual when determining his/her financial eligibility for ABD Medicaid. Use individual income and resource limits.

Medicaid Couple

Consider an SSI or ABD Medicaid A/R who is married and living with another SSI or ABD Medicaid A/R to be a Medicaid couple.

Refer to 2503 Couples for information on considering the income and resources of a Medicaid couple.

Medicaid Individual with Ineligible Spouse

Consider an SSI or ABD Medicaid A/R who is married to and living with a spouse who is not an SSI or ABD Medicaid A/R to be a Medicaid individual with an ineligible spouse.

Refer to 2502 Deeming (ABD) for information on deeming the income and resources of an ineligible spouse.

2502 Deeming (ABD)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Deeming (ABD)		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2502
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-58

Requirements

Deeming is the process by which the income and resources of an ineligible spouse or ineligible parent are included in the budget to determine the A/R's financial eligibility for ABD Medicaid.

Basic Considerations

The ineligible spouse of the A/R may be a legal, non-legal or community spouse. Non-legal marriages established on or after January 1, 1997, are not recognized as marriages in Georgia regardless of the ABD Medicaid Class of Assistance (COA).

Legal Spouses (Prior to 1/1/97)

A legal spouse is a member of a couple who has been married by legal ceremony or common-law. Under Georgia law, two individuals are in a common-law marriage if they live together at least one night, they are holding forth to the community as husband and wife, both are free to marry each other because neither is married to another person, and the relationship was established prior to January 1, 1997. Legality matters in relationships established prior to 1/1/97 only when the A/R is in LA-D or applies under an ABD Medically Needy COA.

Legal Spouses (On or after 1/1/97)

A legal spouse is a member of a couple who has been married by legal ceremony. This definition of a legal marriage is effective as of January 1, 1997. Common–law marriages established after this date are not considered legal. Legality matters in relationships established on or after 1/1/97 for all ABD Medicaid COAs.

Non-Legal Spouses

Non-legal spouses are holding out as husband and wife, but they are not free to marry each other. One or both has a legal spouse. Otherwise known as a non-member.

Community Spouse

A community spouse is a person who is not living in a setting that provides medical care/services, such as a medical institution or nursing facility, and who is married to:

- An institutionalized person, or

- A person who has been determined eligible for a Home and Community-Based Services wavier program.

The community spouse may live in his/her own home (LA-A), in a Personal Care Home/Assisted Living (not A/R in LA-D COA) or in someone else's home (LA-B). If the A/R in LA-D can only be considered under the AMN COA due to income over the Medicaid Cap (no Qualified Income Trust), the spouse at home does not meet the definition of a Community Spouse, and therefore Spousal Impoverishment regulations do not apply.

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 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 registered nurse [RN], licensed vocational nurse [LVN], doctor, etc.), the spouse does not meet the definition of a community spouse and spousal impoverishment policies does not apply.

An incarcerated spouse is **NOT** considered a community spouse for spousal impoverishment purposes.

Medicaid Child

A Medicaid child is a child living with his/her parent(s) who is a SSI or Medicaid eligible under any COA.

Ineligible Child

An ineligible child is a child living with his/her parent(s) who is not receiving Public Assistance payments, such as SSI, TANF or VA pension, and is not applying for or receiving Medicaid under any COA.

Ineligible Parent

An ineligible parent is the natural, adoptive or stepparent of the Medicaid child or ineligible child and is not a Medicaid A/R. If the Medicaid child lives with the ineligible parent, a portion of the ineligible parent's income and resources may be considered in determining the child's eligibility for ABD Medicaid.

Deeming Begins

Spouse to Spouse Deeming begins the month following the month a marital relationship begins. Refer to Section 2501, Marital Relationship.

Parent to Child Deeming begins the month after a parent(s) and child begin living together in the same household (LA-A, B or C).

Deeming Ceases

Spouse to Spouse Deeming ceases the month following the month a marital relationship ends. Refer to Section 2501, Marital Relationship.

Parent to Child Deeming ceases the month following the month parents and their children cease living together in the same household (LA-A, B or C).

After an A/R ceases living with the financially responsible relative, only income actually made available to the A/R is considered in determining the A/R's financial eligibility.

> If the responsible relative is temporarily absent from the home and is expected to return within the same month or the following month, consider the absent relative to be living with the A/R.

When one spouse (or child) enters LA-D, deeming of income ceases for the LA-D A/R the month of admission. Spousal impoverishment resource rules apply the month of admission. If the community spouse is an A/R under a non-LA-D COA, deeming of income and resources ceases for the community spouse the month following the month of admission.

When both spouses enter LA-D, treat both A/Rs as individuals beginning the month of admission in determining income eligibility. See Section 2510-2 for exceptions.

For resource eligibility, treat both A/Rs as a couple the month of admission and as individuals the month following the month of admission.

> Admission to a hospital does not terminate the hospitalized individual's financial responsibility for his/her spouse or child residing in the community. Refer to Special Considerations in Section 2503, Couples.

Deemors are entitled to the same resource exclusions allowed to the A/R. Refer to Chapter 2300, Resources.

Resources Excluded from Deeming

The following pension funds owned by an ineligible/community spouse or parent are not deemed to an A/R: (See Section 2332-2)

- IRAs
- Keoghs
- Private pension funds.

> Private pension funds owned by the A/R are always considered in the resource determination.

Income Excluded from Deeming

The following types of income owned by an ineligible spouse or parent are not deemed to the A/R:

- Income Based on Need (IBON), such as the following:
  - SSI/TANF
  - IV-E payments
  - VA pension

    - Only VA compensation received by the parent(s) of a veteran who died from a service-related cause prior to January 1, 1957.
- Any income used in determining the amount of an IBON payment.
- Portions of scholarships, grants, or fellowships used to pay tuition and/or fees
- Foster care payments for the care of an ineligible child
- Value of Food Stamps/commodities.
- Home produce for personal consumption
- Tax refunds
- Court ordered support payments made by a deemor

> Support payments made by the A/R are not excluded.

- ISM received by a deemor or ineligible child
- Income otherwise excluded by federal statute
- Total earned income of an ineligible child if a student ($400/month, up to $1,620/year)
- Income necessary for a Plan to Achieve Self Sufficiency (PASS)
- Infrequent or irregular income of parents and spouses (one exclusion per marital relationship)
- Funds withdrawn from parent's retirement/pension fund (i.e. IRA) in the month of withdrawal.

> Any funds remaining the month after the withdrawal are a resource.

Procedures

Deeming Resources from an Ineligible Spouse to a Medicaid Individual in LA-A or B

Combine the resources of the Medicaid individual and his/her ineligible spouse and apply them to the appropriate couple resource limit.

If the combined resources do not exceed the couple resource limit, the A/R is eligible based on resources.

Deeming Resources from A Non-legal Ineligible Spouse to a Medicaid Individual in LA-D

If the Medicaid individual enters LA-D, has a non-legal ineligible spouse at home, and the non-legal marital relationship was established prior to 1/1/97, combine the resources of the Medicaid individual and his/her ineligible spouse and apply them to the SSI Couple resource limit only for the month of admission to LA-D. (If the non-legal marital relationship was established on or after 1/1/97, use the individual resource limit.)

Consider only the Medicaid individual's resources beginning the month following the month of admission to LA-D. Use the SSI Individual resource limit.

> If the A/R transfers assets to a non-legal ineligible spouse, apply a transfer of assets penalty. Refer to Section 2342, Transfer of Assets.

Deeming Resources When an A/R with a Community Spouse enters LA-D

Follow the steps below to determine the resource eligibility for an A/R in LA-D who meets all the related eligibility criteria and who has a community spouse for each prior month of Medicaid requested. During the application process the A/R and spouse must have resources under the Spousal Impoverishment Limit. The LA-D spouse cannot avoid ineligibility by transferring excess resources to the community spouse.

Prior Months Eligibility

Combine the countable resources owned by the A/R and the community spouse on the first day of the prior month and apply them to the Spousal Impoverishment resource limit.

If the combined resources are greater than the Spousal Impoverishment resource limit, the A/R is ineligible based on resources. Deny Medicaid for the prior month.

If the combined resources are less than or equal to the Spousal Impoverishment resource limit, the A/R is eligible based on resources for the prior month.

Ongoing Eligibility

If the A/R meets the eligibility criteria for LOS and LOC, follow the steps below to determine the ongoing resource eligibility for an A/R in LA-D who has a community spouse:

Step 1 Combine the countable resources owned by the A/R and the community spouse on the first day of the month of application and apply them to the Spousal Impoverishment resource limit. If the combined resources are greater than the Spousal Impoverishment resource limit, the A/R is ineligible based on resources. Deny the application.

If the combined resources are less than or equal to the Spousal Impoverishment resource limit, the A/R is eligible based on resources. Proceed to Step 2.

Step 2 Apply the countable resources owned by the A/R on the first day of the month of application to the SSI Individual resource limit.

If the resources owned by the A/R are less than or equal to the SSI Individual resource limit, the A/R continues to be eligible based on resources. Consider the ongoing resource eligibility determination for the A/R to be completed.

If the resources owned by the A/R exceed the SSI Individual resource limit, require the A/R to transfer his/her resources in excess of the SSI Individual resource limit to the community spouse or to a third party for the sole benefit of the community spouse by no later than the first annual review.

Proceed to Step 3.

See Chart 2502.1 for definition of “for sole benefit of” the community spouse.

Step 3 Require the A/R to declare in writing the resources s/he intends to transfer to the community spouse or to a third party for the sole benefit of the community spouse.

Step 4 Notify the A/R in writing of the type and value of resources s/he has declared and the requirement to transfer by the first annual review.

A/R Receives an Additional Resource Before the First Annual Review

If the A/R receives an additional resource between the initial determination of eligibility and the first annual redetermination, redetermine the A/R's resource eligibility.

If the additional resource combined with other resources of the A/R does not exceed the SSI Individual resource limit, document the record that the A/R continues to be resource eligible without any further development.

If the additional resource combined with other resources of the A/R exceeds the SSI Individual resource limit, repeat Step 1 above, using the resources of the community spouse for the first day of the month of application and the current month's first day resources for the A/R.

Resource Eligibility Determination at First Annual Review

If the resources of the A/R are less than or equal to the SSI individual resource limit on the first day of the month of the first annual review, consider the A/R to remain eligible based on resources. Verify that the A/R transferred his/her countable assets in excess of the SSI individual resource limit to the community spouse or to a third party for the sole benefit of the community spouse.

If resources of the A/R exceed the SSI individual resource limit on the first day of the month of the review, terminate Medicaid eligibility after giving timely notice. If assets were transferred inappropriately, compute a transfer of assets penalty on the A/R. See Chart 2502.1 and Section 2342, Transfer of Assets.

A/R with a Community Spouse Receives an Additional Resource after the First Annual Review

Follow the steps below when a LA-D Medicaid recipient with a community spouse receives a resource after the first annual review which, combined with other resources, causes the total countable resources of the A/R to exceed the SSI individual resource limit.

Step 1 Require the A/R to declare in writing the intent to transfer his/her resources in excess of the SSI individual resource limit to the community spouse or to a third party for the sole benefit of the community spouse.

Step 2 Allow the A/R 90 days from the date of receipt of the excess resource to transfer the resources to the community spouse.

Step 3 If the A/R transfers the resource within the 90-day grace period, consider the A/R to remain eligible based on resources.

If the A/R fails to transfer the resource within the 90-day grace period, terminate eligibility after giving timely notice.

An individual can only be eligible using the Spousal Impoverishment resource limit one time,

> if the A/R remains institutionalized and continuously Medicaid eligible. However, if the A/R's Medicaid is terminated at any point and the A/R is no longer in LA-D, subsequent applications may reuse the spousal Impoverishment resource limit.

Use the following chart to assess a resource transfer made by a LA-D A/R with a community spouse:

Chart 2502.1 - Resource Transfers by an A/R with a Community Spouse

If	Then
the A/R transfers an asset to the community spouse	Do not apply a transfer of assets penalty.
the A/R transfers an asset to someone else for the sole benefit of the community spouse	Do not apply a transfer of assets penalty. The transfer must be accomplished by a written document that legally binds the third party to a specified course of action, and which clearly states the condition of the transfer and who can benefit from the transfer. The transfer must be made so that no individual or entity can benefit from the transfer, either at the time of transfer or in the future, except the community spouse.
the A/R transfers an asset to someone other than the community spouse	Apply a transfer of assets penalty. Refer to 2342 Transfer of Assets.
If the community spouse transfers an annuity or homeplace to someone other than the A/R spouse, and it is not for the sole benefit of the community spouse,	Apply a transfer of assets penalty. Refer to 2342 Transfer of Assets.
If the community spouse transfers an asset (other than annuity/homeplace) to anyone **after** eligibility has been established for the A/R spouse,	There is no penalty to the A/R, However, if the community spouse subsequently enters LA-D, then she/he will incur a penalty.

Spouse to Spouse Deeming of Income

Complete Spouse to Spouse Deeming of Income on Form 172 when the A/R is a Medicaid individual living with an ineligible spouse in LA-A or B. Refer to Section 2507, Spouse to Spouse Deeming.

> DO NOT deem the income of a spouse for any month eligibility is determined for an A/R in LA-D under a class of assistance that uses the Medicaid CAP as the income limit. Refer to Section 2510, Medicaid CAP Budgeting.

Deeming Resources from Ineligible Parent(s) to a Medicaid Child

If only one parent is living in the household with the Medicaid child, deem the parent's resources as follows:

- Subtract the Individual resource limit appropriate for the COA from the parent's countable resources.
- Deem the amount in excess of the Individual resource limit to the eligible child(ren).

If two parents are living in the household with the Medicaid child, deem the parents' resources as follows:

- Subtract the Couple resource limit appropriate for the COA from the combined countable resources of both parents.

- Deem the amount in excess of the Couple resource limit to the eligible child(ren).

If the Medicaid child enters LA-D, deem the parent(s)' resources for the month of admission to LA-D. Consider only the child's resources beginning the month following the month of admission to LA.

Parent to Child Deeming of Income

Complete parent to child deeming of income on Form 171 if the A/R is a Medicaid child living in the household with his/her parent(s). Refer to Section 2508, Parent to Child Deeming.

DO NOT deem the income of a parent(s) for any month eligibility is determined for a Medicaid child in LA-D under a COA that uses the Medicaid CAP as the income limit. Refer to Section 2510, Medicaid CAP Budgeting.

2503 Couples

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Couples		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2503
	Previous Policy Number(s):	MT 51	**Updated or Reviewed in MT:**	MT-58

Requirements

The income and resources of a Medicaid Couple are considered jointly in determining ABD Medicaid eligibility as long as they live together in LA-A or B.

Basic Considerations

If the Couple resource limit is used to determine resource eligibility, the countable resources of both spouses are combined and applied to the appropriate Couple resource limit.

If the Spousal Impoverishment resource limit is used to determine resource eligibility, the countable resources of both spouses are combined and applied to the Spousal Impoverishment resource limit. Refer to Determining Resources when an A/R with a Community Spouse Enters LA-D in the Procedures portion of Section 2502, Deeming.

If a Couple budget is completed to determine income eligibility, the combined countable income of both spouses and the appropriate Couple income limit are used to complete the budget. Refer to Section 2509, Couple Budgeting.

If a spouse-to-spouse deeming budget is used to determine income eligibility, both the appropriate Individual and Couple income limits are used to complete the budget. Refer to Section 2507, Spouse to Spouse Deeming.

> Effective July 1, 2016 the couple income and resource limit for the individual and the individual's spouse will be used whether or not the spouse is applying (Medicare Eligible) for the QI1 COA.

If a Medicaid CAP budget is used to determine income eligibility, the Medicaid CAP is the income limit used to complete the budget. Refer to Section 2510, Medicaid CAP Budgeting.

Procedures

Determining Financial Eligibility for a Medicaid Couple Living Together in LA-A Or LA-B

Follow the procedures below to determine financial eligibility for a Medicaid Couple living together in LA-A or B and applying under the same class of assistance (COA):

- Combine the countable resources of both spouses and apply them to the appropriate Couple

resource limit to determine resource eligibility.

- Complete a Couple budget using the combined gross countable unearned and earned income of both spouses to determine income eligibility. Use the appropriate Couple income limit.

Deeming Financial Eligibility when Both Spouses enter LA-D

Resource Eligibility

- Combine the countable resources of both spouses and apply them to the Couple resource limit to determine resource eligibility for the month of admission to LA-D.
- Treat each spouse as an Individual in determining resource eligibility beginning the month following the month of admission to LA-D. Apply each Individual's resources to the Individual resource limit.

Income Eligibility

- If both spouses have eligibility determined under a COA that uses the Medicaid CAP as the income limit, treat each spouse as an Individual when determining income eligibility beginning with the month of admission to LA-D. In some instances, a couple Medicaid Cap budget is appropriate. Complete an individual or couple Medicaid CAP budget. Refer to Section 2510, Medicaid CAP Budgeting, for specifics
- If both spouses have eligibility determined as ABD Medically Needy, complete a Couple budget for the month of admission to LA-D. Complete an Individual budget on each spouse beginning the month after the month of admission to LA-D. Refer to Section 2506, Medicaid Individual Budgeting.

Use the following chart to determine treatment of income and resources when both spouses are Medicaid and/or Q Track eligible and have eligibility determined under different classes of assistance. Consider Spouse A to be residing at home in LA-A or B:

Chart 2503.1 - Financial Responsibility for Medicaid Couples

	SPOUSE A	**SPOUSE B**
CLASS OF ASSISTANCE:	**AMN**	**SSI**
Resource:	Use the AMN Couple resource limit.	Use the SSI Couple resource limit.
Income:	Complete a Couple budget.	Complete a Spouse-to-Spouse Deeming budget.
CLASS OF ASSISTANCE:	**AMN**	**CCSP, NOW/COMP, ICWP, Hospital or Hospice at home**
Resource:	Use the AMN Couple resource limit any month in which Spouse B is in the home at least one day.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the hospital, hospice or CCSP, etc. Use the SSI Individual resource limit beginning the month after the month of admission.

	SPOUSE A	SPOUSE B
Income:	Complete a Couple budget if the couple are together at home on the first day of the month.	Complete a Medicaid CAP budget for A/Rs whose income is under the Cap or who have established a Qualified Income Trust (QIT).
CLASS OF ASSISTANCE:	**AMN**	**Nursing Home / Institutionalized Hospice**
Resource:	Use the AMN Couple resource limit through the month of admission of Spouse B to the nursing home (NH). Use the AMN Individual resource limit beginning the month after the month of admission.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the nursing home (NH). Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	Complete a Couple budget through the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission. Include any income diverted from Spouse B in the Individual budget.	Complete a Medicaid CAP budget for A/Rs whose income is under the Cap or who have established a Qualified Income Trust (QIT).
CLASS OF ASSISTANCE:	**AMN**	**AMN IN HOSPITAL**
Resource:	Use the AMN Couple resource limit. Also, refer to Special Considerations at the end of this section.	Use the AMN Couple resource limit. Also, refer to Special Considerations at the end of this section.
Income:	Complete a Couple budget. Also refer to Special Considerations at the end of this section.	Complete a Couple budget. Also refer to Special Considerations at the end of this section.
CLASS OF ASSISTANCE:	**AMN** **(QMB/SLMB eligible)**	**Q Track**
Resource:	Use the AMN Couple resource limit.	Use the Q Track Couple Resource limit.
Income:	Complete a Spouse-to-Spouse Deeming budget.	Complete a Couple budget.
CLASS OF ASSISTANCE:	**AMN** **(not Q Track eligible)**	**Q Track** **(QMB/SLMB eligible)**
Resource:	Use the AMN Couple resource limit.	Use the Q Track Couple resource limit.
Income:	Complete a Couple budget.	Complete a Spouse-to-Spouse Deeming budget. **(QI1 eligible)** Use the QI1 couple income and Q Track couple resource limit.
CLASS OF ASSISTANCE:	**Public Law**	**Q Track**
Resource:	Use the SSI Couple resource limit.	Use the Q Track Couple resource limit.

	SPOUSE A	SPOUSE B
Income:	Complete a Spouse-to-Spouse Deeming budget.	Complete a Spouse-to-Spouse Deeming budget. If Spouse A is ineligible for Q Track. OR Complete a Q Track Couple budget, if Spouse A is QMB or SLMB eligible.
CLASS OF ASSISTANCE:	**Public Law**	**Nursing Home / Institutionalized Hospice**
Resource:	Use the SSI Couple resource limit through the month of admission of Spouse B to the NH. Use the SSI Individual resource limit beginning the month after the month of admission.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the NH. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	Complete a Couple budget through the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission.	Complete a Medicaid CAP budget for A/Rs whose income is under the Cap or who have established a Qualified Income Trust (QIT).
CLASS OF ASSISTANCE:	**Public Law**	**CCSP, NOW/COMP, ICWP, Hospital or Hospice at home**
Resource:	Use the SSI Couple resource limit. Also refer to Special Considerations at the end of this section.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the hospital, hospice or CCSP, etc. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	Complete a Couple budget. Also refer to Special Considerations at the end of this section.	Complete a Medicaid CAP budget for A/Rs whose income is under the Cap or who have established a Qualified Income Trust (QIT).
CLASS OF ASSISTANCE:	**Q Track**	**CCSP, NOW/COMP, ICWP, Hospital or Hospice at home**
Resource:	Use the Q Track Couple resource limit. Also refer to Special Considerations at the end of this section.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to LA-D. Use the SSI Individual resource limit beginning the month after the month of admission.

	SPOUSE A	SPOUSE B
Income:	If Spouse B is Q Track eligible, complete a Couple budget. If Spouse B is not Q Track eligible (no Medicare), complete a Spouse-to-Spouse Deeming budget. If the couple is not Q track eligible because of Spouse B's income, complete an individual budget for Spouse A, not including any income diverted to Spouse A from Spouse B. Refer to Special Considerations at the end of this section.	Complete a Medicaid CAP budget for A/Rs whose income is under the Cap or who have established a Qualified Income Trust (QIT).
CLASS OF ASSISTANCE:	**Q Track**	**AMN in Hospital**
Resource:	Use the Q Track Couple resource limit. Also, refer to Special Considerations at the end of this section.	Use the AMN Couple resource limit. Also, refer to Special Considerations at the end of this section.
Income:	If Spouse B is Q Track eligible, complete a Couple budget. If spouse B is not Q Track eligible (no Medicare), complete a Spouse-to-Spouse Deeming budget. If the couple is not Q track eligible because of Spouse B's income, complete an individual budget for Spouse A, not including any income diverted to Spouse A from Spouse B. Refer to Special Considerations at the end of this section.	Complete a Spouse-to-Spouse Deeming budget if LOS is met. Also, refer to Special Considerations at the end of this Section. If LOS is not met, complete a couple AMN budget.
CLASS OF ASSISTANCE:	**Q Track**	**AMN (S99) in Nursing Home / Hospice in NH**
Resource:	Use the Q Track Couple resource limit through the month of admission of Spouse B to the NH. Use the Q Track Individual resource limit beginning the month after the month of admission.	Use the AMN Couple resource limit the month of admission. Use the AMN individual limit afterwards. Also, refer to Special Considerations at the end of this section.

	SPOUSE A	SPOUSE B
Income:	If Spouse B is Q Track eligible, complete a Couple budget through the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission. If Spouse B is not Q Track eligible (no Medicare), complete a Spouse-to-Spouse Deeming budget through the month of admission. Complete an Individual budget beginning the month after the month of admission.	Complete a Spouse-to-Spouse Deeming budget the month of admission. Afterwards complete an individual AMN budget. Also, refer to Special Considerations at the end of this Section. Remember there will be no vendor payment to the NH.
CLASS OF ASSISTANCE:	**Q Track**	**Nursing Home / Institutionalized Hospice**
Resource:	Use the Q Track Couple resource limit through the month of admission of Spouse B to the NH/IH. Use the Q Track Individual resource limit beginning the month after the month of admission.	If Spouse A is a community spouse, use the Spousal Impoverishment resource limit. If Spouse A is a non-legal spouse, use the SSI Couple resource limit through the month of admission to the NH. Use the SSI Individual resource limit beginning the month after the month of admission.
Income:	If Spouse B is Q Track eligible, complete a Couple budget through the month of admission of Spouse B to the NH. Complete an Individual budget beginning the month after the month of admission. If Spouse B is not Q Track eligible (no Medicare), complete a Spouse-to-Spouse Deeming budget through the month of admission. Complete an Individual budget beginning the month after the month of admission.	Complete a Medicaid CAP budget for A/Rs whose income is under the Cap or who have established a Qualified Income Trust (QIT).
CLASS OF ASSISTANCE:	**Q Track** **(not SSI eligible)**	**SSI**
Resource:	Use the Q Track Couple resource limit.	Use the SSI Couple resource limit.
Income:	If Spouse B is Q Track eligible, complete a Couple budget. If Spouse B is not Q Track eligible (no Medicare). Complete an Individual budget.	Complete a Spouse-to-Spouse Deeming budget.

Special Considerations

Hospitalization Treated as a Temporary Absence

Hospitalization is generally considered to be a temporary absence from the home.

- The hospitalized spouse is considered to be living in the home with his/her Medicaid spouse during the hospital confinement.
- The hospitalized spouse's income and resources are considered when determining the Medicaid eligibility of the Medicaid spouse remaining at home.
- Refer to Chart 2503.1, Financial Responsibility for Medicaid Couples.

Hospitalization Treated as Full Separation of Spouses

Do not consider the income and resources of the hospitalized spouse beyond the month of hospital admission when determining the Medicaid eligibility of his/her spouse at home if the hospitalized spouse meets the length of stay (LOS) basic eligibility requirement

The LOS requirement may be met by the hospitalization, or the hospitalization and a subsequent stay in another LA-D situation. Use this rule on separation even if the hospitalized spouse's eligibility is determined under ABD Medically Needy.

If the hospitalized/LA-D spouse returns home to live with his/her spouse after meeting the LOS requirement, resume considering the income and resources of the spouses jointly for purposes of determining Medicaid eligibility effective with the month following the month the hospitalized/LA-D spouse returns home.

The income of the spouse is not considered if eligibility is determined under a COA that uses the Medicaid CAP as the income limit. Refer to Section 2510, Medicaid CAP Budgeting.

Use the Spousal Impoverishment resource limit in determining the hospitalized/LA-D spouse's eligibility if the conditions for a full separation of spouses are met as outlined above.

2504 Determining Countable Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Determining Countable Income		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2504
	Previous Policy Number(s):	MT 23	**Updated or Reviewed in MT:**	MT-58

Requirements

Countable income for determining ABD Medicaid eligibility may include more or less income than is actually received. Countable income is determined for each month separately based on income received each month.

Basic Considerations

The following are examples of situations where more or less income than the A/R actually receives is included in the eligibility and patient liability/cost share budgets:

- Expenses of obtaining income (less)
- Expenses of converting payments in foreign currency to U.S. dollars (less)
- Garnishment (more)
- Gross earnings, before any deductions (more)
- Infrequent or irregular income (less).

A portion of the A/R's income may be excluded based on the type of income received, such as child support. Refer to Chart 2499.1, Treatment of Income in Medicaid.

Expenses of Obtaining Income

An expense that is essential to obtain a particular payment(s) is deducted from the gross income.

A fee to acquire documentation to establish that an individual has a right to certain income (e.g., a fee for a birth certificate, legal fee, or medical examination) is an essential expense.

A guardianship fee is an essential expense if the presence of a guardian is a requirement for receiving the income. In cases where SSA requires that payments be made to a representative payee, the appointment of a legal guardian is unnecessary, and guardianship fees are not allowable.

Procedures

Expenses of Obtaining Income

Deduct that part of a payment that is an essential expense incurred in obtaining the payment.

- Subtract legal, medical and other expenses connected with an accident from the payment for damages received in the accident.
- Subtract legal fees connected with that claim if an individual receives a retroactive payment from a benefit program other than SSI.

Deduct expenses from the first and any subsequent payments of the same type of income until all expenses are eliminated.

- Deduct those verified expenses which the recipient has previously paid (e.g., a partial payment to an attorney made from the individual's savings account) as long as the expenses are essential.
- Use bills, receipts, contact with the provider, etc., to verify all essential expenses.
- Consider the remainder as unearned income subject to the general rules pertaining to income and income exclusions.

Expenses in Converting Payments in Foreign Currency to U.S. Dollars

An individual may receive income tendered to him/her in a monetary unit other than U.S. dollars.

Consider the U.S. dollar value of a payment made in foreign currency, less expenses, as income.

Count foreign currency payments received. If the individual alleges and can establish that the payment was received too late in the month for conversion, count the payment as income for the following month.

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

If the evidence is not readily available, or if translation of the documents would require a delay beyond the receipt of the next payment, complete the following procedures:

- Accept the individual's signed statement.
- Ask the individual to present his next check before cashing it.

Verify the exchange rate for conversion to the foreign currency into U.S. dollars using one of the following:

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

Presume that an established exchange rate remains constant until the next review. If, at the next review, the exchange rate has changed, presume the change occurred in the month of verification.

If the individual reports that the exchange rate has changed, verify the change and adjust the income charged to reflect the new rate.

Garnishment

A garnishment is withholding of an amount from earned or unearned income in order to satisfy a debt or legal obligation.

Include a garnishment from earned or unearned income as income for Medicaid eligibility and patient liability budgeting purposes.

Include garnishments based on any of the following as income:

- voluntary agreement
- repayment of a debt
- satisfying a legal obligation.

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

Gross Income Withholding

Do not allow the following items as deductions from income for ABD Medicaid eligibility budgeting purposes:

- alimony payments, court ordered or voluntary
- child support payments, court ordered or voluntary
- federal, state, or local income taxes
- garnishments
- guardianship fees if the presence of a guardian is not a requirement for receiving the income
- health or life insurance premiums
- inheritance taxes
- loan payments
- penalty deductions for failure to report changes
- service fees charged on interest-bearing checking accounts
- SMI (Medicare Part B) premiums
- Medicare Part D premiums
- union dues.

Use a document in the individual's possession or contact the source of the payment to verify the amount withheld. Add the amount withheld to the amount received and consider the total as the earned income from that source.

Refer to Chapter 2552, Patient Liability Budgeting, for a list of deductions allowed in the patient liability/cost share budget.

Estimated Income

Estimate current and future monthly income.

If the amount is the same each payday, multiply the amount by the number of paydays in the month to obtain the monthly amount.

When income fluctuates within a month, use representative income to represent the amount of income for each period of receipt.

- Determine representative income by using an average of the amounts from the last 4 periods or by using the amount indicated by the A/R as most representative.
- Multiply the representative income by the number of periods of receipt in the month being budgeted to obtain the anticipated monthly income.

Income Expected Less Than Once a Month

Determine the specific month(s) the income is expected to be received and budget the amount for the appropriate month(s).

Infrequent or Irregular Income

Exclude income received either infrequently or irregularly, provided the total of such income does not exceed the following amounts:

- $30 per quarter of earned income

  AND/OR

- $60 per quarter of unearned income.

In order for this exclusion to apply, income need only be one of the following:

- Infrequent – income received no more than once in a calendar quarter from a single source.
- Irregular – income that the A/R cannot reasonably expect to receive on a regular basis.

Total Exceeds the Limit

Apply this exclusion to both earned and unearned income in the same month, provided the total of each does not exceed the limits above. It is possible to exclude as much as $30 a month under this provision.

Include all income received on an infrequent or irregular basis in the eligibility budget if the total of such income received in a particular month exceeds the limits stated above.

Limit as It Applies to Medicaid Couples or a Medicaid Individual with an Ineligible Spouse

Apply only one exclusion each month to income received infrequently or irregularly by a Medicaid individual, Medicaid couple, ineligible spouse, ineligible parent and ineligible child.

Determining Frequency of Receipt

Determine the frequency of the income by reviewing the receipts of the same type of income from a single source.

Interest Income of $20 or Less per Month

Refer to Interest in Chart 2499.1, Treatment of Income in Medicaid, for information on the exclusion of interest income of $20 per month or less.

Interest Income Earned on Excluded Resources

Exclude from the eligibility determination and PL/CS process ANY interest/dividends earned on countable resources. Include such interest/dividends in the resource determination the month following the month of receipt. Refer to Interest in Chart 2499.1, Treatment of Income in Medicaid.

2505 Income Deductions

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Income Deductions		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2505
	Previous Policy Number(s):	MT 13	**Updated or Reviewed in MT:**	MT-58

Requirements

Income deductions are subtracted from income when budgeting to determine income eligibility for ABD Medicaid. These deductions are not allowed in Medicaid CAP cases.

Basic Considerations

Income deductions apply to all earned and unearned income except Income Based on Need (IBON). IBON includes, but is not limited to, the following types of income:

- TANF
- IV-E Foster Care/Adoption Assistance
- SSI
- VA Pension
- VA compensation only when received by a parent(s) due to his/her child's military related
- death
- Other needs based on payment from private organizations (e.g., Salvation Army, Catholic charities).

Procedures

Unearned Income Deductions

Subtract a $20 general deduction from each month of unearned income. Subtract only one $20 general deduction from the unearned income of each of the following:

- a Medicaid Individual
- a Medicaid Individual and his/her Ineligible Spouse
- a Medicaid Couple
- a Medicaid Child
- an Ineligible Parent(s).

Subtract one third of the amount of any child support payments received for the child A/R. Child support payments are considered as income for the child for whom the payments are intended.

Earned Income Deductions

Subtract earned income deductions for each month of earned income in the following order:

- Deduct up to $400 per month, but not more than $1,620 in a calendar year, of the earned income of a blind or disabled child who is a student.
- Subtract the remainder of the $20 general deduction from the combined earned income of the following A/Rs and/or deemors:
  - Medicaid Individual
  - a Medicaid Couple or a Medicaid Individual with an Ineligible Spouse
  - a Medicaid Child
  - Ineligible Parents
- Deduct $65 of gross earned income. Subtract the deduction from the combined earned income of the following A/Rs and/or deemors:
  - a Medicaid Individual
  - a Medicaid Couple or a Medicaid Individual with an Ineligible Spouse
  - a Medicaid Child
  - Ineligible Parents
- Deduct the earned income of disabled Individuals used to pay impairment-related work expenses.
- Deduct one-half of any remaining earned income.
- Deduct the earned income of blind Individuals used to meet work expenses. Deduct any earned income used to fulfill an approved Plan to Achieve Self Sufficiency (PASS).

Applying Earned Income Deductions

Use the following guidelines when applying the earned income deductions:

- Never reduce earned income below zero
- Do not apply any unused portion of an earned income deduction to unearned income.
- Do not apply any unused portion of an earned income deduction in subsequent months.

Student Child Earned Income Deduction

Deduct up to $400 per month, but not more than $1,620 in a calendar year, of the earned income of a blind or disabled child A/R who is a student regularly attending school.

Give the student earned income deduction to an Individual who meets all the following criteria:

- is a child under age 22
- is unmarried
- is not the head of the household
- is a student regularly attending (or expects to attend) school at least one month of the current

calendar quarter

Apply the deduction using the following guidelines:

- Apply the deduction consecutively to months in which the child has earned income until the deduction is exhausted or the Individual is no longer a student child.
- Apply the deduction only to a student child's own earned income.
- Do not count earnings received prior to the first month of Medicaid eligibility toward the $1,620 annual limit.

Develop the following factors and document them:

- whether the child was regularly attending school in at least one month of the current calendar quarter, or expects to attend school for at least one month in the next calendar quarter;
- the amount of the child's earned income, including payments from Neighborhood Youth Corps, Work-Study, and similar programs;
- the amount of the student earned income deduction for each month it is allowed in the eligibility budget.

Deduction of Blind Work Expenses (BWE)

Deduct the amount of earned income of a blind person which is used to meet any expenses reasonably attributed to earning the income if the blind person meets one of the following criteria:

- is under age 65
- is age 65 or older and received SSI payments or payments under a former state plan for aid to the blind for the month before he/she attained age 65.

Deduct the BWE from earned income only. Do not deduct BWE in excess of the earned income from unearned income.

Deduct BWE from the earned income which remains after applying the $20 general income deduction and all other earned income deductions except income used to fulfill an approved Plan to Achieve Self Support (PASS).

Impairment Related Work Expenses (IRWE) Deductions

Contact the Medicaid Unit at the State Office for instructions on allowing this deduction for a disabled Individual who is currently employed.

2506 Medicaid Individual Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicaid Individual Budgeting		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2506
	Previous Policy Number(s):	MT 6	**Updated or Reviewed in MT:**	MT-58

Requirements

Individual budgeting is completed when an individual residing in LA-A or B applies for or receives ABD Medicaid as a Medicaid Individual with no spouse.

Basic Considerations

An individual budget is completed for a Medicaid Individual residing in LA-A or B without a spouse whose eligibility is determined under the following classes of assistance (COAs):

- SSI (3 months prior or intervening months)
- Public Law Classes, including Disabled Widow(er) and Disabled Adult Child (DAC)
- ABD Medically Needy (AMN)
- QMB
- SLMB
- QI-1
- QDWI

Procedures

Enter the appropriate information in the computer system to allow the system to budget correctly,

OR

Follow the procedures below to manually complete an Individual budget on Form 172:

Step 1

Complete Section A of Form 172.

- Include the income of the Medicaid individual in Section A.
- Use the Individual income limit for the COA under which the Medicaid individual is applying.

Step 2

If there is a deficit on Line 13 of Section A, the Medicaid individual is eligible under this COA based on income.

Step 3

If there is a surplus or zero on Line 13 of Section A, the Medicaid individual is ineligible under this COA. Complete a CMD. Refer to 2052 Continuing Medicaid Determination.

If the individual is applying for QMB and there is a zero on Line 13, the individual is eligible for QMB based on income.

If the individual is being budgeted under AMN and there is a surplus on Line 13, use the amount from Line 13 as the AMN spenddown.

2507 Spouse to Spouse Deeming

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Spouse to Spouse Deeming		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2507
	Previous Policy Number(s):	MT 51	**Updated or Reviewed in MT:**	MT-58

Requirements

Spouse to spouse deeming is completed when an individual residing in LA-A or B with his/her spouse applies for or receives ABD Medicaid as a Medicaid individual with an ineligible spouse.

Basic Considerations

A spouse to spouse deeming budget is completed for a Medicaid individual who is residing in LA-A or B with his/her ineligible spouse and whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs):

- SSI (3 months prior or intervening months)
- Public Law Classes, including Disabled Widow(er) and Disabled Adult Child (DAC)
- ABD Medically Needy (AMN)
- QMB
- QDWI
- SLMB

Effective July 1, 2016 the couple income and resource limit for the individual and the individual's spouse will be used whether or not the spouse is applying (Medicare Eligible) for the QI1 COA.

Procedures

Refer to Section 2502, Deeming, for additional information on when to complete Spouse to Spouse Deeming.

Enter the appropriate information in the computer system to allow the system to budget correctly.

OR

Follow the instructions with Form 172 to manually complete a Spouse to Spouse Deeming budget. Refer to Appendix F, Forms.

2508 Parent to Child Deeming

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Parent to Child Deeming		
	Effective Date:	February 2020		
	Chapter:	2500	**Policy Number:**	2508
	Previous Policy Number(s):	MT 7	**Updated or Reviewed in MT:**	MT-58

Requirements

Parent to child deeming is completed when a child residing with his/her parent(s) applies for or receives ABD Medicaid.

Basic Considerations

A parent to child deeming budget is completed for a Medicaid child who is residing with his/her ineligible parent(s) and whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs):

- SSI (3 months prior or intervening months)
- Deeming Waiver (SSI trial budget)
- ABD Medically Needy (AMN)

Procedures

Refer to 2052 Continuing Medicaid Determination for additional information on when to complete Parent to Child Deeming.

Enter the appropriate information on the computer system to allow the system to budget correctly.

OR

Follow the steps below to complete a Parent to Child Deeming budget on Form 171:

Step 1

Complete Section A of Form 171.

- Include the countable income of the ineligible parent(s) in Section A. **DO NOT** include Income Based On Need (IBON) or any income used to determine IBON.
- On Line 2, subtract the allocation to the ineligible child(ren)* from the ineligible parent(s)' UNEARNED income first.
- If any portion of the allowable allocation amount remains after subtracting it from the unearned income, subtract the remainder from the ineligible parent(s)' EARNED income.

Allocate the amount remaining after subtracting the ineligible child's gross income from the

> living allowance for an ineligible child. The living allowance for an ineligible child is the difference in the Individual and Couple FBRs for LA-A.

Step 2

If there is a deficit or zero on Lines 3 and 6 of Section A, proceed to Step 3.

If there is a surplus on Line 3 and/or Line 6 of Section A (unearned and/or earned income remains), complete Section B of Form 171. Use the unearned and earned income remaining on Lines 3 and 6 of Section A to complete Section B.

Step 3

Complete Section C of Form 171.

- Include all countable income of the Medicaid child.
- Include any income remaining on Line 13 of Section B as unearned income deemed from the ineligible parent(s).

If there is a deficit on Line 13 of Section C, the Medicaid child is eligible under this COA based on income.

If there is a surplus or zero on Line 13 of Section C, the Medicaid child is ineligible under this COA. Complete a CMD. Refer to 2052 Continuing Medicaid Determination.

EXCEPTION:

- If the child's eligibility is determined under the Deeming Waiver COA, complete a Medicaid CAP budget as the final step in determining income eligibility.
- If the child is budgeted as AMN and there is a surplus on Line 13 of Section C, use the amount from Line 13 of Section C as the AMN spenddown.

2509 Couple Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Couple Budgeting		
	Effective Date:	Febuary 2020		
	Chapter:	2500	**Policy Number:**	2509
	Previous Policy Number(s):	MT 51	**Updated or Reviewed in MT:**	MT-58

Requirements

Couple budgeting is completed when an individual and his/her spouse residing in LA-A or B both apply for or receive ABD Medicaid as a Medicaid couple.

Basic Considerations

A couple budget is completed for a Medicaid couple residing in LA-A or B whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs):

- SSI (3 months prior or intervening months)
- Public Law Classes, including Disabled Widow(er) and Disabled Adult Child (DAC)
- ABD Medically Needy (AMN)
- QMB
- SLMB
- QI-1
- QDWI

Procedures

Refer to Section 2503, Couples, for additional information on when to complete a couple budget. Enter the appropriate information in the computer system to allow the system to budget correctly.

OR

Follow the procedures below to complete a manual couple budget on Form 172.

Step 1 Complete Section C of Form 172.

- Include the income of both spouses of the Medicaid couple in Section C.
- Allow only one $20 general deduction and one $65 earned income deduction when completing Section C.

Step 2 If there is a deficit on Line 13 of Section C, the Medicaid couple is eligible under this COA based on income.

Step 3 If there is a surplus or zero on Line 13 of Section C, the Medicaid couple is ineligible under this COA. Complete a CMD. Refer to Section 2052, Continuing Medicaid Determination.

If the couple is applying for QMB and there is a zero on Line 13, the individual is eligible for QMB based on income.

If the couple is being budgeted under AMN and there is a surplus on Line 13, use the amount from Line 13 as the AMN spenddown.

If the couple is ineligible for all COAs using Couple budgeting, complete a Spouse to Spouse Deeming budget on each spouse to determine whether one or the other spouse is eligible based on income as a Medicaid individual with an ineligible spouse.

Effective July 1, 2016 the couple income and resource limit for the individual and the individual's spouse will be used whether or not the spouse is applying (Medicare Eligible) for the QI1 COA.

2510 Medicaid Cap Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicaid Cap Budgeting		
	Effective Date:	June 2021		
	Chapter:	2500	**Policy Number:**	2510
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-64

Requirements

Medicaid CAP budgeting is completed when an individual resides in LA-D and applies for ABD Medicaid.

If the A/R's income exceeds the Medicaid CAP, ABD Medicaid eligibility is determined under ABD Medically Needy (AMN) using the ABD Medically Needy Income Level (AMNIL). See Section 2150. Medicaid will not cover the vendor payment to the nursing home. However, if the A/R has a Qualified Income Trust (QIT), then only the income that the A/R actually receives is counted in the Medicaid Cap budget.

The AMN NH/IH COA is no longer an option as of September 1, 2004.

Basic Considerations

A Medicaid CAP budget is completed for an A/R who is residing in LA-D with or without his/her spouse and whose ABD Medicaid eligibility is determined under the following classes of assistance (COAs):

- Elderly Disabled Waiver Program (EDWP), formerly Community Care Services Program (CCSP)
- Deeming Waiver (Katie Beckett)
- Hospice Care
- Institutionalized Hospice
- Hospital
- Independent Care Waiver Program (ICWP)
- Nursing Home
- NOW/COMP

Procedures

Follow the steps below to complete a Medicaid CAP budget. Document all calculations:

Step 1

Calculate the GROSS countable monthly income of the Medicaid A/R residing in LA-D.

Do **Not** count any income that goes into a QIT. Do **Not** include the income of the A/R's spouse, even if the A/R lives at home in LA-D with his/her spouse.

Step 2

Compare the GROSS countable monthly income to the Individual Medicaid CAP.

Do not allow the income deductions discussed in Section 2505, Income Deductions.

If the A/R's gross income is less than the Individual Medicaid CAP, the A/R is income eligible under the LA-D COA.

Effective September 1, 2004, if the A/R's gross income is greater than or equal to the Individual Medicaid CAP and the A/R has not established a QIT, the A/R is income ineligible under any LA-D COA unless/until a QIT is established. Budget the A/R as Medically Needy. See Section 2150, AMN and Section 2407, QIT.

Special Considerations

Couple Medicaid CAP

Use the Couple Medicaid CAP only when the following conditions are met:

- Both spouses of a Medicaid couple reside together in LA-D at home or in the same nursing home, hospice in the nursing home (Institutionalized Hospice) or hospital.

  AND

- Using the Individual Medicaid CAP results in Medicaid ineligibility for one of the spouses.

If the Couple Medicaid CAP is used, complete the Medicaid CAP budget as follows:

- Combine the gross countable monthly income of the Medicaid couple. Do not include any income placed in a QIT.
- Compare the combined income to the Couple Medicaid CAP.

2550 Patient Liability/Cost Share

2551 Patient Liability/Cost Share Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Patient Liability/Cost Share Overview		
	Effective Date:	December 2022		
	Chapter:	2550	**Policy Number:**	2551
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

A patient liability/cost share is determined for certain Medicaid recipients in long-term care (LA-D).

Basic Considerations

A patient liability/cost share (PL/CS) amount is determined for the following ABD Medicaid recipients:

- a Medicaid recipient in a nursing home whose eligibility is determined under the nursing home or Institutionalized Hospice class of assistance (COA)
- a Medicaid recipient who is receiving Community Care Services Program (CCSP/EDWP) services at home
- a Medicaid recipient who is receiving New Options Waiver or Comprehensive Supports Waiver Program (NOW/COMP) Services at home
- a Medicaid recipient who is receiving Independent Care Waiver Program (ICWP) services at home.

A patient liability/cost share amount is determined at the following times:

- at application
- at each review
- when a change in income occurs
- when a change in incurred medical expenses (IME) occurs
- at the beginning of each new averaging period.

> The monthly PL/CS for a LA-D individual should never exceed the monthly Medicaid billing rate for the facility.

A CCSP/EDWP A/R who enters a nursing home will have a zero-patient liability for the month of admission to the nursing home. The A/R is responsible for paying their regular CCSP/EDWP cost share for the month of admission to the nursing home.

A nursing home A/R who enters CCSP/EDWP will have a zero-cost share for the month of admission to CCSP/EDWP. The nursing home patient liability should be recalculated for the month of discharge using the FBR as the PNA.

When an A/R transfers directly from an out-of-state nursing home to a nursing home in Georgia, calculate the patient liability for the month of admission using the actual payment made to the out-of-state nursing home as an IME.

Effective September 1, 2004, LA-D A/Rs whose income exceeds the Medicaid Cap and who have not established a Qualified Income Trust (QIT) may have eligibility determined as AMN (S99), but no vendor payment will be made to the LA-D provider on their behalf.

Procedures

Follow the steps below to complete the patient liability/cost share determination process:

Step 1

Determine the average income and IME to use in the patient liability budget(s). Refer to 2557 Averaging Income and Incurred Medical Expenses, 2558 Significant Change in Income or IME, and 2418 VA Income for treatment of VA income.

Step 2

Complete a patient liability budget(s). Refer to 2559 Patient Liability / Cost Share Budgeting for information on completion of the patient liability budget.

Special Considerations

Effective Month of Change in Patient Liability

If the A/R or PR reports a change that causes a decrease in patient liability, make the change in patient liability effective no earlier than the month the change is reported. Include the change in the reconciliation process if income and IME are being averaged. Refer to 2557 Averaging Income and Incurred Medical Expenses.

If a decrease in patient liability is not issued in a timely manner, the decrease may be handled by making the appropriate system changes to correct the patient liability amount(s) for the month of change and ongoing.

Refer to 2557 Averaging Income and Incurred Medical Expenses and 2558 Significant Change in Income or IME for instructions on how to handle a reported change that causes an increase in patient liability.

2552 Patient Liability/Cost Share Deductions

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Patient Liability/Cost Share Deductions		
	Effective Date:	December 2022		
	Chapter:	2550	**Policy Number:**	2552
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

The Medicaid recipient who is required to contribute toward the cost of care is allowed specific deductions in the patient liability/cost share budget.

Basic Considerations

The patient liability/cost share is determined by using the recipient's gross income and allowing the following deductions:

- Mandatory Income Deductions (See "Mandatory Deductions" below)
  - FICA
  - Federal Withholding Tax
  - State Withholding Tax
  - Mandatory Insurance
- Medicare Premium (See "Medicare Premium Deduction" below.)
- Protection of Income
- Personal Needs Allowance
- Diversion of income to the following individuals:
  - Community Spouse
  - Dependent Family Member
  - Non-legal spouse
  - Couples under CCSP
- Incurred Medical Expenses (IME)
- One third child support payment received by a child A/R

Procedures

Mandatory Deductions

Mandatory deductions that are withheld from earned or unearned income are deducted from the recipient's gross income. However, if the recipient receives a tax refund from federal or state with-

holding tax after taxes had been allowed as a deduction, this will be considered as income the month the tax refund check is received.

Allow mandatory deductions from the A/R's gross earned and unearned income in the PL/CS budget if any are **required** to be withheld by the employer or agency issuing the income. Do **not** allow any deductions from income that are within the control of the individual. This includes withholdings that are the result of A/R's decisions and/or court-ordered actions (e.g., voluntary income tax withholding and court-ordered deductions for child support, alimony or other garnishments resulting from A/R-induced indebtedness or financial obligations).

Exemption: If a court has entered an order for monthly income for support of the community spouse by the institutionalized spouse, the income allowance for the community spouse **shall not be less than** the amount of the monthly income so ordered.

Medicare Premium Deductions

Medicare premiums are deducted in the patient liability budgets for the first month of Nursing Home, IH, CCSP/EDWP, ICWP or NOW/COMP Medicaid eligibility through the month following the month of Medicaid approval. Do not allow as a deduction in any months in which Medicare premiums are currently being paid or will be paid due to eligibility in another COA, such as Q Track, LIS, SSI, etc.

If an A/R receives Part B and/or Part D Medicare, deduct the Medicare Part B and/or Part D premium(s) as follows:

- Deduct in the patient liability budgets for the first month of nursing home, IH, NOW/COMP, ICWP or CCSP/EDWP Medicaid eligibility through the month following the month of Medicaid approval. See exceptions above.
- Continue to allow Medicare Part D premium payments if AR reports that they are still being deducted from SS check.
- If AR pays a Medicare Part D premium that is higher than the Base Payment then allow the difference as an IME and document.

> Medicare Part D premium payments are not reimbursed like the Medicare Part B premium payments.

Personal Needs Allowance (PNA)

The personal needs allowance (PNA) is the amount the recipient is allowed to retain to pay for incidental personal expenses.

Deduct the PNA after allowing the deduction for protected income. Refer to Appendix A1 ABD Financial Limits 2022 for the current amount of appropriate PNA to use in the patient liability budget.

Protection of Income

Refer to 2553 Protection of Income for procedures on allowing the protection of income deduction.

Diversion of Income

Refer to 2554 Diversion of Income for procedures on allowing the diversion of income deduction.

Incurred Medical Expenses

Refer to 2555 Incurred Medical Expenses for procedures on allowing the deduction for IMEs.

Child Support

Allow as a deduction to the PL/CS budget a one third deduction from child support income received by a child A/R. If the A/R is the payer of the child support, there is no deduction allowed.

2553 Protection of Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Protection of Income		
	Effective Date:	December 2022		
	Chapter:	2550	**Policy Number:**	2553
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

All or part of the recipient's income is protected for the month of admission to or discharge from a nursing home (NH), Institutionalized Hospice, CCSP/EDWP, ICWP or NOW/COMP.

Basic Considerations

Income is protected for the month in which any of the following situations occurs:

- The recipient enters a NH, Institutionalized Hospice, CCSP/EDWP, ICWP or NOW/COMP from LA-A or B.
- The recipient leaves a NH, Institutionalized Hospice, CCSP/EDWP, ICWP or NOW/COMP and enters LA-A or B.
- The recipient has CCSP/EDWP, ICWP or NOW/COMP waivered services and case management is terminated.
- The recipient is admitted to and leaves a NH, Institutionalized Hospice, CCSP/EDWP, ICWP or NOW/COMP in the same month.
- The recipient is admitted to a NH, Institutionalized Hospice, CCSP/EDWP, ICWP or NOW/COMP and dies in the same month.
- The recipient enters a NH, Institutionalized Hospice, CCSP/EDWP, ICWP or NOW/COMP in the same month in which s/he was admitted to a hospital or other LA-D from LA-A or B.
- Goes directly from NH to CCSP/EDWP or CCSP/EDWP to NH.

In the above situation, use the date of admission to the first LA-D as the admission date for determining the amount of protected income.

- For Institutionalized Hospice use the date of election of Hospice services.
- For CCSP/EDWP, ICWP, or NOW/COMP cases, use the date case management begins. Third party vendor payment supplements are not protected. VA Aid and Attendance are not counted in the Patient Liability/Cost Share (PL/CS) budget. Refer to 2418 VA Income.

Allow the protected income deduction when calculating the PL/CS.

Use the following chart to determine the amount of the recipient's income to protect based on when the recipient entered and/or left LA-D. If an A/R enters and leaves a facility/facilities more than once

during the same month, or if the A/R dies during the month of admission, the total number of days spent in the facility/facilities for the entire month is considered in determining protected income. Refer to the following chart.

- Count the day of admission towards the total stay.
- Do not count the day of discharge or death towards the total stay.

CHART 2553.1 – PROTECTION OF INCOME

IF the applicant/recipient	THEN Protect
enters the 1st through the 10th day of the month from LA-A, B, or C	one half income
enters the 11th through 31st day of the month from LA-A, B, or C	ALL income
enters/leaves (leaves/enters) or dies in the same month **AND** the total stay is 10 days or less	ALL income
enters/leaves (leaves/enters) or dies in the same month **AND** the total stay is 11 days or more	one half income
leaves the 1st through 10th day of the month to LA-A, B, or C	ALL income
leaves the 11th through 31st day of the month to LA-A, B, or C	one half income
dies in a NH, Institutionalized Hospice, CCSP/EDWP, ICWP, or NOW/COMP in any month after the month of admission	NO income
Leaves CCSP/EDWP and enters a NH on the same day	ALL income in the month of admission to NH
Leaves NH and enters CCSP/EDWP Case Management on the same day	ALL income for the CCSP/EDWP CS for month of entry. NH PL will have a PNA of the FBR in month of discharge to CCSP/EDWP.
is admitted to an LA-D directly from another LA-D and has been continuously residing in the first LA-D since prior to the first day of the month of entry to the second LA-D (except for NH to CCSP/EDWP **or** CCSP/EDWP to NH)	NO income

2554 Diversion of Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Diversion of Income		
	Effective Date:	July 2022		
	Chapter:	2550	**Policy Number:**	2554
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-65

Requirements

The income of a recipient in a nursing home, Institutionalized Hospice, EDWP (CCSP), NOW/COMP or ICWP may be diverted to a spouse and/or child(ren) at home to meet their needs.

Basic Considerations

Diversion of income is allowed when a recipient with a spouse and/or dependent resides in a nursing home, Institutionalized Hospice or EDWP (CCSP).

The amount of income diverted is determined by subtracting the spouse/dependent(s) income from the appropriate need standard. Income placed in a Qualified Income Trust (QIT) may be used for diversion to community spouse and/or dependent family member.

Income Diverted to a Community Spouse

The Community Spouse Maintenance Need Standard (CSMNS) is used to determine the amount of diverted income if the following conditions are met:

- The community spouse is available to receive the allowance.
- The recipient chooses to make the allowance available to the community spouse or to someone else for the benefit of the community spouse.

Income Diverted to a Dependent Family Member

The Dependent Family Member Maintenance Need Standard (DFMNS), Appendix A1 ABD Financial Limits 2022, Chart A1.10, is used to determine the amount diverted to a financially dependent family member who lives with the community spouse.

The family member must fall within the acceptable degree of relationship. The degree of the relationship can be either to the recipient or the community spouse and is restricted to the following:

- a minor child
- dependent child
- dependent parent
- dependent sibling, including half-sibling.

The family member must be claimed as a dependent on the most recent IRS tax return in order to be considered financially dependent. Family member's age or disability is not a consideration when determining dependency status.

Income is diverted to a dependent family member regardless of the following factors:

- whether the recipient makes the income available to the dependent family member or to someone else on behalf of the dependent family member.
- whether income is diverted to the community spouse with whom the dependent family member is living.

Non-Legal Spouse

Income of the recipient may be diverted to a non-legal spouse/child(ren) at home to meet their needs.

- Use the Individual FBR for LA-A as the diversion standard for a non-legal spouse with no minor children at home.
- Use the TANF standard of need (Appendix A1 ABD Financial Limits 2022) as the diversion standard for a non-legal spouse with minor children at home.

> If the spouse and/or minor children are receiving TANF or SSI, the spouse may decide not to receive the diverted income to avoid possible ineligibility for SSI or TANF.

Couples Under EDWP (CCSP)

Diversion of income applies when both members of a Medicaid couple are in EDWP (CCSP).

When one member of the couple (Spouse A) has income less than the individual FBR for LA-A, divert the income of his/her spouse (Spouse B) as follows:

- Subtract the income of Spouse A from the individual FBR for LA-A.
- Divert the amount from the above calculation (deficit) to Spouse A from Spouse B's income.

Procedures

Obtain a Notification Requirement: Transfer of Assets to Spouse, Form 129, from the recipient or PR during the initial application process.

Obtain a statement from the recipient if the income being diverted is being provided to someone else for the care and upkeep of the community spouse/dependent family member.

Community Spouse

Determine the amount to be diverted using the adjusted gross income of the spouse and/or dependent family member, including In-Kind Support and Maintenance. The adjusted gross income is the individual's income after allowing mandatory deductions from earned and unearned income, such as federal and state income taxes, FICA and Medicare taxes. Refer to 2552 Patient Liability/Cost Share Deductions.

Garnishments, child support and alimony payments are not considered to be mandatory deductions.

To calculate the income of the community spouse, use the same averaging procedures used to calculate the income of the A/R. Refer to 2557 Averaging Income and Incurred Medical Expenses.

Subtract the community spouse's average adjusted gross income from the CSMNS to obtain the amount of income to be diverted, known as the Community Spouse Maintenance Allowance (CSMA).

Dependent Family Member

Verify if the family member meets the following conditions for a dependent family member:

- falls within the degree of relationship
- meets the definition of financial dependency
- lives with the community spouse.

Verify the amount of gross income of the dependent family member. To calculate the income of the dependent family member, use the same averaging procedures used to calculate the income of the A/R. Refer to 2557 Averaging Income and Incurred Medical Expenses.

Subtract the dependent family member's average adjusted gross income from the DFMNS to obtain the amount of income to be diverted, known as the Dependent Family Member Allowance (DFMA), Chart A1.10.

You may divert to a dependent family member when there is NO community spouse in the home. Use the appropriate TANF standard of need, Appendix A1 ABD Financial Limits 2022 for the number of dependents as the diversion standard.

Complete the appropriate fields so the system will calculate patient liability/cost share.

Use the following chart to determine the need standard to use when calculating the amount of the recipient's income to divert to a non-legal community spouse and child(ren).

Chart 2554.1 - Diversion to a Non-Legal Spouse and Child(ren)

IF	THEN
the spouse is potentially SSI eligible	divert up to the SSI FBR for the month of admission through the month following the month of case approval **AND** refer the spouse to SSA to apply for SSI. Diversion of income can extend beyond 2 months only with approval from DMA. Secure approval from the following office: Eligibility Policy Officer Division of Medical Assistance P.O. Box 38445 Atlanta, Georgia 30334

IF	THEN
the spouse and child(ren) are potentially eligible for TANF **OR** the child(ren) are potentially TANF eligible	divert up to the TANF standard of need for the month of admission through the month following the month of case approval **AND** refer this spouse to a TANF intake worker to file a TANF application. Diversion of income can extend beyond 2 months only with approval from DMA.
the spouse is ineligible for SSI for reasons other than income	divert indefinitely up to the SSI FBR. Potential eligibility for SSI must be explored at each review.
the spouse and child(ren) **OR** the child(ren) are ineligible for TANF	divert indefinitely up to the TANF standard of need. Potential eligibility for TANF must be explored at each review.

2555 Incurred Medical Expenses

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Incurred Medical Expenses		
	Effective Date:	December 2022		
	Chapter:	2550	**Policy Number:**	2555
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-68

Requirements

Medical expenses incurred by the recipient that are not subject to payment by Medicaid or other third parties can be deducted in the patient liability/cost share budget.

Basic Considerations

Incurred medical expenses (IME) include the following:

- Health and/or dental insurance premiums (100%)
- Co-insurance and deductible payments not covered by Medicaid
- A prescription drug that is NOT covered on an A/R's Medicare Part D plan may only be allowed as an IME if the A/R provides verification that s/he has gone through the appeals process with their plan's carrier and has received an unfavorable decision.
- Medicare Part D premiums, co-pays and deductibles incurred until such time they are paid by Medicaid. Unless you have evidence to the contrary, assume these bills will be incurred through the month following the month that the case is finalized. The A/R will not be reimbursed for any of these expenses they have paid.
- Deductions for expenses not covered by Medicaid as listed on the DMA pricing document, such as the following:
  - dental services
  - medical supplies
  - orthopedic services
  - physician services
  - prescribed over the counter drugs
  - prescription drugs on the DMA pricing document
  - psychiatric or psychological services.
- Long Term Care Medical Expenses (effective 04-09)

This list is not all inclusive.

IMEs must be incurred by the recipient, but not necessarily paid by the recipient. However, if the recipient's medical expense is paid by a state or federal entity, the IME is not an allowable expense

for an IME.

Institutional Long-Term Care Medical Expenses incurred within three months prior to the month(s) of application that were ineligible due to income or resources may be deducted as an allowable expense.

Long term care medical bills (such as the NH or Hospice provider bill) incurred in months in which a transfer penalty has been imposed may not be deducted from the patient liability/cost share as an IME.

DMA Pricing Document

The DMA pricing document is a list of the medical services and supplies, which are allowable deductions.

The DMA pricing document will also identify certain items or services that are allowable deductions for CCSP recipients but not for nursing home recipients. These are primarily items and services which are included in the nursing home per diem reimbursement rate.

Procedures

Follow the steps below to determine an Incurred Medical Expense:

Health and/or Dental Insurance Premiums

Verify the following information on a health insurance premium from the source:

- that the policy is in force
- the amount of the premium
- the frequency of the premium

Health and/or Dental Insurance IME Deduction for Couples

In situations where both spouses of a Medicaid couple reside in LA-D with a patient liability/cost share, allow the premium as an IME for the spouse who is financially responsible for payment of the premium. If both spouses are equally responsible or neither is designated as having primary financial responsibility for the premium payment, allow 50% of the premium as an IME for each spouse. If A/R in a NH, IH, CCSP has a community spouse and has health insurance premiums for both deducted from A/R's income, allow the full amount of the insurance premium as a deduction from the PL/CS.

Institutional Long-Term Care

Institutional long-term care medical expenses incurred within three months prior to the month of application may be allowed as a deduction at an amount equal to or less than the Medicaid reimbursement rate for that facility. The A/R's monthly income and any other insurance payments made to the Long-Term care facility must be taken into consideration when determining the IME. These expenses are not subject to the three-month IME averaging period and may be combined and rolled over to subsequent months until the full expense(s) is absorbed.

Form 942 is used to verify the amount owed to the facility. When determining the maximum LTC IME allowed for each month, compare the Medicaid reimbursement rate x number of days in the month client was institutionalized to the amount client actually owed/paid for that month after insurance. The maximum LTC IME for a month is the actual owed after insurance versus the Medicaid reimbursement rate x number of days—WHICHEVER IS LESS.

Use Form 942 to determine the items or services requested as IMEs. See Appendix F, Forms, for Form 942 and instructions.

Date form received – Should be date stamped by DFCS office and must be received by the end of the averaging period in which the IME was incurred (the 10th of the reconciliation month) OR the 10th of the month following the month the IME was incurred if eligibility is determined under AMN (however, AMN is not in effect at this time).

DMA Pricing Document

Compare Form 942 with the DMA Pricing Document to see if the item or service is listed. Deduct the amount found in the pricing document or the amount charged by the provider, whichever is less.

IME Query

Send an IME Query form found in Appendix F, Forms to DCH to determine if a medical expense can be deducted as an IME if it does not appear on the pricing document.

Mail to:

DCH
Donna Johnson
P.O. Box 1984
Atlanta, Georgia 30301-1984

OR Fax to: 470-386-6181

Deny the IME deduction if the item or service is not approved by DCH.

For certain expenses, such as drugs, the provider will have to specify quantity, size, strength of dosage, etc., in order for the expense to be correctly identified in the pricing document.

Denial of Medical Expense Hearing Request

When a request for a deduction is denied, send Form 943 to the recipient prior to the last day of the month for which the deduction is requested.

Process a hearing for denial of IMEs using the same regular hearing procedures. Refer to Appendix B, Hearings.

Averaging

Use averaging procedures for the IME deduction. Refer to 2557 Averaging Income and Incurred Medical Expenses.

Averaging Period

Use a monthly average for the 3 months averaging period, when a one-time IME is submitted. This could cause the liability to be reduced to zero for the entire averaging period. Refer to 2557 Averaging Income and Incurred Medical Expenses.

There is no carryover of an excess IME to successive averaging periods.

Allowing the LTC IME Deduction in the System

Calculate the IME deduction (using instructions on 2555-2) to be allowed in the patient liability/cost share budget and enter this amount in the incurred medical field on the NH screen. The system will allow the LTC IME as a deduction as the last step in the budgeting process.

Allowing Incurred Medical Expenses in the System

Enter each Incurred Medical Expense individually in the system. For each Incurred Medical Expense, list the Type, Frequency, Amount, and Date of Service. The system will allow the total of the Incurred Medical Expense(s) as a deduction in the budgeting process.

Client Notification

The system will send notification to the A/R and RP of the patient liability/cost share change for the month(s) for which the deduction is allowed. Customize this notification if more explanation is needed. Refer to 2701 Notification for specifics of notification requirements.

2557 Averaging Income and Incurred Medical Expenses

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Averaging Income and Incurred Medical Expenses		
	Effective Date:	December 2022		
	Chapter:	2550	**Policy Number:**	2557
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

Income and incurred medical expenses (IMEs) used in the patient liability budget are projected using an average of the income and IMEs from the previous three months.

Basic Considerations

Averaging and reconciliation procedures are used in all patient liability and cost share budgets.

Averaging periods are three months, beginning with the month of admission to LA-D or the first month of Medicaid eligibility, whichever is later.

An averaging period may be shortened to avoid reconciling income at the end of a period that would cause hardship to an A/R.

The expected average income and IMEs for the ongoing three months are projected as accurately as possible. The projected average is based on the following:

- regular recurring income/IMEs received/incurred during the three previous months
- regular recurring income/IMEs expected to be received/ incurred during the ongoing three month period
- any irregular or non-recurring income/IMEs expected to be received during the ongoing three-month period (e.g. lump sums, quarterly interest, a large, one-time IME).

The projection should not include income or IMEs received or incurred in the previous three months if it is not expected to be received or incurred in the ongoing three month period.

Averaging periods can be flexible, depending on the receipt of unexpected income.

A budget is completed every three months to reconcile the projected income with the actual income received.

Large medical expenses which are a one–time, non-recurring expense are not treated in the manner of a significant change because it is not a recurring event. These are to be treated separately with no averaging. See Section 2558 – 1.

Procedures

Averaging

Follow the steps below to determine a monthly average income and IME:

Step 1 Verify the gross income received by the individual, including income placed in a Qualified Income Trust (QIT), for each of the three months previous to the first month of the averaging period.

Step 2 Determine the total gross income for each month separately. Round each monthly total down to the nearest dollar.

Step 3 Add the monthly totals together and divide by three. Round down to the nearest dollar.

Step 4 Determine if the individual expects to receive any income in the averaging period which was not received in the previous three months (e.g., yearly farm rental income). Divide this total by three. Round down to the nearest dollar.

Step 5 Add the total from Step 3 to the total from Step 4. This is the projected monthly average income to be used in the patient liability budgets for the averaging period.

Step 6 Verify all allowable IMEs for each of the three months previous to the first month of the averaging period. Refer to 2555 Incurred Medical Expenses.

Step 7 Determine the total amount of IME for each month separately. Round each month's total up to the nearest dollar.

Step 8 Add the monthly totals together and divide by three. Round up to the nearest dollar.

Step 9 Determine if the A/R expects to incur any medical expense in the averaging period which was not incurred in the previous three months. Divide this total by three. Round up to the nearest dollar.

Step 10 Add the total from Step 8 to the total from Step 9. This is the projected monthly average IME to be used in the patient liability budgets for the averaging period.

Step 11 Complete patient liability budgets for the averaging period using the projected monthly averages for income and IME from step 10.

Reconciliation

Reconcile the projected amounts of income and IME used for the averaging period with the actual income/IME received.

Reconciliation occurs in three instances:

- at the beginning of each new averaging period
- whenever a significant change occurs (refer to 2558 Significant Change in Income or IME)
- whenever the vendor payment or cost share is terminated (except for discharges to another

nursing home).

The reconciliation month is the first month of a new averaging period. It must be completed in the current benefit month in the current eligibility system, allowing for timely notice. Refer to 2701 Notification.

The following instructions are for completing manual reconciliation.

Step 1 Reconciliation should be completed in the system answering the Apply towards reconciliation question found on the Income or Medical Expense screens.

Step 2 Verify the actual income received by the individual, including income placed in a QIT, for each month of the just completed three month averaging period.

Step 3 Determine the total gross income for each month separately. Round each monthly total down to the nearest dollar.

Step 4 Combine the three rounded monthly totals from Step 2 to determine the total actual income which should have been used in the just completed averaging period.

Step 5 Combine the three projected average monthly incomes used in the just completed averaging period to determine the total projected income. Compare the total projected income from Step 4 to the total amount from Step 3.

If the total actual income is greater than the total projected income, add the difference in actual income and projected income from the income for the first month of the new averaging period (see Step 9).

Step 6 If the total actual income is less than the total projected income, subtract the difference in actual income and projected income from the income for the first month of the new averaging period (Step 9).

Repeat Steps 1 through 4, using IMEs instead of income. Use only IMEs which have been verified timely to determine actual IME. Round each IME total up to the nearest dollar.

Step 7 Compare the total projected IME with the total actual IME.

- If the total actual IME is greater than the total projected IME, add the difference in actual IME and projected IME to the IME deduction for the first month of the new averaging period (see Step 9).
- If the total actual IME is less than the actual projected IME, subtract the difference in actual IME and projected IME from the IME deduction for the first month of the new averaging period (see Step 9).

Step 8 Use the averaging procedures previously explained to determine new projected averages for both income and IME to use in the new averaging period.

Step 9 Complete a patient liability budget for the first month of the new averaging period.

- Add the income reconciliation amount from Step 5 to the new projected average income used in the patient liability budget for the first month of the new averaging period.
- Add the IME reconciliation amount from Step 7 to the new projected average IME amount used in the patient liability budget for the first month of the new ongoing budget period.

Step 10 Complete patient liability budgets for the second and third months of the new ongoing budget period using the new projected average income and IME amounts.

Step 11 Complete appropriate fields in the computer system to calculate the new patient liability for the months of the new averaging period. Notify the A/R and PR via system generated notice of the change in monthly patient liability.

Notification

Refer to 2701 Notification for notification requirements pertaining to changes in PL/CS.

2558 Significant Change in Income or IME

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Significant Change in Income or IME		
	Effective Date:	December 2022		
	Chapter:	2550	**Policy Number:**	2558
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

A significant change is a change in either income or IME that was not considered when determining the projected averages.

Basic Considerations

A significant change occurs when there is a $20 or more change in income or IME. Significant changes include the following:

- a change in regular, recurring income
- receipt of lump sum income
- a change in regular, recurring IMEs

> A large medical expense that is a one–time non-recurring expense would not be treated in the manner of a significant change because it is not an item creating a recurring event. These one-time expenses are to be treated separately with no averaging. The non-recurring expense is to be deducted from the monthly liability in addition to the average IME deduction so that the allowed expense is offset in full or the liability is reduced to zero. If the one-time amount is not absorbed in full the first month of reduction, the remainder is applied to the second month of reduction with the patient liability again reduced to zero. This procedure is repeated until the non-recurring allowed expense has been absorbed in full.

Procedures

Complete reconciliation and start a new three-month averaging period when a significant change is reported or discovered.

If the change occurred in the current month and timely notice can be given (10 days minimum remain in the month), complete the following actions:

- begin a new averaging period and complete reconciliation in the month of the change.
- Include the amount of both the one-time income/IME and recurring income/IME as part of the projected average income/IME for the new averaging period.

If timely notice (See 2701 Notification) cannot be given in the month in which the change occurs, complete the following actions:

- Begin a new averaging period and complete reconciliation in the earliest month for which notice can be given.
- Include the entire amount of any one-time income or IME as part of the reconciliation amount but not as part of the projected average income/IME for the new averaging period.
- Determine the new projected average income/IME based on the amounts of recurring income/IME.

Do not include income or IMEs in reconciliation that were received or incurred more than three months prior to the month of reconciliation.

Client Notification

Send notice to the A/R of an increase in patient liability/cost share via the system-generated notice. See 2701 Notification for specific notice requirements.

Send notice of termination (vendor payment/eligibility termination) to the A/R no later than 14 days prior to the first day of the effective month.

Use the following chart to determine the required action when a significant change is reported:

Chart 2558.1 - Required Action Based on a Significant Change

IF	THEN
Notice can be given in the month the unexpected income is received or the large unexpected IME is incurred	Begin a new averaging period and include the expense or income as part of the averaged projection for the new three-month averaging period.
Notice cannot be given in the month the income is received or the large IME is incurred	Include the income or IME as a reconciliation amount at the beginning of a new three-month averaging period, to begin with the earliest month in which notice can be given.
The income reconciliation amount exceeds the Medicaid billing rate for the nursing home where the A/R resides	Do not charge more than the billing rate as patient liability for the reconciliation month. Any remaining income is a resource for the following month. If the recipient receives VA A&A, refer to 2418 VA Income.
The IME reconciliation amount or average IME exceeds the A/R's monthly income	Do not carry the IME over to any future averaging period.
Large medical expenses that are one– time non-recurring expense	Deduct from the monthly liability in addition to the average IME deduction so that the allowed expense is offset in full or the liability is reduced to zero. Allow expense until it has been absorbed in full.

2559 Patient Liability / Cost Share Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Patient Liability / Cost Share Budgeting		
	Effective Date:	December 2022		
	Chapter:	2550	**Policy Number:**	2559
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

A patient liability/cost share budget is completed on all Medicaid recipients in a nursing home (NH), Institutionalized Hospice, CCSP/EDWP, ICWP or NOW/COMP.

Basic Considerations

A patient liability/cost share budget is completed at the following times:

- at approval of the application
  - to calculate the patient liability for the first month of eligibility
  - to remove the protection of income deduction
- when a change in income occurs
- when a change in incurred medical expenses (IME) occurs
- at the beginning of each new averaging period.

Procedures

Follow the steps below to complete the patient liability.

Step 1 Determine the amount of the A/R's income to divert to his/her spouse/dependents at home.

- Refer to 2554 Diversion of Income for the correct maintenance need standard to use.
- Use the ADJUSTED GROSS income of the spouse/dependents, including In- Kind Support and Maintenance (ISM) received by the spouse/dependents. Refer to 2430 Living Arrangement and In-Kind Support and Maintenance for ABD Medicaid.

Step 2 If the recipient is Medicaid eligible under the Nursing Home, CCSP/EDWP, Institutionalized Hospice, ICWP or NOW/COMP classes of assistance, use average income and IMEs in the patient liability budget. Refer to 2557 Averaging Income and Incurred Medical Expenses. Proceed to Step 3.

Step 3 Calculate patient liability/cost share. The PL/CS should never exceed the monthly Medicaid billing rate for the facility in which the A/R resides. Complete Section C of Form 968 if a manual budget is used to calculate patient liability/cost share.

- Refer to 2552 Patient Liability/Cost Share Deductions for information on the deductions subtracted.
- Refer to 2418 VA Income for information on VA Aid and Attendance payments in the budget.

Special Considerations

CCSP/EDWP to Nursing Home

Calculate a CCSP/EDWP cost share for the month a recipient enters a nursing home from CCSP. There is no patient liability for the month of nursing home admission.

Nursing Home to CCSP/EDWP

Re-calculate the nursing home patient liability for the month an A/R goes into CCSP/EDWP from a nursing home using the FBR as the PNA. There is no cost share for the month of admission to CCSP.

A/R's Income Exceeds the Medicaid Cap

If the A/R's income is equal to or greater than the Medicaid Cap and the A/R has not established a Qualified Income Trust (QIT), the A/R is not eligible for the nursing home COA. If A/R is eligible under another COA, such as AMN there will be no vendor payment made to the NH nor payments for LTC services (LA-D Providers) on his/her behalf.

A/Rs who establish a QIT may meet the income eligibility requirement based on the income not placed in the QIT. However, the PL/CS calculation uses income the A/R receives and the income placed in the QIT. Refer to 2407 Qualified Income Trust for further instructions.

Transfer from out of state Nursing Home to Georgia Nursing Home

When an A/R transfers directly from an out-of-state nursing home to a nursing home in Georgia, calculate the patient liability for the month of admission using the actual payment made to the out-of-state nursing home as an IME.

2575 Nursing Home Vendor Payment

2576 Vendor Payment Authorization

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Vendor Payment Authorization		
	Effective Date:	February 2020		
	Chapter:	2575	**Policy Number:**	2576
	Previous Policy Number(s):	MT 44	**Updated or Reviewed in MT:**	MT-58

Requirements

A payment to the nursing home (NH) to defray the cost of care may be authorized when Medicaid eligibility has been approved. This Medicaid payment for NH care is called a vendor payment.

Nursing home A/Rs whose income is equal to or above the Medicaid Cap and who do not establish a Qualified Income Trust (QIT) may have their Medicaid eligibility determined under AMN (S99) Medicaid. Vendor payments are not authorized unless the A/R is approved under the NH COA.

Basic Considerations

The vendor payment is authorized by DFCS by entering pertinent data into the computer system.

At application, Form DMA-59 is prepared by the NH and sent to DFCS with the following information completed:

- The recipient's identifying information in Section I
- The **Patient Admitted From** field in Section II.

Form DMA-59 must be signed by the NH administrator (initial application only) and dated. A signature by the NH staff is not necessary on the DMA-59 for subsequent actions reflected on the DMA-59.

Prepayments and deposits may be required by a NH for an individual not already receiving Medicaid on the date of admission.

Refunds of Prepayments or Deposits Made to Nursing Homes by Medicaid Applicants

The facility must return such deposits to the individual or his/her family after eligibility for Medicaid is established. The refund, if made to the patient, is not counted as income to the individual in determining eligibility or patient liability but is considered a resource to the patient at the time of application.

Procedures

Authorize the NH vendor payment via the current eligibility system. This information will be passed to DCH via the interface.

DFCS is not required to return a copy of the initial DMA-59 to the nursing home when the case is approved, and vendor payment is authorized.

Parent/Caretaker with Child(ren) (PCT)/BCCP/PeachCare for Kids® Temporarily in the NH

If a PCT/BCCP/PeachCare for Kids® A/R is temporarily in a NH, authorize the vendor payment by faxing a copy of a DMA-59 to DCH at 404-463-2538. Send it to the attention of the DCH Member Services and Policy unit and annotate the DMA-59 by stating it is “LIM in the NH”, “BCCP in the NH” or “PeachCare for Kids® in the NH”.

Use the following table to determine the Initial “Payment Authorization Date” to enter in the system:

The Initial “Payment Authorization Date” entered in the system **CANNOT** pre-date the effective date of Medicaid eligibility.

Chart 2576.1 - Determining the Initial “Payment Authorization Date of a NH Vendor Payment

IF the A/R is	THEN the initial payment Authorization Date entered in the system is
a Medicaid recipient under any class of assistance whose income is under the Medicaid Cap (except Q Track) upon admission to the NH **AND** has no VA third party contracts	the date indicated on Form DMA-59 as the Admission Date or the Effective Date, whichever is later. A/Rs who enter the NH who are Q Track eligible should be approved for NH in the system as a separate NH Assistance Unit. A/Rs who are approved under the NH COA may also be approved as QMB eligible under a different AU.
not a Medicaid recipient* upon admission to the NH **AND** has no VA third party contracts **AND** Meets all eligibility criteria *This includes Q Track recipients.	the latest of the following dates: • the date indicated on Form DMA-59 as the Admission Date or Effective Date, whichever is later. • the beginning date of Medicaid eligibility. • the first Medicaid eligible day of any month for which the facility has not been paid in full or agrees to make a refund to the patient or family.
a Medicaid recipient in an NH **AND** a VA third party contract is paying the cost of care	the first day after the VA third party contract benefits are exhausted or terminated. A/R can be Medicaid eligible, but no VP is authorized to the NH while the A/R is under a VA contract. The NH will notify DFCS when the contract expires.

Refer to Section 2577 - Limited Stays for more information on Limited Stays.

Code income from VA Aid and Attendance appropriately in the system since it is not included in patient liability or eligibility determinations.

Terminations

Terminate the vendor payment by completing the appropriate fields in the system. It is not neces-

sary to submit a DMA-59 to DCH or the nursing home.

Notification

Notify the recipient and personal representative of the effective date of the vendor payment and the patient liability amounts via the system generated notice.

Process changes in the system to allow timely notice:

- 14 days before the end of the month for an increase in patient liability to be effective the same month. If timely notice cannot be given within 14 days prior to the end of the month, the PL increase will not be effective until the following month.
- 14 days before the end of the month for termination of the vendor payment to be effective the first day of the following month.
- A decrease in patient liability may be processed at any time.

It is not necessary for the nursing home to send a discharge DMA-59 to DFCS if the A/R is discharged to the hospital and readmitted to the same nursing home, even if the hospital stay exceeds seven days.

The nursing home should notify DFCS via DMA-59 if the A/R discharges to another nursing home, home, dies, or becomes otherwise ineligible. However, should DFCS become aware of such a discharge, a DMA-59 is not mandatory to process the change as long as known information is validated.

2577 Limited Stays

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Limited Stays		
	Effective Date:	February 2020		
	Chapter:	2575	**Policy Number:**	2577
	Previous Policy Number(s):	MT 7	**Updated or Reviewed in MT:**	MT-58

Requirements

A level of care (LOC) may be approved for certain LA-D COAs for a specified number of days based on an individual's physical and mental condition.

Basic Considerations

A limited stay LOC is authorized in one of the following ways:

- AHS authorizes limited stays by approving a LOC for a specified number of days on Form DMA-6 for the Deeming Waiver COAs and effective 4/1/03, on an approved LOC instrument for swing bed A/Rs.
- The CCSP Assessment Team approves the limited stay LOC for CCSP A/Rs using the Form 5588.
- Effective 4/1/03, the limited stay LOC for NOW/COMP is approved by a DHR vendor via an approved LOC instrument.
- Effective 4/1/03, ICWP case managers approve the limited stay LOC by completing the Form DMA-6.
- The NH submits a Form DMA-59 to DFCS at initial application for Medicaid under the NH COA. All NH stays are assumed to be permanent stays until notification that the A/R no longer resides in the NH or has switched to another COA. All NH LOCs are treated as "skilled" care.

IC-MR LOC and swing bed residents.

Procedures

Follow the steps below to authorize a vendor payment:

Step 1 Screen every Form DMA-6 or approved LOC instrument for a limited stay when it arrives at the DFCS office.

Step 2 Authorize and terminate the vendor payment for the stay (number of days) indicated on the LOC form. Do not authorize a vendor payment for any day(s) not covered by the LOC instrument.

- Refer to Chart 2576.1 – Determining the Initial Payment Authorization Date of a Vendor Payment to determine the first Payment Authorization Date to enter on the INST screen.
- Enter the day after the last day of the stay approved on Form DMA-6 or approved LOC instrument as the Payment Termination Date of the vendor payment termination. NH payment termination date should be the actual date of discharge/death.

Step 3 Notify the A/R or PR and Medicaid facility of the extended level of care dates.

Step 4 If another Form DMA-6 or other approved LOC instrument is received indicating additional days have been approved for the limited stay, extend the payment termination date to reflect the extension. File the new LOC instrument in the case record.

Refer to Chart 2577.1 – Extending the Limited Stay. Notify the A/R of the extension of the vendor payment.

If another Form DMA-6 or other approved LOC instrument is not received prior to the termination of the Level of Care, complete a CMD. Refer to Section 2055, Continuing Medicaid Determination.

If Medicaid is terminated as a result of the CMD and a new Form DMA-6 other approved LOC instrument is subsequently received within 30 days of the termination date on the system, reopen the case as closed in error. If a new LOC instrument is received more than 30 days after the system termination date, process a new application.

The limited stay has no effect on Medicaid eligibility for an A/R who is eligible under a class of assistance (COA) that does not require the A/R to meet the length of stay (LOS) and level of care (LOC) basic eligibility criteria.

Use the following chart to determine the specific actions to be taken based on whether an additional stay is approved:

Chart 2577.1 – Extending the Limited Stay

IF	THEN
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** the receipt of a second Form DMA-6 or approved LOC instrument indicates that an additional stay has been approved and there is **no** gap in coverage or change in LOC	authorize the vendor payment for the additional stay by completing the appropriate fields on the ABD screen(s) for every affected benefit month and changing the “Term Date” to the day following the end date of the new LOC instrument.

IF	THEN
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** there **is** a gap in days between the end date of the old DMA-6 or approved LOC instrument and the payment date of the new LOC instrument	authorize the vendor payment for the additional stay for every affected benefit month by completing the appropriate fields on the ABD screen(s). Enter a “Discharge Date” that is the same as the original “Payment Term Date.” The admission date will be the new LOC instrument payment date.
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** the receipt of the second DMA-6 or LOC instrument (NOW/COMP, swing bed or ICWP only) indicates there **is** a change in the LOC (Change in LOC is not applicable for CCSP/Hospice/NH A/Rs.)	authorize the vendor payment for the additional stay and change in LOC for every affected benefit month by completing the appropriate fields on the ABD screen(s). Change the LOC to the appropriate new code and update the “Payment Auth Date” to the payment date and the “Payment Term Date” to the day after the end date on the new approved LOC instrument.
the approved stay expires **after** disposition of the application and initial vendor payment authorization **AND** an additional stay has been requested but denied	terminate Medicaid under the existing COA and complete a CMD for a COA not requiring a LOC.
the approved stay expires **prior to** disposition of the application and initial vendor payment authorization **AND** the receipt of a second Form DMA-6 or approved LOC instrument indicates that an additional period of time has been approved	approve retroactive and/or ongoing Medicaid for the month(s) of the limited stay(s) **AND** authorize the vendor payment for the limited stays approved on the two forms. Use the day following the ending date on the second form as the Payment Termination Date in the system.
the approved stay expires **prior to** disposition of the application and initial vendor payment authorization **AND** an additional stay has not been requested **OR** an additional stay has been requested but denied	deny ongoing Medicaid under the existing COA and complete a CMD **AND** approve retroactive Medicaid for the month(s) of the original stay, if eligible **AND** authorize the vendor payment in the system for the period of time of the limited stay approved on Form DMA-6 or approved LOC instrument.

2578 SSI Recipients

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	SSI Recipients		
	Effective Date:	July 2019		
	Chapter:	2575	**Policy Number:**	2578
	Previous Policy Number(s):	MT 49	**Updated or Reviewed in MT:**	MT-56

Requirements

An individual who receives SSI prior to admission to a nursing home (NH) has already had Medicaid eligibility established. A NH vendor payment can be authorized.

Basic Considerations

A NH vendor payment can be authorized for the SSI recipient entering a NH if all the following conditions are met:

- The A/R is a resident of Georgia.
- The A/R has an approved Level of Care (LOC).
- The A/R has not transferred a resource for less than fair market value within 60 months prior to the month of application.

Individuals entering a NH who receive SSI only will have their SSI payment amount reduced to $30.00 the month following the month of NH admission. They will also receive a State Supplement. Please see effective dates and amounts below:

Effective Date	State Supplement Amount
7/1/2006	$20.00
7/1/2018	$35.00
7/1/2019	$40.00

Individuals entering a NH who receive SSI and any other income from another source will have their SSI terminated and changed automatically to ABD Medicaid on the DMA Recipient Data Base.

Authorization of a vendor payment for an SSI recipient should not be delayed pending receipt of the SSI/DMP to MAO list.

Procedures

Follow the steps below to authorize a NH vendor payment for an SSI recipient:

Step 1 Complete and submit Form 107 to the SSA District office to report the SSI recipient's new living arrangement and address.

Step 2 Register, verify (SDX is acceptable) and document all income on the system.

Step 3 Obtain A/R's or PR's statement regarding ownership of resources and possible transfer of assets. If a SSI A/R's countable resources exceed the SSI resource limit, notate on Form 107 and forward to SSA. Unless/until SSA takes action, there is no effect on authorizing the vendor payment. If, however, the SSI A/R (SSI only and SSI/MAO) had assets which have been transferred, compute and impose a transfer penalty. Do not authorize the vendor payment. Refer to 2342 Transfer of Assets. Verify income at the twelve-month review for A/Rs whose SSI will be terminating.

Step 4 Inform A/Rs and their representatives of Estate Recovery and provide them Form 315. Refer to 2398 Estate Recovery for ABD Medicaid.

Step 5 Determine patient liability for the month of admission to LA-D using ALL income available to the A/R that month, INCLUDING SSI. Determine patient liability for the month(s) following the month of admission to LA-D using only the amount of SSI to which the recipient is entitled in LA-D (if any) plus all other income.

> The month of admission to LA-D means the first month of continuous confinement in LA-D, including situations where the SSI recipient entered the NH from a hospital or other LA-D.

Step 6 Do not delay in authorizing the vendor payment on the system and notifying the A/R, PR and the NH, even if you are still waiting on information regarding resources or transfers.

> Use the Admission date or Effective Date on Form DMA-59, whichever is later, as the Payment Authorization date in the system.

Special Considerations

SSI Recipient is not a Resident of Georgia

Follow the procedures below if the SSI recipient entering a NH is not a resident of Georgia:

- Do not authorize a vendor payment.
- Notify DMA via Form 951 that the A/R is not a Georgia resident and therefore not eligible for Medicaid.
- Notify SSA via Form 107 of the A/R's correct state of residence.
- Notify the SSI recipient of his/her ineligibility for a vendor payment.

SSI Recipient is not approved for Level of Care

Follow the procedures below if the SSI recipient entering a NH, Swing Bed, or a facility for the mentally retarded is not approved for a LOC:

- Do not authorize a vendor payment.
- Notify the SSI recipient of his/her ineligibility for a vendor payment.

Reviews

Annual reviews are completed by SSA on SSI only NH recipients. Although it is not necessary for DFCS workers to complete a full annual review on these A/R's, workers should check annually to confirm that recipients continue to receive SSI and remain a resident of the NH while authorizing an annual renewal in the eligibility system for the purposes to extend the Period of Eligibility.

For the AR's that lose their SSI payment DFCS must obtain all the necessary verification and forms (this would include the Declaration of Citizenship form) to determine eligibility at the next review or interim change.

2579 SSI 1619 Individuals

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	SSI 1619 Individuals		
	Effective Date:	February 2020		
	Chapter:	2575	**Policy Number:**	2579
	Previous Policy Number(s):	MT 6	**Updated or Reviewed in MT:**	MT-58

Requirements

Section 1619 of Title XIX of the Social Security Act entitles certain blind and disabled individuals to receive SSI while employed.

Basic Considerations

PL 99-643 created an exception to the rules regarding the treatment of SSI income for individuals eligible for SSI under Section 1619(a) or 1619(b) who entered a nursing home (NH) or CCSP or who remain in LA-A, B or C.

These NH or CCSP individuals will remain eligible for SSI for the first two months in a NH or CCSP. The individual's SSI income is not considered in determining patient liability. Individuals who are not in LA-D may be able to continue their Medicaid eligibility under 1619(a) or (b).

Individuals eligible for SSI under Section 1619(a) and (b) are those disabled or blind individuals who are employed and have earned income the month preceding the month of admission to a NH or CCSP or ongoing for those individuals who are not in LA-D.

1619(a)

Individuals eligible under 1619(a) have earned income of less than the Substantial Gainful Activity (SGA) amount.

1619(b)

Individuals eligible under 1619(b) have earned income of more than the SGA. These individuals have too much income to receive an SSI payment but still receive Medicaid under an SSI ID number.

SSI recipients who are employed and have earnings over the SGA may continue to receive SSI and Medicaid under the authority of SSA Section 1619(a) and, if their earnings exceed the breakeven point, may continue to receive Medicaid (no SSI payment) under the authority of Section 1619(b).

There are also unearned income limits that are considered in calculating the break-even point. Unearned income includes SSI, SSDI and Railroad Retirement Benefits. Therefore, the exact break-even point varies depending on an individual's combination of earned and unearned income.

Refer to Appendix A for the current SGA and break-even point.

Procedures

LA-A, B, or C Individuals

If a working disabled A/R reports that s/he lost SSI eligibility as a result of earnings and is not institutionalized, s/he may have been terminated in error. In that situation, refer the A/R to SSA for eligibility determination under Section 1619(b).

If an individual's earned income will result in terminating medical assistance eligibility, determine if the individual has advised SSA and if SSA has made a decision about Section 1619 status. If not, advise the individual to contact the SSA. Individuals may find it helpful to obtain information about 1619 work incentives by first contacting the Benefits Planning, Assistance & Outreach Program at The Shepherd Center in Atlanta at:

Toll Free: 1-866-SSA-BPAO
1-866-772-2726
TTY: 404-367-1347

The SSA automatically puts an SSI recipient in Section 1619(a) status when their earnings are greater than the SGA amount but less than the break-even point (BEP). The SSI check does not show that they are in Section 1619(a) status. The only change will be a reduction in the amount of their SSI check.

The SSA puts an SSI recipient in Section 1619(b) status when their earnings are greater than the BEP but less than the state threshold amount.

The recipient should receive a notice from the SSA, and their SSI checks will stop. The notice should include the term "1619(b)" and state that the individual will still get Medicaid even though their SSI checks have stopped.

When the SSA notifies DCH of an individual's 1619(b) eligibility, Medicaid continues automatically through the DCH system. It is not necessary for DFCS to take any action when SSA has placed the person in 1619(b) status and DCH has been notified by the SSA.

LA-D Individuals

Verify the A/R's status under Section 1619 by requesting verification from SSA for any A/R who was employed the month prior to entering a NH or CCSP.

Do not include any of the SSI income in the patient liability budget. Treat all other income under the usual rules for determining patient liability.

Authorize the vendor payment to the NH. Refer to Section 2576, Vendor Payment Authorization.

2580 SSI Recipients Temporarily in a Nursing Home

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	SSI Recipients Temporarily in a Nursing Home		
	Effective Date:	February 2020		
	Chapter:	2575	**Policy Number:**	2580
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-58

Requirements

Section 9115 of the Omnibus Budget Reconciliation Act amended the Social Security Act to entitle certain SSI individuals to retain their income for the month of admission to a nursing home (NH) and the following three full months.

Basic Considerations

The SSI recipient must provide SSA with physician certification that the NH confinement should last no more than 90 days. S/he must also show a need to pay outside expenses to maintain their private living arrangements until s/he returns home.

The NH and SSI recipients are responsible for providing the physician certification and documentation of living expenses to the Social Security Administration (SSA).

The SSI recipient's income is not considered in determining patient liability for the month of admission and the following three full months in the NH.

Procedures

Treat all SSI recipients entering a NH according to standard policy UNLESS written documentation from SSA identifies the individual as temporarily in an institution (LA-D).

Follow the steps below to authorize a NH vendor payment if documentation is provided in writing by SSA to verify that the SSI recipient is temporarily in the NH.

Step 1 Authorize the vendor payment to the NH. There is no patient liability for the month of admission and the following three months. Refer to 2576 Vendor Payment Authorization.

Step 2 Generate an alert to review the case toward the end of the third full month of the SSI recipient's NH confinement.

Step 3 If the individual remains in the NH in the fourth month after the month of admission, determine patient liability according to regular policy and procedures.

2581 Swing Beds

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Swing Beds		
	Effective Date:	February 2020		
	Chapter:	2575	**Policy Number:**	2581
	Previous Policy Number(s):	MT 21	**Updated or Reviewed in MT:**	MT-58

Requirements

Designated small rural hospitals are allowed to assign certain hospital beds as nursing facility beds, called swing beds.

Basic Considerations

Hospitals approved as swing bed providers must have a provider number.

The swing bed hospital is required to obtain a level of care (LOC) approval on an approved LOC instrument (may or may not be a DMA-6) from GMCF.

Procedures

Follow the steps below to authorize a vendor payment for an individual placed in a swing bed:

Step 1 If the individual is receiving Medicaid when s/he is placed in the swing bed, proceed to Step 2.

If the individual is not receiving Medicaid when s/he is placed in the swing bed, determine his/her Medicaid eligibility under the Nursing Home or ABD Medically Needy classes of assistance (COA).

> If Medicaid eligibility is determined under the Nursing Home, add a statement to the system generated approval notice informing the recipient that Medicaid is approved only through the month in which the swing bed/LOC approval expires unless the recipient is moved to an NH.

Step 2 Verify the approval of a level of care with an approved LOC instrument from GMCF upon admission to the swing bed. The LOC instrument may not indicate skilled or intermediate. If not, treat as if skilled care.

Step 3 Provide the applicant with all the same forms that are required for a regular NH applicant, including the Estate Recovery Form 315. Refer to forms section, Appendix F, Forms.

Step 4 Determine the recipient's patient liability for the period of time approved for a LOC.

Step 5 Notify the A/R of the patient liability for each approved month.

Step 6 Authorize the vendor payment using the procedures for authorizing a limited stay. Refer to 2577 Limited Stays.

> The NH must request an extension of the LOC approval with the receipt of a new LOC instrument from GMCF at the following intervals:

- fourteen days following admission to the swing bed
- every 30 days thereafter.

Step 7 The purpose of this special arrangement is to move the client to another appropriate place of care as soon as possible.

If a new communication from GMCF approving an extension of the LOC is received, approve an extension of the LOC. Refer to Chart 2577.1, Extending the Limited Stay. Notify the recipient of any change in patient liability.

If a new communication approving an extension of the LOC is not received by the day the previous approval expires and the A/R's COA is Nursing Home, complete a CMD. Refer to 2052 Continuing Medicaid Determination.

2582 Temporary Absence from Nursing Home

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Temporary Absence from Nursing Home		
	Effective Date:	February 2020		
	Chapter:	2575	**Policy Number:**	2582
	Previous Policy Number(s):	MT 7	**Updated or Reviewed in MT:**	MT-58

Requirements

DMA will continue to make a vendor payment for a limited time on an individual residing away from the nursing home (NH) due to hospitalization or a home visit.

Basic Considerations

DMA will continue to make a vendor payment for the actual number of days a bed is held for a recipient while hospitalized, up to a maximum of seven days per hospitalization.

Arrangements can be made between the NH and the recipient to hold the bed longer than seven days.

DMA will continue to make a vendor payment when a recipient visits away from the NH for a specified number of days.

The following chart specifies the number of days DMA will continue the vendor payment to the NH during a home visit or hospitalization.

Chart 2582.1 – Temporary Absence from NH for a Home Visit

IF the recipient is	THEN the Vendor Payment will continue for
A nursing home resident,	a maximum number of 8 days per calendar year.
a potential Alternative Health Services candidate under CCSP	up to 7 days for a trial visit in a Personal Care Home for a maximum of 2 visits per year.
in the hospital	up to 7 days

A day is defined as an overnight stay away from the NH. A DFCS County Department that becomes aware that a facility is consistently disregarding the guidelines concerning absence should contact the state Medicaid Unit through their supervisor.

Procedures

Medicaid will pay the NH for up to 7 hospital bed hold days when an A/R goes into the hospital and is expected to return to the nursing home.

When a recipient remains in the hospital for more than 7 days, assume that the NH has made arrangements with the recipient or family to hold the bed beyond 7 days.

It is not necessary for the nursing home to send a discharge DMA-59 to DFCS if the A/R is discharged to the hospital and readmitted to the same nursing home, even if the hospital stay exceeds seven days.

2600 Family Medicaid Assistance Units and Budget Groups

2610 MAGI Budget Groups / Assistance Units

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	MAGI Budget Groups / Assistance Units		
	Effective Date:	September 2024		
	Chapter:	2600	**Policy Number:**	2610
	Previous Policy Number(s):	MT 71	**Updated or Reviewed in MT:**	MT-73

Requirements

The MAGI Assistance Unit (AU) includes individuals for whom health coverage is requested and for whom Medical Assistance coverage is available.

The MAGI Budget Group (BG) consists of tax filers and their tax dependents, or non-tax filers in their home and their spouses, children under the age of 19 (natural, biological, adopted or step), and for children under the age of 19, natural, biological, adopted and stepparents, and natural, biological, adopted and step siblings under the age of 19. The BG also includes any unborn child of an individual included in the BG who is pregnant. The Family Medicaid Non-MAGI Budget group (BG) consists of specified relative relations. Refer to Section 2620 - Non-MAGI Budget Groups/Assistance Units.

Basic Considerations

Certain individuals living/not living in the home are included in the eligibility determination for the MAGI AU members. These individuals as well as all the MAGI AU members comprise the MAGI Budget Group (BG).

In all Classes of Assistance (COAs), only the AU members receive Medical Assistance upon approval of the application.

Budget Group Composition (Tax Filers)

The BG for tax filers consists of the following individuals:

- the tax filer
- all persons whom the tax filer expects to claim as a tax dependent, who does not expect to be claimed as a tax dependent by another tax filer.
- his/her spouse living in the home even if not filing jointly
- any unborn child of an individual included in the BG who is pregnant.

Budget Group Composition (Non-Tax Filers)

The budget group for non-tax filers consists of the following individuals that live in the home:

- the individual

- the individual's spouse
- the individual's biological/natural, adopted and stepchild(ren) under the age of 19
- for any child under the age of 19, include that child's biological/natural, adopted and stepparents and biological/natural, adopted, half and step sibling(s) under the age of 19.
- any unborn child of an individual included in the BG who is pregnant.

The BG size determines the net taxable income limit(s) for a MAGI Family Medical Assistance COA. The taxable incomes of all individuals that would be required to file a tax return regardless of if they actually file a tax return or not, in the BG are used to determine eligibility.

MAGI Medical Assistance does not include taxable income of a child in the BG when the total taxable amount is below the allowable IRS dependent exemption amount regardless of if the child is required to file a tax return and/or if they do file a tax return. The dependent exemption amount is established by IRS yearly and is set each January for the previous tax year. The dependent exemption will be used for the current MAGI Medical Assistance year.

The threshold for not being required to file a tax return is $6100 for earned income and $1000 for unearned income for tax year 2013.

For tax year 2014, the threshold is $6200 for earned income and $1000 for unearned income.

For tax year 2015, the threshold is $6300 for earned income and $1050 for unearned income.

For tax year 2016, the threshold is $6300 for earned income and $1050 for unearned income.

For tax year 2017, the threshold is $6350 for earned income and $1050 for unearned income.

For tax year 2018, the threshold is $12,000 for earned income and $1050 for unearned income.

For tax year 2019, the threshold is $12,200 for earned income and $1100 for unearned income.

For tax year 2020, the threshold is $12,400 for earned income and $1100 for unearned income.

For tax year 2021, the threshold is $12,550 for earned income and $1100 for unearned income.

For tax year 2022, the threshold is $12,950 for earned income and $1150 for unearned income.

For tax year 2023, the threshold is $13,850 for earned income and $1250 for unearned income.

RSDI income for the tax dependent/child does not count toward the unearned income threshold. Refer to Secton 2499 - Treatment of Income in Medical Assistance.

Filing a tax return and filing for a tax refund are not the same.

If a pregnant woman requests or receives Medicaid, the unborn child is included in the BG for the case, regardless of COA.

The BG size is increased accordingly, in Presumptive Eligibility (PE) Pregnancy Medicaid and Pregnant Woman Medicaid per her statement only, no medical verification is requested.

The BG size, for all other Modified Adjusted Gross Income (MAGI) Medical Assistance Class of Assis-

tance (COA), is increased accordingly if the pregnant woman is carrying more than one fetus per client statement.

Do not refer to the Department of Public Health (DPH) for medical verification. DPH is not medically equipped to medically verify the expected births.

Procedures

A portion of the resources of the sponsor of a sponsored alien is used to determine eligibility.

Step 1 Determine if the individual is a tax filer

Step 2 If individual is a tax filer, include the following people in the BG:

- the tax filer
- all persons whom the tax filer expects to claim as a tax dependent
- his/her spouse living in the home even if not filing jointly
- any unborn child of an individual included in the BG who is pregnant

Please review the exceptions to the tax filing rules in Section 2245 - Living With A Specified Relative when determining BG composition.

Step 3 If individual is not a tax filer, the BG must include the following that live in the home:

- the individual
- the individual's spouse
- the individual's natural, biological, adopted and stepchild(ren) under the age of 19
- for any child under the age of 19, include that child's natural, biological, adopted and stepparents and natural, adopted, half and step-sibling(s) under the age of 19.
- any unborn child of an individual included in the BG who is pregnant

SSI recipients must be included in the budget group for MAGI COAs, but the income of the SSI recipient is not counted in the budget. For Non-MAGI Medicaid SSI recipients and SSI are not counted in the BG.

Step 4 Exclude the following individuals from the Medical Assistance AU, but include them in the MAGI and Non-MAGI Medical Assistance BG:

- an adult who fails to cooperate with the Division of Child Support Services (DCSS) or Third-Party Liability (TPL) requirements

  A child is never excluded from the AU because of an adult's failure to cooperate with DCSS or TPL.

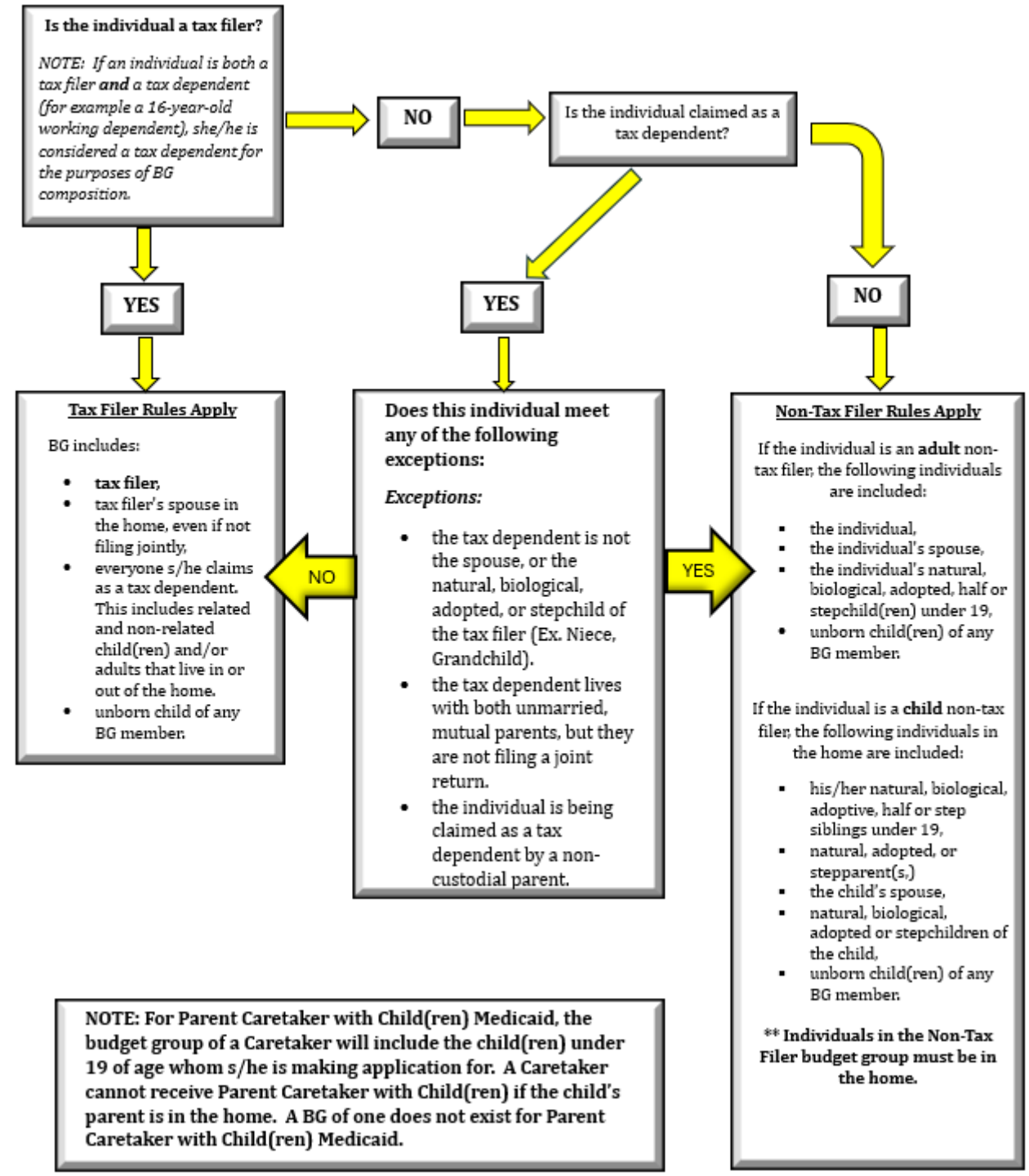
- an individual who does not meet the citizenship or eligible qualified immigrant status requirements (including those with an expired Reasonable Opportunity Period)

  An individual who is not a citizen or a qualified immigrant is **not** required to meet the citizen/immigration status requirement and is potentially eligible for Emergency Medical Assistance (EMA). Refer to Section 2054 - Emergency Medical Assistance.

- an adult who fails to cooperate with the enumeration requirement for him/herself.

  An individual who is not a citizen or a qualified immigrant is **not** required to meet the enumeration requirement and is potentially eligible for Emergency Medical Assistance (EMA). Refer to Section 2054 - Emergency Medical Assistance.

Chart 2610.1 - Determining the AU for Each Applicant or Beneficiary



Use the following chart to determine composition of the MAGI AU and BG:

The term **child** used in this chart includes only those under the age of 19. The terms **parent(s), child(ren) and sibling(s)** used in this chart includes biological, natural, adopted, half or step. The term caretaker used in this chart is limited to a specified relative relationship. Caretakers are adults that are related to the child (blood, adoption, or marriage), care for the child in their home and are not a parent of that child regardless of if they expect/not expect to claim the child on their tax return. The spouse of a Caretaker may also be eligible for MAGI Medical Assistance and should be included in the BG. However, if a Parent is in the home, the non-Parent adult will not be included in the AU but if they are a tax dependent may be included in the BG.

Special Circumstance: If the Tax Filer and Spouse living outside the home are filing jointly, then the spouse living outside the home would not be included in the BG of the tax filer or the tax dependent.

CHART 2610.2 - DETERMINING THE COMPOSITION OF A MAGI AU AND/OR BG

SITUATION	TREATMENT
Adult (Parent, spouse, or caretaker) is absent from the home because of treatment or training.	Include the adult in the AU and/or BG when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the adults to the home AND • the adult continues to exercise care and control of the AU child(ren) Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. Exclude the adult from the AU and/or BG if any of the following conditions exists: • The adult is incarcerated. • The adult is in a public institution. • The adult is legally committed to an institution. For MAGI Medical Assistance if the tax filer expects to claim any of these adults on their return, the adult continues to be counted in the BG but is not allowed in the AU. For Non-MAGI Medicaid these adults will not be included in the BG nor the AU until they return to the home. Refer to Section 2066 - Placement Outside the Home.
Adult (parent, spouse, or Caretaker) is absent from the home because of duty in the uniformed forces of the United States.	Use tax filer or non-tax filer status and include in the BG and AU.

SITUATION	TREATMENT
Child is absent from the home because of treatment or training.	Include the child in the AU when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the child to the home AND • the care and control of the dependent child continues to be the responsibility of the parent or caretaker Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. Refer to Section 2066 - Placement Outside the Home.
Child is placed in a residential dependent care institution, such as GA Baptist Children's Home, United Methodist Children's Home, or GA Sheriffs Boys' ranch.	Consider the child an AU of one and determine the child's Medical Assistance eligibility if the following conditions are met: • the center is privately owned and operated OR • the center is a public facility, and the placement is temporary pending other arrangements appropriate to the child's needs. Refer to Section 2066 - Placement Outside the Home.
Child lives alone.	Consider the child to be an AU of one and determine his/her eligibility for Children Under 19 Years of Age or MN. Continued Medicaid Determination (CMD) to PeachCare for Kids® or Federally Facilitated Marketplace (FFM) when applicable.
Child lives with a Caretaker; everyone applies for health coverage.	Determine if the child and the Caretaker are eligible for Parent/Caretaker with Child(ren) Medicaid. Exclude the Caretaker from the AU and BG if not eligible for Parent/Caretaker with Child(ren) Medicaid. Consider the child to be an AU of one and determine their eligibility for Children Under 19 Years of Age or MN. Continued Medicaid Determination (CMD) to PeachCare for Kids® or Federally Facilitated Marketplace (FFM) when applicable.

Verification

Accept the A/R's statement to determine the MAGI AU and BG composition unless the information provided conflicts with other information available to the agency or is otherwise questionable. A conflicting or questionable situation must be verified and documented.

Documentation

- name and his/her relationship to the MAGI AU members
- tax filer or non-tax filer status

2620 Non-MAGI Budget Groups / Assistance Units

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Non-MAGI Budget Groups / Assistance Units		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2620
	Previous Policy Number(s):	MT 36	**Updated or Reviewed in MT:**	MT-60

Requirements

The Non-MAGI Family Medicaid Assistance Unit (AU) includes individuals for whom Medicaid is requested and for whom Medicaid coverage is available.

The Non-MAGI Family Medicaid Budget Group (BG) includes all AU members, household members who are financially responsible for the AU members, and other household members who are eligible to be included in the BG.

Basic Considerations

Certain individuals living in the home are included in the eligibility determination for the AU members. These individuals as well as all the AU members comprise the Budget Group (BG).

In all Medicaid Classes of Assistances (COAs), only the AU members receive Medicaid upon approval of the application.

Budget Group Composition

The BG consists of the following individuals:

- all AU members
- parents of BG children living in the home with the AU

> If there is a legal father, refer to Chart 2620.1, Determining the Composition of a Non-LIM AU and/or BG.

- the legal spouse of a pregnant woman living in the home
- ineligible aliens who meet all eligibility requirements except citizenship and enumeration

> An ineligible alien can be part of the AU only under Emergency Medical Assistance (EMA). Refer to 2054 Emergency Medical Assistance.

- others who meet relationship requirements and who choose to be included.

The BG size determines the income limit(s) and, if applicable, the resource limit for a Family Medicaid COA. The incomes of all individuals in the BG are used to determine eligibility. The resources, if applicable to the COA, of all individuals in the BG are used to determine eligibility.

If a pregnant woman requests or receives Medicaid under Pregnant Women Medically Needy (P99) Medicaid, the unborn child(ren) is included in the BG for the P99 case. The unborn child is also included in the BG for a Family Medically Needy (F99) case if the pregnant woman is included.

The BG size is increased accordingly if it is medically verified that the pregnant woman is carrying more than one fetus.

The reputed father of the unborn child living with a pregnant woman is included in the Pregnant Women BG **only** if he and the pregnant woman are married. However, if the couple is not married and have a common child, the father's income will be included in the common child's budget but not the pregnant woman's budget.

Children in the same BG can have Medicaid eligibility determined under any Medicaid COA. The composition of the BG for each child does not change, even if each child's eligibility is determined under a different Medicaid COA.

Four Months Medicaid (4MCS) and TMA do not require the same BG composition. Refer to the appropriate section in Chapter 2100, Classes of Assistance.

An A/R may choose to exclude a child(ren) from a Medicaid AU and/or BG. An excluded child may be included in another Medicaid AU/BG of the same or different COA.

The parent(s)' income cannot be allocated to meet the needs of an excluded child.

A child receiving Medicaid under Newborn coverage may or may not be included in another Medicaid BG, at the option of the A/R.

Procedures

Follow the steps below to determine the composition of the Medicaid AU and BG:

Step 1 Determine the person(s) for whom Medicaid is requested.

Step 2 Include in the AU only those individuals in Step 1 for whom Medicaid coverage is available under any Medicaid COA. Refer to Chapter 2100, Classes of Assistance.

Step 3 Include in the BG the following individuals living in the home:

- the parents of any existing children in the AU/BG for whom paternity has been established

  Refer to 2640 Paternity if a legal father exists and the biological father is in the home.

- the legal spouse of a pregnant AU member.

Step 4 Determine if there are others who may be included, at the A/R's option in the AU and/or BG, such as the following:

- siblings or half-siblings
- other children living in the home who are within the degree of relationship to an adult in the BG
- one non-parent adult relative who is a caretaker (aunt, uncle, grandparent, etc.) if there is no parent in the home.

If the sibling/half-sibling(s) or other children meet all eligibility requirements for the COA, include the child(ren) in the BG, at the A/R's option.

If the inclusion of a child(ren) in the AU and/or BG causes financial ineligibility for another child(ren), consider the children in separate AUs. The separate AUs may be the same or different COAs. Repeat Procedure Steps for each AU/BG.

Step 5 If the sibling/half-sibling or other children do not meet all eligibility requirements for the COA, include the child(ren) in the BG at the A/R's option, to increase the income limit.

Children over the age limit for the COA cannot be included in the BG.

Include in the BG the parents of any children added to the AU/BG in Step 4. Include only parents living in the home with their children.

Exclude the following individuals from the AU and BG:

- SSI recipients
- the father of an unborn child unless he is married to the pregnant woman.

The father of an unborn child **must** be included in the BG of a pregnant woman if they are married.

- a stepparent, unless s/he is the parent of biological or adopted children in the BG
- an individual who fails to apply for other benefits for which s/he may be entitled as follows.
  - If the potential benefit is for a parent, exclude the parent and everyone for whom s/he is financially responsible
  - If the potential benefit is for a child, exclude the child only The child may be included in the BG at the A/R's option.
- a minor sibling/half-sibling who is voluntarily excluded by the A/R from another AU and/or BG to avoid consideration of the child's income and/or resources.

Step 6 Exclude the following individuals from the Medicaid AU, but **include** them in the Medicaid BG:

- an adult who fails to cooperate with CSS or TPR requirements

  A child is **never** excluded from the AU because of an adult's failure to cooperate with CSS or TPR.

- an individual who does not meet the citizenship or eligible alien status requirements

  EMA

- an adult who fails to cooperate with the enumeration requirement for him/herself.

  An individual who is not a citizen or an eligible alien is not required to meet the enumeration requirement.

Use the following chart to determine composition of the AU and BG:

The terms **minor** and **child** used in this chart include 18-year olds who are eligible for Medicaid.

Chart 2620.1 - Determining the Composition of a Non-MAGI AU and/or BG

SITUATION	TREATMENT
Adult is absent from the home because of treatment or training.	**Include** the adult in the AU and/or BG when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the adults to the home AND • the adult continues to exercise care and control of the AU child(ren) AND • the adult wants to be included in the AU and BG during the absence and is eligible to be included. Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. **Exclude** the adult from the AU and/or BG if any of the following conditions exists: • The adult is incarcerated. • The adult is in a public institution. • The adult is legally committed to an institution. Refer to 2066 Placement Outside The Home.
Adult (parent, spouse or grantee relative) is absent from the home because of duty in the uniformed forces of the United States.	Exclude from the BG and AU. Budget any income sent to the Medicaid BG from the parent as child support if there are existing children or as a contribution if the money is sent to a pregnant woman from the reputed father of an unborn child.
Biological parent lives in the home with the child who has been adopted AND the adoptive parent(s) is in the home.	Include the biological parent as a sibling of the adoptive child only if both of the following conditions exist: • the biological parent is also the child (adoptive or natural) of the adoptive parent(s) AND • the biological parent meets the age requirement In this situation, adoption terminates the parental relationship.
Biological parent lives in the home with the child who has been adopted AND the adoptive parent(s) is **not** in the home.	Include the biological parent as the grantee relative if s/he is eligible and chooses to be included. In this situation, adoption terminates the parental relationship.

SITUATION	TREATMENT
Biological parent whose parental rights have been terminated lives in the home with the child and a specified relative of the child.	Include either the biological parent or the specified relative as the caretaker relative. Termination of parental rights serves as the legal requirement to be included as a parent; therefore, the specified relative or the biological parent can choose to be included in the AU. If the home is shared with an individual who is not within the specified degree of relationship to the child, then only the biological parent may be included as the caretaker relative.
Both parents live in the home with a mutual child.	Include both parents in the AU and/or BG.
Child is absent from the home because of treatment or training.	Include the child in the AU when all of the following conditions exist: • the absence is temporary, with a plan for treatment or training to return the child to the home AND • the care and control of the dependent child continues to be the responsibility of the caretaker relative AND • the caretaker or other eligible adult wants the child to be included in the AU. Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing homes, and Job Corps facilities. This list is not all-inclusive. Refer to 2066 Placement Outside The Home.
Child is placed in a residential dependent care institution, such as GA Baptist Children's Home, United Methodist Children's Home or GA Sheriffs Boys' ranch.	Consider the child an AU of one and determine the child's Medicaid eligibility if the following conditions are met: • the center is privately owned and operated OR • the center is a public facility and the placement is temporary pending other arrangements appropriate to the child's needs. Refer to 2066 Placement Outside The Home.
Child lives alone.	Consider the child to be an AU of one and determine his/her eligibility for Child(ren) under 19, PCK or MN.
Child lives with a legal guardian who is not within the degree of relationship.	Determine Medicaid eligibility for the child under the appropriate COA. Exclude the legal guardian from the AU and BG.

SITUATION	TREATMENT
Child lives with an individual who has legal custody only (not a legal guardian and not within the degree of relationship).	Determine Medicaid eligibility for the child under the appropriate COA. Exclude the individual with legal custody from the AU and BG.
Parent(s) is required to be in multiple BGs.	Include the parent(s) in each BG. **Example:** A parent has a 5-year-old and a 14-year- old. The 5-year-old and 14-year-old must be in separate Child(ren) under 19 AUs in order to be eligible. The parents **must** be included in both BGs.
Married couple has no mutual child(ren), but they each have a child.	Determine the option that is most advantageous to the family. Combine into one AU or make separate AUs.
Minor parent lives in the home with his/her parent(s).	Minor parent needs Medicaid: include the minor parent as a child with his/her parents in the BG and/or AU. The AU may choose to include or exclude the minor's child. Minor parent's child needs Medicaid: Include the minor parent in the BG and/or AU as an adult if the minor parent's parent does not receive LIM for his/her siblings **and** his/her parent(s) chooses not to be included in the BG. Refer to 2661 Responsibility Budgeting (Family Medicaid) unless the COA is MAGI.
Married minor lives with his/her parent(s) and applies for Medicaid as a child.	Include the married minor in the BG as a child with his/her parents. If s/he has a spouse also living in the home, refer to 2650 Family Medicaid Budgeting Overview.
Married minor lives with his/her spouse and applies for Medicaid as a child.	Married minor is an AU of one because s/he is considered a child but the spouse is financially responsible. If the spouse is also a minor, there can be separate AUs. Refer to 2661 Responsibility Budgeting (Family Medicaid) to determine what income from the spouse is deemed to the AU or the allocation is appropriate.

SITUATION	TREATMENT
Parent is in and out of the home.	**Include** a parent who appears to reside in the home based on any of the following indicators: • The parent has no other residence. • The parent lists the home as his/her address. • The parent shares in household expenses. **Exclude** a parent who appears to visit the home based on any of the following: • The parent does not share in household expenses. • The parent has a specific time frame for his/her visits. • The parent maintains another residence. Thoroughly document the case record to substantiate the inclusion or exclusion of the parent.
Parent(s) lives in the home with the child(ren) and a specified relative who has legal custody of the child(ren). Parental rights have not been terminated.	Include the parent(s) in the BG.
Pregnant minor (no existing children) lives with her parent(s) and applies for MN as a pregnant woman.	Include the parent(s) in the BG. Include the pregnant minor's parent(s) or siblings in the BG. Increase the BG accordingly if there are multiple fetuses.
Pregnant woman lives with the biological father of the unborn child and applies for MN as a pregnant woman.	If married, include both the A/R and spouse in the BG. If not married, do not include the alleged biological father unless he and the applicant have mutual children who are included in the BG. Budget as a contribution any money he gives the pregnant woman if they are not married and have no mutual children.
The biological father of an existing child(ren) lives in the home and there is also a legal father for the child.	Exclude the biological father from the BG and/or AU unless he signs an Affidavit of Paternity, or paternity is established through judicial proceedings or CSE. Refer to 2640 Paternity.
Specified relative other than a parent functions as grantee-relative because there is no parent in the home.	Consider including the specified relative in the BG and/or AU if s/he is within the proper degree of relationship. Refer to 2661 Responsibility Budgeting (Family Medicaid).
Specified relative other than a parent functions as grantee relative because the parent in the home receives SSI.	Consider including the specified relative in the BG and/or AU.
Stepparent lives in the home.	Exclude the stepparent from the AU and BG unless s/he has a child(ren) of his/her own in the BG. Refer to 2661 Responsibility Budgeting (Family Medicaid) unless the COA is MAGI.

Verification

Accept the A/R's statement to determine the AU and BG composition unless the information provided conflicts with other information available to the agency or is otherwise questionable. A con-

flicting or questionable situation must be verified and documented.

Documentation

Document the following for every individual in the home:

- name and his/her relationship to the AU members
- reason the individual is included or not included in the AU and/or BG.

2640 Paternity

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Paternity		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2640
	Previous Policy Number(s):	MT 21	**Updated or Reviewed in MT:**	MT-60

Requirements

The paternity of a dependent child included in a Family Medicaid AU must be established in order to determine relationship, to determine financial responsibility, to determine whether child support is being received from a non-custodial parent and to appropriately make Child Support Services (CSS) referrals.

Basic Considerations

Paternity is established for each child at application and when a child is added to an AU. Paternity is reestablished if a change occurs as a result of one of the following:

- the mother names someone else as the father
- CSS determines the man who is named as the father is not the biological father
- a judicial determination alters paternity, e.g., adoption.

The following chart lists situations and the procedures to follow to establish paternity.

CHART 2640.1 - ESTABLISHING PATERNITY

SITUATION	TREATMENT
Mother is unmarried at the time of the child's birth.	Accept the person she names to be the child's father.
Mother is married at the time of the child's birth.	The spouse is the legal father.

SITUATION	TREATMENT
Mother is married at the time of the child's birth and states a man other than her husband is the biological father.	The husband is the legal father unless one of the following occurs: • the reputed father legitimates the child OR • the child's paternity is determined by a judicial proceeding OR • the reputed father, living in the home with the child, signs Form 185, Affidavit of Paternity OR • an affidavit of paternity is returned by CSS.
Mother is unavailable, e.g., deceased or whereabouts unknown, and an application is filed by a non-parent.	Establish paternity by one of the following: • the child's birth certificate • the reputed father's written statement acknowledging paternity • a document showing that the reputed parent has legitimated the child • written evidence that paternity has been proven in a judicial proceeding • the subsequent marriage of the reputed father to the mother and his acknowledgement that he is the father of the child • prior case record documentation of the mother's statement of paternity • SSA records showing that the child receives benefits from the reputed father's account • records of an employer showing that the child is a dependent of the reputed father for tax or insurance purposes • court records showing that the mother has, under oath, asserted the father's identity. This would not apply when the court has determined the man not to be the father.
CSS provides paternity test results that show the alleged father is not the father of the child AND the mother insists there is no other man who could be the father AND there is no other evidence to the contrary.	Notify CSS that a penalty will not be imposed.

SITUATION	TREATMENT
CSS provides paternity test results that show the alleged father is not the father of the child AND the mother refuses to name another man as the father AND there is supporting evidence to the contrary.	Penalize the Medicaid AU member who failed to cooperate. Refer to 2657 Penalized Individuals.

2650 Family Medicaid Budgeting

2650 Family Medicaid Budgeting Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Budgeting Overview		
	Effective Date:	July 2023		
	Chapter:	2650	**Policy Number:**	2650
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-70

Requirements

All Family Medicaid Assistance Units (AUs) or Budget Groups (BGs) must have income considered in determining financial eligibility through the budgeting process.

Basic Considerations

In Parent/Caretaker with Children, AU and BG are synonymous terms, referring to those individuals both whose income and expenses are considered in determining eligibility and who receive Medicaid assistance.

Non-AU member refers to those whose incomes are considered in responsibility budgeting (deeming/allocating). Non-AU members include the following:

- an ineligible parent enumeration
- a stepparent in which there is no mutual child included I the AU
- a minor caretaker's parent
- a married minor's spouse
- a non-parent caretaker's spouse

This is for non-MAGI COAs only.

In Children Under 19 Years of Age Medicaid, BG refers to those whose income and expenses are considered in determining eligibility. AU refers to those who receive Medicaid assistance.

The budgeting process includes the following

- the prospective budgeting method used to determine the AU's or BG's monthly income and expenses
- the allowable deductions based on certain monthly expenses
- the budgeting procedure used to calculate eligibility using month income and expenses

Prospective Budgeting

Prospective budgeting uses a best estimate of income and expenses based on representative amounts to determine the AU's eligibility. The prospective income and expenses are either esti-

mated using a conversion factor or actual income and expenses are used, depending on the case situation. Prospective income and expenses are used to budget ongoing eligibility.

Actual Budgeting

Actual income and expenses are used to budget prior months eligibility and, if available, used to budget intervening months. Refer to 2053 Retroactive Medicaid.

Actual income must be verified for all Family Medicaid COAs except Pregnant Woman and Newborn.

Deductions

Certain deductions are allowed when determining the AU's eligibility. Family Medicaid Classes of Assistance (COAs) allow deductions to both earned and unearned total income as follows for all non-MAGI COAs:

- the first $50 of child support received each month
- earned income deductions as follows:
  - $90 standard work expense deduction
  - **$30 (obsolete after 1/1/14)**
  - 1/3 of the remaining earned income **(obsolete after 1/1/14)**
  - dependent care expenses

Deductions are applied to the AU's Modified Adjusted Gross Income (MAGI) for MAGI COAs. These deductions are as follows:

- Cost of doing business for self-employed/farming/fishing individuals
- Before-Tax Deductions
- 1040 Deductions
- 5 % of the 100% Federal Poverty Level Deduction

Family Medicaid Income Limits

Family Medicaid requires that the AU/BG have income within the following limits:

- Parent/Caretaker with Children and COAs based on Parent/Caretaker with Children:
  - GIC: the gross countable income of the AU must be less than or equal to the Gross Income Ceiling (GIC) for the AU size.
- Children Under Age 19 Medicaid income limits are based on percentages of the federal poverty level (FPL) as follows:
  - 205% of the FPL for children, birth through the month the child reaches age one for children who are ineligible for Newborn Medicaid
  - 149% of the FPL for children age one through the month in which the child turns six
  - 133% of the FPL for children age six through the month in which the child turns age 19.

- Pregnant Women Medicaid and infants born to Medicaid-eligible mothers are based on 220% of the FPL

> Infants born to Medicaid-eligible mothers are considered to have met the Newborn Medicaid income limit, regardless of the budget group's income at the time of delivery

- Pathways is based on 95% of the FPL.
- Family Medicaid Medically Need Income Limits (FM-MNIL) are based on a percentage of the SON.

The appropriate income limit for a specific COA is used in the following budgeting situations:

- to determine the AU's eligibility based on net income
- to determine the financial responsibility or financial need of an individual who is not eligible to be included in the BG.

Earnings of a Child

The earnings of a child are excluded in non-MAGI Family Medicaid COAs, whether or not the child is a student, and for MAGI COAs if the child is not required to file a tax return.

> The exclusion of earned income does not apply to the earnings of a minor applying as the caretaker and to the earnings of a minor applying as a Pregnant Woman.

Procedures

Use the following rounding procedures when calculating budgets:

Calculate gross monthly income leaving all amounts in dollars and cents. Drop any digits past the hundredth position (second digit to the right of the decimal).

Calculate net monthly income as follows:

- allow all applicable deductions
- leave amounts remaining in dollars and cents after each deduction
- round the net monthly income to the nearest dollar. Round up if 50 cents or more. Round down if less than 50 cents.

Documentation

Document the following for all budgets:

- the amount of all gross income and expenses used in the budget, including the dates income is received and expenses are incurred and the source of verification
- the gross amounts used to calculate the representative income/expenses
- the reason(s) any non-representative amount(s) are not used in calculations.

2653 Prospective Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Prospective Budgeting		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2653
	Previous Policy Number(s):	MT 40	**Updated or Reviewed in MT:**	MT-60

Requirements

Prospective budgeting uses a representative amount of income received and dependent care expenses incurred to determine the Family Medicaid Assistance Unit's (AU's) or Budget Group's (BG's) eligibility and benefit amount.

Basic Considerations

Representative income is the amount that best represents what the AU or BG will receive on an ongoing basis.

Representative dependent care expenses are the amounts that best represent what the AU or BG will incur on an ongoing basis.

Representative Income and Expenses

When the amount of the income or dependent care expense is stable (i.e., does not change from one period to the next), the stable amount is the representative amount.

When income or dependent care expenses vary, representative income and dependent care expenses are calculated as follows:

- the representative income or expense is based on available information and/or verification from the AU
- the representative income or expense may be an average of the last month's income or expense, or it may be for a specific period determined to be the most representative of the situation. In certain instances, more or less than one month income or expense is used if one month income is not representative
- periods with little or no income received or expenses incurred are disregarded when determining representative amounts unless they are determined to be representative.

Monthly income and dependent care expenses are determined by multiplying the representative amounts by the following conversion factors:

Frequency	Conversion Factor
weekly	4.3333
bi-weekly	2.1666

Frequency	Conversion Factor
semi-monthly	2
monthly	1

Representative income and dependent care expenses are calculated at the following times:

- at the initial eligibility determination
- at periodic reviews
- when a change of income or dependent care expenses occurs

Verification

The best estimate of income used in determining an AU's benefit amount is based on verification of at least one full month's stable income or four current consecutive weeks for fluctuating income. In some instances, more than one month's income and expenses is not representative of the AU's ongoing situation. Refer to Chart 2653.1, Minimum Verification Requirements.

If the AU does not have the minimum number of pay stubs for income verification because some are missing, use the year-to-date figures if these are displayed on the other pay stubs. In order to use year-to-date figures, the AU must provide the paycheck stubs for the pay periods immediately prior to and immediately after the missing check stub.

If, because of a new source of income, the AU cannot comply with the minimum verification requirements specified above, obtain verification of all income received from the first receipt of the income to the present.

Refer to 2051 Verification for policy pertaining to acceptable verification sources.

Procedures

Follow the steps below to determine the AU's representative monthly income and dependent care expenses:

Step 1

Determine the following:

- the source and type of income or dependent care expense
- the amount of income or dependent care expense and the frequency with which the income is received or the expense is incurred

Verify all income of the BG from the source. Refer to 2051 Verification.

Accept the A/R's statement of dependent care expense unless questionable. Verification of this expense is not required.

Step 2

Calculate the representative income and/or dependent care expense.

Step 3

Convert the representative amount from Step 2 to determine the AU's monthly gross income or dependent care expense.

Document the following:

- the type and source of income and/or dependent care expenses
- verification source
- the frequency and amount of income and/or dependent care expenses used in determining the representative amount(s)
- the reason for determining that income and/or expenses are not representative, if applicable
- calculation of the representative amount of income and/or dependent care expenses, including conversion calculation.

CHART 2653.1 MINIMUM VERIFICATION REQUIREMENTS

FREQUENCY OF PAY OR EXPENSE	MINIMUM VERIFICATION REQUIRED
Weekly, bi-weekly, or semi-monthly (stable or fluctuating income or expenses)	One month or 4 current consecutive weeks of income or expenses
Monthly	2 months of income or expenses
Irregular	3 months of income or expenses

Use the following chart to calculate monthly income.

CHART 2653.2 - HOW TO DETERMINE MONTHLY INCOME/EXPENSES

IF	THEN
the income is either stable or fluctuating and is received more often than monthly OR the expenses are either stable or fluctuating and incurred more often than monthly	determine a representative amount of income received and/or expenses incurred by computing past, present and/or anticipated income and/or expense amounts that represent regular payments received and/or expenses incurred. Convert to a monthly amount by using the appropriate conversion factor. Document the case record. Explain what income and expenses were used, and why.

IF	THEN
the income is received monthly or less often than monthly OR the expenses are incurred monthly or less often than monthly	do not automatically convert the income or expense. Determine the best estimate based on the following criteria: • If stable, budget the actual income received or expense incurred in the month preceding the application or review month. • If fluctuating, average the income received or expense incurred in the months immediately preceding the application or review month. • In some instances, use more or less than two months of income and/or expenses if the income received or expense incurred in the two months immediately preceding the application or review month is not representative of the ongoing situation. • Convert to a monthly amount when income received or expenses incurred by an AU is intended to cover a specified period of time. To obtain a monthly amount, divide the total income to be received or the total expenses to be incurred during the life of the contract or agreement by the number of months over which the contract or agreement extends. Document the case record. Explain what income and/or expenses were used, and why.
the AU will receive income or will incur expenses, or has received income or has incurred expenses, with no change in the rate at which income has been/will be received or at which expenses have been/will be incurred	determine the representative income. Convert to a monthly amount using the appropriate conversion factors.
the AU will receive income or will incur expenses, or has received income or has incurred expenses, and the rate at which income will be received or at which expenses will be incurred has changed	do not convert. Use the actual and/or representative income/expenses. Use the actual income/expenses for dates that have already occurred AND representative income/expenses for future dates in the month.
the AU will receive less than a full month's income, will incur less than a full month's expense, has received less than a full month's income or incurred less than a full month's expenses because of new, interrupted, or terminated income and/or expenses	do not convert. Use the actual and/or representative income/expense. Use the actual income/expense for dates that have already occurred AND the representative income/expense for future dates in that month.
Child support income is received through the Division of Child Support Services (DCSS)	Determine the monthly amount of income using the last three months of child support income received, if representative. If the AU reports a change after representative income has been determined, use anticipated income to determine the best estimate for future months. Any payments posted within the last two days of the month are considered received in the following month.

If an A/R is receiving income or incurring expenses from more than one source, each source is

treated separately in determining if income/expense is converted to a monthly amount.

A full month's income, if earned, is defined as receipt of or expected receipt of income at each regular pay date during a calendar month.

A full month's income, if unearned, is defined as receipt of or expected receipt of income intended to cover an entire calendar month.

A full month's expense is defined as an expense intended to cover an entire calendar month.

2655 Family Medicaid Deductions

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Deductions		
	Effective Date:	September 2024		
	Chapter:	2650	**Policy Number:**	2655
	Previous Policy Number(s):	MT 57	**Updated or Reviewed in MT:**	MT-73

Requirements

Deductions are applied to the AU's income to determine financial eligibility for Family Medicaid Classes of Assistance (COA). Deductions are applied to the AU's Modified Adjusted Gross Income (MAGI) for MAGI COAs, and to the total household income for Non-MAGI COAs.

Basic Considerations

All Family Medicaid deductions are applied whether income is reported timely or untimely. There is no penalty or loss of deductions for untimely reporting.

Pre-Tax Deductions MAGI Medicaid COAs Only

For each wage earner, there are certain deductions that are taken out of the taxable gross pay and considered pre-tax. These include:

- Health Insurance*
- Dental Insurance*
- Vision Insurance*
- Legal Insurance
- Life Insurance Premiums
- Flexible Spending Accounts
- Deferred Compensation (including retirement plans such as 401(k), 403(b) and 457)

This is not an all-inclusive list. These deductions can usually be found on an A/R's check stub in the before-tax deduction section. These amounts are deducted prior to calculating the MAGI income amount. Not all deductions on taxable income is considered a before-tax deduction.

*Medicare Part A, B, C and D are considered credible health coverage if being paid by the client, not State and should be allowed as a health insurance deduction when calculating budgets that include RSDI income. In addition, if the check stub does NOT specify that Health, Dental, and Vision insurance deductions are pre-tax, allow these deductions in the MAGI financial determination without additional verification.

1040 Deductions MAGI Medicaid COAs Only

For MAGI COAs, deductions that are allowed on the IRS Form 1040 Schedule 1 are allowable deductions. These include the following:

- Self-Employed Health Insurance
- Health Savings Account Contributions
- Student Loan Interest
- Tuition and Fees **(obsolete as of 01/01/2019)**

> Due to the Tax Cuts and Jobs Act of 2017, moving expenses are no longer deducted for tax years 2018 through 2025 except for active-duty service members of the Armed Forces and alimony is no longer considered a deduction or income as of 01/01/2019. Divorces and separations finalized or modified before 01/01/2019, alimony is included as income and can be allowed as a deduction.

Verifications

Pre-tax and 1040 Deductions for MAGI Medicaid COA's must be verified to allow as deduction(s). Pre-tax deductions can be most commonly verified with check stubs but could also be verified with a note from the employer's HR department, especially for new hires. 1040 deductions are verified with 1040 and Schedule 1 to differentiate the specific deductions.

MAGI Income Deductions

For MAGI income, a deduction of 5% of the 100% FPL for the budget group is allowed. This amount is taken off the total Modified Adjusted Gross Income (MAGI limit) for the total budget group. Please refer to Appendix A-2 for the deduction amounts for the budget group size.

Self-Employment

MAGI income deductions are applicable to the earnings of self-employed individuals. Once the countable gross income is determined by deducting the cost of doing business from gross receipts, the MAGI income deductions can be allowed. All IRS allowable deductions should be subtracted from the gross income to calculate the MAGI income. Refer to Section 2415 - Self-Employment.

NON-MAGI COAs

$50 Child Support Deduction

A $50 deduction is applied to any child support income received by the Assistance Unit (AU), whether received through the Division of Child Support Services (DCSS) or directly from the non-custodial parent.

The deduction is applied to the AU's total child support income in all Non-MAGI Family Medicaid COAs.

> Child support and alimony payments made by a BG member cannot be deducted in determining the net countable income of the BG.

Earned Income Deductions

Earned income deductions are applied to the earned income of each employed BG member who is eligible for the deductions.

Potential earned income deductions include the following and are deducted from the gross countable income in the order listed:

- $90 standard work expense for each employed individual
- $30 deduction for each employed individual **(obsolete after 1/1/14)**
- 1/3 of the remaining earned income for each employed individual **(obsolete after 1/1/14)**
- dependent care expenses for each child or incapacitated individual Earned income deductions are applied to the earned income of the following individuals:
  - BG Members
  - penalized individuals

Earned income deductions are applicable to the earnings of self-employed individuals. Once the countable gross income is determined by deducting the cost of doing business from gross receipts, the earned income deductions can be allowed. Refer to Section 2415 - Self-Employment.

Procedures

$50 Child Support Deduction

Use the following procedures to apply the $50 child support deduction.

- Establish the paternity of the child before allowing the deduction. Refer to Section 2640 - Paternity.

> If paternity cannot be established, budget the money paid as a contribution. The $50 CS deduction does not apply.

- Apply the $50 CS deductions prior to the FPL test for PCT and COAs based on PCT.
- Apply only one $50 CS deduction to the total monthly amount of CS received by the BG, regardless of the number of non-custodial parents paying CS.
- Apply the $50 CS deduction to a lump sum CS arrearage payment only in the month the arrearage is received.

$90 Standard Work Expense

Deduct the first $90 of the earnings of each employed individual in the BG, whether employed full or part time.

Dependent Care Deductions

Allowable dependent care deductions include the expenses incurred and paid by an AU or BG member for childcare or for care of an incapacitated individual in the home when the care is necessary because of the employment of an AU or BG member. If there is more than one adult in the AU/BG

and only one adult is employed, the A/R must provide verification of why the unemployed adult is unable to care for the child/ren in order to be eligible for the deduction. Acceptable verification includes a medical statement, proof that adult is attending school, etc. Failure to provide verification will result in the A/R not receiving the deduction. Any portion of dependent care expenses that is paid for or subsidized by another agency or individual is not considered an allowable deduction.

Dependent care deductions are allowed as follows:

- for an individual under two years of age, the lesser of the actual cost or $200 monthly
- for an individual age two or older, the lesser of the actual cost or $175 monthly

A child is considered to be age two the month following the month of the second birthday.

Verification of dependent care expenses is required only if the information provided by the A/R conflicts with information known to the agency or is otherwise questionable.

Document dependent care expenses as follows:

- the employment status which entitles the BG to a dependent care deduction
- the name of the individual(s) for whom dependent care is paid
- the frequency and date/day of week paid
- the name of the person to whom the expense is paid

2657 Penalized Individuals

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Penalized Individuals		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2657
	Previous Policy Number(s):	MT 40	**Updated or Reviewed in MT:**	MT-60

Requirements

An adult who fails to meet certain Family Medicaid program requirements, without Good Cause, is penalized.

Basic Considerations

An adult is penalized for failure to meet, without Good Cause, any of the following Basic Eligibility Requirements:

- enumeration
- cooperation with Division of Child Support Services
- cooperation with Third Party Resources
- verification of citizenship or alienage

The countable income of a penalized individual is considered when determining financial eligibility.

Income of a penalized individual receives all allowable deductions. Do not allocate to a penalized individual.

Countable resources of a penalized individual are considered in their entirety.

A child is **never** penalized, however, the child may be excluded. If an adult fails to comply with the enumeration requirement or citizenship/alienage requirement for a child, exclude the child from the AU. The child may be included or excluded in the BG at the option of the A/R. If an adult fails to comply with application for other benefits for a child, the child(ren) for whom the requirement is not met are excluded from the AU, not penalized. If the potential benefit is for a parent, exclude the parent **and** everyone that s/he is financially responsible for.

A minor caretaker and a minor applying for Medical Assistance due to pregnancy are considered a child.

A child is never penalized or excluded for the adult's failure to cooperate with TPR or Child Support Services for the child.

Penalties are applied to recipients effective the month following the expiration of timely notice.

Penalties are applied to applicants effective the month of refusal.

MAGI

For MAGI COA AUs, if the individual for whom this requirement is not met, without Good Cause, is a child or non-parent relative, exclude the individual and his/her income from the budget.

If the individual for whom this requirement is not met, without Good Cause, is a parent, the parent is penalized. Include the income of the penalized parent in the budget. Include the following individuals in the MAGI AU:

- Spouse
- biological/natural, adopted and step-child(ren) under the age of 19 (including unborn)
- any other eligible child(ren).

Non-MAGI

In Non-MAGI AUs, a penalized individual is an adult who fails to comply with one of the following Basic Eligibility Criteria, without Good Cause:

- failure to cooperate with DCSS

> Cooperation with DCSS is not a requirement for child-only Medical Assistance cases. Also Pregnant Woman receiving Pregnant Women COA is not required to cooperate with DCSS for the unborn or any existing child.

- failure to cooperate with his/her own enumeration requirement (adult AU member only)
- failure to cooperate with TPR requirements
- failure to cooperate with citizenship/alienage verification. (adult AU member only)

A penalized adult remains in the BG, but is not included in the AU. Refer to Chart 2657.1 – Penalties in this Section.

For each penalized individual, determine the amount of income to count in the budgeting process.

MAGI Budgeting Procedures for a Penalized Individual

Follow the steps in 2661 Responsibility Budgeting (Family Medicaid) for budgeting procedures when a parent fails to verify citizenship. Follow the budgeting steps below when a MAGI AU member is penalized for any other reason:

Step 1 Determine all countable earned income of the penalized individual.

Step 2 Add countable unearned income of the penalized adult.

Step 3 Allow all appropriate income deductions:

- Pre-tax deductions
- 1040 deductions
- For self-employed individuals, deduct allowable IRS deductions (Refer to Section 2415)

Step 4 Do not include the penalized individual when selecting the appropriate income limit for the AU.

Non-MAGI Budgeting Procedures for a Penalized Individual

For each penalized individual, determine the amount of income to count in the budgeting process.

Follow the steps below to budget a Non-MAGI penalized individual:

Step 1 Determine all countable earned income of the penalized individual.

Step 2 Allow all appropriate earned income deductions.

- $90 standard work deduction
- $30 earned income deduction, if allowable
- 1/3 of the remaining earned income, if allowable
- Dependent care expenses

Step 3 Add countable unearned income of the penalized adult and allow the $50 child support deduction, if appropriate.

Step 4 Include the penalized individual when selecting the appropriate income (and resource, for FM-MN) limit for the BG. Do not include the penalized individual in the AU.

Use the chart below to determine whom to penalize for failure to comply with certain eligibility requirements.

Chart 2657.1 – Penalties

IF A PENALTY IS IMPOSED FOR:	THEN APPLY THE PENALTY TO:	
	MAGI	Non-MAGI
a parent's failure or refusal to comply with his/her enumeration requirements	The parent. If an adult fails to comply with a child's enumeration requirement, without good cause, exclude the child from the AU.	The parent. If an adult fails to comply with the enumeration requirement for a child, exclude the child from the AU. The child may, however, be included in or excluded from the BG, at the option of the A/R

a parent's failure or refusal to verify his/her citizenship/alienage/id entity status	The parent. If an adult fails to comply with verification of a child's citizenship, alienage, or identity exclude the child from the AU.	The parent. If an adult fails to comply with verification of a child's citizenship, alienage, or identity exclude the child from the AU. The child may be included in or excluded from the BG, at the option of the A/R.
failure to cooperate with DCSS.	The parent. A child is neither penalized nor excluded for an adult's failure to cooperate with DCSS. *A pregnant woman is not required to cooperate with DCSS for the unborn child. Cooperation is also not required for child-only Medical Assistance cases.	No penalties applied. A child is neither penalized nor excluded for an adult's failure to cooperate with DCSS.
failure to cooperate with TPR requirements.	The parent. A woman receiving Pregnant Women Medicaid or PG-MN would be penalized for not cooperating with TPR. A child is neither penalized nor excluded for an adult's failure to cooperate with TPR.	The parent. A child is neither penalized nor excluded for an adult's failure to cooperate with TPR.
failure to cooperate with application for other benefits. Refer to Section 2210 for exceptions to the application for other benefits requirement.	If the benefit is for the parent, the parent and everyone for whom they are financially responsible is excluded from the AU, not penalized. If the benefit is for a child, only the child is excluded from the AU. A pregnant woman who is applying for or receiving Medicaid under Pregnant Women COA is not required to comply with the application for other benefits requirement. A pregnant woman who is applying for or receiving Medicaid under any COA other than Pregnant Women Medicaid and who is in her 2nd or 3rd trimester of pregnancy is not required to apply for UCB.	If the benefit is for the parent, the parent and everyone for whom they are financially responsible is **excluded** from the AU, not penalized. If the benefit is for a child, only the child is excluded from the AU. The child may, however, be included in or excluded from the BG at the option of the A/R.

2659 Contract Employees

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Contract Employees		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2659
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-60

Requirements

Income received from contractual employment is averaged over a 12-month period if the income is not received on an hourly or piecemeal basis.

Basic Considerations

Contractual employment is defined as working for a period of time less than a year.

Contract employees include truckers, certain school employees and others who contract to work on a renewable annual basis.

The contract renewal process may involve one of the following:

- signing a new contract each year
- automatic renewal of a contract
- implied renewal precluding the use of a written contract

Contract employees are considered compensated for an entire year, even during predetermined non-work periods such as summer breaks or vacations.

Income received by contract employees is considered compensation for a full year, regardless of the frequency of pay stipulated in the terms of the contract.

Procedures

Follow the steps below to determine the eligibility of a contract employee:

Step 1

Determine that the individual is a contract employee.

Step 2

Determine the frequency of pay to calculate the monthly gross income.

Step 3

Multiply the monthly gross income by the number of times received to determine the annual gross income.

Step 4

Divide the annual gross income by twelve to determine the average monthly gross income.

Step 5

Add the contract income to all other monthly income to determine the total gross monthly income.

Step 6

Apply income deductions appropriate to the COA under which eligibility is being determined.

Do not apply the above budgeting procedures in the following situations:

- when payments are not made as specified in the contract
- a labor dispute interrupts the flow of earnings as specified in the contract.

2661 Responsibility Budgeting (Family Medicaid)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Responsibility Budgeting (Family Medicaid)		
	Effective Date:			
	Chapter:	2600	**Policy Number:**	2661
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-27

Policy Statement

Responsibility budgeting is used to determine the financial **responsibility** of an individual(s) who is ineligible to be included in the Family Medicaid AU (deemor) or to determine the financial **need** (allocation) of an individual(s) who is ineligible to be included in the AU.

Basic Considerations

A responsibility budget is completed to determine if a deemor has excess income available to be deemed in the following situations:

- the amount of income to deem from an ineligible parent to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a non-AU stepparent to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a minor caretaker's parent(s) to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a non-parent caretaker's spouse to a Family Medicaid AU (excluding RSM)
- the amount of income to deem from a married minor's spouse, when living with parents, to a Family Medicaid AU
- the amount of income to deem from a married minor's spouse, not living with parents, to a Family Medicaid AU.

A responsibility budget is completed to determine if income may be allocated from an AU member to a non-AU member in the following situations:

- the amount of income to allocate from an adult in a LIM AU to his/her ineligible spouse
- the amount of income to allocate from an adult in a LIM AU to his/her ineligible child
- the amount of income to allocate from an adult in a Family Medicaid BG (other than LIM) to his/her ineligible spouse

Deductions

Allowable deductions for responsibility budgeting include the following:

- $90 Standard Work Expense
- For LIM and LIM-related COAs, the Standard of Need (SON) for the number of non-AU dependents living in the home who are or could be claimed as federal tax dependents of the ineligible adult.
- For RSM, the FPL based on:
    - the number of non-AU dependents living in the home (including the ineligible adult) who are or could be claimed as federal tax dependents of the ineligible adult

      AND

    - the age(s) of the children for whom Medicaid is requested
- For FM-MN, the appropriate FM-MNIL for the number of dependents living in the home who are or could be claimed as federal tax dependents of the ineligible adult
    - actual amounts paid to individuals outside the home who are or can be claimed as federal tax dependents
    - actual amount of alimony and/or child support paid to individuals living outside the home.

Procedures

Responsibility Budget

Use only the income of the ineligible adult when completing a responsibility budget. Ineligible adults include the following:

- an ineligible parent
- a non-AU stepparent
- a minor caretaker's parent(s)
- a non-parent caretaker's spouse
- a married minor's spouse

Do not include income received by a dependent child of the ineligible adult.

Follow the steps below to complete a responsibility budget:

Step 1 Determine the gross monthly earned income of the ineligible adult.

Step 2 Deduct the first $90 from the monthly gross earned income of the ineligible adult.

Step 3 Add countable unearned income of the penalized adult and allow the $50 child support deduction, if appropriate.

Step 4 Determine the number of individuals living in the home with the ineligible adult who are or could be claimed as federal tax dependents of the ineligible adult and are not included in the AU. Include the ineligible adult.

> Include a SSI adult or child, disregarding his/her income. Exclude penalized individuals.

Step 5 Subtract the SON, FPL or MNIL for the number of individuals determined in Step 4 from the income calculated in Step 3.

Step 6 Subtract from the income remaining after Step 5 any amounts paid by the ineligible adult to individuals outside the home who are or could be claimed as federal tax dependents.

Step 7 Subtract from the income remaining after Step 6 any alimony and/or child support paid by the ineligible adult to individuals not living in the home.

> Do **not** include child support or alimony already subtracted in Step 6.

Step 8 If a surplus exists, deem as follows:

- from an ineligible parent to a LIM, LIM-related or FM-MN AU deem the total excess income.
- from a non-AU stepparent to a LIM, LIM-related or FM-MN AU deem excess income up to the SON for one.
- from a minor caretaker's parent to a LIM, LIM-related or FM-MN AU deem the excess income up to the SON for one.
- from a non-parent caretaker's spouse to a LIM, LIM-related or FM-MN AU deem up to the SON for one
- from a married minor's spouse to a LIM, LIM-related or FM- MN AU deem up to the SON for one
- from a married minor's spouse to a RSM BG deem the total excess income.

If a deficit exists, there is no income to be deemed to the AU or BG from the ineligible adult. Consider allocation. Refer to Allocation in this section.

Ineligible Parent (Deeming)

An ineligible parent is a parent who cannot be included in a Family Medicaid AU (excluding RSM) with his/her dependent children for one of the following reasons:

- a parent who does not meet the citizenship/alienage requirement
- a parent who is unable to verify his/her citizenship/alienage status.

> This list is all-inclusive.

The amount of income of an ineligible parent to consider in determining eligibility for the AU is calculated by completing a responsibility budget.

Include the following individuals in the AU:

- the dependent child(ren), including any minor siblings, half-siblings and married minor siblings residing in the home
- other eligible adult(s), if applicable. Do **not** include the ineligible parent
- other eligible children.

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from an ineligible parent to the Family Medicaid AU (excluding RSM). Refer to Responsibility Budgeting Procedures in this section.

Stepparent (Deeming)

Stepparent budgeting applies when the dependent child lives in the home with a biological parent and/or the biological parent's spouse by a subsequent marriage.

The amount of income of a non-AU stepparent to consider in determining eligibility for a Family Medicaid AU (excluding RSM) is calculated by completing a responsibility budget.

If a child(ren) lives with a stepparent and the biological parent is not in the home or if the biological parent in the home receives SSI, the stepparent may choose one of the following options:

- elect to be excluded and have his/her income deemed through the responsibility budgeting process

  OR

- elect to be included as a caretaker relative and have his/her income and resources budgeted in their entirety.

Include the following individuals in the AU when there is a stepparent and a biological parent in the home:

- dependent child(ren), including any minor siblings, half-siblings and married minor siblings residing in the home.

  Do **not** include a half-sibling who is a mutual child of the stepparent and biological parent.

- the biological parent

  Do **not** include a SSI recipient.

- other eligible adult (other than the stepparent), if applicable
- other eligible child(ren)

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from a non-AU stepparent to the Family Medicaid AU (excluding RSM). Refer to Responsibility Budgeting Procedures in this section.

Minor Caretaker (Deeming)

Minor caretaker budgeting applies when a child is under age 18, has a child and lives in the home with his/her parents.

A minor parent, whether married, divorced or widowed, who lives with his/her parent(s) is considered a dependent child and remains the financial responsibility of his/her parent(s).

Do not consider the income of a stepparent.

A minor parent living with her/his parents may apply for LIM (as minor caretaker) and his/her child unless the minor's parent(s) receive LIM for the siblings or half-siblings of the minor parent.

If the minor parent's siblings are receiving LIM, the minor parent must be included in the same LIM AU in order to be LIM-eligible. The minor parent's child may be included in the LIM AU also, but cannot receive a separate LIM AU. This child, however, may receive in a separate RSM AU. If the minor's child receives RSM, the income of the minor's parent(s) is not considered in the RSM budget.

If the minor parent is married and the spouse lives in the home, only the minor parent is potentially eligible to receive LIM in an AU with his/her siblings. Income from the spouse of the minor parent is deemed to this AU. The spouse of the minor parent, if under age 19, and the child of the minor parent may be considered for RSM.

Include the following in a minor caretaker's LIM AU:

- the minor parent, as the caretaker
- the dependent child(ren) of the minor parent
- the spouse of the minor caretaker

Exclude the parent and siblings of the minor parent from this AU.

Deem the income of the minor's parent(s) to the LIM AU **only** when a minor parent applies as a caretaker **and** is included in the LIM AU.

Do **not** deem to the LIM AU if the minor parent is receiving SSI, is penalized or is ineligible to be included in the AU for any other reason.

Complete a responsibility budget to determine the amount of income that must be deemed, if any, the from minor caretaker's parent(s) to the Family Medicaid AU (excluding RSM). Refer to Responsibility Budgeting in this section.

Spouse of a Non-Parent Caretaker (Deeming)

Spouse of a non-parent caretaker budgeting applies when a married non-parent is eligible to, and elects to be included in the Family Medicaid AU (excluding RSM). Refer to 2245 Living With A Specified Relative / Tax Filer / Non-Filer Status.

Include the following in a Family Medicaid AU (excluding RSM) when a married non-parent caretaker elects to be included in the AU:

- the children for whom Medicaid is requested
- the non-parent as the grantee relative, if determined eligible to be included by relationship and who chooses to be included
- other eligible child(ren) of the grantee relative, if requested.

The child(ren) of the non-parent caretaker does not have to be included in the AU. This child(ren), however, cannot be included in any other AU in which the non-parent caretaker is included.

If the non-parent caretaker requests a separate eligibility determination for his/her child(ren), the non-parent caretaker must apply for his/her children separately and be included **only** in the BG with his/her children.

If the non-parent caretaker does not elect to be included in the Family Medicaid AU (excluding RSM) and requests a separate eligibility determination for his/her child(ren), the non-parent caretaker **is** eligible to be included in the AU with his/her children.

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from the spouse of a non-parent caretaker to the Family Medicaid AU (**excluding** RSM). Refer to Responsibility Budgeting in this section.

Spouse of a Married Minor Living with Parents (Deeming)

Spouse of a Married Minor - Living with Parents budgeting applies when a married minor lives in the home with his/her parent(s) and spouse.

A married minor who lives with his/her parents and his/her spouse is considered a dependent child and remains the financial responsibility of the parent(s).

For RSM, the minor can be budgeted as an adult if she is pregnant. If the minor has an existing child, he/she can also be budgeted as a minor parent/caretaker. Neither of these situations requires deeming from the married minor's parents.

A married minor who lives with his/her parents and his/her spouse is also the financial responsibility of the spouse.

This policy continues to apply for an 18 year old who is eligible for RSM.

Include the following in the Family Medicaid AU for a married minor living with his/her parents and spouse:

- The married minor
- The parent(s) of the married minor
- Siblings and/or half-siblings of the married minor, if applicable.

Include the following in the RSM BG for a pregnant married minor living with her parents and spouse:

- The pregnant married minor
- The married minor's spouse

- The unborn child(ren)

Complete a responsibility budget to determine the amount of income that must be deemed, if any, from a married minor's spouse to the Family Medicaid AU (including RSM). Refer to Responsibility Budgeting Procedures in this section.

Spouse of a Married Minor - Not Living with Parents (Deeming)

Spouse of a Married Minor - Not Living with Parents budgeting applies when a married minor lives with his/her spouse and there are no parents in the home.

If the married minor applies for RSM-Child for him/herself, complete a responsibility budget to determine the amount of income that must be deemed, if any, from the minor's spouse, regardless of the age of the minor's spouse.

If both the married minor and his/her spouse apply for RSM-Child, eligibility is determined separately. If responsibility budgeting results in a deficit for each minor, each is RSM-Child eligible and deeming does not apply.

Refer to Responsibility Budgeting Procedures in this section.

If the married minor applies for RSM PgW, a responsibility budget is not necessary as the spouse and his income is included in the RSM-PgW BG.

If the married minor and his/her spouse apply for RSM for their child(ren), a responsibility budget is not necessary as both the married minor and the spouse are included in the RSM-Child BG.

Ineligible Spouse or Ineligible Child (Allocation – LIM)

Income may be allocated from a LIM AU member to his/her ineligible spouse and/or ineligible child.

Income is allocated to the ineligible spouse and/or child when the spouse or child is not eligible to be included in the LIM AU and when the spouse or child are any of the following:

- the spouse of a married minor
- a stepparent
- the spouse of a non-parent caretaker
- an ineligible alien or an individual for whom citizenship/legal alien status cannot be verified (spouse or child).

Income is **not** allocated when the spouse or child is one of the following:

- penalized for one of the following reasons:
  - cooperation with CSE
  - enumeration
  - cooperation with TPR requirements
- excluded for failure to comply with application for other benefits
- receives SSI

- a child ineligible because of age
- a child for whom relationship or living arrangements is not established
- a child who is eligible to be included in the AU but was voluntarily excluded
- a child for whom the LIM-eligible adult is a relative other than a parent.

Allocation to an ineligible spouse is calculated using only the income of the spouse in the LIM AU.

Allocation to an ineligible child(ren) is calculated using only the income of the parent in the LIM AU.

Income received for or by a child in a LIM AU may not be considered in determining the amount to allocate to an ineligible individual.

Complete a responsibility budget to determine if income may be allocated to an ineligible spouse. It is not necessary to complete a responsibility budget if allocation is considered for a child(ren) only, as the child's income is not considered when completing a responsibility budget.

Follow the steps below to determine the amount of income, if any, to allocate to the ineligible spouse and/or child.

If the ineligible spouse has income, complete a responsibility budget based on his income, using the appropriate SON.

Step 1

- If a surplus exists, deem as indicated in the responsibility budget

  AND

  do **not** allocate to the ineligible spouse from the LIM AU. Proceed to Step 3 and allocate for any ineligible child(ren) only.

- If a deficit exists, do not deem any income from the ineligible spouse to the LIM AU. Proceed to Step 2.

Step 2 If the ineligible spouse has no income **or** if a deficit exists, allocate to the ineligible spouse and/or child from the LIM caretaker.

Step 3 Determine the Standard of Need (SON) for the number of ineligible individuals for whom allocation can be made.

Step 4 Determine the amount of income to allocate from the LIM caretaker to the ineligible individual(s) based on the following:

- If the only income in the LIM AU belongs to the parent, allocate up to the SON for the number of ineligible individuals. Do not exceed the parent's net income.
- If the income in the LIM AU belongs to the parents **and** others, allocate up to the SON for the number of ineligible individuals. Do not exceed the **parent's** net income.

Step 5 Subtract the allocated amount from the BG's income and continue with the eligibility determination.

Ineligible Spouse (Allocation: other than LIM)

Income may be allocated from a Family Medicaid (other than LIM) BG to his/her ineligible spouse.

Income allocated to the ineligible spouse when the spouse is not eligible to be included in the Family Medicaid (other than LIM) BG and when the spouse is one of the following:

- a stepparent, unless s/he has biological children in the BG
- the spouse of a non-parent caretaker.

The income of a child is never allocated to any individual.

Income is never allocated to a child who is not included in the BG, whether voluntarily or involuntarily excluded.

Income is not allocated to a spouse if s/he is a SSI recipient.

The amount of income that may be allocated to an ineligible spouse is determined by completing a responsibility budget using the appropriate RSM FPL or the MNIL.

Follow the steps below to determine the amount of income, if any, to allocate to the ineligible spouse.

Step 1

- If the ineligible spouse has income, complete a responsibility budget based on his/her income using the appropriate RSM FPL or the MNIL.
- If the ineligible spouse has income, complete a responsibility budget based on the FPL or MNIL for one. Do not deem any of the surplus to a RSM BG

  AND

  do **not** allocate to the ineligible spouse from the RSM or FM- MN BG.

- If a deficit exists, do not deem any income from the ineligible spouse to the RSM or FM-MN BG. Proceed to Step 2.

Step 2 If the ineligible spouse has no income **or** if a deficit exists, allocate to the ineligible spouse from the RSM or FM-MN BG.

For RSM, the amount of allocation is determined by the FPL for 1, based on the age(s) of the child for whom RSM is being determined. This may require multiple allocation budgets for children of different ages.

For FM-MN, the amount of allocation is determined by the MNIL for one.

Step 3 Subtract the allocated amount from the BG's income and continue with the eligibility determination.

2663 Non-Modified Adjusted Gross Income (MAGI) Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Non-Modified Adjusted Gross Income (MAGI) Budgeting		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2663
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-60

Requirements

Non-Modified Adjusted Gross Income (MAGI) budgeting procedures are used to budget all Non-MAGI Family Medicaid applications and periodic renewals.

Basic Considerations

The Non-MAGI budget includes the income of all individuals in the budget group (BG).

A percentage of the Federal Poverty Level (FPL) is used to determine Non-MAGI financial eligibility based on the BG's net countable income.

Countable income is the BG's income after deducting the following:

- $50 child support deduction, if applicable
- allocated income
- earned income of a child
- cost of doing business for self-employed individuals.

Refer to 2655 Family Medicaid Deductions and 2415 Self-Employment. Countable income includes deemed income. Refer to 2661 Responsibility Budgeting (Family Medicaid).

Individuals having financial responsibility in Non-MAGI Medicaid include the following:

- parents are financially responsible for children
- spouses are financially responsible for spouses.

Procedures

Follow the steps below to determine eligibility for Non MAGI COAs.

Step 1 Determine the gross countable income of the BG.

Step 2 For self-employed individuals, deduct all allowable Internal Revenue Service (IRS) deductions. Refer to 2415 Self-Employment.

Step 3 Subtract from the gross countable income the following deductions in the order indicated:

- $50 child support deduction
- $90 earned income deduction for each employed adult BG member
- dependent care expenses for each child or incapacitated individual.

Refer to 2655 Family Medicaid Deductions. Deduct any allocated income. Refer to 2661 Responsibility Budgeting (Family Medicaid).

Step 4 Select the appropriate Non-MAGI income limit, a percentage of the Federal Poverty Level (FPL) for the BG size using the criteria below. Refer to Appendix A2, Financial Limits for Family Medicaid.

Step 5 Compare the net countable income to appropriate Non-MAGI income limit for the BG size.

- If the net countable income is less than or equal to the appropriate Non-MAGI income level, approve the AU members for Non-MAGI Medicaid.
- If the net countable income exceeds the appropriate Non-MAGI income level for the BG size, the AU members are ineligible for Non-MAGI Medicaid. If ineligible, complete a continuing Medicaid Determination (CMD) for ineligible child(ren) to PeachCare for Kids® (PCK) or the Federally Facilitated Marketplace for ineligible children and adults.

2667 Transitional Medical Assistance Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Transitional Medical Assistance Budgeting		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2667
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-60

Requirements

Transitional Medical Assistance (TMA) Budgeting procedures are used to determine continued financial eligibility for TMA during the Additional Six-Month Extension.

Basic Considerations

An AU must have correctly received Parent/Caretaker with Child(ren) in three of the six months preceding the first month of TMA eligibility. Refer to 2162 Parent/Caretaker with Children.

A TMA AU must have received TMA in each of the six months of the initial six-month TMA period and must have provided information in the 4th month of TMA eligibility to qualify for the additional six-month extension of TMA.

The TMA budgeting procedure is used to budget taxable earnings reported on the TMA Quarterly Report Form (QRF) returned to the EW in the seventh and tenth months of TMA eligibility.

All taxable income reported on the QRF must be verified. Data sources or related active program(s)'s verification will be used prior to requesting any verification. Refer to Section 2051, Verification. The A/R is not required to send back the actual QRF.

Refer to 2166 Transitional Medical Assistance (TMA) for the time frames for processing the QRF, budgeting for the first six-month extension, and other policy information.

Procedures

TMA Budgeting

Follow the steps below to budget the three months of taxable earnings reported on the TMA Quarterly Report Form (QRF) in the 4th, 7th and 10th months.

Step 1 Determine the AU's total net taxable income for each month reported on the QRF. Do not include unearned income.

Step 2 Budget each month individually.

Step 3 Add the amounts determined in Step 2 and divide by 3 to obtain the average net monthly earnings.

Step 4 Compare the average net monthly earnings to the TMA income limit for the AU size. Refer to Appendix A2, Financial Limits for Family Medicaid.

- If the average net monthly earnings from Step 4 are less than or equal to the TMA income limit for the AU size, continue TMA coverage.
- If the average net monthly earnings from Step 4 exceed the TMA income limit, discontinue TMA eligibility after giving adequate notice. Complete a CMD.

When the TMA Annual Adjustment Occurs

Follow the steps below when the TMA income limit changes because of the annual adjustment.

Step 1 Add the net taxable income for each month together, subtract allowable MAGI deductions for each month and divide by three.

Step 2 Compare the average net taxable earnings from the three-month period to the average TMA income level for the three-month period.

- If the average net taxable monthly earnings are less than or equal to the average TMA income limit for the AU size, continue TMA coverage.
- If the average net taxable monthly earnings exceed the average TMA income limit, discontinue TMA eligibility after giving adequate notice. Complete a CMD.

2669 MAGI Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	MAGI Budgeting		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2669
	Previous Policy Number(s):	MT 54	**Updated or Reviewed in MT:**	MT-60

Requirements

Modified Adjusted Gross Income (MAGI) methodologies are used to budget all applications and periodic renewals of financial eligibility for Parent/Caretaker with Child(ren), Children Under 19 Years of Age, Pregnant Women Medicaid, PeachCare for Kids® (PCK) and Planning for Healthy Babies® (P4HB).

Basic Considerations

The MAGI budget includes the taxable income of all individuals in the budget group (BG).

Do not include the taxable income of a BG tax dependent child if not required to file a tax return. This amount changes yearly and is determined by the Internal Revenue Service (IRS).

A percentage of the Federal Poverty Level (FPL) is used to determine financial eligibility for Family Medicaid MAGI classes of assistance (COAs) based on the BG's net taxable income

Net taxable income is the BG's income after deducting the following:

- cost of doing business for self-employed or farming/fishing individuals
- Before-Tax deductions
- 1040 deductions
- MAGI 5% FPL deduction

Refer to 2655 Family Medicaid Deductions and 2415 Self-Employment.

A percentage of the Federal Poverty Level (FPL) is used to determine MAGI financial eligibility based on the BG's net countable income.

Procedures

Follow the steps below to determine eligibility for MAGI COAs.

Step 1

For self-employed or farming/fishing individuals, deduct all allowable IRS deductions. Refer to 2415 Self-Employment.

Step 2

Deduct any before-tax deductions of taxable income.

Step 3

Deduct any 1040 deductions of taxable income.

Step 4

Subtract from the net taxable income 5% of the 100% FPL for the budget group size. Please refer to Appendix A-2 for the deduction amounts for each budget group size.

Step 5

Select the appropriate income limit; either the Parent/Caretaker with Child(ren) limit, or the appropriate Pregnant Women or Children Under 19 Years of Age net taxable limit using the criteria below. Refer to Appendix A2, Financial Limits for Family Medical Assistance.

- 247% of the FPL for PCK, for children from birth to the last day of the month of the child's 19th birthday
- 211% of the FPL for eligible women from ages 18-44 (P4HB)
- 220% of the FPL for pregnant women and infants born to Medicaid-eligible women

> Infants born to Medicaid-eligible mothers are considered to have met the Deemed Newborn Medicaid income limit, regardless of the budget group's income at the time of delivery.

- 205% of the FPL for children, birth through the month the child reaches age one for children who are ineligible for Deemed Newborn Medicaid.
- 149% of the FPL for children age one through the month in which the child turns age six.
- 133% of the FPL for children age six through the month in which the child turns age 19.
- Parent/Caretaker with Child(ren) net taxable limit.

Step 6

Compare the net taxable income amount to the appropriate income limit for the BG size

- If the net taxable income is less than or equal to the appropriate income level, approve the AU members for Medical Assistance.

If the net taxable income exceeds the appropriate income level for the BG size, the AU members are ineligible for Medicaid. If ineligible for Parent/Caretaker with Child(ren), complete a CMD to Children Under 19 Years of Age Medicaid coverage; refer the adults to the Federally Facilitated Marketplace (FFM). If ineligible for Children Under 19 Years of Age coverage, complete a CMD to PeachCare for Kids® (PCK). If ineligible for PCK coverage, refer ineligible children to the FFM.

> Prior to referring adult women to FFM who are ineligible for Parent/Caretaker with Child(ren), CMD to P4HB if they confirm they want P4HB. If ineligible for P4HB continue with referral to FFM. Because the Children Under 19 Years of Age income limits vary based on the age of the child, it is possible that a child(ren) may be eligible for Medical Assistance while another child(ren) in the same BG may be ineligible. Complete a CMD as indicated above for

an ineligible child(ren) in a budget group.

2671 Family Medicaid Medically Needy Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Medically Needy Budgeting		
	Effective Date:	June 2020		
	Chapter:	2600	**Policy Number:**	2671
	Previous Policy Number(s):	MT 4	**Updated or Reviewed in MT:**	MT-60

Requirements

Family Medicaid Medically Needy (FM-MN) Class of Assistance (COA) budgeting procedures are used to budget applications and reviews of financial eligibility for the FM-MN COA.

Basic Considerations

The FM-MN budget group includes the income of all individuals in the Budget Group (BG). FM-MN uses LIM criteria for determining the types of included income and expenses.

Procedures

Determining De Facto Eligibility and One-Month Spenddown

Follow the steps below to budget for de facto eligibility or the spenddown for each one-month budget period of the six-month review period in a FM-MN case:

Step 1

Determine prospective gross countable income of the budget group (BG) for each month of the six-month review period.

Step 2

Subtract from the gross countable income the following deductions in the order indicated:

- $50 child support deduction using LIM criteria
- $90 earned income deduction for each employed BG member
- $30 earned income deduction, if allowable, for each employed individual
- 1/3 of the remaining earned income, if allowable, for each employed individual
- dependent care expenses for each child or incapacitated individual.

Refer to 2655 Family Medicaid Deductions.

Step 3

Deduct any allocated income to determine the net countable income. Refer to 2661 Responsibility Budgeting (Family Medicaid).

Step 4

Determine the Medically Needy Income Limit (MNIL) based on the BG size for each one-month budget period in the six-month FM-MN review period. Refer to Appendix A2, Financial Limits for Family Medicaid.

De Facto Eligible

The AU is de facto eligible for FM-MN for each one-month budget period in which the net countable income is less than or equal to the MNIL.

Spenddown

If the net countable income exceeds the MNIL, the excess is the spenddown. The AU is Medicaid eligible when, and only if the spenddown is reduced to zero by subtracting incurred medical expenses.

Refer to 2196 Family Medicaid Medically Needy for information regarding incurred medical expenses and procedures for applying incurred medical expenses to the spenddown.

De Facto Eligibility and Spenddown for a Prior Month

Budget each prior month separately. Each prior month is a one-month budget period.

Step 1

Determine the gross countable income received by the BG in each prior month for which assistance is requested.

Step 2

Subtract the following deductions from each month's income in the order indicated:

- $50 child support deduction using LIM criteria
- $90 earned income deduction for each employed BG member
- $30 earned income deduction, if allowable, for each employed individual
- 1/3 of the remaining earned income, if allowable, for each employed individual
- Dependent care expenses for each child or incapacitated individual.

Refer to Section 2655, Family Medicaid Deductions.

Step 3

Deduct any allocated income to determine net countable income. Refer to Section 2661, Family Medicaid Responsibility Budgeting.

Step 4

Determine the MNIL for the BG size for the prior month. Refer to Appendix A2, Financial Limits for Family Medicaid.

Step 5

Compare the MNIL determined in Step 4 to the net countable income for the prior month.

De Facto Eligible

If the net countable income is less than or equal to the MNIL, the AU is de facto eligible for FM-MN.

Spenddown

If the net countable income exceeds the MNIL, the excess is the spenddown. The AU is Medicaid eligible when, and only if the spenddown is reduced to zero by subtracting incurred medical expenses.

Refer to 2196 Family Medicaid Medically Needy for information regarding incurred medical expenses and procedures for applying incurred medical expenses to the spenddown.

Use the following chart to determine FM-MN budgeting procedures for special situations.

CHART 2671.1 - MEDICALLY NEEDY BUDGETING FOR SPECIAL SITUATIONS

NOTE: The "If" column assumes that all potentially eligible individuals are requesting Medicaid.	
IF family consists of	**THEN complete budgeting as follows:**
minor parent, his/ her child and his/ her parent(s)	Treat both the minor parent and his/her child as dependent children and include them in his/her parent(s)' BG. Budget for FM-MN using all BG income and medical bills. Treat the minor parent as caretaker. Include only the minor parent and his/her child in the BG. If the minor caretaker is treated as a caretaker, use one of the following options to budget. **Option 1** Complete a minor caretaker responsibility budget using the minor's parent(s)' income. Meet needs in the responsibility budget using the MNIL for one (or MNIL for two if there are two parents). Deem all income remaining at the end of the responsibility budget in the minor parent's FM-MN budget. Include the medical bills of the minor, minor's child, and the parent(s) of the minor to meet spenddown. Approve only the minor's child when spenddown is met. **Option 2** Complete a minor caretaker responsibility budget using the minor's parents' income. Meet needs in the responsibility budget using the MNIL for one (or MNIL for two if there are two parents). Include in the minor parent's MN budget the amount (not to exceed the MNIL for one) from the income remaining at the end of the responsibility budget. Use only medical bills of the minor parent and her child to meet spenddown. Approve only the minor's child for Medicaid when spenddown is met.

NOTE: The “If” column assumes that all potentially eligible individuals are requesting Medicaid.	
pregnant minor and her parent(s)	Treat the pregnant minor as a dependent child and include her in a BG with her parents. Budget for MN using all BG income and medical bills. OR Include only the minor parent and her unborn child in the BG. Use the following steps to budget if only the minor parent and her unborn child are included in the BG. **Step 1** Complete a minor caretaker responsibility budget using the pregnant minor’s parent(s)' income. Meet the needs of the minor’s parent(s) using the MNIL for one (or MNIL for two if two parents). **Step 2** Deem to the pregnant minor’s MN budget the amount of income remaining at the end of the responsibility budget, not to exceed the MNIL for one. **Step 3** Add to this any countable income of the pregnant minor with appropriate deductions. **Step 4** Complete MN budgeting. • Approve if de facto eligible. • Place in spenddown status if excess exists. **Step 5** Use only medical bills of the minor parent to meet spenddown. **Step 6** Approve the pregnant minor for Medicaid when spenddown is met.

NOTE: The “If” column assumes that all potentially eligible individuals are requesting Medicaid.	
pregnant minor with an existing child and her parent(s)	Treat the pregnant minor as a dependent child and include her, her child if Medicaid is requested, and her parents in the BG. Budget for FM-MN using all BG income and medical bills. OR Treat the pregnant minor parent as a caretaker. Include the pregnant minor parent, her unborn child and her existing child in the BG. Use the following steps to complete the budget. **Step 1** Complete a minor caretaker responsibility budget using the pregnant minor’s parent(s) income. Meet the needs of the minor’s parent(s) using the MNIL for one (or MNIL for two if there are two parents). The remainder is used in the pregnant minor’s budget. **Step 2** Deem to the pregnant minor’s BG up to the MNIL for one from the remainder in Step 1. **Step 3** Add to Step 2 any income of the pregnant minor and her existing children, allowing appropriate exclusions and deductions. **Step 4** Compare the total in Step 3 to the MNIL for the BG size. • If the total is less than or equals the MNIL, approve the minor’s existing child(ren) as de facto eligible. • If the total exceeds the MNIL, the excess is the spenddown for the minor’s existing child(ren). Medical expenses for the pregnant minor and child(ren) can be used to meet this spenddown. **Step 5** To determine the pregnant minor’s eligibility, complete these calculations. • Deem to the pregnant minor the remainder of Step 1 minus Step 2. The result is the spenddown for the pregnant minor. • Apply allowable medical expenses incurred by the pregnant minor and her existing child to the spenddown. Repeat these steps for each budget period month in the six-month review period.

2700 Case Management

2700 Case Management Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Case Management Overview		
	Effective Date:	May 2023		
	Chapter:	2700	**Policy Number:**	2700
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-69

Requirements

Case Management is the process by which the DFCS eligibility worker (EW) monitors the ongoing eligibility received by the ABD and Family Medicaid recipient. Case Management begins immediately following the approval of a Medicaid application and continues as long as the Assistance Unit (AU) remains eligible for Medicaid.

Basic Considerations

Case Management consists of the following components:

- Notifications
- Renewals
- Changes
- Alerts
- Continuing Medicaid Determinations (CMDs)
- Case Management Lists
- Computer Matches
- Hearings

Notification

An AU must receive proper notification of actions taken on his/her Medicaid case. Refer to 2701 Notification.

Renewal

A periodic renewal of eligibility is conducted to ensure that the recipient continues to be eligible for Medicaid under the correct Class of Assistance (COA). AUs are required to cooperate with the periodic renewal of eligibility. Refer to 2706 Medicaid Renewals.

Changes

AUs are required to report all changes, which may affect their eligibility. A change in resources, income or other circumstances reported by the recipient must be acted upon in a timely manner.

Refer to 2708 ABD Medicaid Changes and 2712 Family Medicaid Changes Overview.

Alerts

The Gateway system generates Alerts, messages to the caseworker to take specific action on a case. Appropriate action should be taken on the Alert in a timely manner.

CMD

If an AU or an individual in an AU is determined ineligible at application or while receiving Medicaid, a Continuing Medicaid Determination (CMD) must be completed. The CMD process is used to explore eligibility for all other COAs before denying or terminating Medicaid. Refer to 2052 Continuing Medicaid Determination.

Case Management Lists

Periodic reports produced by DCH inform the EW of required case actions and aid in monitoring continued Medicaid eligibility for certain recipients. Refer to 2750 DCH Reports-Ex Parte Lists and 2752 DCH Presumptive Reports.

Computer Matches

Computer matches are generated by matching DFCS information with the information of other agencies, such as Georgia Department of Labor, the Social Security Administration and the Internal Revenue Service. These matches assist with verification of the recipient's income and resources and act as an aid in detecting unreported income and resources.

Refer to 2001 Computer Matches Overview for additional information.

Hearings

The applicant or recipient (A/R) has the right to request a hearing on any decision made by DFCS or DCH affecting his/her Medicaid eligibility and/or patient liability/cost share. The EW has certain responsibilities in processing the request for a hearing. Refer to Appendix B, Hearings.

2701 Notification

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Notification		
	Effective Date:	May 2023		
	Chapter:	2700	**Policy Number:**	2701
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-69

Requirements

Written notice to the AU is required when any of the following occur:

- approval or denial of an application for benefits
- change in patient liability/cost share
- addition or deletion of an individual in an AU
- denial, reduction, or termination of an individual's benefits because of a sanction, penalty, or ineligibility
- termination/reduction of benefits to the AU or to an AU member.

Basic Considerations

Written notifications must include the following:

- the proposed action
- the reason for the action
- period of eligibility
- notification of appeal rights and information regarding the filing of an appeal
- the availability of free legal representation, including telephone number
- a telephone number to contact for additional information
- the specific Medicaid regulation must be cited for denials.

Written notice is program specific and is generated by the system. When system-generated notice explanation is inadequate, additional documentation on the notice is required. Generic denial reasons may be used as a secondary or tertiary denial/termination reason, but **never** as the sole reason for denial/termination.

Written notice can be mailed to the AU or hand delivered to the AU during an interview.

Adequate notice is a written communication provided to the AU no later than the date the action is taken.

Timely notice is a written communication provided to the AU with at least a 14-day waiting period

before the date the proposed action is effective.

Procedures

Adequate Notice

Provide adequate notice in the following circumstances:

- mass changes in benefits initiated by the State or federal government including the following:
  - TANF, RSDI and SSI adjustments
  - financial standards and benefits levels
  - deductions
- death of all members of the AU reported through reliable information
- a decrease in PL/CS
- an increase in PL/CS if fourteen days remain in the month in which the change is to be effective (notice and change are effective the same month)
- denial of an application
- a clear written statement from the A/R requesting termination of benefits for the entire AU
- a written request by the AU for voluntary termination
- the AU reports information in writing and ineligibility can be determined without verification
- benefits were approved for a specific time period and the AU was informed in writing of the proposed termination, or change in benefits at approval
- the AU moves out of state.

Timely notice

Implement the proposed change effective the month following the expiration of the 14 day timely notice period. (Exception may be increases/decreases in PL/CS. See bullets above and below.)

If the AU provides information within the 14-day timely notice period that alters the proposed change, stop the action and reevaluate the circumstances.

Allow the system to automatically track the 14-day timely notice period if the action is entered in the system.

Manually track the 14-day timely notice if a manual notice is sent. The AU may request a fair hearing and continuation of benefits. Refer to Appendix B, Hearings for policy regarding continuation of benefits.

Provide timely notice in the following circumstances:

- changes in AU circumstances causes termination/reduction of benefits
- increase in patient liability/cost share if 14 days do not remain in the month in which the notice would be sent

Do not make the change for the current month; make change effective the ongoing month when adequate notice can be given.

- mail returned and/or whereabouts unknown

Notice of Fair Hearing

The following language must be included on all adverse action communications:

“If you do not agree with any action taken on your Medicaid case, you have the right to ask for a fair hearing before a state hearing officer. You may be represented at the hearing by a lawyer, relative, friend or anyone you choose. If you want a hearing on your Medicaid case you must ask for the hearing in writing within thirty (30) days from the date of this notice.”

If the hearing request is to continue receiving benefits while waiting for a hearing decision, the notices must clearly state that they may be required to repay the Department of Community Health.

The following agency information must also be included on all adverse action notifications:

- Georgia Legal Services Program
- Atlanta Legal Aid
- Georgia Senior Legal Hotline
- Office of the State Long-Term Ombudsman
- Georgia Advocacy Office, Inc.

2706 Medicaid Renewals

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicaid Renewals		
	Effective Date:	September 2024		
	Chapter:	2700	**Policy Number:**	2706
	Previous Policy Number(s):	MT 72	**Updated or Reviewed in MT:**	MT-73

Requirements

Medical Assistance Units (AUs) must comply with periodic renewals of continued eligibility.

Basic Considerations

Medical Assistance renewals must be completed:

- Annually for ABD Classes of Assistance (COA)

  ABD Medically Needy renewals must be completed semi-annually.

- Annually for Chafee Independence Program Medicaid
- Annually for Former Foster Care Medicaid
- Annually for Adoption Assistance Medicaid
- Semi-annually for Foster Care Medicaid
- Annually for Non-MAGI Women's Health Medicaid
- Semi-annually, by the end of the sixth month following the month in which the application is approved and every six months thereafter, for ABD and Family Medically Needy
- Annually for Family Medicaid MAGI COA, including:
  - Parent/Caretaker with Children
  - Children under 19 years of age
  - PeachCare for Kids®
  - Planning for Healthy Babies®
  - Pathways

EXCEPTION: Annual renewals are not required for the following Family Medicaid COAs:

- Pregnant Woman Medicaid
- Newborn Medicaid
- Transitional Medicaid Assistance (TMA)
- 4 Months Extended Medicaid (4MEx)

Refer to Chart 2706.1, Family Medicaid Renewals to determine which Family COAs require renewals.

Renewals are also to be completed due to changes reported by or affecting the AU that allow for the completion of the renewal based on the reported change, and renewals initiated in other, related, programs.

For MAGI Medical Assistance, if verification is required for the reported change, only verification for the reported change can be requested. If the reported change alone cannot allow enough information to complete a renewal, then continue with the remainder of the period of eligibility (POE). If the reported change allows for a renewal to be completed use the system function to allow a new 12-month POE to be issued to the AU.

When a Family Medicaid renewal is finalized with a related active program(s), the POE for the Family Medicaid case will match that of the related active program(s).

If the related active Medicaid case involves a Foster Care and/or Adoption COAs (this includes CHAFEE and Former Foster Care Medicaid) contact REV MAX before beginning the renewal.

The renewal process must be completed by the last day of the month the renewal is due.

If an AR does not submit the MAGI renewal form or return the requested verification but does respond within 90 days (last day of the third month following termination), eligibility can be reconsidered without a new application. For MAGI COA, the AU must submit a signed renewal form.

Any AU, BG or Authorized Representative (AREP) may sign a renewal form for Medicaid.

The following points of eligibility must be reviewed, if applicable:

- resources
- income
- dependent care expenses
- third party liability
- application for other benefits
- living arrangements
- possibility of transfer of assets by A/R or spouse transferring annuity or home place.
- pre-tax deduction(s)
- 1040 deduction(s)
- tax filing status
- Qualifying Activities (Pathways)
- any other points of eligibility subject to change

Renewals are completed by one of the following methods:

- administrative renewal (MAGI Medicaid only)

- alternate renewal
- standard renewal

A face-to-face (FTF) renewal cannot be required for any Medicaid COA. At the Case Worker's discretion or the request of the A/R or AREP, a FTF renewal may be scheduled; however, a Medicaid case may **not** be closed for failure to appear for a FTF renewal.

Administrative Renewal

An administrative renewal can be completed at any time, even after the renewal notice has been generated, and also at any time when A/R is reporting changes, applying for or renewing attached programs.

Administrative renewals should not be completed for Medicaid cases whose Medicaid eligibility has been determined using Express Lane Eligibility (ELE) .

An attempt must be made to renew eligibility for MAGI COA without requesting or requiring information from the household. The annual renewal should be conducted using electronic data sources and any other information already available to DFCS (e.g., in a related active case). If the household's eligibility is renewed based on available information, the household must be notified of the results. Do not send a renewal form when an administrative renewal is completed. A signed renewal form and DMA 285 are not required to be signed and returned.

If the AU cannot be renewed based on the available information, the AU falls into the regular process for alternate renewals and a notice will be sent the following month. Upon request MAGI AUs will be provided with a pre-populated renewal form (web services) with information currently used to determine eligibility.

Alternate Renewal

An alternate renewal is completed by mail, telephone, fax, email, or through the Gateway online renewal process.

An alternate renewal notice must contain the following information:

- that a renewal is necessary to continue eligibility
- an alternate renewal form (system or manually issued)
- the date the alternate renewal form is due
- the consequences of failing to comply with the renewal
- the AU's responsibility to provide all required verification
- the AU's right to request a fair hearing
- address to return the renewal form
- telephone # for contacting the agency regarding the renewal or to request a prepopulated renewal form (for MAGI COA only)

The AU may respond to the renewal via:

- Online with Gateway
- Telephone
- Mail
- Other electronic sources (e.g., fax, email)
- In person or authorized representative (AREP)

The AU must be provided at least 30 calendar days in which to respond.

MAGI AUs that respond to the renewal request by means other than online with Gateway or submitting a signed renewal form MUST submit a signed form, either by mail or other electronic sources (e.g., fax, email).

Non-MAGI Medicaid AUs that fail to return the alternate renewal form, or that return an incomplete form, may be contacted by phone to complete the renewal requirements. If missing information is obtained by telephone or other contact, the renewal is considered complete. Document case to this effect.

AUs should be reminded that sending personal information via email is not a secure mode of transmission.

Standard Renewal

A standard renewal is an in-depth FTF interview in which all points of eligibility are examined with an appropriate AU or BG member or a authorized representative (AREP).

A standard renewal is not required for any Medicaid COA. A Medicaid case may not be terminated for failure to appear for a standard renewal even if the AU requested a FTF and failed to show.

A standard renewal appointment notice must include the following:

- that a renewal is necessary to continue eligibility
- that a FTF renewal is not required for continued eligibility and that an alternate renewal may substitute for a FTF renewal
- the date, time, and location of the interview
- the AU's responsibility to provide all required information
- the AU's right to request a fair hearing
- the name and telephone number of the worker

Unearned Income Verification Requirements

At renewal, the A/R's statement of unearned income will be accepted as verification if the source and amount is stated to have remained the same or changed less than $50 since last verified from the source. Income types include but are not limited to direct child support, extended Unemployment Compensation Benefits that are not on DOL, RSDI and SSI that are not updated or not on BENDEX/SDX files, contributions, Veteran's Assistance (VA) benefits, Workmen's Compensation, Alimony, Pensions and Retirement and In-Kind Support and Maintenance (ISM). MAGI Medicaid only includes taxable income.

The amount should be verified by a third-party source when the A/R's statement is questionable. All electronic methods of verification (Clearinghouse, $TARS, etc.) will be utilized prior to accepting the client's statement of income. For MAGI Medicaid COAs all data sources and any active related case information is to be used prior to requesting any verification.

Continuous Eligibility

Effective January 1, 2024, eligibility for Medicaid and PeachCare for Kids® recipients should be renewed every 12 months and no more frequently than once every 12 months. Children under the age of 19 will be provided 12 months of continuous eligibility (CE) coverage regardless of change in circumstances with certain exceptions. The exceptions to CE include the following:

- The child reaches age 19.
- The child is no longer a Georgia resident
- A voluntary request for closure.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- The child is deceased.

CE does not apply to:

- Medically Needy,
- Presumptive Eligibility,
- At renewal, children that are only eligible for Transitional Medical Assistance or
- Emergency Medical Assistance.

If a child becomes incarcerated during their CE period, then the child must remain eligible for the remainder of the CE period while incarcerated.

Procedures

Administrative Renewal

Follow the steps below to process an Administrative Renewal for a MAGI case

Step 1 In the second month prior to the renewal month, identify the MAGI COA case for Administrative Renewal

Step 2 Using electronic data sources (DOL, UCB, SDX, BENDEX, Truv, etc.), review eligibility

Step 3 If the electronic data sources are sufficient to validate eligibility and no additional contact with the AU is required, complete the renewal. The system will extend the renewal period by 12 months.

Step 4 Complete a Continuing Medicaid Determination (CMD) for any case determined no longer eligible under its current COA at renewal.

Step 5 Document case notes that an administrative renewal was completed

Step 6 Notify the AU of renewal by allowing the system to send the disposition notice. If a manual notification is needed, mail Form 214 - Medicaid Notification Form found in Appendix F - TOC.

Alternate Renewal

Follow the steps below to process an Alternate Renewal.

Step 1 Mail the alternate renewal form to the AU no less than 10 days prior to the date the completed form is due to be returned. If the renewal form is not submitted, send a second request.

> AR has the ability to request a renewal form by emailing PaperRenewalForm@dhs.ga.gov.

Step 2 Mail any other required forms.

For MAGI COA

Review the returned renewal form (508 or 508M) or Customer Portal (CP) renewal for all points of eligibility. Contact the AU if the renewal form is not returned, if it is incomplete, or if additional information or verification is required. Contact may be made by telephone or by mail. A system-generated notice that a renewal form was not returned is considered sufficient contact.

If a renewal form is not completed on Gateway Customer Portal, a 297A, and DMA 285 must be sent to the A/R. The signed DMA 285 must be returned or any adult receiving in a Non-MAGI Family Medicaid case will be penalized.

For Non-MAGI COA:

Review the returned renewal form (508 or 508M) or Customer Portal (CP) renewal for all points of eligibility. Contact the AU if the renewal form is not returned, if it is incomplete, or if additional information or verification is required. Contact may be made by telephone or by mail. A system-generated notice that a renewal form was not returned is considered sufficient contact.

For Non-MAGI COA, the renewal may be processed without a signature or completed renewal form if all other required information is obtained by other measures. If a renewal form is not received or if the renewal is not completed on Gateway Customer Portal, then a 297A, and DMA 285 must be sent to the A/R The signed DMA 285 must be returned or the case will be closed. **(EXCEPTION:** SLMB, QI1, and QDWI does not require a DMA 285 be sent).

Step 3 Complete Clearinghouse requirements.

Step 4 Document the information obtained during the renewal process.

Step 5 Upon completion of the renewal and, if applicable, the receipt of any additional information or verification requested, finalize the renewal.

Step 6 Complete a continuing Medicaid determination (CMD) for any case determined no longer eligible under its current COA at renewal

Step 7 Notify the AU of the renewal disposition by allowing the system to send the disposition notice. If a manual notification is needed, mail Form 214 - Medicaid Notification Form found in Appendix F - TOC.

Standard Renewal

Follow the steps below to process a Standard Renewal:

A standard renewal is not required for ANY Medicaid COA. A Medicaid case may not be terminated for failure to appear for a standard renewal.

Step 1 Mail the AU an appointment notice to schedule the standard renewal. The interview must be scheduled for a date that allows sufficient processing time of the renewal by the due date. An appointment notice must be mailed to the AU no less than 10 days prior to the scheduled appointment.

> The 10-day requirement does not apply to appointments scheduled verbally, either in person or by telephone; however, the appointment notice must be mailed.

Step 2 Conduct a FTF interview with the appropriate AU/BG member or AREP. Review all points of eligibility.

Step 3 Request additional information or verification, if appropriate.

Step 4 Complete any forms necessary.

Step 5 Complete Clearinghouse requirements.

Step 6 Document the information obtained during the renewal process.

Step 7 Upon completion of the interview and, if applicable, the receipt of any additional information or verification requested, finalize the renewal.

Step 8 Complete a continuing Medicaid determination (CMD) for any case determined no longer eligible under its current COA at renewal

Step 9 Notify the AU of the renewal disposition by allowing the system to send the disposition notice. If a manual notification is needed, mail Form 214 - Medicaid Notification Form found in Appendix F - TOC.

Use the following chart to determine which Family Medicaid COAs require renewals.

Chart 2706.1 – Family Medicaid Renewals

CLASS OF ASSISTANCE	SPECIAL REVIEWS	RENEWAL PERIOD
Parent/Caretaker with Child(ren)	as needed	Annual (as of 1/1/14)
TMA	quarterly renewals	At the end of the TMA eligibility period.
4MEx	as needed	At the end of 4MEx eligibility period
Deemed Newborn	No	Month the child turns 1
Children Under Age 19	as needed	Annual (as of 1/1/14)
Pregnant Women	month prior to the expected date of delivery and each month thereafter until termination of pregnancy	None
FM-MN	as needed	Every six months
CWFC	as needed	Every six months
Adoption Assistance	yearly renewals	Annual
Women's Health Medicaid (WHM)	yearly renewals	Annual
Planning for Healthy Babies® (P4HB)	yearly renewals	Annual
PeachCare for Kids®	yearly renewals	Annual
Pathways	yearly renewals	Annual
Chafee Independence Medicaid	as needed	Annual
Former Foster Care Medicaid	as needed	Annual

Use the following chart to process a Medicaid Renewal. Refer to Chart 2706.1, Family Medicaid Renewals for COAs that do not require renewal.

Chart 2706.2 - Procedures for Disposition of the Medicaid Renewal

IF	THEN
the AU complies with all requirements	Continue eligibility, if appropriate.
the AU misses a scheduled appointment	contact the AU to obtain required information. This contact may be made by mail and/or by telephone. A standard (FTF) renewal is not required for **ANY** Medicaid COA. A Medicaid case may **not** be terminated for failure to appear for a standard renewal.
the agency did not provide written notice of the appointment 10 days prior to the appointment date and the appointment is missed	contact the AU to obtain required information. This contact may be made by mail and/or by telephone. A standard (FTF) renewal is not required for **ANY** Medicaid COA. A Medicaid case may **not** be terminated for failure to appear for a standard renewal.
the AU fails to provide any requested verification	determine if Medicaid eligibility for any other COA can be established without the requested verification. If so, continue eligibility under the new COA. If not, send timely notice and close the Medicaid case following expiration of the timely notice period. If incomplete and/or incorrect verification is returned, a new checklist must be sent allowing for additional time to return the remainder and/or correct verification. Refer to Section 2051 - Verifications.

IF	THEN
the AU fails to return the Alternate Renewal Form or complete the renewal on Gateway	contact the AU to obtain required information. A system-generated notice that a renewal was not returned is considered sufficient contact. The Non-MAGI Medicaid renewal may be processed without a signature or completed renewal form if all other required information is obtained by other measures. For MAGI Medicaid renewals a signature is required on the renewal form. When received without a signature, and during the renewal period, the renewal form must be returned to the AU and signature requested. Document the case.
The MAGI and Non-MAGI Medicaid AU provides the renewal form or requested verification within 90 days	Process as renewal and reinstate the case back to the first day of closure month, and ongoing, if all information is received with the signed renewal form. The system will generate a new 12-month POE. For Non-MAGI cases process as renewal and reinstate the case back to the first day of closure month, and ongoing, if all renewal requirements are met. The system will generate a new 12-month POE. QMB and P4HB COAs are excluded and do not have the 90-day reinstatement grace period.

2708 ABD Medicaid Changes

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Medicaid Changes		
	Effective Date:	September 2024		
	Chapter:	2700	**Policy Number:**	2708
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-73

Requirements

A change that occurs in the A/R's circumstances between renewal periods or a change in federal or state policy must be reviewed for its effect on ABD Medicaid eligibility and patient liability/cost share.

Basic Considerations

Changes in an A/R's circumstances are to be reported to DFCS by the A/R or Personal Representative within 10 calendar days of the change.

Changes may be reported in any of the following ways:

- in person
- by telephone
- by mail
- by email
- by facsimile
- by Gateway "Report MY Change"
- by automatic system update

Action on all changes reported must be initiated by DFCS within 10 days of receipt of the report. Using appropriate documentation standards, document when the change was received, and the required action completed.

There are two types of ABD Medicaid changes:

- financial
- non-financial

Financial Changes

Financial changes are those that affect an individual's or a couple's Medicaid eligibility due to a change in income and/or resources.

Non-Financial Changes

Non-financial changes are changes that may or may not affect eligibility but do require DFCS action to insure the continued receipt of correct benefits.

Continuous Eligibility

Effective January 1, 2024, children under the age of 19, including those in ABD COAs, will be provided 12 months of continuous eligibility (CE) coverage regardless of change in circumstances with certain exceptions. The exception to CE includes the following:

- The child reaches age 19.
- The child is no longer a Georgia resident
- A voluntary request for closure.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- The child is deceased.

CE does not apply to:

- Medically Needy,
- Presumptive Eligibility,
- At renewal, children that are only eligible for Transitional Medical Assistance or
- Emergency Medical Assistance.

If a child becomes incarcerated during their CE period, then the child must remain eligible for the remainder of the CE period while incarcerated.

Example: if a child under 19 is active on CCSP and during the POE an update to resources is discovered that would result in ineligibility for CCSP, the child cannot cascade to CU19/PCK due to this change since it is not at renewal.

National Voter Registration Act (NVRA) of 1993

The National Voter Registration Act (NVRA) of 1993 requires that DFCS is to provide a voter registration form to the A/R when an address change is reported in person, electronically, or via telephone, facsimile, or mail and would necessitate a change in the A/R's voting location. Refer to Section 2980 - Voter Registration.

2712 Family Medicaid Changes Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Changes Overview		
	Effective Date:	September 2024		
	Chapter:	2700	**Policy Number:**	2712
	Previous Policy Number(s):	MT 70	**Updated or Reviewed in MT:**	MT-73

Requirements

When changes occur in a Medicaid AU's and/or BG's circumstances, ongoing eligibility must be established, based on the new circumstances.

Basic Considerations

The date the change occurs is the day the event actually happens. Examples include the following:

- the date a first paycheck is received
- the date a paycheck reflecting a change in pay is received
- the date unearned income is first received
- the date an A/R becomes aware she is pregnant.

This list is not all-inclusive.

Changes may be reported in any of the following ways:

- in person
- by telephone
- by mail
- by email
- by facsimile
- by Gateway "Report My Change"
- by automatic system update

AUs must report all changes within 10 calendar days of the date the change occurs.

The agency must take action, based on the change, as soon as possible but no later than 10 days after the report.

If the AU fails to report a financial change within 10 days, the agency must determine when the change should have been effective, based on the time frames specified above and allowing for timely notice, if appropriate.

Changes are effective the month after the change occurs or the second month, depending on when the AU reports the change, when DFCS takes action and when timely notice expires.

The National Voter Registration Act (NVRA) of 1993 requires that DFCS is to provide a voter registration form to the A/R when an address change is reported in person, electronically, via telephone, facsimile, or mail and would necessitate a change in the A/R's voting location, Refer to Section 2980 - Voter Registration.

Ineligibility of an individual or an entire AU occurs the month after the required timely or adequate notice expires and a Continuing Medicaid Determination has been completed.

Individuals approved for Emergency Medical Assistance (EMA) have specific days of eligibility.

There is no penalty for late reporting in a Family Medicaid case. Late reporting requires calculation and documentation of when the change should have been budgeted. Financial changes do not affect Medicaid eligibility for pregnant women or child(ren) under 19. See Continuous Eligibility information below. Refer to Section 2184 - Pregnant Woman and Section 2720 - Continuous Coverage for Pregant Women.

Continuous Eligibility

Effective January 1, 2024, eligibility for Medicaid and PeachCare for Kids® recipients should be renewed every 12 months and no more frequently than once every 12 months.Children under the age of 19 will be provided 12 months of continuous eligibility (CE) coverage regardless of change in circumstances with certain exceptions.The exception to CE includes the following:

- The child reaches age 19.
- The child is no longer a Georgia resident
- A voluntary request for closure.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- The child is deceased.

CE does not apply to:

- Medically Needy,
- Presumptive Eligibility,
- At renewal, children that are only eligible for Transitional Medical Assistance or
- Emergency Medical Assistance

Procedures

Follow the steps below to process changes.

Step 1 Document the reported change.

Step 2 Determine if the change is reported timely or untimely. Late reporting requires calculation and documentation of when the change should have been budgeted.

Step 3 Determine if verification is necessary. Request that the AU provide verification within 14 days. Refer to Chart 2712.1 - Required Verification.

Step 4 Take appropriate action based on the change reported.

Step 5 Review all electronic data sources and information known to the agency, and determine if an administrative renewal can be completed without further contact with the AU. Refer to Section 2706 - Medicaid Renewals.

Step 6 Provide the AU with appropriate notice of action taken. Refer to Section 2701 - Notification.

Use the chart below to determine if verification is required when an AU reports a change.

Chart 2712.1 - Required Verification

CHANGE	FAMILY MEDICAID
income - new source or change in amount	client statement, unless questionable for Pregnant Woman Medicaid and Deemed Newborn Medicaid* For all other COAs, self-attestation verified by electronic data sources or other information known to the agency must be used to the maximum extent possible. Refer to Section 2051 - Verification.
resources (vehicle, real property, life insurance, etc.) – acquisition, sale of, etc.	For MAGI COAs, resources are not applicable. For non-MAGI COAs, client statement, unless questionable* The value of all vehicles must be verified. Refer to Section 2308 - Vehicles. Resources must be verified if the total of all liquid and non-liquid resources exceeds 75% of the total resource limit. Refer to Section 2301 - Family Medicaid Resources Overview.
birth of a baby	client statement, unless questionable*
decrease in AU or BG size	client statement, unless questionable* MAGI Medicaid requires tax filing status to be established, document tax status statement.

CHANGE	FAMILY MEDICAID
increase in AU or BG size	A new AU member who is a U.S. citizen must provide verification of his/her citizenship/qualified immigrant status when SVES is not available. A new BG member is NOT required to verify citizenship/ qualified immigrant status or identity. A new AU member who is not a U.S. citizen must provide verification of his/her immigration status in order to confirm on WEB1. A new BG member is NOT required to verify immigration status. Refer to Section 2215 - Citizenship/Immigration/Identity. MAGI Medicaid requires tax status to be established, document tax status statement.
dependent care costs	client statement, unless questionable (non-MAGI COAs only)
medical expenses	yes (Medically Needy only) client statement, unless questionable is acceptable for all other Family Medicaid COAs for prior months requested, verification of medical expenses is not required.
pregnancy due date and the number of expected births	client statement, unless questionable* Refer to Section 2184 - Pregnant Women Medicaid.
residence	client statement, unless questionable* Refer to Section 2713 - Family Medicaid Changes in Residence.
Change in tax status	Statement is accepted, verification of tax return is not required for expected tax filer household (MAGI Medicaid only). For non-tax filer households, statement is accepted (MAGI Medicaid only)
Pre-tax or 1040 deductions (MAGI Medicaid only)	Verification is required when not available via data sources or related active cases. Refer to Section 2655 - Family Medicaid Deductions
Changes in Qualifying Hours and Activities (Pathways)	Electronic data sources may be used when applicable. Third party verification must be received if unable to verify with data sources. Refer to Section 2256 - Pathways Qualifying Activities Reporting.

*If verification is requested, the worker must document WHY the situation was considered questionable.

Use the following chart to determine procedures when an AU fails to provide verification.

Chart 2712.2 - Failure of a Family Medicaid AU to Provide Verification

IF THE AU FAILS TO PROVIDE REQUESTED VERIFICATION OF:	THEN
Questionable income that can't be verified by other sources (new source or change in amount) or change in resources (acquisition, sale, etc.) for non-MAGI COA or questionable increase or decrease in AU and/or BG size or questionable change of residence	terminate Medicaid effective the month following the expiration of timely notice, unless Continuous Eligibility prevents the termination. If all requested verification is returned within 90 days of termination (last day of the third month following termination) the case should be reinstated back to the first month following the month in which timely notice expired.
new medical expense	do not allow the medical expense in the Medically Needy spenddown calculation.
questionable change in dependent care expense (non-MAGI COAs only)	remove the original dependent care expense deduction and do not allow the new expense.
Pre-tax or 1040 deductions (MAGI Medicaid only)	Do not allow the new deductions or remove the previously allowed deductions

2713 Family Medicaid Changes in Residence

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Changes in Residence		
	Effective Date:	May 2023		
	Chapter:	2700	**Policy Number:**	2713
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-69

Requirements

When the AU moves, changes are made to ensure Medicaid cards and notices are received at the correct address.

Basic Considerations

Make address changes on the day they are reported to the agency to ensure that all correspondence is sent to the correct address.

Accept the client's statement as verification, unless questionable.

Determine if the AU still resides in the county or the state when any address change is reported.

Review household composition when the AU reports a change in residence. For MAGI Medicaid tax filing status must be used.

The National Voter Registration Act (NVRA) of 1993 requires that DFCS is to provide a voter registration form to the A/R if he/she reports an address change in person, electronically, or via telephone, facsimile, or mail that would necessitate a change in his/her voting location, Refer to 2980 Voter Registration.

Procedures

Changes of Address Within Georgia

Step 1 Document the following:

- date the AU or BG moved
- new address
- method of verification (client statement or other, if questionable)
- date the new address was reported to the agency
- individuals who reside at the new address and their relationships to the budget group (BG) and/or assistance unit (AU) members.

* For MAGI Medicaid tax status must be used.

Step 2 Determine whether the AU and/or BG compositions have changed. If so, make appropriate additions or deletions according to 2714 Family Medicaid AU/BG Composition Changes.

Step 3 Make the appropriate changes to update the address effective the ongoing month.

Make sure the County field updates to correctly match the new address.

Address Change Out of State

Step 1 Document the following:

- date the agency became aware of the AU leaving the state
- source of information regarding the AU moving from the state
- new address.

Step 2 Change the address, terminate Medicaid, and provide adequate notice.

Step 3 If any AU members remain in Georgia, determine Medicaid eligibility based on the new household composition. For MAGI Medicaid tax status must be used.

2714 Family Medicaid AU/BG Composition Changes

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid AU/BG Composition Changes		
	Effective Date:	June 2020		
	Chapter:	2700	**Policy Number:**	2714
	Previous Policy Number(s):	MT 48	**Updated or Reviewed in MT:**	MT-60

Requirements

Medicaid eligibility must be established upon any change in assistance unit (AU) or budget group (BG) composition.

Basic Considerations

Individuals who are added to an AU must meet all eligibility requirements.

A Declaration of Citizenship/Immigration Status is required if there is no previous Declaration or Application for the person being added to the AU. This is **not** required if a person is being added to the BG only.

Procedures

New AU Member

Complete the following procedures when an individual is added to the AU.

Step 1 Obtain a signed application and accept client statement, unless questionable, of the new AU member and their tax filer/non-tax filer status. Verify his/her citizenship/immigration status/identity income and resources, if applicable for the COA. Refer to 2051 Verification.

Step 2 Complete a trial budget.

If the income and/or resources (if applicable) of a new AU member are required to be included but cannot to be established, allow timely notice and terminate Medicaid for the AU.

Step 3 If the AU is eligible based on the trial budget, complete the following procedures.

- establish all points of eligibility
- request any required verification
- complete any mandatory forms

Step 4 If the AU is **eligible** based on the addition of the new AU member, add the individual and his/her income and resources (if required) to the AU effective the month s/he began living with the AU.

If the AU is **ineligible** based on the trial budget, complete a CMD and terminate Medicaid the month following the expiration of timely notice.

> Do not terminate Medicaid for a pregnant woman if eligible under Continuous Coverage. Refer to 2720 Continuous Coverage For Pregnant Women.

Step 5 Determine eligibility for the new AU member for any prior months requested.

Step 6 Notify the AU.

New BG Member

Complete the following procedures when an individual is added to the BG.

Step 1 Accept client statement, unless questionable, of the new BG member and their tax filer/non-tax filer status. A new application is not required to add a new BG member. Verify his/her income and resources, if applicable for the COA. Refer to Section 2051, Verification.

If the income and/or resources (if applicable) of a new BG member are required to be included but cannot be established, allow timely notice and terminate Medicaid for the AU.

Step 2 Complete a trial budget.

Step 3 If the AU is eligible based on the trial budget, complete the following procedures:

- establish all points of eligibility
- request any required verification
- complete any mandatory forms

Step 4 If the AU is **eligible** based on the addition of the new BG member, add the individual and his/her income and resources (if required) to the BG the month following expiration of timely notice.

If the AU is **ineligible** based on the trial budget, complete a CMD and terminate Medicaid the month following the expiration of timely notice.

- complete a CMD
- terminate Medicaid
- notify the AU

> Do not terminate Medicaid if for a pregnant woman eligible under Continuous Coverage. Refer to 2720 Continuous Coverage For Pregnant Women.

Step 5 Provide notification to the AU.

Birth of a Child

Step 1 Document the following:

- the child's name and date of birth
- the date the change is reported to the agency
- the name of the individual reporting the birth

Step 2 Establish that the child continues to live in Georgia. The parent or guardian's statement is acceptable verification.

Step 3 Approve Parent/Caretaker with Child(ren), if eligible.

If ineligible for Parent/Caretaker with Child(ren), approve Deemed Newborn Medicaid effective the month of the child's birth and ongoing. Refer to 2174 Newborn Medicaid.

Non-Custodial Parent (NCP) Returns Home

Follow procedures, in this Section, for adding a new AU or BG member.

Notify Division of Child Support Services (DCSS) via Form 713 that the NCP has returned home.

AU Member is Penalized

Apply the penalty the month following the expiration of timely notice.

Notify the AU of the penalty and the effect on Medicaid eligibility.

Budget the income and resources of the penalized individual according to the guidelines in 2657 Penalized Individuals.

Remove the penalized individual effective the month following the month the agency determines the penalty. Allow timely notice.

The penalized adult remains in the BG but not the AU unless she is a pregnant woman. Reinstate Medicaid beginning with the month of compliance.

AU Member Becomes SSI Eligible

Document the following:

- the name of the individual receiving SSI
- the date SSI was approved
- the date the change was reported to the agency
- the amount of the SSI benefit and whether RSDI is received
- method of verification (client statement or other verification)

If RSDI is received, determine if dependents of the SSI individual also receive or are potentially eligible to receive RSDI.

Provide adequate notice and make the SSI recipient ineligible effective the month after the change is reported.

> Do **NOT** consider the income and resources of the SSI individual in the Family Medicaid budget. For MAGI Medicaid include the SSI individual in the BG but exclude all income received by the SSI individual (earned or unearned) from the budget.

AU Member Reports A Marriage

Document the following:

- the name of the AU member who married
- the name of the individual s/he married
- the date of the marriage
- the date the marriage was reported to the agency

Determine the relationship of all AU members to the new spouse and his/her tax filer/non-tax filer status. Refer to 2245 Living With A Specified Relative / Tax Filer / Non-Filer Status.

If the new spouse is the parent of an AU child, follow the procedures in "NCP Returns Home", in this section.

Complete a trial budget to determine ongoing eligibility.

If the new spouse is eligible based on the trial budget, add him/her to the AU effective the month of the marriage.

If the AU is ineligible based on the trial budget, complete a CMD and terminate Medicaid the month following the expiration of timely notice.

Notify the AU.

AU or BG Member Moves out of the Home

Document the following:

- the name of the individual who left the home
- the date the individual left the home
- the date the change was reported to the agency Complete a trial budget based on the new AU or BG composition.

If removing the individual causes ineligibility of the entire AU, complete a CMD. If no COA exists under which the remaining AU members are eligible, terminate Medicaid the month following the expiration of timely notice. Otherwise, remove the individual from the AU effective the month after the change is reported.

Notify the AU.

2715 Family Medicaid Changes In Income

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Changes In Income		
	Effective Date:	September 2024		
	Chapter:	2700	**Policy Number:**	2715
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-73

Requirements

When a change in the AU's or BG's financial circumstances occurs, ongoing eligibility must be determined.

Basic Considerations

A change in income includes changes in income and/or expenses that affect the ongoing benefit amount. A change in income includes the following. This list is not all-inclusive.

- Income begins or ends
- Change in employer or obtaining new or additional employment
- Increase or decrease in the rate of pay
- Increase or decrease in dependent care expenses due to a change in provider, number of hours of care, number of individuals for whom care is given, or amount charged (Non-MAGI Medicaid only)
- Change in type of self-employment activity
- Change in self-employment income or expenses
- Change in pre-tax deductions (MAGI COAs only)
- Change in 1040 deductions (MAGI COAs only)
- Change in 5% FPL deduction (MAGI COAs only)

Changes in income must be verified. Self-attestation verified by electronic data sources or other information known to the agency must be used to the maximum extent possible. Refer to Section 2051 - Verification, and Section 2405 - Treatment of Income. Client statement is acceptable verification of income for Pregnant Woman Medicaid and Newborn Medicaid, unless questionable.

A change in financial circumstances requires a recalculation of representative income amount and a calculation of the best estimate of income based on the AU's past, current, and anticipated circumstances.

Representative income is the amount of income that best represents what the AU is most likely to receive in each pay period and is used to calculate the AU's monthly income. Refer to Section 2653 - Prospective Budgeting.

Normal fluctuations in the income amounts are not considered a change in circumstances and do not require a recalculation of representative income. Normal fluctuations include the following:

- overtime not expected to last for more than one calendar month
- a fifth or periodic paycheck
- vacation/sick pay received within a calendar month.

This list is not all inclusive. Refer to Section 2653 - Prospective Budgeting.

Continuous Eligibility

Effective January 1, 2024, children under the age of 19 will be provided 12 months of continuous eligibility (CE) coverage regardless of change in circumstances with certain exceptions. The exceptions to CE include the following:

- The child reaches age 19.
- The child is no longer a Georgia resident
- A voluntary request for closure.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- The child is deceased.

CE does not apply to:

- Medically Needy,
- Presumptive Eligibility,
- At renewal, children that are only eligible for Transitional Medical Assistance or
- Emergency Medical Assistance.

If a child becomes incarcerated during their CE period, then the child must remain eligible for the remainder of the CE period while incarcerated.

Procedures

New Earnings

Document the following:

- date the change is reported to the agency
- who is employed and where s/he is employed
- when employment began and date of the first paycheck
- termination date of previous employment, if applicable
- the estimated number of hours per week of employment and hourly wages

- the frequency of pay and pay dates
- the source of verification
- dependent care expenses (non-MAGI COAs only)
- third party liability, if applicable
- change in pre-tax deductions (MAGI COAs only)
- change in 1040 deductions (MAGI COAs only)

If the AU is ineligible based on the trial budget, complete a CMD and terminate eligibility. Notify the AU.

If the Family Medicaid AU is eligible based on the trial budget, using anticipated income and expenses, refer to Section 2653 - Prospective Budgeting, and complete the following procedures:

- establish representative pay
- budget the income effective the month following the expiration of timely notice and after verification is received, if required

Continue Medicaid for the AU members in Family Medicaid other than FM-MN. In Family Medicaid-Medically Needy (FM-MN) cases:

- Eligibility for all MAGI and Non-MAGI Medicaid COAs and PeachCare for Kids ® must be ruled out prior to determining eligibility under FM-MN
- Recalculate all income received and calculate prospective income for each month remaining in the budget period.
- If the budgeted income places the case in spenddown status or increases the spenddown amount, change the case status in the system and notify the AU

Do not deny a case as over income if it is cascading to FM-MN. Allow the case to cascade and close appropriately if client reports no medical expense or bills. Ensure the A/R receives the correct FM-MN disposition notice as well as a referral to the FFM.

If client reports medical bills/expenses, request the BG to submit any medical bills not covered by Medicaid to apply to the spenddown. If budgeted income does not change the eligibility status, document the record.

Loss of Income or Decrease in Income

Document the following:

- the type of change
- the effective date of the change
- the date the change is reported to the agency
- method of verification
- changes in pre-tax deductions (MAGI COAs only)
- changes in 1040 deductions (MAGI COAs only)

- change in dependent care expenses (non-MAGI COAs only)

Remove or decrease the income the month after the change occurs and was reported. If the AU is in the MN spenddown, recalculate the spenddown.

Late reporting requires calculation and documentation of when the change should have been budgeted.

Explore all benefits to which the AU may be entitled.

Increase in Income

Document the following:

- the effective date of the change
- the date the change is reported to the agency
- the type of increase (number of hours, rate of pay)
- the amount of the increase
- method of verification
- change in pre-tax deductions (MAGI COAs only)
- change in 1040 deductions (MAGI COAs only)
- change in dependent care expenses (non-MAGI COAs only)

Complete a trial budget to determine ongoing eligibility.

If the AU is ineligible based on the trial budget, complete a CMD and terminate eligibility the month following timely notice. Notify the AU.

If the AU is eligible based on the trial budget, refer to Section 2653 - Prospective Budgeting, and complete the following procedures:

- budget income effective the month following the expiration of timely notice
- if the AU is MN, recalculate the income for the budget period. If the increased income affects spenddown, notify the AU.

Late reporting requires calculation and documentation of when the change should have been budgeted.

Change in the Source of Income

Document the following:

- the date the change in income is reported to the agency
- the date that the new or changed income is first received
- who receives the income
- the source and type of the new income

- the frequency of the income and day of the week received
- the amount of the income
- method of verification
- change in pre-tax deductions (MAGI COAs only)
- change in 1040 deductions (MAGI COAs only)
- change in dependent care expenses (non-MAGI COAs only) Complete a trial budget to determine ongoing eligibility.

If the AU is ineligible based on the trial budget, complete a CMD and terminate Medicaid the month following the expiration of timely notice. Notify the AU.

If the AU is eligible based on the trial budget, complete the following procedures:

- determine ongoing eligibility by establishing representative pay, and, if appropriate, converting this income using the correct conversion factor for the ongoing benefit month. Refer to Section 2653 - Prospective Budgeting.
- notify the AU
- if the AU is FM-MN, recalculate the income for the budget period. If the change in income affects spenddown, notify AU and make the necessary changes to the case.

Late reporting requires calculation and documentation of when the change should have been budgeted.

MAGI Medicaid includes taxable income only in the BG.

Non-MAGI Medicaid includes or excludes income differently than MAGI Medicaid in the BG. Refer to Section 2499 - Treatment of Income in Medical Assistance.

Unearned Income: Child or Spousal Support Income

Document the following information if child or spousal support is reported as a new source of income or a change in child or spousal support is reported:

- the date the change is reported to the agency
- the date the new child or spousal support or change in child or spousal support was first received by the AU
- the frequency of receipt of the income
- the day of the week it is received
- the amount of the income
- who pays the child or spousal support and for which child
- method of verification

Calculate a trial budget to determine ongoing eligibility. MAGI Medicaid does not include child support in the budget.

Non-MAGI Medicaid includes child support and spousal support in the budget.

If the AU is ineligible based on the trial budget, complete the following procedures:

- if receiving Parent/Caretaker with Child(ren), change the COA to Four Months Extended Medicaid (4MEx) if all 4MEx requirements are met.

> If the increase in spousal support occurs concurrently with an increase in earned income, TMA may be approved if the earned income change is what caused the case to be ineligible for Parent/Caretaker with Child(ren). Refer to Section 2166 - Transitional Medical Assistance.

- complete a CMD
- if ineligibility will only last for one month, suspend benefits. Offer MN before suspending benefits.
- notify the AU and allow timely notice.

If the AU is eligible based on the trial budget, complete the following procedures:

- determine the amount of child or spousal support and add the child or spousal support to the budget. Refer to Section 2653 - Prospective Budgeting.
- allow timely notice
- notify the AU.

Unearned Income: Loss of Child or Spousal Support

Document the following:

- the date the AU or BG last received child or spousal support
- the date the loss of child or spousal support is reported to the agency
- the reason for the loss of child or spousal support, if applicable
- method of verification

Delete the child or spousal support income for the ongoing benefit month and notify the AU.

> For FM-MN AUs, consider the effect of the loss of child or spousal support on spenddown status.

MAGI Medicaid does not include child support in the budget.

Non-MAGI Medicaid includes child support and spousal support in the budget.

Non-MAGI Medicaid earned income of a child is not included in the BG. Certain unearned income of a child is included in the BG. Refer to Section 2499 - Treatment of Income in Medical Assistance.

Income of a Child

MAGI Medicaid does not include taxable income of a child in the BG when the total taxable amount

is below the allowable IRS dependent exemption amount regardless if the child is required to file a tax return and/or if they do file a tax return. The dependent exemption amount is established by IRS yearly and is set each January for the previous tax year. The dependent exemption will be used for the current MAGI Medicaid year. Refer to Section 2610 - MAGI Budget Groups/Assistance Units for each tax year threshold amount.

Filing a tax return and filing for a tax refund are not the same.

Changes in Deductions to Income

Consider the effect of the following on eligibility:

- Pre-Tax Deductions (MAGI Medicaid only)
- 1040 Deductions (MAGI Medicaid only)
- 5% FPL Deduction (MAGI Medicaid only)
- a change in dependent care expenses (non-MAGI only)
- a change of medical expenses (FM-MN only)
- expiration of the $30 plus 1/3 deduction because of time limitations. **(obsolete as of 1/1/14)**
- $90 work expense (Non-MAGI Medicaid only)

Document the following:

- the type of deduction that changed
- the date the change occurred
- the date the change is reported to the agency
- how the deduction changed
- method of verification (client statement or other verification). Document reason verification was requested.

Complete a CMD, if necessary. Recalculate the budget, including the new deduction amount. Provide timely notice of any change(s) to the AU.

2716 Family Medicaid Miscellaneous Changes

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Miscellaneous Changes		
	Effective Date:	September 2024		
	Chapter:	2700	**Policy Number:**	2716
	Previous Policy Number(s):	MT 69	**Updated or Reviewed in MT:**	MT-73

Requirements

Other changes may occur which may require action. Evaluate reported changes for necessary action.

Basic Considerations

Mass Changes

Mass changes affect all or a large number of AUs receiving benefits. These changes may include the following:

- adjustments to income limits
- adjustments to dependent care deductions
- cost of living adjustments to SSA, SSI, VA, and other benefits
- other changes based on legislative or regulatory actions.

Mass changes are generally completed by system changes and require no worker intervention. Adequate notice is required.

Cases affected by the mass change but not updated by the system may require the worker to initiate a change. A list is generated to notify the worker which cases will not be updated in the mass review so that the worker may take appropriate and timely action.

Closure: AU Request Closure

Document the following:

- the reason for the closure
- the date the closure is requested.

Terminate ongoing benefits after giving timely notice.

If the request for closure is in writing, only adequate notice is required.

EDD Contact on Pregnant Women

Complete the following procedures in contacting a pregnant woman each month beginning with the month prior to the EDD:

- Contact the pregnant woman by telephone, letter or face-to-face.
- Establish by the A/R's statement that the pregnancy continues, reminding the pregnant woman to notify the agency when the pregnancy terminates. Also, remind the pregnant woman of her right to apply for TANF 45 days prior to the expected date of delivery.
- Continue to contact the pregnant woman each month until the pregnancy terminates.

If she reports her pregnancy has terminated but is now pregnant, do not change the EDD information. Terminate the pregnancy by entering termination date on the current pregnancy record. Create a new pregnancy record with the new EDD reported and Circumstance Change Date based on reported on date to prevent billing and medical service issues.

When a pregnancy terminates, continue Medicaid through the 12-month extended postpartum period. Refer to Section 2174 - Newborn Medicaid.

Processing the 12-month Extended Postpartum Period

Complete the following procedures to process the 12-month extended postpartum period Medicaid when pregnancy terminates for a Medicaid eligible pregnant woman.

- Determine date of termination.
- Start the 12-month count beginning the month after termination of pregnancy.
- Continue Medicaid for the pregnant woman through the end of the 12th month .
- Begin a CMD by the 12th month of the postpartum period and complete the process prior to the end of the 13th month.
- If Medicaid eligibility does not continue, terminate Medicaid on the pregnant woman and refer to the Federally Facilitated Marketplace (FFM). Send timely notice.

Processing Newborn Medicaid

When a pregnancy terminates with the birth of a child, use the following procedures to process eligibility for the newborn:

- Determine if Parent/Caretaker with Child(ren) eligibility exists.
- If ineligible for Parent/Caretaker with Child(ren), establish that mother was eligible for and receiving Medicaid on the day the child was born. Refer to Section 2174 - Newborn Medicaid for the definition "receiving Medicaid on the day the child was born".
- Approve Newborn Medicaid for the month of birth and ongoing pending contact with the parent or caretaker.
- Continue ongoing Medicaid for the child if eligible. If ineligible, complete a CMD.
- Discuss third party liability and complete Form DMA-285, Third Party Liability, if necessary.
- Begin a CMD in the 12th month of Newborn eligibility and complete the process by the 10th of the

13th month of eligibility.

- If a child is eligible under another COA, process as required. Complete a renewal, administrative, alternate, or standard, to determine all points of eligibility. If eligibility continues, approve the child under the appropriate COA.

If eligibility does not continue under any COA, provide a termination notice.

Children Under 19 Years of Age Medicaid Recipient Reaches an Age Limit

Use the following procedures when a Children Under 19 Years of Age Medicaid recipient reaches an age limit.

- For a child receiving inpatient services in the month s/he reaches an age limit, refer to Section 2182 - Children Under 19 Years of Age.
- Complete a new budget using the appropriate Children Under 19 Years of Age income level for the child's age.
- If eligibility continues, send a notice to inform the AU of the change in eligibility.
- During interim changes, if CU19 Medicaid recipient is between the ages of 1-5 or 6 and up to 19 is over the income limit, do not refer the child(ren) to PeachCare for Kids® or the FFM/Georgia Access due to continuous eligibility restrictions. Refer to Continuous Eligibility below.

> When a Children Under 19 Years of Age child reaches the 19-year age limit, complete a CMD. Begin this process in the month prior to the individual's 19th birthday and complete the CMD by the 10th of the last month s/he will be 19 years old. If ineligible for any other Medical Assistance COA, then refer the client to the FFM/Georgia Access.

Changes in MN Case During the One Month Budget Period

Use the following procedures to re-calculate eligibility for Medicaid when an A/R reports any of the following changes in a MN case during the one-month budget period:

- an increase or decrease in income
- a change in BG size
- additional medical expenses
- an increase or decrease in resources
- a change in dependent care expenses

> The result of any of these changes may cause the AU to become eligible earlier in the budget period month, may cause the case to go from eligible for Medicaid to spenddown status, or may increase or decrease the spenddown.

- Request verification of the change if required.
- Determine the actual income that has been received and/or the BG size for the budget period.
- Anticipate income and expenses for the remainder of the budget period.
- Determine BG composition for the budget period.

> If a BG member was living in the home at any time in the month, count this individual in determining the BG size.

- Re-calculate eligibility.
- Subtract any allowable deductions from the total income
- Subtract the MNIL from the net income.
- If the result is equal to or less than the MNIL, approve or continue de facto eligibility.

> If this change results in de facto eligibility, the case becomes eligible for Medicaid in the month the change occurred.

- If the result exceeds the MNIL, this is the spenddown amount. Apply any incurred medical expenses chronologically to this spenddown. If spenddown is met, approve MN for the AU on the day spenddown is met. Provide Form 400, as required. If the spenddown is not met, return the case to spenddown status, or continue spenddown the following month.
- Notify the AU of any action on the case.

Other Changes in a MN Case

When the pregnant woman in a MN case reports termination of pregnancy, use the procedures in Chart 2716.1 to process Medicaid.

Continuous Eligibility

Effective January 1, 2024, children under the age of 19 will be provided 12 months of continuous eligibility (CE) coverage regardless of change in circumstances with certain exceptions.The exceptions to CE include the following:

- The child reaches age 19.
- The child is no longer a Georgia resident
- A voluntary request for closure.
- The agency determines that eligibility was erroneously granted at the most recent determination, redetermination, or renewal of eligibility because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- The child is deceased.

CE does not apply to:

- Medically Needy,
- Presumptive Eligibility,
- At renewal, children that are only eligible for Transitional Medical Assistance or
- Emergency Medical Assistance.

If a child becomes incarcerated during their CE period, then the child must remain eligible for the remainder of the CE period while incarcerated.

Use the chart below to determine if verification is required when an AU reports a change.

CHART 2716.1 – OTHER CHANGES IN A MN CASE

IF	THEN
the pregnant woman was correctly approved for Medicaid	provide the 12-month extended postpartum coverage.
the pregnant woman's case was in spenddown status and the bills incurred on the day of the termination of pregnancy met spenddown	verify all actual income and expenses that have been received for the budget period and anticipate income and expenses for the remainder AND recalculate the budget and all incurred medical expenses in chronological order AND approve Medicaid the day spenddown is met through the 12-month extended postpartum period, even if it extends beyond the budget period AND Provide Form 400 as needed. If spenddown is met on the pregnancy termination date or prior, the pregnant woman is eligible for Medicaid and the child is eligible for Newborn coverage.
if the mother is or becomes Medicaid eligible	approve the child for Newborn coverage.

CHART 2716.1 – OTHER CHANGES IN A MN CASE

If an A/R submits an unpaid medical expense that was incurred during or prior to the budget period but after the budget period has expired, apply the bill to the spenddown if the following two conditions are met:

- spenddown for the budget period will be met or adjusted by allowing this expense

AND

- the bill is presented within three months of the expired Budget Period.

If these conditions are met, follow the procedures in this chart.

If the three-month time limit has passed, allow the bill in any current or future budget period if the BG member is still legally obligated to pay the bill and there is no Third-Party Liability coverage available.

2720 Continuous Coverage For Pregnant Women

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Continuous Coverage For Pregnant Women		
	Effective Date:	December 2022		
	Chapter:	2700	**Policy Number:**	2720
	Previous Policy Number(s):	MT 65	**Updated or Reviewed in MT:**	MT-68

Requirements

A pregnant woman, adult or minor, who becomes or would otherwise become ineligible for any Medicaid Class of Assistance (COA) because of a change of an Assistance Unit (AU) or Budget Group (BG) member remains eligible for Medicaid for the remainder of her pregnancy and through the 12-month extended postpartum period.

See Section 2184 Pregnant Women for the eligibility criteria for the 12-month extended postpartum period.

Basic Considerations

Continuous coverage for a pregnant woman applies in the following situations:

- a pregnant woman who becomes ineligible for SSI because of an increase in income or resources
- a pregnant woman who becomes ineligible for any Medicaid COA because of a change such as an increase in net taxable income, sanctioned for failing to cooperate with DCSS, etc.

For Women's Health Medicaid if she becomes pregnant and is eligible for Pregnant Woman Medicaid, a CMD to Pregnant Woman Medicaid must be completed. After her continuous coverage period expires, complete a CMD to Parent/Caretaker with Child(ren) Medicaid. If ineligible for Parent/Caretaker with Child(ren), CMD back to WHM if she is still eligible. Her child(ren) will be a deemed newborn(s). If a PeachCare for Kids_®_ enrollee becomes pregnant, a CMD to Pregnant Woman Medicaid must be completed.

For continuous coverage purposes, an increase in net taxable income includes any one of the following:

- an increase in the AU's or BG's taxable income
- a decrease or loss of MAGI deductions
- a decrease in the number of individuals included in the AU and/or BG per stated tax status
- the addition to the AU and/or BG of an individual with taxable income per stated tax status
- expiration of the MN budget period if the pregnant woman was Medicaid eligible or would have been if her pregnancy was known
- any other change that results in excess net taxable income.

Continuous coverage for a pregnant woman includes reinstatement of Medicaid if a voluntary closure or other termination has occurred, whether or not the pregnancy was known at the time of termination.

A pregnant woman who is approved for EMA is not automatically eligible for the 12- month extended postpartum period. She may, however, qualify for additional days of EMA **during** the 12-month extended postpartum period if she receives pregnancy-related emergency treatment. Refer to Section 2184, Pregnant Women.

Procedures

Use the following procedures to establish continuous coverage eligibility for a pregnant woman:

Step 1

Determine that the pregnant woman would otherwise be ineligible to continue Medicaid under the current COA because of an increase in AU/BG net taxable income or other change.

or

Determine that a pregnant woman is ineligible for SSI because of an increase in income or resources. The following sources may be used to verify SSI ineligibility:

- SSI notification letter
- State Data Exchange (SDX)
- other verification from the Social Security Administration
- GAMMIS

Step 2

Establish that the woman was pregnant during the last month of Medicaid eligibility and that her pregnancy has terminated.

Step 3

Determine that the pregnant woman met non-financial eligibility requirements during the last month of eligibility for the COA under which Medicaid is being or would be terminated.

Step 4

Continue Pregnant Woman coverage or approve Pregnant Woman if the pregnant woman is/was not actively receiving Medicaid under another COA.

Special Considerations

A pregnant woman who is correctly determined Medicaid eligible remains financially eligible from the effective month of approval through the end of the 12-month extended postpartum period, regardless of changes in the BG income.

Pregnant individuals (including Individuals in their postpartum period) can be terminated for the following reasons:

- Voluntary termination
- Moves out of state
- Invalidly enrolled
- Death

> Gaining SSI is not an allowable reason for termination during the 12-month extended postpartum period.

If a pregnant individual is actively enrolled in PeachCare for Kids_®_ at delivery/termination of pregnancy, the individual must remain eligible in PeachCare for Kids_®_ through the last day of the month in which the 12-month extended postpartum period ends regardless of any changes in circumstances that may affect eligibility (aging out, income, household composition, non-payment of premium or becoming Medicaid/SSI eligible).

2750 DCH Reports-Ex Parte Lists

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	DCH Reports-Ex Parte Lists		
	Effective Date:	December 2022		
	Chapter:	2700	**Policy Number:**	2750
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-68

Requirements

Monthly reports are generated by the Department of Community Health (DCH) or DCH's contract entity and are transmitted by Gainwell Technologies to Gateway. Eligibility determinations are completed by local Department of Family and Children Services (DFCS) offices and/ Right from the Start (RSM) Outreach Project offices for required action.

Basic Considerations

As part of the Continuing Medicaid Determination (CMD) process for selected A/Rs whose SSI benefits are terminated or denied, DCH makes temporary determinations of continued eligibility under a new Ex Parte Medicaid Class of Assistance. Four reports listing these individuals are generated and are accessible via Gateway. Gateway generates the following reports for tracking Ex Parte individuals received monthly from the GAMMIS file and the disposition of these cases. The reports are as follows:

- **SSI Ex Parte Determination List**

Monthly report generated on the 2nd business day of the month. Report lists individuals received in the Inbound Ex Parte file for the month.

- **Dispositioned Ex Parte Report**

Monthly report generated on the 2nd business day of the month. Report includes all clients that were processed and authorized as part of the Ex Parte automation and will include all clients approved or denied by eligibility worker the prior month.

- **Pending Ex Parte Report**

Daily report that is ran Monday-Friday. Report includes all clients that were received in Inbound Ex Parte file from GAMMIS that have not been disposed. This includes clients that a verification checklist has been sent requesting more information. The report may show same client multiple times if received during different months. The client received date will be different.

- **SSI Ex Parte Exception**

Monthly report generated on the 2nd business day of the month. Report includes all individuals received on the Inbound Ex Parte file from GAMMIS, but Gateway was unable to automate the application registration for the client. This report is reviewed by designated staff.

Procedures

Effective 09/01/2022, enhancements to Gateway and GAMMIS were made to automate the Ex Parte eligibility determination process

Automated Process

The steps below detail the automated process and the procedures for eligibility worker to complete upon receipt the generated tasks.

Step 1

Gateway receives a monthly file from GAMMIS. This file includes all new SSI Ex Parte determinations and made by DCH for the prior month resulting in eligibility for Aged, Blind, and Disabled (ABD) COAs or MAGI Family Medicaid COA. This includes terminations from SSI.

Step 2

Gateway will automate the application registration. If A/R is known to
Gateway system, it will associate the application to the established case number, if one exists. During case application registration process if the A/R is receiving Ex Parte Medicaid based on an ABD COA, the application will be flagged as ABD to ensure correct routing.

Step 3

Gateway will generate either an Ex Parte Intake or Change task and route to the appropriate worker based on their Gateway role.

Step 4

Worker receives Ex Parte Intake or Change task and using SDX/BENDEX, DOL, Vital Records, Ex Parte interface, related cases, and any other available information, determine eligibility for an appropriate COA, either the COA specified by the report or, if appropriate, a COA that provides a higher level of coverage. If necessary, contact the client to clarify any missing or unclear information. Citizenship/Immigration must be established. If there is not enough information to make a determination, send Form 508, 94A or 700 with an SSI Continuing Medicaid Determination Notice and checklist to the client with an appropriate due date.

In the absence of evidence to the contrary, assume all other eligibility criteria have been met and that SSA has determined there has been no transfer of assets. Ex Parte Interface can be accessed on the Person Detail screen by selecting the “EX” icon or through Interface by entering at minimum the A/R’s SSN to review the information received on the file. For Ex Parte ABD tasks created do not assume that the A/R is Medicare eligible.

NOTES:

- For Waiver COAs Aid Category 449 or Category code “Waivered Services”, use Ex Parte Interface which provides PA begin and PA end dates needed.

Additional LOC and Communicator are not required. Process as EDWP (CCSP), NOW/COMP or ICWP based on PA information on report.

- Assume SSA has forwarded TPR information to DCH

- Prior receipt of SSI is prima facie evidence of disability for 12 months from the SSI termination date unless SSI was terminated for failure to meet disability criteria.
- For Public Law COAs, determine COLA and entitlement to or increases in RSDI based on SDX/BENDEX, using the best estimate possible.
- For Ex Parte ABD tasks, do not assume that the A/R is Medicare eligible.

Step 5

Approve or deny the case and document the case record within 10- days of receipt of the file (this should be equal to the task generation date).

NOTE For Spend Down Cases: The system generated notice, which includes Medicaid eligibility information, replaces Form 962. Complete a Form 962 only if eligibility cannot be entered in the system, such as a three-month prior application that is greater than thirteen months old.

A complete redetermination of eligibility must be completed on all cases when a change is reported, or within 12 months after the SSI termination, whichever comes first. Contact with the individual may be required to complete this process.

Step 6

Notify the A/R of the eligibility decision.

Step 7

Upon completion of case and task disposition, Gateway will notify GAMMIS of A/R's approval or denial through daily interface files sent from Gateway to GAMMIS

Step 8

GAMMIS updates the A/R's eligibility in their system and removes them from the non- confirmation reports.

If Gateway is unable to automate the registration of an Ex Parte A/R received on the monthly file then the A/R will be placed on an Exceptions report and reviewed by designated staff.

Other Considerations

Continued SSI Eligibility

For individuals that are currently receiving SSI, no action is required.

Documentation

Follow current documentation standards

All actions taken on an Ex Parte case must be documented in case note.

Document Management

All forms including cover letter are available in Gateway correspondence.

Eligible in GAMMIS, But Not on List

The CMD process must be documented.

At times an individual may become known to DFCS who is showing eligible on GAMMIS but has never appeared on an Ex Parte list and is not eligible on Gateway, SDX or PeachCare for Kids®. Treat these individuals as Ex Parte individuals by either registering an application or by updating an existing case. Gateway will create a task when an application is registered. Worker will need to create a manual task if updating an existing case is necessary. For both applications and changes, the Ex Parte indicator **MUST** be selected on the Program Request screen when processing the case. Continue by following steps on page 3 beginning with Step 4.

If the A/R is eligible for full Medicaid, approve on Gateway as soon as possible.

If the A/R is not eligible for full Medicaid, such as AMN or Q Track, approve on Gateway beginning with the first month following the end date reflected from DCH.

2751 SSA Medicare Savings Programs Applications

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	SSA Medicare Savings Programs Applications		
	Effective Date:	June 2021		
	Chapter:	2700	**Policy Number:**	2751
	Previous Policy Number(s):	MT 38	**Updated or Reviewed in MT:**	MT-64

Requirements

The **Medicare Improvements for Patients and Providers Act of 2008 (MIPPA)** was enacted on July 15, 2008. MIPPA includes the following provisions that effect policy and procedures for Medicare Savings Programs (MSPs). MSPs include Qualified Medicare Beneficiary (QMB), Specified Low Income Medicare Beneficiary (SLMB), Qualifying Individual (QI-1) and Qualified Disabled Working Individual (QDWI).

Effective January 1, 2010, MIPPA requires the Social Security Administration (SSA) to electronically transmit data from Low Income Subsidy (LIS) applications, both approved and denied, to the State Medicaid agency for the purpose of determining eligibility for MSPs and **other Medicaid classes of assistance.**

Basic Considerations

On January 1, 2010, the Department of Community Health (DCH) began accepting LIS application data daily from SSA. The applicants will be screened on GA Gateway for a matched individual. When a matched individual is not found in GA Gateway, an application is registered with a task generated to determine Medicaid eligibility. When a matched individual is found and not already receiving Medicaid in GA Gateway, an application is registered if applicable and a task generated or a program request task generated to determine Medicaid eligibility. When a matched individual is found and already receiving Medicaid, an application is registered, and the application number withdrawn or denied. DFCS will not receive the actual LIS applications, but the LIS information provided by SSA interface should be processed according to existing Medicaid policy.

Refer to Section 2146, Low Income Subsidy, for completing the Low-Income Subsidy Application (LISA), and refer to Section 2931, Medicare Part D and Low-Income Subsidy for more information on Medicare Part D.

Procedures

Follow the steps below upon receipt of the Medicare Savings Programs Applications list.

Step 1

Register the application if applicable. Do **not** require a separate signed Medicaid application. The signature on the LIS application filed with SSA will be considered a valid signature to apply for Medicaid. The application date will be the date the LIS application is filed with SSA. However,

the date SSA transmits the LIS data file to GA Gateway will be regarded as the beginning date for determining whether cases were completed timely. Cases should be completed within 10 business days of the transmission date for Q-track processing.

Step 2

Using LIS Interface, LIS Information from SSA PDF, SDX/BENDEX, DOL, Vital Records, related cases, and **any other available information**. Determine eligibility for Qualified Medicare Beneficiary Track Medicaid or a COA that provides a higher level of coverage if eligible. In the absence of evidence to the contrary, assume all other eligibility criteria have been met.

NOTES:

- The LIS address data will only contain a mailing address with the zip + 4 digit zip code which may not be the same as the residential address. This may require follow-up with the AU to obtain residential address and additional contact information.
- The income data from the LIS applications is combined for married couples and may not specify individual income. The income may be the result of self declaration, a direct match from the Internal Revenue Service (IRS), or some other source and may be accepted as verification for all Q-track COAs unless questionable.
- The resources data from the LIS applications is also combined for married couples and may not specify individual resources. The resource amount may be the result of self-declaration or some other source and may be accepted as verification for all Q-track COAs unless questionable.
- The income and resources data from the LIS application do **not** meet verification standards for other Medicaid classes of assistance and will have to be verified by third party documentation if the A/R appears eligible under another COA (see Section 2051-1, Verification, of the Medicaid Policy Manual).
- TPR – Social Security Administration does not address assignment of third- party rights in the LIS application. TPR for these applications will have to be addressed in accordance with Section 2230 of the Medicaid policy manual.

Step 3

Send a Verification Checklist or a DHR 700 form along with the Medicare Savings Programs for Information (MIPPA Cover Letter) to request additional information or verification when required. The MIPPA cover letter is available as a MS Word form template. Simply double click the template to open
it in MS Word. The date at the top of the form will be set when the form is saved. After saving the completed form, reopen and print so that the date will print correctly.

Step 4

Eligibility for SLMB, QI1, QDWI and other Medicaid aid categories are to be made retroactive to the month of the LIS application date and, if appropriate, three months prior.

Step 5

Eligibility for QMB begins the month **following** the month of the LIS application **unless** the disposition cannot be completed because of **applicant delay**. If the disposition cannot be completed within the standard of promptness because of applicant delay the eligibility should begin the **month following the month of case disposition**. If the delay is due to

agency or other agency use the QMB override feature to not penalize the A/R for any month(s) of ineligibility (see
to Section 2143-4 Step 6 in the Medicaid Policy manual).

2752 DCH Presumptive Reports

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	DCH Presumptive Reports		
	Effective Date:	June 2020		
	Chapter:	2700	**Policy Number:**	2752
	Previous Policy Number(s):	MT 48	**Updated or Reviewed in MT:**	MT-60

Requirements

DCH notifies DFCS of Presumptive Eligibility determinations and Newborn enrollments through the issuance of four periodic reports. DFCS is required to act on these reports.

Basic Considerations

Certain "qualified providers" are authorized to perform eligibility determinations for pregnant women and most participating providers can enroll Deemed Newborns into Medicaid. DCH notifies DFCS of Presumptive Eligibility Determinations and Deemed Newborn enrollments through the issuance of four periodic Presumptive Eligibility reports. All four reports are available to local DFCS and Right from the Start Project offices on-line at www.mmis.georgia.gov.

The reports are an effective management tool. Proper handling and updating of the information contained on the reports ensure correct closure of Presumptive Eligibility and deemed newborn records when pregnant women and infants are approved under regular categories of medical assistance. Linkage of provider generated member ID numbers to GA Gateway generated client and assistance unit identification numbers eliminates duplication of records and facilitates the Medicaid claims payment process.

Pregnant Women

In order to eliminate barriers to health care and to expedite enrollment into the Medicaid program, qualified hospitals participating in the Hospital Presumptive Eligibility (HPE) program and the following "qualified providers" are authorized to perform temporary or presumptive eligibility determinations for pregnant women:

- Public Health (PH) Departments
- federally qualified health centers
- rural health centers
- Grady Hospital

These providers have the capacity to enter, or have entered for them by DCH's fiscal agent, eligibility information directly into the GAMMIS system. The report produced as a result of these eligibility determinations:

- Presumptive Pregnant Add Report

This report is generated monthly and shows the names of pregnant women determined presumptively eligible for Medicaid by "qualified providers". Information on this report includes the date the pregnant woman's eligibility was added to GAMMIS, her member identification number, her beginning date of eligibility, her date of birth and her address.

Newborns

An infant, born to a woman receiving Medicaid on the day the infant is born, qualifies for Deemed Newborn Medicaid until it reaches its first birthday. There is no separate eligibility determination and most Medicaid participating providers can enroll a deemed newborn into the program. These provider enrollments generate the following two reports:

- Presumptive Newborn Add Report

This report is generated monthly and shows the names of deemed newborns added to GAMMIS as a result of enrollment by a Medicaid participating provider. Information on this report include the deemed newborn's name, member identification number, the date the newborn was added, the beginning date of eligibility, the deemed newborn's date of birth, and the mother's name and address.

- Presumptive Newborn Non-Confirmation Report

This report is generated monthly and shows all entries from the Presumptive Newborn Add Report that are over 30 days old and no action has been taken.

Although the Newborn reports are labeled as Presumptive, there is no presumptive eligibility program or process for newborns. These children are deemed newborns and are not limited to Family Medicaid or ABD Medicaid. They also include deemed newborns born to a mother receiving SSI Medicaid, Women's Health Medicaid, and PeachCare for Kids®.

Procedures

When DFCS receives the Presumptive Eligibility and Newborn reports, they should act on the cases and notify DCH of the correct client ID and case number. Notification is accomplished by accessing and updating information through the GAMMIS system.

Pregnant Women

Either report can be used to update the GAMMIS system. Information pertaining to the pregnant woman is on the web portal. Entry of the member identification number, as shown on either report, in the Member Identification field of the **View/Update Presumptive Eligibility** screen of the web portal, allows access to her data record.

Step 1 "Qualified providers and qualified hospitals" send a Presumptive Eligibility (P.E.) packet to the RSM Project or local county DFCS office. This packet contains the DFCS copy of the PE application, an application for Healthcare coverage, and supporting documents.

Step 2 Register the application in GA Gateway, using the application date contained on the documents in the P.E. packet. This is the date the woman applied for Medicaid with the "qualified provider". This date will be the same as the **ADDED DT** on the report. If there is a discrepancy in the date on the application and the **ADDED DT**, register the application using the **ADDED DT**. This is the date eligibility information was added to GAMMIS. Do **NOT** require an additional signed Healthcare coverage application.

Step 3 Access View/Update of Presumptive Eligibility* screen on the GAMMIS web portal to update and link the member ID and GA Gateway identification numbers.

> It is not mandatory for the update to occur at application registration. However, it must occur before or on the same day the case is approved or denied in GA Gateway.

Step 4 Using SDX/BENDEX, DOL, related cases, and information in the PE packet, determine eligibility for Pregnant Woman Medicaid or other appropriate COA. Contact the client when information needs to be clarified or to obtain missing information.

> If the applicant has children, screen for potential Parent/Caretaker with Child(ren), Children Under 19 Years of Age, or PeachCare for Kids® eligibility.

Step 5 Approve or deny the case and document the case record within 10 days of receipt of the report. If linkage of member ID and GA Gateway identification numbers did not occur after application registration, it must occur the same day the case is either approved or denied on GA Gateway.

Step 6 Notify the A/R of the eligibility decision.

Newborns

Either report can be used to update the GAMMIS system. Information pertaining to the newborn is on the web portal. Entry of the infant's member identification number in the **View/Update Presumptive Eligibility** screen on the portal allows access to the data record.

Step 1 The infant is enrolled by the provider. The county office will not receive an application or packet. For most providers, enrollment is an on-line, paperless process.

Step 2 Register an application on GA Gateway for the deemed newborn using the date of birth from either Newborn list. Do NOT require a signed Healthcare coverage application.

Step 3 Access **View/Update of Presumptive Eligibility** screen on the GAMMIS web portal to update and link the member ID and GA Gateway identification numbers.

> This is not mandatory for newborns added to GA Gateway through the automation process. However, if a newborn is being added manually by the eligibility specialist the linking must occur before or on the same day the case is approved or denied in GA Gateway.

Step 4 Confirm that the deemed newborn's mother correctly received Medicaid on the deemed newborn's date of birth. If the mother correctly received Medicaid, proceed to Step 5. If Medicaid was not received, or was incorrectly received, deny Deemed Newborn Medicaid and complete a CMD.

> The 'correctly receiving' criterion is met if the mother is approved for Medicaid after delivery and the approval includes the delivery date.

Step 5 Confirm that the deemed newborn continues to reside in the state of Georgia. There is no reason to contact the parent or caretaker for that information if the child is on the newborn list, unless DFCS has information to the contrary.

In situations where the deemed newborn does not reside with the birth mother, process eligibility following the steps for when a child lives with a female or male caretaker/relative.

Step 6 Approve or deny the case and document the case record within 10 days of receipt of the report. If linkage of member ID and GA Gateway identification numbers did not occur after application registration, it must occur the same day the case is either approved or denied on GA Gateway.

Step 7 Notify the A/R of the eligibility decision.

> Currently there is an automated process that adds newborns' Medicaid eligibility to GA Gateway via a daily interface file from GAMMIS. For newborns that could not be added through this automation due to exceptions or were not received in the file, they will be added using the steps 1-7 described above.

Non-Confirmation reports

Non-confirmation reports are generated as a result of member identification numbers not being linked to GA Gateway (client and assistance unit) identification numbers. To eliminate cases from this report, update the View/Update Presumptive screen on the GAMMIS web portal, after GA Gateway registration or on the same day the case is approved or denied in GA Gateway.

> If problems are encountered during the update or linking process the worker should send an email to membernotification@dch.ga.gov to report the problem. The worker should include as much client demographic information as possible, including name, date of birth, SSN, member ID number and client ID number.

Other Considerations

GAMMIS/GA Gateway Linkage

The GA Gateway action of approving a case will generate a closure of the Presumptive Eligibility record in GAMMIS if the records are linked. If linkage does not occur at or before this point, the member could have two active records in the GAMMIS system.

GAMMIS will not allow for duplication of action. When successful linkage of a PE record to a GA Gateway record occurs, the system will not allow successive attempts to link the same records.

Incorrect County

If a county receives a list and determines that an individual(s) on the list resides in another county, the receiving county shall correct the address if necessary, and continue processing procedures.

Filing

All counties must keep a central file of all presumptive reports generated by DCH. The county shall annotate for each name any action taken. These reports should be kept by the county office for a period of one year, after which time they can be destroyed.

Case Records

Upload the following in each case record in DIS.

- a copy of the Presumptive Eligibility (PE) packet and any verification sent from the hospitals and health departments. Refer to 2067 Presumptive Eligibility Medical Assistance for full list of items included in PE Packet.
- any additional verification, if any, used to determine eligibility

The CMD process must be fully documented detailing application and information received in the PE packet in case notes.

2756 Medicare Buy-In

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicare Buy-In		
	Effective Date:	December 2022		
	Chapter:	2700	**Policy Number:**	2756
	Previous Policy Number(s):	MT 58	**Updated or Reviewed in MT:**	MT-68

Requirements

When an individual who receives Medicare, benefits is approved for Medicaid in Georgia, the state, through the Department of Community Health (DCH), pays the Medicare premium for the recipient. This process is referred to as the Medicare Buy-In.

Basic Considerations

Medicare is a Federal health insurance program administered through the Social Security Administration. An individual becomes potentially eligible for Medicare when s/he turns age 65 or has received disability benefits through the SSA for 24 months. Medicare insurance coverage consists of two parts:

- Part A is Hospital insurance. There is no premium for this coverage for individuals who have adequate credits for work under Social Security.
- Part B is Supplemental medical insurance. Eligible individuals must pay a monthly premium which is usually deducted from their RSDI check.

DCH is notified of Medicaid eligibility via the system interface. DCH sends a monthly record to the Centers for Medicare and Medicaid Services (CMS) of the newly accreted individuals to the Buy-In. DCH also pays CMS for the recipient's Medicare premium, and the Buy-In process begins. Via an interface, CMS communicates to SSA that the Buy-In has occurred and the effective date. Within 60 to 90 days of the A/R being accreted to the Buy-In, SSA reimburses the Medicaid recipient in a regular RSDI check for the months covered to date. Each monthly RSDI check thereafter should reflect the recipient's full entitlement without the Medicare premium deduction.

Usually the Medicare Buy-In is effective with the first month of Medicaid eligibility. However, for A/Rs who receive Medicaid under an LA-D COA, the Buy-In does not occur until the month after the month of approval for LA-D Medicaid. For this reason, the Medicare premium is an allowable deduction from the PL/CS.

Procedures

For various reasons there may be problems in getting the Buy-In established or in the continuation of the Buy-In. When this occurs, the worker should check the following in the system:

- Make sure the spelling of the A/R's name is as it appears on the Medicare card, not necessarily

the Social Security card.

- Make sure the SSN is correctly entered.
- Make sure the Medicare claim number on the Medicare LUW is correctly entered, including the Beneficiary Identification Code (BIC). (Letter following or preceding the numbers.)
- Make sure the number matches the Medicare claim number entered on the unearned income screen.
- Make sure the case continues as active.

If everything is correct in the system or corrections have been made, use the “Medicare Buy-In Problem” form found in Appendix F to try to resolve Buy-In problems. Please fax the form to 1-866-483-1045 or email the form to gammisbuy-in@gainwelltechnologies.com. This email notifies DCH that a problem exists with the Buy-In. If this does not resolve the Buy-In issue, contact your Medicaid Program Specialist.

2760 Case Record Maintenance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Case Record Maintenance		
	Effective Date:	May 2023		
	Chapter:	2700	**Policy Number:**	2760
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-69

Requirements

The case record consists of hard copy and electronic documents necessary to support all Agency actions taken with regard to the case. The case record must be maintained in such a way that it is readily accessible.

Basic Considerations

This section outlines statewide requirements for a uniform method of filing material in case records or their inclusion in the Document Imaging System (DIS). These procedures provide a definite, consistent organized system for all case files and electronic records which identifies and collects unchanging, permanent mandatory verification, defines the record purging process, and facilitates the reading of case actions.

Documents included in a case record are classified in three general categories:

- permanent verification
- case action support
- Patient Liability/Cost Share support

Permanent Verification

Documents verifying information which does not change and only must be obtained once for a given applicant/recipient or once for the AU in a given renewal period is considered “permanent verification”. When required by policy, the following documents or verification are considered “permanent”:

- application form
- Form 297A, Rights and Responsibilities (if Form 297 was the application)
- Form 297M, Medicaid Addendum (if Form 297 was the application) **Obsolete as of 12/2021.**
- documents verifying age, citizenship, and identity (must only be obtained once for the life of the A/R)
- documents verifying disability
- copies of Social Security and/or Medicare cards
- Notice of Privacy Practices, if available

- DMA Form 285, Health Insurance Information Questionnaire and copy of insurance card and/or trust documents if applicable
- HIPP Referral Forms, if applicable
- Form SS-5, Application for a Social Security Card
- other legal documents such as a marriage license, divorce decree, verification of death, and custody or guardianship papers, Voluntary Placement Agreement, Adoption Assistance Agreement, Termination of Parental Rights orders, Voluntary Surrender, the "contrary to the welfare" order, the "reasonable efforts" order, all custody extension orders, all permanency plan language orders, and any other documents of the court pertaining to a child in placement.
- documents verifying burial designation, property search results, life insurance polices, trust documents and other unchanging resource information
- Bills used in AMN spend-down budgets, case notes should also be documented thoroughly describing the bills with the month/year in which they were used
- any other documents considered permanent verification by the county department
- Level of Care Denial
- Form 138, Child Support Cooperation

For a hard copy case record, permanent documents and verification are to be filed on the left side of the case record.

When scanning into DIS, permanent documents and verifications must be assigned to the appropriate category and be tagged, at a minimum, with the Client ID(s) of the individual(s) the document pertains to and AU ID(s) of the cases impacted.

Case Action Support

Documents or verification that supports an AU's eligibility either at application, renewal or interim change, are considered "case action support" material.

Case action support material must be filed on the right side of a hard copy case record or scanned into DIS under the appropriate category and tagged with a minimum of the Client ID(s) of the individual(s) the document pertains to and AU ID(s) of the cases impacted.

Quality Control referrals, hearing decisions, manual notices and Form 962 are also considered case action support material and should be filed in a hard copy case record on top of the case action to which they pertain and/or scan into DIS under the appropriate category and tagged with a minimum of the AU ID for which it applies.

Multiple Volume Hard Copy Case Records

When the case action support section exceeds the capacity of the folder, all materials from the Permanent Verification Section should be transferred from the previous volume into the new volume.

All materials related to the current application/renewal period should be placed in the Case Action Support section of the new volume and/or scanned into the DIS. GA Gateway should be documented regarding the location of supporting case materials (hard copy or DIS) and material scanned into

DIS may be purged from the hard copy record after 30 days.

All other case record materials should remain in the old volume and should be maintained according to Retention of Materials procedures outlined later in this section or until such time as the material is scanned into the DIS.

Patient Liability/Cost Share

Documents that support Patient Liability or Cost Share determinations are to be filed in chronological order from the oldest to the most current unless scanned into the Document Imaging System. When scanning into the DIS, documents should be scanned in chronological order, oldest to most current, under the appropriate category and tagged, at a minimum, with the Client ID(s) of the individual(s) the document pertains to and AU ID(s) of the cases impacted.

The following forms are filed in the Patient Liability/Cost Share:

- Form 59
- Form DMA-6, or other Level of Care instrument
- EDWP, NOW/COMP, ICWP Communicators
- documentation of transfer of assets penalty

Any of the above documents scanned into the DIS must be filed under the appropriate category and tagged, at a minimum, with the Client ID(s) of the individual(s) to the document(s) pertain(s) to and AU ID(s) of the case(s) impacted.

Application

The following types of information related to an initial application for assistance are to either be filed in the case action section or the hard copy record or scanned into the DIS under the appropriate category and tagged, at a minimum, with the Client ID(s) of the individual(s) to the document(s) pertain(s) to and AU ID(s) of the case(s) impacted.

When filed in a hard copy case record, they are to be filed in the ascending order as listed below:

- all verification provided for the application process other than permanent verification
- copies of all communications with the A/R or PR that are not maintained in the computer system
- all paperwork completed and/or signed by the A/R or PR.
- any other document used to determine eligibility or support the eligibility determination

Obtaining Prior Case Record Documents

When an A/R reapplies in the same county, or a new county, the previous case record **must be** obtained or the Document Imaging System (DIS) be screened for all permanent and current verifications. Pre-existing hard copies must be filed with the new application or scanned into the DIS. A request may be sent to the previous county to scan pre-existing permanent and current verifications into the DIS, with a confirmation notice sent to the requesting worker/office.

If an application is approved based on Gateway documentation or data indicating verification has been previously received, it is the responsibility of the approving county to obtain and review the previous case record, screen DIS, or request the previous county scan documents into DIS to ensure that the verification is present. If the verification in the previous case record or DIS does not match what is documented in Gateway **or does not meet policy requirements,** the appropriate verification **must be** requested. Refer to Section 2051.

Renewal

The following types of information related to a renewal of eligibility for Medicaid are to either be filed in the case action section or the hard copy record or scanned into the DIS under the appropriate category and tagged, at a minimum, with the Client ID(s) of the individual(s) the document(s) pertain(s) to and AU ID(s) of the case(s) impacted.

- copies of written referrals
- all verification provided for the renewal process
- copies of all communications with the A/R or PR that are not maintained in the computer system
- all paperwork completed and/or signed by the A/R or PR, including the renewal form if received
- any other document used to determine eligibility or support the eligibility determination

Interim Changes

The following types of information related to interim changes are to either be filed in the case action section or the hard copy record or scanned into the DIS under the appropriate category and tagged, at a minimum, with the Client ID(s) of the individual(s) the document(s) pertain(s) to and AU ID(s) of the case(s) impacted.

- copies of written referrals
- all verification provided for the processing of the interim change
- copies of all communication with the A/R or PR that are not maintained in the computer system
- all paperwork completed or signed by the A/R or PR
- any other document used to determine eligibility or support the eligibility determination

Retention of Materials for Inactive Cases

Case record material must be retained as long as a federal or state audit of the case record is in progress, or if the case is involved in a hearing.

Inactive case record material, except where noted below, must be retained for a period of ten (10) years dating from the calendar month in which the most recent activity took place. Case material may be purged or destroyed when no activity has taken place for a period of 36 consecutive calendar months. Case record material scanned into the DIS will be retained indefinitely.

The following information must be retained beyond the ten-year limit as specified:

- Any case in the Former SSI Disabled Child Class of Assistance must be retained until three (3)

years after the child turns eighteen (18) years old.

- Any ABD case with an outstanding transfer penalty must be retained until three (3) years after the penalty expires
- Any case when disability was established by SMEU must be retained indefinitely unless the applicant/recipient is deceased, whereupon the record must be retained until three (3) years after the date of death.
- All LA-D cases should be retained for a period of three years after case closure or death of the beneficiary.

Retention of Materials for Active Cases Materials in case records relative to the establishment of eligibility and patient liability/cost share must be retained for ten (10) years. Case record material scanned into the Document Imaging System will be retained indefinitely.

The following documents must be retained beyond the ten-year limit until they are no longer applicable to current eligibility or until the case record is destroyed in the same manner as an inactive record:

- materials associated with, and relative to, the most recent application,
- the permanent verification section
- any verification used to establish eligibility factors on which current eligibility and/or Patient Liability/Cost Share is based.
- Medical bills used for AMN spend-down eligibility

The forms and/or materials listed above must be retained in the case record until they are no longer applicable to current eligibility or until the case record is destroyed in the same manner as an inactive case record.

Computer Forms

Computer-generated reports, reports from DCH/DMA and documentation for these reports are considered case record material and therefore must be retained for a period of ten (10) years from the month in which the last activity took place. Documentation for any computer- generated report must be retained for ten (10) years from the month in which the last activity took place.

A Gateway, Gateway Customer Portal or GAMMIS report that has been printed for caseload management may be destroyed when no longer needed if the report does not serve as documentation in support of action taken on the case or other case record material.

Case Record Destruction

When destroying a case record or any record material containing the names of applicants or recipients or any PHI, the materials must be shredded or burned.

Special Considerations

Adoption Assistance

Revenue Maximization Adoption Assistance case records must be retained for a period of five years from month of receipt of last Adoption Assistance payment. See Section 2885 for those documents and funding determination verification that must remain in the closed Revenue Maximization Adoption Assistance record. A foster care case record is never merged with the Adoption Assistance record but maintained separate and apart.

Foster Care

When a Foster Care case is closed and a CMD is completed for Medicaid, any materials, forms collateral contacts or other documentation that pertain to a child's IV-E eligibility determination and placement in custody must remain in the closed Revenue Maximization Foster Care record. Foster Care Services policy is followed regarding retention of this material. A case record of a child who has spent more than six months of his life in care is retained and safeguarded at least until the child is 23 years old. Reference Foster Care Services: Needs of the child, Record Retention 1011.18. All remaining materials in the case record pertaining to Medicaid eligibility determination are to follow Medicaid policy for retention and destruction as stated in this section.

Chafee Medicaid

Case records for recipients for whom eligibility has expired, (i.e., where the recipient has turned 21), should be returned to the original county DFCS office (i.e. the county that had custody of the child when he or she aged out) to be housed. Due to IV-E Foster Care and Medicaid regulations, Chafee Medicaid records must be retained in their entirety (both IV-E FC material and Medicaid material) for a period of three years from the recipients 21st birthday (i.e., no earlier than the recipient's 24th birthday).

RSM cases

Cases that are closed or denied by RSM will be sent to the DFCS office in the A/R's county of residence to be housed in that county's closed files. RSM staff will use the Residence County field on the Gateway Applicant Group Address-Summary page to keep track of the A/R's county of residence.

2800 Assistance to Children in Placement

2801 Assistance To Children In Placement Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Assistance To Children In Placement Overview		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2801
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

The Assistance to Children in Placement Chapter contains policy on Medicaid Classes of Assistance (COA) and procedures associated with children who are under the legal care and supervision of the state Child Welfare Agency and children that are eligible for Adoption Assistance.

Basic Considerations

Funding for Georgia's Foster Care and Adoption Assistance Programs is available from federal and state sources including Title IV-E, Title IV-B, state funds, Supplemental Security Income (SSI), and Medicaid.

All funding, reimbursability and Medicaid eligibility determinations for foster or adoption assistance children are the responsibility of Revenue Maximization Specialists (RMS) based on information provided by county Social Service Case Mangers (SSCM) through SHINES data entry and submitted to Revenue Maximization staff. Coordination between Social Services and Revenue Maximization is critical to the funding determination and Medicaid coverage for children in placement.

Children who are in an out-of-home placement may be eligible for Medicaid coverage under several Classes of Assistance. These include the following:

- Foster Care under the age of 18
- Foster Care ages 18-21
- Adoption Assistance under age of 18
- Adoption Assistance ages 18-21 DJJ commitment under age of 19
- SSI
- Medically Needy
- Emergency Medical Assistance (EMA).

Children who are Title IV-E or SSI eligible are automatically eligible for Medicaid.

Youth and Young adults that were previously in foster care may be eligible for Chafee and Former Foster Care Medicaid if considered in foster care the month of their 18th birthday.

The state receives reimbursement for administrative costs based on the total number of children eligible for Title IV-E. In order for a state to receive federal reimbursement for the foster care main-

tenance costs of an individual child in care, the child must meet both eligibility and reimbursability criteria. Initial eligibility is determined once, while reimbursability may change on a monthly basis depending on the placement, the child's income and other factors.

The Social Services Case Manager is responsible for the following:

- Gathers and enters child and family data to the SHINES child welfare system and refers all children entering out-of-home care to Revenue Maximization for funding and Medicaid eligibility determinations regardless of length of stay;
- Reviews court orders for the required judicial determinations and provides copies of the petition for custody, the initial order placing the child in foster care, the "contrary to the welfare" order, the "reasonable efforts" order, all custody extension orders, TPR orders, all permanency plan language orders, and any other documents of the court pertaining to the child to the Revenue Maximization RMS through SHINES External Documentation;
- Provides notification of placement and other eligibility factors to the RMS;
- Initiates action with the Social Security Administration for children receiving SSI;
- Provides requested information and documentation to the RMS for redeterminations.

The Revenue Maximization Specialist is responsible for the following:

- Determines initial eligibility Medicaid and reviews, corrects, verifies, documents and validates the SHINES derived funding determination;
- Notifies the SSCM of child and family data clarification required for the initial determination;
- Refers the absent parent(s) to the Division of Child Support Services when appropriate. Refer to 2851 Child Support Referrals for exception criteria;
- Completes six-month IV-E funding reimbursability validation.
- Completes annual Medicaid renewal process in Gateway system.

Children in Joint Custody with DJJ

Situations will occur when DFCS and DJJ share custody of a child. In situations of joint custody, the agency responsible for the placement of the child is responsible for the initial IV-E determination and any subsequent reviews. The Revenue Maximization DJJ Unit has responsibility for children and youth in joint DJJ and DFCS custody where DJJ has placement responsibility.

2805 Funding Sources

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Funding Sources		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2805
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

Maintenance and administrative costs for children in foster care or receiving Adoption Assistance are paid from federal and state funding sources.

Basic Considerations

The funding for Georgia's Foster Care and Adoption Assistance Program is available from federal and state sources including IV-E Foster Care, IV-B Foster Care, IV-E Adoption Assistance, State Funded Adoption Assistance, Supplemental Security Income (SSI), Medicaid and state funds. Federal funding sources are pursued because they share in the cost, therefore conserving state funds.

Another funding source available is child support. The parents of children in care are routinely referred to the Division of Child Support Services (DCSS) and may be obligated by court order to contribute to their child's care and medical support.

IV-E Foster Care Funds

Title IV-E is the federal funding source designated for certain children who are under the care and supervision of the State Child Welfare Agency. IV-E provides reimbursement for costs associated with the care and maintenance of children in placement and for administrative cost related to the State's Child Welfare Program. The IV-E Foster Care Program authorized by the Social Security Act, provides funds to states for the following activities:

- Maintenance of children in foster care placements
- Reimbursement of administrative and case management costs incurred while staff work with the child, the child's family and the care provider
- Reimbursement for training agency staff and providers who work with the child or who administer the foster care program

All children entering foster care must be referred to Revenue Maximization for a IV-E eligibility determination regardless of length of stay in care. Referral to Rev Max is via submission through the SHINES system. To be eligible for IV-E Foster Care maintenance and administrative costs, all IV-E requirements must be met.

Children classified as Title IV-E eligible must have some relationship to the Aid to Families with Dependent Children (AFDC) program in addition to meeting other criteria. IV-E is unrelated to Tem-

porary Assistance to Needy Families (TANF). In the Welfare Reform Act of 1996, Congress mandated that the state AFDC policy in effect on July 16, 1996 be used for determining the AFDC relationship for IV-E eligibility purposes.

Child Welfare Foster Care Funds (IV-B)

The Child Welfare Foster Care (IV-B) Program is a federal child welfare block grant that provides funds to states for foster care expenses. A child who is eligible for IV-B is a child in placement for whom DFCS has partial or total responsibility and who has been determined ineligible for IV-E Foster Care. The Title IV-B grant is capped. Once these limited funds are spent, foster care expenses are paid primarily with state funds. It is advantageous to pursue IV-E Foster Care for all children to conserve the use of state dollars.

Supplemental Security Income (SSI)

Supplemental Security Income (SSI) is a federal payment program for disabled individuals administered by the Social Security Administration. Payments are made directly to the recipient from the federal government on a monthly basis. However, when a child is in DFCS custody, the county department with custody becomes the payee for the child's SSI check. SSI eligible children may be concurrently eligible for IV-E payments.

Medicaid Program

The Medicaid program is a joint federal/state program that is authorized under the Social Security Act. Funds are available to states for providing medical services to eligible recipients and for reimbursing activities that support the administration of the Medicaid program. DFCS accesses Medicaid funds through the Department of Community Health, Division of Medicaid, for case management and services for children in out-of-home care. Children who are IV-E eligible and/or SSI eligible are automatically eligible for Medicaid. However, children whose foster care is paid by state funds are not automatically eligible for Medicaid. An eligibility determination must be completed on each child entering care.

2810 Foster Care Funding and Medicaid Application Processing

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Foster Care Funding and Medicaid Application Processing		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2810
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

The Foster Care Medicaid application process begins with the county Social Service Case managers entering required demographic, removal home, income and resource data into SHINES within 24 hours of a child entering foster care. SHINES pre-populates a Medicaid application for the child. Case Managers must sign, save and submit the SHINES Medicaid application to initiate sending the application to the Gateway system. Rev Max Medicaid Specialist determine foster care Medicaid eligibility at initial entry.

The Social Service Case Manager enters all information in SHINES concerning the child, removal home, Identifying information on the child; use child's formal name and date of birth as it appears on the child's birth certificate; gender, race, Social Security Number, U.S. Citizen status, removal date and pregnancy status; complete the child's parent information; removal household. SHINES populates a IV-E Application based on the demographic information entered in the case. The Social Service Case Manager will need to Save and Submit IV-E application after updating all demographics. Rev Max Specialists (RMS) verify the information and validate the SHINES funding determination correcting all information when found to be incorrect or missing. Upon validation, an Eligiblity Summary page will generate that will need to be verified and saved by the RMS.

Basic Considerations

The county DFCS office is responsible for screening the child on GAMMIS immediately upon entering care.

The Medicaid Application for individual foster children is populated and generated by SHINES The application is signed, saved and submitted by the Social Services Case Manager within 24 hours of child entering foster care.

The Revenue Maximization Medicaid Unit retrieves the submitted Medicaid application from Gateway for registration and assignment to a Rev Max Medicaid Specialist (RMMS) for a Medicaid eligibility determination.

Foster Care Medicaid Eligibility Determination

A Rev Max Medicaid Specialist (RMMS) will screen Gateway and remove the child from all active or pending cases prior to being placed in Foster Care Medicaid. The RMMS will register a new Medic-

aid case, coding the Gateway Child In Placement page living arrangement as FC. This will generate the interface update to GAMMIS. Once the living arrangement FC code is on the member file, the current CMO enrollment segment will close effective the following month of the application is processed in Gateway.

If the child is SSI eligible when entering care, the RMMS will open a Medicaid case on GA Gateway, coding the child's living arrangement as FC. This will generate the interface update to GAMMIS. This will not adversely affect SSI.

The county DFCS office will receive notification of the Medicaid eligibility decision by a Gateway generated letter and by comments in the SHINES Medicaid application page.

IV-E Eligibility Determination

A child in care where DFCS custody is terminated at the 72-hour hearing is referred for an IV-E determination through SHINES. The referral will indicate the custody termination date. The RMS will complete a funding determination in SHINES end dating the Eligibility Summary Page with the date the child left DFCS care. A Medicaid case will not be opened, and the child will not be removed from existing benefit cases. Reference 2815 Foster Care and Medical Assistance for Foster Care Medicaid processing in SHINES.

The Social Service Case Manager (SSCM) must:

- Check all available resources including Gateway to determine if there is any history on or information about the family. Thoroughly screen for EMPI number to prevent duplication of existing cases;
- Complete the requested items of information in SHINES person Detail page to display in the IV-E and Medicaid Application:
  - Identifying information on the child; use child's formal name and date of birth as it appears on the child's birth certificate; gender, race, Social Security Number, U.S. Citizen status, removal date and Pregnancy status.
  - Complete the child's parent information; removal household;
  - Complete the child's Medicaid information.

Prior to the statewide implementation of SHINES in June 2008, IV-E Foster Care and Medicaid application and detail information was submitted on Form 223, IV-E and Medicaid.

Applications, and Form 224, Removal Home Income and Asset Checklist. A copy of the initial court order was faxed to the RMS as soon as available to the county. The funding determination outcome was submitted on Form 225, IV-E Eligibility Documentation and Form 529 with copies to regional accounting and to the county.

Verification

Follow verification guidelines found in the appropriate sections of this manual.

Clearinghouse must be checked for information on each member in the removal home family and for the child in care.

Standard of Promptness

The Revenue Maximization Medicaid Unit staff determine eligibility for Foster Care Medicaid, using the Standard of Promptness (SOP) for that COA. Calculate the SOP beginning with the date of application. Revenue Maximization has a Standard of Promptness for completion of a Foster Care Medicaid eligibility determination within 24 hours of Gateway receiving the Foster Care Medicaid application through the SHINES interface when the application has all required information.

The Foster Care funding determination is completed by a Rev Max Specialist (RMS) and is recorded in the SHINES system.

The standard of promptness for IV-E funding determinations for a foster child is 45 days. In situations when the only verification missing to complete the case is the court order to determine if the order meets the IV-E language and timeliness requirements, the IV-E application may be held up to the 60th day. If, after 60 days the court order language is outstanding, the RMS should finalize the case as IV-B Foster Care, with the understanding that the case may have to be re-rated once the court order is received. If at any point the RMS determines that the child does not meet AFDC relatedness criteria, it is not necessary to wait for the court order language. The application should be approved as IV-B Foster Care.

If the SOP date falls on a weekend or holiday, complete the application by the last workday **prior to** the weekend or holiday.

A CMD must be completed prior to denial or termination of any Foster Care or Adoption Assistance Medicaid COA.

A review of Medicaid eligibility is conducted annually. Reference Section 2870 – Redeterminations for Children in Placement.

Procedures

The following steps provide an overview of the eligibility determination process for Children in Placement.

- The RevMax Medicaid Specialist (RMMS) determines if the child is Foster Care Medicaid eligible and will activate the case on the system and enter the Medicaid eligibility status in SHINES.

The Rev Max Specialist (RMS) determines if the child is title IV-E eligible for funding purposes.

- The RMS will then review, verify, correct information entered, if required, and validate the SHINES system derived funding determination for a child meeting IV-E eligibility funding criteria for the eligibility month. See 2815 Foster Care and Medical Assistance and 2817 Adoption Assistance Medicaid.
- RMS will contact the county SSCM if a copy of the initial court order has not been received within ten (10) working days of the child's placement.
- If the child is IV-E eligible in the eligibility month, they are IV-E eligible for the entire placement episode unless one of the items listed in 2880 Ineligibility For IV-E occurs.
- The RevMax Specialist will determine if the child is IV-E reimbursable. See 2860 IV-E Reimbursability. It is possible for a child to be IV-E eligible but not reimbursable.

If the child is potentially eligible for PeachCare for Kids® (PCK), the Gateway system determine eligibility and submit to GAMMIS.

- RMS will complete the child support referral through SHINES following referral policy and exception criteria.

Accounting Form 529 is completed when the IV-E funding determination is made after the month of entry into Foster Care. Forms are forwarded to the Regional RevMax Supervisor for review and signature. The signed Form 529 is forwarded to regional accounting. The funding determination is recorded in SHINES Eligibility Summary Page.

Abandoned Children

Abandoned children placed in DFCS legal custody are foster children and are categorically eligible for Medicaid.

Accept an application for an abandoned child using the alias or AKA of the child and follow foster care application procedures based on the information provided by the SSCM. Maintain communication with the SSCM and document the efforts being made to obtain information about the child, including police reports, hospital documents and records, court documents, etc.

RevMax must document that a child meets all AFDC eligibility criteria and cannot presume that a child would meet the requirements simply because of abandonment. If required information is provided for the accurate determination of IV-E eligibility at a later date, the case may be re-rated back a maximum of eight quarters for IV-E eligibility and reimbursability.

2812 Department of Juvenile Justice Medicaid Application Processing

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Department of Juvenile Justice Medicaid Application Processing		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2812
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

The Department of Juvenile Justice (DJJ) Medicaid application process begins with the request for medical assistance from the local DJJ office and ends with the GA Gateway system generated notification to the DJJ office of the eligibility determination.

Basic Considerations

The DJJ Revenue Maximization Unit is responsible for screening the child on MHN immediately upon entering care.

If the child is Medicaid eligible in any aid category, including SSI, and is enrolled in a care management organization (CMO), the JPPS is responsible for following CMO contact procedures as outlined in 2853 Foster Care CMO Procedures.

If the child is not Medicaid eligible, the JPPS must complete Forms 223 and 224 as a Word document and send as an attachment to the DJJ Revenue Maximization Unit within two (2) days of coming into care whether or not the child is active on GAMMIS.

Reference 2853 Foster Care CMO Procedures of the Medicaid Policy Manual.

Medicaid Eligibility Determination

DJJ Commitment under age 19 Medicaid must be immediately determined for youth in a DJJ commitment.

When a child is adjudicated delinquent and placed in an out-of-home facility pursuant to a delinquency court order, the county DJJ office will request medical assistance for the child through the DJJ Revenue Maximization Unit. This request must be within two (2) working days of the child's entering placement. The county DJJ office will make the request by completing Form 223, Medicaid and IV-E Application for Foster Care and Adoption Assistance, and Form 224, Removal Home Income and Asset Checklist, as a Word document and sending as an attachment to the DJJ Revenue Maximization Unit. The child's social history face sheet, screening placement form, petition and a copy of the court order should accompany the application.

The DJJ Revenue Maximization Unit will log the application upon receipt. Medicaid Eligibility Specialist (MES) will then review the application and determine eligibility for DJJ Commitment under

age 19 Medicaid

The child must be removed from all active or pending cases prior to being placed in DJJ Commitment under age 19 Medicaid. The DJJ Revenue Maximization Unit will register a new Medicaid case, coding the living arrangement as PLA, Placement in RYDC, CRP, Community Residential Placement or JCA, Joint custody while awaiting placement in RYDC. This will generate the interface update to GAMMIS. Once the living arrangement code is on the member file, the current CMO enrollment segment will close effective the following month.

Reference 2853 Foster Care CMO Procedures of the Medicaid Policy Manual.

If the child is included in pending related cases (Food Stamps, TANF, Medical Assistance, etc.), the MES is responsible for removing the child from the case in order for the DJJ Revenue Maximization Unit to register the foster care case. The DJJ Revenue Maximization MES will take action on all active cases by notifying DFCS county staff to remove the child from Food Stamp, TANF, Medical Assistance cases for the month of application. Adverse Action will be waived for the Medicaid case only in order to facilitate registration of the DJJ Medicaid foster care case.

If the child is SSI eligible when entering care, the DJJ Revenue Maximization MES will open a Medicaid case on Gateway, coding the child's living arrangement PLA, CRP or JCA. This will generate the interface update to GAMMIS. This will not adversely affect SSI.

The DJJ MES will request any additional documentation needed for the IV-E determination. Documentation will be faxed to the appropriate DJJ MES.

IV-E and Medicaid Eligibility Determination

The local DJJ office will receive notification of the decision by a Gateway generated letter.

Interview Requirements

A face-to-face interview is not required. A telephone call to the JPPS will suffice to clarify information on Form 223 and Form 224. Additionally, a telephone call may be used to clarify supporting documents when necessary.

No application should be denied due to the JPPS' failure to cooperate with the eligibility determination process. The DJJ MES is expected to pursue all avenues to obtain required information.

Verification

Follow the verification guidelines found in the appropriate sections of this manual. If no other option is available, the JPPS' statement as to removal home circumstances is acceptable.

The statement must be in writing, signed and dated by the JPPS.

Clearinghouse must be checked for information on all members of the removal home family and the child in care.

Mandatory Forms

Complete the mandatory forms below when processing an application for a child in care:

- Form 223, Medicaid and IV-E Application for Foster Care and Adoption Assistance
- Form 224, Removal Home Income and Asset Checklist
- EDD (does not need to be printed or signed)
- Form 225, IV-E Eligibility Documentation Form
- Form DMA-285 (if the child is covered by insurance other than Medicaid)
- Form 122, Foster Care Referral Form, when applicable. Refer to 2851 Child Support Referrals for exception criteria.

Any application for Medical Assistance can be used as the application for a child in care. Forms 223 and 224 are preferred, as all the information requested on these forms is needed to make an appropriate IV-E determination.

Standard of Promptness

The DJJ Revenue Maximization Unit determines eligibility for DJJ Commitment under age 19 using the Standard of Promptness (SOP) for that COA (Refer to 2065 Family Medicaid Application Processing). Calculate the SOP beginning with the date of application.

If the SOP date falls on a weekend or holiday, complete the application by the last workday prior to the weekend or holiday.

The Standard of Promptness for Medicaid is 45 days.

For title IV-E determinations when the only verification missing to complete the IV-E case is the court order, the application may be held up to the 60th day. If, after 60 days the court order language is outstanding, the DJJ MES should finalize the case as IV-B, with the

understanding that the case will be reviewed for IV-E eligibility once the court order is received. If at any point the DJJ MES determines that the child does not meet the AFDC Relatedness criteria, it is not necessary to wait for the court order language. The application should be approved as title IV-B.

Periods of Eligibility

Approve Medicaid and continue eligibility as long as the child continues to meet the requirements of the COA under which they are approved. A CMD must be completed prior to denial or termination of any Medicaid COA.

Procedures

The following steps provide an overview of the eligibility determination process for Children in Placement. Refer to the Sections in this Chapter for determining eligibility for the specific COA.

Step 1

The DJJ MES determines if the child is DJJ Commitment under age 19 eligible and will activate

the case on the system

Step 2

The DJJ MES will determine if the child meets IV-E eligibility criteria for the eligibility month and notify the JPPS of eligibility.

Contact the JPPS if a copy of the initial court order has not been received by the DJJ MES within ten (10) working days of the child's placement.

Step 3

If the child is IV-E eligible in the eligibility month, they are IV-E eligible for the entire placement episode unless one of the items listed in 2880 Ineligibility For IV-E, occurs.

Step 4

The DJJ MES will determine if the child is IV-E reimbursable. See 2860 IV-E Reimbursability. It is possible for the child to be IV-E eligible but not reimbursable.

Step 5

The DJJ MES completes Form 122, Foster Care Referral Form, and forwards to DCSS when applicable. Refer to 2851 Child Support Referrals for exception criteria. A copy is maintained for the eligibility record and a copy is forwarded to the JPPS.

Step 6

Notify the JPPS of the IV-E and Medical Assistance determination via Form 225, IV- E Eligibility Documentation Sheet.

2815 Foster Care and Medical Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Foster Care and Medical Assistance		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2815
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

Foster Care Medical Assistance provides coverage to children in placement for whom DFCS has temporary or permanent custody.

Basic Considerations

The funding determination for foster care is processed in the SHINES CWIS system by Rev Max Specialists (RMS) and Medicaid eligibility is processed in the Gateway system by Rev Max Medicaid Specialists (RMMS).

The Medicaid Application for Foster Care is submitted to Revenue Maximization Medicaid staff via SHINES to establish a child's Medicaid eligibility. As soon as possible, but no later than 48 hours of child's removal, a Social Services Case Manager (SSCM) enters child and family data in SHINES. This section captures information required for Medicaid eligibility, Child Support and the medical services provided for the child prior to removal. Child support information: FCC stage, Income and Expenditure page; Three (3) Month Prior MAO request: FCC stage, Application and Background page.

Within five (5) working days, the SSCM or designated staff initiates the IV-E funding determination process by entering the required information into SHINES. Once the required pages are completed, the IV-E Application is saved and submitted electronically to RevMax.

IV-E Eligibility Criteria

A child must meet the following AFDC Relatedness and court order criteria to be IV-E eligible:

- The child must meet the following AFDC relatedness criteria in the eligibility month (Reference 2825 AFDC Relatedness):
  - Living with and removal from a specified relative
  - Deprivation
  - Financial need: income and resources
  - U.S. citizen/legal alien status
  - Age

If all AFDC Relatedness criteria is met, then the child must have entered care as a result of a court

order with a judicial determination to the effect that it is *contrary to the welfare of the child to remain in the home, or that placement is in the best interest of the child*, or by a signed Voluntary Placement Agreement. The judicial determination of *contrary to the welfare* or *best interest* must be made in the first court order signed by a judge that sanctions the removal of the child. If the judicial determination is not made in the first order, the child is not eligible for the duration of that placement episode in foster care.

There must also be a judicial determination within 60 days of the removal date to the effect that *reasonable efforts were made to prevent removal of the child* or that *reasonable efforts were not required to prevent removal of the child* with agency specific details of those efforts. A child is not IV-E eligible until the reasonable efforts language is obtained. If the judicial determination is not made within 60 days of the child's date of removal from the home, the child is not IV-E eligible for that entire placement episode. For those children who enter DFCS care and responsibility via a Voluntary Placement Agreement, a judicial determination that reasonable efforts to prevent removal is not required for meeting IV-E eligibility. See 2820 Legal Status.

A child who meets all eligibility criteria is IV-E eligible. Title IV-E eligibility is determined each time a child first comes into the care and responsibility of DFCS via a court order or VPA. Eligibility does not automatically grant federal benefits for maintenance costs. Once established, a child's IV-E eligibility continues as long as the child remains in the same placement episode.

A child loses IV-E eligibility at age 18; the child is in care under a Voluntary Placement Agreement (VPA) and a custody order with a judicial determination to the effect that *continued placement is in the best interest of the child* statement was not obtained within 180 days of the signed VPA; or the child is on trial home visit or run away status beyond six months, unless a court orders a longer trial home visit.

Any youth who has been IV-E eligible, but reaches the age of 18 and signs an agreement to remain in Extended Youth Supportive Services (EYSS), is classified as Foster Care ages 18 to 21 if all eligibility criteria are met. Reference Policy 1012.6, Child Welfare Manual for Extended Youth Support Services and Section 2890, Foster Care Medicaid age 18 to 21.

IV-E Eligibility Effective Date

The eligibility month is the month the Voluntary Placement Agreement was signed by all parties or the month the petition that led to the removal of the child was filed. The effective date of IV-E eligibility is the first day of the month in which all of the eligibility criteria are met. A child remains IV-E eligible during that placement episode. IV-E reimbursability may vary based on case circumstances.

Procedures

Title IV-E Application

A SSCM completes the required items of information in a child's SHINES Person Detail page to display in the IV-E Application:

- Identifying information on the child SHINES Intake stage, Person Detail Page. Use child's formal name and date of birth as it appears on the child's birth certificate.
- Gender, Race: SHINES Intake stage, Person Detail Page.

- Social Security Number: SHINES Intake stage, Person Detail Page. If not available, proceed with the application and submit.
- US Citizenship Status: SHINES FCC stage, Citizenship and Identity Page Answer item “yes” or “no” due to item’s impact on Medicaid eligibility.
- Removal Date: SHINES Investigation, FCF, Custody Page
- Pregnancy status: SHINES FCC stage, Income and Expenditures Documentation Checklist.
- Person ID: SHINES generated and added to Intake stage.

A SSCM completes the child’s parent information. The information in this section allows the case manager to identify the child’s mother and father and all principals in the case excluding the child, as identified by the Relationship – Self in SHINES. This information is captured for the IV-E funding determination as removal household data. Parental and removal household information is entered on the Intake stage, Investigation stage, Person Detail Page.

All court orders related to the child’s removal and giving custody to DFCS are uploaded to SHINES External Documentation based on name, date of birth, legal county and SHINES Person Identification Number (PID).

IV-E Eligibility and Processing

Once the required pages are completed and the court orders uploaded, the IV-E Application is submitted to RevMax via SHINES.

“AFDC Relatedness” Criteria

Eligibility for IV-E requires that the child must have a relationship to the Aid to Families with Dependent Children (AFDC) within six months prior to or during the “eligibility month”. In all references to “AFDC Relatedness”, the eligibility of the child is based on the AFDC program and its policies that were in effect in Georgia on July 16, 1996.

For the RMS to determine if the child meets the “AFDC Relatedness” criteria in the removal home, a Social Services Case Manager (SSCM) provides RevMax with social and family information, the circumstances and financial data at the time of the child’s removal.

Establish eligibility for AFDC (based on Georgia’s July 16, 1996 AFDC policy). Verify that the child meets the AFDC criteria for initial IV-E eligibility in the month that the petition for custody was filed or the Voluntary Placement Agreement was signed.

Establish age and citizenship based on a child’s birth certificate or Vital Records screening.

Establish the child’s deprivation using criteria in Section 2825 – AFDC Relatedness and Section 2826 – Unemployed Parent.

Determine the removal home’s financial need based on Section 2825 – AFDC Relatedness and Section 2845, SSI Eligible Child.

RMS must address household management and verify income and resources through collateral contacts including but not limited to Clearinghouse, BENDEX, $TARS, SDX, Gateway for:

- Household Composition
- AU income and resources

Establish "living with/removal from" criteria

If the child did not live with a specified relative in the eligibility month, determine if s/he lived with a specified relative in any one of the six months prior to the month in which the petition for custody was filed or the Voluntary Placement Agreement was signed. Determine if the child could have received AFDC in the home in the removal month if the child had been living with the specified relative from whom custody was removed. **Reference Section 2825 for Living With/Removal Home Rule prior to March 27, 2000**.

If AFDC relatedness cannot be established, notify the SSCM of the funding determination through the SHINES Eligibility Summary Page

If AFDC relatedness can be established, proceed to review and determine if the court order(s) that brought child into care meet the required judicial determination to the effect that it is *contrary to the welfare of the child to remain in the home*, or that *placement is in the best interest of the child*, or by a signed Voluntary Placement Agreement. The judicial determination of *contrary to the welfare* or *best interest* must be in the first court order sanctioning removal signed by a judge. There must also be a judicial determination within 60 days of the removal date to the effect that *reasonable efforts were made to prevent removal of the child* or that *reasonable efforts were not required to prevent removal of the child* with agency specific details of those efforts.

If the child is IV-E Foster Care eligible, approve the IV-E Foster Care Eligibility Summary Page, documenting the determination details in SHINES Contacts and Summaries.

Assign each foster child an individual case number and case record.

Refer the absent parent(s) to DCSS through SHINES interface with DCSS. Refer to 2851 Child Support Referrals.

Retain all documentation and SHINES print screens in the case record for permanent verification. Retention of all court order(s) is mandatory. The SSCM remains responsible for providing court orders to the RMS. If upon the receipt of the court order(s) the RMS finds the order to be questionable, it should be discussed with the Revenue Maximization supervisor and a second level review completed by the Rev Max State Office. Court Orders determined to be IV-E non-compliant are forwarded to the DFCS Legal Counsel for review.

If all points of eligibility cannot be established or the child is financially ineligible, verify and validate the SHINES determination of IV-E ineligible.

Terminate IV-E Foster Care eligibility for a Voluntary Placement Agreement unless a judicial determination is made within 180 days of the date the agreement was signed.

- Assurance of the required *contrary to the welfare* wording in the court order or validity of the Voluntary Placement Agreement
- The name of the agency or individual to whom the court order gives responsibility for placement of a child

- The date the court order or Voluntary Placement Agreement expires
- The child is in a licensed/approved placement
- The name and address of the placement source

A copy of the initial court orders containing the *contrary to the welfare, best interest* and *reasonable efforts made to prevent removal* or *reasonable efforts were not required* are printed from SHINES External Documentation and become a permanent record of temporary or permanent custody of the child and are maintained in the foster care record

Reimbursability

A child must be determined IV-E eligible in order to be determined IV-E reimbursable. Initial IV-E eligibility is based on the circumstances in the home from which the child was removed, via a custody order or Voluntary Placement Agreement. If a child is determined not eligible for IV-E, the child is ineligible for the duration of that placement episode for both IV-E eligibility and IV-E reimbursability. A placement episode begins at the time the child enters foster care to the point DFCS terminates custody. When a child re-enters DFCS custody, a new placement episode begins and a new IV-E determination is required.

The determination that a child is IV-E reimbursable allows the State to obtain federal IV-E funding for the maintenance, administrative and training costs associated with the child.

SHINES System

The GA Child Welfare Information System (CWIS), SHINES, was implemented statewide in June 2008. Prior to that implementation, all foster care and adoption assistance funding and Medicaid eligibility was processed and tracked through the SUCCESS system.

The below listed forms were completed to document the interaction and exchange of information between SSCMs and RevMax staff prior to the statewide SHINES implementation:

- Form 223 – Medicaid and Application for Foster Care and Adoption Assistance
- Form 224 - Removal Home Income and Asset Checklist
- Form 225 – Title IV-E Eligibility Documentation Sheet
- Form 226 - Medicaid and IV-E Redetermination Form
- Form 227 – Notice of Change in Foster Care or Adoption Assistance
- Form 529 - Authorization of Foster Care Status Change/Termination
- Form 122 – Foster Care Referral for Child Support

Authorizing Medicaid for Out-Of-State IV-E Foster Children Residing in Georgia

Reference 2852 Medicaid Application Processing for Out of State Children Placed In Georgia.

2817 Adoption Assistance Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Adoption Assistance Medicaid		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2817
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

Children who are determined eligible for Adoption Assistance are eligible to receive Adoption Assistance Medicaid if citizenship/alienage criteria are met and are residing in Georgia. The Division of Family and Children Services (DFCS) shall provide Georgia Medicaid under the Consolidated Omnibus Budget Reconciliation Act (COBRA) Reciprocity to a child who is residing in Georgia and receiving Adoption Assistance from another state.

Basic Considerations

The Adoption Assistance Program provides funded subsidies to parents adopting children with special needs. A child does not have to have been in DHS custody to be eligible for Adoption Assistance. Reference Child Welfare Policy Manual 12.1 – Eligibility - Adoption Assistance Payments, Medicaid & Non-Recurring for eligibility criteria for adoption assistance. Eligibility for the Adoption Assistance Program is determined by the Social Services Adoption Unit, SSAU.

Special Needs

In order for a child to qualify as having special needs, application must be made to the State Adoptions Unit to determine if special needs criteria have been met by the child based on one of the following criteria effective March 1, 2010.

- A child has been in the care of a private or public agency or individual other than the legal or biological parent for more than 24 consecutive months.
- A child with a physical, mental, or emotional disability, as validated by a licensed physician or psychologist.
- A child who is a member of a sibling group of two or more placed in the same home.

A funding determination is required before Social Services can authorize Adoption Assistance. A Revenue Maximization RMS validates the funding determination for Adoption Assistance. The funding determination is system derived by SHINES based on the funding determination made at initial entry into foster care; or by review of the IV-E criteria for children who have not been in the permanent custody of DHS; or by criteria established by the Fostering Connections to Success and Increasing Adoptions Act of 2008.

For Adoption Assistance Under Age 18, the child does not have to be continually eligible under IV-E standards but must be determined IV-E eligible at the time of removal from the home.

IV-E eligibility begins at the time of adoptive placement as long as the Adoption Assistance Agreement is in effect. The initial removal court order must contain *the "contrary to the welfare language"*.

> While a court order with the judicial determination that *Reasonable Efforts were made to prevent removal or that Reasonable Efforts were not required to prevent removal* is required for IV-E eligibility for a child entering foster care, this requirement is not a criteria to meet IV-E eligibility for Adoption Assistance.

If the placement is initiated through a Voluntary Placement Agreement, a judicial determination containing "contrary to the welfare" language must be made within the 180- day limitation of the voluntary placement and a IV-E Foster Care payment must be made during the 180-day period.

A child placed pursuant to a Voluntary Placement Agreement under which an IV-E maintenance payment is not made is not eligible to receive IV-E Adoption Assistance.

If placement is initiated by a voluntary relinquishment, the State must petition the court within six months of removal. A judicial determination to the effect that remaining in the home would be "*contrary to the child's welfare*" must be initiated within the six months' time frame. See 2820 Legal Status.

There are two circumstances under which the nature of a child's removal from his/her home is irrelevant:

- When a child is SSI eligible at the time adoption proceedings are initiated and the State determines the child meets the definition of special needs prior to the finalization of the adoption.
- In a subsequent adoption when a child received IV-E Adoption Assistance in a previous adoption that dissolved or in which the adoptive parent(s) died, if the State determines that the child continues to be a child with special needs.

Reviews are not required for Adoption Assistance, but are required for the related Medical Assistance case every 12 months.

> IV-E Adoption Assistance benefits are available through the month of the child's 18th birthday. A child may receive state funded Adoption Assistance after age 18 under certain eligibility criteria and verification. Reference Child Welfare Policy Manual 12.10 – Adoption Assistance Benefits – After 18.

Procedures

The Social Services Case Manager (SSCM) requests a funding determination for the purpose of adoption by sending a SHINES Task to the RMS to complete a SHINES AA Funding Page.

The RMS reviews, verifies eligibility criteria and validates the AA Funding Page with the funding determination and alerts the SSCM of the funding determination.

The SSCM will complete the Adoption Assistance Application and submit to the State Adoptions Unit for review and approval.

For those children determined to be IV-E eligible at initial entry into foster care, the Adoption Assis-

tance will be determined IV-E eligible.

Title IV-E Adoption Assistance

Title IV-E Adoption Assistance – The Title IV-E Adoption Subsidy Program has specific requirements that must be met prior to claiming Federal reimbursement. These requirements include a child meeting both Special Needs Criteria and Title IV-E Eligibility criteria for either the "Applicable Child" or "Non-Applicable" Child as found in Social Services Administration Unit, Section 109 – Adoption Assistance.

Children Not in the Permanent Custody of DHS

Eligibility requirements for Adoption Assistance do not specify that DHS must have custody or placement and care responsibilities for a child. However, a child who is not in the permanent custody of DHS must be Title IV-E eligible and meet the special needs criteria in order to be considered for Adoption Assistance.

A special needs child who is eligible for SSI at the time of the filing of the adoption petition is eligible to receive IV-E Adoption Assistance benefits. These include Monthly Assistance, Medicaid and Non-Recurring Adoption Expenses.

If a special needs child is in the permanent custody of a private, nonprofit agency, the child may be eligible for Adoption Assistance benefits if the child receives SSI; or if it can be verified that a child was removed from the home of a specified relative, was AFDC eligible at the time of removal and a judicial determination was initiated within six months of removal from the home containing the "*contrary to the welfare*" language.

Eligibility is contingent on an application for Adoption Assistance being signed and in effect prior to the finalization of the adoption. Benefits are available to the child once all parental rights have been terminated or surrendered, the child is legally free for adoption, and the child is placed in the adoptive home.

Benefits will terminate on the last day of the child's 18th birthday if the child was never in the permanent custody of DHS. (The family shall be referred to Social Security Administration to apply for SSI.)

Children Not in the Permanent Custody of DHS Adopted by a Specified Relative

A child who has not been in the custody of DHS and is being adopted by a specified relative is potentially eligible for IV-E Adoption Assistance under the following circumstances:

- The child must have been removed from the home of a specified relative by a judicial determination (this may be a termination of parental rights) that includes the "*contrary to the welfare*" language (this may be a constructive removal). At the time of the removal the child must have been AFDC eligible. Reference Section 2825 – AFDC Relatedness.

  OR

- A special needs child who is in the temporary custody of DHS and meets IV-E criteria may receive IV-E Adoption Assistance if adopted by a specified relative. DHS must initiate the TPR

proceedings but may give permanent custody to the relative for the purpose of adoption.

AND

- A special needs determination must be made by the Social Services Adoptions Unit if the child is not eligible based on age and race.

Adoption Assistance Medicaid Under Age 18

Follow the steps below to determine initial Medicaid eligibility.

Obtain the Form 403, ADOPTION Assistance Benefits Memorandum.

- A legally executed adoption assistance agreement is in place between the state and the adoptive parents and the date signed;
- There exists a specific factor or condition which precludes adoptive placement without state adoption assistance. These factors include, but are not limited to the following:
  - Ethnic background
  - Age
  - Membership in a minority or sibling group
  - Presence of a mental condition
  - Physical, mental or emotional disability
- The placement of the child in the adoptive home would not be possible without the Medicaid coverage.
- The child's date of birth.
- The Social Security number (SSN) of the child or statement of intent to apply for a SSN.

Determine the child's Medicaid eligibility as of the month of the adoption finalization. As long as the child is receiving Adoption Assistance and is under the age of 18, Adoption Assistance Under Age 18 Medicaid coverage is provided.

Adoption Assistance Age 18 – 21

A youth may continue beyond the youth's 18th birth month when the youth's circumstances [.underline]#meet the basic eligibility criteria to continue benefits past 18 years of age and when verification is provided that meets the high school or college eligibility criteria. Reference Child Welfare Policy Manual 12.10 – Adoption Assistance Benefits – After 18.

Authorizing Medicaid for Out-of-State Adoption Assistance Children Residing in Georgia

Refer to 2852 Medicaid Application Processing for Out of State Children Placed In Georgia.

2818 Chafee Independence Program Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Chafee Independence Program Medicaid		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2818
	Previous Policy Number(s):	MT 48	**Updated or Reviewed in MT:**	MT-62

Requirements

The Foster Care Independence Act allows Medicaid coverage to be extended to individuals who age out of foster care the month of their 18th birthday up until their 21st birthday.

Applicants may not be determined ineligible based on a diagnosis or pre-existing condition.

Basic Considerations

Chafee Independence Program Medicaid became effective July 1, 2008. Former foster youth may apply for Chafee Independence Medicaid through the Gateway Customer Portal or at any Division of Family and Children Services (DFCS) office.

Reference 2890 Foster Care Medicaid Age 18 to 21 for children in placement for whom DFCS has partial or total custody and may be age 18 to 21.

The eligibility month is the month following a foster child's 18th birthday or the month a former foster child over the age of 18 and under the age of 21 applies for the Chafee Independence Program Medicaid.

Basic Eligibility Criteria

The following basic eligibility criteria must be met to qualify for Chafee Medicaid:

- Age: A youth must have been in foster care the month of his/her 18th birthday and be under the age of 21; self–attestation is accepted for verification of entry into foster care.
- Enumeration;

> Enumeration is not a requirement for Emergency Medical assistance (EMA). Refer to Section 2054, EMA; Reference Section 2220, Enumeration.

- Residency, Reference Section 2225, Residency;
- Citizenship/Immigration Status/Identity;

> Individuals who were in foster care under Title IV-B or Title IV-E of the Social Security Act are exempt from providing additional documentary evidence of citizenship/immigration status/identity as long as they were in Foster Care in Georgia.

- Third Party Liability, Reference Section 2230, TPL;
- Application for other benefits, Reference Section 2210, Application for Other Benefits.

There are **no** income or resource limits for Chafee Medicaid.

Other Considerations

Chafee Medicaid Cases are reviewed on an annual basis until the recipient turns 21. Chafee Independence recipients are eligible for retroactive Medicaid EMA is available under Chafee Independence Medicaid.

Chafee recipients are enrolled in Amerigroup as their CMO enrollment.

Non-MAGI Family Medicaid recipients who are former foster children may request a Class of Assistance change to Chafee Independence Medicaid.

Procedures

Continuing Medicaid Determination

Rev Max will complete a continuing Medicaid determination (CMD) following the steps below for a current foster child in the month of their 18th birthday:

- For eligibility month following the month of individual's 18th birthday:
  - Verify that individual was in a state's legal custody on his or her 18th birthday.
  - For ICPC placements in Georgia, verify through Independent Living Regional Coordinators the foster care status in original state of custody.

    Written verification must be maintained in the case record. An ICPC placement in Georgia aging out of foster care and remaining in Georgia is considered a Georgia resident.

  - Verify that individual will not be eligible for Child Welfare Foster Care Medicaid criteria
  - Accept the client's statement as to Georgia residency
  - Complete the DMA 285 – Third Party Liability

    There is no income or resource test for Chafee Medicaid.

New Applications

For determining eligibility for Chafee Medicaid on new Gateway applications, Rev Max Specialist (RMS) complete the following steps:

- Verify that the individual was in foster care on his or her 18th birthday by screening in SHINES;
- Self-attestation of receipt of Foster Care in another state at the time the youth turned 18 or aged out of the foster care system is acceptable.
- Assume the individual who ages out of care with the State of Georgia meets citizenship/immigration status/identity unless information to the contrary is known to the agency. No additional

citizenship/immigration status or identity documents are required.

> Individuals who were in foster care under Title IV-B or Title IV-E of the Social Security Act are exempt from providing additional documentary evidence of citizenship/immigration status/identity as long as they were in Foster Care in Georgia.

- Verify citizenship/immigration status/identity for individuals who were in foster care in other states and request Chafee Medicaid in Georgia after their 18th birthday.
- Accept the client's statement as to Georgia residency
- Complete the DMA 285 – Third Party Liability

> There is no income or resource test for Chafee Medicaid.

Ongoing Cases

Chafee Medicaid cases are hard case owned by Revenue Maximization staff with no other Gateway benefit cases associated with the Chafee Medicaid case.

Chafee Medicaid Cases are required to have an annual review.

> Court orders and existing foster care documentation must be retained in the closed foster care case record and may NOT be cleansed.

Case Records For Children with Expired Eligibility

Closed Cases – Foster Care case records for recipients for whom eligibility has expired, i.e. where the recipient has turned age 26, should be maintained in Rev Max closed files following the retention schedule found in 2760 Case Record Maintenance. Court orders and existing foster care documentation must be retained in the Chafee Medicaid case record and may not be cleansed.

Retention of Case Records – Due to IV-E Foster Care and Medicaid regulations, Chafee Medicaid case records must be retained in their entirety (both IV-E FC material and Medicaid material) for a period of three years from the recipient's 26th birthday (i.e. no earlier than the recipient's 29th birthday).

2819 Former Foster Care Medicaid

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Former Foster Care Medicaid		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2819
	Previous Policy Number(s):	MT 50	**Updated or Reviewed in MT:**	MT-62

Requirements

The Affordable Care Act allows Medicaid coverage to be extended to individuals who age out of foster care, or age out of Chafee Independence Program, and were receiving Medicaid to the last day of the month they turn 26 years of age. Applicants may not be determined ineligible based on a diagnosis or pre-existing condition.

Basic Considerations

The Former Foster Care Medicaid became effective January 1, 2014, and retro coverage is not available prior to this date.

Former foster youth may apply for Former Foster Care Medicaid through the Gateway Customer Portal or at any Division of Family and Child(ren) Services (DFCS) office.

The eligibility month is the month following the closure of Chafee Medicaid.

Basic Eligibility Criteria

The following basic eligibility criteria must be met to qualify for Former Foster Care Medicaid:

- Age: A youth must have been in foster care the month of his/her 18th birthday and be under the age of 26. The child could have been in foster care in any state.
- Self-attestation of receipt of Foster Care in another state at the time the youth turned 18 or aged out of the foster care system is acceptable.
- Enumeration

> Enumeration is not a requirement for Emergency Medical assistance (EMA). Refer to 2054 Emergency Medical Assistance; Reference 2220 Enumeration.

- Residency, Reference 2225 Residency;
- Citizenship/Immigration Status/Identity.

> Individuals who were in foster care under Title IV-B or Title IV-E of the Social Security Act are exempt from providing additional documentary evidence of citizenship/immigration status/identity as long as they were in Foster Care in Georgia.

- Third Party Liability, Reference 2230 Third Party Liability;

- Application for other benefits, Reference 2210 Application for Other Benefits.

There are **no** income or resource limits for Former Foster Care Medicaid.

Other Considerations

Former Foster Care Medicaid Cases are reviewed on an annual basis until the recipient turns 26.

Former Foster Care Medicaid recipients are eligible for retroactive Medicaid. EMA is available under Former Foster Care Medicaid.

Former Foster Care recipients are enrolled in Amerigroup as their CMO enrollment.

Non-MAGI recipients who are former foster children may request a Class of Assistance change to Former Foster Care Medicaid.

Procedures

For determining eligibility for Former Foster Care Medicaid on new applications, complete the following steps:

- Verify that the individual was in foster care on his or her 18th birthday and receiving Medicaid by screening in SHINES or,
- Self-attestation of receipt of Foster Care in another state at the time the youth turned 18 or aged out of the foster care system is acceptable.
- Assume the individual who ages out of care with the State of Georgia meets citizenship/immigration status/identity unless information to the contrary is known to the agency. No additional citizenship/immigration status or identity documents are required.

> Individuals who were in foster care under Title IV-B or Title IV-E of the Social Security Act are exempt from providing additional documentary evidence of citizenship/immigration status/identity as long as they were in Foster Care in Georgia.

- Verify citizenship/immigration status/identity for individuals who were in foster care in other states and request Former Foster Care Medicaid in Georgia after their 18th birthday.
- Accept the client's statement as to Georgia residency
- Complete the DMA 285 – Third Party Liability

Ongoing Cases

Former Foster Care Medicaid cases are hard case owned by Revenue Maximization staff and will have no active or pending related case associated to the Medicaid case.

Former Foster Care Medicaid Cases are required to have an annual review.

> Court orders and existing foster care documentation must be retained in the closed foster care case record and may NOT be cleansed when transferred to another county DFCS office.

Continuing Medicaid Determinations

If applicant ages out of Chafee (Age 21), the RMS will CMD the applicant to Former Foster Care and maintain the record.

If applicant aged out of Foster Care at 18 but opted to return until age 21 (Foster Care Medicaid Age 18 - 21), the Rev Max Specialist will CMD into Former Foster Care .

Case Records for Children with Expired Eligibility

Closed Cases – Foster Care case records for recipients for whom eligibility has expired, i.e. where the recipient has turned age 26, should be maintained in Rev Max closed files following the retention schedule found in 2760 Case Record Maintenance. Court orders and existing foster care documentation must be retained in the Chafee Medicaid case record and may not be cleansed.

Retention of Case Records – Due to IV-E Foster Care and Medicaid regulations, Former Foster Care and Medicaid case records must be retained in their entirety (both IV-E FC material and Medicaid material) for a period of three years from the recipient's 26th birthday (i.e. no earlier than the recipient's 29th birthday).

2820 Legal Status

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Legal Status		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2820
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

Legal responsibility and care for a child must be given to DFCS or another public agency under contract with Georgia Department of Human Services before Title IV-E eligibility can be established.

Basic Considerations

A child must enter care pursuant to a court order or a Voluntary Placement Agreement.

Court Ordered Removal

There are two types of court orders:

- Permanent - issued when parental rights are severed
- Temporary - issued from the date of removal.

To establish IV-E eligibility, the first court order signed by a judge which sanctions the removal of the child from the home; e.g., the order that is issued as a result of the 72–hour hearing, a Shelter Care Order, Emergency Removal Order, etc. must have the appropriate judicial finding of "*contrary to the welfare*"/"*best interest of the child*". The finding should be explicitly documented in the court order and made on a case-by-case basis; that is, based on the individual circumstances/facts of the case that led the judge to conclude to the finding. The order must enumerate the specific facts of the case or reference the facts contained in such documents as the complaint, petition, etc.

If the required language is not in the initial judicial determination, the child will never be IV-E eligible (or IV-E reimbursable) at any time during that placement episode.

There must be a court order within 60 days of the child's removal that contains a judicial determination to the effect that "*reasonable efforts were made to prevent removal of the child*" or that "*reasonable efforts were not required to prevent removal of the child from the home*". These orders may be known by various names such as the Detention, Shelter Care, Adjudication, Dispositional, Temporary Custody Orders, etc. The child cannot be determined IV-E eligible until "*reasonable efforts*" language is obtained. If the "*reasonable efforts*" language is not obtained within 60 days of the child's removal date, the child is not eligible for IV-E during that placement episode.

Affidavits and *nunc pro tunc* order or orders referencing the judicial court code are not acceptable for meeting the "*contrary to the welfare*" or "*best interest*" judicial language requirement. *Nunc Pro Tunc* orders are court orders that give retroactive effect to a judicial finding included in the order;

the purpose of which is to clear up omissions in a previous court order that were inadvertently excluded. The required language must be stated in the initial court order. If a *nunc pro tunc* order was issued; i.e. the order is signed after the 60 days, but the judge's signature (and not the findings of the court) reference back to the actual date of the hearing, then the language requirement is met.

Electronic or digital signatures for a judge's signature are acceptable.

Court Ordered Removal, Voluntary Placement

A Voluntary Placement Agreement is a signed written agreement between DFCS and the parent(s) or the legal guardian(s) of the child. It specifies the legal status of the child, and the rights and obligations of the parent(s) or legal guardian(s) and the county DFCS while the child is in out-of-home placement. The agreement is limited to 90 days, with the possibility of one additional 90-day extension. No placement is reimbursable without legal authorization for custody. A VPA or court order must currently be in effect for reimbursement.

Federal law allows IV-E eligibility to continue for 180 days under a Voluntary Placement Agreement without a court order. If the child remains in care under a Voluntary Placement Agreement beyond 180 days without acquiring a court order which states that continued voluntary placement is in the "*best interest*" of the child, the child will lose IV-E eligibility on the 181st day and for the remainder of the placement episode.

For those children that enter DFCS care and responsibility via a Voluntary Placement Agreement, a judicial determination that "*reasonable efforts*" to prevent removal is not required for meeting IV-E eligibility.

Voluntary Relinquishment

Voluntary Relinquishment, also called Voluntary Surrender of parental rights, occurs when a parent voluntarily signs the child into foster care for the purpose of adoption. The child is surrendered to the Department of Human Services and the rights and duties of the county

DFCS are the same as if parental rights had been terminated in court. The parent loses all parental rights and responsibilities of the child. The parents may be obligated to pay child support until such time an adoption is finalized.

Foster Care: A child in this situation may only be IV-E Foster Care eligible if the child had last been living with the parent(s) within six months of the date court proceedings were initiated leading to a judicial determination that included "*contrary to the welfare*" and "*reasonable efforts*" language.

Adoption Assistance: An otherwise eligible child who had been living with the specified relative within six months of the date the court order proceedings were initiated leading to a judicial determination that included :contrary to the welfare" language will be eligible for IV- E Adoption Assistance. The "reasonable efforts" determination is not required for IV-E Adoption Assistance eligibility.

Voluntary relinquishments or voluntary surrenders are only taken when adoption is a viable plan for the child. Refer to the Social Services Manual for additional information

Permanency Plan

A judicial determination of the agency's activities to make reasonable efforts to finalize a child's permanency plan is required within 12 months of the child's removal and at least every 12 months thereafter while the child is in foster care. The State is not required to reconcile the permanency plan in effect at the time the judicial determination is due with the reasonable efforts determination itself. The courts may rule on the plan that is in effect at the time of the finding, a plan that has been in effect for a brief period of time, or the activities related to achieving permanency that took place over the prior 12 months, even if the plan had been abandoned during that 12-month period.

If a judicial determination regarding reasonable efforts to finalize a permanency plan is not made within the time frame prescribed, the child loses reimbursability under title IV-E at the end of the month in which the judicial determination was required to have been made and remains non-reimbursable until such a determination is made.

2825 AFDC Relatedness

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	AFDC Relatedness		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2825
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

A child must meet all AFDC relatedness criteria in order to be IV-E eligible.

Basic Considerations

In all references to AFDC relatedness, the eligibility of the child is based on the AFDC program in effect in Georgia's State Plan on July 16, 1996. Receipt of TANF in the eligibility month does not meet the AFDC relatedness criteria.

Eligibility Month

The eligibility month is the month of the initiation of court proceedings (i.e., the filing of the complaint or petition) that led to the removal of the child or the date a voluntary placement agreement (VPA) was signed by all parties.

AFDC Criteria

The criteria which must exist in the removal home to meet the AFDC Relatedness criteria for IV-E purposes are:

- Age
- Living with a specified relative in the removal home
- Deprivation
- Financial need (income and resources)
- Citizenship/immigration

Age

To be IV-E eligible, the child must be under the age of 18. IV-E eligibility always discontinues the first day of the following month after the youth reaches 18.

Living with a Specified Relative in the Removal Home

A child must meet AFDC eligibility criteria in the month in which either a Voluntary Placement Agreement (VPA) is entered into or a court order is initiated to remove the child from the home. If the child is not living with the specified relative/parent from whom child is removed during the

month the VPA is signed or the court order is initiated, a child can be considered AFDC eligible in that month if the following conditions apply:

- The child had been living with the specified relative from whom they are removed and they are removed at some time within the six-month period prior to the month the VPA was signed or the court order initiated

  AND

- The child would have been AFDC eligible in the home of the specified relative from whom they are removed in the month the VPA is signed or the court order initiated if the child had continued to live with the relative.

The "living with" and "removal from" condition must be met by the same Specified Relative. **Reference this section for Living With/Removal Home Rule prior to March 27, 2000.**

A specified relative must be the person identified in the court order as the person to whom it "would be contrary to the welfare" for the child to remain with or whom it is in the "best interest" of the child to be removed from.

Refer to 2245 Living With A Specified Relative / Tax Filer / Non-Filer Status for the definition of a Specified Relative. A Specified Relative includes a relative to be any relation by blood, marriage or adoption who is within the fifth degree of kinship to the dependent child.

The following relationships meet the requirements of a specified relative:

- parents (either by birth, legal adoption or step-relationship)
- grandparents (up to great-great-great)
- siblings (whole, half or step)
- aunts/uncles (up to great-great)
- nieces/nephews (up to great-great)
- first cousin
- first cousin once removed (the child of the first cousin)
- spouses of any person named in the above group, even after the marriage is terminated by death or divorce.

> The spouses of a stepparent or the spouse of a stepsibling is **NOT** within the specified degree of relationship.

Relationship is established by one of the following:

- birth
- marriage
- legal adoption

An individual who has legal custody of a child does **NOT** meet the relationship requirement.

Adoption or severance of parental rights does **NOT** terminate blood relationship for the specified relative requirement.

The biological parent of a child who has been adopted continues to meet the relationship requirement, but is treated as a non-parent relative.

When a child is adopted, the relatives of the adoptive parent(s) assume the new relationships created by the adoption.

If a child is born or adopted after a marriage is terminated, the former spouse is **NOT** within the degree of relationship **UNLESS** s/he is the biological parent of the child.

The requirement for living with a specified relative is met if a newborn child is placed in DFCS care and responsibility directly from its birthplace in a hospital.

When DFCS takes custody of a child, there must be a removal for a child to be IV-E eligible. There are two types of removals:

- **Physical Removal** occurs when the agency has physically removed the child from their current living arrangement. Custody must also be removed from the appropriate person.
- **Constructive Removal** is considered a “paper” removal; State/Tribal agency has obtained legal custody and supervision of the child, but did not physically remove the child from their current living arrangement. A child is considered constructively removed on the date of the first judicial order removing custody, even temporarily, from the appropriate specified relative or the date that the voluntary placement agreement is signed by all relevant parties.

Use the following steps to establish whether the “removal from” and “living with” are the same person and whether the child is potentially IVE eligible:

Determine who was the child’s caretaker in the month the VPA was signed by all parties or the court order initiated. The caretaker is the adult the child was physically living with. (Living With)

Determine from whom legal custody has been removed via VPA or court order. (Removed From)

Use the following chart to determine if the child is potentially IV-E eligible. The child must be removed from and living with the same specified relative at the time of removal, or within six months of the removal month to be IV-E eligible.

Chart 2825.1 - Living With and Removal From a Specified Relative

IF	THEN
The child lives with a specified relative identified in the court order/VPA **AND** The child will continue to live with this relative	The child is NOT IV-E eligible. No removal.

IF	THEN
The child lived with a specified relative identified in the court order/VPA **AND** The child is removed from the home	The child is potentially IV-E eligible. Physical Removal.
VPA or court order initiated to remove custody from a person who does not meet the definition of a specified relative.	The child is NOT IV-E eligible. Type of removal is not an issue.
The child lives with a caretaker who is NOT identified in the court order as the removal home, regardless of relationship **AND** The child lived with the specified relative identified in the court order and was removed within the six months prior to the VPA signature or the initiation of the court order **AND** The child remains with the caretaker.	The child is potentially IV-E eligible. AFDC relatedness is based upon the situation of the specified relative identified in the court order/VPA in the month the VPA was signed or petition filed. Constructive Removal.
The child lives with a specified relative caretaker who is not identified in the court order **AND** The child DID NOT live with the specified relative identified in the court order/VPA within the six months prior to the VPA signature or the initiation of the court order **AND** The child is removed from the caretaker's home.	The child is NOT IV-E eligible. Although the child was physically removed from the home of the related caretaker, that removal cannot be used to determine IV-E eligibility since the removal was not the result of a VPA or judicial determination. Constructive and Physical Removal.
The child lives with a non-related caretaker who is not identified in the court order **AND** The child DID NOT live with the specified relative identified in the court order and was removed within six months prior to the VPA signature or the initiation of the court order **AND** The child is removed from the caretaker's home.	The child is NOT IV-E eligible. Although there was a constructive, "paper" removal, the child had not lived with the specified relative identified in the court order/VPA within six months prior to the VPA signature or initiation of the court order. Constructive and Physical Removal

IF	THEN
The child lives in a multi-generation household in which the specified relative identified in the court order/VPA leaves the home **AND** The VPA or court order is initiated within six months of the specified relative (identified in the court order/VPA) leaving the home **AND** The child remains in the home.	The child is potentially IV-E eligible. AFDC relatedness is based upon the situation of the specified relative identified in the court order/VPA in the month the VPA was signed or petition filed. Constructive Removal.
The child lives in a multi-generation household in which the specified relative identified in the court order/VPA **AND** The VPA or court order is initiated after the specified relative has been gone six months or more **AND** The child remains in the home.	The child is NOT IV-E eligible. Constructive Removal.

Living With/Removal Home Rule prior to March 27, 2000

For children taken into DFCS custody prior to March 27, 2000, and who are in the same placement episode (meaning the child has continuously been in DFCS custody), use old AFDC "living with" regulations in establishing the removal home.

AFDC rules stated that if a parent left a child with another relative and did not return, the child's home was considered to have shifted to the home of the other relative.

If a child was living with a specified relative, regardless of legal custody, and the child was physically removed, the child is potentially IV-E eligible. The removal home was the home from which the child was physically moved.

If a child was living with a specified relative, regardless of legal custody, and if legal but not physical custody was removed, the child is not IV-E eligible.

Deprivation

In order to meet the AFDC deprivation criteria, the child must have been deprived of the care, guidance or support of one or both parents (married or unmarried), if paternity is established. Deprivation must exist in the eligibility month. Statements from family members, DFCS observation or information from available systems must verify deprivation.

Deprivation results from one of the following situations in the removal home:

- **Death**
- **Separation**: parents are legally separated and one of the parents is not living in the same house

- **Divorce:** parents are divorced and one of the parents is not living in the same house
- **Continual absence:** one of the parents is continually absent from the home where the child resides
- **Institutionalized/incarcerated:** one of the parents is in an institution or incarcerated prior to the child's placement

> If incarceration of a parent occurs the same day as the removal, the RMS must determine if the removal was directly related to the incarceration. If the child's removal results in the incarceration because the parent is the alleged perpetrator, the parent is considered part of the assistance unit (AU). If the incarceration occurred because of a previous or unrelated charge, then the parent is not considered as part of the AU.

- **Incapacitated or disabled:** any condition of mind or body which substantially reduces or eliminates the ability of the parent to support or care for the child. The parent's disability should be determined and the disability continues for at least 30 days. If the parent is receiving SSI or Social Security disability benefits, Veteran's Disability benefits (100%), Railroad benefits, or Worker's Compensation benefits, the incapacitation requirement is met and verification of benefits shall be included in the record (such as a copy of the award letter, or copy of a check). If these are not available, third party verification by a doctor is required.
- **Termination of parental rights:** if there has been a termination of parental rights, the child is deprived from the date of the termination of parental rights.
- **Unemployment of the principal wage earner:** this condition only applies when both parents are present in the household. The child can be considered deprived if the principal wage-earning parent is unemployed. The principal wage-earning parent is the parent who earned the greater amount in the 24-month period prior to the eligibility month. See 2826 AFDC Deprivation - Unemployed Parent for more information on AFDC Unemployed Parent policy.

If the child was not deprived of the care and support of one or both parents during the eligibility month, there is no eligibility for IV-E.

Financial Need: Assistance Unit

The Assistance Unit (AU) in the removal home must be established before Financial Need can be determined. The AU is the group of people whose income and resources must be considered in determining if the child meets financial need (income and resource) criteria for AFDC relatedness.

The following persons must be included in the AU if they are present in the Removal Home:

- Birth or adoptive parents
- Child in custody
- Any minor siblings (birth, adoptive or half) of the child in custody.

Any household member receiving SSI benefits is not counted as a member of the AFDC AU. In addition, the SSI benefits and any other income or resources of the SSI recipient are not counted in determining financial need. If the child in custody is a SSI recipient, the AFDC financial need criteria for both income and resources have been met. See 2845 SSI Eligible Child.

An adoptive sibling to the child, who is receiving adoption assistance, may be excluded from the AFDC AU. (The adoptive sibling's income and resources would be excluded).

If the child in custody and under review is receiving adoption assistance, do not count the child's income and resources when determining financial need, however count the child as a member in the AFDC AU.

Financial Need: Resources

The maximum value of resources the Assistance Unit (AU) in the removal home can own is $10,000 to meet the resource limit for the financial need criteria.

If the child was living with either or both parents, the resources of all members of the AU (i.e., the person who would have made application and those dependents on that person) are considered in the determination of financial need.

If the child was living with a specified relative, other than the parents, only the child's resources and members of the child's standard filing unit are considered in the determination of financial need.

If the child is in receipt of SSI in the eligibility month, the child meets financial need criteria for both income and resources.

See 2399 Treatment of Resources by Resource Type Chart for treatment of resources.

Financial Need: Income

Income is calculated utilizing countable earned and unearned income of the removal home AU.

Refer to 2835 AFDC Relatedness Budgeting and 2499 Treatment of Income in Medical Assistance for treatment of income.

If the removal home AU meets the AFDC SON during the eligibility month, pursue IV-E eligibility.

If the removal home AU does not meet the AFDC Standard of Need during the eligibility month, the child is ineligible for IV-E.

Citizenship/ Immigrant Status

The child must be a US citizen or a qualified immigrant to be IV-E eligible. It is the responsibility of the SSCM to verify citizenship or immigration status of applicants for IV-E benefits.

Refer to 2215 Citizenship / Immigration / Identity.

DFCS may claim IV-E for an otherwise eligible child pending Department of Homeland Security (DHS) verification of immigration status. If DHS later verifies the child's immigration status does not meet Medicaid requirements, DFCS must adjust prior IV-E claims accordingly.

2826 AFDC Deprivation - Unemployed Parent

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	AFDC Deprivation - Unemployed Parent		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2826
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

When both parents are in the home, the unemployment of the parent who is the principal earner (PE) deprives a child of parental support.

AFDC-UP is a type of deprivation and not a special type of AFDC. An AFDC-UP AU is subject to all processing requirements of the AFDC program

Basic Considerations

For AFDC-UP purposes, unemployment of the PE is defined as one of the following:

- Being out of work for 30 consecutive days

  OR

- Working fewer than 100 hours in the 30 consecutive calendar days prior to approval

  AND

- Working fewer than 100 hours in a calendar month after approval

Deprivation Requirements

To establish deprivation because of the unemployment of the PE, the PE must meet each of the criteria below:

- Be unemployed for at least 30 consecutive calendar days prior to the AFDC- Relatedness budget month
- Have a recent connection to the workforce

Parents must live together, but are not required to be married to each other at the time of the budget month.

If the PE does not meet the citizenship/alien status requirement and does not have INS authorization to work, the family is ineligible for AFDCUP, and the child cannot be considered deprived due to the unemployment of the parent.

If the PE has INS authorization to work, but does not meet the citizenship/alien status requirement,

the PE is not included in the AU. However, other family members are potentially eligible for AFDC-UP.

Unemployment compensation benefits (UCB) received by the PE are budgeted uniquely. A family is not eligible for AFDC-UP if the PE is unemployed because s/he is on strike.

Procedures

Determine who lives in the home and their relationship to each other.

Explore eligibility for AFDC-UP when a blended family applies and one parent is unemployed as follows:

- When the PE is designated and meets the AFDC-UP definition of unemployed, include the parents, the mutual child(ren), and the child(ren) of each parent in one AU.
- If the AU does not meet the AFDC-UP deprivation requirements, deny AFDC-UP and explore the eligibility of the child in other AU compositions.

Initial Determination

Determine eligibility using the steps on the following pages.

Determine the Principal Earner

Determine the Principal Earner. The Principal Earner (PE) is the parent with the greater earnings in the two years prior to the application month.

Accept the AU's statement to establish which parent had the greater earnings unless the information provided conflicts with other information available to the agency.

Determine the PE at application following the guidelines in Chart 2826.1.

Chart 2826.1 Determining the PE at Application

IF AT APPLICATION	THEN
Both parents have earned income in the 24 months preceding the application month	The parent with the higher earnings in the 24 months is the PE
The earnings of each parent are equal in the 24 months prior to the month of application	The parent with the higher earnings in the most recent six months is the PE.

Determine if the PE meets Unemployment Criteria

Use Chart 2826.2 to determine if the PE meets the unemployment criteria at the time of application.

Chart 2826.2 Establishing Unemployment Status

IF THE PE	THEN
Is not working at the time of application **AND** Has been unemployed for 30 consecutive days	The unemployment criterion is met on the date of application.

IF THE PE	THEN
Is employed at the time of application **BUT** Worked fewer than 100 hours in the 30 consecutive days prior to the application date	The unemployment criterion is met on the day of application.

Establish if the PE Has a Recent Connection to the Workforce

Use Chart 2826.3 to determine recent connection to the work force.

At the point the PE meets any one of the requirements, recent connection to the work force is met.

Determine whether the requirement for recent connection is met in the order listed in the chart.

Chart 2826.3 Recent Connection to the Work Force

IF THE PE	THEN
Currently receives UCB	A recent connection to the work force is met. Verify with Clearinghouse or UCB check stub.
Received UCB within one year prior to the date of application (including the application month and the 12 prior calendar months)	A recent connection to the work force is met. Verify with Clearinghouse or UCB check stub.
Would have been eligible to receive UCB in the year prior to the application month had s/he applied	A recent connection to the work force is met. Verify with Clearinghouse
Performed work which was not covered under Georgia's UCB law, BUT If it had been covered, the PE would have been eligible for UCB. The PE must provide wage information on the nine quarters prior to the application quarter.	Accept the PE's statement of earnings. Complete Form 270 and submit to the Department of Labor (DOL) for a determination of potential eligibility for UCB. If DOL shows potential eligibility for UCB, a recent connection to the work force is met.
Had six calendar quarters of work, education or training within any of the 13 consecutive calendar quarter periods ending within the four years prior to the application. This four-year period may include the application quarter and the prior 16 calendar quarters. The six quarters may be met by a combination of the following: • Wages of at least $50 gross earnings per quarter • Participation in a JTPA education or training activity • Enrolled as a full time student in elementary, secondary (or an equivalent secondary program), vocational or technical training course for any part of a quarter	A recent connection to the workforce is met. Use Clearinghouse to verify $50 in earnings for the work quarters in question. If school attendance is used to meet this requirement, verify attendance through the school.

No more than four quarters of education/training can be applied toward the six required quarters of work. A maximum of four quarters of education/training may be applied in a lifetime.

Determine if the PE Has Refused a Bona Fide Offer of Employment

Determine if the PE failed to accept an offer of employment or training for employment within the 30 consecutive days prior to approval.

If the PE has refused such an offer without good cause, deprivation cannot be met.

Accept the SSCM's statement regarding the offer or acceptance of a bona fide offer of employment unless the agency has information which conflicts with the statement.

Determine the AU's eligibility taking the following into account:

Determine Eligibility Based on Financial Criteria

Apply all normal budgeting procedures with the exception of the budgeting of UCB income. Refer to Section 2835, AFDC Relatedness Budgeting.

Retroactive UCB payments are not treated as a lump sum in AFDCUP. Budget retroactive UCB payments in the month received.

Processing

The initial AFDC Relatedness budgeting is completed by SHINES based on information for the removal home. RMS will review, verify, document and correct information in SHINES that pertains to the removal home circumstances including income, household management in order for the AFDC budgeting to be completed accurately for IV-E funding determination eligibility. Reference Section 2835 – AFDC Relatedness Budgeting.

Redetermination

With passage of the Fostering Connections to Success and Increasing Adoptions Act of 2008 (Public Law 110-351), the AFDC criteria for redeterminations was eliminated. Reference Section 2870 – Redeterminations for Children in Placement for redetermination policy.

2830 AFDC Deductions

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	AFDC Deductions		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2830
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

Deductions are applied to the AU's income to determine IV-E financial need for AFDC Relatedness eligibility.

Basic Considerations

A $50.00 deduction is applied to child support income according to the following criteria:

- Prior to the gross income ceiling (GIC) test
- To the AU's total child support income whether received via DCSS or direct from the non-custodial parent (NCP)
- Whether the child support is reported untimely or timely.

Deductions are applied to earned income according to the following criteria:

- After the GIC test
- To the earned income of each employed individual
- Only to income that is reported.

Employed individuals include the following:

- Employed AFDC AU members
- Sanctioned individuals whose earnings are included in the AFDC budget.

Earned Income Deductions

Earned income deductions include the following:

- $90 standard work expense
- $30 earned income deduction
- 1/3 of the remaining income
- Dependent care expenses.

Do not apply the above listed deductions to the income of individuals whose income is deemed to an AU through the responsibility budgeting process. The deductions allowed in responsibility and

deeming budgeting are unique. Refer to Chapter 2661 – Responsibility Budgeting for allowable responsibility budgeting deductions.

Refer to 2835 AFDC Relatedness Budgeting for instructions on how to apply the deductions.

Processing

SHINES processes the AFDC Relatedness financial need budgeting. Revenue Maximization Specialists (RMS) verify and validate the data for the AFDC Relatedness budgeting.

2835 AFDC Relatedness Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	AFDC Relatedness Budgeting		
	Effective Date:	November 2020		
	Chapter:	2800	**Policy Number:**	2835
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-62

Requirements

AFDC budgets are completed when determining eligibility under IV-E Foster Care.

Basic Considerations

The AFDC Budget is based on the circumstances in the home from which the child was removed.

The Gross Income Ceiling (GIC) test is used to determine financial eligibility based on the AU's gross countable income.

The Standard of Need (SON) test is used to determine financial eligibility based on the Assistance Unit's (AU) net countable income.

Refer to Chart 2835.1 for GIC and SON limits.

Chart 2835.1 - AFDC Income Standards

Number in AU	Gross Income Ceiling	Standard of Need
1	435	235
2	659	356
3	784	424
4	925	500
5	1060	573
6	1149	621
7	1243	672
8	1319	713
9	1389	751
10	1487	804
11+	1591	860
For each additional Member	+44	+24

An individual's income and resources are not considered in two separate AFDC budgets simultaneously.

The resource limit for AFDC relatedness is $10,000.00. Refer to Section 2399 for treatment of resources.

All countable income and resources of the AU members are considered in determining financial eligibility.

The countable income of the following non-AU members are considered in determining financial eligibility:

- Ineligible Parents
- Stepparents
- Parents of a minor caretaker
- Spouses of married minors
- Intentional Program Violation (IPV) disqualified individuals as noted in GA Gateway
- Sanctioned Standard Filing Unit (SFU) individuals.

Employed individuals include the following:

- Employed AFDC AU members
- Sanctioned SFU individuals whose earnings are included in the AFDC budget.

An SSI recipient's income and resources are not considered in determining AFDC eligibility. However, any income given to the AFDC AU by a recipient of SSI is treated as a contribution.

A responsibility budget is completed in the following situations:

- To determine whether a non-parent relative can be included in the AU as caretaker.
- To determine how much of the income of a stepparent or the parent(s) of a minor caretaker to include in the AFDC budget.
- To determine how much income an AFDC eligible adult can allocate to meet the needs of his/her AFDC ineligible spouse and/or child.

Procedures

Gross Countable Income

Gross countable income is the AU's income after subtracting the following:

- The $50 child support deduction
- Allocated income
- The earnings of an AFDC child (see PROCEDURES, Earnings of an AFDC child, in this section)
- Any other income excluded by law (refer to Chapter 2400, Income)
- Unemployment Compensation Benefit (UCB) received by the Principal Earner in an AFDC-Underemployed/Unemployed Parent AU.

Gross countable income includes income deemed from a responsibility budget and earnings from self-employment after subtracting the cost of doing business.

Gross countable income is used in completing the GIC test. Refer to Section 2499 for treatment of

income for types of countable income.

Net Countable Income

Net countable income is the AU's income after allowing all deductions (refer to 2830 AFDC Deductions). Net countable income is applied to the SON to determine eligibility.

Earnings of an AFDC Child

Exclude an AFDC child's earnings from gross countable income for up to six months per calendar year if the child is in school at least equal to the amount of time worked according to the following:

- Compare full-time school attendance to full-time work, etc., to determine in school at least equal status.
- After six months of the exclusion, include the earnings as income when completing the GIC test.
- If the AU is eligible based on the GIC test, exclude the child's earnings from the remainder of the budgeting process.

Determining Financial Eligibility

Follow the steps below to establish the AU's financial eligibility for AFDC.

Determine the members of the AU (refer to 2610 MAGI Budget Groups / Assistance Units).

Identify non-AU members whose income and resources are considered in determining financial eligibility and benefit level.

Determine the countable resources, income and expenses of the AU members and those identified in Step 2.

Verify all resources, income and expenses on all household members as required.

Determine that the AU has resources less than or equal to the AFDC relatedness resource limit ($10,000.00).

AFDC Budget

SHINES calculates the AFDC Relatedness budget based on data verified, documented and validated by Rev Max RMS. The steps below complete an AFDC Relatedness budget.

Complete the GIC test by comparing the gross countable income of the AU to the gross income ceiling (GIC) for the AU size.

If the gross countable income is equal to or less than the GIC, continue to the next calculation.

If the gross countable income is greater than the GIC, the child is not IV-E eligible. Notify the SSCM through the SHINES Eligibility Summary Page. Complete a Continuing Medicaid Determination (CMD).

Determine if there are employed individuals in the AU.

If there is an employed individual(s) proceed to complete a SON trial budget to determine eligibility for the $30 plus 1/3 deduction. (Step C: Standard of Need Test on the AFDC budget sheet.)

- Subtract the $90 standard work expense from the gross earned income of each employed individual.
- Subtract dependent care not to exceed the maximum from the earned income of each employed individual who incurs and pays this expense.
- Add the unearned income of all individuals whose income is considered.
- Compare the total net income to the SON for the AU size.

If the total net income is less than the SON, a deficit, for that AU, then allow the $30 plus 1/3 deduction earned income deduction.

If the total net income is greater than or equal to the SON, the child is not IV-E eligible. Notify the SSCM. Complete a CMD.

Determine the AU's income deficit. (Step D: Payment Budget of the AFDC budget sheet.)

- Apply all applicable earned income deductions to the gross countable earned income of each employed individual to determine the net earned income
- Add the unearned income of all individuals whose income is considered, including any deemed income, to the net earned income to determine the net countable income.
- Subtract any allocated income.
- Deduct the net countable income from the SON.

If the net countable income is less than the SON (there is a deficit), AFDC relatedness (financial need) for the child is established.

If the net countable income is greater than or equal to the SON, AFDC relatedness (financial need) for the child is not established and the child is not eligible for IV-E. Complete a CMD.

For complicated budgeting situations, refer to the Economic Support Services Manual, in effect July 1996.

Processing

AFDC Relatedness budgeting is calculated by SHINES as a function of the eligibility determination at the initial application.

2840 IV-E Budgeting

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	IV-E Budgeting		
	Effective Date:	September 2024		
	Chapter:	2800	**Policy Number:**	2840
	Previous Policy Number(s):	MT 62	**Updated or Reviewed in MT:**	MT-73

Requirements

IV-E Budgeting procedures are used as the financial eligibility step when determining IV-E Foster Care reimbursability at renewal.

Basic Considerations

This budget is used at the six-month review of IV-E Foster Care reimbursability. The AU size used in IV-E budgeting is always one, as the child is in placement.

A unique payment standard is used at IV-E redeterminations. AFDC policy is used in determining net countable income.

Reference Section 2860 - IV-E Reimbursability for additional information.

Procedures

IV-E Budget

SHINES calculates the IV-E reimbursability budget based on existing data in the child's case. The steps below determine the financial eligibility for an IV-E child at renewal for reimbursability.

Apply all of the child's countable resources to the $10,000 resource limit. If the child is under the resource limit, proceed to net countable income. If the child is over the resource limit, the child is non-reimbursable for IV-E. Complete the re-rate process to change the case from IV- E to IV-B funding.

Allow the $50.00 child support disregard in determining the child's net countable income.

When siblings or half siblings receive child support from the same absent parent, each child is entitled to the $50.00 child support disregard in his/her own AU.

Exclude SSI benefits received by a IV-E child in determining eligibility.

Apply all net countable income of the IV-E child to the Foster Care Payment Standard. Reference Section 2499 - Treatment of Income in Medical Assistance.

If the child's net income is less than the Foster Care Payment Standard, approve the child for IV-E Foster Care reimbursability. Report net countable income to the Social Services Case Manager

(SSCM).

If the net income is greater than the Foster Care Payment Standard, complete an Eligibility Summary Page indicating nonreimbursability and complete the re-rate process with regional accounting. Report reimbursability determination to the SSCM.

Use the chart below for determining the appropriate Foster Care Payment Standard for budgeting based on the child's age at redetermination.

Processing

The IV-E budget is calculated by SHINES as a function of the redetermination and reimbursability of each case.

FOSTER CARE PAYMENT STANDARD Effective 7/1/2022	**Child's Age**	**Daily Rate X 30**	**SON**
	Birth through 5	$27.80 X 30 =	$834.00
	6 through 12	$29.99 X 30 =	$899.70
	13 and older	$32.62 X 30 =	$978.60

2845 SSI Eligible Child

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	SSI Eligible Child		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2845
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

SSI benefits do not affect a child's IV-E eligibility; a child receiving SSI should always be IV- E eligible if the child meets all the IV-E eligibility criteria.

Basic Considerations

SSI income is exempt (not counted) in determining if the child meets the financial need requirement for AFDC relatedness. If the child receives SSI in the eligibility month, the child meets AFDC relatedness financial need criteria for both income and resources.

As of February 4, 1994, federal policy has allowed the concurrent receipt of SSI and IV-E foster care reimbursement benefits. The RevMax Specialist (RMS) should continue to aggressively determine IV-E reimbursability for all children, including those receiving or eligible to receive SSI benefits. When a child is IV-E reimbursable, the RMS must determine whether to continue the child's SSI benefits to cover board and care costs or cover the board and care costs under IV-E. It is not in the child's best interest to lose SSI income while in out- of-home care if it appears the child may be returning home soon or is over the age of 16 yrs and 6 months, due to the need to have SSI income available upon return home or leaving foster care.

The cost of care for a child receiving SSI should not be made IV-E reimbursable unless the *monthly federal financial participation (FFP)* amount for IV-E reimbursement of the placement cost for that child exceeds the SSI monthly payment. The SSI payment is reduced dollar for dollar by the amount of any Federal Title IV-E reimbursement payments for board and care. In other words, at the point the cost of care multiplied by the FFP amount (the federal Medicaid percentage, FMAP) is more than the SSI amount, the FFP amount should be considered. SSI is a set amount of federal funds. SSI funding is 100% federal dollars while IV-E funding requires a state funds match. SSI is adjusted every January. Title IV-E federal funds are not limited, and will reimburse allowable costs.

Guidelines to follow when considering a child in receipt of SSI:

- A child who is eligible for SSI and IV-E reimbursability should continue to receive the SSI check if the SSI payments are more than the IV-E reimbursable FFP for the foster care per diem. The child will be IV-E *eligible*, but not IV-E *reimbursable* for covering the cost of board and care.
- The cost of care for a child who is receiving SSI and meets all IV-E reimbursable criteria should be made IV-E reimbursable if the federal IV-E reimbursement for the foster care per diem is more than the SSI payment. In this situation the RMS is responsible for determining the IV-E

reimbursability of the child. The SSCM should notify the Social Security Administration (SSA) that the child is receiving a IV-E foster care per diem, including the amount and the effective date. The child's SSI check would be suspended as required by the dollar for dollar rule, and there would be no concurrent receipt of two federal funding sources.

> The FFP and the SSI payments change annually. It is the responsibility of the SSCM to notify the Social Security Administration of foster care status. The Social Security Administration is responsible for the suspension or reduction in the SSI payment amount.

Programmatic reasons not to discontinue a child's SSI benefits:

- If the child is expected to be in out-of-home care a short period of time (i.e., 60 days or less);
- The child is in the adoption process;
- The child is approaching age 18 or is in an independent program.

If a child is SSI eligible when entering care, Rev Max will open a Medical Assistance case on Gateway coding the Child in Placement page living arrangement as FC. This will generate the interface update to GAMMIS. The Medicaid case for a foster child will remain open in Gateway and services will be provided through fee-for-service.

Procedures

Revenue Maximization Specialist (RMS) will determine the most appropriate funding source based on the individual child's circumstances and the determination status on the SHINES Eligibility Summary page.

Verification

Follow verification guidelines found in the appropriate sections of this manual.

Clearinghouse must be checked for information on each member in the removal home family and for child in care.

Standard of Promptness

The standard of promptness for Medicaid is 45 days.

The Medicaid is provided through federal Medicaid and is not reviewed for eligibility.

> The SSCM will notify SSA of the change in custody, placement and funding source in sufficient time to allow the SSA to process the request and begin issuing an SSI check to the designated payee.

RMS will code the SHINES Eligibility Summary page with the selected eligibility for SSI when it has been determined that receipt of SSI benefits are in the best interest of the child and the agency. The SSCM has responsibility to contact the Social Security Administration to advise of foster care status and funding determination.

2848 Relative Care Placement

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Relative Care Placement		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2848
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

The Adoptions and Safe Families Act (ASFA) recognizes that a fit and willing relative caretaker may be able to provide the best permanent living arrangement for a child placed in care. To increase the frequency of out-of-home placement with relatives, the agency has developed policy and practices to support the Relative Care Support Program Options.

Basic Considerations

Federal regulations require that a foster family home (relative or nonrelative) must meet the standards for full approval as a foster family to be a IV-E reimbursable placement.

There are two types of relative placements:

- Relative Home refers to a placement in the home of a relative who does not receive a foster care per diem for the care of the child, but may receive an Enhanced Relative Rate (ERR) or other benefits. The child is in the legal custody of the Department. This is not a reimbursable placement.
- Relative Foster Home refers to a placement in the home of a relative, which meets the same requirements as a regular foster home and to which a foster care per diem reimbursement is made. The child is in the legal custody of the Department. This is a reimbursable placement.

Child in DFCS Legal Custody

Children who are not in full or partial DFCS custody are not considered “foster care” for eligibility.

A child in DFCS custody and placed in a Relative Home Placement means that foster home standards have not been met, and therefore, a per diem is not paid.

A SSCM notifies RevMax when a foster child who remains in the Department’s legal custody is placed with a relative. The RMS will review the case’s reimbursability based on the new circumstances. The RMS will code and document Gateway and SHINES with the details of all placement changes. The living arrangement code will remain FC on the Child in Placement page as long as the child remains in DFCS legal custody. The case will remain with RevMax.

Once the new address is on the member’s file, the Gateway interface updates GAMMIS with the physical location of the child for Amerigroup Care Management organization (CMO) to assign primary providers.

Reviews on a child remaining in DFCS legal custody will continue to be requested until notified by the SSCM that the Department no longer has custody.

DFCS Relieved of Legal Custody

A county requests closure of a foster child's case where the Department has been relieved of legal custody. The SSCM provides the current placement circumstances, new address of the child and a copy of the court orders relieving DFCS of custody. The RMS will complete a CMD on the existing child's case. If the case meets all eligibility requirements under any Medicaid COA, the RMS will approve the case under the most appropriate COA and will code and document Gateway with details of all placement changes and custody changes. SHINES will be documented as to the change in circumstances. The physical case record will remain with RevMax for audit purposes. Case will be released from Hard Ownership and CMD will be maintained by the Office of Family Independence (OFI).

Use the following chart to determine appropriate class of assistance for children in a relative care placement. Follow guidelines in Chapter 2800 – Children in Placement or Chapter 2600 – Family Medicaid.

Chart 2848.1 - Relative Care Placement Options

Option	DFCS Legal Custody	IV-E Eligible Program	IV-E Reimbursable	Medicaid COA	Other Coverage
Relative Home – child placed in a relative home that does not receive a foster care per diem. Relative may receive Enhanced Relative Rate (ERR).	YES	YES	NO	Foster Care Under Age 18	
Relative Foster Home – child placed in a relative home that meets requirements of a regular foster home. Relative receives foster care per diem.	YES	YES	YES	Foster Care under age 18	
Relative Care Subsidy (RCS) – Child who is transferred from the legal custody of DFCS, by the courts, to the permanent legal custody of an approved relative caregiver. Child's income/benefits are diverted to the relative caregiver following transfer of legal custody.	NO	NO	NO	Child Under Age 19	PeachCare
Enhanced Relative Care Subsidy (ERCS) – Child who is in legal custody transferred from DFCS, by the courts, to the permanent legal custody of an approved caregiver. Child's income/benefits are diverted to the relative caregiver following transfer of legal custody. Relative may be eligible for a higher payment, 80% of current family foster care rates based on the child's current age.	NO	NO	NO	Child Under Age 19	PeachCare

Option	DFCS Legal Custody	IV-E Eligible Program	IV-E Reimbursable	Medicaid COA	Other Coverage
Subsidized Guardianship (SG) – Child, placed with an approved relative caregiver, who has been in the custody of DHS for a minimum of twelve (12) months and reunification with the birth parents, is unlikely. Transfer of legal custody of the child from DHS to the guardianship of a relative through Juvenile Court is required. Relative may be eligible for a higher payment, 80% of current family foster care rates based on the child's current age.	NO	NO	NO	Child Under Age 19	PeachCare
Enhanced Subsidized guardianship (ESG) - Child, placed with an approved relative, who has been in the custody of DHS for a minimum of twelve (12) months and reunification with the birth parents is unlikely. Transfer of legal custody of the child from DHS to the guardianship of a relative through Juvenile Court is required. Relative may be eligible for a higher payment, 80% of current family foster care rates based on the child's current age.	NO	NO	NO	Child Under Age 19	PeachCare

2850 Special Considerations

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Special Considerations		
	Effective Date:	January 2020		
	Chapter:	2800	**Policy Number:**	2850
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Minor Parent and Child in Care

The Title IV-E program allows a state to claim IV-E reimbursement for the costs of a child living in the same placement as its minor parent. (Note: DFCS custody of the child is not necessary in this situation). If the minor parent has been determined IV-E eligible and reimbursable, the added cost of care for the child living in the same placement may be reimbursed through the mother's Title IV-E status. The child does not have a IV-E status since there is not a separate judicial removal or custody into foster care. In order to claim reimbursement, the cost of care for both the minor parent and their child must be contained in one payment to the substitute care provider, and the child's cost of care is assigned to the mother's cost of care.

If the child is legally removed from the minor parent and placed in a separate substitute care placement, the child is considered a foster child and would require a determination for Title IV-E eligibility and reimbursability. The child's Title IV-E eligibility would be determined like that of any child being removed from his/her parent.

Joint DFCS and DJJ Custody

A child may be in the joint custody of DFCS and the Department of Juvenile Justice (DJJ). If DFCS has placement authority, refer to 2810 Foster Care Funding and Medicaid Application Processing for application processing procedures. If DJJ has placement authority, refer to 2812 Department of Juvenile Justice Medicaid Application Processing for application processing procedures.

The child cannot be IV-E reimbursable while placed in a Regional Youth Development Center (RYDC) or a Youth Detention Center (YDC). Refer to 2860 IV-E Reimbursability.

Child Placed with Relatives

RevMax will retain those cases of children who are placed in a Relative Home but remain in the Department's custody. As relatives apply for TANF, Food Stamps and Family Medicaid, in Gateway, OFI eligibility staff will code the foster child out of Family Medicaid applications. The foster child will remain in a Foster Care MA COA and the case will remain with Rev Max. until the department no longer has custody. Refer to 2848 Relative Care Placement.

Medicaid for an Out-Of-State AA Child Residing in GA

Refer to 2852 Medicaid Application Processing for Out of State Children Placed In Georgia.

Georgia AA Child Moves Out-Of-State

When a child receiving Adoption Assistance from Georgia moves to another state, the child's Georgia Medicaid is terminated effective the month following the move. Medicaid for the child should be applied for in the resident state.

> The agency may agree to continue the adopted child on Georgia Medicaid in order for Georgia Medicaid providers to continue a specific care plan for the child.

Special Immigrant Juvenile Status

An undocumented child who had been abused, neglected or abandoned can petition U.S. Citizenship and Immigration Services for lawful permanent resident status provided they came under the protection of a state juvenile court and will not be returned to his or her parents. This benefit is called Special Immigrant Juvenile Status and if granted the child attains lawful, permanent resident status.

Use the following chart to determine financial eligibility and appropriate class of assistance for children in IV-E foster care.

Chart 2850.1 - Special Situations in IV-E

IF	THEN determine eligibility for the child in the following order:	AND determine financial eligibility as follows
A Georgia IV-E FC child is placed out-of-state	IV-E FC. Georgia is responsible for initial and ongoing determinations and provides verification of this eligibility to GA SSCM who forwards the information to the state of current residence. Process as any other IV-E FC case. Because the Georgia Medicaid card cannot be suppressed, have it sent to the SSCM for destruction.	Initial eligibility requires an AFDC determination for AU from which the child is removed. Final financial determination is child only.
A child enters FC under a voluntary placement	1. IV-E FC. If determined eligible, this eligibility is for 90 days with one 90 day extension only unless a judicial determination is obtained within this time frame that states that continued placement is in the best interest of the child. If the child remains in care under a voluntary placement agreement beyond 180 days without acquiring a court order which states that continued placement is in the best interest of the child, the child would lose IV-E eligibility on the 181st day and for the remainder of the placement episode. 2. CWFC funding 3. MN Medicaid	1. Initial eligibility requires an AFDC determination for the AU from which the child is removed. Final financial determination uses child only as an AU of one. 2. Budget the child as an AU of one. 3. Budget the child as an AU of one.

IF	THEN determine eligibility for the child in the following order:	AND determine financial eligibility as follows
Trial Visit: A IV-E child is returned to the specified relative from whom he/she was removed.	IV-E FC reimbursability is terminated but IV-E eligibility is retained during a trial visit of less than six months, or longer if the court orders a longer home visit. A new application must be filed for IV-E FC when the child returns to a FC placement but AFDC eligibility does not have to be reestablished. If the trial home visit extends beyond six months or the court authorized time period, and the child is subsequently returned to foster care, the placement must be considered a new placement and requires a new (initial) determination of all eligibility factors. The judicial determinations regarding *contrary to the welfare* and *reasonable efforts to prevent removal* are required. Placement with the parent who was not the specified relative from whom the child was removed is not considered a home visit but a relative placement. Unlike other specified relatives, a parent is financially responsible for their child and the parent's income is included in the budget.	Budget the child as an AU of one. Initial eligibility requires an AFDC determination for AU from which the child is removed. Final financial determination uses child only as an AU of one. Reference Section 2600 Family Medicaid Assistance Units and Budget Groups.
A IV-E child runs away	IV-E FC reimbursability is terminated but IV-E eligibility is retained if the child returns within six months and the court order is still in effect. A new application must be filed for IV-E FC when the child returns to a FC placement but AFDC eligibility does not have to be reestablished. (All other eligibility must be met.) If the child is on runaway status longer than six months or the court order expires and the child subsequently returns to foster care, the placement must be considered a new placement, and requires a new (initial) determination of all eligibility factors. The judicial determinations regarding *contrary to the welfare and reasonable efforts to prevent removal* are required.	Budget the child as an AU of one. Initial eligibility requires an AFDC determination for the AU from which the child is removed. Final financial determination uses the child only as an AU of one.

IF	THEN determine eligibility for the child in the following order:	AND determine financial eligibility as follows
IV-E child's adoptive placement changes because of disruption, dissolution or removal. **Disruption:** The removal of a child(ren) from an adoptive placement after the signing of the placement agreement but before legal finalization. **Dissolution:** The termination/voluntary surrender of parental rights by the adoptive parent(s) of a child(ren) on whom the adoption has been legally finalized. **Removal from adoptive home:** The removal of the child occurs after the adoption is final. The child is placed in the agency's custody.	IV-E FC reimbursability is terminated but IV-E eligibility is retained. **Disruption:** A new application must be filed for IV-E FC but AFDC relatedness does not have to be established. (All other eligibility criteria must be met.) **Dissolution, Removal:** If the removal of a child is from the adoptive home in which the adoption has been finalized, the child's foster care eligibility is determined using the same procedures as when a child is removed from any other home and placed in the agency's custody. Forms 223 and 224 are required, and a determination is based on the child's home of removal. The adoptive parents are treated as the legal parents and their income and resources are considered in the IV-E eligibility determination. If the parental rights are later terminated or if a voluntary surrender occurs, the policy applicable to disruption/dissolution would be appropriate.	Budget the child as an AU of one.
A IV-E child's adoptive placement ends because of the death(s) of the adoptive parents.	In the event of the death of the single parent in a single parent adoption or the deaths of both adoptive parents in two parent adoptions, the child retains their IV-E AA eligibility in a subsequent adoption. A new application must be filed for IV-E FC, but AFDC relatedness does not have to be established. All other eligibility criteria must be met.	Budget the child as an AU of one.
The mother of a child was AFDC eligible, the child was placed for adoption at birth, the adoptive placement fails and the child is placed in FC.	1. IV-E eligibility if the child is placed in FC within six months of the initial adoptive placement and a court order was initiated with the appropriate judicial language during the six months. 2. CWFC, then RSM	1. Initial eligibility requires an AFDC determination for the AU (birth mother) from whom the child was removed. Final financial determination uses child only as an AU of one. 2. Budget the child as an AU of one.
A IV-E FC child has a child living with him/her and assistance is requested for the minor parent's child.	1. IV-E FC minor parent can apply for LIM for his/her child. 2. Newborn if eligible. 3. CWFC, then RSM	1. Budget the minor's child as an AU of one and include any contributions from the mother. 2. N/A 3. Child and parent are included in the BG. The parent's per diem must be included.

IF	THEN determine eligibility for the child in the following order:	AND determine financial eligibility as follows
A IV-E FC child has a child living in a separate FC placement.	1. IV-E eligibility if all criteria are met. 2. CWFC, then RSM	1. Initial eligibility requires an AFDC determination for the AU from which the minor parent's child is removed. The IV-E budget is based on an AU of one (the minor parent's child). 2. Budget the minor parent's child as AU of one.
A IV-E FC child has a child living in the same FC placement but DFCS has separate placement and care responsibilities for the minor parent and for the minor parent's child.	1. IV-E eligibility if all criteria are met for the minor parent's child. IV-E eligibility would be determined individually for each. 2. CWFC, then RSM.	1. Initial eligibility requires an AFDC determination for the AU from which minor parent's child is removed. The IVE budget is based on an AU of one (the minor parent's child). 2. Budget the minor parent's child as an AU of one.

2851 Child Support Referrals

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Child Support Referrals		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2851
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

When a child enters care, the SSCM has the responsibility to inform parents of their continuing obligation to support their child in care. The parent(s) of a foster child are referred to the Division of Child Support Services, with some exceptions.

Basic Considerations

The parent(s) may be financially responsible for expenses incurred by the State in serving his/her child in care and for providing health care coverage if available and reasonable in cost. Parental information is documented in SHINES by the SSCM at the initial foster care entry. The SSCM is responsible for SHINES documentation for any additional information that becomes available or as changes occur. The parent(s) is referred to DCSS by the Revenue Maximization Specialist (RMS) through a SHINES interface with DCSS' STARS system unless one of the following criteria is met:

- The child is in the permanent custody of DHS.
- The child receives Adoption Assistance from Georgia.
- The child has returned home at the time the eligibility determination is completed.
- The parent is unknown.
- In a relative placement
- No per diem entered in SHINES
- Federal regulations do not require DCSS to provide services when a child is in prison/detention.
- Good Cause not to refer exists and is supported by a written statement signed by the County Director or the Social Services County Program Director.

> The SSCM is responsible for obtaining and providing the Rev Max Specialist with written approval of Good Cause from the County Director/County Program Director. Retain the documentation in the eligibility record and upload the documentation to SHINES External Documents.

RMS makes a child support referral to DCSS through the SHINES Eligibility Summary page.

Procedures

Revenue Maximization DJJ MES

Child support will not accept referrals from the Department of Juvenile Justice as a youth in a DJJ commitment remains in parental custody.

2852 Medicaid Application Processing for Out of State Children Placed In Georgia

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicaid Application Processing for Out of State Children Placed In Georgia		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2852
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

Children from other states may be living in Georgia due to foster care placements or adoptive parents moving to Georgia with children receiving adoption assistance from other states.

Basic Considerations

The Medicaid determinations require special considerations not necessary for children receiving Georgia foster care or adoption assistance.

The application for ICPC foster care Medical Assistance will come either from the SSCM or from the supervising provider, and the ICAMA application for adoption assistance MA may come from the State Adoptions Unit or the adoptive parent(s).

The adoptive family may apply for Medicaid through any County DFCS office or Gateway Customer Portal.

The SOP for these cases is the same as for Georgia children.

Procedures

Authorizing Medicaid For Out-of-State IV-E FC Child Residing in Georgia

Follow the procedures below to authorize Medicaid for an out-of-state IV-E FC placed in Georgia when the ICPC worker assigned in the county initiates an FCC stage in SHINES. SHINES generates a Medicaid application that is signed, saved and submitted and interfaces with the Gateway system.

The State Office ICPC unit establishes IV-E FC eligibility by verifying the following:

- The child receives IV-E FC per diem from the state of origin.
- The child is currently residing in Georgia in an approved foster care placement. Verify the date of the move.
- The child is under age 18. The child's DOB on the Medicaid card of the out- of-state origin is sufficient verification.
- Obtain the child's Social Security number.

- All ICPC documentation, including the child's IV-E determination, should be uploaded into SHINES under external documents.
- The Rev Max Medicaid Unit will register the MA application and assign to the appropriate regional Rev Max unit to process.

Some children are placed not under the supervision of GA DFCS, but under the supervision of a private agency. In these cases, the private agency will apply for Medical Assistance using the Form 94 (application for Medical Assistance).

Private agency will email the following information to the Regional Rev Max Supervisor:

- Form 94 including child's name, DOB and SSN
- Copy of the Form 100A indicating the child's IV-E Eligibility from state of origin

Continue Medicaid until the child is no longer IV-E eligible; has reached age 18; is no longer living in Georgia or until the SSCM/Private Agency requests case closure.

Complete reviews of the child's eligibility for IV-E FC Medicaid in Georgia annually based on information from the sending state.

The IV-E determination and per diem payments remain the responsibility of the state with legal custody.

Authorizing Medicaid For an Out-of-State IV-B funded Child Placed in Georgia

A foster child in the custody of another state and funded through IV-B is ineligible for Georgia Medicaid under any COA. The child is considered a legal resident of the state that retains custody and will not meet the residency criteria for Georgia Medicaid. The SSCM will assist the other state in locating Georgia providers who will accept the other state's Medicaid coverage.

Authorizing Adoption Assistance Medicaid For Children from Another State

Under COBRA Reciprocity, Medicaid coverage for a IV-E or State Adoption Assistance child is available in any state that has signed the COBRA agreement. The RMS must verify that the paying state has signed the COBRA agreement through the State Adoption Unit.

The IV-E or State AA payments remain the responsibility of the state of origin, but Medicaid coverage is the responsibility of the state of residence. Medicaid covered services for the AA child are based on the coverage available in the state of residence, not the state of origin.

Request from Adoptive Family at a County DFCS Office

Follow the procedures below for an out-of-state AA child residing in Georgia when the request comes from the adoptive family at a county DFCS office or through the Gateway Customer Portal. The MA application will be assigned to Rev Max for an eligibility determination.

Verify that the child is a recipient of IV-E or State Adoption Assistance. Use the current certified copy of the approved adoption assistance agreement from the state of origin. Make a copy of the agreement for the Georgia file.

The adoptive parents must be able to provide this agreement and other documents showing IV-E or State AA eligibility in the other state.

Establish that the child is under age 18 for IV-E Adoption Assistance and under 21 for state adoption assistance.

The child's birth date on his previous state's Medicaid card is sufficient or the written statement from the other state as to the child's date of birth is acceptable.

Establish that the child resides in Georgia and document the date the child moved to Georgia. Obtain the child's Social Security number.

The information may be obtained from the parents or the state of origin.

SSAU has responsibility for establishing the case in SHINES and submitting a Medicaid application to the appropriate Rev Max Regional Unit for any out of state Adoption Assistance child residing in Georgia.

Rev Max will determine Medicaid eligibility and the appropriate Adoption Assistance Class of Assistance.

OFI staff should not process the Adoption Assistance child for MA but may include the child for other benefits if the family applies for any assistance that would include the adoption assistance child.

The RMS will notify SAU of the Medicaid determination.

Request from the Office of Adoptions

Follow the procedures below to activate Medicaid for an out of state AA child residing in Georgia when the request comes from the State Adoption Unit (SAU).

SSAU will send a SHINES MA application to the appropriate Rev Max Regional Unit requesting a MA determination for an out of state AA Child residing in Georgia. The SHINES Medicaid application will include whether the child is receiving IV-E or State funded AA, the name of the other State and identifying information on the child and adoptive parents.

Determine Medicaid eligibility under the appropriate Adoption Assistance Class of Assistance.

A Rev Max Specialist will complete the SHINES funding summary as notification of the Medicaid determination and complete the application in Gateway.

Medicaid eligibility in Georgia begins the first month of Georgia residency, regardless of Medicaid status in the state of origin.

Adoption Assistance Medicaid For a GA Child Residing in Another State

When a child receiving IV-E or State Adoption Assistance from Georgia moves to another state, the child's Georgia Medicaid is terminated effective the month after the move. Medicaid for the child should be applied for in the other state.

A child receiving Adoption Assistance from Georgia but residing in another state may request to continue receiving Georgia MA in order to continue services from a GA. provider under a care plan.

Guardianship Assistance Program (GAP)

A child receiving IV-E GAP assistance payments is categorically eligible for Medicaid in the child's State of residence regardless of whether the State of residence covers the Guardianship Assistance Program under its IV-E State plan.

The SHINES Medicaid application will be submitted by the State Adoption Unit with copies of all documentation forwarded to the appropriate RevMax Regional Unit. Processing follows ICAMA IV-E Adoption Assistance processing in SHINES and Gateway and documented as Guardianship Assistance Program.

2853 Foster Care CMO Procedures

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Foster Care CMO Procedures		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2853
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

A child in placement qualifies for enrollment for medical assistance services provided to pay for eligible recipients to conserve state funds for children ineligible for medical assistance.

Basic Considerations

The Medical Assistance program provides funds to the state for the costs of providing medical services to Medicaid eligible recipients. DFCS should utilize these funds for services to children in placement in order to conserve state funds for those children who have been determined Medicaid ineligible.

Within 24 business hours of a child entering care, the Georgia Medicaid Management Information System (GAMMIS) shall be screened on the child to determine current Medicaid eligibility prior to any non-emergency medical services being obtained. This will avoid potential billing issues and use of county funds for otherwise Medicaid covered services.

Procedures

Screen each child entering foster care in the Georgia Medicaid Management Information System (GAMMIS) within one business day of child entering foster care.

Document all known information (i.e. demographic, removal, financial, etc.) on the required pages in Georgia SHINES within 24 hours of a child's entry into foster care to generate the MA application.

The SSCM will sign, save and submit the Medicaid application in Georgia SHINES.

The SSCM will notify Amerigroup CMO, the Revenue Maximization (Rev Max) Medicaid unit, and the Georgia Department of Community Health (DCH) via the Amerigroup GA Families 360° DFCS Referral Form (E Form) within 24 hours of a child entering or exiting foster care.

Submission of the Amerigroup GA Families Referral Form does not constitute an application for Medical Assistance.

Notify Rev Max via the Notification of Change (NOC) in Georgia SHINES and include the child's current legal status and placement information to allow Rev Max to transition the child to another Medicaid Class of Assistance when:

a. A child in foster care turns 18.

b. A child exits foster care.

Inform youth 18 and older exiting foster care to contact their assigned case manager to continue medical assistance and prevent case closure. Instruct youth to respond to Gateway application of former foster child status.

When a MA application is received by the Revenue Maximization Medicaid Unit, the unit will:

- Remove the child from all pending or active benefit cases in the Gateway system and register a new Medicaid case, coding the Child in Placement page living arrangement as FC. This will generate the interface update to Dept. of Community Health.
- The Medicaid Unit will assign the Gateway MA case to the appropriate regional Rev Max Unit for ongoing maintenance.

For children not active on Gateway, Revenue Maximization Medicaid Unit will:

- Register a new Medicaid case coding the Child in Placement page living arrangement code as FC.
- The MA application is processed for eligibility determination. Once completed, the case is assigned to the appropriate regional Rev Max unit for ongoing maintenance.

  Gateway will interface with DCH/GAMMIS within 24 to 48 hours removing the child from benefit cases and establishing foster care under age 18 Medicaid eligibility

- The child will be enrolled in Amerigroup CMO

If a child does not meet Medicaid eligibility, the Gateway system will determine eligibility for enrollment in PeachCare for Kids® with the Gateway Child in Placement page completed with placement and living arrangement code.

For an SSI Child entering care, Rev Max Medicaid unit will follow above Gateway process coding the child's living arrangement as FC. SSI recipients are exempt from CMO enrollment.

Child(ren) Leaving DFCS Custody

Once a child leaves DFCS custody, the following steps must be taken:

- SSCM must notify the Rev Max RMS through a SHINES Notice of Change (NOC) of the change in custody
- SSCM uploads the court order terminating DFCS custody into External Documentation
- SSCM enters the new placement and address of the child in SHINES
- RevMax completes a Continuing Medicaid Determination (CMD) for non- SSI children using the new information and changing the child's living arrangement to AH in Gateway.

The child's case is not closed but transferred out of Rev Max hard case ownership in Gateway to OFI.

If the child is aging out of care, the RevMax worker must CMD to Chafee Medicaid.

2860 IV-E Reimbursability

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	IV-E Reimbursability		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2860
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

The determination that a child is IV-E reimbursable qualifies the State to obtain federal IV-E funding for maintenance costs (board and care) associated with the child.

Basic Considerations

Title IV-E reimbursability may fluctuate from month to month. A child may lose and regain IV-E reimbursability depending on changes in the child's income and resources, the circumstance in the placement, or in obtaining the required judicial determinations while the child remains in DFCS custody or the custody of another public agency under contract with Georgia Department of Human Services. The loss of IV-E reimbursability does not deprive the child of future IV-E reimbursability once the reimbursability criteria are met again.

The following criteria must be met for a child to be IV-E reimbursable:

- child is under the age of 18.
- child meets financial need criteria (based on only the child's income and resources once initial IV-E eligibility has been established).
- child resides in an IV-E reimbursable placement;
- child is in the custody of DFCS or another public agency under contract with Georgia Department of Human Services.
- there is a judicial determination of reasonable efforts to finalize the child's permanency plan that is in effect within 12 months of the child's removal and at least every 12 months thereafter while the child is in foster care.
- for those children in DFCS care under a VPA, Federal financial participation is claimed only for voluntary foster care maintenance expenditures within the first 180 days of a child's placement in foster care unless there has been a judicial determination of a *best interest* or *contrary to the welfare* by a court: otherwise the child is IV-E reimbursable for the first 180 days only.

Social Services has a 90 day requirement that must be met. The only eligibility requirement is by the 180th day. The 90 day requirement applies only to Social Services.

Any time that reimbursability is lost, the child is reclassified as CWFC (IV-B) effective the first day of the month following the month in which the change occurred.

If the child regains reimbursability, the child is reclassified as IV-E effective the first day of the month in which the change occurred.

A change in placement affects the reimbursability as of the date of the change.

A child cannot receive two IV-E payments for the same day. If a child is moved from one IV-E reimbursable placement to another the same day, the IV-E payment is made to the home where the child "spent the night". The SSCM's judgment as to where the child spends the night is accepted.

Another situation that requires consideration of payment sources is when a child is in a concurrent placement. A concurrent placement is defined as follows: It is the planned, purposeful absence of a child from his original foster home/facility which continues to be paid at the same time his temporary payment is made.

If and when you are notified of a concurrent payment to another IV-E placement, the concurrent payment must be made from IV-B funds while the IV-E per diem to the original placement continues. It is the responsibility of the SSCM notify the assigned RMS through a SHINES Notification of Change (NOC). When the information is provided the RMS will complete the required Form 529 to authorize payment from IV-B funds to a concurrent placement.

A change in placement affects the reimbursability as of the date of change. The standard of promptness for changes is 10 days.

IV-E Reimbursable Placement

Federal regulations, effective March 27, 2000 require that a foster family home (relative or non-relative) and a residential childcare facility must meet the standards for full approval as a foster family or residential childcare facility. *Temporary approvals of foster families or residential childcare facilities do not meet the full approval/licensure requirement.*

There are four types of providers which meet the legal definition of an IV-E reimbursable facility:

- a licensed or approved foster family home
- a licensed or approved relative foster home
- a private, non-profit group home or childcare facility licensed by the state; and
- a public (government) non-medical child group home or childcare facility licensed for no more than 25 children

Non-IV-E Reimbursable Placements

Non-IV-E reimbursable placements include the following:

- regional youth detention centers (RYDC)
- youth forestry camps (YFC) (secure and non-secure)
- youth development centers (YDC) and other public or private facilities (secure and non-secure) that are operated primarily for the detention of delinquent children, which must be (a) physically restricting and (b) likely to be non-operational without a population of children adjudicated delinquent (i.e., hardware secure, locked facilities)

- medical facilities. If a child enters a reimbursable foster care placement for part of a month but is subsequently moved to a non-reimbursable facility for part of the same month, the child's cost of care is not reimbursable beginning on the date of placement in the non-reimbursable placement. The child is not IV-E reimbursable until entering a reimbursable placement.
- relative homes. Refer to 2848 Relative Care Placement and 2850 Special Considerations for more information.

2870 Redeterminations For Children In Placement

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Redeterminations For Children In Placement		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2870
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

Medicaid eligibility for foster children is redetermined annually. IV-E reimbursability is reviewed at six month intervals with each of the past six months and reimbursability for the next six months established. Adoption Assistance Medicaid is redetermined annually.

Basic Considerations

Once the child is determined IV-E eligible, the child continues to be eligible unless one of the circumstances specified in 2880 Ineligibility For IV-E exists. Once a child loses IV- E eligibility, s/he cannot be IV-E eligible or reimbursable during the current placement episode.

IV-E reimbursability may fluctuate from month to month. A child may lose and regain IV-E reimbursement, depending upon changes in the child's income and resources, the placement circumstances, or in obtaining the required judicial language while the child remains in DFCS custody. The loss of IV-E reimbursement in one month does not preclude the child's IV-E reimbursement in subsequent months.

There are circumstances, however, where this is not possible. While historical changes are made in accounting (rerates), no historical changes are made in the Medicaid COA.

Procedures

IV-E Foster Care Redeterminations

SHINES generates a Reimbursability Summary Page pre-populated with data entered at the initial entry into foster care. To validate the SHINES derived initial funding determination and to assure accuracy in the initial IV-E decision, all initial documentation and information is reviewed for accuracy or changes from the initial determination information at the **first six (6) month review.**

First Six Month Review After Initial Funding Determination

At the initial six-month review, RevMax RMS are required to:

- Review SHINES data for changes from the initial information;
- Verify income and resources for all members of the removal home using collateral contacts. The Dept of Labor may often post earned income up to 6 months after receipt and additional income may be discovered after the initial determination has been made.

- Validate the budget.
- Verify any changes in the initial removal household and address household management in the removal month.
- Review court orders for *CTW/BI* and *Reasonable Efforts to prevent removal* finding within 60 days of the child's removal.
- Verify age, citizenship, deprivation, living with/removal from specified relative criteria.
- Document in SHINES the results of a review of the initial funding determination at the first six-month review.

A SHINES Amended Application is completed, if deemed appropriate, when additional information becomes available that affects the initial IV-E eligibility at the time of removal. The Amended Application is completed only after the SHINES Initial Application has been submitted, validated, and approved. Additional information includes, but is not limited to, resources/income, removal household members, court order language, etc. This allows the Department to determine a child's IV-E eligibility status more accurately. The SHINES Amended Application functionality is supported on the Application and Background page.

If information is obtained after the initial funding determination and the outcome is not impacted by the information, RMS are required to document SHINES Contact and Summary Page that the change has been addressed but does not impact the initial funding determination.

Amended Applications are not meant to correct errors or a failure to verify or validate. It is mandatory that RMS research and verify a case prior to completing the initial determination.

Effective April 8, 2010, the Children's Bureau eliminated AFDC Relatedness from re-determination criteria once the initial determination is made at removal.

Financial Need: Resources

Redetermination criteria for all cases that are IV-E eligible and reimbursable and IV-E eligible and non-reimbursable:

Once a child meets IV-E eligibility, only the resources of the child are considered in determining if the child continues to meet financial need for ongoing IV-E reimbursement. A child's resources may not exceed $10,000. For the month(s) a child's countable resources exceed $10,000, the child is not IV-E reimbursable. The child may become IV-E reimbursable once the child's resources no longer exceed $10,000 if all other criteria are met.

Financial Need: Income

The child's income cannot exceed 185% of the foster care rate. This is the only standard to which income is compared in determining if the child meets ongoing IV-E reimbursement. The AFDC Standard of Need is only used at the initial eligibility determination. Establish current financial eligibility for the child using IV-E Budgeting standards. Refer to 2840 IV-E Budgeting.

Judicial Requirements

Determine that the court order is valid or has been renewed without interruption, and that a judi-

cial determination of *reasonable efforts were made to finalize the permanency plan* language has been obtained in a court order if the child has been in custody at least twelve (12) months.

Determine that the child remains in an approved placement.

Determine that the child meets the age requirement for the Class of Assistance and IV-E.

Determine that there has been no lapse in custody. Reference 2820 Legal Status.

Child Welfare Foster Children

Child Welfare foster children that have been determined non-IV-E eligible have no requirement to review the determination at the first six-month review. Child Welfare foster children will require an annual Medicaid renewal.

Medicaid Third Party Resource

Screen GAMMIS for a Third Party Liability. Verify with SSCM that insurance coverage continues for the foster child. If a child is no longer covered by TPL, follow procedures in Section 2230 – Third Party Liability for Health Management Systems to remove the TPL coverage.

Determine that the child did not become IV-E ineligible during the past six months.

Determine IV-E Reimbursability for the next six months. Complete Form 529, if necessary, to reflect historical periods of non-reimbursability or that the child became ineligible. This form is signed by the Revenue Maximization Supervisor who is responsible for the form's content and forwarding to regional accounting. RMS update the Eligibility Summary Page in SHINES; upload the signed, completed Form 529 to SHINES.

This process is not applicable to Rev Max DJJ MES.

Project IV-E eligibility and reimbursability for the ongoing six months. Document the IVE-E eligibility and reimbursability appropriately in SHINES and notify the SSCM of findings via SHINES NOC.

SSI Eligible Children

An SSI eligible child will have an active case in Gateway. Medicaid eligibility comes with SSI eligibility.

The Revenue Maximization RMS is responsible for conducting a review at six-month intervals to confirm that IV-E reimbursability still exists. These reviews must be tracked manually for IV-B cases. Complete periodic reviews by using the appropriate procedures for that Medicaid COA.

Adoption Assistance

A review is not required for Adoption Assistance, but an annual review is required for a related Medicaid case.

Sixty days prior to the Adoption Assistance Medicaid review month, Rev Max provides each county with a listing of Adoption Assistance cases requiring a Gateway Medicaid renewal. Medicaid renewal not completed in the month due results in the Medicaid case closing the following month.

One month prior to the review month, Form 403, Adoption Assistance memorandum, should be reviewed by Regional PAD Case Managers. If over six months old, the PAD Manager will request information from the family to complete and upload a new Form 403. Rev Max will be notified by email of the new form upload.

The renewal process in Gateway for Adoption Assistance Medicaid is a two-part process. Adoptive parent(s) are required to initiate the Gateway renewal process by verifying current address. training on this process for adoptive parents is provided by DFCS PAD Managers and SSAU staff. The RMS is responsible for completion of the process by verifying child continues to receive Adoption assistance.

Adoption Assistance Children Residing Outside of Georgia

Children living outside Georgia who receive Georgia who receive Adoption Assistance from Georgia will receive Medicaid from the state of residency under COBRA Reciprocity. Children placed in states that do not participate in COBRA Reciprocity will be the responsibility of the State Adoptions Unit.

The agency will agree to continue Georgia Medicaid for an adopted child when the care plan requires services from a specific provider or a facility to provide the child with continuity of care.

2880 Ineligibility For IV-E

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Ineligibility For IV-E		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2880
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

There are circumstances that cause a child to no longer be IV-E eligible. Once a child loses IV-E eligibility, s/he cannot be IV-E eligible or reimbursable during the current placement episode.

Basic Considerations

A child will lose IV-E eligibility if one of the following circumstances exists:

- The child no longer meets age requirement;
- DFCS no longer has custody per a court order;
- The child is in DFCS care and responsibility under a voluntary placement agreement (VPA) and a judicial determination to the effect that continued voluntary placement is in the best interests of the child was not obtained within 180 days of the signed VPA;
- The child is on a trial home visit or run away status beyond six months or the trial home visit exceeds the time frame authorized by the court.

The court may return a child who has been in out-of-home care back into the removal home for a *trial visit* for an unspecified period of time. If the trial visit, with continuous DFCS custody, is six months or less and the child returns to out-of-home care, the child retains IV-E eligibility. If the court authorizes a time frame longer than six months, the child can retain IV-E eligibility, provided the child returns to out-of-home care at the end of the specified time frame.

Special eligibility considerations exist when a child returns home on a trial visit.

- A child is never reimbursable when living in the home of a parent
- If the six-month time frame or the court's authorized time frame is exceeded, the child loses IV-E eligibility. If the child subsequently re-enters care, the placement is considered a new episode. A new initial custody order must be obtained pertaining to the current removal including a judicial determination of *contrary to the welfare/best interest and reasonable efforts to prevent removal*. A new IV-E eligibility determination must be made based on the child's eligibility in the home which s/he was subsequently removed.
- The same IV-E principles for trial home visits apply to IV-E eligible children on run away status.

2883 Standard Filing Unit

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Standard Filing Unit		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2883
	Previous Policy Number(s):	MT 20	**Updated or Reviewed in MT:**	MT-63

Requirements

The Assistance Unit (AU) in the removal home must be established using the 1996 AFDC Standard Filing Unit (SFU) policy.

Basic Considerations

The SFU consists of the foster child for whom a IV-E determination is requested and certain individuals living in the removal home with the foster child who must be included in the AU. The following individuals are required to be included in the SFU:

- Eligible minor siblings of the foster child (half, whole or adoptive siblings)
- Biological or adoptive parents.

EXCEPTIONS:

- SFU does not apply to a IV-E or CW-FC child who applies for TANF for his/her child. The child of the IV-E or CWFC child can be an AU separate from the minor parent for TANF purposes.
- Any household member receiving SSI benefits is not counted as a member of the AFDC AU. In addition, the SSI benefits and any other income or resources of the SSI recipient are not counted in determining financial need. If the child in custody is a SSI recipient, the AFDC financial need criteria for both income and resources has been met. See 2845 SSI Eligible Child.
- An adoptive sibling to the child, who is receiving adoption assistance, may be excluded from the AFDC AU. (The adoptive sibling's income and resources would be excluded.)

The foster child must have lived with a relative within the proper degree of relationship in the removal home. Refer to Living with a Specified Relative in the Removal Home.

Other individuals living in the home may be included because of their relationship to the specified relative from whom custody was removed.

Children in the AU do not have to be related to each other.

Procedures

Follow the steps below to determine the composition of the AFDC AU.

Step 1 Begin with the dependent child for whom the IV-E determination is requested and determine the following:

- The removal home
- Who lived in the home with the child at the time of removal

Step 2 Include the eligible minor sibling(s) and half sibling(s) who lived in the home with the child identified in Step 1.

Step 3 Include the biological or adoptive parent(s) of the children included in the AU by Steps 1 and 2. Include only the parents who actually live in the home with their children.

Step 4 Include, if advantageous to the IV-E child, any children in the home who are within the proper degree of relationship to an eligible adult in the AU. If a child is added for this process, repeat Steps 1 through 3 treating the child being added as the child in Step 1.

Step 5 If there is no parent of the foster care child in the home, consider including an adult who is in the home and within the proper degree of relationship to the AU children. If the foster child is eligible without the inclusion of the adult, do not include the caretaker in the AU.

Step 6 Exclude the following individuals from the AU:

- A child who is not deprived
- A child who does not meet the relationship requirement to the grantee relative
- An individual who does not meet the citizenship/alienage requirement
- An individual ineligible because of the receipt of a lump sum
- A parent living in the home who is sentenced to perform unpaid public work or community service in lieu of imprisonment
- An adult relative who fails to cooperate with the third party resource requirements, even if the information the A/R refuses to provide is regarding TPR coverage of a child in the AU.
- An SSI recipient.

Accept the SSCM's statement to determine AU composition. If conflicting information is known, the discrepancy must be resolved.

Document the following for every individual in the removal home:

- The name of the individual and their relationship to the foster child
- The reason the individual is included or not included as an AU member

Use the following chart to determine the composition of the AFDC Unit (AU), starting with the foster child for whom a IV-E determination has been requested.

Chart 2883.1 Determining the Composition of the AFDC AU

IF	THEN
Adult is absent from the home because of treatment or training.	Include the adult in the AU when all of the following conditions exist: • The absence is temporary, with a plan for treatment or training to return the adult to the home AND • The adult continues to exercise care and control of the AU child(ren) AND • It is advantageous to the IV-E child to include in the AU during the absence Treatment or training may be received at locations such as schools, general hospitals, private psychiatric hospitals, nursing home, and Job Corps facilities. This list is not all inclusive. **Exclude** the adult from the AU if any of the following conditions exists: • The adult is incarcerated. • The adult is in a public institution for the treatment of tuberculosis or a mental disease. The adult is legally committed to an institution
Alien lives in the home.	Include the alien in the AU if s/he meets citizenship requirements and is required to be in the AU. Exclude if the citizenship requirements are not met.
AU resides in a shelter.	Determine the AU composition of individuals residing in facilities such as homeless or battered women and children shelters as for any other group of related individuals who live together.
Biological parent lives in the home with the child who has been adopted AND The adoptive parent(s) is in the home Adoption terminates both legal responsibility and the SFU requirement to be included as a parent.	Include the biological parent as a sibling only if both of the following conditions exists: • The biological parent is also the child (step, adoptive or natural) of the adoptive parent(s) AND • The biological parent meets the age and deprivation requirements
Biological parent lives in the home with the child who has been adopted AND The adoptive parent(s) is not in the home.	Include the biological parent as the grantee relative if s/he is eligible and it is advantageous. Adoption terminates both the legal responsibility and the SFU requirement to be included as a parent.

IF	THEN
Biological parent whose parental rights have been terminated lives in the home with the child and a specified relative.	Include either the biological parent or the specified relative as the caretaker relative. Termination of parental rights severs legal responsibility to be included as a parent; therefore, the specified relative or the biological parent can include only if advantageous to the IV-E child. The individual who is included in the AU must be in financial need. If the home is shared with a person who is not within the specified degree of relationship to the child, then only the biological parent may be included as the caretaker relative.
Both parents live in the home with a mutual child.	Include both parents in the AU if one is either disabled or meets AFDC-UP criteria. The parents do not have to be married to each other. If the mother was legally married to another man at the time of the child's birth, exclude the biological father living in the home unless paternity is established through judicial proceedings or completing of the Form 185, Affidavit of Paternity.
Child lives with a legal guardian who is not within the AFDC degree of relationship.	Does not meet AFDC criteria.
Child lives with an individual who has legal custody only (not a legal guardian and not within the degree of relationship).	Does not meet AFDC criteria.
Dependent child is in and out of the home.	Include the dependent child in the AU when the absence is to be temporary and care and control of the dependent child remain with the parent(s)
Couple lives together AND They are not married AND There is no eligible mutual child(ren) but each has a child.	Determine eligibility based on an AU of the parent of the foster child and the foster child.

IF	THEN
Minor parent (no spouse) lives in the home with her parents.	Include the minor parent as a dependent child if one of the following conditions exists: • The minor has sibling(s). • The minor's parent is included as a caretaker. DO NOT include the minor's spouse in the AU unless his/her child is included in the AU. Consider his/her income in determining eligibility. Include or exclude the minor's child; whichever is more advantageous. If ineligible, count the minor parent as caretaker if the minor lives with her parent(s).
Minor parent and her spouse live in the home with her parents.	Include the minor parent as a dependent child if one of the following conditions exists: • The minor has sibling(s). • The minor's parent chooses to be included as a caretaker. DO NOT include the minor's spouse in the AU unless his/her child is included in the AU. Consider his/her income in determining eligibility (refer to AFDC Policy, Section 1457, "Spouse of a Married Minor Budgeting.") The AU may choose to include or exclude the minor's child. If ineligible, count the minor parent as caretaker if the minor lives with her parent(s). Include the minor's spouse in the AU if he is the parent of the minor's child. If he is included, consider the AU's eligibility for AFDC-UP or disability.
Parent is in and out of the home.	**Include** a parent who appears to reside in the home based on any of the following indicators: • The parent has no other residence. • The parent lists the home as his/her address. **Exclude** a parent who appears to visit the home based on any of the following: • The parent maintains another residence. • The parent does not share in household expenses • The parent has a specific time frame for his/her visits. Thoroughly document the record to substantiate the inclusion/exclusion of a parent.
Parent lives in the home with the child(ren) and a specified relative who has legal custody/legal guardianship of the child(ren) (parental rights have not been terminated).	Include the parent in the AU as the caretaker relative.

IF	THEN
Roomer or boarder lives with the AU.	Determine the AU composition without regard to others living with the AU and paying a fee for food and/or shelter unless they meet relationship or other SFU criteria.
Stepparent lives in the home AND The stepparent has no children of his own living in the home.	Include stepparent in the AU, (if advantageous) if one of the following situation exists: • There is no parent living in the home OR • The parent living in the home receives SSI.
Married couple has no eligible mutual child(ren)	Determine the option that is most advantageous to the family. Combine in one AU or make separate AUs.
Child is placed in a residential childcare institution, such as GA. Baptist Children's Home, United Methodist Children's Home or GA. Sheriffs Boys' Ranch.	Determine the child's eligibility if the following conditions are met: • The center is privately owned and operated **OR** • The center is a public facility and the placement is temporary pending other arrangements appropriate to the child's needs. If a IV-E foster care child is placed in a public childcare facility, continue IV-E eligibility only if the facility accommodates no more than 25 children.

2885 Transition from Foster Care to Adoption Assistance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Transition from Foster Care to Adoption Assistance		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2885
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-63

Requirements

For Children who receive an Adoption Assistance Payment, Foster Care Medicaid case will be closed and an Adoption Assistance Medicaid case opened only after the adoption has been finalized.

Basic Considerations

When children move from foster care to adoptive status with the signing of the placement agreement, their Foster Care Medicaid case will remain open under their birth name. After the adoption is finalized, the Foster Care Medicaid case will be closed and an Adoption Assistance case will be opened under the adoptive name. The name change is not legal until the adoption is finalized.

Reference SHINES Job Aids details for SSCM and RMS processing of funding source determination at adoptive placement and at adoption finalization.

The Social Security Administration cannot issue a new SSN until the adoption is finalized. Once SSA issues a new SSN, all references to the old SSN are lost. They do not cross-reference SSNs in adoption situations.

SSA will not issue a new SSN in the following situations:

- The child is receiving Title II auxiliary benefits or Title XVI benefits, and the child will continue to receive payments;
- The child knows the previously assigned SSN and/or the child knows that he/she is adopted;
- The adopting parent is a stepparent;
- The adopting parent is a grandparent;
- The child has worked.

Procedures

When the adoption is finalized, the SSCM will upload Form 403, Adoption Assistance Benefits Memorandum, and the final adoption decree to SHINES External Documentation and send notification to the assigned RMS. Form 403 will have the date the adoption was finalized and the name that should now appear on the child's Medicaid card.

The RMS will close the Foster Care Medicaid Case and open an Adoption Assistance Case, if the child receives an Adoption Assistance payment. RMS will end date the appropriate funding summary in SHINES to allow a stage progression to finalized adoption case. Reference SHINES Job Aids.

- Using the child's new legal name
- Using the new SSN

For confidentiality, only the new name and new SSN will be entered into GA Gateway when opening an Adoption Assistance case after finalization of the adoption. If the new SSN is unknown, contact the SSCM for verification of the new number or the SSA documentation of denial to issue a new SSN and leave GA Gateway SSN field blank. New AU and Client ID numbers are to be used for opening the new case in GA Gateway.

For a relative adoption where the child's name is not legally changed and a new SSN is not issued, the foster care case may remain open with the Class of Assistance changed to the appropriate Adoption Assistance GA Gateway code and documentation added in GA Gateway.

Revenue Maximization staff enter the new Medicaid number issued by GAMMIS into SHINES Person Detail Page for all new adoption cases.

The RMS must copy and file mandatory, specific foster care documentation and verification in the Adoption Assistance case as a permanent record to verify the funding determination for payment of Adoption Assistance:

- All initial court orders
- All funding determination, funding notification, budgets and payment authorization forms
- GA Gateway documentation screen print
- SSI award letter, if applicable
- Birth certificate
- Social Security Card
- Screen print of SHINES Eligibility Summary Page, if applicable
- Screen print of SHINES Initial Application Page, if applicable

The above documents are to be filed in the Adoption Assistance case record as permanent funding verification for audit purposes. The foster care record will never be merged with the Adoption Assistance record and will be maintained separate and apart to retain the above original documentation as a permanent record for funding determination verification for foster care as it is also subject to audit.

Revenue Maximization Adoption Assistance case records must be retained for a period of five years from month of receipt of last Adoption Assistance payment. Reference Section 2760 – Case Record Maintenance.

When a Foster Care case is closed and a CMD is completed for Medicaid, any materials, forms, collateral contacts, or other documentation that pertain to a child's IV-E eligibility determination and placement in custody must remain in the closed Revenue Maximization Foster Care record. Foster Care Services policy is followed regarding retention of this material. A case record of a child who

has spent more than six months of his life in care is retained and safeguarded at least until the child is 23 years old. Reference Foster Care Services: Needs of the child, Record Retention 1011.18.

2890 Foster Care Medicaid Age 18 to 21

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Foster Care Medicaid Age 18 to 21		
	Effective Date:	January 2021		
	Chapter:	2800	**Policy Number:**	2890
	Previous Policy Number(s):	MT 49	**Updated or Reviewed in MT:**	MT-63

Requirements

Foster Care Medicaid Age 18 to 21 provides coverage to youth ages 18 to 21 who have signed back into foster care and are receiving Extended Youth Support Services.

Basic Considerations

Beginning March 2014, eligibility for any non-IV-E foster care child under the age of 18 will no longer include the Child Welfare Foster Care Class of Assistance (COA). Eligibility for foster youth age 18 to 21 who have returned to foster care must be determined under Foster Care Medicaid Age 18 to 21.

A youth committed to the Department of Juvenile Justice has Medicaid eligibility determined for DJJ Medicaid Under Age 19.

Basic Eligibility Criteria

Foster Care Medicaid Age 18 to 21 youth must meet the following Basic Eligibility Criteria:

- Age 18 to 21 years
- Receiving Extended Youth Support Services and in extended Foster Care
- Application for other benefits, Reference Section 2210, Application for Other Benefits
- Residency, reference Section 2225, Residency
- Citizenship/immigration status

> Individuals who were in foster care are exempt from providing additional documentary evidence of citizenship/immigration status/identity as long as in foster care in Georgia.

- Enumeration
- Third party liability, Reference Section 2230, TPL

> When a youth reaches the age of 18 he or she will remain in a foster care setting without interruption, and continue to receive independent living services if eligibility criteria was previously met. Those youth between the ages of 18 – 21 who have elected to exit foster care may request to return and participate in the Extended Youth Support Services, EYSS, within six months. Any requests beyond the six month period for EYSS are subject to DFCS approval.

Financial Eligibility Criteria

Foster Care Medicaid Age 18 – 21 years youth must meet Medicaid income and resource limits.

Refer to 2650 Family Medicaid Budgeting Overview and Appendix A2, Financial Limits for Family Medicaid.

The youth's eligibility for Foster Care Medicaid age 18 – 21 years is determined according to the youth's circumstances. Income and resources of the parent(s) or other specified relative(s) are not considered.

All earnings of a child are disregarded regardless of the age of the child; therefore, the earnings of a child up to 21 are disregarded. Although the child's earnings are disregarded, the child's resources must be considered and applied to the resource limit. If the child's resources exceed the limit, he/she is ineligible for Foster Care Medicaid Age 18 – 21 years.

Other Considerations

Foster Care Medicaid Age 18 – 21 years eligibility continues through the month in which the youth reaches age 21, if all financial and non-financial requirements continue to be met.

Eligibility for Medicaid is not determined for the month of placement if the youth received Medicaid under another COA during that month.

Procedures

Follow the steps below to determine Medicaid eligibility under Foster Care Medicaid Age 18 – 21 years.

Determine eligibility of the youth under all basic Medicaid eligibility criteria except living with a specified relative.

Determine all resources of the child and complete the budgeting process using the Foster Care Medicaid Age 18 – 21 years resource limits.

If the youth meets all requirements, authorize Foster Care Medicaid Age 18 – 21 years and send a SHINES NOC to notify the SSCM. Include in the notification the beginning date of Medicaid eligibility and the Medicaid recipient number.

Continue Medicaid eligibility through the month in which the youth reaches age 21, as long as the youth continues to meet all requirements.

If the youth is determined ineligible for Foster Care Medicaid Age 18 – 21 years, complete a CMD prior to termination of Medicaid.

A Medicaid review is required annually.

If a Foster Care Medicaid Age 18 – 21 years youth under the age of 21 voluntarily leaves Extended Youth Support Services, upon receipt of notification and residential information, Rev Max will CMD the Medicaid case to Chafee Medicaid, reference Section 2818 – Chafee Medicaid.

Once a youth reaches the age of 21, Rev Max will CMD the case to Former Foster Care Medicaid upon receipt of notification and residential information, reference Section 2819 – Former Foster Care Medicaid.

2900 Referrals

2900 Referral Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Referral Overview		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2900
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-60

Requirements

In addition to the Services provided through the Medicaid Program, assistance is available through other public and private agencies.

Basic Considerations

This section outlines the services provided by various agencies. The list is not all inclusive.

Clients MUST be asked if they are interested in Voter Registration and Health Check referrals. All Medicaid recipients under age 21 are eligible to participate in Health Check.

2901 Division of Aging Services (DHS)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Division of Aging Services (DHS)		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2901
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-60

Requirements

The Division of Aging Services (DAS) administers a statewide system of services for older Georgians and adults with disabilities. These programs seek to secure maximum independence and dignity for individuals, especially the vulnerable elderly.

Basic Considerations

Services are administered through Area Agencies on Aging (AAAs), each coordinating service delivery in a designated geographic area of the state. The following are services offered:

- Aging and Disability Resource Connection (ADRC) provides accurate information about publicly and privately financed long-term supports and services and offers a consumer-oriented approach to learning about the availability of services in the home and community. The ADRC also provides preliminary screening and referral for the Medicaid Waiver Programs administered by the Department of Community Health and those operationally managed by the Department of Behavioral Health and Developmental Disabilities using a “no wrong door” approach to inquiries for long term care assistance.
- In-Home Services, such as homemaker/chore and personal care services, are provided to older citizens. Home delivered meals are distributed as part of the statewide nutrition program. Other in-home services include respite care, friendly visiting, telephone reassurance and home management.
- Community Services include congregate nutrition services, which provide meals, nutrition education and counseling and other supportive services to older persons in centers throughout the state. The services may also include adult day care, legal assistance, elder abuse preventions programs, health promotion/disease prevention programs and health insurance counseling.
- Long-Term Care Ombudsmen investigate and work to resolve complaints regarding the quality of care and protection of the rights of long-term care residents. See Section 2937, Ombudsman, for additional information.
- Employment opportunities for economically disadvantaged persons 55 and over are available through the Senior Community Service Employment Program (SCSEP). These opportunities include training, part-time community service employment and placement in unsubsidized employment.
- The Alzheimer’s Disease and Related Disorders Program provides support to people with dementia disorders and their caregivers. Projects serve clients with in-home respite care, day

care center services and referrals.

- The National Family Caregiver Support Program (NFCSP) provides support services to functionally impaired elders and their caregivers such as in-home respite care and day care, information and training, and assistance with access to services. This program also may assist seniors who are caring for grandchildren.
- GeorgiaCares is a statewide coalition to assist low income Georgians in applying for the various drug assistance programs sponsored by pharmaceutical companies. This program also provides health insurance information, counseling and community education to Georgia's citizens. Customers may call 1-866-552-4464, option 4, or their local Area Agency on Aging for assistance in this program. See Section 2926, GeorgiaCares, for additional information.
- The Nursing Home Transitions program transitions eligible individuals from long-term inpatient facilities back into community settings.
- The Georgia Elderly Legal Assistance Program (ELAP) serves people age 60 and older by providing legal representation, information and education in civil legal matters throughout the State of Georgia

Services administered directly by Division of Aging staff:

- Adult Protective Services provides a mechanism to report abuse, neglect or exploitation of disabled adults or elder persons who are not residents of nursing homes or personal care homes. Calls that are for emergency situations should be directed to call "911". Non-emergency reports should be directed to:

  APS Central Intake Unit
  Toll-Free 1-866-552-4464, option 3

- The Public Guardianship Office (PGO) of the Division of Aging Services is assigned oversight and delivery of guardianship case management services on behalf of the Department of Human Services. The Department of Human Services is the appointed guardian of last resort when there is no willing or suitable person to act as the guardian for an adult whom the probate court has determined lacks enough capacity to make or communicate significant responsible decisions concerning health or safety

The Area Agency on Aging (AAA) coordinates a variety of services and information for the elderly and their caregivers. The AAA serves as an entry point for all programs and services, determining both client eligibility and the type of services needed. To find the nearest AAA for your area, call 1-866-552-4464, and press 2.

Listed below are Georgia's 12 AAA Service Areas:

ATLANTA REGIONAL COMMISSION	**NORTHEAST GEORGIA**
Area Agency on Aging – (404) 463-3333 (Atlanta)	Area Agency on Aging – (800) 474-7540 (Athens)
Cherokee, Clayton, Cobb, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Rockdale, and Henry.	Barrow, Clarke, Elbert, Greene, Jackson, Jasper, Madison, Morgan, Newton, Oconee, Oglethorpe and Walton.

CENTRAL SAVANNAH RIVER Area Agency on Aging (Augusta) (888) 922-4464 Burke, Columbia, Glascock, Hancock, Jefferson, Jenkins, Lincoln, McDuffie, Richmond, Screven, Taliaferro, Warren, Washington and Wilkes.	**NORTHWEST GEORGIA (formerly Coosa Valley/North Georgia)** Area Agency on Aging – (800)759-2963 (Rome) Bartow, Catoosa, Chattooga, Dade, Fannin, Floyd, Gilmer, Gordon, Haralson, Murray, Paulding, Pickens, Polk, Walker and Whitfield.
COASTAL Area Agency on Aging – (800) 580-6860 (Darien) Bryan, Bullock, Camden, Chatham, Effingham, Glynn, Liberty, Long and McIntosh.	**SOUTHERN GEORGIA** Area Agency on Aging – (912) 285-6097 (Waycross) Atkinson, Bacon, Ben Hill, Berrien, Brantley, Brooks, Charlton, Clinch, Coffee, Cook, Echols, Irwin, Lanier, Lowndes, Pierce, Tift, Turner and Ware.
LEGACY LINK, INC. (Georgia Mountains) Area Agency on Aging – (855) 266-4283(Oakwood) Banks, Dawson, Forsyth, Franklin, Habersham, Hall, Hart, Lumpkin, Rabun, Stephens, Towns, Union and White.	**THREE RIVERS** Area Agency on Aging – (866) 854-5652 (Franklin) Butts, Carroll, Coweta, Heard, Lamar, Meriwether, Pike, Spalding, Troup and Upson.
HEART OF GEORGIA/ ALTAMAHA Area Agency on Aging – (912) 367-3648 (Baxley) or (888) 367-9913 Appling, Bleckley, Candler, Dodge, Emanuel, Evans, Jeff Davis, Johnson, Laurens, Montgomery, Tattnall, Telfair, Toombs, Treutlen, Wayne, Wheeler and Wilcox.	**SOUTHWEST GEORGIA (SOWEGA)** Area Agency on Aging – (800) 282-6612 or 229) Baker, Calhoun, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas and Worth.
MIDDLE GEORGIA Area Agency on Aging – (888) 548-1456 (Macon) Baldwin, Bibb, Crawford, Houston, Jones, Monroe, Peach, Pulaski, Putnam, Twiggs and Wilkinson.	**RIVER VALLEY** Area Agency on Aging – (800) 615-4379 (Columbus) Chattahoochee, Clay, Crisp, Dooly, Harris, Macon, Marion, Muscogee, Quitman, Randolph, Schley, Stewart, Sumter, Talbot, Taylor and Webster.

2903 Brain and Spinal Injury Trust Fund

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Brain and Spinal Injury Trust Fund		
	Effective Date:	November 2023		
	Chapter:	2900	**Policy Number:**	2903
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-71

Requirements

The Brain and Spinal Injury Trust Fund provides disbursements from the Trust Fund to offset the costs of care and rehabilitative services to citizens of the state who have survived neurotrauma with brain or spinal cord injuries. The Trust Fund will be utilized after the individual has exhausted all other resources.

History

Senate Bill 110 created the Brain and Spinal Injury Trust Fund during the 1998 General Assembly. Senator Charles Walker authored the bill. This legislation created a 10% surcharge on all DUI fines beginning January 1, 1999, to offset the high costs of needed services for persons with traumatic brain injuries or spinal cord injuries. The Trust Fund began receiving funds from the various courts through the state beginning April 1999.

A fifteen-member Commission appointed by the Governor is responsible for administering the Trust Fund and setting criteria for disbursement of the funds. Individuals with brain or spinal cord injuries, or their family members, hold eight of the fifteen Commission seats.

Basic Considerations

An individual with brain or spinal cord injuries may be considered eligible for a disbursement from the Trust Fund if he/she:

- Has sustained a neurotrauma with brain or spinal cord injuries
- Is a citizen of the state at the time of application and during the provision of services in Georgia
- Has exhausted all other insurance and governmental funding sources or if the service needed is outside the scope of other funding sources or is otherwise unavailable
- Submits a completed application form

Categories of care and rehabilitative services covered by the Trust Fund include but are not limited to:

- Assistive Technology
- Computers
- Dental Services

- Durable Medical Equipment/Wheelchairs
- Health and Wellness
- Home Modifications
- Personal Support Services/Attendant Care
- Respite
- Recreation
- Therapeutic/Rehabilitative Services
- Transportation/Vehicles
- Vision Services
- Vocational Support

Definitions

Definitions listed below are for the purpose of the Brain and Spinal Trust Fund Commission Distribution Policies.

1. “Brain Injury” means a traumatic injury to the brain, not of a degenerative or congenital nature, but arising from blunt or penetrating trauma or from acceleration-deceleration forces, that is associated with any of the symptoms or signs attributed to the injury.
2. “Neurotrauma” means an injury to the central nervous system i.e., a traumatic brain or spinal cord injury that is caused by external physical forces.
3. “Rehabilitative services” shall mean products or services for people with brain and spinal cord injuries that: (a) Enable them to have control of their own lives including their daily routine; (b) Enable them to progress toward the goal of living in the community; (c) Strengthen and enhance the support infrastructure, including the family, to avoid institutionalization; and (d) Identify desired outcomes that can be measured over time.
4. “Spinal Cord Injury” means a traumatic injury to the spinal cord, not of a degenerative nature, but caused by an external physical force resulting in paraplegia or quadriplegia, which can be a partial or total loss of physical function.

Procedures

For more information about the Brain and Spinal Injury Trust Fund, visit the website at: bsitf.georgia.gov/ or the customer may call the Commission’s Office at the phone number below. Applications may be submitted by mail, fax, or electronically.

Applications may be downloaded or completed and submitted online at: bsitf.georgia.gov/.

Applications that have been downloaded and completed should be submitted to:

Brain and Spinal Injury Trust Fund Commission
200 Piedmont Avenue SE
Suite 472-F
Atlanta, GA 30334

Office: 404-651-5112
Toll-free: 888-233-5760
Fax: 404-656-9886
Email: DPH-INFO-BSITF@dph.ga.gov

2905 Cancer State Aid Program

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Cancer State Aid Program		
	Effective Date:	November 2023		
	Chapter:	2900	**Policy Number:**	2905
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-71

Requirements

The Cancer State Aid Program was established in 1937 by the Georgia legislature at the request of Georgia physicians to provide cancer treatment to uninsured and under-insured low-income cancer patients. The program funds diagnosis and treatment for medically needy cancer patients in Georgia.

Basic Considerations

To be eligible for the program, patients must meet the following **financial, citizenship, residency, and medical** criteria:

- Family income must be at or below 250 percent of federal poverty income guidelines
- Must be uninsured or underinsured and not be eligible for full coverage Medicaid
- Must be a U.S. citizen or lawful permanent resident
- Must be a resident of Georgia
- Must receive active medical treatment for cancer **and** be likely to benefit from active medical treatment
- Must receive treatment from facilities that participate in the Cancer State Aid Program
- Must be accepted for treatment by a physician affiliated with a Cancer State Aid participating facility.
- Due to funding restrictions, a limited number of applicants are accepted each fiscal year. Applications will be considered based on the date they are received and the availability of funding.

Participating provider types include:

- Hospitals (25)
- Free standing radiation therapy treatment centers (5 providers across multiple locations)
- Pharmacies (Number varies depending on location of need)

Covered services include:

- Inpatient and outpatient cancer related diagnostic and treatment services
- Prescription drugs related to treatment of cancer. Prior approval is required from the Cancer

State Aid Program.

- Limited outpatient cancer related home services may be considered. Prior approval is required from the Cancer State Aid Program.

Procedures

Cancer State Aid Program information may be obtained by calling the Georgia Department of Public Health (DPH), Division of Health Protection, **Cancer State Aid Program at 404-463-5111**. Information may also be obtained from:

- Social services personnel and financial counselors at participating facilities

Applications are submitted directly from participating providers to the Cancer State Aid Program for eligibility determination. Eligibility determination will take approximately 5 working days from receipt of all required information.

Mailing address:

Cancer State Aid Program
Georgia Department of Public Health Division of Health Protection
200 Piedmont Avenue SE
Atlanta, GA 30334
Phone: 404-463-5111
Fax: 404-657-6316

The Cancer State Aid Program web site is dph.georgia.gov/cancer-aid.

2907 Champions for Children

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Champions for Children		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2907
	Previous Policy Number(s):	MT 32	**Updated or Reviewed in MT:**	MT-60

Requirements

The Champions for Children program is designed to assist children and families that do not meet the eligibility requirements for the TEFRA/Katie Beckett Medicaid program.

Basic Considerations

Who is eligible?

- Children 21 and under
- Who live at home
- Who have a physical, cognitive, developmental or medical disability
- Not eligible for Medicaid What services are provided?
- Respite care
- Specialized medical supplies and equipment
- Medical services
- Therapies (OT, PT, and ST)
- Dental and optical services
- Travel reimbursements for medical appointments
- Recreational/therapeutic activities
- Other services related to the child's disability not covered by other payment sources
- Parent to Parent of Georgia and other resources

Procedures

Families can access Champions for Children by calling 1-866-584-3742 or be referred to the web site www.championsforchildrenga.org/.

2908 Children's Medical Services

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Children's Medical Services		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2908
	Previous Policy Number(s):	MT 39	**Updated or Reviewed in MT:**	MT-60

Requirements

Children's Medical Services (CMS) provides care coordination and other needed medical/health services for children with chronic medical conditions from birth to 21 years of age.

Basic Considerations

Who is eligible?

Children from birth to 21 years of age that reside in Georgia and meet both a medical and financial criterion are eligible for services. The range of medically eligible conditions include but is not limited to the following:

- Asthma, cystic fibrosis and other lung disorders
- Neurological disorders including seizures, benign tumors, hydrocephalus, and others
- Orthopedic and/or neuromuscular disorders including cerebral palsy, spina bifida, scoliosis, clubfeet, congenital or traumatic amputations of limbs, and others
- Some vision and hearing disorders
- Diabetes and other endocrine and genetic disorders
- Craniofacial anomalies such as cleft lip/palate
- Congenital cardiac conditions

Click and search here for a Comprehensive List of Conditions.

One of the four following supports financial eligibility criteria:

- Family income 247% of the FPL or less
- Medicaid enrolled (including Katie Beckett/Deeming Waiver)
- Receiving SSI
- Child is in foster care What services are provided?

Children with special health care needs require multiple services from several health providers. An assigned care coordinator works closely with primary care providers, specialists and community partners to coordinate services and provide access to specialty health care. CMS may provide, arrange and/or pay for the following, as funds are available, and as it relates to the eligible medical

condition: comprehensive physical evaluations, genetic counseling, diagnostic testing, inpatient/outpatient hospitalization, medications, durable medical equipment and transportation. Services such as health care transition planning, translation and health education are also provided for enrolled families. CMS enrollees also have access to specialty health care clinics in select areas.

Procedures

To initiate a referral contact the county in which the child resides by clicking here Local CMS Office.

To obtain more information on our policies or connect for training opportunities visit the main website at dph.georgia.gov/CMS or contact the state office by phone at (404) 657-2850 or email childrens.medical@dph.ga.gov.

To receive more information about referrals or community resources for families caring for a child with special health care needs please contact the statewide toll free number at 1-800-229-2038.

2910 Child Support Services

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Child Support Services		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2910
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-60

Requirements

In Georgia, the Division of Child Support Services (DCSS) provides the following services:

- locate the noncustodial parents (NCP)
- establish paternity
- establish and enforce child support orders
- establish and enforce medical support orders
- collect and distribute child support payments
- modify child support orders when appropriate

Controlling Legislation

The DCSS program was established under Title IV-D of the Social Security Act and is further developed in the Title 45 Code of Federal Regulations.

History

In 1975, the Social Security Act was amended to include Title IVD, which requires states to establish a program to enforce the obligation of NCPs to support their children.

The federal Family Support Act of 1988 places the responsibility of paying child support on parents. Georgia enacted legislation in 1989 (HB 139) which made it one of the first states in the nation to meet the standards of the Family Support Act by setting guidelines for child support awards and requiring an income deduction for child support cases handled by DCSS.

Procedures

Customers may contact DCSS using the following self-service options to obtain case information, to include payment information:

- DCSS On the Go App (Apple device and Android device)
- Customer Online Service Portal
- Contact Center **1-844-MYGADHS (1-844-694-2347)**
- **Online Chat** (Chat with Us)

- **State Office** email request

2920 Domestic Violence

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Domestic Violence		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2920
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-60

Requirements

Free, confidential services are available from family violence shelters and programs supported by the Department of Human Services.

DFCS will not share the information with anyone outside the agency without the applicant/recipient's knowledge.

Basic Considerations

Domestic violence occurs on all social and economic levels, regardless of employment or education, race or ethnic background, religion, marital status, physical ability, age or sexual orientation.

24-Hour Help Line

Georgia has 44 certified family violence shelters, operated by private, nonprofit organizations. They provide 24-hour crisis lines; legal and social service advocacy; children's programs; parenting support and educational; emotional support; and community education.

All county DFCS offices have domestic violence assessors who assist DFCS staff to identify and provide crisis intervention and relocation services to domestic violence victims receiving or applying for TANF assistance.

Customers may call 1-800-33HAVEN to speak to someone at a local family violence shelter. The number automatically connects the caller to the local family violence shelter. Customers may call from anywhere in the state to find a safe place to stay for themselves and their children, and to get other resources.

Workers may call the DFCS Safety Management Section (Family Violence Services) at 404-657-3413 for more information or assistance.

The brochure "What Every Woman Needs to Know" (form # 522) is available in English and Spanish through the DFCS State Office (see Appendix F) and may be used to assist the worker and/or customer in determining if a Domestic Violence referral is appropriate. When in doubt, offer the help line number to the customer.

More information can be obtained about domestic violence by visiting the "Georgia Commission on Family Violence" website at www.gcfv.georgia.gov/.

2925 The Food Stamp Program (DHS/DFCS)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	The Food Stamp Program (DHS/DFCS)		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2925
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-60

Requirements

The purpose of the Food Stamp Program is to promote the well-being of the state's population by raising the level of nutrition among low-income assistance units.

The Food Stamp Program provides monthly benefits through Electronic Benefit Transfer (EBT) to low income families to help pay for the cost of food.

Controlling Legislation

The Food Stamp Program is authorized by the Food Stamp Act of 1977. The eligibility provisions of the Act are further developed in Title 7, Code of Federal Regulations, parts 210 through 299. The Food Stamp Program is administered by the Food and Nutrition Service under the United States Department of Agriculture. Title IV of the 2008 Farm Bill renames the Food Stamp Program as the Supplemental Nutrition Assistance Program (SNAP).

History

The legal basis for the Food Stamp Program is the Food Stamp Act of 1977, the Omnibus Reconciliation Act of 1981, and the Food Security Act of 1964. Benefits are funded 100 percent by the federal government, and administrative costs are shared by the state and federal governments on a 50-50 basis.

Basic Considerations

Applications for Food Stamps are accepted at the local DFCS office and Social Security Administration. Applications taken at the Social Security Administration are forwarded to DFCS for processing.

2926 GeorgiaCares

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	GeorgiaCares		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2926
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-60

Requirements

GeorgiaCares is a volunteer-based program that provides free, unbiased and factual information and assistance regarding Medicare and other related insurance. GeorgiaCares provides one-on-one counseling, community outreach, and education.

History

GeorgiaCares is the State Health Insurance Assistance Program (SHIP). SHIPs provides personalized counseling, education and outreach to assist Medicare beneficiaries with their Medicare questions and benefits. GeorgiaCares can help Medicare beneficiaries make informed decisions about their health care options and can provide ways to protect against fraud, waste and abuse.

Basic Considerations

GeorgiaCares helps people with Medicare understand their choices and enroll in a Medicare plan that meets their needs. GeorgiaCares can help beneficiaries understand Medicare and get the most out of their healthcare benefits.

GeorgiaCares provides information about:

- Original Medicare (Medicare Parts A and B)
- Medicare Advantage Plans (Medicare Part C)
- Medicare Prescription Drug Plans (Medicare Part D)
- Medigap policies (Medicare Supplement Insurance)
- Health Care Fraud, Waste and Abuse
- Long-term Care Insurance
- Consumer Protection
- Medicare Financial Assistance Programs

GeorgiaCares provides help with:

- Applying for Medicare financial assistance programs
- Submit Medicare Appeals and Grievances

- Reviewing Medicare Summary Notices (MSN)
- Review the Explanations of Benefits (EOB)
- Enroll in Medicare Health and/or Drug Plans

GeorgiaCares also provides these services:

- Volunteer opportunities
- Referrals to other appropriate agencies
- Community education and outreach
- Counseling in-person and by phone

Procedures

To contact for GeorgiaCares, customers may call 1-866-552-4464 (Option 4). For more information about GeorgiaCares, visit www.mygeorgiacares.org.

GeorgiaCares counselors are available Monday through Friday during regular business hours.

2928 Georgia Hearing Aid Distribution Program

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Georgia Hearing Aid Distribution Program		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2928
	Previous Policy Number(s):	MT 30	**Updated or Reviewed in MT:**	MT-60

Requirements

The Georgia Hearing Aid Distribution Program, enacted by the Georgia Legislature, provides hearing aids to Georgians, subject to eligibility requirements.

History

The Public Service Commission has contracted with the Georgia Lions Lighthouse Foundation, a nonprofit organization that has provided hearing aids to low income Georgians for over thirty years.

Basic Considerations

In order to qualify for this program, the applicant must meet the following guidelines:

- Applicant must be a Georgia resident for at least one year
- Applicant must present a recommendation from a state-licensed hearing care provider
- Hearing aids will only be dispensed through a state-licensed hearing care provider
- Applicant's income must not exceed 200% of the Federal Poverty guidelines;

This program will only provide hearing aids to individuals 18 years of age or older as Georgia Medicaid provides hearing aids to those under age 18.

Procedures

For more information on this program contact the Georgia Lions Lighthouse Foundation at (404)325-3630, or 1-800-718-7483 outside of metro Atlanta. Georgia Lions Lighthouse Foundation can also be contacted at the following website: www.lionslighthouse.org.

2930 EPSDT Services

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	EPSDT Services		
	Effective Date:	December 2022		
	Chapter:	2900	**Policy Number:**	2930
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-68

Requirements

The Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit provides coverage for a comprehensive array of preventive, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Social Security Act (the Act). The EPSDT benefit is designed to assure that children receive early detection and care, so that health problems are averted or diagnosed and treated as early as possible. The goal of the EPSDT benefit is to assure that individual children get the health care they need when they need it. When a preventive health examination indicates the need for further evaluation of a child's health, the child should be appropriately referred for diagnostic and treatment services without delay. States are required to arrange for and cover under the EPSDT benefit any Medicaid covered service listed in Section 1905(a) of the Act if that treatment or service is determined to be medically necessary to correct or ameliorate defects and physical and mental illnesses or conditions. This includes physician, nurse practitioner and hospital services; physical, speech/language, and occupational therapies; home health services, including medical equipment, supplies, and appliances; treatment for mental health and substance use disorders; treatment for vision, hearing and dental diseases and disorders, and much more. This broad coverage requirement results in a comprehensive, high quality health benefit for children under age 21 enrolled in Medicaid.

The EPSDT benefit is available for Medicaid-eligible children from birth up to twenty-one (21) years of age and PeachCare for Kids®-eligible children from birth up to nineteen (19) years of age.

Basic Considerations

The EPSDT benefit allows for: an assessment of a child's health at key points in his/her life so that potential diseases can be prevented or detected early enough to allow for treatment, thus assuring continued healthy development and; tests, procedures and treatments when needed to correct or ameliorate diseases and conditions.

EPSDT providers include Physicians (pediatricians, family practitioners, general practitioners, etc.), Nurse Practitioners, Physicians' Assistants, Rural Health Clinics, Federally Qualified Health Clinics and Public Health Departments that are enrolled in the Health Check program.

The EPSDT program provides reimbursement for preventive and primary health services, immunization administration, vision, hearing and dental screenings, and developmental screenings. Other Medicaid program areas reimburse providers for services provided under the EPSDT benefit.

EPSDT preventive health services align with the AAP's Bright Futures Periodicity Schedule and

include, but are not limited to the following:

- A preventive health visit, which includes the following age-appropriate components:
  - a comprehensive physical examination (unclothed to the extent necessary)
  - comprehensive health and developmental history
  - developmental assessment including mental, emotional and behavioral
  - alcohol and drug use assessment
  - depression screening
  - measurements, including BMI
  - anticipatory guidance and health education
  - dental/oral health assessment
  - vision and hearing screenings
  - nutritional screening
  - immunizations according to the Advisory Committee on Immunization Practices (ACIP)
  - certain laboratory procedures (including Blood Lead Level Screening)
  - TB and lead risk assessments
  - STI/HIV screening
- Other available services include:
  - notification to the Medicaid/PeachCare for Kids® member of necessary EPSDT Services
  - assistance with transportation arrangements
  - assistance with scheduling appointments
  - assistance in locating the nearest EPSDT provider
  - provision of information to the blind, deaf, illiterate, or non-English speaking through suitable communication resources.

Procedures

Inform the applicant about the program verbally and in writing at the time of application for Family Medicaid.

Document in the system how the member was informed of the services available under the EPSDT benefit (i.e., face to face, telephone, brochure, or video).

Upon approval, a description of the EPSDT program and contact information is sent to A/R via the GA Gateway approval notice.

Explain the benefits of preventive health care services and the services offered under the program including the following:

A. Benefits
   - prevention of some diseases/disability before occurrence

- early detection can prevent disease/disabilities from progressing
- diseases/disabilities can be corrected if diagnosed and treated early
- early medical and dental intervention can help a child achieve his/her full potential.

B. Services – see listing above

C. Upon a determination of eligibility for Medicaid, all individuals under age 21 are eligible for the EPSDT benefit.

D. Upon a determination of eligibility for PeachCare for Kids all individuals under age 19 are eligible for the EPSDT benefit.

2931 Medicare Part D and Low-Income Subsidy

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicare Part D and Low-Income Subsidy		
	Effective Date:	June 2021		
	Chapter:	2900	**Policy Number:**	2931
	Previous Policy Number(s):	MT 20	**Updated or Reviewed in MT:**	MT-64

Requirements

Beginning January 1, 2006, a new Medicare program will provide prescription drug coverage for Medicare recipients. This program is a part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and is called Medicare Part D. There will be a variety of plans from which the Medicare recipient may select coverage. Medicare recipients may also decline Part D coverage altogether. December 31, 2005 is the last day a Medigap Plan with prescription coverage will be available with the prescription benefit. Anyone with one of those plans can continue with that plan “as is” or with the prescription portion dropped. The Medigap Plan’s prescription coverage will not be as good as the Medicare Part D prescription coverage.

A Low-Income Subsidy (LIS) is also available for some low-income recipients to help defray the costs of the Medicare Part D coverage. **Refer to Section 2146, Low Income Subsidy, for completing the Low-Income Subsidy Application (LISA), and refer to Section 2751, SSA Medicare Savings Programs Applications, for processing Low-Income Subsidy applications received via LIS system interface.**

A/Rs who receive Medicare AND FULL Medicaid benefits in Georgia will no longer have their prescriptions covered through Medicaid, but through Medicare Part D as of January 1, 2006. If these A/Rs decline Part D coverage, they will no longer have any drug coverage through Medicaid.

Basic Considerations

The Medicare Part D program will work like an insurance policy in the following ways:

- The Medicare recipient selects a plan based on which plan provides the best coverage for his/her needs.
- There will be a monthly premium to pay.
- There will be a deductible.
- There will be a co-pay.

See Appendix A-1 for approximate cost of premiums, deductibles, out of pocket costs, etc.

The prescription coverage will be provided through:

- Prescription Drug Plans (PDPs)
- Medicare Advantage Plans (MA-PDs)

To be eligible for the Part D coverage, the Medicare recipient must:

- Be entitled to Medicare Part A and/or enrolled in Medicare Part B
- Reside in their chosen plan's service area
- Must enroll in a Medicare prescription plan in order to get the Medicare Part D drug plan.

Enrollment

A Medicare recipient may be enrolled by:

- Themselves, directly with the drug plan sponsor
- A personal representative
- Enlisting the assistance of others, such as GeorgiaCares or DFCS.

Refer recipients who wish to enroll in a Medicare Part D Plan to GeorgiaCares beginning October 2005 at 1-800-669-8387. Recipients may compare drug plans online beginning October 13, 2005, at www.medicare.gov - Finding a Medicare Prescription Drug Plan. They may also call 1-800-MEDICARE (1-800-633-4227) or TTY users, call 1-877-486-2048.

If a Medicare recipient waits to enroll beyond the enrollment period, there may be a higher monthly premium. There could be a 1% increase in the monthly premium for every month someone waits to enroll. This increase in premiums would be for those:

- Who were eligible but did not enroll and
- Who had drug coverage that was NOT at least as good as a Medicare prescription drug plan.

The source of the prescription coverage should notify the Medicare recipient if their prescription plan is at least as good as the Medicare prescription drug coverage.

Medicare Part D Initial Enrollment Period

The Initial Enrollment Period for Medicare Part D is November 15, 2005, through May 15, 2006. This is the time frame for current Medicare recipients or those who will become eligible in November or December 2005 and January 2006. For all others, there is a 7-month enrollment period as follows:

- Three months before Medicare eligibility begins
- The month Medicare eligibility begins
- Three months after Medicare eligibility begins

Automatic Enrollment

Medicare recipients who receive FULL Medicaid benefits (not Q Track only) have until December 31, 2005, to select and enroll in a Part D plan. If this has not been done by the end of 2005:

- They will be automatically enrolled in a Medicare prescription drug plan.
- Their coverage will begin January 1, 2006.
- They may change their Medicare Part D plans monthly.

Beginning January 1, 2006, Medicare recipients who apply for and are eligible for any type of Medicaid, including AMN and Q Track, will automatically be enrolled, if not already enrolled, in Medicare Part D effective the month following the month in which eligibility is determined. DCH will cover prescriptions until the Part D coverage begins. The LIS is effective the first month of Medicaid eligibility. However, there will be no reimbursement of co-pays, deductibles or premiums for the Part D already paid. Automatic enrollment of one member of a spouse for Part D and/or LIS does not automatically enroll the non-Medicaid member of the couple. Complete the LIS for the non-Medicaid individual but include income and resource information on the spouse and have the spouse sign the LIS also.

Facilitated Enrollment

The following Medicare recipients have until May 15, 2006, to select and enroll in a Medicare Part D Plan:

- Those who receive Q Track only Medicaid
- Those who are not receiving any Medicaid assistance, but who have applied for and have been determined eligible for the LIS.

If enrollment in a Part D Plan has not been done by the end of the Initial Open Enrollment:

- They will be automatically enrolled in a Medicare Prescription drug plan.
- Their coverage will begin June 1, 2006.
- They will have a one-time opportunity to change to another Medicare prescription drug plan of their choice without waiting for the next enrollment period.

Annual Election Period

There will be an Annual Election Period each year from November 15 through December 31. During this time period, the eligibility for Medicare Part D will be reviewed and if the individual is not a Medicaid recipient, this is when s/he may select a different plan. Medicare recipients who are Full Medicaid recipients may switch plans monthly.

Special Enrollment Period

There may also be times when a Special Enrollment may occur. An enrollment or a change in plan may also occur under the following circumstances:

- When a Medicare recipient moves out of their plan's service area
- When an involuntary loss, reduction or non-notification of creditable coverage occurs
- Other exception circumstances.

Disenrollment

A Medicare recipient may voluntarily disenroll from Medicare Part D only during:

- Annual Election Period
- Special Enrollment Period.

A Medicare recipient enrolled in Medicare Part D will be involuntarily disenrolled when s/he:

- Permanently moves out of the service area
- Loses eligibility for Medicare prescription drug coverage
- Dies
- Is enrolled in a plan that is terminating its contract
- Misrepresents third party Medicare prescription drug plan coverage.

A Medicare recipient may also be disenrolled for:

- Not paying their monthly premium in a timely manner
- Disruptive behavior.

Low Income Subsidy

Beginning in May 2005, the Social Security Administration (SSA) is launching an outreach campaign regarding Medicare Part D low-income subsidies. These subsidies are geared to help pay all or some of the costs involved to the individual with the Medicare Part D Plan, such as deductibles, monthly fees, co-pays, etc. May 27 through August 16, 2005, SSA will mail low-income subsidy applications (LISAs) to potentially eligible groups. There are three identified groups of Medicare recipients who are potentially eligible for the low-income subsidy. Each group has a different level of benefit from the subsidy. See Appendix A-1 for the current benefit level.

The low-income subsidy groups are:

- Group 1 – Medicare recipients who receive FULL Medicaid benefits. This will include SSI recipients and all Full Medicaid recipients. This would not include Q Track only A/Rs.
- Group 2 – Medicare recipients who are Q Track only and those not currently receiving Medicaid but have income below 135% of the Federal Poverty Level (FPL) with limited resources.
- Group 3 – Medicare recipients whose income is below 150% of the FPL and who have limited resources.

Deemed Eligible for Low Income Subsidy

Certain Medicare/Medicaid recipients will be deemed eligible for the LIS and do not need to file a separate application for the LIS. Deemed eligible include:

- Medicare recipients with full Medicaid benefits (not Q Track).

If an AMN client meets spenddown, they are considered deemed eligible for the remainder of the enrollment period and do not have to reapply for the LIS even if spenddown is met for only one month.

- Medicare recipients with Medicare Savings Program benefits (Q Track).

Medicare Part D Fraud and Abuse

For fraud, waste and abuse complaints regarding Medicare Part D, CMS has established Medicare

Drug Integrity Contractors (MEDICs) to assist with this analysis. The MEDIC for the Atlanta Region is Health Integrity. They may be contacted at 1-877-772-3379 or MEDICinfo@healthintegrity.org or by fax at 410-819-8698.

Medicare Advantage Plan

The Medicare Advantage Plan fully supplants Medicare. However, the Medicare recipient is still considered Medicare eligible; the plan just covers the services that Medicare currently covers. The plan may offer extra benefits such as extra days in the hospital, lower co-payments, and prescription drug coverage. For these extra benefits, there may be an additional premium paid to the plan. Also, the plan may restrict the member to seeing doctors that belong to the plan or to certain hospitals for services. These members may still want to receive Q Track Medicaid for payment of their Medicare premiums, etc., and they are potentially eligible for Medicare Part D and the LIS.

2933 Georgia Pediatric Program

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Georgia Pediatric Program		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2933
	Previous Policy Number(s):	MT 44	**Updated or Reviewed in MT:**	MT-60

Requirements

The Model Waiver Program (MWP) and the Exceptional Children's Service were merged into the Georgia Pediatric Program (GAPP) effective 3/30/03. The program provides specialized medical services to a Medicaid recipient who is under age 21 and respirator or oxygen dependent.

Basic Considerations

A request for GAPP services is made when an individual is in need of a particular medical service that is not usually covered by Medicaid. The Prior Authorization (PA) Unit of Georgia Health Partnership (GHP) is responsible for determining appropriateness for these services.

To be eligible for GAPP services, the A/R must meet the following conditions:

- The A/R is a Medicaid recipient under the most advantageous COA, including SSI, Family Medicaid or ABD Medicaid.
- The A/R is under the age of 21.
- The A/R is respirator or oxygen dependent.
- The A/R is approved for a nursing home level of care (LOC).
- The A/R is approved by the PA Unit for GAPP services.

The PA Unit is responsible for obtaining the required LOC unless Medicaid eligibility is determined under the Deeming Waiver COA.

Eligibility for GAPP services is approved manually and is not entered on the DFCS system.

Procedures

Medicaid Recipient

Follow the steps below to initiate GAPP services if the individual requesting these services is **currently** receiving Medicaid.

Step 1 Verify Medicaid eligibility

Step 2 Verify that the A/R is under age 21.

Step 3 Document the PR's statement that the individual is respirator or oxygen dependent. File any supporting medical documentation in the case record.

Step 4 Inform the PR to have the A/R's physician or hospital discharge planner contact the PA Unit at the following address to arrange for GAPP services:

Georgia Medical Care Foundation
Prior Authorization (GAPP)
P.O. Box 105406
Atlanta, GA 30348

Or electronically at: www.mmis.georgia.gov.

Explain to the PR that additional information may be required by the PA unit, such as Form DMA-6(A) completed by the physician.

If the A/R is approved for GAPP services, DCH notifies the county DFCS of the approval with a copy of the approval letter that is sent to the PR.

Step 5 Review the income of the GAPP A/R. Contact a state Medicaid consultant regarding calculations of a cost share if the A/R has income in excess of the FBR for LA-A.

Changes in Medicaid or GAPP Eligibility Participating Provider Types

Complete a CMD if an individual has been terminated from ongoing Medicaid and is receiving GAPP services. Refer to Section 2052, Continuing Medicaid Determination.

Medicaid Applicant

Follow the steps below to determine Medicaid eligibility and initiate GAPP services if the individual requesting these services is **not** currently receiving Medicaid.

Step 1 Accept the A/R's Medicaid application.

Step 2 Verify that the A/R is under age 21. Document the A/R's respirator or oxygen dependency in the case record

Step 3 Screen for Medicaid eligibility under all COAs, including SSI, Family Medicaid and ABD Medicaid. Determine eligibility under the COA most advantageous to the A/R.

- If the A/R is ineligible for Medicaid under all other COAs and is a child under age 19, determine Medicaid eligibility under the Katie Beckett COA.
- If eligibility is determined under the Katie Beckett COA, forward a copy of the GMCF LOC approval letter to the PA unit as soon as it is returned to DFCS from GMCF.

Step 4 Tell the PR to have the A/R's physician or hospital discharge planner contact the PA Unit. Refer to Step 4 of the Procedures to initiate GAPP services for an individual who is currently receiving Medicaid listed above.

> GAPP services cannot be approved while an application for Medicaid is pending.

Special Considerations

SSI PNA

A disabled child may be eligible for a $30 SSI personal needs allowance from SSA if s/he meets the following criteria:

- Is disabled
- Received SSI benefits (limited to PNA) while in a medical treatment facility
- Is ineligible for SSI solely because of deemed income or resources of the parents
- Is currently eligible for Medicaid under one of the following COAs:
  - Katie Beckett
  - CCSP

    OR

  - Is receiving services under GAPP

If the child meets the above criteria, refer the parent(s) to SSA to continue the SSI $30 PNA payment and Medicaid. Continue to maintain the child under the COA above unless the child no longer meets the criteria for that program.

Nurse Services

In order for Medicaid to pay for the services of a nurse, the GAPP child must be approved under a skilled LOC and would have to be oxygen or ventilator dependent on a continuing basis.

2935 Non-Emergency Medical Transportation Broker System

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Non-Emergency Medical Transportation Broker System		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2935
	Previous Policy Number(s):	MT 47	**Updated or Reviewed in MT:**	MT-60

Requirements

The Medicaid Non-Emergency Medical Transportation (NEMT) program provides transportation through a NEMT Brokerage System. NEMT is provided only in the absence of other transportation.

Basic Considerations

Five NEMT regions have been established in the state – North, Atlanta, Central, East and Southwest. The Department of Community Health (DCH) has contracted with a Broker in each of the five NEMT regions to administer and provide non-emergency medical transportation for eligible Medicaid members. The Brokers are reimbursed a monthly capitation rate for each eligible Medicaid member residing in their region.

Procedures

Eligible Medicaid members who need access to medical services covered by Medicaid and have no other means of transportation must contact the Broker servicing their county to arrange for appropriate transportation.

Each Broker is required to have toll free telephone access for scheduling NEMT services Monday through Friday from 7:00 a.m. to 6:00 p.m.

The Division of Medicaid monitors the quality of services brokers provide. For any questions, comments or complaints about the NEMT program, contact DXC Technology at 1-866-211-0950 or the NEMT Broker at the numbers provided in the below chart.

DCH has contracted with two companies to provide NEMT services; **Southeastrans, Inc.**, which serves the Atlanta Region and North Region; and, **LogistiCare**, which serves the Central Region, East Region and the Southwest Region. County groupings and related Broker scheduling telephone numbers for each region are as follows:

Region	NEMT Broker & Phone Number	Counties Served
North	**Southeastrans** *Toll free* 1-866-388-9844 *Local* 678-510-4555	Banks, Barrow, Bartow, Catoosa, Chattooga, Cherokee, Cobb, Dade, Dawson, Douglas, Fannin, Floyd, Forsyth, Franklin, Gilmer, Gordon, Habersham, Hall, Haralson, Jackson, Lumpkin, Morgan, Murray, Paulding, Pickens, Polk, Rabun, Stephens, Towns, Union, Walker, Walton, White and Whitfield
Atlanta	**Southeastrans** 404-209-4000 For Georgia Families 360° 1-866-991-6701	Fulton, DeKalb and Gwinnett
Central	**LogistiCare** *Toll free* 1-888-224-7981	Baldwin, Bibb, Bleckley, Butts, Carroll, Clayton, Coweta, Dodge, Fayette, Heard, Henry, Jasper, Jones, Lamar, Laurens, Meriwether, Monroe, Newton, Pike, Putnam, Rockdale, Spalding, Telfair, Troup, Twiggs and Wilkinson
East	**LogistiCare** *Toll free* 1-888-224-7988 For Crisis Stabilization Units and Psychiatric Residential Treatment Facilities 1-800-486-7642 Ext. 461 or 436	Appling, Bacon, Brantley, Bryan, Bulloch, Burke, Camden, Candler, Charlton, Chatham, Clarke, Columbia, Effingham, Elbert, Emanuel, Evans, Glascock, Glynn, Greene, Hancock, Hart, Jeff Davis, Jefferson, Jenkins, Johnson, Liberty, Lincoln, Long, Madison, McDuffie, McIntosh, Montgomery, Oconee, Oglethorpe, Pierce, Richmond, Screven, Taliaferro, Tattnall, Toombs, Treutlen, Ware, Warren, Washington, Wayne, Wheeler and Wilkes
Southwest	**LogistiCare** *Toll free* 1-888-224-7985	Atkinson, Baker, Ben Hill, Berrien, Brooks, Calhoun, Chattahoochee, Clay, Clinch, Coffee, Colquitt, Cook, Crawford, Crisp, Decatur, Dooly, Dougherty, Early, Echols, Grady, Harris, Houston, Irwin, Lanier, Lee, Lowndes, Macon, Marion, Miller, Mitchell, Muscogee, Peach, Pulaski, Quitman, Randolph, Schley, Seminole, Stewart, Sumter, Talbot, Taylor, Terrell, Thomas, Tift, Turner, Upson, Webster, Wilcox and Worth

2936 Exceptional Transportation Services

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Exceptional Transportation Services		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2936
	Previous Policy Number(s):	MT 54	**Updated or Reviewed in MT:**	MT-60

Requirements

The Georgia Department of Community Health, Division of Medical Assistance (DCH/DMA) provides reimbursement for Exceptional Transportation Services for Medicaid members to obtain medically necessary treatment out-of-state when the member is financially unable to provide his/her own transportation.

Basic Considerations

Definition

Exceptional Transportation Services (ETS) is defined as non-emergency medical transportation necessary under extraordinary medical circumstances that require **out-of- state** travel for treatment not normally provided through in-state medical providers.

Medicaid members enrolled in a Care Management Organization (CMO) must request services covered under the ETS program through their CMO plan and not DFCS.

Meals and lodging may be reimbursed for **in-state** travel if the treatment is not available through a provider in the member's region and over 50 miles from the member's residence. **In-state** transportation is coordinated by the NEMT broker responsible for the county in which the member resides.

ETS is **not** available for travel to certain medical providers within fifty (50) miles of the state's border who are utilized for routine care by individuals living in Georgia's border counties and to medical facilities that have been designated as exceptions to the fifty-mile limit. Refer to Chart 2936.1 in this Section for a list of these facility exceptions.

DFCS Responsibilities

The DCH/DMA contracts with the Department of Human Services, Division of Family and Children Services (DHS/DFCS) to arrange, coordinate, and provide exceptional transportation services for Medicaid members.

The DFCS state office Medicaid Policy Unit is responsible for:

- determining the need for ETS;
- submitting required DMA-322 Exceptional Transportation Prior Authorization Request form to

DCH/DMA for approval;

- notifying the county DFCS office of the DCH/DMA determination, including the prior authorization number.

The DFCS Regional Accounting Office is responsible for:

- gathering the information necessary for an ETS eligibility determination;
- notifying the Medicaid member of the ETS decision;
- providing payment for approved transportation costs.

Eligibility Requirements

ETS is available to Medicaid members **only** if **all** the following conditions are met:

- the member's out-of-state medical care has been pre-certified by Georgia Health Partnership (GHP);
- the member is financially unable to pay for his/her transportation costs;
- the member has no other means of transportation, such as a household member, relative, or friend.

Covered Expenses

Expenses covered by ETS include:

- automobile mileage
- parking, tolls
- taxi service
- commercial transportation costs (airplane, bus, train)
- meals
- lodging

Approval for ETS does not automatically entitle the member to all potentially covered services. The DCH/DMA approval will specify what expenses are approved.

Transportation expenses for an **escort** may be covered for members who are:

- under age 21
- blind
- deaf
- intellectually disabled
- other situations or conditions that preclude travel without an escort

Procedures

Upon receipt of the request for ETS , follow the steps below:

Step 1 Notify the DFCS state office Medicaid Policy Unit via telephone, (404) 657-7543, that ETS services have been requested.

Step 2 Obtain the following information and provide to the DFCS state office Medicaid Policy Unit:

- pre-certification number for the out-of-state medical services (available from the member's local or out-of-state medical provider);
- out-of-state medical provider's name, address, telephone number, and contact person;
- member's name, address, telephone number, date of birth, and Medicaid number;
- member's diagnosis and procedure to be performed;
- member's explanation of his/her circumstances that justify the request for and approval of ETS.
- W-9 Form completed by the member or member's representative.

Step 3 Upon notification from the state office Medicaid Policy Unit, inform the member of the ETS decision.

Step 4 Provide ETS payment(s) to the approved commercial carrier(s) and/or ETS advance to the member according to the DCH/DMA decision.

Reimbursement

To receive reimbursement from DCH for covered ETS expenses, DFCS must complete and submit a HCFA-1500 claim form through the DCH web portal as stated below:

Step 1 Go to the GA MMIS website at www.mmis.georgia.gov/portal. Click on the Provider Information tab, and then click on Documents and Forms. Click on full list and click on CMS1500. Print as many copies as you need.

Step 2 To obtain instructions on how to submit a claim, please reference the ETS Policies and Procedures Manual (Appendix F) which can be downloaded at www.mmis.georgia.gov. For information on how to navigate the web portal, you may download a copy of the Navigational Manual for Providers.

Step 3 In order to request reimbursement through the web portal you must be registered. If the Regional Office is not registered, contact the Medicaid Policy Unit at (404) 657-7543 to obtain a copy of the Web Portal Registration form. This form needs to be completed and faxed to DXC at the number listed on the form. Any billing problems should be addressed with the counties' local DXC Provider Field Representative.

Chart 2936.1 – Participating Non-Georgia Hospitals

Alabama	
Flowers General	Dothan
George H. Lanier	Langdale

Alabama	
Lakeview Community	Eufaula
Southeast Alabama Medical Center	Dothan
Phenix Regional	Phenix City
Stringfellow Memorial	Anniston
Florida	
Baptist Medical Center	Jacksonville
Baptist Medical Center-Nassau	Fernandina Beach
Ed Fraser Memorial	Macclenny
Saint Vincent's	Jacksonville
Shands - University of Florida	Gainesville
Tallahassee Community	Tallahassee
Tallahassee Memorial Regional Medical Center	Tallahassee
University Medical Center	
North Carolina	
Angel Community	Franklin
District Memorial	Andrews
Harris Regional	Sylva
Highland Cashiers	Highland
Murphy Medical Center	Murphy
South Carolina	
Abbeville County Memorial	Abbeville
Allen Bennett Memorial	Greenville
Anderson Area Medical Center	Anderson
Greenville Memorial	Greenville
Hillcrest	Greenville
Aiken Regional	Aiken
Tennessee	
Bradley Memorial	Cleveland
Chattanooga Rehabilitation	Chattanooga
Cleveland Community	Cleveland
Copper Basin	Copper Hill
East Ridge	Chattanooga
Erlanger Medical Center	Chattanooga
Grandview Medical Center	Jasper
Memorial	Chattanooga
Parkridge Medical Center	Chattanooga
T.C. Thompson Children's	Chattanooga
Siskin	Chattanooga

2937 Ombudsman

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Ombudsman		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2937
	Previous Policy Number(s):	MT 8	**Updated or Reviewed in MT:**	MT-60

Requirements

Residents and anyone with a question or concern about long-term care facilities may contact the Georgia Long-Term Care Ombudsman Program for assistance with problems or with obtaining information.

Background

The Long-Term Care Ombudsman Program is guided by the Office of the State Long-Term Care Ombudsman. The Division of Aging Services of the Department of Human Services contracts with Area Agencies on Aging who in turn contract with 13 community programs throughout the state to provide ombudsman services. The Ombudsman Program is funded by federal, state and local dollars and governed by the federal Older Americans Act and by Georgia Law.

Basic Considerations

The Long-Term Care Ombudsman Program seeks to improve the quality of life of the residents of long-term care facilities. These facilities include nursing homes, personal care homes, often called assisted living facilities or residential care facilities. Ombudsmen also serve residents of community living arrangements.

There is no charge for services provided by the ombudsman program. Functions of the Long-Term Care Ombudsman include the following:

- Investigates and works to resolve problems or complaints affecting long-term care facility residents.
- Identifies problem areas in long-term care and related services.
- Provides information about long-term care and related services.
- Promotes resident, family and community involvement in long-term care.
- Educates the community about the needs of long-term care facility residents.
- Coordinates efforts with other agencies concerned with long-term care.
- Visits long-term care facilities routinely to talk to residents and monitor conditions.
- Educates facility staff about resident rights and other issues.

The Ombudsman handles a variety of issues including the following:

- Rights of long-term care residents
- Care provided in long-term care facilities
- Transfers and discharges from long-term care facilities, including assistance with appeals.
- Access to public benefits

The brochure “Ombudsman: Long-Term Care Residents' Advocate” is available from the Office of the State Long-Term Care Ombudsman. It is recommended that these brochures be available for customers of the ABD program.

Address
Office of the State Long-Term Care Ombudsman
Division of Aging Services
2 Peachtree Street, NW
Suite 9-231
Atlanta, GA 30303-3142

888-454-LTCO (5826)

Contact List for Georgia Long-Term Care Ombudsman Program

Office of the State Ombudsman
Becky A. Kurtz, Esq., State Ombudsman, bakurtz@dhr.state.ga.us
2 Peachtree Street, NW, Suite 9-231
Atlanta, Georgia 30303-3142
888/454-5826
FAX 404/463-8384
TTY 404/657-1929

Andrea H. Nash, Program Manager, ahnash@dhr.state.ga.us
Jeni S. Coyne, Program Manager, jscoyne@dhr.state.ga.us
Andrew Hales, Program Consultant, jahales@dhr.state.ga.us
Tracey R. Williams, Administrative Assistant, trwilliams@dhr.state.ga.us

Community Ombudsman Programs	Counties Served
ATLANTA Atlanta Legal Aid Society Atlanta Ombudsman Program 246 Sycamore Street, Suite 248 Decatur, Georgia 30030 Phone: (404) 371-3800 FAX: (404) 371-3811	Cobb ,Cherokee, Clayton, DeKalb, Douglas, Fayette, Fulton, Gwinnett, Henry, Rockdale

Community Ombudsman Programs	Counties Served
CENTRAL SAVANNAH RIVER AREA (CSRA) Georgia Legal Services Program 209 7th Street, Suite 400 Augusta, GA 30901 Phone: (706) 721-2327 FAX: (706) 721-4897	Burke, McDuffie, Columbia, Richmond, Glascock, Screven, Hancock, Taliaferro, Jefferson, Warren, Jenkins, Washington, Lincoln, Wilkes
COASTAL Georgia Legal Services Program 10 Whitaker St. P.O. Box 8667 Savannah, GA 31412 Phone: (912) 651-2180 (888) 220-8399 (for counties in service area) FAX: (912) 651-3300	Bulloch, Bryan, Camden, Chatham, Effingham, Glynn, Liberty, Long, McIntosh
GEORGIA MOUNTAINS Legacy Link, Inc. 508 Oak St., Ste. 1 P.O. Box 2534 Gainesville, GA 30503-2534 Phone: (770) 538-2685 FAX: (770)-538-2696	Banks, Stephens, Dawson, Towns, Forsyth, Union, Franklin, White, Habersham, Hall, Hart, Lumpkin, Rabun
HEART OF GEORGIA ALTAMAHA Heart of Georgia Community Action Agency 324 Pine Street P.O. Box 398 Eastman, GA 31023 Phone: (478) 374-4301 FAX: (478) 374-7648 **Baxley office:** 1329 Hatch Pkwy. N. Suite F Baxley, GA 31513 Phone: (912) 367-5244 FAX: (912) 367-5932	Bleckley, Toombs, Dodge, Treutlen, Johnson, Toombs, Laurens, Wheeler, Montgomery, Telfair **Baxley office:** Appling, Jeff Davis, Candler, Tattnall, Emanuel, Wayne, Evans

Community Ombudsman Programs	Counties Served
LOWER CHATTAHOOCHEE Direct Service Corporation 2210 Wynnton Building P.O. Box 5801 Columbus, GA 31906 Phone: (706) 323-7243 (706) 327-5208 FAX: (706) 327-1071 **Americus office:** 476 Lane Store Road Americus, GA 31709 Phone: (229) 924-8304 FAX: (229) 924-1708	**Columbus office:** Chattahoochee, Quitman, Clay, Randolph, Harris, Stewart, Marion, Talbot, Muscogee **Americus office:** Crisp, Sumter, Dooley, Taylor, Macon, Webster, Schley
MIDDLE GEORGIA Middle Georgia Community Action Agency P.O. Box 2286 Warner Robins, GA 31093-2286 Phone: (478) 922-4464 FAX: (478) 922-7320	Baldwin, Peach, Bibb, Pulaski, Crawford, Putnam, Houston, Twiggs, Jones, Wilkinson, Monroe
NORTHEAST GEORGIA Athens Community Council on Aging 135 Hoyt Street Athens, GA 30601-2646 (706) 549-4850 FAX (706) 549-7786 E-Mail: ltco@accaging.org	Barrow, Oconee, Clarke, Oglethorpe, Elbert, Walton, Greene, Jackson, Madison, Morgan
NORTHEAST GEORGIA McIntosh Trail Management Services P.O. Box 308 Meansville, GA 30256 (770) 567-5951 FAX (770) 567-5953	Jasper, Newton

Community Ombudsman Programs	Counties Served
NORTHWEST GEORGIA Georgia Legal Services Program 1100 Spring Street, NW, Suite 200-B Atlanta, GA 30309-2848 Phone: (800) 822-5391 (404) 894-7707 FAX: (404) 894-7705 **Dalton office:** P.O. Box 2004 1508 Chattanooga Rd, Suite 100 Dalton, GA 30722-2004 Phone: (888) 408-1004 (706) 272-2924 FAX: (706) 272-2259	**Atlanta office:** Bartow, Chattooga, Floyd, Haralson, Paulding, Polk **Dalton office:** Catoosa, Dade, Fannin, Gilmer, Gordon, Murray, Pickens, Walker, Whitfield
SOUTHEAST GEORGIA Ward Management Rt. 2, Box 3504 Folkston, GA 31537 Phone: (912) 496-3948 FAX: (912) 496-4079 **Valdosta office:** mailing address: P.O. Box 5683 Valdosta, GA 31603 Phone: (229) 241-1017 FAX: (229) 241-8822	**Folkston office:** Atkinson, Clinch, Bacon, Coffee, Brantley, Pierce, Charlton, Ware, **Valdosta office:** Ben Hill, Tift, Berrien, Turner, Brooks, Cook, Echols, Irwin, Lanier, Lowndes
SOUTHERN CRESCENT **(Chattahoochee-Flint area)** Georgia Legal Services Program 1100 Spring Street, NW Suite 200-B Atlanta, GA 30309-2848 Phone: (404) 894-7713 (800) 822-5391 FAX: (404) 894-7705 **(McIntosh Trail area)** McIntosh Trail Management Services P.O. Box 308 Meansville, GA 30256 Phone: (770) 567-5951 FAX: (770) 567-5953	**(Chattahoochee-Flint area)** Carroll, Coweta, Heard, Troup, Meriwether **(McIntosh Trail area)** Butts, Lamar, Pike, Spalding, Upson

Community Ombudsman Programs	Counties Served
SOUTHWEST GEORGIA (SOWEGA) SOWEGA Council on Aging 309 Pine Avenue Albany, GA 31701-2508 Phone: (229) 432-1131 (866) 463-7070 FAX: (229) 446-7899	Baker, Lee, Calhoun, Miller, Colquitt, Seminole, Decatur, Terrell, Dougherty, Thomas, Early, Worth, Grady, Mitchell

2938 Georgia Family Healthline

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Georgia Family Healthline		
	Effective Date:	May 2020		
	Chapter:	2900	**Policy Number:**	2938
	Previous Policy Number(s):	MT 40	**Updated or Reviewed in MT:**	MT-60

Requirements

The Georgia Family Healthline is a statewide toll-free telephone number that provides healthcare referrals.

History

Georgia Family Healthline is managed by Healthy Mothers, Healthy Babies Coalition of Georgia. It was established in 1984 as a means of directing pregnant women to prenatal services.

Georgia Family Healthline's mission was expanded in 1989 via a contract with the Georgia Department of Human Services to assist women and children in accessing Medicaid providers and public health programs. Georgia Family Healthline is funded by the Division of Public Health of the Georgia Department of Community Health.

Today, Georgia Family Healthline provides healthcare referrals to any Medicaid, PeachCare for Kids® and uninsured Georgians.

Basic Considerations

Georgia Family Healthline can assist both English and Spanish speaking customers in gaining accesses to the following services:

- Medicaid Doctors
- Dental Referrals
- Low-cost Prenatal Referrals
- Low-cost healthcare resources for the uninsured
- Women Infant and Children (WIC), and Children 1st.
- Referrals to HIV testing
- Referrals for Breastfeeding Questions
- Other Public Health Programs

The Georgia Family Healthline also utilizes Language Line to provide additional translation in 180+ languages.

Georgia Family Healthline maintains a database of Georgia's Medicaid and PeachCare for Kids® accepting providers. For those not eligible for Medicaid or PeachCare for Kids®, referrals are made to healthcare providers who offer low-cost or sliding scale fee services.

Procedures

To access Georgia Family Healthline, call 1-800-300-9003 from 8:00 AM to 5:00 PM, Monday through Friday.

Clients may call for themselves, or the worker may call on their behalf. Clients may search for referrals directly online 24/7 at: www.resourcehouse.com/hmhb/.

More information and resources may be obtained at the following web site: www.hmhbga.org/.

2939 Money Follows The Person

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Money Follows The Person		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2939
	Previous Policy Number(s):	MT 42	**Updated or Reviewed in MT:**	MT-60

Requirements

The Money Follows the person Initiative (MFP) is a grant awarded to shift Medicaid Long Term Care from its emphasis on institutional care to Home and Community-based services. The MFP grant opportunity was made available as part of the Federal Deficit Reduction Act of FY 2006. Georgia's grant of over $34 million in federal funds will operate from May 1, 2007 until the grant funds have been exhausted.

Basic Considerations

The Money Follows the Person Initiative (MFP) is a collaboration between the Georgia Department of Community Health (DCH) and the Department of Human Services (DHS) to transition over 1000 Georgians from institutional settings to the community through the Medicaid waiver programs: Elderly and Disabled waiver programs operating as the Community Care Services Program (CCSP) and Service Options Using Resources in Community Environment (SOURCE), NOW/COMP, and Independent Care Waiver Program (ICWP). Under the grant, the goal is for states to develop alternative long-term care opportunities which will enable the elderly and people with disabilities to fully participate in their communities.

MFP will provide necessary transitional supports for eligible members who choose to leave the nursing home and receive care at home or community-based settings. Barriers will be removed to allow for payments of deposits for utilities/rent, adaptive equipment, and for transportation needs such as dialysis treatment.

- Persons eligible for MFP include those who have resided in an institution for a minimum of six months and whose care has been covered by Medicaid in the month preceding their transition to home and community-based services.
- The MFP individual must continue to meet institutional level of care criteria after transitioning to the community.

To inquire more about Community options or designing a transition plan from an institution, the A/R, or a representative can contact the Area Agency on Aging 1-866-552-4464, Georgia Department of Community Health, Medicaid Division, Money Follows the Person project, at 404-651-9961; or email gamfp@dch.ga.gov; or visit our website at dch.georgia.gov/programs/hcbs/money-follows-person.

2940 Prescription / Medical Prior Approval (DMA)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Prescription / Medical Prior Approval (DMA)		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2940
	Previous Policy Number(s):	MT 27	**Updated or Reviewed in MT:**	MT-60

Requirements

A/Rs whose physicians have ordered more than the approved five prescriptions in a month may request approval from DMA for Medicaid to cover these extra prescriptions. Physicians or medical providers may also obtain prior approval from DMA for medical procedures, etc. DMA may approve or deny the request.

Basic Considerations

Although the process to get additional prescriptions/procedures covered by Medicaid is not an activity completed by eligibility workers, it is a question that is frequently asked of the Medicaid staff. Information on this process is contained in this section so that staff can inform A/Rs and providers on how to get additional prescriptions/procedures approved and also for emergency billing procedures.

Procedures

To request prior approval, the A/Rs physician or pharmacist is to follow the instructions provided in the DMA Provider Policy Manual, which may be found on the Georgia Medicaid Management Information System website at www.mmis.georgia.gov/portal/. An outline of the instructions follows.

Prior Approval

The physician/pharmacist requests DMA prior approval by calling (404) 298-1228 or toll free at (800) 766-4456. They can also access the web portal to do the prior approval or fax requests to (866) 483-1044 or mail to GHP, P.O. Box 7000, McRae, Georgia 31055. The written requests should be on the provider's letterhead and include the following information:

- Provider name
- Provider number
- Member name
- Member ID number
- Date of service
- Procedure code and/or diagnosis code
- Name and phone number of person to whom to return approval/disapproval notice.

Approval may be granted over the telephone or in writing. If the request is denied, the appeal process is explained at the time of the denial. The provider is responsible for the appeal process.

A prescriber may request a prescription prior approval review by simply providing the members' date of birth, name and Social Security Number (SSN) to the SXC Call Center Representative even if no active member ID exists. S/he is then assigned a member ID number which is valid for three to six months. When the member becomes active in GA Gateway, then the prescriber should again contact SXC to have the assigned member ID number merged with the new member ID number assigned when GA Gateway interfaced with MHN.

Emergency Billing

Emergency billing or prescribing is for emergency situations only. The physician or pharmacist is to follow the instructions in the DMA Provider Policy Manual. Providers having questions about emergency billing or prescribing should call DMA staff pharmacists at (404) 656-4044. A/Rs having questions about emergency procedures are to call CIC Member Inquiry at (866) 211-0950 or (770) 570-3373 in Atlanta area.

2942 Public Health

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Public Health		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2942
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-60

Requirements

The Division of Public Health promotes the well-being of Georgians of all ages by providing health care, health education, counseling, referral and environmental monitoring.

Basic Considerations

Family Health

Women and children receive nutritious foods and nutrition information through the Women, Infants, and Children program (WIC). The perinatal case management program works with low-income pregnant women to help them have healthy pregnancies and healthy babies. Family planning services are provided to men and women. Chronically ill and physically disabled children are helped through the Children's Medical Services Program. Infants, children and adults are immunized against infectious diseases. School children are screened for vision, dental health, hearing and scoliosis and visit the health department for assessment and care.

Community Health

County health departments treat persons for gonorrhea and syphilis. At public health clinics, people are screened for hypertension and women are screened for cervical and breast cancer. Migrant workers are treated or referred for treatment by the migrant health program in the Columbus, Macon, Metter and Dublin districts.

Emergency Health and Environmental Health

The division's regulatory functions include licensing and monitoring ambulance services and certifying Emergency Medical Technicians. Other regulatory activities include evaluations of personal care homes and inspections of restaurants, tourist accommodations, and other facilities.

AIDS Project

Health education, testing for HIV infection, counseling and referral services are provided throughout Georgia.

Epidemiology

The Office of Epidemiology collects data on reportable diseases and investigates disease outbreaks.

Laboratory

The state laboratory in Atlanta and three regional laboratories aid in the control of infections and chronic disease by processing patient specimens and performing exams on these specimens.

Vital Records

The unit registers records of births, deaths, spontaneous abortions, induced abortions, marriages and divorces.

Primary Health Care

Fifteen federally-funded and five state-funded centers provide primary health care. Clinics in Atlanta and Savannah, which are state-supported, provide basic health care to homeless persons.

2945 Refugee Resettlement Program

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Refugee Resettlement Program		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2945
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-60

Requirements

The Refugee Resettlement Program (RRP) provides cash and/or medical assistance to refugee adults and families in the United States who meet eligibility criteria. RRP is approved without regard to national origin. It is the purpose of RRP to provide for the effective resettlement of refugees and to assist them to achieve economic self-sufficiency as quickly as possible.

Cash and medical assistance benefits are available to refugees, asylees, Cuban/Haitian entrants, Vietnamese Amerasians and victims of human trafficking who do not qualify for TANF and/or Medicaid. Victims of human trafficking must be certified by the U.S. Department of Health and Human Services (HHS) eligible for benefits. These benefits are available during their first eight months in the country, or after having been granted status in one of the above.

Controlling Legislation

The legal basis for RRP is the Immigration and Naturalization Act (INA) and the Refugee Act of 1980, as amended.

History

The Refugee Resettlement Program (RRP) was authorized by the Refugee Act of 1980 (P.L. 96-212) to provide cash assistance, medical assistance, and social services to refugees. The Fascell-Stone Amendment to the Refugee Education Assistance Act of l980 (P.L. 96-422) extended to Cuban and Haitian entrants the same benefits and services available to refugees. The law was amended by the Refugee Assistance Amendments of 1982 (PL 97-363). In the Continuing Resolution of 1983 (PL 97-377), the Cuban/Haitian Entrant Program was combined with the RRP so that both refugees and entrants were served by the same program. The law was further amended by the Refugee Assistance Extension Act of l986 (P.L. 99-605). In 1988 the Amerasian Homecoming Act (P.L. 100-202) admitted Amerasians and their families as immigrants, making them eligible for refugee benefits. In 2000 the Trafficking Victims Protection Act (P.L. 106-386) made victims of severe forms of trafficking eligible for refugee benefits and services.

Basic Considerations

Applications for the Refugee Resettlement Program for refugees in the metropolitan Atlanta area are accepted at different sites located throughout metropolitan Atlanta, and the multi-county Refugee Resettlement Unit located at DeKalb County DFCS, 2300 Parklake Dr., N.E., Atlanta, Georgia

30345. Refugees may also apply at local DFCS offices in other areas of the state and at Refugee Resettlement Voluntary Agencies (VOLAGs).

2947 Healthcare Facility Regulation (DCH)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Healthcare Facility Regulation (DCH)		
	Effective Date:	November 2023		
	Chapter:	2900	**Policy Number:**	2947
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-71

Requirements

The Healthcare Facility Regulation Division (HFRD), a division of the Department of Community Health (DCH), is responsible for health care planning, licensing, certification and oversight of various health care facilities and services in Georgia. This is accomplished through periodic inspection and the investigation of complaints. The division was created in 2009 as a result of the passage of two laws, HB 228 (2009) and SB 433 (2008). These laws transferred functions previously performed by the Office of Regulatory Services to DCH in 2009. It works to ensure that facilities and programs operate at acceptable levels, as mandated either by the state statutes and rules and regulations adopted by the Board of Human Resources. HFRD also certifies various health care facilities to receive Medicaid and Medicare funds through contracts with the Center for Medicare and Medicaid Services of the U.S. Department of Health and Human Services.

Basic Considerations

Health Care Facilities

HFRD regulates both long-term and primary care facilities. Long-term care facilities include skilled nursing homes and intermediate care nursing homes and personal care homes. Primary care facilities and programs include general and specialized hospitals, clinical laboratories, home health agencies, rehabilitation centers, end-stage renal centers, drug abuse treatment facilities, hospices, ambulatory surgical treatment centers, x-ray machines, and several other types of facilities such as rural health clinics. Many of the regulated health care facilities are certified by HFRD for reimbursement under the Medicare and Medicaid programs.

More detailed information about specific programs, including a link to applicable rules and regulations can be found at dch.georgia.gov/divisionsoffices/hfrd. A listing of all regulated providers is also available at that site.

Complaints about regulated programs can be submitted by telephone, online or in writing. Complaints regarding health care facilities can be filed by calling 404-657-5726 or 1-800-878-6442. Written complaints for all programs can be sent to:

Healthcare Facility Regulation Division
2 Martin Luther King Jr. Drive SE
East Tower, 17th Floor
Atlanta, Georgia 30334

2950 Rehabilitation Services

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Rehabilitation Services		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2950
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-60

Requirements

The Georgia Vocational Rehabilitation Agency offers a full range of services to meet the needs of Georgians with physical, mental and emotional disabilities. Employees include physicians, nurses, counselors, evaluators, adjudicators, instructors and health service technicians who deliver services statewide.

Basic Considerations

Competitive Employment

Georgians with disabilities are returned to employment through the services offered by rehabilitation counselors located in 53 offices statewide. The services, which are free to eligible persons, include vocational, psychological and medical evaluations, guidance, vocational counseling and job placement.

State-operated rehabilitation centers in Augusta, Cave Springs, Atlanta, Rome and Milledgeville provide various combinations of services including vocational evaluations, adjustment services, psychological testing, and medical consultations, as well as sheltered employment at some locations.

Sheltered Employment

The Division operates and contracts with community-based facilities for sheltered employment programs for persons who are severely disabled and currently unable to work in the competitive labor market.

Georgia Industries for the Blind provide training and employment in manufacturing and packaging for persons who are blind or have other visual impairments. Plants located in Bainbridge, Griffin, and Atlanta employ disabled workers. In addition, persons who are blind work in the Business Enterprise Program, operating vending facilities throughout the state.

Independent Living

Field-based independent living programs, currently in Atlanta, Columbus, Albany, Savannah, Gainesville and Macon, teach persons with disabilities the skills they need to become more self-sufficient in the community. Services include technical assistance, information and referral.

Disability Adjudication

Georgians with physical disabilities file claims for Social Security disability and receive eligibility decisions from the department's Disability Adjudication Section.

Roosevelt Warm Springs Institute for Rehabilitation

The institute provides extensive residential and outpatient services for persons with physical and mental disabilities. Services include medical and vocational rehabilitation, independent living skills training, education and research.

Specialized Services

In 1988, the division opened the Georgia Sensory Rehabilitation Center in College Park offering specialized rehabilitation, job training and job placement for persons with sensory disabilities. Through a cooperative agreement with the Georgia Head Injury Foundation, Inc., the Traumatic Brain Injury Center serves Georgians from across the state. The Georgia Interpreting Services Network provides sign language interpreters.

2955 Service Options Using Resources In A Community Environment (SOURCE)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Service Options Using Resources In A Community Environment (SOURCE)		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2955
	Previous Policy Number(s):	MT 16	**Updated or Reviewed in MT:**	MT-60

Requirements

Service Options Using Resources in a Community Environment (SOURCE) is available to elderly and disabled people who meet Supplemental Security Income (SSI) Medicaid eligibility criteria. Individuals under the age of 65 are eligible if they have a significant disability.

Basic Considerations

A comprehensive assessment is made by SOURCE staff to identify the participant's needs. Each participant has a care plan designed based on the need for medical monitoring and assistance with functional tasks.

SOURCE's goal is to link primary medical care with long-term health services in an individual's home or community to avoid preventable hospital or nursing home care or to return to the community from a nursing home or hospital.

SOURCE services include:

- Home Delivered Meals
- Home Delivered Services
- Adult Day Health
- Personal Support Services/Extended Personal Support
- 24 hour Medical Access
- Alternative Living Services
- Emergency Response System

Procedures

SOURCE is only available in certain areas of the state. A participant must be a resident of one of the counties served by this program. To apply for SOURCE, the customer must call the number listed for the program serving their county:

Listed below are the SOURCE providers in Georgia:

Albany ARC
Albany: 229-883-2710
Counties: Baker, Calhoun, Clay, Colquitt, Decatur, Dougherty, Early, Grady, Lee, Miller, Mitchell, Seminole, Terrell, Thomas, Worth

Blue Ridge Source/UHS-Pruitt
Blue Ridge: 706-632-9263 or toll-free 800-632-2101
Atlanta: 770-925-1143 or toll-free 866-864-4325
Counties: Butts, Cherokee, Clayton, Cobb, Douglas, Fannin, Fayette, Gilmer, Gwinnett, Henry, Lumpkin, Murray, Paulding, Pickens, Rockdale, Towns, Union, Walker

Columbus Regional Healthcare System
Columbus: 706-571-1946
Counties: Chattahoochee, Marion, Muscogee

Diversified Resources, Inc.
Waycross: 912-285-0367
Counties: Atkinson, Ben Hill, Berrien, Brantley, Brooks, Camden, Charlton, Clinch, Coffee, Cook, Echols, Glynn, Irwin, Lanier, Lowndes, Pierce, Tift, Turner, Ware, Wilcox

Legacy Links, Inc.
Gainesville: 770-538-2650
Counties: Banks, Dawson, Franklin, Habersham, Hall, Hart, Stephens, White

Source Care Management
Butler: 478-862-5886 or toll-free 888-762-2420
Augusta: 706-737-0705
Macon: 478-741-0782
Counties: Bibb, Bleckley, Burke, Columbia Crawford, Crisp, Dodge, Dooly, Glascock, Greene, Hancock, Harris, Houston, Jefferson, Johnson, Laurens, Lincoln, Macon, Marion, McDuffie, Peach, Pulaski, Quitman, Randolph, Richmond, Schley, Stewart, Sumter, Talbot, Taliaferro, Taylor, Twiggs, Upson, Warren, Washington, Webster, Wilkes, Wilkinson

St. Joseph/Candler Health System
Savannah: 912-819-1520
Counties: Appling, Bacon, Bryan, Bulloch, Candler, Chatham, Effingham, Evans, Jeff Davis, Liberty, Long, McIntosh, Montgomery, Tattnall, Toombs, Wayne

Wesley Woods (Atlanta Source)
Atlanta: 404-728-6555
Counties: DeKalb, Fulton

For more information, please call 404-651-6889.

2960 Temporary Assistance For Needy Families (TANF)

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Temporary Assistance For Needy Families (TANF)		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2960
	Previous Policy Number(s):	MT 37	**Updated or Reviewed in MT:**	MT-60

Requirements

The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 eliminated the open-ended entitlement of Aid to Families with Dependent Children (AFDC). The PRWORA created a block grant for states to provide time-limited cash assistance for needy families, with work requirements for most recipients. The law also made far-reaching changes to childcare, the Child Support Enforcement Program and benefits for legal immigrant.

Basic Considerations

The PRWORA eliminated the AFDC program, JOBS, and Emergency Assistance (EA), and created the Temporary Assistance to Needy Families (TANF) Block Grant. The purposes of TANF are to:

- provide assistance to needy families so that children can be cared for in their homes or in the homes of relatives
- end the dependency of needy parents on government benefits by promoting job preparation, work, and marriage
- prevent and reduce the incidence of out-of-wedlock pregnancies and establish annual numerical goals for preventing and reducing the incidence of these pregnancies
- encourage the formation and maintenance of two-parent families.

Promoting the well-being of the children of Georgia is the mission of the Department of Human Services, Division of Family and Children Services. In order to fulfill its mission, the Department assists families in their efforts to acquire the necessary means to achieve economic self-sufficiency. Assistance is provided in the following manner:

- work activities that include job search, job training, and assistance with job placement,
- support services such as child-care, transportation, and other necessary expenditures that assist families in obtaining employment and remaining employed, thus eliminating the need for cash assistance,
- cash assistance that is provided either by check or electronic benefit transfer,
- support services intended to support and maintain two-parent families, and
- support services intended to prevent teen and out-of-wedlock pregnancies.

Procedures

Applications for TANF are accepted at the local DFCS office and online at www.gateway.ga.gov.

2980 Voter Registration

	Georgia Division of Family and Children Services National Voter Registration Act (NVRA) Policy Manual			
	Policy Title:	Voter Registration		
	Chapter:	3400	**Effective Date:**	February 2022
	Policy Number:	3402	**Previous Policy Number(s):**	FS Policy 3010, MA Policy 2980, TANF Policy 1008

Background

Congress enacted the National Voter Registration Act of 1993 (NVRA), which established requirements designed to afford individuals who apply for and receive public assistance an opportunity to register to vote at the point of application, recertification/renewal, change of address, and upon request by a customer who wants to register to vote. 52 U.S.C. § 20501 et seq. (Also, see the section of Georgia's law on the "Registration of Voters" found at O.C.G.A. § 21-2-222).

Requirements

Consistent with the NVRA and Georgia law, the Department of Human Services (DHS), Division of Family and Children Services (DFCS) staff and its' providers are required to distribute to Food Stamp (FS), Medicaid (MA), and Temporary Assistance for Needy Families (TANF) customers the following documents – at application, recertification/renewal, and when a change of address is reported:

1. a Voter Registration Application form; and
2. the Voter Registration Information (formerly called the Declaration Statement), which states the following:

   "If you are not registered to vote where you live now, would you like to apply to register to vote here today?
   ____ Yes
   ____ No
   ____ I do not want to answer the Voter Registration question

   Applying to register or declining to register to vote will not affect the amount of assistance that you will be provided by this agency. If you would like help in filling out the voter registration application form, we will help you. The decision whether to seek or accept help is yours. You may fill out the application form in private. If you believe that someone has interfered with your right to register or to decline to register to vote, your right to privacy in deciding whether to register or in applying to register to vote, or your right to choose your own political party or other political preference, you may file a complaint with the Secretary of State at: 2 Martin Luther King Jr. Drive, Suite 802, West Tower, Atlanta, GA 30334 or by calling 404-656-2871. IF YOU DO NOT CHECK EITHER BOX, YOU WILL BE CONSIDERED TO HAVE DECIDED NOT TO REGISTER TO VOTE AT THIS TIME.

A copy of the Georgia Voter Registration application is included with DFCS applications, renewals, and change of address forms. You can also request a Voter Registration application from your caseworker. If you complete a Voter Registration application, submit it to the Georgia Secretary of State's Office following the instructions provided on the Voter Registration application."

Procedures

The following forms were updated to incorporate the Voter Registration Information within the form itself. **Prior versions of the forms should be disposed of and replaced with the most current versions**:

- Form 297 (Application for Benefits) **(version 9/20 or later)**;
- Form 298 (Application for Senior SNAP) **(version 7/21 or later)**;
- Form 508 (Food Stamp/Medicaid/TANF Renewal Form) **(version 9/20 or later)**;
- Form 846 (Change Report Form) **(version 7/21 or later)**;
- Form 94 (Medicaid-only Application) **(version 1/22 or later)**;
- Form 94A (Medicaid Streamlined Application) **(version 1/22 or later)**; and
- Form 700 (Application for Medicaid and Medicare Savings for Qualified Beneficiaries) **(version 1/22 or later)**.

When providing customers with the forms listed above, please ensure that a "STATE OF GEORGIA APPLICATION FOR VOTER REGISTRATION" is attached.

The NVRA packet [i.e., the NVRA cover letter and Declaration Statement] should no longer be provided separately with the forms referenced above, since the Voter Registration Information is now incorporated within these forms.

Workers must read the Voter Registration Information, as it appears in Gateway, when completing an application, renewal/recertification, or change of address (for example, when completing a telephonic application). If the interaction involves a change of address, then the worker must ask the Voter Registration Information to any applicant or recipient who is of the legal voting age, and is either on the telephone or in-person, for that individual to answer on his/her own behalf.

Upon receiving a returned Voter Registration Information page **or** any version of a completed paper application, renewal, or change report form, locate the customer's response provided to the question: "If you are not registered to vote where you live now, would you like to apply to register to vote here today?" *(Note: This question is a part of the Voter Registration Information section).* Caseworkers are required to document each customer's response to the Voter Registration Information section on the appropriate screens in the Gateway worker portal.

The DFCS NVRA Coordinator at the State Office will be responsible for maintaining and transmitting a monthly report to the Georgia Secretary of State's Office, which will provide customer responses to the Voter Registration Information captured in Gateway. The monthly report will be maintained by the DFCS NVRA Coordinator for at least 24-months.

VOTER REGISTRATION APPLICATIONS: County DFCS staff must advise customers who want to

submit a Voter Registration Application to complete and transmit the application to the Georgia Secretary of State's Office using the instructions provided on the Voter Registration Application.

At any time, upon request, county DFCS staff must provide customers a Voter Registration Application and assist customers with completing and mailing the Voter Registration Application. If customers ask that DFCS staff mail the Voter Registration Application for them (or if we otherwise receive a Voter Registration Application via fax, mail, or drop box), staff must mail the customer's Voter Registration Application to the Georgia Secretary of State's Office, upon receipt, using the instructions found on the Voter Registration Application.

DFCS STAFF SHALL NOT:

- seek to influence or discourage a customer's political preference or party registration
- display any such political preference or party allegiance
- make any statement to an applicant or take any action to discourage the customer from registering to vote
- make any statement to a customer or take any action that the customer's decision to register or not to register has any bearing on the customer's application for or receipt of public assistance benefits
- hold completed voter registration applications

Upon receipt, staff must mail completed Voter Registration Applications using the self-addressed stamped envelope provided with the Voter Registration Application.

Additional Voter Registration Information for Customers

Register Online: To apply to register to vote where you live now, visit sos.ga.gov.

Print an application: You may print an application by visiting sos.ga.gov.

If you want a Georgia Voter Registration application mailed to you, you may call the Georgia Secretary of State's office at 404-656-2871, call DFCS' Customer Contact Center at 877- 423-4746, or visit sos.ga.gov.

Voter Registration Application

Each office should keep a two-week supply of Voter Registration Applications. The Voter Registration Applications can be downloaded from the Secretary of State by visiting sos.ga.gov.

DFCS staff shall not alter Voter Registration Applications in any way. Voter Registration Applications must be provided to DFCS customers in the same format as provided by the Georgia Secretary of State's Office.

Confidential Information and Records

Information and records that are considered confidential for Voter Registration purposes:

- Identifying information and records about a public assistance applicant or recipient, including

but not limited to: the individual's name, date of birth, address, telephone number, Social Security Number, driver's license or state identification, driver's license number and customer case files.

- A customer's response to the Voter Registration Information section, which is a document included within the customer's case file.

All confidentiality laws, rules, and policies that involve public assistance applicant and recipient information and records also apply to Voter Registration information and records that are maintained by DHS/DFCS.

Getting Help

Please contact the Georgia Secretary of State Office for assistance:

Secretary of State Elections Division
2 Martin Luther King Jr. Drive
Suite 802 West Tower
Atlanta, Georgia 30334
Email: gaelections@sos.ga.gov

Inquiries regarding the status of a Voter Registration Application should be directed to the Georgia Secretary of State Office. Additional voter registration information can be obtained by visiting the Secretary of State Elections Division at: www.sos.ga.gov.

2985 Women, Infant and Children (WIC) Services

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Women, Infant and Children (WIC) Services		
	Effective Date:	June 2020		
	Chapter:	2900	**Policy Number:**	2985
	Previous Policy Number(s):	MT 1	**Updated or Reviewed in MT:**	MT-60

Requirements

The Women, Infants, and Children (WIC) Special Supplemental Nutrition Program is a short-term intervention program designed to influence nutrition and health behaviors in a targeted, high-risk population.

Applicants/recipients for Medicaid are referred to the Department of Public Health or other WIC agency for possible participation in the WIC program if they fall into one of the following categories:

- pregnant women
- infants
- women who are breast-feeding through the first 12 months after the birth of the child
- children under age 5
- postpartum women (eligible for six months following the termination of pregnancy).

Procedures

Follow the procedures below to refer A/Rs to WIC services. Verbally inform the A/R of the WIC services available and the location of the Department of Public Health.

Include this information in the explanation of services.

What WIC Provides

- Special checks to buy healthy foods from WIC-authorized vendors-milk, eggs, break, cereal, juice, peanut butter, and much more;
- Information about nutrition and health to help families eat well and be healthy;
- Support and information about breast-feeding;
- Help in finding health care and other community services.

Document the case record to indicate that the A/R was notified and referred for WIC services.

Appendix A1 ABD Financial Limits

Appendix A1 ABD Financial Limits 2024

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Financial Limits		
	Effective Date:	July 2024		
	Chapter:	Appendix A1	**Policy Number:**	Appendix A1
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-72

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual with a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/QI-1	$9,430	$14,130	N/A	1-24
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$154,140 + 2000 = $156,140	1-24

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$943	$1415	1-24
(SSI Limit)	B	$629	$943	
	C	$943	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2829	$5658	1-24
QDWI	A	$5,105	$6,899	3-24
	C	$5,105	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$5,105	N/A	
QMB	A	$1,255	$1,704	4-24
SLMB	A	$1,506	$2,044	4-24
QI-1	A	$1,695	$2,300	3-24

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$10,025.00	4-24

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$334.33	$491.66	$471.66	1-24
FBR	$334.33	$491.66	$471.66	1-24
QMB	N/A	N/A	$574.66	4-24
SLMB	N/A	N/A	$688.00	4-24
QI-1	N/A	N/A	$773.00	3-24

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1550	1-24
Blind individuals	$2590	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1971	$2915	$963	$1435	1-24
B	$1342.34	$1971.68	$648.67	$963.34	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$6,659.73 (31 days)	04-24
ICF/ID	$32,736.00 (31 days)	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate:	$104.90 (effective 1-14) $121.80 (effective 1-16) $134.00 (effective 2017 and 2018) $135.50 (effective 2019) $144.60 (effective 2020) $148.50 (effective 2021) $170.10 (effective 2022) $164.90* (or higher depending on income) (effective 2023) $174.70* (or higher depending on income) (effective 2024)
Effective 01/2016 Medicare Part B Premium rates may vary. Check BENDEX for applicable rate. *Most SSA recipients will pay less that this amount.	

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$70	Effective 7-19
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$70	Effective 7-19

a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in EDWP/CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3,853.50	4-24
Dependent Family Member Need Standard	$2,555	4-24

CHART A1.11-TANF Standard of Need (SON)

HOUSEHOLD SIZE	SON	HOUSEHOLD SIZE	SON	EFF. DATE
1	$235.00	7	$672.00	2022
2	$356.00	8	$713.00	
3	$424.00	9	$751.00	
4	$500.00	10	$804.00	
5	$573.00	11	$860.00	
6	$621.00	12	$884.00	

CHART A1.12 - FEDERAL POVERTY LIMITS

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$15,060.00	$20,331.00	$22,590.00	2024
2	$20,440.00	$27,594.00	$30,660.00	
3	$25,820.00	$34,857.00	$38,730.00	
4	$31,200.00	$42,120.00	$46,800.00	
5	$36,580.00	$49,383.00	$54,870.00	

The FPL (100% level) is increased by $5,380 for each additional person in the household.

CHART A1.13 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1		Group 2	Eff. Date
Resource Limit	None		Individual - $17,200 Couple - $34,360	2024
Income Limit	Full Medicaid		Less than 150% of FPL	
Monthly Premium	$0		Sliding Scale	
Deductible Per Year	$0		$0	
Coinsurance up to $7400 **Out of Pocket**	$1.55 - $4.60 Copay		15% Coinsurance	
Catastrophic 5% or Copay	$0		$4.50 - $11.20 Copay	

CHART A1.14 - Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 – 26.43
2018 – 24.53
2019 - 25.68
2020 – 25.34
2021 - 29.80
2022 - 32.38
2023 - 37.30
2024 - 44.23

A1.15 – Medically Needy Mileage Reimbursement Rate

48.5 cents per mile – 09/10/05 – 12/31/05
44.5 cents per mile – 01/01/06 – 01/31/07
48.5 cents per mile – 02/01/07 – 03/31/08
50.5 cents per mile – 04/01/08 – 07/31/08
58.5 cents per mile – 08/01/08 – 12/31/08
55.0 cents per mile – 01/01/09 – 12/31/09
50.0 cents per mile – 01/01/10 – 12/31/10
51.0 cents per mile – 01/01/11 – 04/16/12
55.5 cents per mile – 04/17/12 – 12/31/12
56.5 cents per mile – 01/01/13 – 12/31/13

56.0 cents per mile - 01/01/14 – 12/31/14
57.5 cents per mile – 01/01/15 – 12/31/15
54.0 cents per mile – 01/01/16 – 12/31/16
53.5 cents per mile – 01/01/17 - 12/31/17
54.5 cents per mile – 01/01/18 – 12/31/18
58.0 cents per mile – 01/01/19 - 12/31/19
57.5 cents per mile - 01/01/20 - 12/31/20
56.0 cents per mile - 01/01/21 - 12/31/21
58.5 cents per mile - 01/01/22 - 06/30/22
62.5 cents per mile - 07/01/22- 12/31/22
65.5 cents per mile - 01/01/23 - 12/31/23
67.0 cents per mile - 01/01/24 - present

Appendix A1 ABD Financial Limits 2023

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	ABD Financial Limits		
	Effective Date:	November 2023		
	Chapter:	Appendix A1	**Policy Number:**	Appendix A1
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-71

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual with a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/QI-1	$9090	$13,630	N/A	1-23
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$148,620 + 2000 = $150,620.00	1-23

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$914	$1371	1-23
(SSI Limit)	B	$609.34	$914	
	C	$914	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2742	$5484	1-23
QDWI	A	$4945	$6659	3-23
	C	$4379	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4379	N/A	
QMB	A	$1215	$1644	4-23
SLMB	A	$1458	$1972	4-23
QI-1	A	$1641	$2219	3-23

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$9,584.00	4-23

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$324.66	$477.00	$477.00	1-23
FBR	$324.66	$477.00	$477.00	1-23
QMB	N/A	N/A	$554.66	4-23
SLMB	N/A	N/A	$664.00	4-23
QI-1	N/A	N/A	$746.00	3-23

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1470	1-23
Blind individuals	$2460	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1913	$2827	$934	$1391	1-23
B	$1303.68	$1913	$629.34	$934	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$6,658.49 (31 days)	04-23
ICF/ID	$24,269.59 (31 days)	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate:	$104.90 (effective 1-14) $121.80 (effective 1-16) $134.00 (effective 2017 and 2018) $135.50 (effective 2019) $144.60 (effective 2020) $148.50 (effective 2021) $170.10 (effective 2022) $164.90 or higher depending on income(effective 2023) (See NOTE below)
Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate. Most SSA recipients will pay less that this amount (164.90 on average).	

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$70	Effective 7-19
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$70	Effective 7-19

a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in EDWP/CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3715.50	1-23
Dependent Family Member Need Standard	$2465	4-23

CHART A1.11-TANF Standard of Need (SON)

HOUSEHOLD SIZE	SON	HOUSEHOLD SIZE	SON	EFF. DATE
1	$235.00	7	$672.00	2022
2	$356.00	8	$713.00	
3	$424.00	9	$751.00	
4	$500.00	10	$804.00	
5	$573.00	11	$860.00	
6	$621.00	12	$884.00	

CHART A1.12 - FEDERAL POVERTY LIMITS

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$14,580.00	$19,683.00	$21,870.00	2023
2	$19,720.00	$26,622.00	$29,580.00	
3	$24,860.00	$33,561.00	$37,290.00	
4	$30,000.00	$40,500.00	$45,000.00	
5	$35,140.00	$47,439.00	$52,710.00	

The FPL (100% level) is increased by $5,140 for each additional person in the household.

CHART A1.13 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non-Q Track Individual - $10,590 Non-Q Track Couple - $16,630	Individual - $16,660 Couple - $33,240	2023
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	$0.00	104.00	
Coinsurance up to $7400 **Out of Pocket**	$1.45 - $4.30 Copay	$4.15 - $10.35 Copay	15% Coinsurance	
Catastrophic 5% or Copay	$0	$0	$4.15 - $10.35 Copay	

CHART A1.14 - Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 – 26.43
2018 – 24.53
2019 - 25.68
2020 – 25.34
2021 - 29.80
2022 - 32.38
2023 - 37.30

A1.15 – Medically Needy Mileage Reimbursement Rate

48.5 cents per mile – 09/10/05 – 12/31/05
44.5 cents per mile – 01/01/06 – 01/31/07
48.5 cents per mile – 02/01/07 – 03/31/08
50.5 cents per mile – 04/01/08 – 07/31/08
58.5 cents per mile – 08/01/08 – 12/31/08
55.0 cents per mile – 01/01/09 – 12/31/09

50.0 cents per mile – 01/01/10 – 12/31/10
51.0 cents per mile – 01/01/11 – 04/16/12
55.5 cents per mile – 04/17/12 – 12/31/12
56.5 cents per mile – 01/01/13 – 12/31/13
56.0 cents per mile - 01/01/14 – 12/31/14
57.5 cents per mile – 01/01/15 – 12/31/15
54.0 cents per mile – 01/01/16 – 12/31/16
53.5 cents per mile – 01/01/17 - 12/31/17
54.5 cents per mile – 01/01/18 – 12/31/18
58.0 cents per mile – 01/01/19 - 12/31/19
57.5 cents per mile - 01/01/20 - 12/31/20
56.0 cents per mile - 01/01/21 - 12/31/21
58.5 cents per mile - 01/01/22 - 06/30/22
62.5 cents per mile - 07/01/22- 12/31/22
65.5 cents per mile - 01/01/23 - present

Appendix A1 ABD Financial Limits 2022

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$8400	$12,600	N/A	1-22
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$135,400+ 2000 = $137,400.00	1-22

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR **(SSI Limit)**	A	$841	$1261	1-22
	B	$560.67	$840.67	
	C	$841	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2523	$5046	1-22
QDWI	A	$4615	$6189	3-22
	C	$4379	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4379	N/A	
QMB	A	$1133	$1526	4-22
SLMB	A	$1359	$1831	4-22
QI-1	A	$1529	$2060	3-22

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$9034.00	4-22

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$300.33	$440.33	$420.33	1-22
FBR	$300.33	$440.33	$420.33	1-22
QMB	N/A	N/A	$490.66	4-22

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
SLMB	N/A	N/A	$587.33	4-22
QI-1	N/A	N/A	$660.00	3-22

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1350	1-22
Blind individuals	$2260	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1767	$2607	$861	$1281	1-22
B	$1206.34	$1766.34	$580.67	$860.67	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$6279.36 (31 days)	04/22
ICF/ID	$14,381.21 (31 days)	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14)
$121.80 (effective 1-16)
$134.00 (effective 2017 and 2018)
$135.50 (effective 2019)
$144.60 (effective 2020)
$148.50 (effective 2021)
$170.10 (effective 2022)
Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate.

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$70	Effective 7-19
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$70	Effective 7-19

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3435	1-22
Dependent Family Member Need Standard	$2289	4-22

TANF Standard of Need (SON)

HOUSEHOLD SIZE	SON	HOUSEHOLD SIZE	SON	EFF. DATE
1	$235.00	7	$672.00	2022
2	$356.00	8	$713.00	
3	$424.00	9	$751.00	
4	$500.00	10	$804.00	
5	$573.00	11	$860.00	
6	$621.00	12	$884.00	

CHART A1.11- FEDERAL POVERTY LIMITS

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$13,590.00	$18,347.00	$20,385.00	2022
2	$18,310.00	$24,719.00	$27,465.00	
3	$23,030.00	$31,091.00	$34,545.00	
4	$27,750.00	$37,463.00	$41,625.00	
5	$32,470.00	$43,835.00	$48,705.00	

The FPL (100% level) is increased by $4,720 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date

Resource Limit	None	Non-Q Track Individual - $9,900 Non-Q Track Couple - $15,600	Individual - $15,510 Couple - $30,950	2022
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $99.00	Up to $99.00	
Coinsurance **up to $7050 Out of Pocket**	$1.35 - $4.00Copay	$3.95 - $9.85 Copay	15% Coinsurance	
Catastrophic **5% or Copay**	$0	$0	$3.95 - $9.85 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 – 26.43
2018 – 24.53
2019 - 25.68
2020 – 25.34
2021 - 29.80
2022- 32.38

A1.13 – Medically Needy Mileage Re-Imbursement Rate

48.5 cents per mile – 09/10/05 – 12/31/05
44.5 cents per mile – 01/01/06 – 01/31/07
48.5 cents per mile – 02/01/07 – 03/31/08
50.5 cents per mile – 04/01/08 – 07/31/08
58.5 cents per mile – 08/01/08 – 12/31/08
55.0 cents per mile – 01/01/09 – 12/31/09

48.5 cents per mile – 09/10/05 – 12/31/05		
50.0 cents per mile – 01/01/10 – 12/31/10		
51.0 cents per mile – 01/01/11 – 04/16/12		
55.5 cents per mile – 04/17/12 – 12/31/12		
56.5 cents per mile – 01/01/13 – 12/31/13		
56.0 cents per mile - 01/01/14 – 12/31/14		
57.5 cents per mile – 01/01/15 – 12/31/15		
54.0 cents per mile – 01/01/16 – 12/31/16		
53.5 cents per mile – 01/01/17 - 12/31/17		
54.5 cents per mile – 01/01/18 – 12/31/18		
58.0 cents per mile – 01/01/19 - 12/31/19		
57.5 cents per mile - 01/01/20 - 12/31/20		
56.0 cents per mile - 01/01/21 - 12/31/21		
58.5 cents per mile-	01/01/22 - 06/30/22	
62.5 cents per mile-	07/01/22- present	

Appendix A1 ABD Financial Limits 2021

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7970	$11,960	N/A	1-21
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$130,380+ 2000 = $132,380.00	1-21

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$794	$1191	1-21
(SSI Limit)	B	$529.34	$794	
	C	$794	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2382	$4764	1-21
QDWI	A	$4379	$5893	3-21
	C	$4379	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4379	N/A	
QMB	A	$1074	$1452	4-21
SLMB	A	$1288	$1742	4-21
QI-1	A	$1449	$1960	3-21

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$8821.00	4-21

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$284.66	$417.00	$397.00	1-21
FBR	$284.66	$417.00	$397.00	1-21
QMB	N/A	N/A	$490.66	4-21

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
SLMB	N/A	N/A	$587.33	4-21
QI-1	N/A	N/A	$660.00	3-21

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1310	1-21
Blind individuals	$2190	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1673	$2467	$814	$1211	1-21
B	$1143.68	$1673	$549.34	$814	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$6344.46 (31 days)	04/21
ICF/MR	$14,846.21 (31 days)	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14)
$121.80 (effective 1-16)
$134.00 (effective 2017 and 2018)
$135.50 (effective 2019)
$144.60 (effective 2020)
$148.50 (effective 2021)
Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate.

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$70	Effective 7-19
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$70	Effective 7-19

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3259.50	1-21
Dependent Family Member Need Standard	$2178.00	4-21

CHART A1.11- FEDERAL POVERTY LIMITS

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$12,880.00	$17,388.00	$19,320.00	2021
2	17,420.00	23,517.00	26,130.00	
3	21,960.00	29,646.00	32,940.00	
4	26,500.00	35,775.00	39,750.00	
5	31,040.00	41,904.00	46,560.00	

The FPL (100% level) is increased by $4,540 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date

Resource Limit	None	Non-Q Track Individual - $9,470 Non-Q Track Couple - $14,960	Individual - $14,790 Couple - $29,520	2021
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $92.00	Up to $92.00	
Coinsurance **up to $3600 Out of Pocket**	$1.30 - $4.00Copay	$3.70 - $9.20Copay	15% Coinsurance	
Catastrophic **5% or $2/$5 Copay**	$0	$0	$3.70 - $9.20Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 – 26.43
2018 – 24.53
2019 - 25.68
2020 – 25.34
2021 - 29.80

A1.13 – Medically Needy Mileage Re-Imbursement Rate

48.5 cents per mile – 09/10/05 – 12/31/05
44.5 cents per mile – 01/01/06 – 01/31/07
48.5 cents per mile – 02/01/07 – 03/31/08
50.5 cents per mile – 04/01/08 – 07/31/08
58.5 cents per mile – 08/01/08 – 12/31/08
55.0 cents per mile – 01/01/09 – 12/31/09
50.0 cents per mile – 01/01/10 – 12/31/10
51.0 cents per mile – 01/01/11 – 04/16/12
55.5 cents per mile – 04/17/12 – 12/31/12
56.5 cents per mile – 01/01/13 – 12/31/13

56.0 cents per mile - 01/01/14 – 12/31/14
57.5 cents per mile – 01/01/15 – 12/31/15
54.0 cents per mile – 01/01/16 – 12/31/16
53.5 cents per mile – 01/01/17 - 12/31/17
54.5 cents per mile – 01/01/18 – 12/31/18
58.0 cents per mile – 01/01/19 - 12/31/19
57.5 cents per mile - 01/01/20 - 12/31/20
56.0 cents per mile - 01/01/21 - present

Appendix A1 ABD Financial Limits 2020

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7860	$11,800	N/A	1-20
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$128,640 + 2000 = $130,640.00	1-20

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR **(SSI Limit)**	A	$783	$1175	1-20
	B	$522	$783.34	
	C	$783	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2349	$4698	1-20
QDWI	A	$4339	$5833	3-20
	C	$4339	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4339	N/A	
QMB	A	$1064	$1437	4-20
SLMB	A	$1276	$1724	4-20
QI-1	A	$1436	$1940	3-20

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$8517.00	4-20

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$281.00	$411.66	$391.66	1-20
FBR	$281.00	$411.66	$391.66	1-20
QMB	N/A	N/A	$485.66	4-20

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
SLMB	N/A	N/A	$581.33	4-20
QI-1	N/A	N/A	$653.33	3-20

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1260	1-20
Blind individuals	$2110	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1651	$2435	$803	$1195	1-20
B	$1129	$1651.68	$542	$803.34	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$6,111.96 (31 days)	04/20
ICF/MR	$14,846.21 (31 days)	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14)
$121.80 (effective 1-16)
$134.00 (effective 2017 and 2018)
$135.50 (effective 2019)
$144.60 (effective 2020)
Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate.

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$70	Effective 7-19
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$70	Effective 7-19
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:
an individual in CCSP	the current amount of the Individual FBR for LA-A
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard
an individual in NOW/COMP	the current Medicaid Cap

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3216.00	1-20
Dependent Family Member Need Standard	$2155.00	4-20

CHART A1.11- FEDERAL PROVERTY LIMITS

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$12,760.00	$17,226.00	$19,140.00	2020
2	17,240.00	23,274.00	25,860.00	
3	21,720.00	29,322.00	32,580.00	
4	26,200.00	35,370.00	39,300.00	
5	30,680.00	41,418.00	46,020.00	

The FPL (100% level) is increased by $4,480 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date

Resource Limit	None	Non-Q Track Individual - $9,360 Non-Q Track Couple - $14,800	Individual - $14,610 Couple - $29,160	2020
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $89.00	Up to $89.00	
Coinsurance up to $3600 Out of Pocket	$1.30 - $3.90 Copay	$3.60 - $8.95 Copay	15% Coinsurance	
Catastrophic **5% or $2/$5 Copay**	$0	$0	$3.60 - $8.95 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 – 26.43
2018 – 24.53
2019 - 25.68
2020 – 25.34

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 09/10/05 – 12/31/05
44.5 cents per mile – 01/01/06 – 01/31/07
48.5 cents per mile – 02/01/07 – 03/31/08
50.5 cents per mile – 04/01/08 – 07/31/08
58.5 cents per mile – 08/01/08 – 12/31/08
55.0 cents per mile – 01/01/09 – 12/31/09
50.0 cents per mile – 01/01/10 – 12/31/10
51.0 cents per mile – 01/01/11 – 04/16/12
55.5 cents per mile – 04/17/12 – 12/31/12

56.5 cents per mile – 01/01/13 – 12/31/13
56.0 cents per mile - 01/01/14 – 12/31/14
57.5 cents per mile – 01/01/15 – 12/31/15
54.0 cents per mile – 01/01/16 – 12/31/16
53.5 cents per mile – 01/01/17 - 12/31/17
54.5 cents per mile – 01/01/18 – 12/31/18
58.0 cents per mile – 01/01/19 - 12/31/19
57.5 cents per mile - 01/01/20 - present

Appendix A1 ABD Financial Limits 2019

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7730	$11,600	N/A	1-19
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$126,420 + 2000 = $128,420.00	1-19

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR **(SSI Limit)**	A	$771	$1157	1-19
	B	$514	$771.34	
	C	$771	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2313	$4626	1-19
QDWI	A	$4249	$5723	3-19
	C	$4249	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4249	N/A	
QMB	A	$1041	$1410	4-19
SLMB	A	$1249	$1691	4-19
QI-1	A	$1406	$1903	3-19

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$6768.00	4-19

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$277.00	$405.66	$385.66	1-19
FBR	$277.00	$405.66	$385.66	1-19
QMB	N/A	N/A	$476.66	4-19

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance			Effective Date
SLMB	N/A	N/A				4-19
				$570.33		
QI-1	N/A	N/A	$641.00			3-19

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1220	1-19
Blind individuals	$2040	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	**Couple**	**Individual**	**Couple**	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$5,942.39 (31 days)	04/19
ICF/MR	$14,809.94 (31 days)	
Hospital	$5,462.45	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14)
$121.80 (effective 1-16)
$134.00 (effective 2017 and 2018)
$135.50 (effective 2019)
Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate.

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$70	Effective 7-19
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$65	Effective 7-18

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3160.50	1-19
Dependent Family Member Need Standard	$2114.00	4-19

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$12,490.00	$16,861.50	$18,735.00	2019
2	16,910.00	22,828.50	25,365.00	
3	21,330.00	28,795.50	31,995.00	
4	25,750.00	34,762.50	38,625.00	
5	30170.00	40,729.50	45,255.00	

The FPL (100% level) is increased by $4,420 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date

Resource Limit	None	Non Q Track Individual - $9,230 Non Q Track Couple - $14,600	Individual - $14,390 Couple - $28,720	2019
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $85.00	Up to $85.00	
Coinsurance **up to $3600 Out of Pocket**	$1.25 - $3.80 Copay	$3.40 - $8.50 Copay	15% Coinsurance	
Catastrophic **5% or $2/$5 Copay**	$0	$0	$3.40 - $8.50 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 – 26.43
2018 – 24.53
2019- 25.68

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 09/10/05 – 12/31/05
44.5 cents per mile – 01/01/06 – 01/31/07
48.5 cents per mile – 02/01/07 – 03/31/08
50.5 cents per mile – 04/01/08 – 07/31/08
58.5 cents per mile – 08/01/08 – 12/31/08
55.0 cents per mile – 01/01/09 – 12/31/09
50.0 cents per mile – 01/01/10 – 12/31/10
51.0 cents per mile – 01/01/11 – 04/16/12
55.5 cents per mile – 04/17/12 – 12/31/12
56.5 cents per mile – 01/01/13 – 12/31/13
56.0 cents per mile - 01/01/14 – 12/31/14
57.5 cents per mile – 01/01/15 – 12/31/15

54.0 cents per mile – 01/01/16 – 12/31/2016
53.5 cents per mile – 01/01/17 - 12/31/2017
54.5 cents per mile – 01/01/2018 – 12/31/2018
58.0 cents per mile – 01/01/2019 - present

Appendix A1 ABD Financial Limits 2018

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7560	$11,340	N/A	1-18
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$123,600 + 2000 = $125,600.00	1-18

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$750	$1125	1-18
	B	$500	$750	
	C	$750	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2250	$4500*	1-18* corrected in 12/2018
QDWI	A	$4133	$5573	3-18
	C	$4133	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4133	N/A	
QMB	A	$1012	$1372	4-18
SLMB	A	$1214	$1646	4-18
QI-1	A	$1366	$1852	3-18

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$6707.00	4-18

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$270.00	$395.00	$375.00	1-18
FBR	$270.00	$395.00	$375.00	1-18
QMB	N/A	N/A	$477.00	4-18
SLMB	N/A	N/A	$568.66	4-18

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$637.24	3-18

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CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1180	1-18
Blind individuals	$1970	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$5,629.91 (31 days)	04/18
ICF/MR	$20,614.30 (31 days)	
Hospital	$5,680.95	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14)
$121.80 (effective 1-16)
$134.00 (effective 2017 and 2018)
Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate.

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$65	Effective 7-18
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$65	Effective 7-18

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3090.00	1-18
Dependent Family Member Need Standard	$2058.00	4-18

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$12,140.00	$16,389.00	$18,210.00	2018
2	16,460.00	22,221.00	24,690.00	
3	20,780.00	28,053.00	31,170.00	
4	25,100.00	33,885.00	37,650.00	
5	29,420.00	39,717.00	44,130.00	

The FPL (100% level) is increased by $4,320 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date

Resource Limit	None	Non Q Track Individual - $9,060 Non Q Track Couple - $14,340	Individual - $14,100 Couple - $28,150	2018
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $83.00	Up to $83.00	
Coinsurance **up to $3600 Out of Pocket**	$1.25 - $3.70 Copay	$3.35 - $8.35 Copay	15% Coinsurance	
Catastrophic **5% or $2/$5 Copay**	$0	$0	$3.35 - $8.35 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 – 26.43
2018 – 24.53

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 09/10/05 – 12/31/05
44.5 cents per mile – 01/01/06 – 01/31/07
48.5 cents per mile – 02/01/07 – 03/31/08
50.5 cents per mile – 04/01/08 – 07/31/08
58.5 cents per mile – 08/01/08 – 12/31/08
55.0 cents per mile – 01/01/09 – 12/31/09
50.0 cents per mile – 01/01/10 – 12/31/10
51.0 cents per mile – 01/01/11 – 04/16/12
55.5 cents per mile – 04/17/12 – 12/31/12
56.5 cents per mile – 01/01/13 – 12/31/13
56.0 cents per mile - 01/01/14 – 12/31/14

57.5 cents per mile – 01/01/15 – 12/31/15
54.0 cents per mile – 01/01/16 – 12/31/2016
53.5 cents per mile – 01/01/17 - 12/31/2017
54.5 cents per mile – 01/01/2018 - present

Appendix A1 ABD Financial Limits 2017

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7390	$11,090	N/A	1-17
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$120,900 + 2000 = $122,900.00	1-17

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$735	$1103	1-17
(SSI Limit)	B	$490.00	$735.33	
	C	$735	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2205	$4410	1-17
QDWI	A	$4105	$5499	3-17
	C	$4105	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4105	N/A	
QMB	A	$1005	$1354	4-17
SLMB	A	$1206	$1624	4-17
QI-1	A	$1357	$1827	3-17

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$6360.00	4-17

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGI-BLE CHILD

Income Limit	PMV for an Individ-ual	PMV for a Couple	Living Allowance	Effective Date
AMN	$265.00	$387.67	$367.67	1-17
FBR	$265.00	$387.67	$367.67	1-17
QMB	N/A	N/A	$458.00	4-17
SLMB	N/A	N/A	$548.00	4-17

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$615.67	3-17

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CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1170	1-17
Blind individuals	$1950	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$5,404.54	04/17
ICF/MR	$14,669.20	
Hospital	$5,680.95	4/17

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14) 121.80 (effective 1-16) 134.00 (effective 2017) Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate.

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:
an individual in NOW/COMP	the current Medicaid Cap

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$3022.50	1-17
Dependent Family Member Need Standard	$2030.00	4-17

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$12,060.00	$16,281.00	$18,090.00	2017
2	16,240.00	21,924.00	24,360.00	
3	20,420.00	27,567.00	30,630.00	
4	24,600.00	33,210.00	36,900.00	
5	28,780.00	38,853.00	43,170.00	

The FPL (100% level) is increased by $4140 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,890 Non Q Track Couple - $14,090	Individual - $13,820 Couple - $27,600	2017
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $82.00	Up to $82.00	
Coinsurance up to $3600 Out of Pocket	$1.20 - $3.70 Copay	$3.30 - $8.25 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$3.30-$8.25 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78
2017 - 26.43

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08
55 cents per mile – 1/1/09 – 12/31/09
50 cents per mile – 1/1/10 – 12/31/2010
51 cents per mile – 01/01/11 – 04/16/2012
55.5 cents per mile – 04/17/2012 – 12/31/2012
56.5 cents per mile – 01/01/2013 – 12/31/2013
56 cents per mile — 01/01/2014 – 12/31/2014
57.5 cents per mile – 01/01/2015 – 12/31/15
54.0 cents per mile – 01/01/2016 – 12/31/16
53.5 cents per mile- 01/01/2017- Present

Appendix A1 ABD Financial Limits 2016

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7280	$10,930	N/A	1-15
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$119,220 + 2000 = $121,220.00	1-15

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$733	$1100	1-15
(SSI Limit)	B	$488.67	$733.33	
	C	$733	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2199	$4398	1-15
QDWI	A	$4045	$5425	3-16
	C	$4045	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$4045	N/A	
QMB	A	$990	$1335	4-16
SLMB	A	$1188	$1602	4-16
QI-1	A	$1337	$1803	3-16

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$6175.00	4-16

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$264.33	$386.67	$366.67	1-15
FBR	$264.33	$386.67	$366.67	1-15
QMB	N/A	N/A	$437.00	4-14
SLMB	N/A	N/A	$525.00	4-14

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$590.00	3-14

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CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1090	1-15
Blind individuals	$1820	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$5281.78	04/16
ICF/MR	$14738.64	
Hospital	$163,873.50	4/16

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14) or (121.80 effective 1-16)
Effective 01/2016 Medicare Part B Premium rates may vary check BENDEX for applicable rate.

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:
an individual in NOW/COMP	the current Medicaid Cap

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2980.00	1-15
Dependent Family Member Need Standard	$2032.50	4-16

HOUSEHOLD SIZE	100%	135%		150%		EFF. DATE
1	$11,880.00	$16,038.00		$17,820.00		2016
2	16,020.00	21,627.00		24,030.00		
3	20,160.00	27,216.00		30,240.00		
4	24,300.00	32,805.00		36,450.00		
5	28,440.00	38,394.00		42,660.00		

The FPL (100% level) is increased by $4,060 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,780 Non Q Track Couple - $13,930	Individual - $13,640 Couple - $27,250	2016
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $74.00	Up to $74.00	
Coinsurance **up to $3600 Out of Pocket**	$1.20 - $3.60 Copay	$2.95 - $7.40 Copay	15% Coinsurance	
Catastrophic **5% or $2/$5 Copay**	$0	$0	$2.95 - $7.40 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47
2016 – 25.78

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08
55 cents per mile – 1/1/09 – 12/31/09
50 cents per mile – 1/1/10 – 12/31/2010
51 cents per mile – 01/01/11 – 04/16/2012
55.5 cents per mile – 04/17/2012 – 12/31/2012
56.5 cents per mile – 01/01/2013 – 12/31/2013
56 cents per mile — 01/01/2014 – 12/31/2014
57.5 cents per mile – 01/01/2015 – 12/31/15

54.0 cents per mile – 01/01/2016 - Present

Appendix A1 ABD Financial Limits 2015

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7280	$10,930	N/A	1-15
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$119,220 + 2000 = $121,220.00	1-15

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$733	$1100	1-15
(SSI Limit)	B	$488.67	$733.33	
	C	$733	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2199	$4398	1-15
QDWI	A	$3989	$5375	3-15
	C	$3989	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3989	N/A	
QMB	A	$981	$1328	4-15
SLMB	A	$1177	$1593	4-15
QI-1	A	$1325	$1793	3-15

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$5931.00	4-15

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$264.33	$386.67	$366.67	1-15
FBR	$264.33	$386.67	$366.67	1-15
QMB	N/A	N/A	$437.00	4-14
SLMB	N/A	N/A	$525.00	4-14

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$590.00	3-14

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CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1090	1-15
Blind individuals	$1820	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$5164.60	04/15
ICF/MR	$14729.96	
Hospital	$5432.06	4/15

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14).

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2980.00	1-15
Dependent Family Member Need Standard	$1992.00	4-15

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$11,770.00	$15,889.00	$17,655.00	2015
2	15,930.00	21,505.00	23,985.00	
3	20,090.00	27,121.00	30,135.00	
4	24,250.00	32,737.00	36,375.00	
5	28,410.00	38,353.00	42,615.00	

The FPL (100% level) is increased by $4,060 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,780 Non Q Track Couple - $13,930	Individual - $13,640 Couple - $27,250	2015
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $66.00	Up to $66.00	
Coinsurance up to $3600 Out of Pocket	$1.20 - $3.60 Copay	$2.65 - $6.60 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2.65 - $6.60 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62

2011 – 32.83

2012 – 31.18
2013 – 34.22
2014 – 29.32
2015 – 26.47

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08
55 cents per mile – 1/1/09 – 12/31/09
50 cents per mile – 1/1/10 – 12/31/2010
51 cents per mile – 01/01/11 – 04/16/2012
55.5 cents per mile – 04/17/2012 – 12/31/2012
56.5 cents per mile – 01/01/2013 – 12/31/2013
56 cents per mile — 01/01/2014 – 12/31/2014
57.5 cents per mile – 01/01/2015 - Present

Appendix A1 ABD Financial Limits 2014

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$7160	$10,750	N/A	1-14
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$117,240 + 2000 = $119,240.00	1-14

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$721	$1082	1-14
(SSI Limit)	B	$480.67	$721.33	
	C	$721	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2163	$4326	1-14
QDWI	A	$3955	$5309	3-14
	C	$3955	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3955	N/A	
QMB	A	$973	$1311	4-14
SLMB	A	$1167	$1573	4-14
QI-1	A	$1313	$1770	3-14

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$5825.00	4-14

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$260.33	$380.67	$360.67	1-14
FBR	$260.33	$380.67	$360.67	1-14
QMB	N/A	N/A	$437.00	4-14
SLMB	N/A	N/A	$525.00	4-14

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$590.00	3-14

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CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1070	1-14
Blind individuals	$1800	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT		
Level of Care	**Monthly Amount**	**Effective Date**
Skilled Nursing Facility	$5825.00	04/14
ICF/MR	$8967.00	
Hospital	**$4879.72**	**4/14**

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-14).

Medicare Part D Base Premium rate: 32.42(effective 1-14)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:
an individual in CCSP	the current amount of the Individual FBR for LA-A
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard
an individual in NOW/COMP	the current Medicaid Cap

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2931.00	1-14
Dependent Family Member Need Standard	$1967.00	4-14

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$11,670.00	$15,754.50	$17,505.00	2014
2	15,730.00	21,235.50	23,595.00	
3	19,790.00	26,716.50	29,685.00	
4	23,850.00	32,197.50	35,775.00	
5	27,910.00	37,678.50	41,655.00	

The FPL (100% level) is increased by $4,060 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,660 Non Q Track Couple - $13,750	Individual - $13,440 Couple - $26,860	2014
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $63.00	Up to $63.00	
Coinsurance **up to $3600 Out of Pocket**	$1.20 - $3.60 Copay	$2.55 - $6.35 Copay	15% Coinsurance	
Catastrophic **5% or $2/$5 Copay**	$0	$0	$2.55 - $6.35 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22
2014 – 29.32

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08
55 cents per mile – 1/1/09 – 12/31/09
50 cents per mile – 1/1/10 – 12/31/2010
51 cents per mile – 01/01/11 – 04/16/2012
55.5 cents per mile – 04/17/2012 – 12/31/2012
56.5 cents per mile – 01/01/2013 – 12/31/2013
56 cents per mile — 01/01/2014 - Present

Appendix A1 ABD Financial Limits 2013

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI / LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB / SLMB / QI-1	$7080	$11,800	N/A	1-13
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$115,920 + 2000 = $117,920.00	1-13

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$710	$1066	1-13
	B	$473.33	$710	
	C	$710	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2130	$4260	1-13
QDWI	A	$3899	$5235	3-13
	C	$3899	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3899	N/A	
QMB	A	$958	$1293	4-13
SLMB	A	$1149	$1551	4-13
QI-1	A	$1293	$1745	3-13

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$5627.08	4-13

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$256.67	$375.33	$355.33	1-13
FBR	$256.67	$375.33	$355.33	1-13
QMB	N/A	N/A	$417.00	4-13
SLMB	N/A	N/A	$503.00	4-13
QI-1	N/A	N/A	$568.00	3-13

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1040	1-13
Blind individuals	$1740	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$4332.00	05/12
ICF/MR	$8895.00	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $104.90 (effective 1-13).

Medicare Part D Base Premium rate: 31.17 (effective January 2013)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2898.00	1-13
Dependent Family Member Need Standard	$1939.00	4-13

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$11,490.00	$15,512.00	$17,235.00	2013
2	15,510.00	20,939.00	23,265.00	
3	19,530.00	26,366.00	29,295.00	
4	23,550.00	31,793.00	35,325.00	
5	27,570.00	37,220.00	41,355.00	

The FPL (100% level) is increased by $4,020 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,580 Non Q Track Couple - $13,620	Individual - $13,300 Couple - $26,580	2013
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $66.00	Up to $66.00	
Coinsurance up to $3600 Out of Pocket	$1.15 - $3.50 Copay	$2.65 - $6.60 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2.65 - $6.60 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18
2013 – 34.22

A1.13 – Medically Needy Mileage Reimbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08

55 cents per mile – 1/1/09 – 12/31/09
50 cents per mile – 1/1/10 – 12/31/2010
51 cents per mile – 01/01/11 – 04/16/2012
55.5 cents per mile – 04/17/2012 – 12/31/2012
56.5 cents per mile – 01/01/2013 – present

Appendix A1 ABD Financial Limits 2012

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB / SLMB / QI-1	$6940	$10,410	N/A	1-12
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$113,640 + 2000 = $115,640.00	1-12

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$698	$1048	1-12
	B	$465.34	$698.00	
	C	$698	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2094	$4188	1-12
QDWI	A	$3789	$5109	3-12
	C	$3789	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3789	N/A	
QMB	A	$931	$1261	4-12
SLMB	A	$1117	$1513	4-12
QI-1	A	$1257	$1703	3-12

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4988.33	4-12

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$252.66	$369.33	$337.00	1-12
FBR	$256.66	$369.33	$337.00	1-12
QMB	N/A	N/A	$427.00	4-12
SLMB	N/A	N/A	$511.00	4-12
QI-1	N/A	N/A	$574.33	3-12

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1010	1-12
Blind individuals	$1690	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$4332.00	05/12
ICF/MR	$8895.00	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $99.90 (effective 1-12).

Medicare Part D Base Premium rate: 31.18 (effective January 2012)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability / Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2841.00	1-12
Dependent Family Member Need Standard	$1892	4-12

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$11,170.00	$15,080.00	$16,755.00	2012
2	15,130.00	20,426.00	22,695.00	
3	19,090.00	25,772.00	28,635.00	
4	23,050.00	31,118.00	34,575.00	
5	27,010.00	36,404.00	40,515.00	

The FPL (100% level) is increased by $3,960 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,440 Non Q Track Couple - $13,410	Individual - $12,910 Couple - $25,010	2012
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $53.00	Up to $62.00	
Coinsurance up to $3600 Out of Pocket	$1.10 - $3.30 Copay	$2.60 - $6.50 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2.60 - $6.50 Copay	

Low-Income Part D Premium Subsidy Amount

2010 – 29.62
2011 – 32.83
2012 – 31.18

A1.13 – Medically Needy Mileage Reimbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08
55 cents per mile – 1/1/09 – 12/31/09

50 cents per mile – 1/1/10 – 12/31/2010
51 cents per mile – 01/01/11 – 04/16/2012
55.5 cents per mile – 04/17/2012 – to present

Appendix A1 ABD Financial Limits 2011

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1	$6680	$10,020	N/A	1-11
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$109,560 + 2000 = $111,560.00	1-09

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$674	$1011	1-09
(SSI Limit)	B	$449.34	$674.00	
	C	$674	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2022	$4044	1-09
QDWI	A	$3695	$4969	3-11
	C	$3695	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3695	N/A	
QMB	A	$908	$1226	4-11
SLMB	A	$1089	$1471	4-11
QI-1	A	$1226	$1655	3-11

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4916.55	4-09

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$244.66	$357.00	$337.00	1-09
FBR	$244.66	$357.00	$337.00	1-09
QMB	N/A	N/A	$415.34	4-11
SLMB	N/A	N/A	$497.00	4-11

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$558.34	3-11

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1000	1-10
Blind individuals	$1640	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $96.40 (effective 1-09).

Medicare Part D Base Premium rate: 32.34 (effective January 2011)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2739	1-09
Dependent Family Member Need Standard	$1822	4-09

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$10,890.00	$14,701.50	$16,335.00	2011
2	14,710.00	19,858.50	22,065.00	
3	18,530.00	25,015.50	27,795.00	
4	22,350.00	30,172.50	33,525.00	
5	26,170.00	35,329.50	39,255.00	

The FPL (100% level) is increased by $3,820 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,100 Non Q Track Couple - $12,910	Individual - $12,910 Couple - $25,010	2010
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $53.00	Up to $62.00	
Coinsurance up to $3600 Out of Pocket	$1.10 - $3.30 Copay	$2.50 - $6.30 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2.50 - $6.30 Copay	

Low-Income Premium Subsidy Amount

2010 – 29.62

2011 – 32.83

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08
55 cents per mile – 1/1/09 – 12/31/09
50 cents per mile – 1/1/10 – 12/31/2010
51 cents per mile – 01/01/11 to present

Appendix A1 ABD Financial Limits 2010

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB / SLMB / QI-1	$6680	$10,020	N/A	1-11
QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$109,560 + 2000 = $111,560.00	1-09

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$674	$1011	1-09
	B	$449.34	$674.00	
	C	$674	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2022	$4044	1-09
QDWI	A	$3675	$4922	3-09
	C	$3675	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3675	N/A	
QMB	A	$903	$1215	4-09
SLMB	A	$1083	$1457	4-09
QI-1	A	$1219	$1640	3-09

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4916.55	4-09

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$244.66	$357.00	$337.00	1-09
FBR	$244.66	$357.00	$337.00	1-09
QMB	N/A	N/A	$411.66	4-09
SLMB	N/A	N/A	$492.33	4-09
QI-1	N/A	N/A	$553.33	3-09

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$1000	1-10
Blind individuals	$1640	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $96.40 (effective 1-09).

Medicare Part D Base Premium rate: 31.94 (effective January 2010)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability / Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2739	1-09
Dependent Family Member Need Standard	$1822	4-09

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$10,830.00	$14,620.50	$16,245.00	2009
2	14,570.00	19,669.50	21,855.00	
3	18,310.00	24,718.50	27,465.00	
4	22,050.00	29,767.50	33,075.00	
5	25,790.00	34,816.50	38,685.00	

The FPL (100% level) is increased by $3,740 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $8,100 Non Q Track Couple - $12,910	Individual - $12,910 Couple - $25,010	2010
Income Limit	Full Medicaid	Q Track or Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $53.00	Up to $62.00	
Coinsurance up to $3600 Out of Pocket	$1.10 - $3.30 Copay	$2.50 - $6.30 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2.50 - $6.30 Copay	

Low-Income Premium Subsidy Amount

2010 – 29.62

A1.13 – Medically Needy Mileage Reimbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – 2/1/07 – 03/31/08
50.5 cents per mile – 4/1/08 – 7/31/08
58.5 cents per mile – 8/1/08 – 12/31/08
55 cents per mile – 1/1/09 – 12/31/09
50 cents per mile – 1/1/10 to present

Appendix A1 ABD Financial Limits 2009

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1/QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$109,560 + 2000 = $111,560.00	1-09

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$674	$1011	1-09
(SSI Limit)	B	$449.34	$674.00	
	C	$674	N/A	
	D	$30	N/A	
Medicaid CAP	D	$2022	$4044	1-09
QDWI	A	$3675	$4922	3-09
	C	$3675	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3675	N/A	
QMB	A	$903	$1215	4-09
SLMB	A	$1083	$1457	4-09
QI-1	A	$1219	$1640	3-09

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4916.55	4-09

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$244.66	$357.00	$337.00	1-09
FBR	$244.66	$357.00	$337.00	1-09
QMB	N/A	N/A	$411.66	4-09
SLMB	N/A	N/A	$492.33	4-09
QI-1	N/A	N/A	$553.33	3-09

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$980	1-09
Blind individuals	$1640	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $96.40 (effective 1-09).

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in NOW/COMP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2739	1-09

Diversion Standard	Amount	Effective Date
Dependent Family Member Need Standard	$1822	4-09

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$10,830.00	$14,620.50	$16,245.00	2009
2	14,570.00	19,669.50	21,855.00	
3	18,310.00	24,718.50	27,465.00	
4	22,050.00	29,767.50	33,075.00	
5	25,790.00	34,816.50	38,685.00	

The FPL (100% level) is increased by $3,740 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $7,620 Non Q Track Couple - $12,190	Individual - $11,710 Couple - $23,410	2009
Income Limit	100% of FPL or full Medicaid	Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $53.00	Up to $53.00	
Coinsurance up to $3600 Out of Pocket	$1.10 - $3.20 Copay	$2.40 - $6.00 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2.40 - $6.00 Copay	

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05	
44.5 cents per mile – 1/1/06 – 1/31/07	
48.5 cents per mile – 2/1/07 – 03/31/2008	
	50.5 cents per mile – 04/01/2008 – 7/31/08
	58.5 cents per mile – 8/1/08 – 12/31/08
	.55 cents per mile – effective 1/01/2009 to present

Appendix A1 ABD Financial Limits 2008

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1/QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$104,400 + 2000 = $106,400.00	1-08

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$637	$956	1-08
	B	$424.67	$637	
	C	$637	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1911	$3822	1-08
QDWI	A	$3552	$4752	3-08
	C	$3552	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3552	N/A	
QMB	A	$867	$1167	4-08
SLMB	A	$1040	$1400	4-08
QI-1	A	$1170	$1575	3-08

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4614.90	4-08

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$232.33	$338.67	$318.67	1-08
FBR	$232.33	$338.67	$318.67	1-08
QMB	N/A	N/A	$395.56	4-08
SLMB	N/A	N/A	$473.33	4-08
QI-1	N/A	N/A	$531.67	3-08

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$860	1-06
Blind individuals	$1450	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $96.40 (effective 1-08).

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in MRWP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2610	1-08

Diversion Standard	Amount	Effective Date
Dependent Family Member Need Standard	$1770	4-08

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$10,400.00	$14,040.00	$15,600.00	2008
2	14,000.00	18,900.00	21,000.00	
3	17,600.00	23,760.00	26,400.00	
4	21,200.00	28,620.00	31,800.00	
5	24,800.00	33,480.00	37,200.00	

The FPL (100% level) is increased by $3,600 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $7,620 Non Q Track Couple - $12,190	Individual - $11,710 Couple - $23,410	2007
Income Limit	100% of FPL or full Medicaid	Less than 135% of FPL	Less than 150% of FPL	
Monthly **Premium**	$0	$0	Sliding Scale	
Deductible **Per Year**	$0	Up to $53.00	Up to $53.00	
Coinsurance **up to $3600 Out of Pocket**	$1 - $3.10 Copay	$2.15 - $5.35 Copay	15% Coinsurance	
Catastrophic **5% or $2/$5 Copay**	$0	$0	$2.15 - $5.35 Copay	

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05	
44.5 cents per mile – 1/1/06 – 1/31/07	
48.5 cents per mile – 2/1/07 – 03/31/2008	
	50.5 cents per mile – effective 04/01/2008

Appendix A1 ABD Financial Limits 2007

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB / SLMB / QI-1 / QDWI	$4000	$6000	N/A	1-89
Spousal Impoverishment	N/A	N/A	$101,640 + 2000 = $103,640.00	1-07

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$623	$934	1-07
	B	$415.33	$623	
	C	$623	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1869	$3738	1-07
QDWI	A	$3489	$4649	3-07
	C	$3489	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3489	N/A	
QMB	A	$851	$1141	4-07
SLMB	A	$1021	$1369	4-07
QI-1	A	$1149	$1541	3-07

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4358.57	4-07

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$227	$331.34	$311.34	1-07
FBR	$227	$331.34	$311.34	1-07
QMB	N/A	N/A	$387.00	4-07
SLMB	N/A	N/A	$463.00	4-07
QI-1	N/A	N/A	$520.34	3-07

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$860	1-06
Blind individuals	$1450	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $93.50 (effective 1-07).

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability / Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in MRWP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2541	1-07

Diversion Standard	Amount	Effective Date
Dependent Family Member Need Standard	$1712	4-07

HOUSEHOLD SIZE	100%	135%	150%	EFF. DATE
1	$10,210.00	$13,783.50	$15,315.00	2007
2	13,690.00	18,481.50	20,535.00	
3	17,170.00	23,179.50	25,755.00	
4	20,650.00	27,877.50	30,975.00	
5	24,130.00	32,575.50	36,195.00	

The FPL (100% level) is increased by $3,480 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $7,620 Non Q Track Couple - $12,190	Individual - $11,710 Couple - $23,410	2007
Income Limit	100% of FPL or full Medicaid	Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	Up to $53.00	Up to $53.00	
Coinsurance up to $3600 Out of Pocket	$1 - $3.10 Copay	$2.15 - $5.35 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2.15 - $5.35 Copay	

A1.13 – Medically Needy Mileage Reimbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05
44.5 cents per mile – 1/1/06 – 1/31/07
48.5 cents per mile – effective 2/1/07

Appendix A1 ABD Financial Limits 2006

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1/QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$99,540 + 2000 = $101,540.00	1-06

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR **(SSI Limit)**	A	$603	$904	1-06
	B	$402	$603	
	C	$603	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1809	$3618	1-06
QDWI	A	$3352	$4485	3-06
	C	$3352	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3352	N/A	
QMB	A	$817	$1100	4-06
SLMB	A	$980	$1320	4-06
QI-1	A	$1103	$1485	3-06

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4257.60	4-06

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$221	$321.34	$301.34	1-06
FBR	$221	$321.34	$301.34	1-06
QMB	N/A	N/A	$373..33	4-06
SLMB	N/A	N/A	$446.67	4-06
QI-1	N/A	N/A	$501.67	3-06

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$860	1-06
Blind individuals	$1450	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1271	$1873	$603	$904	1-06
B	$869	$1271	$402	$603	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $88.50 (effective 1-06).

Medicare Approved Drug Discount Card: up to $30 (effective 6/04)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$50	Effective 7-06
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in MRWP	the current Medicaid Cap	

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2488.50	1-06
Dependent Family Member Need Standard	$1670	4-06

CHART A1.11 – FEDERAL POVERTY LEVEL TABLES FOR MEDICARE PART D - LOW INCOME SUBSIDY

HOUSEHOLD SIZE	100%	135%	140%	145%	150%	EFF. DATE
1	$9,800.00	$13,230.00	$13,720.00	$14,210.00	$14,700.00	2006
2	13,200.00	17,820.00	18,480.00	19,140.00	19,800.00	
3	16,600.00	22,410.00	23,240.00	24,070.00	24,900.00	
4	20,000.00	27,000.00	28,000.00	29,000.00	30,000.00	
5	23,400.00	31,590.00	32,760.00	33,930.00	35,100.00	

The FPL (100% level) is increased by $3,260 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $6000 Non Q Track Couple - $9000	Individual - $10,000 Couple - $20,000	2005
Income Limit	100% of FPL or full Medicaid	Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	$0	$50.00	
Coinsurance up to $3600 Out of Pocket	$1 - $3 Copay	$2 - $5 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2 - $5 Copay	

A1.13 – Medically Needy Mileage Re-imbursement Rate

48.5 cents per mile – 9/10/05 – 12/31/05

44.5 cents per mile – effective 1/1/06

Appendix A1 ABD Financial Limits 2005

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI/LA-D	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1/QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$95,100 + 2000 = $97,100.00	1-05

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$579	$869	1-05
	B	$386	$579	
	C	$579	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1737	$3474	1-05
QDWI	A	$3255	$4342	3-05
	C	$3255	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3255	N/A	
QMB	A	$798	$1069	4-05
SLMB	A	$958	$1283	4-05
QI-1	A	$1077	$1443	3-05
$600 TA		$12,569.00/yr. $1047.42/mo.	$16,862.00/yr. $1405.17/mo.	6/04

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$4167.33	4-05

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$213	$309.67	$289.67	1-05
FBR	$213	$309.67	$289.67	1-05
QMB	N/A	N/A	$356.00	4-05

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
SLMB	N/A	N/A	$427.66	4-05
QI-1	N/A	N/A	$481.05	3-05

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$830	1-05
Blind individuals	$1380	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1223	$1803	$579	$869	1-05
B	$837	$1223	$386	$579	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $78.20 (effective 1-05).

Medicare Approved Drug Discount Card: up to $30 (effective 6/04)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$30	Effective 01-92 Effective 04-03
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:
an individual in MRWP	the current Medicaid Cap

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2377.50	1-05
Dependent Family Member Need Standard	$1624	4-05

CHART A1.11 – FEDERAL POVERTY LEVEL TABLES FOR MEDICARE PART D - LOW INCOME SUBSIDY

HOUSEHOLD SIZE	100%	135%	140%	145%	150%	EFF. DATE
1	$9,570.00	$12,919.50	$13,398.00	$13,876.50	$14,355.00	2005
2	12,830.00	17,320.50	17,962.00	18,603.50	19,245.00	
3	16,090.00	21,721.50	22,526.00	23,330.50	24,135.00	
4	19,350.00	26,122.50	27,090.00	28,057.50	29,025.00	
5	22,610.00	30,523.50	31,654.00	32,784.50	33,915.00	

The FPL (100% level) is increased by $3,260 for each additional person in the household.

CHART A1.12 – COSTS AND GUIDELINES FOR RECEIPT OF MEDICARE PART D - LOW INCOME SUBSIDY

	Group 1	Group 2	Group 3	Eff. Date
Resource Limit	None	Non Q Track Individual - $6000 Non Q Track Couple - $9000	Individual - $10,000 Couple - $20,000	2005
Income Limit	100% of FPL or full Medicaid	Less than 135% of FPL	Less than 150% of FPL	
Monthly Premium	$0	$0	Sliding Scale	
Deductible Per Year	$0	$0	$50.00	
Coinsurance up to $3600 Out of Pocket	$1 - $3 Copay	$2 - $5 Copay	15% Coinsurance	
Catastrophic 5% or $2/$5 Copay	$0	$0	$2 - $5 Copay	

Appendix A1 ABD Financial Limits 2004

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1/QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$92,760 + 2000 = $94,760.00	1-04

CHART A1.2 - ABD MEDICAID NET INCOME LIMITS (GROSS - $20)

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR (SSI Limit)	A	$564	$846	1-04
	B	$376	$564	
	C	$564	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1692	$3384	1-04
QDWI	A	$3169	$4229	3-04
	C	$3169	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3169	N/A	
QMB	A	$776	$1041	4-04
SLMB	A	$931	$1249	4-04
QI-1	A	$1048	$1406	3-04
$600 TA		$12,569.00/yr. $1047.42/mo.	$16,862.00/yr. $1405.17/mo.	6/04

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$3860	4-04

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGI-BLE CHILD

Income Limit	PMV for an Individ-ual	PMV for a Couple	Living Allowance	Effective Date
AMN	$208	$302	$282	1-04
FBR	$208	$302	$282	1-04
QMB	N/A	N/A	$353.61	4-04

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
SLMB	N/A	N/A	$423	4-04
QI-1	N/A	N/A	$475.05	3-04

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$810	1-04
Blind individuals	$1350	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1193	$1757	$564	$846	1-04
B	$817	$1193	$376	$564	
D	$145	$205	$50	$80	7-88

CHART A1.7 – MONTHLY AVERAGED MEDICAID RATES FOR KATIE BECKETT

Level of Care	Monthly Amount	Effective Date
Skilled Nursing Facility	$3645	11/04
ICF/MR	$6667	

A1.8 – MEDICARE EXPENSES

Medicare Part B Premium rate: $66.60 (effective 1-04).

Medicare Approved Drug Discount Card: up to $30 (effective 6/04)

CHART A1.9 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$30	Effective 01-92 Effective 04-03
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:
an individual in MRWP	the current Medicaid Cap

CHART A1.10 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2319	1-04
Dependent Family Member Need Standard	$1582	4-04

Appendix A1 ABD Financial Limits 2003

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/ QI-1/QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$90,660 + 2000 = $92,660.00	1-03

CHART A1.2 - ABD MEDICAID INCOME LIMITS

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$552	$829	1-03
(SSI Limit)	B	$368	$552	
	C	$552	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1656	$3312	1-03
QDWI	A	$3059	$4105	3-03
	C	$3059	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3059	N/A	
QMB	A	$749	$1010	4-03
SLMB	A	$898	$1212	4-03
QI-1	A	$1011	$1364	3-03

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$3673	4-03

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGI-BLE CHILD

Income Limit	PMV for an Individ-ual	PMV for a Couple	Living Allowance	Effective Date
AMN	$204	$296.33	$277	1-03
FBR	$204	$296.33	$277	1-03
QDWI	N/A	N/A	$680	3-03
QMB	N/A	N/A	$343.33	4-03
SLMB	N/A	N/A	$410.67	4-03

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$461.33	3-03

CHART A1.5 - SUBSTANTIAL GAINFUL ACTIVITY

Category	Income Limit	Effective Date
Non-Blind individuals	$800	1-03
Blind individuals	$1330	

CHART A1.6 – BREAK-EVEN POINTS

Living Arrangement	Earned Income		Unearned Income		Effective Date
	Individual	Couple	Individual	Couple	
A	$1,169	$1,723	$552	$829	1-03
B	$801	$1,170.34	$368	$552.67	
D	$145	$205	$50	$80	7-88

Medicare Part B Premium rate: $58.70 (effective 1-03).

CHART A1.7 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home or Institutionalized Hospice	$30	Effective 01-92 Effective 04-03
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in MRWP	the current Medicaid Cap	

CHART A1.8 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2266.50	1-03
Dependent Family Member Need Standard	$1535	4-03

Appendix A1 ABD Financial Limits 2002

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/QIS/ QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$89,280 + 2000 = $91,280.00	1-02

CHART A1.2 - ABD MEDICAID INCOME LIMITS

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR	A	$545	$817	1-02
(SSI Limit)	B	$363.34	$545	
	C	$545	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1635	$3270	1-02
QDWI	A	$3019	$4045	3-02
	C	$3019	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$3019	N/A	
QMB	A	$739	$995	4-02
SLMB	A	$886	$1194	4-02
QI-1	A	$997	$1344	3-02
QI-2	A	$1293	$1742	3-02

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$3131	4-02

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$201.66	$292.33	$273	1-02
FBR	$201.66	$292.33	$273	1-02
QDWI	N/A	N/A	$670	3-02
QMB	N/A	N/A	$339	4-02

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
SLMB	N/A	N/A	$405	4-02
QI-1	N/A	N/A	$455	3-02
QI-2	N/A	N/A	$588	3-02

QI-2 Refund Amount is $3.91 effective 1-02.

Medicare Part B Premium rate is $54.00 effective 1-02.

Maximum earnings for substantial gainful activity (SGA) are $780.00 per month.

CHART A1.5 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.	$90	Effective 1-92 (Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	
an individual in MRWP	the current Medicaid Cap	

CHART A1.6 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2232	1-02
Dependent Family Member Need Standard	$1513	4-02

Appendix A1 ABD Financial Limits 2001

CHART A1.1 - ABD MEDICAID RESOURCE LIMITS

Type Limit	Individual Limit	Couple Limit	LA-D Individual With a Community Spouse	Effective Date
SSI	$2000	$3000	N/A	7-88
AMN	$2000	$4000	N/A	4-90
QMB/SLMB/QIs/ QDWI	$4000	$6000	N/A	1-89
Spousal Impoverish-ment	N/A	N/A	$87,000 + 2000 = $89,000.00	1-01

CHART A1.2 - ABD MEDICAID INCOME LIMITS

Type Limit	LA	Individual Limit	Couple Limit	Effective Date
AMN	All	$317	$375	10-90
FBR **(SSI Limit)**	A	$530 / $531	$796/ $796	1-01/8-01
	B	$353.34/ $354	$530/ $530.67	
	C	$530/ $531	N/A	
	D	$30	N/A	
Medicaid CAP	D	$1590/ $1593	$3180/ $3186	1-01/8-01
QDWI	A	$1392/$1432	$1876/$1935	3-00/3-01
	C	$1432	N/A	Effective 3-98, ISM no longer applies to this COA eliminating LA-B.
	D	$1432	N/A	
QMB	A	$696/$716	$938/$968	4-00/4-01
SLMB	A	$836/$859	$1126/$1161	4-00/4-01
QI-1	A	$940/$967	$1267/$1307	3-00/3-01
QI-2	A	$1218/$1253	$1642/$1694	3-00/3-01

CHART A1.3 - TRANSFER OF RESOURCE PENALTY DETERMINATION

Averaging Nursing Home Private Pay Billing Rate	$2930/$3042	4-96/4-01

CHART A1.4 - PRESUMED MAXIMUM VALUE (PMV) OF ISM AND LIVING ALLOWANCE TO EACH INELIGIBLE CHILD

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
AMN	$196.66/$197	$285.33	$266/$266	1-01
FBR	$196.66/$197	$285.33	$266/$266	1-01
QDWI	N/A	N/A	$625.33/$651.67	3-00/3-01
QMB	N/A	N/A	$313/$329.34	4-00/4-01
SLMB	N/A	N/A	$375.33/$393.67	4-00/4-01

Income Limit	PMV for an Individual	PMV for a Couple	Living Allowance	Effective Date
QI-1	N/A	N/A	$422.33/$443	3-00/3-01
QI-2	N/A	N/A	$547.33/$571.34	3-00/3-01

QI-2 Refund Amount is $3.09 effective 01-01.

Medicare Part B Premium rate is $50.00 effective 01-01.

CHART A1.5 - PERSONAL NEEDS ALLOWANCES (PNA) FOR AN LA-D RECIPIENT

IF the LA-D Recipient is	THEN use the following as the PNA in the Patient Liability/Cost Share Budget:	
an individual in a nursing home	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has dependents	$30	Effective 1-92
a VA pensioner or his/her surviving spouse in a nursing home who has no dependents	$90	Effective 1-92
The VA check for these individuals is reduced to the amount of the PNA, regardless of other income.		(Effective 1-93 for the Surviving Spouse)
an individual in CCSP	the current amount of the Individual FBR for LA-A	
an individual in ICWP	the current amount of the Community Spouse Maintenance Need Standard	

CHART A1.6 - NEED STANDARDS FOR DIVERSION OF INCOME TO A COMMUNITY SPOUSE OR DEPENDENT FAMILY MEMBER IN A PATIENT LIABILITY/COST SHARE BUDGET

Diversion Standard	Amount	Effective Date
Community Spouse Maintenance Need Standard	$2175	1-01
Dependent Family Member Need Standard	$1472	1-01

Appendix A2 Family Medicaid Financial Limits

Appendix A2 Family Medicaid Financial Limits 2024

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2024 (effective 03/01/2024)		
	Effective Date:	07/01/2024		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):	70	**Updated or Reviewed in MT:**	MT-72

2024 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	205% Child 0-1 TMA	Plus 5%	211% P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%	95% Pathways	Plus 5% Pathways
1	310	373	3100	3163	2573	2636	2649	2712	1870	1933	1670	1733	1193	1256
2	457	543	4208	4294	3492	3578	3595	3681	2538	2624	2266	2352	1619	1705
3	551	659	5315	5423	4411	4519	4541	4649	3206	3314	2862	2970	2045	2153
4	653	783	6422	6552	5330	5460	5486	5616	3874	4004	3458	3588	2470	2600
5	752	905	7530	7683	6250	6403	6432	6585	4543	4696	4055	4208	2896	3049
6	826	1001	8637	8812	7169	7344	7378	7553	5211	5386	4651	4826	3322	3497
7	903	1101	9745	9943	8088	8286	8324	8522	5879	6077	5247	5445	3748	3946
8	970	1190	10852	11072	9007	9227	9270	9490	6547	6767	5844	6064	4174	4394
9	1034	1277	11959	12202	9926	10169	10216	10459	7215	7458	6440	6683	4600	4843
10	1113	1378	13067	13332	10845	11110	11162	11427	7883	8148	7036	7301	5026	5291
11	1194	1481	14174	14461	11764	12051	12108	12395	8551	8838	7632	7919	5452	5739
12	1244	1554	15282	15592	12683	12993	13054	13364	9219	9529	8229	8539	5878	6188
For each additional member, add:	$150	$173	$1108	$1131	$920	$943	$946	$969	$669	$692	$597	$620	$426	$449

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Percentage of the Federal Poverty Level (FPL) (continued)

Family Size	220% PGW Newborn	Plus 5%	200% WHM	235% ELE/CU19	FAMILY MEDICAID MNIL
1	2761	2824	2510	2950	208
2	3748	3834	3407	4003	317
3	4734	4842	4304	5057	375
4	5720	5850	5200	6110	442
5	6707	6860	6097	6174	508
6	7693	7868	6994	8218	550
7	8679	8877	7890	9271	600
8	9666	9886	8787	10325	633
9	10652	10895	9684	11378	667
10	11638	11903	10580	12432	708
11	12625	12912	11477	13486	758
12	13611	13921	12374	14539	808
For each additional member, add:	987	1010	897	1054	(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Regarding Express Lane Eligibility, if child is in an active SNAP or TANF case, and they are over the 235%, but under 247% FPL (PCK Limits), the child ELE PCK.

2024 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement

67.0 CENTS PER MILE EFFECTIVE 01/01/2024

Appendix A2 Family Medicaid Financial Limits 2023

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2023 (effective 07/01/2023)		
	Effective Date:	07/01/2023		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-70

2023 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	205% Child 0-1 TMA	Plus 5%	211% P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%	95% Pathways	Plus 5% Pathways
1	$310	371	3002	3063	2491	2552	2564	2625	1811	1872	1616	1677	1155	1215
2	457	540	4060	4143	3369	3452	3468	3551	2449	2532	2186	2269	1562	1644
3	551	655	5118	5222	4247	4351	4372	4476	3087	3191	2756	2860	1969	2072
4	653	778	6175	6300	5125	5250	5275	5400	3725	3850	3325	3450	2375	2500
5	752	899	7233	7380	6004	6151	6179	6326	4364	4511	3895	4042	2782	2929
6	826	994	8291	8459	6882	7050	7083	7251	5002	5170	4465	4633	3189	3357
7	903	1093	9349	9539	7760	7950	7987	8177	5640	5830	5035	5225	3596	3785
8	970	1181	10407	10618	8638	8849	8891	9102	6278	6489	5604	5815	4003	4214
9	1034	1267	11465	11698	9516	9749	9794	10027	6917	7150	6174	6407	4410	4642
10	1113	1367	12523	12777	10394	10648	10698	10952	7555	7809	6744	6998	4817	5070
11	1194	1469	13581	13856	11271	11546	11601	11876	8193	8468	7313	7588	5224	5498
12	1244	1541	14639	14936	12150	12447	12506	12803	8831	9128	7883	8180	5631	5927
For each additional member, add:	$150		$1058		$879		$904		$639		$570		$407	

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Percentage of the Federal Poverty Level (FPL) (continued)

Family Size	220% PGW Newborn	Plus 5%	200% WHM	235% ELE/CU19 (see NOTE)	FAMILY MEDICAID MNIL
1	2673	2734	2430	2856	208
2	3616	3699	3287	3862	317
3	4558	4662	4144	4869	375
4	5500	5625	5000	5875	442
5	6443	6590	5857	6882	508
6	7385	7553	6714	7889	550
7	8327	8517	7570	8895	600
8	9270	9481	8427	9902	633
9	10212	10445	9284	10908	667
10	11154	11408	10140	11915	708
11	12096	12371	10996	12921	758
12	13039	13336	11854	13928	808
For each additional member, add:	$943		$857	$1007	(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Regarding Express Lane Eligibility, if child is in an active SNAP or TANF case, and they are over the 235%, but under 247% FPL (PCK Limits), the child ELE PCK.

2023 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	2	3	4	5	6	7	8	9	10	11	12
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement

65.5 CENTS PER MILE EFFECTIVE 01/01/2023

Appendix A2 Family Medicaid Financial Limits 2022

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2022 (effective 03/01/2022)		
	Effective Date:	03/01/2022		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-65

2022 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	205% Child 0-1 TMA	Plus 5%	211% P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%
1	$310	367	2798	2855	2322	2379	2390	2447	1688	1745	1507	1564
2	457	534	3769	3846	3128	3205	3220	3297	2274	2351	2030	2107
3	551	647	4741	4837	3935	4031	4050	4146	2860	2956	2553	2649
4	653	769	5712	5828	4741	4857	4880	4996	3446	3562	3076	3192
5	752	888	6684	6820	5547	5683	5710	5846	4032	4168	3599	3735
6	826	981	7655	7810	6354	6509	6540	6695	4618	4773	4122	4277
7	903	1078	8627	8802	7160	7335	7370	7545	5204	5379	4646	4821
8	970	1165	9599	9794	7966	8161	8200	8395	5790	5985	5169	5364
9	1034	1248	10570	10784	8773	8987	9030	9244	6376	6590	5692	5906
10	1113	1347	11542	11776	9579	9813	9859	10093	6963	7197	6215	6449
11	1194	1448	12513	12767	10385	10639	10689	10943	7549	7803	6738	6992
12	1244	1517	13485	13758	11192	11465	11519	11792	8135	8408	7261	7534
For each additional member, add:	$150		$972		$807		$830		$587		$524	

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Percentage of the Federal Poverty Level (FPL) (continued)

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
1	2492	2549	2265	208

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
2	3357	3434	3052	317
3	4223	4319	3839	375
4	5088	5204	4625	442
5	5953	6089	5412	508
6	6819	6974	6199	550
7	7684	7859	6985	600
8	8549	8744	7772	633
9	9415	9629	8559	667
10	10280	10514	9345	708
11	11145	11399	10132	758
12	12011	12284	10919	808
For each additional member, add:	$866		$787	(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2022 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement

58.5 CENTS PER MILE EFFECTIVE 01/01/2022-06/30/2022
62.5 CENTS PER MILE EFFECTIVE 07/01/2022-PRESENT

Appendix A2 Family Medicaid Financial Limits 2021

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2021 (effective 3/01/2021)		
	Effective Date:	03/01/2021		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-64

2021 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	205% Child 0-1 TMA	Plus 5%	211% P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%
1	$310	364	2652	2706	2201	2255	2265	2319	1600	1654	1428	1482
2	457	530	3586	3659	2976	3049	3063	3136	2163	2236	1931	2004
3	551	643	4521	4613	3752	3844	3862	3954	2727	2819	2434	2526
4	653	764	5455	5566	4528	4639	4660	4771	3291	3402	2938	3049
5	752	882	6390	6520	5303	5433	5458	5588	3855	3985	3441	3571
6	826	975	7324	7473	6079	6228	6257	6406	4418	4567	3944	4093
7	903	1071	8259	8427	6854	7022	7055	7223	4982	5150	4447	4615
8	970	1157	9193	9380	7630	7817	7853	8040	5546	5733	4950	5137
9	1034	1239	10127	10332	8405	8610	8651	8856	6109	6314	5453	5658
10	1113	1337	10062	10286	9181	9405	9450	9674	6673	6897	5957	6181
11	1194	1437	11996	12239	9957	10200	10248	10491	7237	7480	6460	6703
12	1244	1506	12931	13193	10732	10994	11046	11308	7801	8063	6963	7225
For each additional member, add:			$935		$776		$799		$564		$504	

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
1	2362	2416	2147	208
2	3194	3267	2904	317

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
3	4026	4118	3660	375
4	4859	4970	4417	442
5	5691	5821	5174	508
6	6523	6672	5930	550
7	7356	7524	6687	600
8	8188	8375	7444	633
9	9020	9225	8200	667
10	9853	10077	8957	708
11	10685	10928	9714	758
12	11517	11779	10470	808
For each additional member, add:	$833		$757	(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2020 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement: .56 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2020

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2020 (effective 03/01/2020)		
	Effective Date:	03/01/2020		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-59

2020 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	205% Child 0-1 TMA	Plus 5%	211% P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%
1	$310	364	2627	2681	2180	2234	2244	2298	1585	1639	1415	1469
2	457	529	3549	3621	2946	3018	3032	3104	2141	2213	1911	1983
3	551	642	4471	4562	3711	3802	3820	3911	2697	2788	2408	2499
4	653	763	5393	5503	4476	4586	4607	4717	3254	3364	2904	3014
5	752	880	6315	6443	5242	5370	5395	5523	3810	3938	3401	3529
6	826	973	7238	7385	6007	6154	6183	6330	4366	4513	3897	4044
7	903	1069	8160	8326	6772	6938	6971	7137	4922	5088	4394	4560
8	970	1154	9082	9266	7538	7722	7758	7942	5479	5663	4890	5074
9	1034	1237	10004	10207	8303	8506	8546	8749	6035	6238	5387	5590
10	1113	1335	10926	11148	9068	9290	9334	9556	6591	6813	5884	6106
11	1194	1434	11848	12088	9834	10074	10121	10361	7148	7388	6380	6620
12	1244	1503	12770	13029	10599	10858	10909	11168	7704	7963	6877	7136
For each additional member, add:			$923		$766		$788		$557		$497	

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Percentage of the Federal Poverty Level (FPL)

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
1	2340	2394	2127	208

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
2	3161	3233	2874	317
3	3982	4073	3620	375
4	4804	4914	4367	442
5	5625	5753	5114	508
6	6446	6593	5860	550
7	7268	7434	6607	600
8	8089	8273	7354	633
9	8910	9113	8100	667
10	9732	9954	8847	708
11	10553	10793	9594	758
12	11374	11633	10340	808
For each additional member, add:	$822		$747	(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2020 RESOURCE LIMITS

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT NUMBER OF INDIVIDUALS IN FM-MN BG

1	2	3	4	5	6	7	8	9	10	11	12
$ 2000	**4000**	**4100**	**4200**	**4300**	**4400**	**4500**	**4600**	**4700**	**4800**	**4900**	**5000**

FM-MN Allowable Mileage Reimbursement .575 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2019

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2019		
	Effective Date:	03/01/2019		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-55

2019 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	205% Child 0-1 TMA	Plus 5%	211% P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%
1	$310	363	2571	2624	2134	2187	2197	2250	1551	1604	1385	1438
2	457	528	3481	3552	2889	2960	2974	3045	2100	2171	1875	1946
3	551	640	4391	4480	3644	3733	3751	3840	2649	2738	2365	2454
4	653	761	5301	5409	4399	4507	4528	4636	3198	3306	2854	2962
5	752	878	6210	6336	5155	5281	5305	5431	3747	3873	3344	3470
6	826	971	7120	7265	5910	6055	6083	6228	4295	4440	3834	3979
7	903	1066	8030	8193	6665	6828	6860	7023	4844	5007	4324	4487
8	970	1151	8940	9121	7420	7601	7637	7818	5393	5574	4814	4995
9	1034	1234	9850	10050	8175	8375	8414	8614	5942	6142	5304	5504
10	1113	1331	10759	10977	8930	9148	9191	9409	6491	6709	5794	6012
11	1194	1431	11669	11906	9685	9922	9968	10205	7039	7276	6284	6521
12	1244	1499	12579	12834	10440	10695	10746	11001	7588	7843	6774	7029
For each additional member, add:			$910		$755		$778		$549		$490	

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Percentage of the Federal Poverty Level (FPL) (continued)

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
1	2290	2343	2082	208

Family Size	220% PGW Newborn	Plus 5%	200% WHM	FAMILY MEDICAID MNIL
2	3101	3172	2819	317
3	3911	4000	3555	375
4	4721	4829	4292	442
5	5532	5658	5029	508
6	6342	6487	5765	550
7	7152	7315	6502	600
8	7963	8144	7239	633
9	8773	8973	7975	667
10	9583	9801	8712	708
11	10394	10631	9449	758
12	11204	11459	10185	808
For each additional member, add:	$811		$737	(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2019 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement: 58 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2018

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2018 (effective 03/01/2018)		
	Effective Date:	03/01/2018		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-52

2018 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size

Parent/ Caretaker with Children

Plus 5%

361
526
638
758
875
967
1062
1147
1229
1326
1425
1493
247%

PeachCare for Kids®

205%

Plus 5%

2550
3457
4365
5272
6179
7086
7993
8901
9808

10715
11622
12529
Child 0-1 TMA

Plus 5%

2125
2881
3637
4393
5149
5905
6661
7417
8173
8929
9685
10441
211% P4HB

Plus 5%

2186
2964
3741
4519
5296
6074
6852
7629
8407
9184
9962
10740
149%

Child 1-5

133%

Plus 5%

1397
1894
2391
2887
3384
3881

4378
4875
5371
5868
6365
6862

Plus 5%

1559
2113
2668
3222
3776
4331
4885
5440
5994
6548
7103
7657
Child 6-19

1 $310
2 457
3 551
4 653
5 752
6 826
7 903
8 970
9 1034
10 1113
11 1194
12 1244
For each additional member, add:
2499
3388
4278
5167
6056
6945
7834
8724
9613
10502
11391
12280

$890
2074
2812
3550
4288
5026
5764
6502
7240
7978
8716
9454
10192

$738
2135
2895
3654
4414
5173
5933
6693
7452
8212
8971
9731
10491

$760
1508
2044
2581
3117
3653
4190
4726
5263
5799
6335
6872
7408

$537
1346
1825
2304
2782
3261

3740
4219
4698
5176
5655
6134
6613

$479

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

Page 1 (03/01/2018)

Family Size
220% PGW

Plus 5%

2277
3087
3897
4707
5517
6327
7137
7947
8757
9567
10377
11187
Newborn

200% WHM
FAMILY MEDICAID MNIL

1 2226
2 3018
3 3810
4 4602
5 5394
6 6186
7 6978
8 7770
9 8562
10 9354
11 10146
12 10938

For each
2024 208
2744 317
3464 375
4184 442
4904 508
5624 550
6344 600
7064 633
7784 667
8504 708
9224 758
9944 808
(+) PER
additional member, add:
$792
$720
ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2018 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement: 54.5 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2017

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits (effective 04/01/2017)		
	Effective Date:	04/01/2017		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-51

2017 Income Limits

Plus 5%

1388
1868
2350
2830
3310
3792
4272
4753
5233
5714
6195
6675
7154
7633
8112
8591
9070
9549

Plus 5%

2112
2843
3575
4306
5037
5769
6500
7232
7963
8694
9427
10158

10886
11614
12342
13070
13798
14526
Percentage of the Federal Poverty Level (FPL)

Family Size

Parent/ Caretaker with Children

Plus 5%

361
525
637
756
872
964
1058
1143
1224
1320
1419
1486
1553
1620
1687
1754
1821
1888
247%

PeachCare for Kids®

220% PGW

Plus 5%

2533
3411
4490
5149
6044
6923
7800
8679
9556

10433
11312
12189
13063
13937
14811
15685
16650
17433
Newborn

205%

Plus 5%

2262
3046
3830
4613
5397
6181
6964
7749
8532
9315
10100
10883
11663
12452
13223
14003
14783
15563
Child 0-1 TMA

200% WHM P4HB

Plus 5%

2061
2775
3490
4203
4917
5632
6345
7060
7774
8487

9202
9916
10627
11338
12049
12760
13471
14182
149%

Child 1-5

133%

Plus 5%

1549
2085
2622
3158
3694
4231
4767
5304
5840
6376
6913
7449
7983
8517
9051
9585
10119
10653
Child 6-19

FAMILY MEDICAID MNIL
1 $310
2 457
3 551
4 653
5 752
6 826
7 903
8 970
9 1034
10 1113
11 1194
12 1244

13 1294
14 1344
15 1394
16 1444
17 1494
18 1544
For each additional member, add:
2483
3343
4204
5064
5924
6785
7645
8506
9366
10226
11087
11947
12804
13661
14518
15375
16232
17089

$857
2211
2978
3744
4510
5277
6043
6809
7576
8342
9108
9875
10641
11404
12176
12930
13693
14456
15219

$763
2061

2775
3489
4203
4917
5631
6345
7059
7773
8487
9202
9916
10627
11338
12049
12760
13471
14182

$711
2010
2707
3404
4100
4797
5494
6190
6887
7584
8280
8977
9674
10368
11062
11756
12450
13144
13838

$694
1498
2017
2536
3055
3574
4093
4612
5131
5650

6169
6688
7207
7724
8241
8758
9275
9792
10309

$517
1337
1800
2264
2727
3190
3654
4117
4580
5043
5507
5970
6433
6895
7357
7819
8281
8743
9205

$462
208
317
375
442
508
550
600
633
667
708
758
808
858
908
958
1008
1058

1108
(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2017 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement: 54 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2016

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2016 (effective 04/01/2016)		
	Effective Date:	04/01/2016		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-50

2016 Income Limits

Plus 5%

1367
1843
2319
2796
3272
3747
4226
4704
5183
5661
6139
6618
7098
7577
8056
8536
9015
9494

Plus 5%

2080
2804
3528
4254
4978
5702
6430
7158
7886
8614
9342
10070

10800
11529
12258
12988
13717
14446
Percentage of the Federal Poverty Level (FPL)

Family Size

Parent/ Caretaker with Children

Plus 5%

360
524
635
755
871
962
1057
1141
1222
1319
1417
1484
1552
1619
1686
1754
1821
1888
247%

PeachCare for Kids®

220% PGW

Plus 5%

2496
3365
4234
5104
5973
6843
7715
8589
9463

10336
11210
12084
12960
13836
14712
15588
16464
17340
Newborn

205%

Plus 5%

2228
3004
3780
4557
5333
6109
6888
7669
8450
9229
10009
10790
11572
12353
13134
13916
14697
15478
Child 0-1 TMA

200% WHM P4HB

Plus 5%

2030
2737
3444
4152
4859
5566
6276
6987
7698
8408

9119
9830
10542
11253
11964
12676
13390
14098
149%

Child 1-5

133%

Plus 5%

1526
2057
2588
3120
3651
4182
4715
5249
5783
6317
6851
7385
7921
8456
8991
9527
10062
10597
Child 6-19

FAMILY MEDICAID MNIL
1 $310
2 457
3 551
4 653
5 752
6 826
7 903
8 970
9 1034
10 1113
11 1194
12 1244

13 1294
14 1344
15 1394
16 1444
17 1494
18 1544
For each additional member, add:
2446
3298
4150
5002
5854
6707
7561
8418
9275
10130
10987
11844
12702
13560
14418
15276
16134
16992

$858
2178
2937
3696
4455
5214
5973
6734
7498
8262
9023
9786
10550
11314
12074
12842
13606
14370
15134

$764
2030

2737
3444
4152
4859
5566
6276
6987
7698
8408
9119
9830
10542
11254
11966
12678
13390
14102

$712
1980
2670
3360
4050
4740
5430
6122
6816
7510
8202
8896
9590
10284
10978
11672
12366
13060
13754

$694
1476
1990
2504
3018
3532
4046
4561
5078
5595

6111
6628
7145
7663
8181
8699
9217
9735
10253

$518
1317
1776
2235
2694
3153
3611
4072
4533
4995
5455
5916
6378
6840
7302
7764
8226
8688
9150

$462
208
317
375
442
508
550
600
633
667
708
758
808
858
908
958
1008
1058

1108
(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2016 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement: 54 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2015

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2015 (effective 04/01/2015)		
	Effective Date:	04/01/2015		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-49

2015 Income Limits

Plus 5%

1355
1833
2311
2790
3268
3746
4225
4703
5182
5661
6139
6617
7097
7576
8055
8535
9014
9493

Plus 5%

2061
2789
3517
4245
4973
5701
6429
7157
7885
8613
9341
10068

10797
11525
12253
12982
13710
14438
Percentage of the Federal Poverty Level (FPL)

Family Size
Parent/ Caretaker with Children

Plus 5%

360
524
635
755
871
962
1057
1141
1222
1319
1417
1484
1552
1619
1686
1754
1821
1888
247%

PeachCare for Kids®

220% PGW

Plus 5%

2473
3346
4220
5094
5967
6840
7715
8588
9461
10336

11209
12082
12957
13831
14705
15580
16454
17328
Newborn

205%

Plus 5%

2208
2988
3768
4548
5328
6108
6888
7668
8448
9228
10008
10788
11569
12349
13129
13910
14690
15470
Child 0-1 TMA

200% WHM P4HB

Plus 5%

2012
2722
3433
4144
4854
5565
6276
6986
7697
8408
9118

9829
10541
11252
11963
12675

14097
149%

Child 1-5

133%

Plus 5%

1512
2045
2579
3114
3647
4181
4715
5249
5782
6317
6850
7384
7919
8453
8987
9522
10056
10590
Child 6-19

FAMILY MEDICAID MNIL
1 $310
2 457
3 551
4 653
5 752
6 826
7 903
8 970
9 1034
10 1113
11 1194
12 1244
13 1294

14 1344
15 1394
16 1444
17 1494
18 1544
For each additional member, add:
2423
3279
4136
4992
5848
6704
7561
8417
9273
10130
10986
11842
12699
13556
14413
15270
16127
16984

$857
2158
2921
3684
4446
5209
5972
6734
7497
8260
9022
9785
10548
11311
12074
12837
13600
14363
15126

$763
2011
2722

3433
4143
4854
5565
6275
6986
7697
8407
9118
9828
10539
11250
11961
12672
13383
14094

$711
1962
2655
3349
4042
4735
5429
6122
6815
7509
8202
8895
9589
10283
10977
11671
12365
13059
13753

$694
1462
1978
2495
3012
3528
4045
4561
5078
5594
6111

6627
7144
7661
8178
8695
9212
9729
10246

$517
1305
1766
2227
2688
3149
3610
4071
4532
4994
5455
5916
6377
6839
7301
7763
8225
8687
9149

$462
208
317
375
442
508
550
600
633
667
708
758
808
858
908
958
1008
1058
1108

(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2015 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement: 57.5 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2014

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2014 (effective 04/01/2014)		
	Effective Date:	04/01/2014		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-48

2014 Income Limits

Percentage of the Federal Poverty Level (FPL)

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	220% PGW Newborn	Plus 5%	205% Child 0-1 TMA	Plus 5%	200% WHM P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%	FAMILY MEDICAID MNIL
1	$310	358	2404	2453	2141	2190	1995	2044	1946	1995	1450	1499	1295	1344	208
2	457														
3	551														
4	653														
5	752														
6	826														
7	903														
8	970														
9	1034														
10	1113														
11	1194														
12	1244														
13															
14															
15															
16															
17															
18															

Family Size	Parent / Caretaker with Children	Plus 5%	247% PCK	Plus 5%	220% PGW Newborn	Plus 5%	205% Child 0-1 TMA	Plus 5%	200% WHM P4HB	Plus 5%	149% Child 1-5	Plus 5%	133% Child 6-19	Plus 5%	FAMILY MEDICAID MNIL
For each additional member, add:			$838		$746		$695		$678		$506		$451		(+) PER ADDITIONAL BG MEMBER 50

A Budget Group of One does not exist for Parent/Caretaker with Child(ren) Medicaid or Pregnant Woman Medicaid.

2014 Resource Limits

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	2	3	4	5	6	7	8	9	10	11	12
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

FM-MN Allowable Mileage Reimbursement: 56 Cents Per Mile

Appendix A2 Family Medicaid Financial Limits 2013

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2013 (effective 02/01/2013)		
	Effective Date:	02/01/2013		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-46

2013 Income Limits

	LIM	LIM	PCK	RSM PgW, NB, WHM, P4HB, PE	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	2252	1916	1773	1275	958	208
2	659	356	3039	2586	2393	1720	1293	317
3	784	424	3826	3256	3012	2166	1628	375
4	925	500	4614	3926	3632	2611	1963	442
5	1060	573	5401	4596	4252	3057	2298	508
6	1149	621	6188	5266	4872	3502	2633	550
7	1243	672	6975	5936	5491	3948	2968	600
8	1319	713	7763	6606	6111	4393	3303	633
9	1389	751	8550	7276	6731	4838	3638	667
10	1487	804	9337	7946	7351	5283	3973	708
11	1591	860	10124	8616	7971	5728	4308	758
12	1635	884	10911	9286	8591	6173	4643	808
(+) PER ADDITIONAL BG MEMBER	44	24	787	670	620	445	335	50

2013 Resource Limits

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	56.5 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2012

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2012 (effective 02/01/2012)		
	Effective Date:	02/01/2012		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-44

2012 INCOME LIMITS

	LIM	LIM	PCK	RSM PgW, NB, WHM, P4HB, PE	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	2188	1862	1723	1239	931	208
2	659	356	2964	2522	2333	1678	1261	317
3	784	424	3739	3182	2944	2117	1591	375
4	925	500	4515	3842	3554	2555	1921	442
5	1060	573	5290	4502	4165	2994	2251	508
6	1149	621	6066	5162	4775	3433	2581	550
7	1243	672	6841	5822	5386	3872	2911	600
8	1319	713	7617	6482	5996	4311	3241	633
9	1389	751	8392	7142	6606	4750	3571	667
10	1487	804	9168	7802	7216	5189	3901	708
11	1591	860	9944	8462	7826	5628	4231	758
12	1635	884	10720	9122	8436	6067	4561	808
(+) PER ADDITIONAL BG MEMBER	44	24	776	660	610	439	330	50

2012 Resource Limits

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	51 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2011

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2011 (effective 02/01/2011)		
	Effective Date:	02/01/2011		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-42

2011 Income Limits

	LIM	LIM	PCK	RSM PgW, NB, WHM, P4HB, PE	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	2134	1815	1679	1207	908	208
2	659	356	2881	2452	2268	1631	1226	317
3	784	424	3628	3089	2857	2054	1545	375
4	925	500	4378	3725	3446	2478	1863	442
5	1060	573	5125	4362	4035	2901	2181	508
6	1149	621	5873	4999	4624	3324	2500	550
7	1243	672	6622	5635	5213	3748	2818	600
8	1319	713	7370	6272	5802	4171	3136	633
9	1389	751	8120	6910	6393	4596	3455	667
10	1487	804	8870	7548	6984	5021	3774	708
11	1591	860	9620	8186	7575	5446	4093	758
12	1635	884	10370	8824	8166	5871	4412	808
(+) PER ADDITIONAL BG MEMBER	44	24	750	638	591	425	319	50

2011 Resource Limits

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	51 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2010

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2010 (effective 01/01/2010)		
	Effective Date:	01/01/2010		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-42

2010 Income Limits

	LIM	LIM	PCK	RSM PgW, NB	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	2121	1805	1670	1201	903	208
2	659	356	2854	2429	2247	1615	1215	317
3	784	424	3586	3052	2823	2030	1526	375
4	925	500	4319	3675	3400	2444	1838	442
5	1060	573	5051	4299	3976	2859	2150	508
6	1149	621	5783	4922	4553	3273	2461	550
7	1243	672	6516	5545	5130	3688	2773	600
8	1319	713	7248	6169	5706	4102	3085	633
9	1389	751	7982	6793	6284	4517	3397	667
10	1487	804	8716	7417	6862	4932	3709	708
11	1591	860	9450	8041	7440	5347	4021	758
12	1635	884	10184	8665	8018	5762	4333	808
(+) PER ADDITIONAL BG MEMBER	44	24	734	624	578	415	312	50

2010 Resource Limits

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	50 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2009

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2009 (effective 02/01/2009)		
	Effective Date:	02/01/2009		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-34

2009 Income Limits

	LIM	LIM	PCK	RSM PgW, NB	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	2121	1805	1670	1201	903	208
2	659	356	2854	2429	2247	1615	1215	317
3	784	424	3586	3052	2823	2030	1526	375
4	925	500	4319	3675	3400	2444	1838	442
5	1060	573	5051	4299	3976	2859	2150	508
6	1149	621	5783	4922	4553	3273	2461	550
7	1243	672	6516	5545	5130	3688	2773	600
8	1319	713	7248	6169	5706	4102	3085	633
9	1389	751	7982	6793	6284	4517	3397	667
10	1487	804	8716	7417	6862	4932	3709	708
11	1591	860	9450	8041	7440	5347	4021	758
12	1635	884	10184	8665	8018	5762	4333	808
(+) PER ADDITIONAL BG MEMBER	44	24	734	624	578	415	312	50

2009 RESOURCE LIMITS

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	55 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2008

2008 Income Limits

	LIM	LIM	PCK	RSM PgW, NB	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FED-ERAL POVERTY LEVEL (FPL)**	**200% FED-ERAL POVERTY LEVEL (FPL)**	**185% FED-ERAL POVERTY LEVEL (FPL)**	**133% FED-ERAL POVERTY LEVEL (FPL)**	**100% FED-ERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	2038	1734	1604	1153	867	208
2	659	356	2743	2334	2159	1552	1167	317
3	784	424	3448	2934	2714	1951	1467	375
4	925	500	4153	3534	3269	2350	1767	442
5	1060	573	4858	4134	3824	2749	2067	508
6	1149	621	5563	4734	4379	3148	2367	550
7	1243	672	6268	5334	4934	3547	2667	600
8	1319	713	6973	5934	5489	3946	2967	633
9	1389	751	7678	6534	6044	4345	3267	667
10	1487	804	8383	7134	6599	4744	3567	708
11	1591	860	9088	7734	7154	5143	3867	758
12	1635	884	9793	8334	7709	5542	4167	808
(+) PER ADDI-TIONAL BG MEMBER	44	24	705	600	555	399	300	50

2008 RESOURCE LIMITS

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	50.5 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2007

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2007 (effective 02/01/2007)		
	Effective Date:	02/01/2007		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-27

2007 Income Limits

	LIM	LIM	PCK	RSM PgW, NB	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL (FPL)**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$ 435	235	2000	1702	1575	1132	851	208
2	659	356	2682	2282	2111	1518	1141	317
3	784	424	3363	2862	2648	1904	1431	375
4	925	500	4045	3442	3184	2289	1721	442
5	1060	573	4726	4022	3721	2675	2011	508
6	1149	621	5408	4602	4257	3061	2301	550
7	1243	672	6089	5182	4794	3446	2591	600
8	1319	713	6771	5762	5330	3832	2881	633
9	1389	751	7453	6342	5867	4218	3171	667
10	1487	804	8135	6922	6404	4604	3461	708
11	1591	860	8817	7502	6941	4990	3751	758
12	1635	884	9499	8082	7478	5376	4041	808
(+) PER ADDITIONAL BG MEMBER	44	24	682	580	537	386	290	50

2007 RESOURCE LIMITS

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	48.5 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2006

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2006 (effective 02/01/2006)		
	Effective Date:	02/01/2006		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-20

2006 Income Limits

	LIM	LIM	PCK	RSM PgW, NB	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL (FPL)**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	1920	1634	1511	1087	817	208
2	659	356	2585	2200	2035	1463	1100	317
3	784	424	3252	2767	2560	1840	1384	375
4	925	500	3917	3334	3084	2217	1667	442
5	1060	573	4583	3900	3608	2594	1950	508
6	1149	621	5250	4467	4132	2971	2234	550
7	1243	672	5915	5034	4656	3348	2517	600
8	1319	713	6580	5600	5180	3724	2800	633
9	1389	751	7248	6168	5706	4102	3084	667
10	1487	804	7916	6736	6232	4480	3368	708
11	1591	860	8584	7304	6758	4858	3652	758
12	1635	884	9252	7872	7284	5236	3936	808
(+) PER ADDITIONAL BG MEMBER	44	24	668	568	526	378	284	50

2006 RESOURCE LIMITS

LIM RESOURCE LIMIT	$1000
FM-MN ALLOWABLE MILEAGE REIMBURSEMENT	44.5 CENTS PER MILE

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**

$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2005

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2005 (effective 02/01/2005)		
	Effective Date:	02/01/2005		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-15

2005 Income Limits

	LIM	LIM	PCK	RSM PgW, NB	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL (FPL)**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	1875	1596	1476	1061	798	208
2	659	356	2512	2138	1978	1422	1069	317
3	784	424	3151	2682	2481	1784	1341	375
4	925	500	3791	3226	2984	2145	1613	442
5	1060	573	4427	3768	3485	2506	1884	508
6	1149	621	5067	4312	3988	2867	2156	550
7	1243	672	5706	4856	4492	3229	2428	600
8	1319	713	6343	5398	4993	3590	2699	633
9	1389	751	6982	5942	5496	3952	2971	667
10	1487	804	7621	6486	5999	4314	3243	708
11	1591	860	8260	7030	6502	4676	3515	758
12	1635	884	8899	7574	7005	5038	3787	808
(+) PER ADDITIONAL BG MEMBER	44	24	639	544	503	362	272	50

2005 RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$ 2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2004

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Family Medicaid Financial Limits 2004 (effective 07/01/2004)		
	Effective Date:	07/01/2004		
	Chapter:	Appendix A2	**Policy Number:**	Appendix A2
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-11

2004 Income Limits

	LIM	LIM	PCK	RSM PgW, NB	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL (FPL)**	**200% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	1824	1552	1436	1032	776	208
2	659	356	2447	2082	1926	1385	1041	317
3	784	424	3070	2612	2416	1737	1306	375
4	925	500	3692	3142	2907	2090	1571	442
5	1060	573	4315	3672	3397	2442	1836	508
6	1149	621	4938	4202	3887	2795	2101	550
7	1243	672	5561	4732	4377	3147	2366	600
8	1319	713	6183	5262	4868	3500	2631	633
9	1389	751	6806	5792	5359	3853	2896	667
10	1487	804	7429	6322	5850	4206	3161	708
11	1591	860	8052	6852	6341	4559	3426	758
12	1635	884	8675	7382	6832	4912	3691	808
(+) PER ADDITIONAL BG MEMBER	44	24	623	530	491	353	265	50

2004 RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2003

2003 Income Limits

	LIM	LIM	RSM PgW, NB, PCK	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	1761	1385	996	749	208
2	659	356	2374	1869	1344	1010	317
3	784	424	2990	2353	1692	1272	375
4	925	500	3605	2837	2040	1534	442
5	1060	573	4219	3321	2388	1795	508
6	1149	621	4834	3805	2736	2057	550
7	1243	672	5450	4289	3084	2319	600
8	1319	713	6063	4773	3432	2580	633
9	1389	751	6678	5258	3781	2842	667
10	1487	804	7293	5743	4130	3104	708
11	1591	860	7908	6228	4479	3366	758
12	1635	884	8523	6713	4828	3628	808
(+) PER ADDITIONAL BG MEMBER	44	24	615	485	349	262	50

2003 RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$ 2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2002

2002 Income Limits

	LIM	LIM	RSM PgW, NB, PCK	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FED-ERAL POVERTY LEVEL (FPL)**	**185% FED-ERAL POVERTY LEVEL (FPL)**	**133% FED-ERAL POVERTY LEVEL (FPL)**	**100% FED-ERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	1736	1366	982	739	208
2	659	356	2339	1841	1324	995	317
3	784	424	2942	2316	1665	1252	375
4	925	500	3545	2791	2007	1509	442
5	1060	573	4148	3266	2348	1765	508
6	1149	621	4751	3741	2689	2022	550
7	1243	672	5355	4215	3031	2279	600
8	1319	713	5958	4690	3372	2535	633
9	1389	751	6562	5166	3714	2792	667
10	1487	804	7166	5642	4056	3049	708
11	1591	860	7770	6118	4398	3306	758
12	1635	884	8374	6594	4740	3563	808
(+) PER ADDI-TIONAL BG MEMBER	44	24	604	476	342	257	50

2002 RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix A2 Family Medicaid Financial Limits 2001

2001 Income Limits

	LIM	LIM	RSM PgW, NB, PCK	RSM CHILD 0-1, TMA, WIC	RSM CHILD 1-5	RSM CHILD 6-19	FM-MNIL
BUDGET GROUP (BG) SIZE	**GROSS INCOME CEILING (GIC)**	**STANDARD OF NEED (SON)**	**235% FEDERAL POVERTY LEVEL (FPL)**	**185% FEDERAL POVERTY LEVEL (FPL)**	**133% FEDERAL POVERTY LEVEL (FPL)**	**100% FEDERAL POVERTY LEVEL (FPL)**	**FAMILY MEDICAID MNIL**
1	$435	235	1683	1325	953	716	208
2	659	356	2275	1791	1288	968	317
3	784	424	2867	2257	1623	1220	375
4	925	500	3457	2722	1957	1471	442
5	1060	573	4050	3188	2292	1723	508
6	1149	621	4642	3654	2627	1975	550
7	1243	672	5232	4119	2961	2226	600
8	1319	713	5824	4585	3296	2478	633
9	1389	751	6416	5051	3631	2730	667
10	1487	804	7008	5517	3966	2982	708
11	1591	860	7600	5983	4301	3234	758
12	1635	884	8192	6449	4636	3486	808
(+) PER ADDITIONAL BG MEMBER	44	24	592	466	335	252	50

2001 RESOURCE LIMITS

LIM RESOURCE LIMIT: $1000

FAMILY MEDICAID MEDICALLY NEEDY (FM-MN) RESOURCE LIMIT

NUMBER OF INDIVIDUALS IN FM-MN BG											
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**
$2000	4000	4100	4200	4300	4400	4500	4600	4700	4800	4900	5000

Appendix B Hearings

Appendix B Hearings

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Hearings		
	Effective Date:	July 2024		
	Chapter:	Appendix B	**Policy Number:**	N/A
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-72

Requirements

The fair hearing process entitles an applicant or recipient (A/R) to an impartial hearing, upon his/her request, to appeal an agency action or inaction.

Basic Considerations

Notification of the Right to a Fair Hearing

The A/R must be informed, in writing, of his/her right to a fair hearing, the methods of requesting a hearing, and that assistance with completing the required forms will be provided, if requested. The A/R must be informed of this right at the following times:

- at application
- when any action is taken that affects benefits
- when the A/R requests a restoration of lost benefits

Request for a Hearing

A request for a hearing, either orally or in writing, is an expression by the A/R or his/her authorized representative (AREP) of the desire for an opportunity to present the case to a reviewing authority.

> Authorized representative is defined as a person or organization designated by the A/R or beneficiary to assist with the application, renewal of eligibility and other ongoing communications with the agency. Elected AREP may have verbal or written designation. If the designation is written, the applicant's signature is required. Court orders establishing legal guardianship or a valid power of attorney is to be treated as written designations.

DHS Form 5459 Release of Information does not assign the entity or individual as the AREP and does not give permission to act on client's behalf.

A request for a hearing may be submitted to any Division of Family and Children Services (DFCS) office.

> DFCS is prohibited from disclosing Personally Identifiable Information (PII) or Protected Health Information (PHI) to unauthorized individuals. Therefore, DFCS will not disclose, discuss or allow access to the A/R's PII or PHI without authorization. DFCS processes hearing requests that are submitted on behalf of an A/R when DFCS is provided valid legal authoriza-

tion.

Assistance, such as language assistance, must be provided to the A/R and the AREP, if requested, with completing the necessary document(s).

A qualified interpreter must be provided for any A/R and the AREP in the preferred language identified by the A/R (or the AREP), so that DFCS' hearing procedures are explained in a language understood by the A/R.

The A/R must request a hearing within thirty (30) days of notification of the decision with which s/he disagrees (42 C.F.R. § 431.221(d)).

In the event an oral request is made, the A/R must submit a written request within fifteen (15) days of the original request.

All hearing requests will be forwarded to OSAH, regardless of when the request was received. For untimely requests received, DFCS' hearing representative will enter into evidence the untimely policy and the Administrative Law Judge (ALJ) will determine if good cause exists. If DFCS fails to submit a hearing request to OSAH within 30 days after DFCS receives such request, the applicant, recipient, or authorized representative can file a petition directly with OSAH to request a hearing (referred to as a Direct Petition).

OSAH is responsible for scheduling hearings and notifying the parties (the Petitioner and the DFCS hearing representative) of the date, time, and location of the hearing.

A hearing request received from an A/R who is planning to move out of state before the hearing decision is reached may be expedited so that a decision may be issued before they move.

Women's Health Medicaid (WHM)

Upon receipt of a WHM hearing request, DFCS will follow the standard hearing process. All hearing notifications must be e-mailed to DCH, Shameeka Miller at shameeka.miller@dch.ga.gov. DCH will notify Department of Public Health on all second-level reviews that have been scheduled for a hearing.

Continuation of Benefits

Upon the A/R's request, Medicaid eligibility and patient liability/cost share may be continued, provided the request for continuation is received within 10 days of the date of timely or adequate notice. Refer to 2701 Notification and Chart B.1, Continuation of Medicaid Pending a Hearing Decision.

The Department of Community Health (DCH) reserves the right to require the A/R to repay continued benefits if s/he loses the hearing.

Allowance should be made in the event the A/R's reports late receipt of notification due to mail processing time. If the A/R provides the envelope in which the notice was received, allow 12 days from the U.S. Postal Service date stamp to determine if benefits are to be continued. If the A/R cannot provide the envelope in which the notice was received, allow 14 days from the date on the notice to determine if benefits are to be continued. In the event the 14th day is a weekend or holiday, allow

until the close of business on the first workday following the 14th day.

EMA

Effective January 1, 2006, continuation of benefits for ongoing EMA services pending a hearing will not be allowed as no future dates of service for EMA are applicable per policy.

SSI

SSI recipients who have had SSI benefits terminated and who wish to continue Medicaid pending the outcome of an appeal of SSI/Medicaid may do so. This should occur in the interface between SSA and DCH. However, if the SSI A/R reports that this has not occurred and that Medicaid benefits have terminated, have the A/R provide written verification from SSA that they have appealed the SSI termination. Contact your Medicaid Field Program Specialist to have the A/R's eligibility restored pending the outcome of the appeal. The Program Specialist will need to provide the written proof to DCH to have the A/R updated in DCH's system. If the A/R only wants to appeal the Medicaid termination and not the SSI, there are no Medicaid benefits to continue since the Medicaid went along with the SSI. DFCS should complete a CMD on the A/R and approve or deny as appropriate. At that point, the A/R may make an appeal of the Medicaid benefits denied through DFCS.

The Hearing

An OSAH Administrative Law Judge (ALJ) conducts hearings. See exceptions in chart below. The hearing includes consideration of the following:

- any agency action, including the following:
  - denial or approval of an application
  - calculation of patient liability or cost share
  - termination of benefits
  - change in COA
  - change in patient liability or cost share
- the agency's delay in action or failure to act, including:
  - delay in application processing
  - failure to act, or delay in action on a change

The list above is not inclusive.

AGENCY HEARINGS

Program	Hearing Agency
SSI money payment	Social Security Administration (SSA)
SSI Medicaid Denial/Termination	OSAH
DFCS Medicaid COAs	OSAH
Level of Care (LOC) for Katie Beckett	Department of Community Health Legal Services
Breast & Cervical Cancer Program	OSAH
Medicare Part D Low Income Subsidy	Social Security Administration (SSA)

Program	Hearing Agency
SMEU	OSAH

State law prohibits the ALJ from providing legal advice to any party, including the state agency. As such, OSAH cannot assist the agency or the petitioning A/R in determining who should be present as witnesses at the hearing or what evidence is necessary to establish the case.

An ALJ shall have all the powers of the ultimate decision maker in the agency with respect to a contested case. Hearing decisions are based on evidence introduced at the hearing. Hearing decisions specify the reason for the decision, which includes findings of fact, conclusions of law, and a disposition of the case.

Hearings: Rights and Responsibilities of the A/R and DFCS

The A/R or his/her AREP has the right to the following:

- examine the contents of the case record and all pertinent documents and records prior to the hearing.

> Certain confidential case record information may not be released to or viewed by anyone, including the A/R. Refer to Section 2010 Confidentiality and 2011 Health Information Portability and Accountability Act of 1996 for additional information, including what may not be released and penalties for unauthorized release.

Confidential information that is protected from release and other documents or records that the A/R may not contest or challenge may not be presented at the hearing.

- present the case with or without the aid of a representative, including legal counsel, a relative, friend or other spokesperson
- request assistance from the agency for transportation to/from the hearing.

The A/R and DFCS have the right to the following:

- bring and/or subpoena witnesses
- establish all pertinent facts and circumstances
- present arguments without undue interference
- question or refute any testimony or evidence, including the opportunity to question and cross-examine adverse witnesses.

DFCS has the responsibility for the following:

- ensuring the presence at the hearing of staff members with direct knowledge of the facts in dispute
- ensuring that all relevant agency records and copies are legible and available as evidence
- ensuring that non-agency witnesses and records are present, either voluntarily or by subpoena.

Withdrawal, Cancellation or Postponement of the Hearing

The withdrawal, cancellation or postponement may be requested by the A/R or his/her AREP and may be made orally or in writing.

If received 5 days or less from the scheduled hearing date, notify the Administrative Law Judge contact as indicated on the appointment notice by facsimile or electronic mail. These should include the docket number.

The Final Hearing Decision

The Final Hearing Decision is issued within ninety (90) days from the date the written request for a hearing is received by the agency, except in the event of a postponement or continuance.

No action may be taken to reduce or terminate Medical Assistance until the decision is final.

Effective May 8, 2018, in accordance with O.C.G.A. Section 50-13-41(c), every decision by an OSAH ALJ is a final decision that may only be appealed by filing a petition for judicial review, with proper service in accordance with the applicable law, in the Fulton County Superior Court or in the Superior Court in the county of residence of the petitioner.

See Appendix B Appeal in this section for final decision appeal information and procedures.

Procedures

Processing a Hearing Request

Step 1 Upon receipt of a hearing request, follow the steps below.

Within three (3) business days of agency's receipt of hearing request,review the record to determine the following:

- Was correct action taken? If not, correct the case and notify the A/R. S/he may choose to withdraw the request for a hearing.
- Was a Continuing Medicaid Determination (CMD) completed?
- Is the A/R eligible based on all other points of eligibility with the exception of the one at issue?

Step 2 Within three (3) business days of agency's receipt of hearing request, discuss the complaint with the A/R or his/her AREP prior to submitting the hearing request to OSAH (using the OSAH Form-1 and the items listed in Step 4, below), to ensure that a hearing is necessary.

If a mutually satisfactory decision is reached, the A/R may choose to withdraw the request for a hearing – verbally or in writing. If a verbal withdrawal is received, the OSAH Form 1 will not be submitted and the agency will send correspondence to the A/R confirming the verbal withdrawal.

How to handle withdrawals of hearing requests after the agency has transmitted the OSAH Form-1.

i. **Verbal withdrawals:** If the A/R contacts DFCS to verbally withdraw his/her hearing request after the agency has sent the OSAH Form-1, Fair Hearing Specialist will inform the A/R to contact OSAH to request that the A/R's hearing be removed from the OSAH hearing calendar. No written correspondence will be sent to A/R if the verbal withdrawal is received after the 3rd business day.

ii. **Written withdrawals:** If the A/R contacts DFCS by submitting a written withdrawal of his/her hearing request after the agency has sent the OSAH Form-1, the Fair Hearing Coordinator will forward the A/R's written withdrawal to OSAH (via physical letter or email) and copying the A/R to *all* related correspondence.

Step 3 Inform the A/R that timeliness in filing the hearing request affects continuation or reinstatement of benefits and that late filing may result in denial of the request for a hearing.

Step 4 If a mutually satisfactory solution cannot be obtained and the A/R does *not* submit a hearing request withdrawal, submit the following documents to OSAH within five (5) business days of receipt of the hearing request, even if unable to contact the A/R to discuss the complaint.

The information should be sent to:

Office of State Administrative Hearings (OSAH)
225 Peachtree Street NE
Suite 400, South Tower
Atlanta, GA 30303

Referral for hearing request can be sent electronically from the Fair Hearing Coordinator to the OSAH clerk's office (Jason Rouse, Chief Clerk - jrouse@osah.ga.gov; Devin Hamilton, Deputy Chief Clerk - devinh@osah.ga.gov).

Include:

- Form 118, Request for Hearing, or any written request for hearing presented by the A/R
- Decision notice which pertains to the action in dispute
- OSAH Form 1-Medicaid

Make sure that any available contact numbers for the A/R are included on the OSAH-Form-1.

It is the responsibility of the case manager to present the following documents at the hearing:

- the application or renewal for assistance related to the matter(s) in dispute
- all records documenting or verifying facts, including records of telephone conversations, interviews, etc., which pertain to the action in dispute and any other materials that were made part of the case file in the normal course of business and on which the agency relied for the action taken, including budgets
- subpoenas for individuals and/or documents prepared for the ALJs. If subpoenas are required for documents, include the type of document, the document custodian's name and address

The request for subpoena form must be completed setting forth the relevance of the testimony/documents sought. This form must be attached to the subpoena sent to OSAH. Copies of the request form and the subpoena must be provided to all parties involved in the hearing. The subpoena, after being signed by the ALJ, is returned to DFCS for personal service on the witness or for mailing to the witness via certified mail. A copy of a form or sample subpoena is available on OSAH's website.

Step 5 Determine if the A/R is entitled to continued or reinstated benefits. Continue or reinstate Medicaid benefits if allowed. Refer to Chart B.1 for continuation of benefits.

Inform the A/R that a request for continuation or reinstatement of patient liability (PL) or cost share (CS) pending a hearing decision may result in an increase of the A/R's financial responsibility if the hearing decision is adverse to the A/R or a decrease of the A/R's financial responsibility if the hearing decision is favorable to the A/R.

If the hearing request submitted by or for the A/R does not indicate that the A/R has waived continuation of benefits, assume continuation is desired.

Step 6 Allow the A/R opportunity to examine documents and records that will be used in the hearing. Allow the A/R's representative the opportunity to examine these documents if the A/R signs a Form 5459, Authorization to Release Information.

Step 7 Report any changes in the circumstances related to the hearing, including address changes, OSAH.

Forward any subsequent documents received concerning the hearing to OSAH.

PeachCare for Kids® and Planning for Healthy Babies®

The RSM Group staff will process all PeachCare for Kids® and Planning for Healthy Babies® (P4HB) administrative eligibility reviews and fair hearings. The RSM Group will follow the procedures below:

Step 1 Requests for Administrative Eligibility Reviews or Hearings must be submitted within thirty (30) days of the written notification in which parent or A/R disagrees. If verbal request is made, the parent or A/R must submit a written request within fifteen (15) days of the original request. If the written request is not received, no further action is required. Administrative Eligibility Review of Fair Hearing requests can be submitted by the parent or A/R through fax: (912) 632-0389, mail: P.O. Box 786, Alma, GA 31510, email: RSM South Hub at rsm.mailfax@dhs.ga.gov or received by the Division of Family and Children Services (DFCS) and forwarded to RSM for processing.

Step 2 The administrative Eligibility Review request, client(s) and case will be reviewed by an impartial RSM caseworker. Eligibility or renewal should be completed, if possible. The RSM caseworker will notify the parent or A/R in writing of the outcome and request the parent or A/R to submit a withdrawal.

RSM will document using the case notes in GA Gateway and upload in document management the request and any related items. Worker will create case notes with adequate documentation of the current case status and resolution.

- Document Management uploading the admin information; make sure to put a comment in the box: **PCK or P4HB Admin Review Only.**

Step 3 If the case is not approved or not resolved and the parent or A/R has not withdrawn the request, RSM will attempt to contact the parent or A/R by phone, email, or mail to review case and to request withdrawal.

Step 4 If the case cannot be resolved or withdrawn, then a Fair Hearing Request Notice will be manually mailed or emailed to the parent or A/R and uploaded into Gateway by RSM. The notice will notify the parent or A/R to contact the agency within 10 days from the date of the letter to request an OSAH hearing. If no response is received, the Administrative Eligibility Review is considered complete after the 10th day and a case note will be placed in Gateway by RSM. No further action is required.

Step 5 If customer responds and would like to proceed with an OSAH Hearing, the procedures for Medicaid hearings must be followed. RSM must upload all related items into Document Management under Hearings and document in Case Notes.

- DHS legal is sent the information and PCK or P4HB Hearing inbox should be copied on all OSAH referrals.
- Continue with above Steps 1 through 7 of Processing a Hearing Request.

Implementation of a Final Hearing Decision

Follow the steps below to implement a hearing decision.

Step 1 Determine whether the decision is favorable to the A/R or the agency and adjust the A/R's ongoing benefits, including patient liability or cost share, if necessary.

Step 2 Notify the A/R of the action taken via manual notice. The notice must indicate that the action taken is the result of the hearing decision. Include each month's circumstance and eligibility status. Do not include information regarding further appeals.

Appendix B Appeal

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Appeal		
	Effective Date:	July 2024		
	Chapter:	Appendix B	**Policy Number:**	N/A
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-72

Requirements

Both the A/R and DHS/DFCS have the right to request a judicial review of a hearing decision.

Basic Considerations

Effective May 8, 2018, in accordance with O.C.G.A. Section 50-13-41(c), every decision by an OSAH ALJ is a final decision that may only be appealed by filing a petition for judicial review, with proper service in accordance with the applicable law, in the Fulton County Superior Court or in the Superior Court in the county of residence of the petitioner.

Appeals of the Final Hearing Decision

The A/R, AREP, or the agency has the right to appeal the final OSAH hearing decision. The internal process for the agency to request an appeal is outlined below.

Agency Appeal of the Final Hearing Decision

Clearance from the DFCS Medicaid Policy Unit should be obtained to ensure the appeal request meets the hearing criteria before submitting its request for an appeal. If an appeal is warranted, the County Request for a Final Appeal, Form 136 and supporting documentation should be sent to the Fair Hearing Coordinator Supervisor who will email all documents to the DFCS Office of General Counsel (OGC). The OGC will review to determine the validity of the appeal and submit all approved requests for appeal to the Office of Attorney General to request that a civil action be commenced by the filing of a petition for judicial review in the appropriate Superior Court.

> A party has 30 days after service of the final decision to file a petition for judicial review. Service of the final decision is defined as the date the final decision was mailed, i.e., the date of the postmark or the date of the email (if delivered electronically). **If staff request an appeal of a final decision, the request must be submitted to OGC within 10 calendar days of the date the final decision was mailed/postmarked/emailed from OSAH (and if such time has expired, submit immediately).**

Because the petition for judicial review must be filed in the appropriate Superior Court within 30 days after service of the final decision, timely notification to the OGC is essential.

The designated reviewing authority reviews the final hearing decision, all related materials, renders a final decision, and notifies all parties of the final decision.

Applicant/Recipient Appeal of the Final Hearing Decision

The A/R or his/her authorized representative has the right to the following:

- appeal an initial decision within thirty (30) days from receipt of the decision

The A/R has the right to request continuation of Medicaid benefits pending a **final appeal decision**, provided the request for continuation is received within 14 days of the date of the initial hearing decision. For continuation of benefits, refer to Chart B.2 CONTINUATION OF MEDICAL ASSISTANCE PENDING AN APPEAL OF A FINAL HEARING DECISION.

The Department of Community Health (DCH) reserves the right to require the A/R to repay continued benefits if s/he loses the hearing.

County DFCS Appeal of the Final Hearing Decision

The county DFCS has the right to appeal an initial decision, within thirty (30) days.

Procedures

Processing a Final Appeal

Follow the steps below if the A/R or the county DFCS office requests an appeal of the final hearing decision:

Client Appeal - If DFCS receives a Petition for Judicial Review from the A/R or his/her authorized representative, the employee receiving such Petition must immediately email a copy of the Petition to the DFCS OGC.

Agency Appeal - Clearance from the DFCS Medicaid Policy Unit should be obtained to ensure the appeal request meets the hearing criteria before submitting appeal. If an appeal is warranted, Form 136 and supporting documentation should be sent to the Fair Hearing Coordinator Supervisor who will e-mail all documents to OGC. OGC will review to determine validity of appeal and submit to the Special Assistant Attorney General (SAAG) for filing in Superior Court. Petition must be filed in appropriate court within 30 days after service of the final decision. A courtesy copy of the petition will be sent to Department of Community Health.

Client & Agency Appeal - Superior Court reviews the A/R's Appeal, renders a decision and notifies all parties (A/R, DFCS). Note that there are instances where a Petition may be withdrawn.

Appendix B OSAH Responsibilities

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	OSAH Responsibilities		
	Effective Date:	July 2024		
	Chapter:	Appendix B	**Policy Number:**	N/A
	Previous Policy Number(s):	MT 60	**Updated or Reviewed in MT:**	MT-72

Requirements

The Office of State Administrative Hearings (OSAH) has specific duties regarding the conduct and requirements of a hearing, which are conducted consistent with Georgia's Administrative Procedure Act, other applicable laws, regulations, and OSAH's Administrative Rules of Procedure.

Basic Considerations

OSAH Actions and Responsibilities

The OSAH initiates the following actions as needed:

- provides, at least ten (10) days prior to the hearing, advance written notice to all involved parties to permit adequate preparation of the case
- changes the time and/or location of the hearing upon its own motion or for good cause shown by the applicant/recipient (A/R)
- adjourns, postpones, or reopens the hearing for receipt of additional information at any time prior to the mailing of the state's decision on the case
- conducts a group hearing, consolidating cases where the sole issue involved is one of state and/or federal law, regulation or policy
- conducts a single hearing for multiple programs, if determined appropriate
- conducts the hearing on a newly emerged issue if, at the hearing it becomes evident that the issue involved is different from the one on which the hearing was originally requested
- orders an independent medical assessment or professional evaluation, at agency expense, if the hearing involves medical issues such as a diagnosis, an examining physician's report or a medical review team's decision. The source of the evaluation must be satisfactory to the A/R and the agency.

  Members of the medical review team may not be subpoenaed.

- determines numbers of persons who may attend the hearing
- denies or dismisses a hearing request.
- utilizes only the facts or opinions that are evidence of record or which may be officially noticed and are, therefore, subject to the rights of objection, rebuttal, and/or cross examination by the involved parties. The Administrative Law Judge (ALJ) is the sole "trier of facts".

- makes a decision within ninety (90) days from the date of the receipt of the written request for a hearing
- mails the hearing decision to all involved parties
- informs the claimant of appeal rights and that an appeal may result in a reversal of the final hearing decision.

The Hearing Decision

Hearing decisions become a part of the case record and must meet the following criteria:

- comply with all federal and state laws, regulations and policies
- take into consideration only those issues directly related to the action appealed
- be based on evidence and other material introduced at the hearing
- be accessible to the public, with the identity of the A/R protected

The Administrative Law Judge's Official Record

The Administrative Law Judge (ALJ) official record must meet the following criteria:

- contain the substance of what transpired at the hearing and all papers and requests filed in the official proceedings
- be available to the A/R or its representative by appointment for copying and inspection
- requesting a response to any additional material or documentary evidence from the agency
- basing the final decision on the record from the ALJ.
- notifying the A/R in writing of the final decision and the right to a judicial review.

Use the following chart to determine whether to continue, reinstate or change benefits pending an initial hearing decision.

CHART B.1 - CONTINUATION OF BENEFITS PENDING A FINAL HEARING DECISION

IF THE A/R REQUESTS A HEARING	THEN, WHILE THE INITIAL HEARING DECISION IS PENDING,
within 14 days of the date of the timely notice and requests continuation of benefits	continue Medical Assistance at a level equivalent to the level prior to the date of the timely notice. Continue the vendor payment and patient liability or cost share, if applicable.
within 14 days of the date of the adequate notice and requests continuation of benefits	reinstate Medical Assistance at a level equivalent to the level prior to the date of the adequate notice. Reinstate the vendor payment and patient liability or cost share, if applicable.
and claims Good Cause for not appealing during the 14-day timely notice period	Reinstate benefits only upon approval by the ALJ.
and the Medically Needy budget period has ended	determine spend-down for a new budget period and allow the A/R to submit medical bills.

IF THE A/R REQUESTS A HEARING	THEN, WHILE THE INITIAL HEARING DECISION IS PENDING,
and a change, other than a mass change, affecting eligibility occurs	change the benefits appropriately unless the A/R requests a hearing on the subsequent change and requests continuation of benefits. Notify the ALJ.
and a mass change is required	change the benefits appropriately and notify the ALJ. Continuation or reinstatement following a mass change is appropriate only if the ALJ determines that the mass change was incorrectly applied.

Use the following chart to determine whether to continue, reinstate or change benefits pending an appeal of an initial hearing decision

CHART B.2 - CONTINUATION OF MEDICAL ASSISTANCE PENDING AN APPEAL OF A FINAL HEARING DECISION

IF THE A/R REQUESTS AN APPEAL OF THE FINAL HEARING DECISION	THEN, WHILE THE APPEAL OF THE FINAL DECISION IS PENDING
within 14 days of the final hearing decision and requests continuation of benefits	continue Medical Assistance, including vendor payment and cost share or patient liability, previously continued pending the final hearing decision.
and claims Good Cause for not appealing the final hearing decision within 14 days of the decision	reinstate benefits, including vendor payment and patient liability/cost share, only upon approval by the DFCS Medicaid Policy Unit.
and the Medically Needy budget period has ended	determine eligibility for a new budget period and allow the A/R to submit medical bills.
and a change, other than a mass change, affecting eligibility occurs	change the benefits appropriately and notify the DFCS Medicaid Policy Unit.
and a mass change is required	change the benefits appropriately and notify the DFCS Medicaid Policy Unit. Continuation or reinstatement following a mass change is appropriate only if the DFCS Medicaid Policy Unit determines that the mass change was incorrectly applied.

CHART B.3 - ADJUSTMENT OF MEDICAL ASSISTANCE BASED ON THE DECISION FROM AN FINAL HEARING OR THE APPEAL OF AN FINAL HEARING

IF BENEFITS WERE	THEN
continued or reinstated prior to the hearing or appeal and the decision is favorable to the A/R	continue Medical Assistance benefits. Take action to issue any corrective vendor payment as authorized by the ALJ or Superior Court.
not continued or reinstated prior to the hearing or the appeal and the decision is favorable to the A/R	approve Medical Assistance retroactively and issue corrective vendor payments as directed by the ALJ or DFCS Medicaid Policy Unit.

IF BENEFITS WERE	THEN
continued or reinstated prior to the hearing or the appeal and the decision is favorable to the agency	provide adequate notice and reflect the decrease in benefits the month following the decision. Do not advise the A/R that s/he may request another hearing, as the hearing decision serves as adequate notice of appeals rights.
not continued or reinstated prior to the hearing or the appeal decision is favorable to the agency	maintain case in current status.

Appendix C Medicaid Issuance

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicaid Issuance		
	Effective Date:	October 2022		
	Chapter:	Appendix C	**Policy Number:**	Appendix C
	Previous Policy Number(s):	MT 64	**Updated or Reviewed in MT:**	MT-67

Requirements

Medicaid cards are issued to individuals eligible for Medicaid only benefits. Recipients present the cards to Medicaid providers to verify Medicaid eligibility.

Medicaid providers should confirm Medicaid eligibility at each visit via the Interactive Voice Response system (IVR) or GAMMIS web portal.

Basic Considerations

Medicaid eligibility determined by DFCS, is transmitted to the Department of Community Health (DCH) through interfaces.

Medicaid Cards

Upon approval of a Medicaid application, verification of eligibility for each member is included in the approval notice generated by the DFCS eligibility system and sent to the Head of Household (HOH). Thereafter, DCH issues each Medicaid eligible member a onetime Medicaid ID card to be used when the member wishes to obtain Medicaid services. The member's eligibility or ineligibility and any limitations associated with a particular COA under which eligibility is determined is reflected to the provider when the Medicaid eligibility is verified via the IVR or the GAMMIS web portal.

Certain Medicaid recipients are not issued or reissued a Medicaid card. Members who will not receive cards are those approved for:

- SLMB
- QI-1
- QDWI
- EMA under any COA
- Retroactive eligibility under any COA
- No reissuance of a Medicaid card if not eligible in current month
- Hospice if no "Lock In" received from the Hospice provider

Medicaid eligibility in DCH's computer system, Georgia Medicaid Management Information System (GAMMIS), may be viewed at www.mmis.georgia.gov by the member and by DFCS staff, if proper id and password have been provided.

The Gainwell Technologies Member Contact Center will be available by phone Monday through Friday (excluding state holidays) from 7am to 7pm at 770-325-2331 local or toll free outside the metro area at 1-866-211-0950.

Members may also confirm eligibility in GAMMIS by calling the Gainwell Technologies Member Contact Center and accessing the Interactive Voice Response system (IVR) at 1-866-211-0950.

The Gainwell Technologies Provider Contact Center is available to providers by phone Monday through Friday (excluding state holidays) from 7am to 7pm at 770-325-9600 local or toll free outside the metro area at 1-800-766-4456.

Providers may call the Gainwell Technologies Provider Contact Center to access the IVR at 1-800-766-4456. The IVR is operational 24 hours a day, seven days a week. Callers who prefer speaking with a person may opt out of the IVR once it is accessed. Providers may verify pharmacy eligibility by calling Optum Rx at 1-800-766-4456. For clinical-prior authorization support, call 1-866-525-5827. Members eligible for SLMB, QI-1 or QDWI only will be shown as ineligible on the web portal and IVR.

DCH performs nightly card runs to issue cards to newly eligible members and to members who have reported lost or undelivered cards. Members enrolled in a CMO will have their Medicaid card mailed from the assigned CMO only. Recipients should not expect the Medicaid card for seven to ten days from date of Medicaid approval or request for replacement card. Replacement cards will not be issued to A/Rs who are not eligible in the month of request or who were not to be issued a card as outlined on page 1. Also, replacement Medicaid cards cannot be ordered through the GAMMIS system for members enrolled in a CMO.

Medicaid cards are mailed to the residential or mailing address provided to DCH by SSA or DFCS through computer system interfaces.

Medicaid cards that cannot be delivered to the HOH are returned to the facility in Tucker, Georgia. Members who need a replacement card should notify the Member Contact Center to update the address and reissue the card. If the member is enrolled in a CMO, they should contact their CMO for a replacement card. The member should also notify DFCS of any change in address to be changed in Gateway. Gateway data is the source data and will override what is manually changed in GAMMIS. Thus, if the address is changed in GAMMIS, but not in Gateway, the problem will reoccur. DCH is responsible for verifying Medicaid eligibility for all Georgia Medicaid members for Medicaid providers.

Medicaid Identification Numbers

A 9-digit client ID number is assigned by Gateway and passed to DCH via the interface. GAMMIS assigns a 12-digit Medicaid number. Numbers issued prior to 11/1/10 will start with '111', numbers issued after 11/1/10 will start with '222'. A Medicaid provider should be able to file Medicaid claims by using DCH's 12-digit number. SSI recipients may use their 9-digit Social Security Number plus an "S" (i.e.,123456789S) or the 12-digit GAMMIS number.

Other Medicaid Eligibility Forms

Other Medicaid eligibility forms are issued to the member in the following situations:

- Form 962, Certification of Medicaid Eligibility, when medical services are needed prior to the time a Medicaid card is issued by DCH, when the member requests verification of retroactive Medicaid, or eligibility cannot be entered in Gateway (Refer to Chart C.1). The DFCS worker uploads a copy of Form 962 to GAMMIS Web Portal at www.mmis.georgia.gov. The Form 962 revised 07/2021 is used for both current and historical months. Please refer to the MA SharePoint for most current version of Form 962.

  Form 962 should never be issued for QMB, SLMB, QI-1, or QDWI recipients

- Form DMA 632 (Presumptive Pregnant Women), and 632H, (Hospital Presumptive Eligibility), is issued by the Public Health Department and certain "qualified Providers", and a copy is forwarded to DFCS/RSM. The presumptive Medicaid number is used by the member until such time a plastic Medicaid card is mailed.
- Form DMA 632W (Eligibility Determination for Women's Health Medicaid Program) is issued by the Public Health departments and its designated partner providers. A copy is forwarded to the local RSM worker. This certification form entitles women, who have been diagnosed with breast or cervical cancer, to all Medicaid covered services

Procedures

Non-Emergency Situations

Form 962 or other historical database corrections should be uploaded to GAMMIS Web Portal at www.mmis.georgia.gov. Please refer to the MA SharePoint for Instructions for Uploading 962's.

For newly approved/recertified SSI clients, upload the SSI Certification Letter to the GAMMIS Web Portal at www.mmis.georgia.gov. Optum Rx will be updated for prescriptions via the GAMMIS interface.

Existing/ongoing SSI clients should report changes/corrections through the Member Contact Center by accessing the Interactive Voice Response system (IVR) at 1-866-211-0950.

GAMMIS and Optum Rx will be updated with eligibility via the interface.

Emergency Situations

For newly approved SSI clients complete the following:

- Upload the SSI Certification letter to the GAMMIS Web Portal at www.mmis.georgia.gov.
- In the event of an emergency call the Member Contact Center using the dedicated DFCS line at 1-877-512-3130 (ask for Member Enrollment) to have the client added to GAMMIS. Please inform the Member Enrollment agent if prescriptions are needed.

For emergency prescriptions or other COAs with prescription problems, complete the following:

- Verify in GAMMIS that the customer is showing active. Use either the web portal or IVR. If A/R is not showing eligible in GAMMIS, send the emergency request to membernotification@dch.ga.gov.

Prior Approval and Emergency Doctor's Visits

For out-of-state providers rendering emergency services, providers follow Policies and Procedures for Hospital Services, Section 909 as found on the GAMMIS web portal, Provider's Manuals.

Out-of-State Providers and Service Limitations: Out-of-State hospital providers not enrolled in the Georgia Medicaid program as participating providers will be reimbursed for covered services provided to eligible Georgia members while out-of-state if the claim is received within twelve months from the month of services, and if at least one of the following conditions is met:

- The service was prior authorized by the Division, OR
- The service was provided as a result of an emergency or life-endangering situation occurring out-of-state. (If the out-of-state provider believes the medical record supports the existence of an emergency situation but the diagnosis does not justify an emergency, the claim must be submitted with a copy of the medical record.)

Providers can obtain more information regarding filing claims, or other questions at www.mmis.georgia.gov.

For physicians to have procedures prior approved, they should submit the Prior Authorization via the GAMMIS web portal.

In situations where A/Rs have used all of their allotted twelve doctors' appointments and who now need another doctor's visit, the doctor will need to file the claim manually and write on the top of the form that this is an emergency doctor visit and explain the nature of the emergency.

Georgia Families

Georgia Families is a partnership between the Department of Community Health (DCH) and Care Management Organizations (CMOs) to expand managed care in Georgia and promote increased access to and utilization of primary and preventative care. The Department of Community Health has contracted with three CMOs to provide these services throughout the state. They are:

Amerigroup 800-600-4441
www.amerigroup.com/medicaid

Peach State Health Plan 800-704-1484
www.pshpgeorgia.com

CareSource 855-202-0729
www.caresource.com

Members can contact Georgia Families for assistance to determine which program best fits their family's needs. If members do not select a plan, Georgia Families will select a health plan for them.

Members can visit the Georgia Families Website at www.georgia-families.com or call 1-800-GA-

ENROLL (1-888-423-6765) to speak to a representative who can give them information about the CMOs and the health care providers.

Children, pregnant women and women with breast or cervical cancer on Medicaid, as well as children enrolled in PeachCare for Kids® are eligible to participate in Georgia Families.

Enrollment in a (CMO) is a requirement for recipients in the following programs:

- Parent/Caretaker Medicaid
- Pregnant Woman Medicaid
- Child Under 19 Medicaid
- PeachCare for Kids®
- Women's Health Medicaid
- Transitional Medical Assistance
- Planning for Healthy Babies

The following recipients are not required to enroll in a CMO:

- People who need special medical services or live in an institution
- People on Medicaid who qualify for Medicare
- People on Medicaid that are government approved as part of an Indian tribe
- People who qualify for Supplemental Security Income (SSI)
- Children in the Children's Medical Services Program
- Children in the Georgia Pediatric Program
- Children with care coordination by the Multi-Agency Team for Children (MATCH) program
- People in Long Term Care
- People in the Service Options Using Resources in Community Environments (SOURCE) program
- People in Pre-Admission Screening and Resident Review
- People receiving Hospice Care
- People who get Health Insurance Premium Payments (HIPP)

CMO Issues

CMO issues that an A/R is unable to resolve by contacting the individual CMO should be forwarded to the Regional Medicaid Field Program Specialist, who will then route to the State Office for resolution.

Use the following chart to determine when Medicaid cards will be issued by DCH/and when DFCS should issue Medicaid authorization forms.

Chart C.1 - Issuance of Form 962, Certification of Medicaid Eligibility

IF	THEN
A newly eligible SSI recipient requires medical services prior to receiving his/her first Medicaid card from DCH **Non-emergency**	Advise the recipient to obtain a “Certification for SSI Eligibility Form” from SSA, AND once received in the county DFCS office, complete and issue a Form 962 to the recipient for the **current month only**, AND Upload a copy of the Certification for SSI Eligibility Letter to GAMMIS Web Portal at www.mmis.georgia.gov. OptumRX will be updated via the GAMMIS interface regarding prescriptions.
A newly eligible SSI recipient requires medical services prior to receiving his/her first Medicaid card from DCH **Emergency**	Advise the recipient to obtain a “Certification for SSI Eligibility Form” from SSA, AND Once received in the county DFCS office, complete and issue a Form 962 to the recipient for the **current month only,** AND County designee should **telephone the dedicated DFCS line to the Member Contact Center** at 1-877-512-3130 to add eligibility to GAMMIS, AND Upload a copy of the Certification for SSI Eligibility Letter to GAMMIS Web Portal at www.mmis.georgia.gov, AND If recipient needs emergency prescriptions, inform Gainwell Technologies member enrollment agent during update.

IF	THEN
An eligible Georgia SSI recipient **Life Threatening**	Advise the recipient to obtain a “Certification for SSI Eligibility Form” from SSA, AND Once received in the county DFCS office, complete and issue a Form 962 to the recipient for the **current month only,** AND County designee should **telephone the dedicated DFCS line to the Member Contact Center** at 1-877-512-3130 to add eligibility to GAMMIS, AND Upload a copy of the Certification for SSI Eligibility Letter to GAMMIS Web Portal at www.mmis.georgia.gov, AND Add a note to the 962 if prescriptions are needed for a life-threatening situation.
An SSI recipient from another state moves to Georgia AND continues to be eligible for Medicaid through SSI in Georgia AND Needs medical services the month of move	Advise the recipient to obtain a “Certification for SSI Eligibility Form” from SSA, AND Once received in the county DFCS office complete and issue a Form 962 to the recipient for the **current month only**, AND Request county designee to notify CIC by **telephone** 1-866-211-0950 that Form 962 is being issued, AND Upload a copy of the Certification for SSI Eligibility Letter to GAMMIS Web Portal at www.mmis.georgia.gov. AND If recipient needs emergency prescriptions, include a note on the 962.
A newly eligible Gateway A/R needs medical care or prescriptions before GAMMIS and Optum can update eligibility	Check GAMMIS for eligibility AND Upload Form 962 to GAMMIS Web Portal at www.mmis.georgia.gov for eligibility update and include case notes for the request

IF	THEN
Other situations	Other than the situations mentioned above, it is appropriate to upload a Form 962 for an A/R ONLY* in situations in which it is not possible to enter information into Gateway. These are: • Any month(s) over 13 months prior to current month • An AMN spenddown month which needs to have the first day liability amount decreased or the begin authorization date earlier than is shown in Gateway. *Form 962 should NEVER be given to providers, Nursing Homes, Cost Recovery agency, etc.

Please see next page for a Claims or Billing issue cheat sheet.

Other Considerations

You have a Claims or Billing Issue?

The Department of Community Health contracts with DFCS to perform correct eligibility determinations and to insure those are transmitted correctly to the GAMMIS Web Portal. When you are contacted with a claims or billing issue, you should:

- Check whether all months of eligibility are correct on Gateway, including any LA-D issues such as facility, patient liability, etc. If not, correct all months in Gateway. If so, proceed to your next step.
- Check whether all months are correct on the GAMMIS Web Portal. If not, FAX a 962 for correction to Gainwell Technologies Member Contact Center at 1-866-483-1045. Enter case notes in Gateway for any actions that cannot be corrected in the system
- If Gateway and GAMMIS are correct, you have no recourse to find a solution for the provider or member. At this point we need to make referrals to Gainwell Technologies or DCH if the Gainwell Technologies referral is not successful.

For Providers: All providers should have a policy manual regarding their billing and claims. They also have access to information including banner messages on www.mmis.georgia.gov.

Gainwell Technologies Provider Voice Response System: 1-800-766-4456
Gainwell Technologies Contact Us: www.mmis.georgia.gov

For Hospice Providers: Form for election/discharge/revocation/transfer are faxed to 1-866-483-1045, ATTN: Member Enrollment. Providers should follow up with their **field representatives** whenever there is a problem, with proof of their submission. Member enrollment is allowed 7 to 10 business days for this update from date of receipt.

For Members: Member information (non-eligibility specific) is found on www.mmis.georgia.gov
Gainwell Technologies Member Contact Center: 1-866-211-0950

DCH contact numbers are available on their website under Contact Us at dch.georgia.gov. This is available to the public, providers, and members.

Problem Resolution

Requests for manual updates that cannot be done via **Gateway** must be faxed to 1-866-483-1045.

Please allow 3-5 business days for Gainwell Technologies to update the information.

If there is not a timely response, please forward the issue through the appropriate chain of command within your office before using the emergent needs procedures below.

DCH has established a group email distribution list that will be monitored several times a day, for emergency issues only. This email address is membernotification@dch.ga.gov. Please use this email for the following escalated or emergent issues:

- Member approved in Gateway but not showing on the portal and the member has a medical emergency
- Name misspelling/DOB/SSN mismatch, and if it is an emergency which prevents the member from receiving services.
- Duplicate ID's
- Twins – only one showing up on the portal even though both are in Gateway
- Child put under wrong mother due to similar name or
- DOB with another child
- Optum Rx pharmacy updates/issues
- Buy-In request (problem issues not resolvable through Gainwell Technologies-use the Word buy-in form but send to the DCH address listed above.

Buy-in inquiries and buy-in data corrections should be faxed to the Gainwell Technologies Buy-In Unit at 1-866-483-1045. Workers should use the Buy-In template that is available in Appendix F. Gainwell will send written response to DFCS of the action taken on the inquiry/discrepancy.

Appendix E Glossary

:previous-policy-number:67

TERM or ABBREVIATION	DEFINITION
A & A	Aid and Attendance - The VA pays a medical benefit to certain vets, spouses of disabled vets and surviving spouses who are in need of nursing home care. Refer to Section 2499, "VA Aid and Attendance".
AA	Adoption Assistance – subsidy paid to adoptive parents through state and/or federal funds. See Sections 2817 and 2895.
ABD MEDICAID	Aged, Blind and Disabled Medicaid – Medical assistance for aged, blind or disabled individuals who are not eligible for SSI. These individuals receive Medicaid only.
ABD-MTF	Aid to Aged, Blind, or Disabled-Medicaid Treatment Facility - a class of medical assistance; covers ABD Medicaid nursing home recipients who received vendor payments in 12/73, and who have remained eligible under AABD standards. Previously referred to as "Grandfathered". Individuals covered under this COA are now eligible under the Nursing Home COA due to resource policy simplification effective in 1992.
ABON	Assistance Based on Need - a money payment based on financial need and funded solely by state or local finds (no federal or private funds involved).
AFA	Application for Assistance – the SUCCESS generated application for assistance. Obsolete as of 09/5/2017.
ADEQUATE NOTICE	Notification to the A/R of initial approval or a change in Medicaid eligibility or patient liability/cost share. Adequate notice must include the action taken, the effective date and a manual reference as a basis for the action.
AFDC	Aid to Families with Dependent Children - state administered cash assistance program for low-income families with dependent children under age 18. The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 eliminated the open-ended entitlement of AFDC. The PRWORA created the Temporary Assistance to Needy Families (TANF) block grant. However, some AFDC policies and procedures continue to be used in Medicaid classes of assistance for Children in Placement.
Alliant	Alliant - a private organization which contracts with DCH to determine whether individuals are suitable candidates for institutionalized care. Alliant determines the LOC for certain Medicaid A/Rs in Georgia. See Section 2240.
ALLOCATION	The amount set aside to provide for the needs of an ineligible child/spouse from the income of an ineligible spouse or ineligible parent before deeming the spouse/parent’s income to the Medicaid individual/child. The allocation amount is determined by subtracting the ineligible child’s adjusted gross income from the living allowance for an ineligible child. Refer to Living Allowance.
AMN	ABD Medically Needy - an ABD COA. To be considered under this COA, an A/R’s income and/or resources must exceed the limits for all other comparable COAs.
AMNIL	ABD Medically Needy Income Level - the MNIL used for the ABD Medically Needy (AMN) COA. Refer to MNIL.
APPLICATION	The action by which an individual indicates in writing his desire to receive assistance. The "date" of an application is the date a signed application is received by a local DFCS office or DCH.
A/R	Applicant/Recipient - applicant or recipient of public assistance or medical assistance only.

TERM or ABBREVIATION	DEFINITION
Assets	Assets include both income and resources, including income and resources which the A/R or spouse is entitled to but does not receive because of action by: • The A/R or spouse • A person, including a court or administrative body, with legal authority to act in place of or on behalf of the A/R or spouse • Any person, including any court or administrative body, acting at the direction or upon the request of the A/R or spouse.
AU	Assistance Unit – a group or individual(s) applying for or receiving benefits.
AV	Actual Value of ISM - The AV or PMV, whichever is less, is unearned income.
BAD	Begin Authorization Date - the first day of Medicaid eligibility for an AMN A/R., or the day the AMN spenddown is met.
BENDEX	Beneficiary Data Exchange System – A file that contains RSDI benefit information on individuals who are current or past recipients of public assistance.
BLINDNESS	Blindness is defined under Title XVI in the same medical terms as blindness is defined under Title II, namely, a central visual acuity of 20/200 or less in the better eye with the use of a correcting lens, or a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees. Unlike the Title II DIB Program, there is no duration requirement for blindness under Title XVI. If a Title XVI claimant is found to be otherwise eligible and is blind, he is eligible regardless of the anticipated duration of his blindness, i.e., the 12-month duration requirement does not apply when "blindness" is established. Also, unlike Title II, a blind individual is eligible for SSI payments even if he is engaging in substantial gainful activity provided, he meets the other requirements for eligibility, e.g., income and resources specifications.
BOARDER	An individual to whom lodging and meals are furnished and who pays a reasonable compensation for lodging and meals.
BONA FIDE EFFORT TO SELL	Real or personal property, which would be countable resources are excluded while an A/R is making an effort to sell said property. Refer to Section 2304, "Treatment of Resources for ABD Medicaid".
BG	Budget Group – A term that includes the AU members and the financially responsible parents who live with them. The budget group may also include other individuals who meet Family Medicaid relationship requirements.
CASH VALUE	The value of a liquid resource.
CCSP	Community Care Services Program - an ABD COA available to A/R's who are suitable candidates for NH care. Refer to Section 2131, "Elderly Disabled Wavier Program".
CHAMPUS/TriCare	TriCare provides medical care insurance for dependents of military personnel, dependents of deceased veterans, and retired military personnel and their dependents, a TPL.
CHILD	An individual who is neither married nor the head of household and is (1) under the age of 18, or (2) under the age of 22 and a student regularly attending a school, college, or university or a course of vocational or technical training designed to prepare him/her for gainful employment.
CLIENT ID	A randomly assigned number identifying an A/R or other household member in Gateway.
CMD	Continuing Medicaid Determination - formerly referred to as "ex parte" redetermination. A recipient's Medicaid eligibility cannot be terminated without considering eligibility under all COAs, including AMN.

TERM or ABBREVIATION	DEFINITION
CMS	Centers for Medicare and Medicaid Services – The section within the Department of Health and Human Services (HHS) which has the primary administrative responsibility for the Medicaid program. Formerly known as the Health Care Finance Administration (HCFA).
CMV	Current Market Value - the resale value of a non-liquid resource. Also, refer to Equity Value (EV), Fair Market Value (FMV), and Uncompensated Value (UV).
COA	Class of Assistance
COLA	Cost of Living Adjustment - an increase in RSDI or SSI benefits based on a rise in the cost of living, usually received every January.
COLOR OF LAW	Term applied to certain aliens residing in the U.S. in a status other than lawfully admitted for permanent residence.
COMMON LAW MARRIAGE	In the state of Georgia, a common law marriage is formed if both persons involved satisfy the following three conditions: (1) they are both free to marry, (2) they live together for at least one night and (3) they hold forth to the community as married. The common law marriage must have existed prior to 1/1/97 to be considered a marital relationship.
COMMINGLED FUNDS	The inclusion or combining of both excluded and non-excluded assets within a single financial account.
COMMUNITY SPOUSE	The legal spouse of an ABD A/R in Living Arrangement D who lives in the community.
CONVERTED INDIVIDUAL	Individual who was receiving AABD in 12/73 and who was automatically converted to SSI in 1/74; not to be confused with "Grandfathered". Refer to "Grandfathered".
COST SHARE	The amount of available income an EDWP recipient has to pay towards community care services received. This is comparable to patient liability for a NH recipient.
COUPLE	A man and woman who are married and living together. Non-legal marriages established on or after January 1, 1997, are not recognized in Georgia. Refer to Section 2502, Deeming.
CSE	Child Support Enforcement – administers the federal requirements to establish a program to enforce the obligation of absent parents to support their children.
CSV	Cash Surrender Value of a life insurance policy - the equity value, or the amount of money an owner of a policy will receive upon "cashing in" a policy. The CSV may or may not be an excluded resource.
CWFC	Child Welfare Foster Care – Children in Placement Medicaid COA funded through IV-B.
DAC	Disabled Adult Child - an adult child (18 years old or older) who receives RSDI disability on his/her parent's account.
DAS	Disability Adjudication Section - SSA section responsible for establishing disability for RSDI and SSI A/Rs.
DCH	Department of Community Health – agency responsible for maximizing the state's health care purchasing power, planning coverage for uninsured Georgians, coordinating health planning for state agencies and insuring individuals under the State Health Benefit Plan and various Medicaid programs and DCH initiatives.
DEEMING	Procedure which takes into account the income and resources of the responsible relative(s) of SSI and ABD Medicaid A/Rs.
DEEMED INCOME	The amount of income of a non-recipient that is budgeted as unearned income to the AU.
DEEMOR	The spouse with whom a LA-A or B A/R lives or the parent(s) with whom a child lives in LA-A, B, or C.

TERM or ABBREVIATION	DEFINITION
DEPENDENT FAMILY MEMBER	The spouse or dependent relative who lives on the A/R's homeplace during the A/R's absence from the homeplace. A relative is defined as one of the following: spouse, son, daughter, grandson, granddaughter, stepson, stepdaughter, in-laws, mother, father, stepmother, stepfather, grandmother, grandfather, aunt, uncle, sister, brother, stepsister, stepbrother, half-sister, half-brother, niece, nephew, cousin. Dependency may be found where the relative alleges any reasonable degree of reliance on the A/R's home place. Reasonable factors of dependency would be age, medical reasons, financial circumstances, etc. The degree of dependency is not material in this context. For example, it is not necessary to ascribe a dollar limitation for determining whether financial dependency exists.
DFACS or DFCS	Division (Department) of Family and Children Services - state/local agency under contract with DMA to determine a non- SSI A/R's eligibility for Medicaid
DISABILITY	Disability is defined under Title XVI in the same medical terms as under Title II, namely an inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment(s) which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. Unlike the Title II DIB program, Title XVI provides for a finding of disability in the case of a child under the age of 18 (who is neither married nor the head of a household) if he suffers from any medically determinable physical or mental impairment of "comparable severity," i.e., comparable to that which would prevent an adult from engaging in substantial gainful activity. Childhood disability will be determined solely upon consideration of medical factors.
DMA	Division of Medical Assistance – the division under DCH responsible for administering the Medicaid program in Georgia.
EDD	Eligibility Determination Document - SUCCESS generated interview document. (Obsolete as of 2017)
EDD	Estimated Date of Delivery – the date pregnancy is expected to terminate.
EDWP (CCSP)	Elderly Disabled Waiver Program formally known as Community Care Services Program - an ABD COA available to A/R's who are suitable candidates for NH care. Refer to Section 2131, "Elderly Disabled Waiver Program".
ELIGIBLE CHILD	The SSA term used for a child who is applying for or receiving SSI. The comparable ABD Medicaid term is Medicaid Child. Refer to Section 2502, Deeming.
ELIGIBLE COUPLE	The SSA term used for a couple when both spouses are applying for or receiving SSI. The comparable ABD Medicaid term is Medicaid Couple. Refer to Section 2502, Deeming.
ELIGIBLE INDIVIDUAL	The SSA term used for an adult who is not currently in a marital relationship who is applying for or receiving SSI. The comparable ABD Medicaid term is Medicaid Individual.
ELIGIBLE INDIVIDUAL WITH AN INELIGIBLE SPOUSE	The SSA term used for an Eligible Individual who lives with his/her Ineligible Spouse. The comparable ABD Medicaid term is Medicaid Individual with an Ineligible Spouse.
EMA	Emergency Medical Assistance – provides medical coverage to individuals who meet all requirements for a Medicaid COA except for citizenship/alienage and enumeration requirements and who require or have received an emergency medical service.
ESSENTIAL PERSON	An ineligible spouse whose needs were included in his/her eligible spouse's AABD grant in 12/73.
EV	Equity Value – CMV/FMV less any outstanding loans, mortgages, or other encumbrances on the asset. Generally used as the countable value of a non-excluded resource. Similar to the Uncompensated Value (UV) which refers to transferred assets.

TERM or ABBREVIATION	DEFINITION
ELE	Express Lane Eligibility- Enrollment strategy which begins with consent to an ELE determination for a child(ren)'s potential Medicaid eligibility and ends with notification to the Assistance Unit (AU) of its eligibility status.
EXTENDED CARE	Skilled NH care for Medicare recipients admitted to Medicare approved SNFs within 30 days of discharge from a hospital.
FBR	Federal Benefit Rate - maximum SSI benefit based on the A/R's living arrangement and marital relationship. The FBR is used as the income limit in determining eligibility for SSI and some ABD COAs.
FCI	Federal Countable Income - net income, consisting of gross income less income exclusions and deductions that is budgeted to determine eligibility when using the FBR as the income limit.
FICM	Family Independence Case Manager – DFCS employee responsible for determining an A/R's eligibility for TANF, Food Stamps and Medicaid.
FM	Family Medicaid - provides Medicaid benefits for low-income families and individuals who are not receiving SSI or any ABD Medicaid COA. Benefits are provided through a variety of COAs, each with its own specific eligibility criteria.
FM-MN	Family Medicaid Medically Needy – provides Medicaid coverage for children under 18 years of age and pregnant women whose BG income exceeds limits for all Family Medicaid COAs and PeachCare for Kids.
FMV	The Fair Market Value is the same as the Current Market Value (CMV). It is the value of an asset at the time it is transferred, or its value determined for resource eligibility. The FMV is an estimate of the value of an asset, if sold at the prevailing price at the time it was actually transferred or on the month(s) of request for Medicaid eligibility (if it is to be considered as a resource). Refer to "Uncompensated Value (UV)" and "Equity Value (EV)".
FPL	Federal Poverty Level - the monthly income amounts upon which the income limits for QMB are based.
FV	Face Value of a life insurance policy - the amount of money the beneficiary will receive upon the death of the insured.
GATEWAY	An integrated computer system that records information and generates benefits to AUs.
GRANDFATHERED	Status given to persons exempted from a change in regulations as follows: 1. Persons in MTFs who have been continuously eligible under AABD regulations since 12/73 (see MTF-AABD). 2. Non-residents residing in LA-D and receiving Georgia Medicaid continuously prior to implementation of Georgia residency regulations in 2/80. 3. Persons receiving Medicaid continuously since prior to the transfer of assets policy effective 3/1/81. 4. Persons eligible before 7/1/84.
HIPP	Health Insurance Premium Payment – the purchase by DMA of a Medicaid individual's private health insurance if it is determined to be cost effective. Refer to Section 2230.
HOLDING OUT	Marital relationship of two persons of the opposite sex who are not legally married, but who live together and present themselves to the community as husband and wife. Refer to Section 2502.
IBON	Income Based on Need - payments based on financial need and which are made from partial or total federal funds, or from private charitable organizations, such as TANF, VA pensions and Salvation Army grants. IBON is not entitled to the $20 general deduction. Also, refer to Assistance Based on Need (ABON).

TERM or ABBREVIATION	DEFINITION
ICWP	Independent Care Waiver Program - the COA that provides Medicaid to individuals receiving in-home care through DMA approved providers. Refer to Section 2139, Independent Care Waiver Program.
ICF	Intermediate Care Facility - an institution furnishing, on a regular basis, health-related care and services to individuals who do not require the degree of care and treatment which a hospital or skilled nursing facility is designed to provide, but who, because of their mental or physical condition, require care and services (beyond the level of room and board) which can be made available to them only through institutional facilities. Considered to be LA-D.
ICF-MR	Intermediate Care Facility for the Mentally Retarded - an institution which provides diagnosis, treatment, or rehabilitation to mentally retarded persons or persons with related conditions in a protected residential setting which offers ongoing evaluation, planning, twenty-four hour supervision, and coordination and integration of health or rehabilitative services. Considered to be LA-D.
IEVS	Income Eligibility Verification System - periodic federally mandated system matches with other state and federal agencies, such as the Department of Labor and Social Security Administration.
IMMEDIATE FAMILY MEMBER	Family members of A/Rs determined eligible under an FBR COA for the purpose of determining some burial resource exclusions. Includes the A/R's spouse, minor and adult children, stepchildren, and adopted children, brothers, sisters, parents, adoptive parents, and the spouses of those persons. Dependency and living in the same household are not factors. Immediate family does not include the members of an ineligible spouse's family unless they are also within the appropriate degree of relationship to the eligible individual as defined above.
INDIVIDUAL	An A/R who is not currently in a marital relationship.
INELIGIBLE CHILD	A child under 18, or 22 if a student, who is not applying for or receiving Public Assistance (SSI, TANF or other IBON) or any category of Medicaid.
INELIGIBLE SPOUSE	The spouse of an SSI or ABD Medicaid A/R who is not applying for or receiving SSI or ABD Medicaid.
INS	Immigration and Naturalization Service see USCIS
IRA	Individual Retirement Account - private pension accounts held by financial institutions or investment firms.
IRA	Interstate Residency Agreement - an agreement between two states, whereby each state agrees to waive the state residency requirement for NH A/Rs who are under 18 or who became incapable to state intent prior to age 18. Refer to Section 2225, Residency.
IRS	Internal Revenue Service - an interface system that provides data on leads for investigating possible unreported/unearned income and undisclosed resources. Information is given to the state via a tape match with the IRS files. This is a mandated IEVS match.
ISM or S&M	In-kind Support and Maintenance (Support and Maintenance) - unearned income provided to an A/R in the form of food or shelter. Refer to Section 2430, Living Arrangement and In-kind Support and Maintenance.
LA	Living Arrangement - an A/R's LA establishes which income and resource limit to use and whether to develop ISM.
LEGAL MARRIAGE	A marriage that is formed under common law criteria or a legal ceremony.
LEGAL SPOUSE	A person who is married to another person by means of a legal ceremony or common law.
LIM	Low-Income Medicaid – provides Medicaid benefits for children up to age 18 and adults who are not receiving SSI.
LIVING ALLOWANCE	A specified amount used to determine the amount of income allocated to an ineligible child from the income of an ineligible spouse or parent(s) before deeming the spouse/parent's income to the Medicaid individual or Medicaid child(ren).

TERM or ABBREVIATION	DEFINITION
LOC	Level of Care - an eligibility requirement for all LA-D A/Rs. LOC verifies the mental/physical need for services received by an A/R residing in LA-D. Refer to Section 2240, Level of Care.
LOS	Length of Stay - an eligibility requirement for most LA-D A/Rs. Generally, an A/R must have been in LA-D for 30 continuous days to meet the LOS requirement. Refer to Section 2235, Length of Stay.
LTC	Long Term Care
MAGI	Modified Adjusted Gross Income (MAGI)-used to budget all applications and periodic renewals of financial eligibility for Parent/Caretaker with Child(ren), Children Under 19 Years of Age, Pregnant Women Medicaid, PeachCare for Kids® (PCK) and Planning for Healthy Babies® (P4HB).
MARITAL RELATIONSHIP	A relationship where two persons live together and hold forth to the community as married. The relationship does not have to be a legal marriage to be considered a marital relationship.
MAO	Medical Assistance Only - medical assistance for individuals who receive Medicaid through an ABD or Family Medicaid COA.
MBR	Master Benefits Record - the SSA response to a DFCS "query card" request for verification of an A/R's RSDI benefits. Contains data not on BENDEX or SDX.
MCCA	Medicare Catastrophic Coverage Act - the law that abolished the penalty of Medicaid ineligibility for transferring resources.
MEDICAID	Title XIX of the Social Security Act that provides grants to states for the establishment of medical assistance programs for low-income individuals and families.
MEDICAID CAP	The income limit used to determine income eligibility for an ABD Medicaid A/R in LA-D under certain COAs.
MEDICAID DESIGNEE	DFCS employee who has been designated to communicate by phone with the DMA.
MEDICAID NUMBER	A '111' or '222' number assigned to each Medicaid recipient that must be presented to Medicaid providers for the submission of claims. Refer to Appendix C, Medicaid Issuance.
MEDICARE	A federal health insurance program administered by the SSA for people 65 or older and certain disabled people. **PART A** - Hospital insurance. There is no premium for this coverage for persons who have adequate credits for work under Social Security. **PART B** - Supplemental medical insurance. Eligible persons must pay a monthly premium.
MIL	Minimum Income Level - a MSS term for the figure that ensures that an individual converted from AABD to SSI will not suffer a reduction in income (AABD/SGA plus FCI).
MMIS	Medicaid Management Information System - DMA's computer system.
MNIL	Medically Needy Income Level - the income level used to determine the spenddown under Medically Needy. Based on 133% of the TANF Family Maximum.
MONTH OF AUTHORIZATION	The month an application is approved for assistance.
MQT	Medicaid Qualifying Trust - A trust that meets the following conditions is considered to be a MQT: (1) The trust was set up by the A/R or deemor (2) with the A/R or deemor named as beneficiary and (3) contains the A/R's or deemor's own assets. Refer to Section 2336, Trust Property, Medicaid Qualifying.
MTF	Medical Treatment Facility - refers to any in-patient facility that renders medical treatment, such as a private and public general hospital, mental hospital or NH. See Title XIX MTFs.
MSS	Mandatory State Supplement - federally required state supplement payments to those converted individuals who would have had less income under SSI than they would have had if the AABD program had continued. The program is administered by SSA.

TERM or ABBREVIATION	DEFINITION
NCF or NF	Nursing Care Facility - a term which encompasses all NH levels of care: SNF, ICF and ICF-MR.
NH	Nursing Home
NON-RESTRICTED ACCESS	A term indicating that each co-owner of a jointly owned checking or savings account may withdraw funds without the signature(s) of the other co-owner(s), thereby making the entire account a countable resource to each co-owner.
NOW/COMP	New Options Waiver (NOW) and Comprehensive Supports Waiver Program (COMP)- A COA that provides in home and community-based services to Medicaid eligible mentally retarded and developmentally disabled individuals. Refer to Section 2132 New Options Waiver (NOW) and Comprehensive Supports Waiver Program (COMP).
PATIENT FUND ACCOUNT	An individual account set up by the NH for the convenience of the patient, whereby the patient may deposit his/her cash on hand until needed. All cash in a patient's account on the first day of the month is considered a resource for the entire month.
PE	Presumptive Eligibility – allows Qualified Providers, authorized by DMA, to make temporary determinations of Medicaid eligibility for pregnant women who meet income criteria.
PL	Public Law - A congressional law that creates a given COA, such as Public Law 94-566 (Pickle).
PL	Patient Liability - the portion of a Medicaid recipient's income that s/he is required to pay toward the cost of NH care.
PNA	Personal Needs Allowance - A specific amount of an A/R's income that s/he is allowed to retain prior to applying the remainder toward the cost of their patient liability or cost share.
PMV	Presumed Maximum Value - a limitation placed on the value of ISM that can be counted as unearned income to an individual residing in LA-A. The PMV is equivalent to one-third the FBR for LA-A plus the $20 general deduction.
POMS	Program Operations Manual System - SSA's manual containing procedural instructions and policies for all SSA programs. Prior to POMS, the SSI Manual was referred to as the SSI Claims Manual (CM).
PR	Personal Representative - a person who is in a position to know the financial and non-financial circumstances of the A/R, but who is not necessarily "financially responsible" for the A/R. A PR may make application for the A/R.
PRIOR MONTH	Any one of the three months prior to the month of application for SSI, ABD or Family Medicaid. Refer to Section 2053, Retroactive Medicaid.
PRO-RATA SHARE	The amount of household expenses divided by the number of people in the household. An amount used to determine an A/R's LA and amount of inside ISM.
PSI	Policy Studies, Inc.- previously administered PeachCare for Kids program through VIDA.
QDWI	Qualified Disabled Working Individuals - a "non-Medicaid" COA under which recipients are entitled only to Medicaid payment of their monthly Part A Medicare Premium.
QMB	Qualified Medicare Beneficiaries - a "non-Medicaid" COA under which recipients are entitled to limited Medicaid services, such as payment by Medicaid of their Medicare Premiums, deductibles, and co-insurance.
RESTRICTED ACCESS	A term indicating that the signatures of all co-owners of a checking or savings account are required for each co-owner to withdraw funds. "Restricted" accounts are not resources unless the only co-owners are spouses or parents and their minor children.
RETROACTIVE MONTHS	The three months prior to the month of application for SSI, ABD or Family Medicaid.
RR	Railroad Retirement - a benefit paid to disabled or retired employees of the railroad. Widow(er)s of former RR employees may also qualify for RR.

TERM or ABBREVIATION	DEFINITION
RSDI	Retirement, Survivors, Disability Insurance - the program of cash benefits administered by SSA. Entitlement is based upon the individual's employment history. Also known as OASDI.
RSM	Right from the State Medicaid – provides Medicaid to eligible children through the month in which the child turns 19 years of age and to pregnant women who meet all RSM eligibility criteria.
SCI	State Countable Income - December 1973 gross income less all AABD income exclusions and deductions. The "net income" used in computing AABD state grant amounts.
SDX	State Data Exchange - SSA interface system that provides information about SSI transactions. Information is provided through Federal SDX tapes and is available through Gateway inquiry.
SGA	State Grant Amount - the amount of cash assistance (not in excess of 6/73 standards of $99) received by AABD recipients in 12/73.
SLMB	Specified Low-Income Medicare Beneficiaries - a "non-Medicaid" COA that provides only for payment of the recipient's monthly Part B Medicare premium.
SOP	Standard of Promptness - the maximum number of days allowed to dispose of an application. Refer to Sections 2060, ABD Application Processing, and 2065, Family Medicaid Application Processing.
SPECIAL AGE 72 BENEFITS	A special monthly SSA cash payment made to a man who attained age 72 before 1972 or a woman who attained age 72 before 1970 who has worked under Social Security but has not earned enough quarters to be eligible for regular Social Security benefits. Also referred to as Prouty Benefits.
SMEU	State Medical Eligibility Unit - the unit responsible for making disability decisions for ABD Medicaid A/R's under age 65 if disability is not determined by DAS.
SNF	Skilled Nursing Facility - a nursing facility that provides more nursing care than an ICF. Refer to ICF (Intermediate Care Facility). Also, refer to Extended Care.
SNR	Special Needs Reduction - a MSS term that applies to the amount of decrease in an AABD/SGA caused by a reduction or termination of a special need, such as personal care.
SPOUSAL IMPOVERISHMENT POLICIES	Policies that apply to legal spouses when one spouse enters LA-D and the other spouse remains in the community. These policies include the following: (1) a substantial couple resource limit, (2) a provision for the LA-D spouse to transfer excess resources to the community spouse and (3) a provision allowing the LA-D spouse to divert a sizeable amount of income to the community spouse in the patient liability/cost share budget.
SPOUSE	A legal spouse is a member of a couple who has been married by legal ceremony. Refer to Section 2502 for the definition of a legal spouse prior to January 1, 1997.
SSA	Social Security Administration - the federal agency responsible for administering and providing RSDI, SSI, and Medicare to eligible individuals.
SSN	Social Security Number - The furnishing of a SSN is an eligibility requirement for all A/Rs except for individuals applying for EMA.
STATE BUY-IN	An automatic procedure whereby Medicaid pays the Medicare premiums of Medicaid eligible individuals. SSA bills DMA directly. The procedure should begin the second month following the month an individual is approved for Medicaid.
SSI	Supplemental Security Income - Title XVI of the Social Security Act provides for a federally administered cash assistance program based on financial need for low-income individuals who are aged, blind, or disabled. Considered IBON.
SUCCESS	System for the Uniform Calculation and Consolidation of Economic Support Services – an integrated computer system that records information and generates benefits to AUs. (Obsolete as of 2017)

TERM or ABBREVIATION	DEFINITION
SXC	SXC Health Solutions, Incorporated- The private contractor handling pharmacy claims and drug prior approval requests for DMA's pharmacy program. (Obsolete, OPTUM has replaced this vendor.
TANF	Temporary Assistance to Needy Families – Replaced AFDC as a cash assistance program for needy families.
TEFRA	Tax Equity and Fiscal Responsibility Act- The law that provides for a transfer of resources penalty of an unlimited number of months of Medicaid ineligibility for recipients who have been continuously eligible for Medicaid since on or before 6/30/88 but not prior to 7/01/84.
THIRTY CONTINUOUS DAYS	The length of time an individual is required to remain (or is expected to remain) in an LA-D situation in order to meet the Length of Stay (LOS) basic eligibility requirement. Refer to Section 2235, Length of Stay.
TIMELY NOTICE	A 12-day advance notification to advise recipients that benefits will be decreased or terminated unless they appeal before the expiration of the notice. Timely notice must include all information required for an adequate notice. Refer to Adequate Notice.
TITLE XIX (19)	The section of the Social Security Act that provides grants to states for the purpose of establishing medical assistance programs for low-income individuals and families.
TPR	Termination of Parental Rights – A court order which terminates the parent's rights and obligations with respect to the child and all rights and obligations of the child to the parent, including the rights of inheritance. Refer to the Foster Care Manual, Section 1013.9, for more information.
TPR/TPL	Third Party Resource/Third Party Liability - a medical benefit that provides for full or partial payment of a medical service(s) by Medicaid. Refer to Section 2230, Third Party Resources.
UCB	Unemployment Compensation Benefit – benefits administered by the Department of Labor to eligible unemployed benefits.
USCIS	United States Citizenship and Immigration Services- Agency within the Federal government that administers immigration services including permanent residence, naturalization, and asylum.
UV	Uncompensated value is the difference between the FMV/CMV at the time of transfer (less any outstanding loans, mortgages, or other encumbrances on the asset) and the amount received for the asset.
VA	Veterans Administration - the federal agency that provides VA benefits to some military veterans and their dependents and/or survivors.
VTR	Value of the One-Third Reduction - a one-third reduction in the value of the FBR for LA-A, or the difference between the FBR for LA-A and LA-B. The VTR takes into account ISM received by an A/R residing in LA-B. Refer to Section 2430, Living Arrangement and In-kind Support and Maintenance.
WHMP	Women's Health Medicaid Program – a Medicaid program for women diagnosed with breast and/or cervical cancer. This program is administered by the public health departments and their partner providers and offers the full range of Medicaid covered services to eligible women. Also known as the Breast and Cervical Cancer Prevention and Treatment Program.

Appendix F Forms TOC

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Table of Contents		
	Effective Date:	N/A		
	Chapter:	Appendix F	**Policy Number:**	Appendix F
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-73

Policy Statement

Only State Office approved forms may be used.

Voter Registration Application Form Information

For a copy of the Voter Registration Application Form and information on how to apply to register to vote, visit: sos.ga.gov/sites/default/files/forms/GA_VR_APP_2019.pdf Also, refer to Form # VRA-95.

Medicaid Forms Table of Contents

Form Number	Form Title	Revision Date	Order Info	Owner
1	<<medicaid:appendix-f::index:::attachment$form-1.docx	OSAH-1-Medicaid (Hearing Request)>>	07/23	Screen Print
OSAH	1	PeachCare for Kids Flyer (English)		Gainwell
DCH	6	LOC Approval/NH		Gainwell
DCH	6A	<<medicaid:appendix-f::index:::attachment$form-6a.docx	Physician's Recommendation for Pediatric Care>>	08/24
Screen Print	DCH	21	PeachCare for Kids Handbook	
Gainwell	DCH	41	PeachCare for Kids Handbook (Spanish)	
Gainwell	DCH	59	Authorization for NH Facility Reimbursement/Vendor Payment	

Form Number	Form Title	Revision Date	Order Info	Owner
Gainwell	DCH	71	Medicaid Disability Determination Inquiry (Obsolete as of 09/2013)	02/11
Screen Print	DHS	89	<<medicaid:appendix-f::index:::attachment$form-89.docx	Medicare Savings Programs Request for Information>>
08/24	Screen Print	DHS	94	<<medicaid:appendix-f::index:::attachment$form-94.docx
Medicaid Application>>	10/22	SO	DHS	94 LP
<<medicaid:appendix-f::index:::attachment$form-94-lp.docx	Medicaid Application (Large Print)>>	01/22	SO	DHS
94 SP	<<medicaid:appendix-f::index:::attachment$form-94-es.docx	Medicaid Application (Spanish)>>	10/22	SO
DHS	94 LP SP	<<medicaid:appendix-f::index:::attachment$form-94-es-lp.docx	Medicaid Application (Large Print Spanish)>>	01/22
SO	DHS	94A	<<medicaid:appendix-f::index:::attachment$form-94a.docx	Medicaid Streamlined Application>>
07/23	SO	DHS	94A LP	<<medicaid:appendix-f::index:::attachment$form-94a-lp.docx
Medicaid Streamlined Application (Large Print)>>	01/22	SO	DHS	94A SP
<<medicaid:appendix-f::index:::attachment$form-94a-es.docx	Medicaid Streamlined Application (Spanish)>>	10/22	SO	DHS

Form Number	Form Title	Revision Date	Order Info	Owner
94A LP SP	<<medicaid:appendix-f::index:::attachment$form-94a-es-lp.docx	Medicaid Streamlined Application (Large Print Spanish)>>	01/22	SO
DHS	94A Appendix A	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-a.docx	Streamlined Application Appendix A>>	07/23
SO	DHS	94A Appendix A SP	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-a-es.docx	Streamlined Application Appendix A (Spanish)>>
09/17	SO	DHS	94A Appendix A LP	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-a-lp.docx
Streamlined Application Appendix A (Large Print)>>	09/17	SO	DHS	94A Appendix A SP LP
<<medic-aid:appendix-f::index:::attach-ment$form-appendix-a-es-lp.docx	Streamlined Application Appendix A (Spanish Large Print)>>	09/17	SO	DHS
94A Appendix B	<<medicaid:appendix-f::index:::attachment$form-appendix-b.docx	Streamlined Application Appendix B>>	07/23	S0
DHS	94A Appendix B SP	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-b-es.docx	Streamlined Application Appendix B (Spanish)>>	09/17
SO	DHS	94A Appendix B LP	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-b-lp.docx	Streamlined Application Appendix B (Large Print)>>

Form Number	Form Title	Revision Date	Order Info	Owner
09/17	SO	DHS	94A Appendix B SP LP	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-b-es-lp.docx
Streamlined Application Appendix B (Spanish Large Print)>>	09/17	SO	DHS	94A Appendix C
<<medic-aid:appendix-f::index:::attach-ment$form-appendix-c.docx	Streamlined Application Appendix C>>	07/23	SO	DHS
94A Appendix C SP	<<medicaid:appendix-f::index:::attachment$form-appendix-c-es.docx	Streamlined Application Appendix C (Spanish)>>	04/22	SO
DHS	94A Appendix C LP	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-c-lp.docx	Streamlined Application Appendix C (Large Print)>>	09/17
SO	DHS	94A Appendix C SP LP	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-c-es-lp.docx	Streamlined Application Appendix C (Spanish Large Print)>>
09/17	SO	DHS	94A Appendix D	<<medic-aid:appendix-f::index:::attach-ment$form-appendix-d.docx
Streamlined Application Appendix D>>	07/23	SO	DHS	106
<<medic-aid:appendix-f::index:::attach-ment$form-106.docx	Insurance Clearance>>	06/24	Screen Print	DHS
107	<<medicaid:appendix-f::index:::attachment$form-107.docx	SSI Status Change>>	06/24	Screen Print

Form Number	Form Title	Revision Date	Order Info	Owner
DHS	109	<<medic-aid:appendix-f::index:::attach-ment$form-109.docx	SSI Cont Med Determination Notice (Ex Parte Cover Letter)>>	06/24
Screen Print	DHS	109 SP	<<medic-aid:appendix-f::index:::attach-ment$form-109-es.docx	SSI Cont Med Determination Notice (Ex Parte Cover Letter) (Spanish)>>
06/24	Screen Print	DHS	118	<<medic-aid:appendix-f::index:::attach-ment$form-118.docx
Request for Hearing>>	01/22	Screen Print	DHS	118 SP
<<medic-aid:appendix-f::index:::attach-ment$form-118-es.docx	Request for Hearing (Spanish)>>	02/10	Screen Print	DHS
123	Interagency/Interoffice Update and Follow-Up		Forms OL	DHS
124	<<medicaid:appendix-f::index:::attachment$form-124.pdf	Application for Health Insur-ance Premium Payments>>	11/22	Screen print
DCH	124I	Instructions: Application for Health Insur-ance Premium Payments	11/21	Screen Print
DCH	125	<<medic-aid:appendix-f::index:::attach-ment$form-125.pdf	CHIPPRA Appli-cation>>	05/23
Screen Print	DCH	129	<<medic-aid:appendix-f::index:::attach-ment$form-129.docx	Recipient Notice for Spousal Impoverish-ment>>
06/24	Screen Print	DHS	130	<<medic-aid:appendix-f::index:::attach-ment$form-130.docx
TANF and Fam-ily Medicaid Child and Med-ical Support Letter>>	06/16	Screen Print	DHS	130 SP

Form Number	Form Title	Revision Date	Order Info	Owner
<<medic-aid:appendix-f::index:::attach-ment$form-130-es.docx	TANF and Family Medicaid Child and Medical Sup-port Letter (Spanish)>>	06/16	Screen Print	DHS
136	<<medicaid:appendix-f::index:::attachment$form-136.docx	County Request for Final Appeal>>	02/10	Screen Print
DHS	138	<<medic-aid:appendix-f::index:::attach-ment$form-138.docx	Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Coop-erate with DCSS>>	6/16
Screen Print	DHS	138 SP	<<medic-aid:appendix-f::index:::attach-ment$form-138-es.docx	Notice of Requirement to Cooperate and Right to Claim Good Cause for Refusal to Coop-erate with DCSS (Spanish)>>
6/16	Screen Print	DHS	139	<<medic-aid:appendix-f::index:::attach-ment$form-139.docx
Contribution Statement>>	02/10	Screen Print	DHS	139 SP
<<medic-aid:appendix-f::index:::attach-ment$form-139-es.docx	Contribution Statement (Spanish)>>	02/10	Screen Print	DHS
171	<<medicaid:appendix-f::index:::attachment$form-171.docx	Parent to Child Deeming Work-sheet>>	10/12	Screen Print
DHS	172	<<medic-aid:appendix-f::index:::attach-ment$form-172.docx	ABD MAO Indi-vidual/Cou-ple/Spouse to Spouse Deem-ing>>	10/12
SO	DHS	172I	Instructions: ABD MAO Indi-vidual/Cou-ple/Spouse to Spouse Deem-ing	

Form Number	Form Title	Revision Date	Order Info	Owner
Screen Print	DHS	173	<<medic-aid:appendix-f::index:::attach-ment$form-173.docx	Verification Checklist>>
06/10	Screen Print	DHS	173 SP	<<medic-aid:appendix-f::index:::attach-ment$form-173-es.docx
Verification Checklist (Span-ish)>>	06/10	Screen Print	DHS	173I
Instructions: Verification Checklist		Screen Print	DHS	174
<<medic-aid:appendix-f::index:::attach-ment$form-174.docx	SMEU Medical Records Cover Letter>>	06/24	Screen Print	DHS
184	SMEU Data Report	06/24	SO	DHS
185	<<medicaid:appendix-f::index:::attachment$form-185.docx	Affidavit of Paternity>>	10/12	SO
DHS	214	<<medic-aid:appendix-f::index:::attach-ment$form-214.docx	Medicaid Notifi-cation Form>>	08/24
SO	DHS	214 SP	<<medic-aid:appendix-f::index:::attach-ment$form-214-es.docx	Medicaid Notifi-cation Form (Spanish)>>
11/07	SO	DHS	216	<<medic-aid:appendix-f::index:::attach-ment$form-216.docx
Declaration of Citizenship>>	06/24	Screen Print	DHS	216 SP
<<medic-aid:appendix-f::index:::attach-ment$form-216-es.docx	Declaration of Citizenship (Spanish)>>	06/24	Screen Print	DHS

Form Number	Form Title	Revision Date	Order Info	Owner
217	<<medicaid:appendix-f::index:::attachment$form-217.docx	Affidavit to Establish Identity for Medicaid Applicant/Recipients < 16>>	06/24	SO
DHS	217 SP	<<medicaid:appendix-f::index:::attachment$form-217-es.docx	Affidavit to Establish Identity for Medicaid Applicant/Recipients < 16 (Spanish)>>	06/24
SO	DHS	218	<<medicaid:appendix-f::index:::attachment$form-218.docx	Citizenship/Identity Verification Checklist>>
06/24	Screen Print	DHS	218 SP	Citizenship/Identity Verification Checklist (Spanish)
01/14	Screen Print	DHS	219	<<medicaid:appendix-f::index:::attachment$form-219.docx
Affidavit of Facts Concerning Citizenship>>	06/24	Screen Print	DHS	219I
Instructions: Affidavit of Facts Concerning Citizenship			DHS	219 SP
<<medicaid:appendix-f::index:::attachment$form-219-es.docx	Affidavit of Facts Concerning Citizenship (Spanish)>>	06/24	Screen Print	DHS
223	<<medicaid:appendix-f::index:::attachment$form-223.docx	Medicaid and IV-E Application for Foster Care>>	10/12	Screen Print
DHS	223I	Instructions:Medicaid and IV-E Application for Foster Care		Screen Print

Form Number	Form Title	Revision Date	Order Info	Owner
DHS	224	<<medic-aid:appendix-f::index:::attach-ment$form-224.docx	Removal Home Income and Asset Check-list>>	10/12
Screen Print	DHS	224I	Instruc-tions:Removal Home Income and Asset Checklist	
Screen Print	DHS]	225	<<medic-aid:appendix-f::index:::attach-ment$form-225.docx	IV-E Eligibility Documentation Sheet>>
10/12	Screen Print	DHS	226	<<medic-aid:appendix-f::index:::attach-ment$form-226.docx
Medicaid and IV-E Redetermi-nation Form>>	10/12	Screen Print	DHS	226I
Instruc-tions:Medicaid and IV-E Rede-termination Form	10/12	Screen Print	DHS	227
<<medic-aid:appendix-f::index:::attach-ment$form-227.docx	Notification of Change in Foster Care or Adoption Assistance>>	10/12	Screen Print	DHS
227I	Instructions:Notification of Change in Foster Care or Adoption Assistance	10/12	Screen Print	DHS
238	<<medicaid:appendix-f::index:::attachment$form-238.docx	Medically Needy Budget Sheet>>	08/11	SO
DHS	239M	<<medic-aid:appendix-f::index:::attach-ment$form-239m.docx	MAGI Budget Sheet>>	04/23
Screen Print	DHS	243	<<medic-aid:appendix-f::index:::attach-ment$form-243.docx	Providing Veri-fication of Citi-zenship for Medicaid>>

Form Number	Form Title	Revision Date	Order Info	Owner
05/08	Screen Print	DHS	243 SP	<<medicaid:appendix-f::index:::attachment$form-243-es.docx
Providing Verification of Citizenship for Medicaid (Spanish)>>	05/08	Screen Print	DHS	245
SMEU Request Form	06/24	SO	DHS	256
Interview Guide for TANF/FS/Medicaid		SO	DHS	285
Third Party Liability	01/06	Gainwell	DCH	297
<<medicaid:appendix-f::index:::attachment$form-297.docx	Application for TANF Food Stamps or Medical Assistance>>. For voter registration information refer to Voter Registration Application Form Information	07/23	SO	DHS
297	Application for TANF Food Stamps or Medical Assistance (Arabic Chinese Farsi Hmong Italian Portuguese Russian or Vietnamese)		Hard Copy Only	DHS
297 SP	<<medicaid:appendix-f::index:::attachment$form-297-es.docx	Application for TANF Food Stamps or Medical Assistance (Spanish)>> For voter registration information refer to Voter Registration Application Form Information	10/22	SO
DHS	297 LP	<<medicaid:appendix-f::index:::attachment$form-297-lp.docx	Application for TANF Food Stamps or Medical Assistance (Large Print)>>. For voter registration information refer to Voter Registration Application Form Information	12/21

Form Number	Form Title	Revision Date	Order Info	Owner
SO	DHS	297 SPLP	<<medicaid:appendix-f::index:::attachment$form-297-es-lp.docx	Application for TANF Food Stamps or Medical Assistance (Spanish Large Print)>>. For voter registration information refer to Voter Registration Application Form Information
12/21	SO	DHS	297A	Rights and Responsibilities
10/22	SO	DHS	297A	Rights and Responsibilities
	Hard Copy Only	DHS	297A SP	Rights and Responsibilities (Spanish)
10/22 (Spanish)]	SO	DHS	297A LP	<<medicaid:appendix-f::index:::attachment$form-297a-lp.docx
Rights and Responsibilities (Large Print)>>	12/21	SO	DHS	297A SPLP
<<medicaid:appendix-f::index:::attachment$form-297a-es-lp.docx	Rights and Responsibilities (Spanish Large Print)>>	12/21	SO	DHS
297M	Medicaid Addendum to Form 297 (Obsolete as of 12/2021)	01/14	SO	DHS
297M SP	Medicaid Addendum to Form 297 (Spanish) (Obsolete as of 12/2021)	01/14	SO	DHS
306	<<medicaid:appendix-f::index:::attachment$form-306.docx	Annuity Issuer Notification>>	08/24	Screen Print
DHS	315	<<medicaid:appendix-f::index:::attachment$form-315.docx	Official Notice of Georgia Medicaid Estate Recovery Program>>	10/21
Screen Print	DCH	315 SP	<<medicaid:appendix-f::index:::attachment$form-315-es.docx	Official Notice of Georgia Medicaid Estate Recovery Program (Spanish)>>

Form Number	Form Title	Revision Date	Order Info	Owner
10/21	Screen Print	DCH	315 LP	<<medicaid:appendix-f::index:::attachment$form-315-lp.docx
Official Notice of Georgia Medicaid Estate Recovery Program (Large Print)>>	10/21	Screen Print	DCH	315 SPLP
<<medicaid:appendix-f::index:::attachment$form-315-es-lp.docx	Official Notice of Georgia Medicaid Estate Recovery Program (Spanish Large Print)>>	10/21	Screen Print	DCH
327	<<medicaid:appendix-f::index:::attachment$form-327.docx	Estate Recovery Notification Form>>	07/22	Screen Print
DCH	328	<<medicaid:appendix-f::index:::attachment$form-328.docx	Quarterly Report Form>>	06/24
Screen Print	DHS	328 SP	<<medicaid:appendix-f::index:::attachment$form-328-es.docx	Quarterly Report Form (Spanish)>>
06/24	Screen Print	DHS	400	Medically Needy First Day Liability Authorization for Reimbursement
4/93	Hard Copy Only	DCH	403	<<medicaid:appendix-f::index:::attachment$form-403.docx
Adoption Assistance Benefits Memorandum>>	05/11	Screen Print	Adoptions	411
<<medicaid:appendix-f::index:::attachment$form-411.docx	Undue Hardship Waiver Application>>	06/24	Screen Print	DHS
411 SP	<<medicaid:appendix-f::index:::attachment$form-411-es.docx	Undue Hardship Waiver Application (Spanish)>>	06/24	Screen Print

Form Number	Form Title	Revision Date	Order Info	Owner
DHS	508	<<medicaid:appendix-f::index:::attachment$form-508.docx	Food Stamp TANF Medicaid Renewal Form>>.For voter registration information refer Voter Registration Application Form Information	10/22
SO	DHS	508 SP	<<medicaid:appendix-f::index:::attachment$form-508-es.docx	Food Stamp TANF Medicaid Renewal Form>>. For voter registration information refer to Voter Registration Application Form Information
10/22 (Spanish)	SO	DHS	508 LP	<<medicaid:appendix-f::index:::attachment$form-508-lp.docx
Food Stamp TANF Medicaid Renewal Form (Large Print)>>. For voter registration information refer to Voter Registration Application Form Information	12/21	SO	DHS	508 SPLP
<<medicaid:appendix-f::index:::attachment$form-508-es-lp.docx	Food Stamp TANF Medicaid Renewal Form (Spanish Large Print)>>. For voter registration information refer to Voter Registration Application Form Information	12/21	SO	DHS
512	<<medicaid:appendix-f::index:::attachment$form-512.docx	Notification of Eligibility-EMA>>	06/24	Screen Print
DHS	512 SP	<<medicaid:appendix-f::index:::attachment$form-512-es.docx	Notification of Eligibility-EMA (Spanish)>>	06/24

Form Number	Form Title	Revision Date	Order Info	Owner
Screen Print	DHS	526	<<medicaid:appendix-f::index:::attachment$form-526.docx	Physician's Statement for EMA>>
08/24	Screen Print	DCH	700	<<medicaid:appendix-f::index:::attachment$form-700.docx
Application for Medicaid & Medicare Savings for Qualified Beneficiaries>>	10/22	SO	DHS	700 SP
<<medicaid:appendix-f::index:::attachment$form-700-es.docx	Application for Medicaid & Medicare Savings for Qualified Beneficiaries (Spanish)>>	10/22	SO	DHS
700 LP	<<medicaid:appendix-f::index:::attachment$form-700-lp.docx	Application for Medicaid & Medicare Savings for Qualified Beneficiaries (Large Print)>>	01/22	SO
DHS	700 SPLP	<<medicaid:appendix-f::index:::attachment$form-700-es-lp.docx	Application for Medicaid & Medicare Savings for Qualified Beneficiaries (Spanish Large Print)>>	01/22
SO	DHS	701	<<medicaid:appendix-f::index:::attachment$form-701.docx	Q-Track Brochure>>
08/24	SO	DHS	703	<<medicaid:appendix-f::index:::attachment$form-703.docx
Medicare Buy-In Problem Template>>	06/24	Screen Print	DHS	704
<<medicaid:appendix-f::index:::attachment$form-704.docx	TEFRA/Katie Beckett Cost Effectiveness Form>>	10/04	Screen Print	DCH

Form Number	Form Title	Revision Date	Order Info	Owner
705	<<medicaid:appendix-f::index:::attachment$form-705.docx	TEFRA/Katie Beckett LOC Determination Routing Form>>	05/12	Screen Print
DCH	706	<<medicaid:appendix-f::index:::attachment$form-706.docx	TEFRA/Katie Beckett Medical Necessity LOC Statement>>	01/18
Screen Print	DCH	713	<<medicaid:appendix-f::index:::attachment$form-713.docx	Interagency Interoffice referral/ Follow Up>>
11/10	SO	DHS	809	<<medicaid:appendix-f::index:::attachment$form-809.docx
Verification of Earned Income>>	06/16	SO	DHS	809 SP
<<medicaid:appendix-f::index:::attachment$form-809-es.docx	Verification of Earned Income (Spanish)>>	06/16	SO	DHS
936	<<medicaid:appendix-f::index:::attachment$form-936.docx	QIT Certification>>	06/24	Screen Print
DCH	937	<<medicaid:appendix-f::index:::attachment$form-937.docx	QIT Review Letter>>	06/24
Screen Print	DHS	937 SP	<<medicaid:appendix-f::index:::attachment$form-937-es.docx	QIT Review Letter (Spanish)>>
06/24	Screen Print	DHS	938	[Understanding Medicaid (Spanish)]
	Gainwell	DCH	939	[Understanding Medicaid]
	Gainwell	DCH	942	<<medicaid:appendix-f::index:::attachment$form-942.docx
IME Verification Form>>	08/24	Screen Print	DHS	943

Form Number	Form Title	Revision Date	Order Info	Owner
<<medic-aid:appendix-f::index:::attachment$form-943.docx	Notification of Deduction of Medical Expense>>	06/24	Screen Print	DHS
944	<<medicaid:appendix-f::index:::attachment$form-944.docx	IME Query Form>>	06/24	Screen Print
DCH	945	<<medic-aid:appendix-f::index:::attachment$form-945.docx	QIT Trustee Guide>>	06/24
Screen Print	DCH	945 SP	<<medic-aid:appendix-f::index:::attachment$form-945-es.docx	QIT Trustee Guide (Spanish)>>
06/24	Screen Print	DCH	946	<<medic-aid:appendix-f::index:::attachment$form-946.docx
QIT Frequently Asked Questions and Worksheet>>	06/24	Screen Print	DCH	946 SP
<<medic-aid:appendix-f::index:::attachment$form-946-es.docx	QIT Frequently Asked Questions and Worksheet (Spanish)>>	06/24	Screen Print	DCH
947	<<medicaid:appendix-f::index:::attachment$form-947.docx	QIT Approved Format Deviation>>	08/24	Screen Print
DHS	948	<<medic-aid:appendix-f::index:::attachment$form-948.docx	QIT Approved Template 1>>	08/24
Screen Print	DCH	949	<<medic-aid:appendix-f::index:::attachment$form-949.docx	QIT Checklist>>
08/24	Screen Print	DCH	950	<<medic-aid:appendix-f::index:::attachment$form-950.docx
Facility Action Request>>	10/12	Screen Print	DHS	954

Form Number	Form Title	Revision Date	Order Info	Owner
<<medic-aid:appendix-f::index:::attach-ment$form-954.docx	OptumRx Prescription Update Template>>	06/24	Screen Print	DHS
955	<<medicaid:appendix-f::index:::attachment$form-955.docx	Notice of Review of Promissory Note Loan or Property Agree-ment>>	06/24	Screen Print
DHS	955 SP	<<medic-aid:appendix-f::index:::attach-ment$form-955-es.docx	Notice of Review of Promissory Note Loan or Property Agree-ment (Span-ish)>>	06/24
Screen Print	DHS	956	<<medic-aid:appendix-f::index:::attach-ment$form-956.docx	Special Needs Trust Routing Form>>
08/24	Screen Print	DHS	958	<<medic-aid:appendix-f::index:::attach-ment$form-958.docx
Nursing Facility Information Request>>	06/24	Screen Print	DHS	960
<<medic-aid:appendix-f::index:::attach-ment$form-960.docx	IME Pricing Document>>	08/24	Screen Print	DCH
962	Certification of Medicaid Eligibility	07/23	SO	DHS
963	Medicaid Notification Form	01/07	SO	DHS
963I	Instructions: Medicaid Notification Form			DHS
966	<<medicaid:appendix-f::index:::attachment$form-966.docx	Absent Parent Information Form>>	08/24	Screen Print
DHS	967	<<medic-aid:appendix-f::index:::attach-ment$form-967.docx	Non-Emergency Medical Trans-portation Infor-mation Sheet (NEMT)>>	08/24
Screen Print	DCH	967 SP	Non-Emergency Transportation Broker Sheet (Spanish)	

Form Number	Form Title	Revision Date	Order Info	Owner
Screen Print	DCH	968	<<medicaid:appendix-f::index:::attachment$form-968.docx	MN PL Budget Sheet>>
10/12	Screen Print	DHS	969	<<medicaid:appendix-f::index:::attachment$form-969.docx
Living Arrangement Determination - LA/ISM Guide>>	10/12	Screen Print	DHS	970
<<medicaid:appendix-f::index:::attachment$form-970.docx	VA Communication Form>>	08/24	SO	DHS
984	<<medicaid:appendix-f::index:::attachment$form-984.docx	Burial Contract Verification>>	07/24	Screen Print
DHS	985	<<medicaid:appendix-f::index:::attachment$form-985.docx	Burial Exclusion and Designation>>	08/24
Screen Print	DHS	986	<<medicaid:appendix-f::index:::attachment$form-986.docx	MAO Cemetery Lot Verification>>
08/24	Screen Print	DHS	987	<<medicaid:appendix-f::index:::attachment$form-987.docx
Designation of Cemetery Lot>>	08/24	Screen Print	DHS	988
<<medicaid:appendix-f::index:::attachment$form-988.docx	Notice of Review of Annuity>>	06/24	Screen Print	DCH
988 SP	<<medicaid:appendix-f::index:::attachment$form-988-es.docx	Notice of Review of Annuity (Spanish)>>	06/24	Screen Print
DCH	991	<<medicaid:appendix-f::index:::attachment$form-991.docx	MAO Property Search Record>>	08/24

Form Number	Form Title	Revision Date	Order Info	Owner
SO	DHS	995	<<medic-aid:appendix-f::index:::attach-ment$form-995.docx	Pathways Qualifying Activities Report Form>>
07/23	Screen Print	DHS	996	<<medic-aid:appendix-f::index:::attach-ment$form-996.docx
Pathways Good Cause RM and RA Form>>	07/23	Screen Print	DHS	998
<<medic-aid:appendix-f::index:::attach-ment$form-998.docx	Notice of Termination of Medicaid Benefits Due to Contract(s)>>	08/24	Screen Print	DHS
1610-U2	Public Assistance Agency Information	02/82	SSA	Social Security
3327	<<medicaid:appendix-f::index:::attachment$form-3327.docx	Health Check Brochure>>	10/22	Gainwell
DCH	3328	Health Check Brochure (Spanish)		Gainwell
DCH	3329	Health Check Brochure (Braille)		Gainwell
DCH	5459	<<medic-aid:appendix-f::index:::attach-ment$form-5459.docx	Authorization for Release of Information>>	07/16
SO	DHS	5459 SP	<<medic-aid:appendix-f::index:::attach-ment$form-5459-es.docx	Authorization for Release of Information (Spanish)>>
07/16	SO	DHS	5460	<<medic-aid:appendix-f::index:::attach-ment$form-5460.docx
Notice of Privacy Practices>>	12/23	Screen Print	DHS	5460 SP
<<medic-aid:appendix-f::index:::attach-ment$form-5460-es.docx	Notice of Privacy Practices (Spanish)>>	12/23	Screen Print	DHS

Form Number	Form Title	Revision Date	Order Info	Owner
	Notice of Privacy Practices (Arabic Chinese Farsi Hmong Italian Portuguese Russian Vietnamese)		Hard Copy Only	DHS
G-845-S	INS SAVE Document Verification		DHS	INS
SS-5	Application for a Social Security Card		SSA	Social Security
	<<medicaid:appendix-f::index:::attachment$form-foster-care-worker-card.docx	Foster Care Worker Card>>	04/04	Screen Print
DHS		<<medicaid:appendix-f::index:::attachment$form-gmwd-fact-sheet.docx	GMWD Fact Sheet>>	09/17
Screen Print	DHS		ICAMA Member Contact List	
NA	DHS		ICAMA Non-Member Contact List	
	DHS		<<medicaid:appendix-f::index:::attachment$form-iv-e-budget-sheet.docx	IV-E Budget Sheet>>
10/12	Screen Print	DHS		<<medicaid:appendix-f::index:::attachment$form-dcss-noncooperation-letter.docx
Letter of Non-Cooperation with DCSS>>	10/12	Screen Print	DHS	
<<medicaid:appendix-f::index:::attachment$form-level-of-care-agreement.docx	Level of Care Agreement>>		NA	DBHDD
	<<medicaid:appendix-f::index:::attachment$form-medicaid-review-repsonse-form.docx	Medicaid Review Response Form>>	05/16	Screen Print
DHS		<<medicaid:appendix-f::index:::attachment$form-medically-needy-option-statement.docx	Medically Needy Option Statement>>	05/15

Form Number	Form Title	Revision Date	Order Info	Owner
Screen Print	DHS		<<medic-aid:appendix-f::index:::attach-ment$form-medicare-part-d-complaint-checklist.docx	(Medicare) Part D Complaint Checklist>>
	Screen Print	CMS		<<medic-aid:appendix-f::index:::attach-ment$form-peachcare-spe-cial-request-form.docx
PeachCare Spe-cial Request Form>>		Screen Print	DCH	
<<medic-aid:appendix-f::index:::attach-ment$form-record-of-life-ins-poli-cies.docx	Record of Life Insurance Policies>>	01/07	Screen Print	DHS
	<<medicaid:appendix-f::index:::attachment$form-tefra-kb-cover-letter.docx	TEFRA/Katie Beckett Cover Letter>>	05/12	Screen Print
DHS		<<medic-aid:appendix-f::index:::attach-ment$form-tefra-kb-cover-letter-es.docx	TEFRA/Katie Beckett Cover Letter (Span-ish)>>	04/05
Screen Print	DHS		<<medic-aid:appendix-f::index:::attach-ment$form-tefra-kb-work-sheet.docx	TEFRA/Katie Beckett Work-sheet>>
08/11	Screen Print	DHS		<<medic-aid:appendix-f::index:::attach-ment$form-undue-hard-ship-letter.docx
Undue Hard-ship Waiver Letter>>	02/07	Screen Print	DHS	
<<medic-aid:appendix-f::index:::attach-ment$form-whm-pst.pdf	Women’s Health Medicaid Physician’s Statement of Treatment>>	09/23	Screen Print	DHS

Form Number	Form Title	Revision Date	Order Info	Owner
	Women’s Health Medicaid Physician’s Statement of Treatment (Spanish)	04/23	Screen Print	DHS
	Women’s Health Medicaid Review Form (Obsolete as of 21/2022)	01/14	Screen Print	DHS

Forms Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Forms Overview		
	Effective Date:	N/A		
	Chapter:	Appendix F	**Policy Number:**	Appendix F
	Previous Policy Number(s):		**Updated or Reviewed in MT:**	MT-41

Policy Statement

Only State Office approved forms may be used.

Basic Considerations

Medicaid Eligibility Specialists must **not** require more of applicant/recipients than placed by federal and state regulations and policies.

System generated notices and forms issued by the State Medicaid Unit and other State agencies are listed in Appendix F.

Use of State Office approved forms safeguards the following:

- Accessibility of the Medicaid Program
- Minimization of barriers to applying for benefits
- Simplification of the renewal process
- Compliance with the Office of Civil Rights
- Timely and Adequate notice of eligibility decisions

Forms Issued by Other Policy Units

Information obtained via forms issued by other policy units may be used in making Medicaid eligibility decisions, but should not be routinely used by MES'.

Forms issued by other policy units that **will** be used by MES' on a regular basis include the following:

- Form 138, Notice of Requirement to Cooperate with CSS
- Form 256, Interview Guide for TANF/FS/MAO
- Form 713, Interagency/Interoffice Referral and Follow-Up
- Form 809, Verification of Earned Income and Deductions
- Form 990, Verification of Unearned Income

Administrative Review Forms

Administrative Review Forms are located in Appendix H, Administrative Reviews. These forms may be obtained by screen print or by ordering through the State Office. See instructions later in this section.

Administrative Review Forms include the following:

- Family Medicaid CAR Selection Guide
- Family Medicaid Reading Guide
- Form 965, ABD Medicaid Supervisory Review
- Form 974, ABD Medicaid Monthly Supervisory Review Summary Sheet
- Foster Care Supervisory Review Form
- IV-E Supervisory Review Summary
- Non-IV-E Supervisory Review Summary

Ordering Forms

Most Medicaid forms are available in MS Word format in Appendix F of the Medicaid Manual found in the Department of Human Services' On-Line Directives Information System (ODIS) www.odis.dhr.state.ga.us.

The Appendix F Table of Contents indicates how to obtain forms.

Screen Print Forms

Screen Print: The form must be printed when accessing ODIS. There is no central printing or storage of this form

DCH Forms

DCH forms should be ordered through the GAMMIS web portal following these procedures:

1. Go to www.mmis.georgia.gov
2. Click the “contact us” tab in the upper-right hand corner of the page.
3. Complete the information in the fields and click “submit”.

The e-mail must include the name and phone number of person ordering the form, the form number and quantity of forms requested, specifying English, Spanish or Braille and the shipping address.

Department of Homeland Security (DHS Forms)

DHS: This form must be printed from the following Department of Homeland Security web site: uscis.gov/graphics/formsfee/forms/files/g-845s.pdf

The instructions for use of the form are at the bottom of page two of the form. Once the form is completed and documentation attached, the form should be mailed to:

U.S. Citizenship and Immigration Services Atlanta District
Martin Luther King, Jr.
Federal Building 77 Forsyth Street, SW
Atlanta, GA 30303

Forms OL

Forms OL: These forms must be printed when accessing DFCS Forms On-Line www.dfcs.dhr.georgia.gov/. From the DFCS home page, click on “About Us”. Then click on “Publications”. Then click on “DFCS Forms On-line”.

SSA Forms

SSA: Social Security Administration (SSA) forms must be printed from the following website:

EXCEPTIONS:

- Form SS-5 and instructions may be printed from the SSA website. The SS-5 is then submitted to the local SSA office either by mail or in person. The A/R must complete the form.

English version:
www.socialsecurity.gov/online/ss-5.pdf

Spanish version:
www.socialsecurity.gov/online/ss-5sp.pdf

- Form SS-1610-U2 must be ordered from the local SSA office.

N/A Forms

N/A: These forms are either generated by another agency or are reference only. Screen print is acceptable if available on ODIS.

Secretary of State Forms

Sec State: These forms must be ordered from the Secretary of State’s office at cfuller@sos.state.ga.us. The request should be to the attention of Carol Fuller. Fax requests must be made to 404-657-5367. The UPS shipping address and telephone contact number are required.

State Office Forms

SO: These forms must be ordered through the DFCS State Office.

PeachCare for KidsTM Forms

PeachCare for KidsTM applications and brochures can be ordered by using the PCK Special Request form located in Appendix F. This form can be emailed to sgreen@dch.ga.gov, or faxed to (770)344-3793.

Appendix G Cover Letters

MT 73 Cover Letter

MT 72 Cover Letter

MT 71 Cover Letter

MT 70 Cover Letter

MT 69 Cover Letter

MT 68 Cover Letter

MT 67 Cover Letter

MT 66 Cover Letter

MT 65 Cover Letter

MT 64 Cover Letter

MT 63 Cover Letter

MT 62 Cover Letter

MT 61 Cover Letter

MT 60 Cover Letter

MT 59 Cover Letter

MT 58 Cover Letter

MT 57 Cover Letter

MT 56 Cover Letter

MT 55 Cover Letter

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MT 27 Cover Letter

MT 26 Cover Letter

MT 25 Cover Letter

MT 24 Cover Letter

MT 23 Cover Letter

MT 22 Cover Letter

MT 21 Cover Letter

MT 20 Cover Letter

MT 19 Cover Letter

MT 18 Cover Letter

MT 17 Cover Letter

MT 16 Cover Letter

MT 15 Cover Letter

MT 14 Cover Letter

MT 13 Cover Letter

MT 12 Cover Letter

MT 11 Cover Letter

MT 10 Cover Letter

MT 9 Cover Letter

MT 8 Cover Letter

MT 7 Cover Letter

MT 6 Cover Letter

MT 5 Cover Letter

MT 4 Cover Letter

MT 3 Cover Letter

MT 2 Cover Letter

MT 1 Cover Letter

Appendix H Medicaid Administrative Review Overview

	Georgia Division of Family and Children Services Medicaid Policy Manual			
	Policy Title:	Medicaid Administrative Review Overview		
	Effective Date:	June 2021		
	Chapter:	Appendix H	**Policy Number:**	Appendix H
	Previous Policy Number(s):	MT 45	**Updated or Reviewed in MT:**	MT-64

Requirements

Medicaid records are subject to review by the Department of Community Health/Quality Control, the Georgia Office of Audits, DCH PERM Contractor, and by supervisory and administrative staff of the Georgia Department of Human Services/Division of Family and Children Services.

Basic Considerations

ME QC Reviews

The MEQC program is a statutory requirement under Section 1903(u) of the Social Security Act. It requires States to annually provide an estimate of improper payments in Medicaid based on eligibility reviews of States' recipients. MEQC is directed at improving the quality of State eligibility determinations. In Georgia, the MEQC process is managed by DCH and reviews are conducted on a monthly basis. DCH QC reviews 400 case records per month. This is a State level review and is not a measurement of benefit or claim errors but is used to measure the overall quality of case work conducted by DFCS Medicaid case managers.

LIM Negative Reviews

MEQC completes 150 desk reviews a month on LIM cases that are closed.

County staff are expected to take appropriate action in a timely manner as specified in the Communicator.

QC Rebuttals

Counties wishing to rebut QC findings should send a request for rebuttal to: mpayne@dch.ga.gov. In the request, counties should include the following:

- Case name
- AU ID number
- Review number

- County name, contact person, and phone number
- Reason for rebuttal

PERM Reviews

Payment Error Rate Measurement (PERM) is a Federal review overseen by the Center for Medicare and Medicaid Services (CMS), the Federal Medicaid oversight agency, which measures improper payments in Medicaid and the Children's Health Insurance Program (CHIP) based on reviews of States' eligibility determinations of applicants and recipients. Each state is reviewed once every three years, with the entire country being reviewed in a given three-year period. The next PERM sample period for Georgia will start October 2012.

Requests for Case Records

Cases for MEQC reviews are requested for the identified sample month on or around the 5th of each month. This request is sent to the DFCS Medicaid policy unit and the cases are screened in SUCCESS for their current location, COA and status of the case. The results are entered in an Excel spreadsheet and sorted by Region and county and includes the Load ID from STAT. Each Region is required to submit to the State Office Medicaid Unit a Case Record Request that includes:

- the name and contact information of a primary individual responsible in the Region for disseminating the record request to the counties in the Region
- the name and contact information of a back-up individual in case the request comes when the primary individual is away from the office
- the process the Region will use to disseminate the request to the counties in the Region, including time frames
- the process the Region will use to validate that case records have been mailed timely

Case records requests, including MEQC record requests, are sent to the primary and secondary contacts identified in the Region Case Record Request plan and to the Regional Management and Medicaid Field Program Specialists along with the due date specified by DCH. Case records are due to DCH by noon on the due date.

The county DFCS office for which the case is listed in SUCCESS as currently residing is responsible for returning the case record to DCH.

Cases should be checked prior to being sent in to ensure to the current volume is being sent; that documentation is complete; and that it has all received verification filed in it. Permanent verification should be pulled forward from any earlier volumes to current volume. If an action was completed in the review month by the Call Center which required verification, verification should be requested immediately from the Call Center and filed in the case record before forwarding to DCH.

The record should contain a cover sheet on where to return the record after the review is completed by DCH. Case records for different sample months should NOT be sent in the same package.

Five business days prior to the date due to DCH MEQC, each Region will report to the DFCS OFI Medicaid Unit that the case records have been sent to MEQC or why they have not been using the

original spreadsheet sent for the Request. Each record will be annotated sent or not sent, with an explanation for why any record was not sent.

For case records that cannot be located, the Region must:

- provide an explanation of the efforts taken to locate the record
- steps taken to ensure the legitimacy of the original actions taken; and
- for active cases where the record cannot be located within 30 days, conduct a complete renewal of all points of eligibility, including obtaining any required verification (including any needed permanent verification) no later than the month following the month the record was requested

If the Medicaid unit does not hear from a Region by the close of business on the fifth business day prior to the due date of the records, the Regional Manager will be called the following business day requesting an explanation.

A case that is reviewed and found correct will be returned to the county which currently has the case in SUCCESS. **The county which completed the action under review will get credit for a correct case.**

RSM Project MEQC/PERM Procedures

When case records are requested for MEQC/PERM review that are still with the RSM Project-

- the RSM Supervisor whose worker has the case will review the case prior to sending it in for review.
- If previous SUCCESS coding/documentation of citizenship/ID verification was used to approve the case, the RSM Supervisor will request of the originating county via email copies of the applicable verification be faxed directly to him or her.
- The email will have in the subject line “MEQC/PERM Verification Request, due (date)
- A copy of the email will go to the RSM Project Manager, the RSM Project Director, and the Medicaid Field Program Specialist for the Region.
- If there is no response after 5 days, the RSM Project supervisor will file a printed copy of the e-mail in the case record to show the documentation was requested from the original county.

The MEQC Citizenship/ID exception for such cases will be charged against the original county.

Mailing Addresses MEQC Reviews

Records for the MEQC review should be sent to:

Melanee Payne (mpayne@dch.ga.gov)
Medicaid Quality Control Program Director
Department of Community Health
P.O. Box 1984
Atlanta, GA 30301

If using UPS as the carrier, send to:

Melanee Payne (mpayne@dch.ga.gov)
Medicaid Quality Control Program Director
Department of Community Health
2 Peachtree St., NW 39th Floor
Atlanta, GA 30303

PERM Reviews

PERM case record requests should be returned to:

PERM Records Clerk
Medicaid Quality Control Program
Department of Community Health
P.O. Box 1984
Atlanta, GA 30301

If you are sending by UPS, send to:

PERM Records Clerk
Medicaid Quality Control
Department of Community Health
2 Peachtree St., NW 39th Floor
Atlanta, GA 30303

Please attach a printout of the spreadsheet listing the case record(s) being returned with the case(s) highlighted.

PERM/ME QC Review Responses

Responses requested are to be sent via email within 15 calendar days to the DCH reviewer and copied to the Medicaid Unit Manager and designee. No hard copy response is required. The response must include:

- Name of member reviewed
- Review #
- Type of Review (ME QC, PERM or LIM – this should be indicated at the top of the communicator)
- DCH reviewer
- Name/County/Position of the responder
- Include on the subject line: “MEQC (or PERM or LIM) Response: Member Name – Review # - County Name”.

Counties may use the MEQC/PERM Response form in Appendix F attached to an email to respond to ME QC, PERM and LIM errors. DCH email addresses are formatted first initial and last name followed by “@dch.ga.gov”. E.g. jdoe@dch.ga.gov.

Rebuttals

Rebuttals of MEQC, PERM or LIM errors should be submitted as soon as possible but no later than 15 Calendar days from receipt of the error.

Rebuttals must be routed through the Region Medicaid FPS who should review to ensure the rebuttal is appropriate and correctly address policy.

- Send to Melanee Payneat DCH (mpayne@dch.ga.gov) and CC the Medicaid Unit manager and designee.
- Include on the subject line: "MEQC (or PERM or LIM) Rebuttal: Member Name – Review # - County Name".
- Ensure that any copies of verification sent or faxed with the rebuttal are legible.

Errors/Exceptions on Transferred Cases

For cases that were transferred to another county after the sample month and are determined to have an error in sample month:

- The case record with the error summary will be returned to the county that sent in the record.
- The county should contact the Regional FPS indicating an exception or error was found on a transferred in case., who should contact the county that completed the action found to be an exception or in error (or the FPS for the Region if the county is in another Region) informing them of the exception/error.
- The county which completed the action under review is responsible for making any correction and will be assigned the exception/error.
- If necessary, the case should be transferred back to the responsible county to complete any necessary changes or corrections.
- After appropriate corrections and responses have been made, the case should be transferred back to the county of residence (if it had been transferred back to the original county) and the case record mailed back to that county.
- The FPS should inform the State Medicaid Unit when this occurs.

Department of Audits and Accounts

The Georgia Department of Audits and Accounts will conduct yearly reviews on a randomly selected sample of cases. Auditors reviewing cases are looking for the following:

- Application form
- Form 297A, if applicable
- Form 297M, if applicable
- Verification/Documentation of Citizenship/Immigration Status
- Verification/Documentation of Georgia Residency
- Verification/Documentation of Income

- Verification/Documentation of Resources
- Child Support forms, if applicable
- Third Party Liability Documentation/Form 285, if applicable
- CCSP and other Communicators, if applicable
- Medical bills for spend-down budgets
- Timely reviews and review forms

Findings from this review are shared with the Division of Family and Children Services and are generally not case specific.

State Medicaid Single Audit

A yearly single audit is conducted for DCH by the firm of Metcalf Davis, Mauldin & Jenkins. Included in the audit is a review of DFCS eligibility processes. Five counties are chosen for review with a total sample of 60 case records. This review is conducted July through August of each year. Findings from this review are shared with DCH and the Division of Family and Children Services and are generally not case specific.

County/Regional Reviews

County supervisors, administrative staff and Medicaid Program Specialists also review Medicaid records.

Each Medicaid supervisor should complete Medicaid Quality Checks on cases for members of his or her unit prior to being finalized in SUCCESS. The number of Quality Checks completed should be of a reasonable number but should not exceed 5 checks per month per worker in the unit.

Medicaid Quality Check

The Medicaid Quality Check is a targeted review completed by a supervisor or other designated reviewer prior to the Medicaid case being completed in SUCCESS. The elements under review are based on error trends identified in the MEQC, LIM or PERM review process. Elements for review can also be identified based on County or Regional needs. The Quality check is intended to be flexible and adaptive in order to reflect current needs and trends rather than identify issues or trends from three to six months in the past.

The objective of the Medicaid Quality Check is to ensure cases are determined correctly prior to finalization and that AUs are issued the Medicaid benefits for which they are entitled. Other objectives include:

- To identify error trends at various levels, from individual workers to statewide.
- To provide county and Regional departments with information necessary to request technical or training assistance from the State Office.
- To provide the State Office with information necessary to offer technical assistance to county departments and to develop quality improvement plans.

Targeted areas are read on a pass/returned basis. A case passes that has had all targeted areas of eligibility determined correctly in accordance with all relevant policy and procedures, including documentation standards. Cases which pass are those that can stand on their own in SUCCESS and the material in the case record without requiring additional explanation or documentation.

Quality Check Returns

A case is returned as part of the Medicaid Quality Check when any element under review does not pass. There are no deficiencies. All targeted elements should be read even when an element does not pass.

There six general reasons for which a particular area may not pass a quality check. These are:

- Policy misapplied
- Incomplete documentation
- Failure to verify
- Incorrect coding (SUCCESS)
- Reported information disregarded or not applied
- Computational error

These reasons should be annotated on the Quality Check form and compiled and reported as part of the county's monthly report of Case Review results.

A case that does not pass all targeted areas is subject to "return" and must be sent back to the case manager for correction prior to finalization. The reviewer should give the "return" an appropriate time frame in which to be resubmitted and subjected to another Quality Check.

Cases should be submitted for Quality Checks in a timely fashion to ensure completion within the applicable Standard of Promptness (SOP). Supervisors should select the cases for Quality Check and should NOT permit staff to select the cases to be checked. The supervisor should select a variety of case actions and COAs for review.

General guidelines for the current elements targeted in the Medicaid Quality check may be found in the Medicaid Quality Check Guidelines document.

Administrative Reviews

County Program Directors (CPD), Economic Support Administrators (ESA) or Medicaid Program Specialists, in the absence of a CPD/ESA, should complete second level reviews. The sample size for second level reviews should be 5% of the total number of Quality Checks read per supervisor and/or unit (not to exceed 3 per unit or supervisor) monthly. Cases should be selected from all Quality Checks completed in the previous month. In counties with second level administrative positions, Program Specialists should review randomly selected second level reviews to ensure correctness and verify all required corrections were completed in a timely manner.

The objective of Administrative Reviews is to ensure that the Quality Check process is being followed correctly and that front-line reviewers are accurately reviewing the cases.

An Administrative review finding is either correct or incorrect, there are no deficiencies. A correct case is one in which the front-line reviewer correctly determined “pass” or “fail” on the Medicaid Quality Check. For Children in Placement review requirements please ref

Revenue Maximization Reading Requirements

For Children in Placement review requirements please refer to the CAR Selection Process Guide, Revenue Maximization Unit. All Medicaid specific elements are explained in the Family Medicaid Reading Guide, Revenue Maximization Unit. Both are found in Appendix H – Administrative Review.

For Children in Placement, the following definitions are used in case reading:

- Correct Case – Medicaid eligibility, COA, funding source and reimbursability are correctly determined and thoroughly documented in case record and SUCCESS.
- Deficient Case – Initial, review or change element insufficiently addressed in case record and/or SUCCESS documentation and all eligibility and reimbursability elements are correctly determined.
- Error Case – May be any of the following:
  - Incorrect eligibility and/or reimbursability determination
  - Eligible for and not receiving benefits.
  - Incorrect AFDC Relatedness criteria determination: financial need, deprivation, specified relative, living with/removal from, age
- Ineligible for but receiving benefits
- Denial or closure of a case that was actually eligible

ABD Reading Requirement

Selection Criteria

Supervisors will select the cases to be read based on the activity completed in the month under review. This may be the previous or current month’s case actions. Do NOT permit staff to select the cases to be read. The supervisor will select a variety of case actions and COAs for review. However, as needed, the Medicaid Unit and/or the Medicaid Program Specialist may indicate specific targeted policy issues, elements or COAs for review, which may override the usual selection criteria. The reading of a dually eligible case (full Medicaid and Q Track COA only) count as one review, not two. However, two full Medicaid COAs count as two supervisory reviews.

There are two selection standards depending on whether the supervisor manages ABD/FS staff only or multiple programs. The number of cases selected will depend on the number of workers supervised as well as supervision being program specific or multi-program. If the supervisor is reading FS cases, it is permissible to include the related ABD case as part of the ABD reading requirement. However, not all ABD cases read should have a related FS case.

Consult your Medicaid Program Specialist for reading requirements on specialized caseloads, such as intake only or QMB/AMN caseloads only.

A supervisor of ABD and related FS staff only will read four times the number of workers s/he supervises, not to exceed 30 ABD cases per month. This does not necessarily mean four cases per worker. For example, for a new MES or a MES on a work plan, more than four cases each may need to be read per month. For every four cases reviewed, read two applications, one negative action (closure or denial, and one annual review or special.

A multi-program supervisor (covers ABD Medicaid and program(s) other than related FS) will read three times the number of MES staff supervised, not to exceed 25 ABD cases. This does not necessarily mean three cases per worker. For example, for a new MES or a MES on a work plan, more than three cases each may need to be read per month. For every three cases reviewed, two should be applications (one of which may be a denial) and one a special or annual review.

How to Read

Supervisor's review findings will be as of the moment the case is read. Do NOT withhold supervisory review findings to give the MES an opportunity to make corrections. The accuracy rate is based on the findings as of the initial supervisory review. Corrections are made after the accuracy rate is determined.

Applications: Read for all affected months, beginning with the earliest of the prior months (if any) through the ongoing benefit month.

Annual Reviews: Read only the month of the review for all data elements required for the COA. Errors which occurred in months other than the month read will be counted incorrect only if the error affects the month being read for the review/special.

Specials: A "Special" is any case action taken other than application, annual review or denial. Read the entire case. However, only consider elements in error that were the result of the action taken by the current worker when calculating the accuracy rate of the case. All errors must be corrected.

Denials: Read all screens applicable to the denial and the reason for the denial. This includes at a minimum: Case Record, NARR, ADDR, STAT, AREP, and Notice Requirements.

Refer to the instructions accompanying Form 965 and Form 974 for specifics on how to complete. It is important to strictly adhere to the guidelines to ensure statewide standards and fairness.

Online Review Site

ABD reviews should be completed using the ABD online review site. While the supervisor may review a case using the Form 974, Supervisory Review Summary Sheet, and keep a copy in a central file, it is not necessary to submit a copy to the State Office. Findings on each case reviewed should be reported via the ABD Medicaid Supervisory Review Database. These results are automatically reported to the State Office Data Analysis and Reporting section, which completes monthly reports on a county, regional and state level.

Case Accuracy Review Selection Process

Overview

Case accuracy reviews are an essential tool used to ensure all mandated case accuracy standards are met. Full reviews from initial determination through review month in each Medicaid Class of Assistance are necessary so that not only error prone areas but all areas will be looked at for accuracy. The CASE ACCURACY REVIEW (CAR) form and instructions have been developed to review all OFI programs (excluding ABD) for case accuracy. The new case accuracy review form will enable supervisors and others to identify strengths and error prone areas. Automation of the Case Accuracy Review Form will enable supervisors and others to monitor the strengths and training needs of not only the state, but also individual counties and workers. The following guidelines are established for case accuracy reviews:

- First level reviews will be completed **monthly** for Children in Placement Medicaid in all counties/regions.
- The Rev Max Quality Assurance Unit will perform second level reviews during regional visits.

Random Sampling Methods Overview

The number of reviews completed must be random and will be based on the following:

- A minimum of 5 cases per Rev Max Specialist with a **maximum** of 25 cases per supervisor for all COA's to be reviewed each month.
- Regions are also encouraged to read cases in error prone areas such as earned income and unearned income cases.
- If additional cases need to be read, supervisors should select samples from active and closed cases within the review month.

Sampling Method by Program

Medicaid:

- Deficiencies are now possible in Family Medicaid
- If additional reviews are to be pulled, supervisors should select samples from recently closed cases, using the case manager's monthly work cards or cases identified through other methods
- At least quarterly, cases from all Medicaid COAs must be reviewed

First Level Reviews

The number of reviews can be adjusted to accommodate the demographics of a region's caseload. Any adjustments would need to be approved by the Rev Max Director.

Second Level Reviews

Second level reviews are completed by Quality Assurance unit members. This review is required to ensure first level reviews are completed in accordance with all program policy and CAR proce-

dures. The sample size for second level reviews will be 100% of the total IV-E cases read per region.

Document Completion

The CAR form is designed to improve the process of case reading for Title IV-E and Medicaid programs. Completion of a form for each case reviewed is mandatory. The original review form will be maintained in the case record and the summary sheet will be filed with the supervisor's monthly CAR file for reporting purposes. In addition, the reviewer will document each case reviewed on the CAR form with the following information:

- The date the review was completed
- The findings, noted as correct, error or deficiencies
- If the case is incorrect, the error/deficiency must be documented with correction(s) needed and the due date for correction(s) to be made

It is vital regions track noted errors and deficiencies to ensure all required corrections are completed. A reasonable timeframe for completion of necessary corrections is to be established and adhered to for all programs. Quality Assurance Unit members will review each error/deficient case for corrective action accuracy.

Definitions

Where appropriate the following definitions will be used:

- Accuracy Rate

  #Cases Initially Correct + #Cases Initially Deficient / #Cases Read

- Correct Case

  Medicaid eligibility, COA, funding source and reimbursability are correctly determined and thoroughly documented in case record and at all appropriate screens in Gateway and SHINES.

- Deficient Case

  Initial determination, review item or notice of change insufficiently addressed in case record and/or SHINES/Gateway documentation **and** there is no error in the eligibility and reimbursability determination.

- Error Case
  - Incorrect eligibility/COA and/or reimbursability determination, OR
  - Eligible for and not receiving benefits, OR
  - Incorrect AFDC Relatedness criteria determination: financial need, deprivation, specified relative, living with/removal from, age, OR
  - Ineligible for but receiving benefits, OR
  - Denial or closure of a case that was actual eligible

Reporting

Reports of accuracy findings are due by the fifteenth of the month following the review month. Regions must report all case reviews completed, including errors discovered prior to finalization.

- Reports are due by the 15th of each month; if the 15th falls on a weekend or a holiday, the report is due the following workday. Revisions are not possible after the deadline.
- One report per region should be submitted in a single e-mail as attachments with the region number in the subject line.

Request for Reduction

The minimum number of case accuracy reviews for all programs is required to be completed each month unless a reduction request is submitted and approved by the Rev Max Unit Manager.

No reduction will be approved for a prior month. The request must be approved by the Rev Max Director prior to the month of reduction request.

Regional Case Accuracy Review Plan

A case accuracy review plan will be developed by each region. The plan will be approved by the RevMax Unit Manager. The first plan is due to the RevMax Unit Manager prior to implementation of the new CAR process. The case accuracy review plan will include the following:

1. The total number of case accuracy reviews with a percentage breakdown of each funding source being reviewed.
2. A process for reading records when there are supervisor/worker vacancies or supervisors/workers out on extended leave.
3. This plan should not utilize Field Program Specialists as a first option in completion of case reviews.

In summary, the case accuracy review is an important tool for supervisors to use to monitor not only the quality of work being done but also the building of stronger families. The full record in conjunction with SHINES reviews will ensure supervisors are looking at the quality of the case and compliance with Title IV-E statutory and regulatory provisions and application of Medicaid policy.

Effective Dates for Implementation of CAR Revisions

These instructions are effective with the review month of July 2021 case actions. Results from the July 2021 review month will be due by August 15.

Medicaid CAR Guide Instructions

1. Application/review form/change form
    - For applications, is a signed application in the CR? For reviews, is the review document in the CR? For changes, is the change form in the CR?
    - Documented for all case actions and indicate type of contact and/or action taken?
2. Correct forms in case record?
    - All appropriate forms in case record?
    - Is the case record organized per established standards?
3. Address correct?
    - Is the placement name and address correct in Residential Address?
    - Is the custody county name and address correct in Mailing Address?
4. Adoptive placement/relative care established and documented?
    - Are adoptive parents documented as AREP?
    - For a new relative care placement for a child in DFCS custody, is the relative name, address and relationship entered as AREP? Documented?
5. Denial/closure completed timely, accurately and documented?
    - If case was denied, was correct denial reason used, and was denial reason thoroughly documented in Remarks?
    - If case was closed/CMD, was correct closure reason entered? Closure reasons thoroughly documented in Remarks?
6. Timely and correct notice for action taken?
    - Is a notice sent to the SSCM, by the SOP of the application, review, change explaining the AU's eligibility?
7. Retroactive Medicaid documented and correctly coded?
    - Retroactive months correctly determined, documented and processed?
8. Period of eligibility addressed and documented?
    - Correct month of eligibility?
    - Historical changes
    - Denial of removal month explained
9. CMD completed?
    - Was a CMD completed, if appropriate? Circumstances and outcome of CMD?
10. Alerts addressed?
    - Have all alerts been completed and documented?
11. Deprivation established, coded and documented?
    - Was deprivation correctly determined and documented?

12. Pregnancy verified and documented?
    - Pregnancy verified? Was correct date of termination entered?
13. Citizenship and identity documented and verified?
    - Citizenship addressed? Any verification provided? Is copy in record?
    - If alien, WEB-1 VIS/CPS verified and documented as to DHS status and date of entry? Alien status documented?
14. TPR/Immunization and Health Check addressed and documented?
    - Were TPR and Health Check addressed and documented?
15. Screens coded and documented?
    - Is SSN entered and if there is no SSN or a matching problem, is there documentation to resolve discrepancy in record?
    - Are DOB, sex, race, marital status and living arrangement coded correctly?
    - Is SSI documented correctly for AU member who receives SSI benefits?
16. EMA verified and documented?
    - Are EMA dates of service keyed correctly?
    - Is correct, signed form 526 in record?
17. School information documented, if known?
18. Each case action documented in detail with date, type of action, Rev Max Specialist's last name, first initial and regional unit identified and phone number?
    - Prior month's MAO addressed, and action taken
19. Clearinghouse checked and all discrepancies in information researched and documented?
20. SDX/BENDEX/UCB discrepancies addressed and documented?
    - Are the SDX, BENDEX, and UCB screen results documented and addressed?
    - Unearned income entered for RSM COA?
    - If member receives SSI or RSDI, is SDX/BENDEX result documented and verified with the SSCM's statement to verify income?
21. Verification obtained and documented?
    - Is the type of income received verified and documented?
    - Child support coded correctly? CS/CD/GP
        - If child support is received through OCSS, is the income coded as (CS) on the child's line number who receives the income?
        - If the county receives direct child support from an absent parent, is the income coded as (CD) and on the child's line number who receives the income?
22. Document OSOP reason?

Medicaid Quality Check Guidelines

SOP

Was case submitted within SOP? If not, was the reason coded on MISC and documented on REMA? Was the reason accurate? E.g. client delay should NOT be used when verification is NOT requested in time to be returned before the case hits SOP – that is worker delay; other agency should NOT be used when a case is on a vacant caseload and just assigned to a worker – that is agency delay.

Class of Assistance (COA)

Was the correct COA assigned to the case (ABD or FM)? Was the case potentially LIM eligible? Was LIM ineligibility documented? Was reason for LIM ineligibility correct? For ABD, was case potentially FBR?

Identity

If the verification for citizenship was NOT a US Passport (not limited passports), a Certificate of Naturalization (N-550 or N-570), or a Certificate of Citizenship (N-560 or N-561), was identity also verified using acceptable verification as listed on Form 218? Was the Declaration of Citizenship in the case record? Was it used for ID for any children under 16? Are there children in the case 16 or over? Was proper ID requested for them? (See Form 218 – Declaration of Citizenship good as ID only for those under 16.) Was SUCCESS documented appropriately?

Income

Was income, earned or unearned, entered correctly in SUCCESS? Is there appropriate verification in the case record? Was Representative Pay determined correctly? Was SUCCESS documented correctly? Was DOL addressed and were any discrepancies explored and documented? Was Data Broker pulled and was any information found, explored with the customer and documented? Were SDX and BENDEX pulled and addressed, if appropriate?

Application for Other Benefits

Any deceased spouse or parent? Was RSDI explored? Any military service? Were VA benefits explored? Did anyone recently lose a job (including quitting) or does DOL show potential for UCB? Was the A/R required to apply for UCB? Was SUCCESS documented with client's statement as to intent to apply (was an alert created to follow up in three months) or why client not required to apply? If not required due to disability, was this verified and documented?

FM Medically Needy & LIM

Resources

For MN and LIM cases, were resources addressed and documented? Is there appropriate verification in the case record? Did Data Broker show property or a vehicle? If so, was it addressed? Did the credit report provide any resource leads? If so, were they followed up on? Does SDX or BENDEX show direct deposit? If so, was a bank account explored? For ABD, was the Burial Exclusion applied appropriately? Were life insurance policies coded correctly in order to count in SUCCESS when the CSV is a countable resource?