

Division of Family Support

OPERATION MANUAL  
Volume IV

[OMTL-472](#)

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MS 1000

[FAMILY MEDICAID OVERVIEW

Family MA is extended to those adults and children who meet certain technical and financial eligibility factors. Medicaid is administered in compliance with Title XIX of the Social Security Act and provides a wide range of medical services to both categorically needy and medically needy individuals.

DMS is the state agency with designated responsibility for the administration of Medicaid, in compliance with Title XIX of the Social Security Act.

- A. DCBS field staff are responsible for determining initial and continuing eligibility for Family MA and AFDC Related MA.
- B. DMS is responsible for establishing the scope of medical services and paying for these services.

An individual can receive MA in one category only. Money payment recipients, including SSI recipients, receive MA under the money payment program code.

- A. An SSI recipient may be payee in a Family MA case but is not considered as a member of the assistance group, not included in the MA family size and their income and resources are not considered available to the assistance group.
- B. An SSI essential person (EP) is not SSI eligible in their own right. If technically eligible for Family MA, the EP may be included in any assistance group for which application is made. IF the EP is included in the MA family size, countable income and resources are considered.]

MS 1050 [FAMILY AND AFDC-RELATED MA DEFINITIONS (1)

Terms used in Family MA and AFDC-Related Medicaid:

**ADMINISTRATIVE ESTABLISHMENT OF RELATIONSHIP:** Relationship established by specific documentary evidence and/or notarized statement or affidavit of either parent acknowledging relationship. Refer to [MS 2420](#).

**AFDC-RELATED MA:** Medicaid category with eligibility requirements based on the rules which governed the former Aid to Families with Dependent Children (AFDC) program before July 16, 1996.

**ANTICIPATED INCOME:** Money expected to be received in the future.

**ASSESSED VALUE:** The value of a piece of property or an asset shown on records in the county property valuation office.

**ASSISTANCE GROUP or UNIT:** Any household member included in the same case receiving Medicaid.

**BURIAL INSURANCE:** Insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

**BURIAL RESERVES:** Identifiable funds or resources designated as set aside for the burial expense of a member of the Medicaid assistance group. These funds or resources include life insurance policies designated for burial, burial trust funds, annuities designated for burial and prepaid and/or prearranged funeral contracts.

**BURIAL SPACES:** Conventional grave sites, crypts, mausoleums, urns, vaults, caskets, headstones, and the costs of opening and closing the grave.

**CARETAKER RELATIVE:** Natural or adoptive parent or legal guardian of a child when living in the home with the child. If the natural or adoptive parent or legal guardian is not in the home, the specified relative (SR) is the caretaker relative. Great-great-great-grandparents, step-grandparents, and first cousins once removed are not eligible to receive Medicaid as a caretaker/specified relative.

**CASH SURRENDER VALUE (CSV) OF LIFE INSURANCE:** The dollar amount the client would receive if cashing in a life insurance policy. This is the cash value less indebtedness.

**CHILD:** A child who meets the financial eligibility criteria and is deprived of parental support due to the death, incapacity or absence of a parent and is living in the home of an SR. Deprivation and living in the home of a parent or other SR are not technical eligibility requirements for the "I" and "Y" categories.

**CONTINUING INCOME:** Money received and expected to recur on a regular ongoing basis.

**COUNTABLE EARNED INCOME:** Total earned income considered in a Medicaid case minus appropriate deductions.

**DEDUCTIONS:** Amounts, which vary by case type, subtracted from income to allow for specific expenses or allowances such as the work expense standard and dependent care. See [MS 3870](#) - [MS 3880](#).

**DEEMED ELIGIBLE NEWBORN.** A baby born to a mother who received Medicaid in Kentucky at the time of birth is guaranteed Medicaid from the birth month through the 12th month without regard to technical or financial eligibility factors.

**EARNED INCOME.** Money derived from direct involvement in a work-related activity.

**EARNED INCOME CREDIT (EIC).** A credit given to individuals with children that file Federal taxes with the filing status of head of household or married, filing jointly. The credit is determined using a scale with the largest credit going to the individuals that fall in the middle of the income range. The credit is received as part of the individual's federal income tax refund.

**ELECTRONIC INCOME VERIFICATION (EIV).** A method of verifying income through the transmission of information by various electronic systems.

**EPSDT LONG TERM CARE (LTC) CHILD:** A child with special health care needs who receives treatment in an Early Periodic Screening Diagnosis and Treatment Services (EPSDT) LTC facility, in or out-of-state, certified by the Department for Medicaid Services, EPSDT program.

**EQUITY VALUE:** The assessed value of a piece of property or an asset minus indebtedness.

**EXCLUDED INCOME:** Income received by a Medicaid household member that is not considered when determining Medicaid eligibility.

**EXCLUDED RESOURCE:** Available money, real property, personal property or other assets not counted in determining eligibility.

**FACE VALUE (FV) OF LIFE INSURANCE:** The basic death benefit or maturity amount of the policy which is specified in the policy. The FV does not include dividends, additional amounts payable because of accidental death or other special provisions.

**FAIR MARKET VALUE: (FMV)** Estimated value of property, based on the sale of like property in the vicinity. The FMV is considered to be at least equal to the assessed value.

**FIRST COUSIN ONCE REMOVED:** The child of a first cousin.

**GROSS INCOME:** The total sum of earned or unearned income prior to any deductions.

**INCOME:** Earned or unearned money received from any source of funding such as statutory benefits, child support, labor or services, rental property, investments, business operations, or non-recurring lump sum income.

**IN-KIND INCOME:** Any gain or benefit (not in the form of money) payable directly to the household for a service. Examples of in-kind income are meals, clothing, free rent or produce from a garden.

**INSTITUTIONALIZED SPOUSE.** An individual in an LTC facility legally married (or considered legally married by a state that recognizes common-law marriage) to a spouse who is not in an LTC facility. Individuals receiving waiver services such as Home and Community Based Services (HCBS) and Support for Community Living (SCL) are considered institutionalized spouses if married to and living in the home with a non-HCBS/non-SCL spouse. An individual in a personal care home or family care home with a spouse remaining at home is not considered an institutionalized spouse.

Note: Kentucky does not recognize common-law marriage.

**JOINT CUSTODY:** The sharing of parental responsibility (whether adjudicated or not) for the rearing of children upon the dissolution of a marriage or relationship. Both parents continue to make decisions and arrangements in the child's best interest. Both parents are involved in providing parental support and care. If the terms of the agreed order are followed, the child is not deprived of parental support and care.

**KENTUCKY CHILDREN'S HEALTH INSURANCE PROGRAM (KCHIP):** Program of Medicaid coverage for uninsured children under age 19, in compliance with Title XXI of the Social Security Act.

**KYHEALTH CHOICES CARD:** The permanent plastic card issued to all Medicaid, Medicare Cost Saving, and KCHIP recipients for use in obtaining medical services.

**LAND CONTRACT:** A contract when a buyer of real property, after making an initial payment, agrees to pay the seller specified amounts at established times until the total purchase is paid.

**LEGAL GUARDIAN:** An individual appointed through the State district courts to be in charge of the affairs and finances of a minor. Additionally, the individual is usually required to be bonded upon appointment and to file periodic financial settlements with the district court on behalf of the ward.

**LIFE ESTATE INTEREST:** A form of legal ownership where the individual possesses and uses the property until death. The life estate owner cannot sell the property.

**LIQUID ASSETS:** Cash, savings accounts, checking accounts, stocks, bonds, mutual fund shares, promissory notes, mortgages, land contracts, certificates of deposit, or other reserves readily converted into cash for immediate use.

**LIVING APART:** Not sharing a common household due to divorce, separation, disability, or illness.

**LIVING WITH:** Sharing a common living arrangement in a household.

**MA FAMILY SIZE:** Individuals, including unborn children, whose income and resources are used to determine eligibility of the assistance group. This includes individuals in the home such as the parents, a sanctioned SR, a technically excluded un-enumerated member, and any or all other MA eligible or potentially eligible children (including deemed eligible newborns), if advantageous to the assistance group.

**Note:** An SSI recipient, parent or child, is a technically excluded individual and is not eligible to be included in the MA family size. The SSI recipient's income and resources are not considered in the MA family size when determining eligibility of the non-SSI children included in the case.

**MEDICAID (MA).** Medical benefits provided to eligible individuals in compliance with Title XIX of the Social Security Act as administered by DCBS under contract to the Department for Medicaid Services (DMS).

**MEDICARE:** The federal program of health insurance for aged individuals and certain disabled persons. Medicare provides Hospital Insurance Benefits (HIB) - Part A; Supplementary Medical Insurance (SMI) - Part B; and prescription drug coverage – Part D (beginning 1/1/06), for eligible individuals. A premium is charged for these medical benefits.

**MINOR PARENT:** For Family MA and AFDC-Related MA, a minor parent is a parent under age 18, whose child is living with him/her. This also includes a minor pregnant woman under age 21.

**NATURAL ASSETS:** Rights to oil, gas, coal, timber, or other asset on land not owned by the client.

**NET WAGES:** Wages minus appropriate deductions.

**NON-HOME PROPERTY:** Real property, other than homestead property, owned by a client.

**NON-RECURRING LUMP SUM INCOME:** A sum of income received at one time and not expected to continue.

**NON-RESPONSIBLE SPECIFIED RELATIVE:** Relatives, other than the parents, who provide a home for a dependent child without necessarily assuming financial responsibility for that child.

**PARENT:** The natural or adoptive mother or father of a child. The natural parent is:

- A. The mother who gave birth to the child;
- B. The father who was married to and living with the mother within 10 months prior to the child's birth; or
- C. The father as established by paternity adjudication.

**PATERNITY ADJUDICATION:** Paternity of a child is established by paternity action through the courts.

**PERSONAL PROPERTY:** Any property which is movable such as jewelry, or furniture, other than real property.

**PREPAID BURIAL FUND:** Monies deposited to a fund in a financial institution in the name of a mortician, bank official or any other individual or group licensed to accept burial reserves, with whom the client has a written agreement for providing funeral services.

**PROFIT:** Amount of income remaining after allowable deductions are applied to self-employment income.

**PROMISSORY NOTE:** A written promise to pay on demand or on a specified date, a certain sum of money to a seller or lender for a piece of property or an asset.

**REAL PROPERTY:** Land, including the buildings or improvements on it, its natural assets and mobile homes or trailers when used as a dwelling.

**RESOURCES:** Available money, property or other assets.

**RSDI:** The Social Security benefits payable under Title II of the Social Security Act. The term stands for Retirement, Survivors, Disability Insurance (RSDI) and is known by other acronyms such as:

- A. SSD – Social Security Disability;
- B. SSDI – Social Security Disability Insurance; or
- C. Title II Benefits.

**SECOND COUSIN:** The second cousin is the child of a parent's first cousin.

**EXAMPLE 1:** Your mother's aunt (grandmother's sister) has a child. This child is your mother's first cousin. The child of your mother's first cousin is your second cousin and your mother's first cousin once removed.

**EXAMPLE 2:** Your mother's sister, your aunt, has a child. This child is your first cousin. Your child and your first cousin's child are second cousins.

**SECOND PARENT:** An individual included in the AFDC-Related or Family MA case because:

- A. The individual is living in the home; and
- B. The individual is:
  - 1. Legally married; or

2. Recognized as married through common-law by another state, to the parent who is included in the MA case as specified relative (SR); or
  3. Adjudicated either by the court or by an administrative establishment of relationship; or
- C. One parent must meet the criteria of unemployment or incapacity. The second parent can be either parent.
- D. The individual is the incapacitated stepparent who is living in the home, NOT a parent of a sibling of an MA child AND legally married to the parent who is included as an SR OR recognized as married to the parent who is included as SR through common law by another state.

**SELF-EMPLOYMENT:** Earned income when NO taxes are withheld before it is received by the individual.

**SIBLINGS:** One of two or more persons having one or both parents in common. Includes brother or sister, and half brother or half sister, but does not include stepbrother or stepsister. Additionally, the unborn child of a pregnant woman is considered a sibling.

**SPECIFIED RELATIVE (SR):** A child's natural or adoptive parent.

**SPEND DOWN:** Time-Limited Medicaid issued to individuals or a family who meets all technical and resource eligibility but has income in excess of the MA scale for the family size.

**Supplemental Security Income (SSI):** The federal program of money payments to aged, blind and disabled persons under Title XVI of the Social Security Act as amended. The term stands for Supplemental Security Income.

**STEP-PARENT FAMILY SIZE:** Step-parents and their dependents living in the home and not in the MA case, who are or could be claimed by the stepparent on federal personal income tax. This may include SSI recipients.

**TERM INSURANCE:** A type of life insurance that does not have a cash surrender value. Generally the insurance protection is only to cover a specified or limited period of time.

**TOTAL COUNTABLE INCOME:** The sum of countable earned income and countable unearned income.

**UNCOMPENSATED VALUE:** Fair market value of a piece of property or an asset, minus any compensation received.

**UNEARNED INCOME:** Money received which does not involve direct physical activity by the individual.]

MS 1070

CATEGORIES OF ASSISTANCE

Individuals in households with children may receive Medicaid in a K-TAP, Family MA or AFDC Related MA category. Additionally, disabled children can receive Medicaid in the Adult MA category. See Vol. IVA, [MS 1810](#), [MS 1820](#), [MS 2950](#), [MS 3220](#) and [MS 3560](#). The following are categories a child may receive Medicaid benefits:

"C" [K-TAP

The specified relative (SR), second parent (SP) and children under age 16, or age 16 to 18 who meet school attendance requirements (up to their 19<sup>th</sup> birthday), are eligible for Medicaid and a K-TAP payment. K-TAP recipients who are penalized for failing to participate in the Kentucky Works Program (KWP) are not eligible to receive MA. See Vol. IIIA, [MS 4750](#) and [MS 4770](#). The child must be deprived of parental support due to death, incapacity, unemployment, or absence of a parent and live in the home of an SR.

"E" AFDC-Related MA

The SR, SP, and children under age 18, or age 18 (up to their 19<sup>th</sup> birthday) who meet school attendance requirements, and who meet the AFDC Program criteria in effect on July 16, 1996, and are not receiving a K-TAP grant for any reason. The child must be deprived of parental support due to death, incapacity, unemployment, or absence of a parent. For eligibility information, refer to subchapter AFDC related MA, 4300-4535.

"I" For children regardless if they have secondary health insurance or not:

1. (P1) – Family MA  
Children at least age 6, but under 18, whose family income does not exceed the 100% of Poverty Level MA Scale for the appropriate family size.
2. (P2) – Family MA  
Children under age 6, whose family income does not exceed the 133% of Poverty Level MA Scale for the appropriate family size.
3. (P3) – Family MA  
Pregnant women and children under age 1, whose family income does not exceed the 185% of Poverty Level MA Scale for the appropriate family size.

For children who DO NOT have secondary health insurance:

4. (P5) - K-CHIP

Children age 6 years up to their 19<sup>th</sup> birthday who do not have health insurance, from 101% through 133% poverty level for appropriate family size.

5. (P6) - K-CHIP

Children age 0 (not deemed eligible) up to their 19<sup>th</sup> birthday who do not have health insurance, from 134% through 150% poverty level for appropriate family size.

6. (P7) - K-CHIP

Children age 1 to their 19<sup>th</sup> birthday who do not have health insurance, from 151% to 200% of poverty level and children under 1, from 186% to 200% of poverty level for appropriate family size.

"K" Adult MA

Blind children who meet SSA's definition of blind. See Volume IVA, [MS 3400](#) and [MS 3560](#).

"L" Family MA

1. The SR, SP, and children under age 18, or age 18 (if meeting school attendance requirement), who except for technical eligibility requirements would be eligible for AFDC-Related MA. The child must be deprived of parental support due to death, incapacity or absence of parent.
2. Individuals who meet technical eligibility requirements but are over the income standards (including pregnant women), if the deprivation factor is met, are eligible for a Spend Down. For more on Spend Down eligibility refer to Volume IVA, MS 2650-2799; or
3. Transitional Medical Assistance (TMA)

This allows those families whose K-TAP ("C") or AFDC-Related (6) month extension can be granted if:

- a. The family income does not exceed the 185% FPL; and
- b. All technical and financial eligibility is met.

"M" Adult MA

Disabled children considered permanently and totally disabled who may or may not be eligible for MA in a Family or AFDC-Related MA category and do not receive SSI. See Volume IVA, [MS 3400](#) and [MS 3560](#).

"N" Family MA  
Same as individuals in program code "L"; however, the deprivation factor is unemployment or underemployment, as defined by federal regulations.

TMA

This allows those families whose K-TAP ("W") or AFDC-Related ("T") continue to be eligible for Medicaid for a six (6) month period. An additional six (6) month extension can be granted if:

1. The family income does not exceed the 185% FPL; and
2. All technical and financial eligibility is met.

"P" Family MA  
For children in foster care. These cases are all handled by Child Benefit Workers (CBW).

"S" Family MA  
Children placed by the Division of Protection and Permanency into a subsidized adoption who are Title IV-E eligible. These children are categorically eligible and the cases are handled by the CBW.

"T" AFDC-Related MA  
The SR, SP and children under age 18, or age 18 (up to their 19<sup>th</sup> birthday) who meet school attendance requirements, and who meet the AFDC Program criteria in effect on July 16, 1996, and are not receiving a K-TAP grant for any reason. The child must be deprived of parental support due to unemployment or underemployment of one parent or both parents living with the child. For additional eligibility information, refer to subchapter AFDC Related MA, 4300-4535.

"U" Family MA  
Children who are under the age of 18 and who have been a patient in an approved psychiatric hospital, a Psychiatric Residential Treatment Facility (PRTF), or an Institution for Mental Disease (IMD) for 30 or more days. These children are not Medicaid eligible in any other Medicaid category due to parental income. While the local DCBS office has

limited responsibility for these cases, central office processes and carries these cases refer to Volume IV, [MS 2670](#).

"W" K-TAP

The SR, SP and children under age 18, or age 18 meeting school attendance requirements (up to their 19<sup>th</sup> birthday), who are eligible for Medicaid and a K-TAP payment. The child must be deprived of parental support due to the unemployment or underemployment of the parent who is designated as the principal wage earner.

"X" Family MA

Children placed by the Division of Protection and Permanency into foster care. These cases are all handled by the CBW.

"Y" Family MA

Children under age 18, or age 18 who meet school attendance requirements (up to their 19<sup>th</sup> birthday). Deprivation and living in the home of a parent or other SR are NOT technical eligibility requirements for this category. Pregnant woman can receive regular MA or spend-down coverage in the "Y" category.]

MS 1100\*

DISCLOSURE OF MEDICAID INFORMATION

Information concerning Medicaid released to the following, provided they comply with HIPAA. Refer to Volume I, [MS 0127](#):

- A. Public employees including any identified representative of the Department of Health and Human Services in the performance of his/her duties in connection with the administration of the public assistance or child support enforcement programs pursuant to part D of Title IV of the Social Security Act.
- B. Law enforcement agencies and their representatives including county and commonwealth attorneys, district and circuit court judges, and grand juries in discovering and prosecuting cases involving fraud.

A potential fraud situation in the K-TAP, Medicaid and other benefit programs may be identified by the Kentucky State Police during the course of other investigations. Form KSP-58, Request for Confidential Information, is utilized by the Kentucky State Police when requesting information concerning fraud or potential fraud investigations, whether identified by DCBS or another source.

Upon presentation of form KSP-58 for the release of information, ensure it is completed in its entirety.

If the form KSP-58 is not completed in its entirety, DO NOT release the information and DO NOT sign the form. Refer to the procedural instructions for form KSP-58.

If the requesting officer indicates he/she wishes to take case record material with him/her, offer to provide photo copies. If he/she indicates only originals will suffice, make photo copies for the case record. Annotate the case record.

If the entire case record is requested, discuss with the officer what specific pertinent information may be acceptable rather than the entire case record. If the entire case record is still requested and photo copies will not suffice, make photo copies of the last two packets for the case record.

- C. Members of Congress and the General Assembly, limited to cases of individual constituents who have requested information regarding their application or payment status.

- D. Any representative that has requested a hearing before an agency hearing officer, to the extent necessary for the proper presentation of the case. The release of information under this provision is limited to only that information applicable to the hearing request. In addition, any information or names obtained shall not be used for commercial or political purposes.
- E. Any audit or similar activity; e.g., review of expenditure reports or financial review, conducted in connection with the administration of any federal or federally assisted program. For Medicaid, the audit/activity must be conducted in connection with the administration of the Medicaid program. This is limited to governmental entities authorized by law to conduct such an audit or activity.
- F. Officials administering any title IV-E foster care and adoption assistance programs.
- G. Local law enforcement agency, the Kentucky State Police, Commonwealth or county attorney to report known or suspected instances of child abuse or neglect of a child receiving assistance. The local office cooperates in providing information necessary to verify a suspected or known, senior or child abuse situation which has been reported to the proper authorities.
- H. Attorneys, absent parents, etc., who appear in the local office with a COURT ORDER carrying a signature of a judge or an individual with the authority of a judge such as a Domestic Relations Commissioner. If the court ordered information is due within 10 calendar days, the information can be released. If the local office has any questions on whether the court order meets the specified criteria or the local office has in excess of 10 calendar days to provide the information, contact the Eligibility Services Branch through the Regional office. Unless otherwise notified by regional office staff or the court, court orders must be followed. For procedures regarding subpoena requests, refer to [MS 0130](#).
- I. Only Board of Elections officials may view forms and/or information utilized directly in the voter registration process. Otherwise, voter registration information remains confidential.

Note: Any material released via fax to the above mentioned entities is monitored per HIPAA requirements. The receipt of faxes must be arranged so that the person receiving the fax is available to immediately retrieve the faxed information.

MS 1200

RIGHT TO APPLY

(1)

[Individuals can apply for programs offered by the agency either in-person or by telephone. When applying in-person, individuals can make an application in any county office, regardless of the county of residence. Applications can be made by the individual, his/her parent, statutory benefit payee, guardian, power of attorney, or authorized representative.]

A. KAMES generates the KYHealth card to the county where the recipient resides.

[B. If the individual is applying in a county other than the county of residence or by telephone, the application is taken as follows:

If the applicant is hospitalized, follow the procedures outlined in Vol. IV, [MS 1205](#), and Vol. IVA, [MS 1370](#), as appropriate.

1. Enter the application on KAMES.
2. Process the application if all mandatory verification is provided.
3. Provide the applicant with a Request for Information (RFI) instructing them to return any additional verification to the office located in the county of residence.
4. Ensure that all documentation/verification received is "attached" to the case on Electronic Case File (ECF) before the case is transferred to the county of residence.
5. Transfer the pending application to the vacant caseload code in the appropriate county.]

C. Applications or information brought into any DCBS office are accepted and action is taken on that information. If the information is for a case in another county, the individual accepting the information should complete the following steps to transfer the material to the appropriate county on the same day it is received.

1. [Scan the documentation into ECF.
2. Notify the office that documentation has been scanned into the ECF inbox.

Example: Recipient turns in information to the Scott County office, but their case is carried in Fayette Co. The individual in Scott County, who accepts the information, scans the information into ECF, then notifies the Fayette County office that verification has been scanned into the ECF inbox.]

D. A separate MA application is not required for persons applying for or receiving K-TAP or Kinship Care. In situations where the individual received a money payment or Medicaid card from another state and the

Kentucky K-TAP application is denied due to excess income or considering the payment received from the other state, KAMES will make a determination of eligibility for MA using the appropriate MA scales.

MS 1205      TAKING THE FAMILY/AFDC-RELATED MA APPLICATION      (1)

[Individuals have the right to apply in-person or by telephone for programs administered by the agency. No individual is refused the right to apply even if it appears that eligibility requirements are not met. All individuals have the right to make an application and receive a decision on their eligibility for Medicaid. Individuals have 10 days to return requested information, unless additional time is requested by the individual, before the application denies. Applications in the "I" or KCHIP categories have 30 days to return requested information.]

- A. The application is signed by the applicant, the applicant's statutory benefit or SSI payee, guardian, power of attorney (POA), or authorized representative (AR). If the application is signed by a mark (X), another person, either related or unrelated, must sign the application as a witness. Use the applicant's name for the case name even if the application is signed by someone other than the applicant.

If anyone **other than** the statutory benefit payee, guardian, power of attorney (POA), or authorized representative (AR) comes in to apply, enter the first four screens only and transfer the application pending, if applicable.

Note: The statutory benefit payee is the payee for the applicant/recipient's SSI or statutory benefits (RSDI, VA, Railroad Retirement).

- [B. If the initial contact with the agency is in a county other than the county of residence or by telephone, the application is entered on KAMES.

1. The office where the application is taken:
  - a. Enters the application on KAMES;
  - b. Explains to the applicant that the application will be sent to the county of residence;
  - c. Processes the application if all mandatory verification is provided;
  - d. Provides the applicant with a Request for Information (RFI) instructing them to return any additional verification to the office located in the county of residence;
  - e. Ensures that all documentation/verification received is "attached" to the case on Electronic Case File (ECF) before the case is transferred to the county of residence; and
  - f. Takes the appropriate action on KAMES to complete the case transfer.]
  
2. The local office in the county where the applicant resides:
  - a. Sends another RFI, the same day the case is received, if additional information is needed in order to process the application.
  - b. Processes the application once all mandatory verification is received.

[C. Applications or information brought into any DCBS office are accepted and action is taken on that information. If the information is for a case in another county, the individual accepting the information should complete the following steps to transfer the material to the appropriate county on the same day it is received.

1. Scan the documentation into ECF.
2. Notify the office that documentation has been scanned into the ECF inbox.

Example: Recipient turns in information to the Scott County office, but their case is carried in Fayette Co. The individual in Scott County, who accepts the information, scans the information into ECF, then notifies the Fayette County office that verification has been scanned into the ECF inbox.】

D. The statutory benefit payee, guardian, power of attorney (POA), or authorized representative (AR) cannot be required to travel outside his/her county of residence to apply or complete recertification for an individual who resides in another county.

If the application, recertification or follow-up visit is conducted in the home county of the statutory benefit payee, guardian, power of attorney (POA), or authorized representative (AR):

1. Request the case record from the applicant/recipient's county of residence, if not available as an ECF;
2. Once the application/recertification is processed, transfer the case back to the applicant/recipient's county of residence.
3. Information or verification received regarding a case change is forwarded to the county where the applicant/recipient resides. If the information or verification is scanned into ECF, notify the office that it has been scanned to the ECF Inbox.

E. IF THE INDIVIDUAL IS PHYSICALLY OR MENTALLY DISABLED OR IS ELDERLY, provide reasonable accommodation to any special needs the individual may have no matter where the interview is conducted. Accommodation to special needs may include, but is not limited to:

1. Interpreter services for hearing impaired individuals. Refer to Vol. I, [MS 0220](#)
2. Additional space for the interview to accommodate an individual in a wheelchair;
3. Scheduling appointments when special transportation services are available; or
4. Making a home visit.

- F. IF THE INDIVIDUAL IS NON-ENGLISH SPEAKING, obtain interpreter services. Refer to Vol. I, [MS 0230](#).
- G. For an inquiry not resulting in an application, complete PA-97, Assistance Program Inquiry, on KAMES function I - Inquiry/Update.

**NOTE:** PA-97 is only completed if the client does not want to make application. It is not to be used as a statement of ineligibility. Eligibility can only be determined if an application is entered on KAMES.

- H. Department for Juvenile Justice (DJJ) cases are carried in designated counties that are responsible for maintaining the case record.
1. The county may be different from where the DJJ child is physically located.
  2. The DJJ child's case county code must be the DJJ child's county of residence. Both the case mailing address and case residence address must be the DJJ child's physical location.
  3. When the DJJ child's county of residence and the DJJ worker's location are the same, the case mailing address is the DJJ worker's address and the DJJ child's case residence address is the physical location of the DJJ child.
- I. When a child is in the custody of the Cabinet, the Child Benefits Worker (CBW) has responsibility for the child's Medicaid eligibility including patient liability. If the child is admitted to waiver services after Medicaid eligibility has been approved, the patient liability for the child is \$0 even if the child has income. This is because the child was otherwise eligible for Medicaid and was admitted to waiver services after Medicaid eligibility was established. The CBW enters the application and maintains the case record.

**NOTE:** The CBW does not have responsibility for a child's Medicaid if the child is receiving SSI. The local office is responsible for Medicaid eligibility, including patient liability, of a child receiving SSI.

MS 1210\*

ELECTRONIC SIGNATURE

(1)

At each application and recertification, clients have the option of choosing to sign future applications electronically. This only applies to future applications that are submitted via a telephone interview. Clients cannot sign an **initial** application electronically.

- A. These questions will display at disposition for an application or recertification:
1. "Do You Want To Sign Future Applications Electronically, If Eligible?" If "Y", the client must provide a PIN number.
  2. "If Yes, What Is The PIN To Be Used For Future Electronic Signatures?" The PIN must be a 4 digit number. The PIN is retained in KAMES. In cases of reapplication, the PIN will display at disposition if the reapplication is within 20 days from the date the case denied or discontinued.
- B. At the next application or recertification completed by a telephone interview, "Do You Agree To Submit This Application By Signing Electronically?" "PIN:\_\_\_\_" will appear on screen HRKIMA05 of the Application (this is the first screen AFTER the household member screen HRKIMA04). If a PIN for electronic signature has previously been set up for that case and the answer is "Y" to "Pend For Signed Application" and if the reason is "PI", then the "sign electronically" signature fields can be answered:
1. If the client states that they will sign electronically, ask for their PIN number.
  2. If the entered PIN matches what is stored in KAMES, the application is considered signed.
  3. If the PIN does not match, the client has 2 more attempts. If the correct PIN is not entered on the 3<sup>rd</sup> attempt, the client cannot sign electronically. In this situation, the application pends for a signed application. The client will have the opportunity at case disposition to request future applications be signed electronically.
- C. "Electronically" is printed on the client signature line of applications signed electronically. Comments must include a statement on who the worker interviewed as this is not shown on the signature line.
- D. KAMES inquiry indicates if an application was signed electronically.
- E. DO NOT enter the client's PIN number in case comments.

MS 1212

FAMILY MA INTERVIEW PROCESS

(1)

[Complete the Medicaid application/reapplication/recertification during a face-to-face or telephone interview, except for individuals who choose to apply for assistance in the "I" category via a mail-in application (see [MS 2871](#)).

If the applicant is unable to come into the office or complete the interview over the telephone, the worker should conduct a home visit when possible.

The following procedures are followed when conducting an interview: ]

A. Before the interview:

1. Gather mandatory forms that must be provided to applicants;
2. Review the case record thoroughly;
3. Run all system checks including, SSI, Bendex, 4B, 39, 48, and 68; and
4. Inquire KAMES and review case comments for crucial case history.

B. During the interview:

1. Enter comments on KAMES as the interview progresses while the applicant/recipient is present;
2. Inform individuals of their rights and responsibilities:
  - a. Provide all mandatory informational pamphlets/forms required at application/recertification.
  - b. Advise the individual that changes impacting eligibility must be reported within 10 days of the date of change, as well as any changes which occur prior to processing the application. Provide form PA-17, Responsibilities for Reporting Changes.
  - c. Explain the potential for prosecution for committing fraud and have the individual sign form MA-2, Medicaid Penalty Warning.
  - d. Advise the individual of the right to appeal any adverse decision.
  - e. Explain how to access EPSDT services and review form PA-3, Facts about the Early and Periodic Screening, Diagnosis and Treatment Services. Give a copy of form PA-3 to the applicant. For additional information on EPSDT refer to Volume IV, [MS 4100-MS 4170](#).
  - f. If the head of household, who is age 18 or will be 18 before the next election, is present at the time of the interview explain the voter registration process and complete the voter registration questions on KAMES. The head of household signs form PAFS-706, Voter Registration Rights and Declination.
  - g. Explain services available related to child care, medical, and WIC. Advise the individual of the availability of the Child Care Assistance Program (CCAP).

3. Inform the individual of Medicaid eligibility processes:
  - a. Explain the KYHealth card is issued upon approval of the application and is used for services not covered by a Managed Care Organization (MCO). Advise the applicant that the KYHealth card is a plastic card which is intended to be permanent. Instruct the applicant not to throw away the card, even if the case is discontinued or the household moves to another county. Advise the applicant/recipient that Medicaid Member Services answers all questions regarding coverage and/or billing and the phone number is listed on the back of the KYHealth card.
  - b. Explain retroactive MA coverage and how eligibility is determined. Refer to [MS 1400](#).
  - c. Explain the Managed Care program. For more information on Managed Care refer to Vol. IV, [MS 1600](#).
  - d. Explain third party liability (TPL) and that Medicaid is the payer of last resort. Any other health or hospital insurance is billed before Medicaid. Enter all health insurance information on KAMES. If KAMES is not available, complete form PA-40, Third Party Liability Health Insurance.
  - e. If a member of the assistance unit appears to have a disabling health condition, such as quadriplegia or a head injury, refer the individual to apply for Social Security benefits with the Social Security Administration using form PAFS-5.1, Report or Referral to the District Social Security Office. Do NOT delay taking the individual's application for assistance pending a determination of the Medical Review Team, Social Security or SSI entitlement.
4. Explain to the applicant/recipient what is required to process the case timely and that the case will be denied if mandatory verification is not returned within allotted timeframes;
5. Explain the difference between mandatory and optional verification;
6. Explain that additional time can be requested in order to obtain mandatory verification. If additional time is allowed, ALWAYS note in comments why more time is needed and the new due date for return of information;
7. Answer all of the applicant/recipient's questions; and
8. If all verification is provided at the interview, process the application/recertification at that time. A case may be pended, even if all verification has been provided, for later processing by answering "N" to "Is app/recert ready to dispose?" This should only be done when it is necessary for a worker to enter more detailed comments, double check system entries, or complete supervisory reviews.

When this question is answered "N", the case will pend, but no RFI will be generated. When this question is answered "N", it must be updated each time the case is updated or when returning from the comments screen. If this question is answered "N", the case will still

process timely. It will not pend the action beyond the normal timeframe.

When this question is answered "Y", and all verification is entered, the case will dispose.

C. After the interview:

1. [All documents pertaining to eligibility for the current certification period must be scanned into the Electronic Case File (ECF). Do not scan medical records into the ECF.]
2. Send anything requiring review by the Department of Medicaid Services, such as annuities or trusts, to the regional Program Specialist within two days of receipt.
3. If additional information is required from the Medical Support and Benefits Branch (MSBB), send the request to the regional Program Specialist immediately to prevent delays in processing the case.

MS 1213\*

## WHO SIGNS THE APPLICATION

The individual(s) allowed to sign the application may vary depending specific program requirements. Below are the policy specifications regarding who can sign the application:

- A. Applications for K-TAP are signed by the specified relative. See Volume III, [MS 2025](#).
- B. Applications for food stamps must be signed by an adult individual or their adult authorized representative.
- C. Applications for MA are signed by:
  1. The individual or the parent if applying for a child;
  2. The aged, blind or disabled individual, the statutory benefit payee, committee, guardian or the authorized representative (AR). See [MS 1330](#);
  3. The representative of the responsible agency, Department of Juvenile Justice (DJJ) or Children's Benefits Worker (CBW), for a child in foster care or state subsidized adoption;
  4. The parent or the AR for a mentally ill or mentally retarded child;
  5. The parent or other specified relative (SR), of a needy child or AR for the parent;
  6. For N and T cases, either parent may sign the application to protect the filing date. DO NOT refuse to take an application signed by a non-qualifying parent; or
  7. For "I" or "Y" cases:
    - a. The parent, other SR or the AR, when the child does not live with a parent or other SR; or
    - b. The pregnant woman, her spouse, or an AR:
      - (1) If the pregnant woman under age 18 is receiving services from an authorized child welfare agency, an agency representative may sign the application.
      - (2) If the pregnant woman under age 18 is receiving basic maintenance needs from her own parents, either she or her parents sign the application.

MS 1214

APPLICATIONS FOR THE DECEASED

(1)

[Applications for the deceased are accepted but additional requirements apply depending on the nature of the deceased individual's circumstances.

- A. Accept and process MA applications made after the applicant's death if:
  - 1. Medical bills were incurred during the three months prior to application or during application month; and
  - 2. The individual was technically and financially eligible at the time services were rendered.
- B. Take an application for an SSI applicant who dies before SSI entitlement is established or dies before a hearing can be requested and held. See Volume IVA, [MS 4662](#).
- C. A field determination of disability can be made if Medicaid eligibility is requested only for the month of death.
- D. If an individual is determined eligible for Medicaid and dies prior to case approval, if all technical and financial requirements are met process the application accordingly. Process the application for remaining members, based on the current situation.
- E. For any MA case where a parent dies prior to approval, explore eligibility for the child based on the death of a parent.]

MS 1216

OUT-OF-STATE APPLICANTS

MA can be requested by or for a Kentucky resident who is temporarily out-of-state. The individual, an interested party or an out-of-state agency may request assistance by letter or telephone.

- A. To request assistance by letter or telephone the following conditions MUST exist:
  - 1. An emergency situation arises;
  - 2. Care and services are needed immediately; and
  - 3. Health would be endangered if the individual attempted to return to Kentucky.
- B. Send an application dated the day the request is received, to the requesting person. When the form is returned, treat the application as an emergency and complete necessary forms according to usual procedures.

MS 1220

ENTITLED BENEFITS

Individuals are required to apply for any benefits to which they may be entitled. These benefits include, but are not limited to, Veteran's compensation and/or pension, Black Lung, RSDI, Railroad Retirement, annuities, pensions, IRA disbursements, retirement and Unemployment Insurance Benefits.

- A. Before approval, there must be verification from the appropriate agency of application for the potential benefit; however, do not deny assistance based on projected income.
- B. For Medicaid eligibility purposes, the Department for Medicaid Services (DMS) considers IRA funds in the same manner as entitled benefits. Individuals are required to withdraw IRA funds if the funds are available. Generally, this will occur at age 59 ½ but may be earlier or later. Minimum amounts are determined by the financial institution. Failure to comply with this requirement results in ineligibility for Medicaid.
- C. Spot check each month to verify receipt and amount of benefit or denial of benefit.
- D. If an individual refuses to apply for entitled benefits, eligibility does not exist unless good cause for not applying is established.
  - 1. Good cause includes such reasons as previous denial of benefits with no change in circumstances, or inability to prove eligibility.
  - 2. If any type of denial of potential benefits is alleged, the individual must present written documentation of the denial.
- E. K-TAP or SSP payments, SSI benefits, VA Aid and Attendance Allowance or cash benefits of a similar nature are NOT considered entitled benefits.

NOTE: If a member of the assistance unit appears to have a disabling health condition, such as, quadriplegia or a head injury, refer the individual to the SSA using form PAFS-5.1, Report or Referral to the District Social Security Office, to apply for SSI/Social Security benefits. Do NOT delay the individual's application for assistance, pending a determination of the individual's Social Security or SSI entitlement.

MS 1230

PENDING SSI APPLICATIONS

[Accept and process an application for Family MA for an individual with a pending SSI application.]

Spot check each month to verify receipt or denial of SSI. Take appropriate action if SSI is approved.

MS 1240

DENIAL OF SSI BENEFITS

[When an individual applies for Family MA following an SSI denial, accept and process the application.] Determine if the individual has any reconsideration rights remaining and spot check, if appropriate.

If the individual applies for MA in any category within 60 days of an SSI denial based on non-disability and the individual would have been MA eligible in a category other than disability had the individual applied earlier, use the SSI application date as the MA application date.

If an SSI application is denied for reasons other than nondisability, and the individual applies for MA within 60 days of the SSI denial, the date of the DCBS application is the date of the SSI application that was denied.

MS 1250\*

CASE RECORD CONTENT

All case records represent a continuing documentation of eligibility for assistance. The case record contains sufficient material to substantiate validity of all authorized assistance.

- A. The PA case record contains the following material as appropriate.
  1. Applications;
  2. Appropriate worksheets;
  3. Computer entry forms;
  4. Other forms used to document and verify technical and financial eligibility for assistance, or certification forms for vendor payments;
  5. Notices;
  6. Hearing information;
  7. Information regarding overpayments and underpayments, as appropriate; and
  8. Additional information/verification.
- B. All forms required to establish eligibility in a PA case, but not completed at each case action, are moved forward and retained in the current packet. Subjects include, but are not limited to, the following:
  1. Work registration;
  2. Child Support;
  3. EPSDT;
  4. Incapacity/disability determination; and
  5. Third Party Liability.

MS 1251 FAMILY/AFDC RELATED MEDICAID DOCUMENTATION

Documentation for Family/AFDC Related MA cases is important in capturing relevant case information that may conflict with system entries or may require explanation beyond case data found on KAMES inquiry screens. In certain situations, procedures that fall outside normal policy are followed and documentation is necessary to address unusual circumstances regarding an individual's case. This applies to all case actions including applications, recertifications, interim changes and special circumstances.

Along with general items, found in Volume I, [MS 0130](#), Documentation, the following is a list of additional items that may be applicable to a Family/AFDC Related Medicaid case and is required to be addressed in case comments. Service Region Administrators (SRA) and other management can request added documentation beyond the minimum requirement for areas in which workers have shown difficulty applying correct policy.

Document unusual circumstances pertaining to:

A. Technical Eligibility such as:

1. Methods used to verify Citizenship/Identity.
2. Medical Support Enforcement (MSE) referrals and good cause.
3. Notices received from Child Support Enforcement (CSE) or Central Office requiring a penalty. If the individual does not have good cause for non-compliance with MSE, document that a penalty was imposed.
4. When multiple deprivation factors exist, document the reason for the factor chosen.
5. When separate cases are set up to accommodate different household situations such as the shared custody of children within a household or if certain household members are excluded.
6. When a referral to the Medical Review Team (MRT) is made for a determination of incapacity or disability or when a field determination of incapacity is made.

B. Resources such as:

1. Certificates of deposit or money market accounts.
2. Those that are reduced by a verified liability.
3. When spot checks are entered because resources are near the maximum.

4. How jointly held resources are considered or why excluded.
5. Those considered unavailable.
6. Those exchanged for another type of resource such as a Life Time Care Agreement.

C. Income such as:

1. When computations conflict with normal policy procedures.
2. When unusual expenses and deductions are allowed for self-employment, rental and farm income.
3. When the \$90 disregard is not allowed for VA income, such as compensation.
4. Special directions mandated by DMS review of Federal or Private Pensions.
5. Situations in which relative responsibility exists.
6. Income which is deemed or conserved.
7. When the DEFRA support deduction is appropriately distributed among more than one child in the household.

D. Medical Expenses such as:

1. Retroactive coverage issued for prior verified expenses.
2. Third Party Liability (TPL) individuals who have health insurance.
3. How medical expenses were verified and utilized for Spend Down cases.
4. Whether the MA effective date for a Spend Down quarter was incorrectly established.
5. Unusual consideration of deductible expenses

E. Procedural/Case Record information such as:

1. Whether the MA effective date was backdated or if the standard of promptness was not met.
2. If needed spot check(s) were entered.
3. If computer matches that conflict with what the client stated during the interview were resolved.
4. If a suspected fraud claim referral was completed for Medicaid or for an overpayment of State Supplementation. The reason for

determining information as questionable and if it is determined not to be fraud, how the issue was resolved.

5. Changes in the certification period.
6. Special circumstance issuances.
7. Clarifications/directives from Central office.
8. Reasons for any delays in case processing.
9. The household's voluntary request for a denial or discontinuance.

NOTE: DO NOT editorialize, offer personal opinions, or air disagreements in case comments. DO NOT include names of Central Office personnel, regional management, program specialists, or any supervisory staff when specific case mandates are received. Case comments are a part of the official case record, which is subject to review by supervisory staff, Central Office, Quality Control, Management Evaluation staff, the Hearing Branch, Department for Medicaid Services staff, clients and their legal counsel.

MS 1252\*

CASE NUMBER ASSIGNMENT

The case number for a KAMES case is the SSN, whether verified or unverified, of the head-of-household.

1. If the head-of-household does not know his/her SSN or has never applied for SSN, assign a pseudo number by entering an "X" on the "Application/Recertification" Menu in the field, "For Option 1, if you wish an SSN assigned, please enter "X". Refer to SSN Applications, MS 2012.
2. DO NOT manually assign the case a pseudo number unless this is a reapplication which was originally assigned a pseudo number. In this particular instance, enter the same pseudo number.

MS 1254\*

## ASSIGNMENT OF CASELOAD CODES

Each worker and supervisor is assigned a unique caseload code.

If a new caseload is established, a previously unassigned caseload code in sequential order is given.

If a vacant caseload is filled, the new worker assumes the existing assigned caseload code.

The assignment of a new caseload code is requested via forms 219A and 219B mailed to the Office of Administrative and Technology Services, 275 E. Main St., LLW-1, Frankfort, Ky. 40621. A change in the assignment of the code is reported by CHFS Security Request e-mailed to CHFS OIT Security [HelpDesk@ky.gov](mailto:HelpDesk@ky.gov). These forms are located in the Intranet.

MS 1256

DETERMINING CASELOAD CODE  
AND COUNTY OF RESIDENCE

(1)

[A caseload code, address and county code are all separate functions on KAMES. The caseload code is assigned to the worker responsible for a designated group of cases. The caseload code is always in the county where the responsible caseworker is stationed. The county code and address of the recipient is the county where the recipient resides and can be different from the county of the caseworker responsible for case maintenance. Consider the following when determining the county of residence for a particular case:

1. The case is carried in the county of residence for the applicant/recipient even when a statutory benefit payee/committee/guardian exists;
2. If the applicant/recipient is represented by a power of attorney (POA) the case is still carried in the county where the recipient resides even if the representative is the POA or the payee for statutory benefits such as RSDI, SSI, Railroad Retirement, or VA.]

MS 1270

HOUSEHOLD MEMBER OVERVIEW

(1)

One application is taken for children sharing at least one common parent and residing in the same household. All children included in one application must meet all eligibility requirements.

The following are examples of family living situations and options when applying for or receiving Family MA.

- A. An individual has the option when applying for or receiving Family MA to include in the same case all Family MA technically eligible individuals in the home, or to exclude one or more individuals.
  - 1. If the inclusion of all technically eligible MA children in one Family MA case prevents otherwise MA eligible children in the home from receiving Family MA, separate cases may be established. For example, this may occur when one of the parents is a common parent to all of the children including an unborn child, and the other is a parent to some, but not all of the children.
  - 2. If the inclusion of a technically eligible MA child prevents an otherwise MA eligible parent from receiving Family MA, the child may be excluded. For example, this may occur when the specified relative (SR) has no income, but the child has income which exceeds the MA Scale for 2.
- B. When there is no common parent, the children have separate applications. If separate applications are signed by the same SR, the SR is included as the SR in only one case.
- C. If the mother and father have a child in common and one parent is an SSI recipient or receiving in the "J", "K", or "M" category, one case may be established which includes the non-SSI individual, the child in common and all siblings, or separate cases may be established. If the only common child is an unborn child, the father cannot be included in the case.
- [D. If both parents are in the home, but are not married, and paternity has been adjudicated or administratively established, then the father must be included in the case if the definition of second parent is met. Do NOT include a spouse in an MA case as a member with a pregnant woman who has NO children; the spouse must be coded as a "R58".]
- E. If the parent and stepparent have a child in common and deprivation of incapacity or unemployment exists, a case may be established which includes the parent, stepparent and all children, or separate cases may be established.
- F. [If an individual under the age of 18, or age 19 and meeting school attendance requirements, does not live with his/her parent(s) or other

caretaker relative, then a case may be established in the individual's name.】

- G. If a minor parent lives with his/her parent, who is applying for or receiving Family MA for siblings of the minor parent, the household has the following options:
1. Establish a case for the parent, minor parent when included in the case as a child, siblings of the minor parent and child of the minor parent.
  2. Establish a case for the parent and siblings of the minor parent and a separate case for the minor parent and child of the minor parent; or
  3. Establish a case for the parent, siblings of the minor parent and minor SR and a separate case for the child of the minor parent, if the minor parent requests assistance for his/her child.
  4. If the minor parent and the child are applying for K-TAP, take a separate K-TAP application. Do not include the minor parent or child in the Family MA case.
- H. The incapacitated parent, unless receiving SSI or applying for MA in the "J", "K", or "M" category, may be included in the MA case as a second parent (SP), if the definition of an SP is met.
- I. The parents, who are the SR and/or the SP, who meet the definition of incapacity or unemployment, may be included in the MA case, if the only child living in the home receives SSI.
- J. When a foster care child is moving to the home of a relative meeting the definition of an SR, the Children's Benefits Worker (CBW) makes arrangements for the relative to apply for assistance for the child. Accept a request by the relative to apply for the child, but the child cannot be added to the case prior to the first of the month the child begins living in the home. If the only child living in the home receives a foster care payment, the SR may receive MA in a separate case, if technical and financial eligibility applicable to the MA category exists.
- K. The stepparent may be included in the MA case, if otherwise eligible, when either the stepparent or the parent in the Family MA or K-TAP case is disabled or incapacitated. If the stepparent and the parent do not have a child in common and the stepparent meets these criteria, the stepparent may be added to the case at application, recertification, program transfer or interim change.
- L. 【Any child committed to the Justice Cabinet (with the exception of the "P" category), including a married, non-pregnant "I" or "Y" child, without an SR, the case name and number must be an interested party or payee in order for MSE referrals to be made when appropriate. Enter the interested party or payee's address as the case address. Enter the child's name and address as the mailing address. Enter "c/o" and the child's name on the

first line of the mailing address since the case name will be different. This will ensure the MAID and mail are sent to the address where the child resides. Code the interested party or payee as a nonmember in the MA case. If there is no interested party or payee for the case, use the payee resource files established in the local office to obtain a payee for the case.】

M. Below are instructions on KAMES entry of Juvenile Justice cases and applications made by adoption agencies where parental rights have been or will be severed:

1. Enter the child as the applicant;
2. Answer "yes" to the IM representative question;
3. Enter the Juvenile Justice Worker as the IM representative who is responsible for the application; and
4. Refer to MS 4270 for deprivation procedures.

When you reach the deprivation screen for a child in the custody of Juvenile Justice or who is adopted and parental rights have been or will be severed:

1. Leave both parents' names and SSN's blank;
2. Answer "N" to "Is he/she in the home?";
3. Answer "Y" to "Unknown"; and
4. KAMES loads "Unknown" in the name fields and assigns a deprivation factor of "60", no deprivation. This bypasses the KASES Referral Screens.

MS 1290

ADDING A HOUSEHOLD MEMBER

(1)

When an individual requests that a family member, other than a deemed eligible newborn, be added to the case or pending application, annotate the date of the request on the Change Report form (PAFS-126) or in KAMES. For more information regarding deemed eligible newborns refer to [MS 2850](#) and [MS 2851](#). Completion of a new application is not required.

- A. If the change is entered on KAMES at the time the client is reporting the change, in person or by phone, form PAFS-126 is not required unless the client has companion cases affected by the change in another worker's caseload. If the change is not entered on KAMES at the time that the client is reporting the change, in person or by phone, form PAFS-126 is completed. Use the date the change is reported, or documented on form PAFS-126, as the effective date to add the individual to the case. If the new member is a deemed eligible newborn, the effective date is the first day of the birth month.
1. In order to meet the SAVE requirement for a qualified alien, see Vol. IV, [MS 2035](#), for citizenship verification of the added member. Citizenship verification is not required for a deemed eligible newborn.
  2. If an individual under age 21 is being added to the household, review form PA-3, Facts About the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Services.
- B. If the information or verification provided is incomplete, provide/send a Request for Information (RFI). Include any needed information on the RFI such as verification of income, resources, enumeration, citizenship, etc., and schedule an interview if needed. Use the date the information was reported as the effective date to add the individual to the case.
1. If the SR/payee fails to keep the appointment, take appropriate action to deny the request to add the member to the case based on failure to provide sufficient information to determine eligibility. KAMES processes the member add denial automatically.
  2. If the recipient returns income verification for the new member, but fails to enumerate the new member, the new member is technically excluded from the case. If advantageous to the assistance group, the technically excluded individual may be considered in the MA family size.

NOTE: Each member of the benefit group, other than a deemed eligible newborn, is required to furnish a Social Security Number (SSN) or apply for an SSN as a technical eligibility requirement. However, include the individual in the case when the individual, who must be enumerated, does not yet have an SSN and is cooperating with the enumeration process.

Do NOT require an individual to provide an SSN or apply for an SSN who will not be a member of the MA benefit group.

3. Follow established procedures for documenting eligibility, entering data on KAMES, etc., whichever is appropriate.
4. Do not complete a new application unless the case is due for recertification.

MS 1320

STANDARDS OF PROMPTNESS

[The Department for Medicaid Services (DMS) sets time-frames, policy and procedures. DCBS is contracted by DMS to determine eligibility for individuals using the policy and procedures set by DMS. Applicants have 10 days to provide mandatory verification. If additional time is requested to obtain mandatory verification, pend the case over 10 days. All applications must be processed within 30 days of the date of application.

Applications in the "I" or KCHIP categories are allowed 30 days to provide mandatory verification. Refer to [MS 2891](#). These categories also have a 30 day grace period after the application/recertification is denied/discontinued to return requested information without having to complete a new application.

All applications or reapplications must be acted on promptly. The case is to be processed the day all verification is returned, if possible, but no later than 5 days from the date the information is received in the local office. No more than 30 days should elapse between the application date and the approval or denial action date. If the case cannot be processed within the time standard, document in the case record the reason for the delay. A case must never pend indefinitely.

A. The 30 day time frame allows:

1. The client time to return requested information; and
2. DMS to review annuities and trusts.

B. For applications when the 30<sup>th</sup> day falls on a weekend or holiday:

1. If all verification is received in the local office before the 30<sup>th</sup> day, the case must be processed prior to the 30<sup>th</sup> day.
2. If verification is not received before the 30<sup>th</sup> day, and the applicant has not requested good cause, KAMES will deny the case on the 30<sup>th</sup> day or the first workday following the weekend or holiday.

Cases processed on the first workday following the 30<sup>th</sup> day are not considered past-due when the 30<sup>th</sup> day falls on a weekend or holiday.

C. If the case cannot be processed within the time standard due to UNUSUAL CIRCUMSTANCES, document the reason for the delay. Examples of unusual circumstances include:

1. A policy clarification was requested timely and a timely response is not received from MSBB (document in the case record);

Note: To ensure that processing timeframes are met send clarification requests to MSBB on a daily basis through your regional chain of command.

2. Waiting for an annuity or a trust to be completed or reviewed;
3. Delays in receiving MRT decisions for applications involving incapacity determinations;
4. Delay in receiving the Medicare Explanation of Benefits for spend down cases; or
5. Information is discovered that the worker was not aware of at application. Mail a new RFI requesting the additional verification.

Note: If the newly discovered information was worker error allow additional time if needed and send an RFI with a new due date. However, if the newly discovered information was due to client's failure to report, mail a new RFI with an explanation of the additional information that is needed, a new due date is not appropriate and the original due date assigned is left as is.

- D. Requested documentation from a third party may take more than 30 days. If the applicant/representative can show that effort has been made to obtain the required documentation, the worker may allow a reasonable amount of time past the 30 days. This must be approved by a supervisor and the case comments are to be documented ;

Note: If the applicant cannot show that effort was made to obtain the required documentation, allow the application to deny. Do not assume more time is needed.

- E. GOOD CAUSE CODES allow cases that are pending for certain types of verification or reviews additional time past the 30-day time period to be considered as untimely with "good cause." As there are times that MA cases go past due through NO FAULT OF THE WORKER, a good cause code is available for pending applications, re-applications, and program transfers. No fault of the worker means:

1. The information did not get to the worker timely;
2. A policy clarification was requested timely but a timely response is not received. Note, to ensure that processing timeframes are met send any clarification requests to MSBB on a daily basis through your regional chain of command.

Example 1: Application is taken August 2nd; the due date is August 12. A policy clarification request is sent to the Program Specialist on August 5th. The response is not received from MSBB until September 2nd. Using a good cause code is appropriate in this situation.

Example 2: Application is taken August 2nd; the due date is August 12th. A policy clarification request is sent to the Program Specialist on August 18th. The response is not received from MSBB until September 2nd. This would not be considered good cause as the worker did not request the clarification timely, therefore using a good cause code would be inappropriate.

3. An annuity or trust was sent for review timely but a timely response was not received; or
  4. The client requested additional time to obtain mandatory verification.
- F. The following are GOOD CAUSE reasons and the appropriate code for each type:
- 1 = Proof of citizenship;
  - 2 = Client request for additional time to provide mandatory verification such as trusts, income verification, etc.;
  - 3 = Medical Review Team (MRT) decision;
  - 4 = Department for Medicaid Services (DMS) response on reviews of trusts, annuities, etc.; and
  - 5 = Spend down.

Good cause codes do not change the time standards set by DMS.

- G. Cases with a good cause entry will pend for supervisor approval before the case will dispose. The good cause reason field is not a required entry and can be deleted by either the worker or the supervisor, if the entry is not appropriate. If the case has pended over 30-days, the worker will need to page through the application to allow the case to process as appropriate. Do not change the "N" to a "Y" on the disposition screen if the case is no longer to pend. Enter a good cause code if appropriate.

When a good cause code is entered one of the following messages will display on both the worker and the supervisor's DCSR:

1. Good cause code has been entered and the application is only pending due to the good cause code: "PDG SVSR APR GOOD CAUSE";
2. Good cause code has been entered and the application is pending for mandatory verification: "PDG SVSR APR GOOD CAUSE – MMV"; and
3. Good cause code has been entered and the application is pending for optional verification: "PDG SVSR GOOD CAUSE – MOV."

Once the case is processed, the code will remain in the case history. Document case comments thoroughly with the reason the case was not processed timely.

The following reports used in tracking case processing will reflect the cases that are untimely with good cause separately from those without good cause:

HRFSSR1 – Combined Caseload Activity report;  
HRKRMR1A – Application Activity by Unit report;  
HRKRMR1B – Application Activity by Caseload report;  
HRKRMR14 – Application Activity by County report;  
HRKRMR17 – Application Activity Statewide report; and  
HRKRMR1U – Applications Processed Untimely report.]

MS 1340

CO-PAY FOR MEDICAID RECIPIENTS

Some Medicaid recipients are subject to co-payments for medical services and prescription drugs. [Once approved for Medicaid recipients are placed in one of 4 benefit plans by the Department for Medicaid Services (DMS). The benefit plan determines their coverage and co-pays.

The following are the 4 benefit plans:

- A. Global Choices – The largest covered groups for most categories of eligibility.
- B. Family Choices – covers most children. Part of this plan includes Kentucky Children’s Health Insurance (KCHIP)
- C. Optimum Choices – covers members with mental retardation or development disabilities who need long term care such as ICF/MR or SCL.
- D. Comprehensive Choices – covers members who meet nursing facility (NF), Home and Community Based (HCB) Model II Waiver (ventilator-dependent) and Acquired Brain Injury (ABI) Waiver level of care.

For more information or if recipient have specific questions concerning coverage and co-pays, refer the recipient to the Department for Medicaid Services (DMS) at 1-800-635-2570.]

MS 1342\*

### CASELOAD RESPONSIBILITY

Caseload responsibility is based on the following:

- A. The county of residence of the applicant/recipient;
- B. The county of residence of their statutory benefit payee, committee or guardian if other than the count of residence of the applicant/recipient; or
- C. The county where the Family Service Worker, Child Benefit Worker or the Department for Juvenile Justice caseworker applies.

- 1. If the county of residence of the recipient's parent/statutory benefit payee/committee/representative/power of attorney is the same as his/her county of residence or the county in which the LTC facility is located, the case is carried in that county.
- 2. If the county of residence of the recipient's parent/statutory benefit payee/committee is different from the county in which the LTC facility is located or the LTC facility is out-of-state, the case is carried in the county where the parent/statutory benefit payee/committee resides.

If there is a representative or power of attorney, the case is carried in the county where the recipient resides unless the power of attorney is also the statutory benefit payee for other forms of assistance, such as SSI, RSDI, RR or VA.

- 3. If the recipient is a member of a K-TAP or Family MA case, including an LTC recipient, the case continues to be carried in the county where the family resides.
- 4. If the recipient's parent/statutory benefit payee/committee/representative/power of attorney resides out-of-state, the case is carried in the county where the LTC facility is located.
- 5. Case responsibility for K-TAP or Family MA is as follows:
  - a. The LTC individual is in a facility and the family group is in a different county.
    - (1) The case remains in the county in which the family lives; and
    - (2) DCBS field staff in the county in which the facility is located maintains contact with the LTC individual.
  - b. LTC individual in an out-of-county facility applies for assistance based on disability.
    - (1) Accept and process the application; and
    - (2) Coordinate activity with the caseworker having responsibility for the family case.

MS 1400

ONGOING/RETROACTIVE MEDICAID

(1)

[A separate determination of retroactive Medicaid eligibility is made independent of the ongoing determination.]

A. ONGOING ELIGIBILITY

Criteria for Family or AFDC Related Medicaid eligibility must be established for the month of application and ongoing months in order to approve an application. The effective date of ongoing MA eligibility is:

1. The first day of the month and up to 3 months prior to the month of application, if eligible for retroactive coverage;
2. The first day of the month in which the 30th day of absence occurs when the deprivation factor is desertion;
3. The first day of the month in which the applicant is a resident in a Spouse Abuse Center when the deprivation factor is forced separation;
4. The 31st day of unemployment when the deprivation factor is unemployment. The 31st day may occur in the 3 months prior to the application month, or the month following the application month;
5. The first day of the month in which the request to add a member is made;
6. The actual day during the 3-month period when spend down liability is met.
7. The first day of the month of birth of the deemed eligible child. When the newborn is not deemed eligible the MA start date is the first day of the month when the application is made or the first day of the month up to three months prior to the month of the application. The start date cannot be prior to the first day of the month when the child is born.
8. The first day of the month the applicant established permanent residence in Kentucky, if the applicant moved to Kentucky from another state.

B. RETROACTIVE ELIGIBILITY

To be eligible for retroactive coverage criteria for Family or AFDC Related Medicaid eligibility must be established.

1. Medical services must be received during the 3 months prior to application. If the applicant states medical services were not received, document in comments and DO NOT authorize retroactive coverage.
  2. If medical services were received, determine if technical, resource, and income eligibility exists in each of the 3 months prior to application. If technical, resource, and income eligibility exists:
    - a. In each of the 3 prior months, authorize coverage effective the 1st day of the third month prior to the month of application.
    - b. In months medical services were received but income eligibility does not exist, determine spend down status for the months medical services were received.
    - c. In one or two of the months, authorize coverage only for the months eligibility exists and medical services were received.
  3. If pregnancy is verified for the retroactive months, include the unborn child in the MA family size when determining retroactive Medicaid.
  4. When adding a member to an active Medicaid case, if the new member is eligible for retroactive coverage, establish the effective date of retroactive Medicaid eligibility. This is the first day of the month, up to 3 months prior to the month the individual is added to the case. This does not apply to newborns. [See MS 2850](#) for newborn eligibility start dates.
- C. Document the case record to indicate the method used to establish months of coverage. Also document that an explanation of retroactive Medicaid coverage was provided to the applicant.

MS 1460           TIMELY NOTICE OF DECREASE/DISCONTINUANCE

[If information in a MA case indicates reduction or discontinuance of benefits for any or all members in a case, the client must be notified of the proposed action 10 calendar days prior to the effective date, unless one of the exceptions to the timely notice requirement applies. This 10-day period is the timely notice period.

A. KAMES sends form KIP-105 when the change is entered on the system. If the system issued notice has an incorrect denial/discontinuance reason, immediately send a manual form MA-105, Notice of Eligibility or Ineligibility, informing the client of the correct denial/discontinuance reason.

B. Case changes entered on the system with a timely notice period expiring on or before the monthly KAMES adverse action date for the current month are effective the following month.

Example: Client reports an increase in income on 10/5/10. The change is processed on 10/9/10. KAMES issues form KIP-105 notifying client of adverse action. Because the change was processed PRIOR to adverse action, the change will be effective 11/1/10.

C. If the timely notice period does not expire in the month the KIP-105 is sent, action is taken by KAMES the day following the expiration of the timely notice period, and is effective the next administratively feasible month.

Example: Client reports an increase in income on 10/11/10. The change is processed on 10/25/10. KAMES issues form KIP-105 notifying client of adverse action. Because the change was processed AFTER adverse action, the change will be effective 12/1/10.]

D. The following situations are EXCEPTIONS to the 10-day timely notice:

1. Death of a recipient has been verified.
2. Location of the recipient is unknown and mail has been returned.
3. The recipient has moved out of state or it has been verified that assistance has been applied for or approved in another state.
4. The recipient enters a penal or correctional facility, or is under age 65 and enters a TB hospital or is between age 21 and 65 and enters a mental hospital.
5. A recipient requests discontinuance by a signed statement.
6. Time limited Medicaid (TMA) is terminated and the recipient was informed in writing at the time of approval that automatic termination at the end of a specified period or under specified conditions would take place.

MS 1470

TIMELY NOTICE

Timely notice of adverse action is not required in the following situations:

- A. Location of the recipient is unknown and mail has been returned;
- B. Assistance has been approved in another state;
- C. [A "P" case is discontinued; ]
- D. An MA child is removed from the home because of court action;
- E. The recipient enters a penal or correctional facility;
- F. Is between age 21 and 65 and enters a mental hospital;
- G. A recipient requests discontinuance by a signed statement; or
- H. Time-limited MA is terminated and the recipient has been informed in writing at the time the allowance or assistance was granted, of automatic termination at the end of a specified period or under specified conditions.

MS 1490

REASONS FOR NEGATIVE ACTION

(1)

Denials and discontinuances result from failure to meet technical or financial eligibility requirements Medicaid, failure to comply with technical requirements to meet patient status, or for other reasons. KAMES generates negative action notices when income increases or medical expenses decrease. The MA-105, Notice of Eligibility or Ineligibility, is only completed if KAMES does not generate the required notice. Prepare form MA-105 according to procedural instructions in the Forms Manual on the DCBS Intranet and give a brief but thorough and easily understood explanation of the reason for the action, in addition to the section number. Refer to one of the following reasons for negative action:

A. 4095.1 Financial reason:

- Income or resources exceeds MA standard;
- Income has increased;
- Medical expenses decrease; or
- Ineligibility period is still in effect.

B. 4095.2 Technical eligibility does not exist:

- Child's parent(s) is in the home;
- Child is married;
- Child's parent is not incapacitated;
- Qualifying parent does not meet the definition of unemployment;
- Child(ren) is not living in the home with a relative responsible for his/her care according to our policies;
- Child is not properly related to the person responsible for his/her care;
- Child is age 18 and is not meeting school attendance requirements;
- Person responsible for the child's care is on strike;
- Child(ren) is already receiving assistance;
- Child is living in a public institution;
- The foster care child is not in an eligible placement;
- Citizenship requirements are not met;
- Receipt of Supplemental Security Income (SSI);
- Child is too old to receive assistance;
- Qualifying parent refused to register for work with Employment Services;
- Qualifying parent refused to accept employment without good cause;
- Qualifying parent refused to accept training or education;
- Qualifying parent does not have enough prior employment;
- Qualifying parent is temporarily unemployed;
- Qualifying parent is employed part-time and cannot accept full-time employment;
- Qualifying parent terminated employment without good cause;
- Qualifying parent is employed over 100 hours per month;

- Qualifying parent reduced hours of employment without good cause;
- Qualifying parent terminated or reduced hours of training without good cause; or
- The person applying for assistance is deceased.

C. 4095.3 Failure to comply with technical requirement:

- Failure to fully complete or return application forms;
- Failure to keep an appointment for an interview, including an OIG interview;
- Failure to provide sufficient information or clarify conflicting information so that a determination of eligibility could be made;
- Refused to explore eligibility for Unemployment Benefits;
- Failure to explore eligibility for entitled benefits, such as Veterans Benefits, Railroad Retirement Benefits, pensions, Black Lung Benefits, Social Security Benefits, etc.; or
- Failure to cooperate in Medical Support Enforcement activity without good cause; or
- Disqualified, no extraordinary circumstance.

D. 4095.4 Failure to meet patient status in a privately owned and operated ICF/MR facility.

E. 4095.5 Other reasons, including:

- Request of recipient or formal withdrawal;
- Inability to locate;
- Change of Agency policy; or
- Individual is not a resident of Kentucky.

MS 1500

MISREPRESENTATION AND FRAUD

[If you learn a recipient or responsible party withheld information in order to receive MA, follow Medicaid Program Violation (MAPV) procedures. See [Volume I, MS 1750-1795.](#)]

If situations of suspected provider fraud or abuse are reported, send a memorandum with a summary of the situation to the OIG. Attach a copy of any available documentation with the OIG memorandum. Keep any original documentation in the local office.

Office of Inspector General (OIG)  
Division of Special Investigations  
275 E. Main Street, [5E-D]  
Frankfort, KY 40621-0001

[If an individual reports fraud to the local office, provide the OIG's toll-free fraud hotline telephone number (800) 372-2970.]

MS 1510\*

INTERIMS

Process as interims, the results of spot checks or recipient reported changes considered to be a change in circumstances that require a recomputation of countable income.

- A. A change in circumstances is defined as a change in income or dependent care expenses which may affect ongoing MA eligibility. This includes:
  - 1. Beginning or ending employment;
  - 2. Increase or decrease in the number of work hours;
  - 3. Pay rate change;
  - 4. Dependent care expense change; or
  - 5. Change in farming/self-employment activities.
  
- B. Do not consider normal fluctuations in income or expense amounts as a change in circumstances and do not require a recomputation of countable income. This includes:
  - 1. A change in work hours which will not exceed 30 days;
  - 2. A 5th or periodic paycheck; or
  - 3. Holidays, vacation days or sick leave not to exceed 30 days.

The following are the procedures in regards to Family MA policy for issuing benefits by special circumstance in Family MA cases.

A. Situations when the Special Circumstance Function is used:

1. To authorize a retroactive special payment to correct an administrative error on a denied or discontinued case;
2. To correct MA eligibility for prior months not issued through regular issuance;
3. To issue a MA vendor payment for a recipient who is active in an "S" or "X" case, and has been admitted to and discharged from a facility;
4. To issue a vendor payment for an inactive case; and
5. To correct patient liability for an active or an inactive case on KAMES.

B. Procedures

1. When completing a special circumstance to issue a MA only or vendor payment:
  - a. Check inquiry to determine if Medicaid eligibility existed for the time period to be covered by the special circumstance action.
  - b. Inquire the Member General Information Segment "AA" to obtain the recipient status code.
  - c. Enter the case number and select Function "R" on the Case Change Menu. The special circumstance menu appears.
  - d. Any previous special circumstance actions that are pending are listed on this screen which allows for selecting and updating if needed. If creating a new special circumstance, answer "Y" to "Do you wish to add a selection not listed above?" and indicate the type of action by entering "E" (Education Bonus), "G" (Money Payment) or "M" (Medical cards).
2. Special Circumstance – first screen appears. Complete the screen as appropriate, using information from the case record. Most of the fields are self-explanatory, but additional information is provided below on some specific entries.
  - a. If the special circumstance action has been initiated in error, use "Delete" to delete the segment. This can only be done before Medicaid eligibility is issued, the same day disposed or while action is still pending.
  - b. Enter the case name, address and other information carefully, as this information does not match against existing cases.

- c. The "MA Begin Date" is always the first day of the month in which the MA eligibility starts except for spend downs and KCHIP 3.
  - d. The "MA End Date" must be the last day of the month MA eligibility expires.
  - e. Complete "List SSN's of Members" by entering information about the case members included in the request. List only the members needing Medicaid eligibility for the months listed.
3. Special Circumstance – second screen. Complete the screen as appropriate, using information from the case.
    - a. The Help function contains all of the codes used on this screen;
    - b. If issuing a LTC vendor payment or correcting an inactive case for patient liability, answer "Y" to "Do you want to add corrected patient liability?"
    - c. To issue or corrected patient liability complete the screen using information from the case. Enter as follows:
      - (1) The 13 digit provider number;
      - (2) The patient liability as dollars with no cents;
      - (3) The effective date is the first day of the time period for which eligibility is being issued;
      - (4) The end date for the time period that is being corrected or issued;
      - (5) The institutional status;
      - (6) The facility code;
      - (7) Skip the next 2 sections for private pay dates;
      - (8) The admission date; and
      - (9) The discharge date is entered if the client is no longer in that facility.
4. Special Circumstance – last screen. Complete comments with explanation for the action.
  5. Supervisory approval is required for all special circumstance transactions.
  6. To inquire a special circumstance transaction:
    - a. Select "B" on the KAMES Main Menu;
    - b. Select "L" on the Inquiry Menu;
    - c. Enter the case number to the right of item "L";
    - d. Enter the selection number of the transaction you wish to view on the Inquiry Special Circumstance Menu and select the appropriate segment. The options include issuance, comments, notices and corrected patient liability.
    - e. Special Circumstance actions may not be displayed in chronological order. Use PF8 to view all issuances.

### C. Sign-off Requirements

All special circumstance actions will pend for supervisory approval.

1. Once a special circumstance action is initiated, the system will display the message "action pending – take case to supervisor".

2. The case file must be taken to the principal, supervisor or designated individual. In order to successfully sign off on the special circumstance action, the supervisor or designated individual must be logged on to KAMES in his/her own "HR11" code.
3. If the special circumstance action is not signed off on the same date the action is initiated, the worker and supervisor will receive a DCSR message "Awaiting Aprvl – Spec Circum" the next work day as a reminder the action has pended.
4. The supervisor or designated individual cannot update or change any data on a pending special circumstance action. Any needed changes must be given back to the worker initiating the action for corrections before the payment is approved.
5. The supervisor or designated individual cannot initiate a special circumstance action. If a supervisor attempts to enter "Y" to the "Do you wish to add a selection not listed above?" on the special circumstance screen, the error message "Entry not allowed" is posted.
6. The supervisor or designated individual who approves special circumstances can view the KAMES Daily Case Status Report Menu screen through option "O", "Special Circumstance Approved", at any time. This also appears on the DCSR screens at sign on. The listing provides information on all special circumstance actions approved using that individual's "HR11" code and password.
  - a. The actions remain on the listing for 14 calendar days from the approval date and cannot be deleted or removed.
  - b. The listing indicates the type of special circumstance transaction completed:
    - (1) Type E - Education bonus;
    - (2) Type G - Money payments; or
    - (3) Type M - Medical cards.
  - c. The supervisor or designated individuals are to view the listing on a daily basis for any discrepancies. If any payments on the listing were not authorized by the individual indicated, report the information immediately to the appropriate staff for investigation.

MS 1530\*

## KYHEALTH CARD

The KYHealth card is issued at approval to all recipients eligible for Medicaid on a continuing basis, and on initial approval for periods of eligibility for excess income spend down cases. A new card is not issued for subsequent Spend Down quarters unless the recipient no longer has the original card.

Recipients use the KYHealth card to obtain medical services from participating providers. The KYHealth card is presented to the medical provider at the time of service.

If the recipient maintains no fixed or permanent address, and can provide no mailing address, the KYHealth card can be issued in care of the local DCBS office. This procedure is used at the recipient's request when no other means of delivering the KYHealth card are available.

MS 1540\*

NONRECEIPT OF KYHEALTH CARDS

If an undelivered KYHealth card is received in the local office, take the following action:

- A. Send the KYHealth card to the new address, if available, and assure appropriate action is taken to correct the address; or
- B. If ineligible, assure appropriate action is taken to discontinue eligibility.
- C. Before local office input of recipient requests for a duplicate KYHealth card, determine if the card has been returned by Central Office to the local office.
  1. Requests for duplicate cards for SSI recipients are processed by local office staff on KAMES MAID-ISS file.
  2. Except for emergency medical need situations, do not process requests for duplicate KYHealth cards on new approvals less than ten days from the case disposition.



- F. Review form PA-3, Facts About the Early and Periodic Screening Diagnosis and Treatment Services (EPSDT) and explain the EPSDT services available and how to access them.
- G. Do not redetermine disability unless form PA-6, Incapacity Determinations, indicates the need for reexamination, or an improvement in the condition of the recipient is noted.
- H. Evaluate changes in the deprivation factor to determine need for documentation.
- I. Refer recipients who have reached 64 years 9 months of age to the District Social Security Office for a determination of eligibility for HIB, SMI, and other benefits.

MS 1560\* NO SHOW RECERTIFICATIONS (1)

The following explains the procedures related to the automatic discontinuance of Medicaid cases for failure to keep recertification appointments.

- A. When an individual fails to keep a recertification appointment, form KIM-105.5 is generated that evening to inform the individual that the case will be discontinued. At the end of the 10-day timely notice period, the system discontinues the case.

Example: The individual fails to keep an appointment on 6/3. The KIM-105.5 is generated the evening of the no show appointment. The case discontinues the evening of 6/13, effective 7/1.

- B. KAMES recognizes only one rescheduled recertification appointment if the appointment is rescheduled on KAMES no later than the end of the day of the first scheduled appointment.

Example 1: The individual is scheduled for a recertification on 6/6. The individual calls on 6/5 to reschedule her appointment to 6/12. The worker reschedules the appointment on KAMES that same day. Form KIM-105.5 is not generated on 6/6, but if the individual fails to show on 6/12, form KIM-105.5 will be generated the evening of 6/12.

Example 2: The individual is scheduled for a recertification on 6/3. The individual fails to show and form KIM-105.5 is generated the evening of 6/3. On 6/6, the individual calls to reschedule her appointment for 6/11. If the individual fails to keep her 6/11 recertification appointment, the case will discontinue the evening of 6/13. The discontinuance date of 6/13 was set based on the individual failing to show for the original 6/3 recertification date because she did not reschedule her appointment on or before 6/3.

If the individual reschedules a second time or more, even when the additional appointments are rescheduled on KAMES, the system only recognizes the first rescheduled appointment date in applying the no show recertification process. If the original appointment on KAMES is rescheduled due to a conflict in the worker's schedule, this counts as the first rescheduled appointment.

- C. If the appointment is not kept, or rescheduled on or before the first appointment date, the auto discontinuance process starts and the case discontinues at the end of the 10-day period, or cutoff, whichever comes first.
1. If during the 10-day period, the individual reschedules, keeps the appointment and the RECERTIFICATION is entered on KAMES within the 10-day period, the case will not discontinue.

2. If a recertification is not entered by the 10th day of the timely notice period, the case will discontinue.
  3. If an individual calls to reschedule the recertification appointment prior to the end of the 10-day period, but the appointment cannot be rescheduled until after the expiration of the 10-day period, when the individual keeps the rescheduled appointment, an application must be entered on KAMES.
  4. If the timely notice period expires after the monthly cutoff date, the system discontinues the case at cutoff. In this instance, if the individual comes in for recertification during the 10-day period (but the case discontinued at cutoff), enter an application on KAMES.
- D. The case is entered as a REAPPLICATION if the case is correctly discontinued (e.g., the individual failed to show or call to reschedule his/her recertification appointment prior to the end of the 10-day period).

MS 1600 INTRODUCTION TO MANAGED CARE (1)

Managed Care Organizations (MCO) link Medicaid recipients with participating physicians who are responsible for coordinating and providing primary medical care to these recipients.

- A. The purpose of managed care is to:
  - 1. Assure needed access to care;
  - 2. Provide for continuity of services;
  - 3. Strengthen the patient/physician relationship;
  - 4. Promote the educational and preventive aspects of health care;
  - 5. Prevent unnecessary utilization and cost; and
  - 6. Improve the quality of care received.
  
- B. The following Medicaid recipients are **exempt** from enrolling with an MCO:
  - 1. Members in long term care (LTC) facilities such as nursing facilities, Institutionalized Hospice and ICF/MR/DD;
  - 2. Members receiving waiver services (except non-institutionalized Hospice);
  - 3. Members whose eligibility is time limited such as Spend Down and Time Limited Aliens;
  - 4. Members in the Medicaid Works Program; and
  - 5. Members in "Z" Cases.
  
- C. Non-exempt recipients are required to enroll with an MCO. If the recipient fails to select an MCO, Medicaid assigns each member in the case an MCO. After enrollment, the MCO helps the recipient select a primary care provider (PCP). Members will get a handbook and other instructional material from the MCO.
  
- [D. When recipients contact the agency with an address change, the worker makes the change on KAMES according to normal procedures.]
  
- E. The Department for Medicaid Services maintains a managed care toll-free telephone number to assist providers and recipients who have questions pertaining to managed care. The Medicaid managed care number is 1(855)446-1245, and is available from 8 a.m. to 5 p.m. Eastern Time, Monday through Friday.





MS 1603

MANAGED CARE ENROLLMENT

(1)

The non-exempt managed care Medicaid applicant is given the opportunity to select a Managed Care Organization (MCO) and a preferred physician during the application process. The individual may change that MCO/physician within the first 90 days of initial enrollment which begins with the start date listed on the MCO Inquiry screen. After that, members have the opportunity to switch MCOs annually, similar to private health insurance open enrollment. Every effort should be made to complete the MCO/physician selection for all family members during the application interview.

A. During the application interview if:

1. The member is subject to managed care; provide a brief explanation of the managed care program;

[2. The member knows who their preferred MCO/physician is, access <https://prd.chfs.ky.gov/ManagedCare/> and locate the appropriate MCO/physician provider number. This information is entered on the KAMES MCO screen.]

Note: This website is used to locate MCO's.

B. When a member is approved for Medicaid they will be contacted by their MCO for enrollment and issued the same KYHealth Card that is issued to Medicaid recipients. They also receive a one-time managed care card from their MCO after enrollment and selection of a Primary Care Provider (PCP). If members have specific managed care questions they must contact managed care Medicaid services at 1-855-446-1245 or call their designated MCOs:

[CoventryCares Of Kentucky;  
WellCare of Kentucky;  
Passport; and  
Humana]

Passport and Humana are valid for Region 31 only. Toll-free telephone numbers are listed on the back of both cards.

C. The member can select an MCO/provider during the application interview. If the member does not know who they want to select during the interview, the member can call back with the MCO/provider information. The DCBS worker can make the assignment as long as the application has not been processed. Once the application has been processed the DCBS worker can no longer complete an assignment on KAMES. The member will have to contact Medicaid Managed Care Services at 1-855-446-1245 for any MCO changes.

If the applicant fails to select an MCO/physician Medicaid will assign an MCO. The MCO will then contact the member to assign a primary care provider (PCP).

Note: MCO changes are only made during the initial 90-day period of enrollment and annually. Members with questions regarding changes to their MCO are to contact Medicaid Managed Care Services at 1-855-446-1245. Members with questions regarding their provider are referred to the MCO assigned to them. The number to that MCO is on their MCO card.

- D. For reapplications approved within 60 days of the effective date of discontinuance, case members will be reassigned to the same MCO unless a new provider is requested.
- E. For member adds, follow procedures in items A, B, and C. If an individual is added to an active case the effective date is the first day of the month of the requested change.
- F. Members who are exempt from managed care are only issued a regular Medicaid card.
- G. If a member moves from one part of the state to another the only required action on the worker's part is to make the address change on KAMES. Any further action to change the MCO or PCP is handled by the member's MCO. Advise the member to contact their MCO to make changes or other arrangements.
- H. There are no fair hearing procedures for managed care as the delivery method of Medicaid is not a qualifying event for a fair hearing. Managed Care has a grievance procedure for issues such as dissatisfaction with a provider assignment. These are explained in the member handbook.

MS 1606 EXEMPT/NON EXEMPT MANAGED CARE RECIPIENTS (1)

[Workers determine eligibility and provide basic information about managed care to applicants and recipients.]

A. The following Medicaid members are non-exempt and required to participate with an MCO:

1. Individuals receiving in a Family or AFDC-Related MA category such as:

- a. Individuals receiving Medicaid through Kentucky Transitional Assistance Program (K-TAP).
- b. Individuals receiving Kinship Care;
- c. Family MA recipients;
- d. Children under 21 years of age, in a Psychiatric Residential Treatment Facility (PRTF);
- e. Individuals receiving Non-institutionalized Hospice waiver services;
- f. Children in Guardianship Foster Care and children in the Special Needs Adoption Program (SNAP).

2. Individuals receiving non-institutionalized care in an Adult MA category such as:

- a. Individuals receiving Medicaid who are aged, blind or disabled;
- b. Pass Through recipients;
- c. State Supplementation recipients;
- d. Supplemental Security Income (SSI) recipients;

B. The following Medicaid members are exempt and not required to participate in an MCO:

1. Spend Down recipients;
2. Alien recipients of Time Limited Coverage;
3. Individuals receiving waiver services such as SCL, HCBS, etc.

EXCEPTION: Individuals receiving Non-institutionalized Hospice waiver services are **NOT** exempt.

4. Members in long term care (LTC) facilities, such as nursing facilities, Institutionalized Hospice, and ICF/MR/DD; and
5. Members receiving Medicare Savings Plan benefits such as QMB, QDWI, SLMB, and QI1.

MS 1720 [RECIPIENTS MOVING INTO OR OUT OF KENTUCKY]

System edits in KAMES prevent individuals from receiving duplicate benefits within the state of Kentucky. However there are no system edits available to prevent duplicate benefits for individuals who move into Kentucky and have received out-of-state benefits or for individuals who move out of Kentucky and apply in their new state of residence. In order to avoid overlapping Medicaid eligibility for individuals or households who move into Kentucky or move out of Kentucky follow these procedures.

A. Recipients Moving Into Kentucky

For applications with members, who received in another state:

1. Contact the other state agency to determine the effective date of discontinuance;
2. If the benefit period from the other state is still in effect take a hardcopy application;
3. Deny the application for the months already issued in the other state. Issue by special circumstance action any remaining period of eligibility;

Example: Client applies on September 5. The other state has advised that the effective date of discontinuance will be September 11. The first day of potential eligibility in Kentucky is 9/11/10. Deny the application for the month of September and approve ongoing benefits beginning October 1. Authorize benefits by special circumstance for the time period of September 11 through September 30.

4. Document the action in comments.

B. SSI Recipient Moving Into Kentucky

SSI recipients who move from another state into Kentucky and require medical services can receive a KY Health Card based on the following:

1. SSI and Medicaid eligibility is on the SDX system; or
2. The Social Security Administration verifies to the Medical Support and Benefits Branch (MSBB) that eligibility exists.

Send the recipient's name and social security number to MSBB. MSBB will contact SSA to verify eligibility. If eligibility is verified, MSBB will issue the eligibility.

C. Recipients Moving Out of Kentucky

When an individual contacts the local office to have their case benefits discontinued because they have moved out of the state, close the case effective the next feasible month.

If the applicant is unable to obtain Medicaid coverage in another state because Kentucky has issued Medicaid coverage for a specific month, the applicant may request immediate termination of Kentucky Medicaid. Refer out-of-state recipients requesting immediate termination of Medicaid to the Member Services Branch, at (800) 635-2570 or (502) 564-2574.

Note: DMS will require the individual to provide a signed statement requesting that Medicaid coverage be terminated. If no medical claims have been paid on the recipient's behalf for the requested month of termination, DMS will provide a written statement verifying Medicaid termination effective with the requested month.

- D. Individuals from other states who need information regarding Medicaid are referred to the Member Services at 1-800-635-2570.]

MS 2000

INTRODUCTION TO TECHNICAL ELIGIBILITY

Technical eligibility of families or children under age 18 or 19, if appropriate, uses the deprivation and relationship criteria of the K-TAP program and in addition includes:

- A. [Deprivation of unemployment in K-TAP "W" criteria];
- B. Recognition of a pregnant woman as a special eligibility factor;
- C. Placement in a foster care arrangement; and
- D. Placement in a subsidized adoption.

[EXCEPTION: Deprivation and living in the home of a parent or other SR are NOT technical eligibility requirements for the "I" and "Y" categories.]

MS 2010

ENUMERATION

Require each member, other than a deemed eligible newborn, applying for or receiving MA to furnish an SSN or to apply for a number if one has not been issued. Do not require an individual not applying for MA to furnish their SSN.

[Refusal to furnish the number or to make application for a number results in the unenumerated member being technically excluded from MA.] A member technically excluded from MA due to enumeration may be included in the MA family size if advantageous to the assistance group. [For good cause criteria for failure to enumerate, see MS 2016.]

Approve applications, add members or continue eligibility during the period pending issuance of the SSN.

Verification procedures for MA approvals or active cases on KAMES:

- A. If the individual can provide a social security card or other official documentation provided by an organization or source which verifies the SSN, make a copy of the card or documentation, file this information in the case record and use verification source code OR.
- B. A copy of the SS card with the new name is required for verification of a name change. KAMES will not allow the change to be completed if the name has not been changed with Social Security because KAMES does a match with State On-Line Query (SOLO) and the name must match the SS number.
- C. If primary verification is not available and the individual knows the SSN, enter CS for verification of the individual's stated SSN. [No additional verification is required, unless questionable.]
- D. Enter SSN verification as follows:
  1. If verification is provided, enter the appropriate verification source code on the member's General Information screen.
  2. If the SSN is known but no verification is provided, enter "CS" as the verification code.
  3. [Include the individual in the case when the individual, who must be enumerated, does not yet have an SSN and is cooperating with the enumeration process. The individual is cooperating when he:
    - a. Allows DCBS to mail original documentation to SSA with completed form SS-5; or
    - b. Returns a signed system-generated receipt issued by SSA.

Additionally, individuals may obtain an SSN application form on the SSA website <http://www.ssa.gov/ssnumber/>.

4. A system or worker assigned pseudo number is used until the SSN is entered on the system through an SSN change action. The system applied SSN is indicated by "SA" verification source code. If the unenumerated head-of-household or member is discontinued, the previously system-assigned pseudo number is obtained through Inquiry or review of the previous case record. Enter the pseudo number at reapplication if the individual has not yet obtained an SSN. Do not answer "Y" to the "Assign Number?" question. Receipt of documentation from SSA serves as verification of the SSN.
- 5]. The verification code of "SA" is uploaded for all SSN's that are system verified by the Social Security Administration (SSA).

For additional information on enumeration, refer to [MS 2012](#) for information concerning the SSN application process.

MS 2012\*

## SSN APPLICATIONS

If an application for an SSN with the Social Security Administration (SSA) is verified, do not complete form SS-5, Application for a Social Security Card. Obtain a copy of the signed system-generated receipt issued by SSA for the case record.

Form SS-5 is available on the SSA website at: <http://www.ssa.gov/ssnumber/>. In completing form SS-5 for a member, verify the date of birth, identity, and citizenship of the individual using evidence required by SSA and procedures for form SS-5.

Ensure each individual who completes form SS-5 understands the use of the number and has read and understands "The Privacy Act and Your Request for a Social Security Number" which is printed on page 4 of form SS-5.

To preserve the anonymity of the natural parents and to assure the contents of the original case record remain confidential for children placed for adoption or subsidized adoption, follow enumeration procedures outlined on the SSA website at the above address.

A. VERIFICATION. Acceptable proofs of age include:

1. Birth certificate from any hospital NOT shown in the appendix to the procedural instructions for form SS-5;
2. Verification of birth registration (Notification of Birth Registration issued by Vital Statistics);
3. Kentucky Vital Events (KVETS) Birth Index File data;
4. Hospital record;
5. Baptismal record;
6. School record; and
7. INS records.

If a birth certificate, birth registration, baptismal record, etc., is used for proof of date of birth, additional verification is required to establish that the document is actually that of the applicant. Procedural instructions to form SS-5 give a complete listing of acceptable evidence of age and identity. Any document showing a birth place in the United States establishes citizenship.

DO NOT use one document to verify both age and identity (e.g., driver's license); a driver's license verifies identity only. An additional document to verify age is required.

Applicants born outside the United States, Puerto Rico, Guam, U.S. Virgin Islands or American Samoa must prove legal entry into the United States or present proof of citizenship

- B. INTERVIEWING. The SSA conducts the required face-to-face interviews for all individuals age 12 or over applying for the first SSN card.
- C. PROCESSING. Send completed forms SS-5 along with original verification of birth and identity each week to the Regional or District SSA office serving the specific county, unless the applicant wishes to submit the application himself/herself. SSA is responsible for returning original verification to the applicant.
  - 1. Enumeration is completed by entering an SSN change on KAMES immediately upon receipt of the verified SSN.
  - 2. Spot check the case at 90 days for the receipt of the SSN. Contact the member to determine if the member has received the SSN. Spot checks are posted to the DCSR Report Menu, Pending Case Actions, Expiring Enumeration.
    - a. If the member has received the SSN, manually enter the SSN.
    - b. If the member has applied for the SSN but has not received the SSN, reinitiate the SS-5 process.
  - 3. At recertification, review the case to ensure enumeration is complete and the SSN has been entered for all members.

MS 2014\*

FAILURE TO COMPLY WITH ENUMERATION

- A. Failure to comply with enumeration requirements means:
1. A statement of intent not to provide/apply for a SSN;
  2. Failure to apply for a SSN; or
  3. The member fails to supply documentation required for completion of form SS-5 without good cause. As long as a good faith effort is being made to provide the SSN, good cause exists for failing to provide the number.
- B. Technically exclude the members, other than a deemed eligible newborn, who are not enumerated. A member technically excluded for enumeration may be included in the MA family size if advantageous to the assistance group.

The excluded household member becomes eligible upon providing the Agency with a SSN or applying for a SSN at the local office, if otherwise eligible.

MS 2016\*

ENUMERATION GOOD CAUSE CRITERIA

Good cause criteria for non-cooperation with enumeration requirements are as follows:

- A. If the household member, based on religious grounds refuses to provide an SSN, the member has good cause for failing to comply.
- B. If the household member is unable to provide evidence such as out-of-state birth records which are necessary for completing form SS-5, the member has good cause for failing to comply as long as he is making a good faith effort to obtain the evidence.

If you question whether the member is making a good faith effort to obtain the out-of-state birth records, require the household to provide verification such as copies of letters sent to request the information.

MS 2018\*

USE OF THE SSN

The Department for Community Based Services is authorized to use SSN's in the administration of benefit programs. The SSN is used in the following ways:

- A. Access BENDEX information regarding individuals who currently receive K-TAP, MA, or State Supplementation benefits and receive benefits under Title II of the Social Security Act (RSDI);
- B. Access the State Data Exchange (SDX), to determine if any household member is currently receiving SSI income and the amount;
- C. Access other computer files available to the Department, e.g., IEVS, UI, etc.; and
- D. Prevent duplicate participation and determine the accuracy and/or reliability of other income information given by households, e.g., wage records.

MS 2030

AGE REQUIREMENTS

This section outlines the age requirements for Medicaid eligibility in all Family MA and AFDC Related MA cases.

A. [To be eligible in the Family MA categories of "L", "N", "P", "U" or "Y" or AFDC Related MA categories of "E" or "T", a child must be age 17 or under, or age 18 if in regular full-time attendance in high school, or the equivalent level of vocational or technical school, and expected to complete a course of study before reaching age 19.] Completion of a course of study is defined as the date the student takes the last exam or attends the last class, whichever is earlier. School attendance is not an eligibility factor in MA for dependent children under age 18.

1. [A child is eligible during the month the child reaches age 18 if not in school unless the 18<sup>th</sup> birthday is on the first day of the month.
2. A child is eligible during the month the child reaches age 19 if in school and is expected to graduate before attaining age 19 unless the 19<sup>th</sup> birthday is on the first day of the month.

Example 1: The child will graduate on May 15<sup>th</sup> and will turn age 19 on May 25<sup>th</sup>. The child remains eligible through May 31<sup>st</sup>.

Example 2: The child will graduate on May 15<sup>th</sup> and will turn age 19 on June 1<sup>st</sup>. The child remains eligible through May 31<sup>st</sup>.

Example 3: The child will graduate on May 15<sup>th</sup> and will turn age 19 on May 1<sup>st</sup>. The child's eligibility ends on May 31<sup>st</sup>, the month of his 18<sup>th</sup> birthday.

B. To be eligible in the "I" category under the:

1. 100% of the Poverty Level MA Scale (P1), a child must be at least age 6 and under age 19;
2. 133% of Poverty Level MA Scale (P2 and P5), a child must be under age 6;
3. 150% of Poverty Level MA Scale (P6), a child must be at least 1 year of age and under age 19;
4. 185% of Poverty Level MA Scale (P3), a child must be under age 1; and
5. 200% of Poverty level MA Scale (P7), a child must be under age 19.

C. A child receiving MA in the "L", "N", "P" or "Y" category, or in the K-TAP "C" or "W" category, who is hospitalized in an acute care hospital at the time the child becomes age ineligible continues to receive MA for the

duration of the hospitalization if certain criteria are met. When this situation occurs, Regional Office staff are to contact the Medical Support and Benefits Branch (MSBB) for specific instructions for determining eligibility for additional months of MA coverage.]

For an "I" case child who becomes age ineligible and is hospitalized, follow policy outlined in [MS 2880](#).

[D.] Birth records are necessary only if there is reason to question the child's age.

[E.] Use form PA-33D, Child's Certification of School Enrollment/Attendance, to verify school attendance, if required.



a. TIER 1 (highest reliability)

Acceptable primary documentation for identification and citizenship may be one of the following:

- 1) A U.S. Passport;
- 2) A Certificate of Naturalization (DHS Forms N-550 or N-570);  
or
- 3) A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).

b. TIER 2 (satisfactory reliability)

Acceptable secondary documentation to verify proof of citizenship:

- 1) A Certification of Birth issued by the Department of State (Form DS-1350, FS-240 or FS-545);
- 2) A U.S. birth certificate (workers may print a copy of a birth certificate from KVETS, the birth index file search program). Workers may access the website for vital statistics to obtain information for the applicant/recipient on how they can request birth certificates from other states at <http://www.vitalchek.com/listphone.asp>;
- 3) A U.S. Citizen I.D. card (DHS Form I-197 or I-179);
- 4) The SAVE database is confirms citizenship for naturalized citizens;
- 5) An American Indian Card, Form I-872, issued by the Department of Homeland Security with the classification code "KIC";
- 6) Final adoption decree;
- 7) Evidence of Civil Service employment by the U.S. government before June 1976;
- 8) An official military record of service showing a U.S. place of birth; or
- 9) A Northern Mariana Identification Card, Form I-873.

c. TIER 3 (satisfactory reliability – use only when primary or secondary evidence is not available)

Acceptable third-level documentation to verify proof of citizenship:

- 1) U.S. hospital birth record on hospital letterhead that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth. (DO NOT accept a souvenir birth certificate.);
- 2) Life, Health or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date;
- 3) Religious records recorded in the U.S. within three months of the birth; or
- 4) Early school records.

d. TIER 4 (lowest reliability)

Acceptable fourth-level documentation to verify proof of citizenship:

- 1) Birth records of citizenship filed with Vital Statistics within five years of the birth; or
- 2) Federal or State census record showing U.S. citizenship or a U.S. place of birth for persons born 1900 through 1950. The applicant or worker completes Form DC-600, Application for Search of Census Records and Proof of Age. In remarks, state U.S. citizenship data requested for Medicaid eligibility. This form is on the U.S. Census website at <http://www.census.gov>; or
- 3) Institutional admission papers from a nursing home, skilled nursing care facility or other institution that was created at least 5 years before the initial Medicaid application date and indicates a U.S. place of birth; or
- 4) A medical (clinic, doctor, or hospital) record that was created at least 5 years before the initial Medicaid application date that indicates a U.S. place of birth unless the application is for a child under age 5; or
- 5) Indian tribal records. Forward this type verification to the Medical Support and Benefits Branch (MSBB) for approval by the Department for Medicaid Services.

e. LAST RESORT

Notarized statements may be accepted for citizenship verification only when no other documentation is available. Naturalized citizens are permitted to utilize this process as well.

Procedures are as follows:

- 1) Written notarized statements MUST be signed under penalty of perjury, from two individuals of which only one can be related;
- 2) These two individuals MUST have personal knowledge of the events establishing the applicant's claim of citizenship. At least one statement must contain information regarding why other documentation is not available;
- 3) The person signing the notarized statement must provide proof of his/her own citizenship and identity.

B. [Identification requirements for MA program for individuals age 16 and older are as follows:

- 1) Individuals who provide acceptable primary documentation from Tier 1 have met the identification technical requirements for MA.

- 2) Individuals who verify citizenship by documentation items listed in Tiers 2, 3 or 4, as well as those signing notarized statements for applicants, must also provide proof of identification. Acceptable original documentation to verify identity consists of the following:
  - a) Current state driver's license bearing the individual's picture or state identity document with the individual's picture; or
  - b) Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document; or
  - b) Other official documentation issued by the state in which the individual resides; or
  - d) The use of three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas, and employer ID cards; or
  - e) Data matches or documentation from other agencies which include:
    - (1) SNAP (for head of household only);
    - (2) Child Support;
    - (3) Law enforcement;
    - (4) Correctional agencies, including juvenile detention;
    - (5) Division of Motor Vehicle records;
    - (6) Expired driver's license – unless questionable;
    - (7) Protection and Permanency documentation, including materials relating to child protection; or
    - (8) Other official documentation issued by local, state or federal governments from the individual's place of birth or residence.
  - f) The facility director or administration may attest to the identity for disabled individuals in a residential care facility.
  - g) An affidavit or notarized statement signed under penalty of perjury by a parent or guardian attesting to the child's identity for children age 16 or older.]

C. Identification for children under age 16 may be documented by one of the following: ]

1. School identification card with a photograph;
2. Military dependent's identification card if it contains a photograph;
3. School record that shows date and place of birth and parent(s) name;
4. Daycare or nursery school record showing date and place of birth;
5. [Form KIP-106, Attestation of Identity, can be generated and used to verify the identity of children under the age of 16 applying for Medicaid, when no other proof of identity is available.

Note: The KIP-106 can only be generated at application, program transfer or recertification]

As always, assist individuals who encounter any difficulty in obtaining documentation for verification of identification and citizenship. Please be especially mindful of potential challenges facing the elderly, the disabled, the blind and those coping with other types of limitations.

MS 2036

MA CASE PROCESSING  
FOR CITIZENSHIP VERIFICATION

(1)

To be eligible for MA, an individual must be a citizen of the United States or qualified alien.

- A. If the applicant declares qualified alien status, follow procedures in [MS 2037](#).
- B. If the applicant has verification of citizenship at the time of the application, re-application or member add, answer a "Y" to the question, "IS HE/SHE A U.S. CITIZEN?" and enter the citizenship verification source original record "OR" or written statement "WS". Document the original citizenship verification source in case comments and copy verification for the case record.
- [C. If the applicant declares United States citizenship but does not have adequate verification:
  1. Accept the applicant's statement and approve benefits by answering a "Y" to the question, "IS HE/SHE A U.S. CITIZEN?".
  2. Enter the citizenship verification source "CS".
  3. Explain to the applicant they are being approved to receive benefits for up to 90 days from the date of application while they attempt to obtain the required citizenship verification.
- D. System processing when verification is not provided:
  1. A file is sent to the Social Security Administration (SSA) for verification of citizenship for all members with a "CS" verification source at application, reapplication and member add.
  2. If citizenship is not verified by the SSA, a Request for Information (RFI) is sent by KAMES to the member advising them they have 90 days to verify.

If verification is not returned within the first 60 days from the application approval date, a 2<sup>nd</sup> notice is sent by KAMES requesting verification of citizenship be returned within 30 days. If verification is not received, after the 30 days the system changes the "CS" verification source to "NV", not verified. The member is removed from the case and is not eligible until citizenship verification is provided.

Note: If the verification source of "CS" was manually removed and verification is not returned the system applied verification code of "98" appears discontinuing Medicaid for that member.

The case will remain active for the members that have met the citizenship and identity requirements if all other technical and financial requirements have been met.

3. Do not deny, delay, reduce or terminate benefits for a period of up to 90 days from the initial application for benefits. If the member is removed from the case but provides verification that they are making a good faith effort and the delay in obtaining the documentation is beyond their control, issue eligibility for missed months of coverage once verification is received.

Note: Assist the applicant in obtaining documentation if feasible however the burden of providing verification lies with the applicant.

- E. If the member(s) removed for failure to verify citizenship reapplies for Medicaid, either by reapplication or member-add, they must provide verification of citizenship to be reapproved for Medicaid. The "NV" or "98" verification source cannot be replaced with "CS" as the member has already been provided 90 days to verify citizenship. The only acceptable verification source is "OR" or "WS" for citizenship. The individual is to be advised that the member(s) removed from case will not be approved until verification is received.
- F. ACCEPTABLE worker entered verification codes for citizenship are;
  1. WS (written statement);
  2. OR (original record);
  3. CS (client statement); or
  4. Not Verified (NV)

Any other codes entered will trigger an error message and the screen cannot be exited.

- G. Individuals who are receiving Medicare Part A, Medicare Part B or who are conditionally enrolled in or are entitled to enroll in Medicare Part A are not required to verify citizenship as they have already provided this information to the Social Security Administration. Enter a "Y" to the question, "IS HE/SHE A U.S. CITIZEN?" and enter the citizenship verification source "OR".
- H. A member who is deemed eligible or is in the first 6 months of Transitional Medical Assistance (TMA) will remain active if verification of citizenship is not provided.
- I. Applications in behalf of a deceased individual are not allowed 90 days to provide verification of citizenship as the individual is not being denied access to services while the documentation is located.
- J. Individuals applying for spend down are allowed the 90 days to return verification of citizenship. The application is processed if otherwise eligible and the individual is attempting to obtain satisfactory citizenship verification. If the case is inactive when verification is received, file in the case record for future applications as the individual is not allowed another 90 days to provide verification.]

MS 2037

CRITERIA FOR QUALIFIED ALIENS

(1)

[Individuals must be U.S. citizens or qualified legal aliens to receive Medicaid benefits. Nationals of Puerto Rico, U.S. Virgin Islands, American Samoa, the Northern Mariana Islands or Swain's Island are equivalent to U.S. citizens. Qualified legal aliens are individuals that have been granted legal immigration status through the U.S. Citizenship and Immigration Services (USCIS). Depending on how a qualified alien acquired qualified legal status is what determines if they are subject to the 5 year date of entry ban imposed by Medicaid.

- A. The following qualified aliens are subject to the 5 year date of entry ban imposed by Medicaid and cannot receive Medicaid (except for the time-limited MA, see [MS 2038](#)) until they have remained in qualified alien legal status for at least 5 years from their date of entry into the United States:
1. Aliens lawfully admitted for permanent residence ON or AFTER August 22, 1996;
  2. Aliens paroled in the U.S. under Section 212(d)(5) of the INA for a period of one year. If INS document I-94 indicates the individual will be in U.S. for at least 1 year, eligibility may potentially start after parolee status is granted;
  3. Any individuals listed in item B. 6 below that have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them; they are NOT eligible under the provision listed below in B. 6.
  4. Aliens who are battered or subjected to extreme cruelty in the U.S.
    1. Either as an adult or as a child if battered or subjected to extreme cruelty by:
      - a. A spouse or a parent of the alien without the active participation of the alien in the battery or cruelty; or
      - b. A member of the spouse or parent's family residing in the same household as the alien – and the spouse or parent consented to the battery or cruelty;
    2. The battered individual must:
      - a. No longer reside in the household with the individual responsible for the battery or cruelty;
      - b. Have a substantial connection between the battery or cruelty and the need for the benefit; and
      - c. Have been approved or has a petition pending for:
        - 1). Status as a spouse or child of the U.S. citizen;
        - 2). Status as a permanent resident alien;
        - 3). Suspension of deportation status pursuant to Section 244(a)(3) of the INA.B

Note: "Battered or subjected to extreme cruelty" means an individual who has been subjected to:

1. Physical acts that resulted in, or threatened to result in, physical injury to the individual;
2. Sexual abuse;
3. Sexual activity involving a dependent child;
4. Being forced as the caretaker relative of a dependent child to engage in nonconsensual sexual acts or activities;
5. Threat of, or attempts at, physical or sexual abuse;
6. Mental abuse; or
7. Neglect or deprivation of medical care;

B. The following qualified aliens can receive Medicaid and are not subject to the 5-year ban from their date of entry:

1. Aliens lawfully admitted for permanent residence before August 22, 1996;
2. Afghan and Iraqi aliens who are granted special immigration status under Section 1059 of the National Defense Authorization Act (NDAA) of 2006 or Section 1244 of the NDAA of 2008 are treated in the same manner as refugees admitted under Section 207 of the Immigrations and Nationality Act. These Iraqi and Afghan aliens served as translators for the U.S. military. This special immigration status also applies to their spouses and unmarried dependent children. The law applies to Afghan and Iraqi aliens who were already in the U.S. with special immigration status on the effective date of the law, December 19, 2009, and who enter on or after that date.
3. Refugees who were admitted under Section 207 of the Immigration and Nationality Act (INA) and asylees who were granted asylum under Section 208 of the INA.

Note: Sometimes refugees and asylees are granted permanent legal resident status after only 1 year of being admitted into the United States. Their status changes from being covered under sec. 207 or 208 of the INA act to being covered under sec. 209 of the INA act. Individuals covered under sec. 207, 208 or 209 are not subject to the 5 year entry ban.

4. Children under the Child Citizenship Act of 2000, who automatically acquire citizenship on the date that all of the following requirements are satisfied:

- a. At least one parent is a U.S. citizen whether by birth or naturalization;
- b. The child is under 18 years of age; and
- c. The child is residing in the United States in the legal and physical custody of the citizen parent pursuant to a lawful admission for permanent residence.

The parent can apply for a Certificate of Citizenship by filing Form N-600. They can also apply for a U.S. passport. If the applicant has other documentation that verifies the parent to the child is a U.S. Citizen, such as the child's birth certificate or the parent's birth certificate, then this can be used and the Certificate of Citizenship would not be necessary.

5. Aliens who are verified by the Office of Refugee Resettlement (ORR) to be victims of human trafficking, and eligible relatives. Refer to Vol. I, [MS 0562](#).
6. Aliens granted status as a Cuban or Haitian entrant (as defined by Section 501(e) of the Refugee Assistance Act of 1980) whose I-94 is annotated with the words "refugee".

Section 501(e) defines Cuban and Haitian entrants as any individual who is:

- a. Granted parole status as a Cuban/Haitian entrant (status pending);
- b. Granted parole status as a Cuban/Haitian entrant under Section 212 which is considered in the same manner as those entering under Section 501.
- c. Granted any other special status established under INA laws for these nationals;
- d. Being a national of Cuba or Haitian paroled into the U.S. and has not acquired another status under INA;
- e. Subject to exclusion or deportation proceedings under INA; or
- f. Having an application for asylum pending with Immigration and Naturalization Service (INS).

If any of the individuals listed in item 6 have a final, non-appealable, legally enforceable order of deportation or exclusion entered against them, they are NOT eligible under this provision.

7. Aliens granted status as a Cuban or Haitian refugee who present an I-551 with a category status of 'CU6' (for Cuban refugee), 'HA6' (for Haitian National paroled under Haitian Refugee Fairness Act), or 'RE6' (Refugee who entered the U.S. on or after Apr. 1, 1980).
8. Aliens admitted as an Amerasian immigrant under Section 584 of the Foreign Operations Export Financing and Related Programs Appropriation Act of 1988 (letter coded AM-1, AM-2, AM-3, AM-6, AM-7 and AM-8);

9. Aliens whose deportation is being withheld (I-94 annotated with the words political asylees) under Section 243(h) of the INA or after April 1, 1997, the renumbered Section 241(b) of the INA;
  10. Permanent resident aliens who are veterans honorably discharged for reasons other than alienage, their spouses or unmarried dependent children;
  11. Permanent resident aliens who are on active duty, other than active duty for training in the Armed Forces of the United States and fulfills the minimum active duty service requirements established in 38 U.S.C. 5303A(d), their spouses or unmarried dependent children;
  12. Aliens who are granted conditional entry pursuant to Section 203(a)(7) of the INA as in effect prior to 4/1/80;
- C. Aliens designated as PRUCOL, permanently residing under color of law, are NOT eligible for Medicaid (except for time-limited MA, see [MS 2038](#)).
- D. The unqualified aliens may receive for their children if the children are citizens or qualified aliens.]

MS 2038\*

## TIME-LIMITED MA ELIGIBILITY

Effective October 1, 1999, any alien, legal, illegal or legalized who, does not meet the qualified alien requirements for ongoing MA, may be eligible for time-limited MA due to an emergency medical condition. Aliens currently in this country on a temporary visa, including students and tourists, may be eligible for time-limited emergency Medicaid coverage, if eligibility requirements are met. Aliens with a visa designation of "T1" victims of human trafficking, qualify for time-limited emergency medical coverage.

- A. The alien must still meet all and financial and technical requirements (i.e., deprivation, disability, etc.) for Adult or Family MA, with the exception of enumeration to be eligible for time-limited emergency coverage. KCHIP3 (150% - 200% of the Federal Poverty Level) does not provide alien time-limited MA coverage.
- B. Aliens applying for time-limited MA due to an emergency medical condition are exempt from enumeration requirements.
  - 1. Enter the SSN if provided, but do not require the alien to apply for an SSN if there is none.
  - 2. If there is no SSN, KAMES will assign a pseudo number.
- C. Time-limited MA coverage includes the first day of the month in which the emergency medical condition begins and continues through the following month. It is important to note that no service related to any transplant may be provided on an emergency basis.
- D. An emergency medical condition is defined as a medical condition in which the absence of immediate medical treatment could result in:
  - 1. Placing the patient's health in serious jeopardy;
  - 2. Serious impairment to bodily functions; or
  - 3. Serious dysfunction of any bodily organ or part.

The normal delivery of a baby is considered an emergency and a covered service. The MA eligibility only covers the month of delivery and the following month. The individual is not eligible for postpartum coverage. The newborn is considered deemed eligible.

Verify the emergency medical condition by obtaining a written statement from the medical provider. The statement must contain information about the medical condition, the date of the emergency treatment, and indicate the medical provider considers the condition an emergency medical condition.

If the statement is lacking information or the information is unclear, contact the medical provider for additional information or clarification. This contact may be done by telephone or letter.

The emergency medical condition must have occurred in the month of application or within the 3 months prior to application.

- E. Use procedures outlined in Volume IV or Volume IVA to determine program category, technical and financial eligibility. Establish a separate case for two month time-limited recipients. Do not include time-limited recipients in the same case with ongoing eligible household members.

MS 2039\*

EXTENSION OF TIME-LIMITED MA

An extension of time-limited MA may be requested by a recipient if the emergency medical condition continues. The individual must file a new application and submit a new physician's statement verifying the emergency event is an on-going/continuing condition.

- A. An extension of time-limited emergency medical coverage for a non-qualified alien is based on an approval by the Department for Medicaid Services (DMS). The extension request must be received by the Medical Support and Benefits Branch (MSBB) within 30 days of the end of the emergency Medicaid eligibility period. MSBB forwards the request to DMS.

For aliens who request additional coverage 30 days beyond the expiration of the eligibility period, send form MA-105, Notice of Eligibility or Ineligibility, for denials of the extensions.

- B. Obtain a new written statement from the medical provider verifying the emergency medical condition will exist for a period beyond the time-limited coverage. The new statement must contain detailed information of the recipient's emergency medical condition including the medical provider's estimate of how long the emergency medical condition will continue.
- C. Mail or fax a memorandum to Medical Support and Benefits Branch (MSBB):

Division of Family Support  
Attn: Medical Support and Benefits Branch  
275 East Main Street, 3E I  
Frankfort, Kentucky 40621

(502) 564-4021 (fax)

The memorandum must contain the following information:

- 1. Case name and number;
  - 2. Case member for whom the extension is requested;
  - 3. A statement of how long the emergency medical condition will continue; and
  - 4. Attach the medical provider's statement.
- D. Retain a copy of the memorandum and the medical provider's statement in the case record.

- E. MSBB forwards the request to the Department for Medicaid Services (DMS) who approves or denies the extension. For approvals, DMS provides the effective dates of the extension.
- F. After the DMS determination is made, MSBB notifies field staff of the decision.
- G. Upon receipt of an extension approval, update the case accordingly.
  - 1. Enter the extension information on disposition screen PC14.
  - 2. KAMES discontinues MA for the alien once the approved coverage expires.

MS 2040

GENERAL RESIDENCY

To be eligible to receive MA, the individual must be a resident of Kentucky.

A. Individuals Under Age 21.

1. For individuals under age 21, if married and capable of indicating intent, or emancipated from parental control, the state of residence is the state in which the individual is living with the intention to remain permanently or for an indefinite period.
2. For noninstitutionalized individuals under age 21 whose MA eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.
3. [For other noninstitutionalized individuals under age 21, use K-TAP residency criteria:
  - a. A child and the relative with whom the child lives must be actually residing in the state and be either citizens of the United States or aliens legally admitted for permanent residence.

EXCEPTION: If a child of an illegal alien is born in the United States, the child is considered a U.S. citizen. The illegal alien parent may not be included in the case, but may be payee for the child.

- b. A child physically present in the home of the applicant/recipient day-by-day is considered living in the home.

EXCEPTION: In cases of joint custody, eligibility may not exist. In determining joint custody, a case-by-case decision is made based on facts of the individual situation as they relate to the provisions of continued absence and the "living with" requirement. Refer to [MS 2560](#).

- c. If the recipient maintains no fixed or permanent address and can provide no mailing address, issue benefits in care of the local DCBS office. Use this procedure at the recipient's request when no other means of delivering benefits are available.
    - d. Consider applicants/recipients residents if they meet any of the following definitions:
      - 1) The person is living in the state voluntarily and not for a temporary purpose;
      - 2) A child is a resident of the state in which he/she is living other than on a temporary basis; or

- 3) The person is, at the time of application, living in Kentucky and is not receiving assistance from another state. Under this definition, the child is a resident of the state in which the caretaker relative is a resident. Migrants are considered residents.]
- B. Over 21, Noninstitutionalized Individual. The state of residence is the state where the individual lives if incapable of stating intent, or for the capable individual the state where the individual lives with the intention to remain permanently or for an indefinite period, or living and which the individual ENTERED with a job commitment or seeking employment.
- C. [Individuals who are residing in the state on a temporary basis DO NOT meet residency requirements for Medicaid eligibility. Persons residing in the state on a temporary basis include, but are not limited to, students, Job Corps participants whose caretaker relative resides out-of-state, visitors, tourists, certain aliens who enter the U.S. on a temporary basis and individuals who enter the state for medical treatment and who intend to leave as soon as the treatment is completed.
1. If there is a reason to believe that an applicant is residing in the state on a temporary basis, the worker is to thoroughly question the individual and document the case record regarding the individual's statements of residency.
    - a. Individuals who state they are residing in Kentucky for a limited period, for example, students who state they will return to their home state at the end of the school year, do not meet residency requirements.
    - b. Individuals age 21 and over and those under 21 who are capable of indicating intent, who enter the state and indicate intent to remain in the state permanently or for an indefinite period of time, may meet residency requirements. Refer to Vol. IVA, [MS 1580](#) for policy relating to indicating intent to remain.
  2. Non-qualified aliens may be eligible for time-limited Medicaid coverage for emergency medical conditions if all financial and technical eligibility requirements, including residency, are met. See [Vol. I, MS 2075 – 2099.](#)]
- D. Do not deny MA because the individual:
1. Has not lived in the state for a specified period;
  2. Did not establish residence in the state before entering an institution;
  3. Does not maintain a fixed or permanent address.
- E. In cases of disputed residency, if 2 or more states cannot resolve which is the state of residence, the state of residency is the state where the individual is physically located.

MS 2050

EMERGENCY SHELTER

Consider an individual or family group as living in an emergency shelter, when in a public institution on a temporary basis while awaiting a placement appropriate to the needs. [For example, if a child is in a detention center until a foster home placement can be made, the child is in an emergency shelter. If a child is in a detention center and is or will be committed to a Division of Protection and Permanency (P&P) residential facility, such as Green River Boys Camp, the child is considered to be living in a public institution.]

- A. The individual is not technically eligible when in a public institution serving a sentence or awaiting trial, or in a public detention facility because of a delinquent or status offense.
- B. Individuals or family groups who are in an emergency shelter for a temporary period of time are eligible for MA under certain conditions. These conditions are as follows:
  1. The individual or family group must be residents of emergency shelters no more than 3 months in any 12-month period; and
  2. The individual or family group must be otherwise eligible when outside the emergency shelter. Eligibility must have existed immediately prior to admittance to the shelter or must exist immediately after leaving the shelter.
- [C.] Spot check MA recipients residing in emergency shelters each month.
  1. Ensure the individual has been a resident of the shelter for no more than 3 months in a 12-month period; and
  2. Take appropriate case action when the individual leaves the shelter.
- [D. Consider income and resources of the individual or family group residing in an emergency shelter the same as for a "P" child in foster care. See [Volume IV, MS 3120.](#)]

MS 2060\*

SPECIAL SITUATIONS

- A. Consider placements by any entity recognized under state law as acting in behalf of the state as placements by that state.
  - 1. Consider the state arranging or actually making the placement as the placed individual's state of residence.
  - 2. Providing basic information to individuals about another state's MA program or assisting an individual in locating an institution in another state is not considered a placement if the individual is capable of indicating intent and independently decides to move.
  - 3. When a competent individual leaves a facility of state placement, the individual becomes a resident of the state in which that individual is physically located.
- B. If an individual is in a spouse abuse center, the individual's MA eligibility is not affected; however, a child must be living with the parent unless temporary absence of the child existed prior to the parent entering the Spouse Abuse Center.
- C. Do not consider an individual in a VA hospital as living in a public institution for MA eligibility purposes. An individual in a VA hospital, if otherwise eligible to be included in an AFDC Related MA case may receive MA; however, the cost of care in a VA hospital is not covered.
- D. Consider children in subsidized adoptions residents of Kentucky so long as the subsidy agreement continues in effect, even though the home of the adoptive parents may be in another state.

MS 2070

DPP CHILD

[A child committed to the Division of Protection and Permanency (DPP) and placed in a public institution is eligible in a "P" case if:

- A. In a community residence as defined in [MS 2080](#); or
- B. Hospitalized in a general medical facility.
  - 1. If an application is taken, and the interruption of institutional status occurred anytime during the 3 months before the month of application, approve the application by Special Circumstance Transaction, if all other eligibility factors are met. Special Circumstance Transactions must be signed off by the supervisor or principal worker.
  - 2. If the application is taken at the time of need, treat it as an emergency and process within 24 hours of receipt of all necessary verification. Spot check the month of anticipated discharge from the general hospital to discontinue the case.

[All "P" cases are carried by the Children's Benefits Worker (CBW).]

MS 2080

COMMUNITY RESIDENCE

An otherwise eligible person living in a publicly operated community residence:

- A. Is eligible for MA if:
  - 1. The community residence is set up for and serves no more than 16 residents; and
  - 2. Provides training in socialization, motivational therapy, counseling, etc., in addition to food and shelter.
- B. An otherwise eligible person is ineligible if the facility is a correctional or holding facility which provides for individuals whose personal freedom is restricted because of court-ordered holding.

MS 2100

[THIRD PARTY LIABILITY (TPL)]

As a condition of eligibility for Medicaid, Federal law requires the assignment of rights for third party health insurance payments to the Cabinet for Health and Family Services. It is also mandated by State law, that Medicaid is payer of last resort, therefore other health or hospital insurance is billed before Medicaid.

A. At Application/Recertification/Interim Change

1. Explain to the Specified Relative (SR) applying for or receiving assistance:
  - a. The technical eligibility requirement to cooperate with TPL;
  - b. The obligation to notify medical providers if they have other medical coverage;
  - c. The obligation to reimburse Medicaid for medical expenses paid by Medicaid if later they are covered by insurance settlements or payments.

Example: Mindy was involved in a car wreck. Medicaid pays for the treatment of Mindy's injuries. A couple years later Mindy is awarded a \$10,000 settlement for the car wreck. Medicaid must be reimbursed for the medical expenses they paid which have now been covered by the settlement.

2. Determine if the recipient has health insurance or other health care coverage, such as a health maintenance plan or TRICARE (Champus) or has had changes in coverage previously reported. If it appears that health care coverage information has been deliberately withheld, report to the fraud hotline at 1-800-372-2970.
3. If the applicant is covered by health insurance or other health care coverage, enter all information on KAMES. If KAMES is not available, complete form PA-40, Third Party Liability Health Insurance. A statement assigning third party payments to the Cabinet is included on the Medicaid application form and on form PA-40.

Enter policies on a separate screen, if a member has multiple health insurance policies, such as Medicare and a supplement.

4. Re-determine eligibility if the Department for Medicaid Services (DMS) reports resources received from insurance settlements, etc.
5. Inform the appropriate SSA District office, using the Report on Referral to the District Social Security Office form (PAFS-5.1) of ANY changes in SSI individual's TPL coverage.
6. If it is determined the recipient no longer has health insurance enter the "Verified Policy End Date" and verification source on the KAMES

health insurance screen. Never enter "Y" in the "Invalidate" field when ending health insurance as this will prevent the information from being transferred to Medicaid. Even if the information entered is incorrect, simply enter an end date, but do NOT use the invalidate field.

Note: If a future date is entered in the "Verified Policy End Date" field, the system deletes the health insurance segment at the end of the month it was end dated. If the health insurance policy has expired, the "Verified Policy End Date" may be a prior date. If a prior date is entered, the segment is system-deleted immediately.

B. Refusal to Cooperate

If the SR refuses to cooperate with TPL, without good cause, the SR is ineligible, unless the SR is the mother to a deemed eligible newborn. She may be eligible for Medicaid for herself without cooperating in TPL for the deemed eligible newborn. However, when the deemed eligibility is over the mother is then required to cooperate as a condition of her Medicaid eligibility. Failure of the SR to assign third party payments does not affect the eligibility of the children in the case.

C. Good Cause for Refusing to Cooperate

Good cause reasons for the individual's inability to cooperate with TPL may be considered if one of the following applies:

1. The SR and spouse are estranged, therefore the individual is unable to provide the requested TPL information; or
2. Due to a physical and/or mental impairment of the applicant, the TPL information cannot be provided.

If the individual refuses to cooperate and alleges good cause, submit a memorandum requesting a TPL Good Cause Determination to:

Department for Community Based Services  
Medical Support and Benefits Branch (MSBB)  
275 E. Main street, 3E-1  
Frankfort, KY 40621

Include the reasons the individual alleges for refusing to cooperate and any verification which substantiates the individual's claim.]

MS 2140 INTRODUCTION TO THE MEDICARE SAVINGS PROGRAM

Medicare Savings Programs can assist individuals receiving Family MA or AFDC Related MA in paying for their Medicare Premiums. Medicare Savings Programs include: Qualified Medicare Beneficiaries (QMB) for individuals who receive Medicare Part A and/or Part B and Specified Low-Income Medicare Beneficiaries (SLMB) for individuals who receive Medicare Part B. QMB and SLMB individuals in a Family MA or AFDC Related MA case must meet all technical eligibility requirements for Family MA or AFDC Related MA. Individuals receiving Family MA or AFDC Related MA are not eligible to receive Medicare Qualified Individuals Group 1 (QI1) as dual eligibility does not exist for QI1 recipients in any category. Dual eligibility can exist for QMB or SLMB individuals. Individuals who receive QMB or SLMB benefits and regular MA benefits in another category are referred to as having dual eligibility.

Note: QMB/SLMB eligibility needs to be explored for any Family MA or AFDC Related MA applicant with Retirement/Survivors/Disability Income (RSDI). Enter all Medicare information on KAMES and enter the Supplementary Medical Insurance (SMI) premium as a medical deduction.

A. QMB

QMB recipients are eligible for limited MA and for Buy-In. Coverage for QMB individuals provides for payment of Medicare Part A and Medicare Part B premiums, Medicare deductibles, and Medicare coinsurance amounts. Due to payment of coinsurance amounts, QMB coverage is extended to all Medicare services or items outside the scope of MA coverage. Individuals with dual eligibility receive the above benefits in addition to regular MA coverage. For QMB the effective date is the first day of the month after the month of approval. There is no retroactive coverage for QMB.

B. SLMB

For individuals whose countable income is in excess of the QMB standard, determine eligibility for SLMB. SLMB recipients meet all of the requirements for QMB benefits, except for having income in excess of the QMB standard but less than or equal to the SLMB Scale maximum limit. Coverage for SLMB individuals provides for payment of the Medicare Part B premium only. SLMB is effective the month of application. SLMB can be retroactive to 3 months prior to month of application, if all eligibility criteria are met.

C. For additional information regarding QMB or SLMB benefits refer to Volume IVA, MS 4400 - MS 4535.

MS 2200                      Medical Support Enforcement (MSE)                      (1)

Medical insurance coverage or medical support is pursued for children with deprivation of voluntary absence applying for or receiving SSI, Family MA or AFDC Related MA. This includes spend down cases, Transitional Medical Assistance (TMA) cases, and extended MA for AFDC Related or K-TAP cases discontinued due to child or spousal support. Require the parent/legal guardian, except for a pregnant/postpartum woman in the "I" category, to cooperate with Child Support Enforcement (CSE) and law enforcement officials in all phases of MSE activities. This includes, but is not limited to, identifying and locating the absent parent, establishing paternity, obtaining medical support and assignment of medical support to the Cabinet for Health and Family Services (CHFS).

[MSE referrals for SSI children are completed by Child Support Enforcement (CSE), in the department for Income Support.]

A. Cooperation with MSE:

Only MA cases, including MA cases of SSI children, with deprivation of voluntary absence are required to cooperate with MSE. By accepting assistance, a parent/legal guardian, other responsible party or non-responsible relative assigns to the Agency any medical support owed for the child not to exceed the amount of MA payments made on behalf of the recipient.

Request that the individual applying for or receiving MA for Family MA children deprived of parental support due to voluntary absence, assign any medical support or other third party payments of the MA child to CHFS.

Initiate MSE for Family MA and complete an MSE referral:

1. At application;
2. When a child, for whom MSE is required, is added to an active case;
3. To determine on-going eligibility for a deemed eligible newborn's mother when the postpartum period eligibility has ended;
4. Any time prior to the end of the newborn's deemed eligibility period at the request of the newborn's mother;
5. When there is more than one alleged father; or
6. When the parent names an alleged father and there is also a legal father, send a referral on both the legal and alleged or biological father.

B. Non-Cooperation with MSE

The following is considered non-cooperation or refusal to cooperate:

1. Refusal to sign the MSE referral, KIM-125 generated from KAMES;

2. Refusal to provide any information, including what is required for completion of the MSE referral, available to the parent/legal guardian and required by CSE or law enforcement officials to conduct medical support activities;
3. Failure to appear as a witness in judicial or other hearings;
4. Refusal under penalty of perjury to provide correct information or attest to the lack of information;
5. Dismissal of a pending court action or initiation of a dismissal; or
6. Initiation or completion of action to terminate or lower an existing court order.

Note: Sanctions apply only if a parent/legal guardian refuses to cooperate without good cause. For more on non-cooperation procedures refer to [MS 2240](#).

C. Good Cause for Non-Cooperation:

Each parent is given written notification by form CS-333, Facts About the Child Support Enforcement Program. If the parent, other than a "I" category pregnant/postpartum woman, refuses to cooperate and claims to have a good reason for not cooperating, review good cause reasons with the parent. To determine if their refusal to cooperate meets good cause criteria refer to [MS 2270](#), [MS 2275](#), and [MS 2280](#).

D. Cooperation with MSE is not a technical MA requirement in the following situations:

1. Family/AFDC Related MA children living with both parents, another responsible party, or a non-responsible relative. The following instructions are used on the deprivation screen on KAMES for situations involving children in the custody of Juvenile Justice and private adoption agencies and their representatives who make applications for children:
  - a. Leave both parents' name and SSN blank;
  - b. Answer "N" to "Is he/she in the home?";
  - c. Answer "Y" to "Unknown"; and
  - d. KAMES loads "Unknown" in the name fields and bypasses the KASES Referral Screens.
2. Unborn children;
3. Deemed eligible newborns. Cooperation with MSE is not a technical requirement for deemed eligible newborns, unless the SR wants to pursue MSE; or
4. Children receiving in "I" or KCHIP categories are not subject to MSE. A MSE referral is completed if requested by the parent, specified relative or non-responsible specified relative.

- E. Do not complete a referral to CSE when one of the following exists:
1. The absent parent is hospitalized or confined in a penal institution, and intends to return to the home upon release;
  2. The legal parent is dead;
  3. A single parent adoption; or
  4. Joint custody with a 50/50 agreement for physical custody is followed.

MS 2240

NON-COOPERATION PROCEDURES

[When a parent or legal guardian, other than the "I" category pregnant/postpartum woman and children in the "I"/K-CHIP category, refuses to cooperate with MSE and does NOT file a good cause claim, make a finding of noncooperation.

- A. Use form PAFS-2, Application Letter or Notice of Expiration to request verification of cooperation be provided within 10 calendar days. If verification is returned timely and all other eligibility factors are met, the parent/legal guardian is MA eligible effective with the month in which verification is received by the worker that the individual is now cooperating with the Child Support Enforcement (CSE).

Verification of cooperation consists of proof:

1. That the parent/legal guardian met with the contracting official; or
2. A medical support enforcement referral is completed on KAMES.

Note: If the contracting official cannot reschedule the parent or legal guardian's appointment within 30 calendar days, accept the notification of the rescheduled appointment as verification of cooperation.

- B. If verification of cooperation is provided timely, do NOT remove the individual's needs from the case. Notify CSE or the contracting official by updating the parent/legal guardian, absent parent or child's comments screen.
- C. If the individual refuses to cooperate without good cause disqualify the parent on KAMES;

Note: The disqualified parent, if otherwise eligible, may receive MA, in the appropriate category, provided the child in the home for whom the parent is being disqualified does not receive MA.

- D. If a parent/legal guardian files a good cause claim, complete form PA-121, Good Cause Claim/ Determination, and record the good cause claim for noncooperation in medical support activities, record findings regarding the good cause claim, and notify the applicant/recipient of the agency's decision regarding the claim.
- E. If an SSI parent refuses to cooperate with the office of CSE without good cause for an MA child in the parent's home:

1. The KYHealth card of the SSI parent is blocked. When notified by CSE, the local DCBS office requests the card to be blocked by sending an email to the CHFS Medicaid Mailbox. The email needs to include the name and SSN of the SSI parent and the month/year for which the non-cooperation applies.
  
2. When notified by CSE that the SSI parent agrees to cooperate, the blocked KYHealth card of the SSI parent is reinstated by MSBB. Send an email to the CHFS Medicaid Mailbox, including the name, SSN of the SSI parent and the effective date of the cooperation with MSE.]

MS 2250

WORKER RESPONSIBILITIES

(1)

Referrals to Child Support Enforcement (CSE) are made for SSI, Family MA, and AFDC Related MA children living with a parent/legal guardian and deprived of parental support due to:

1. Birth out-of-wedlock, regardless of the age of the child or previous legal action to establish paternity;
2. Desertion; or
3. Divorce.

The worker is responsible for:

1. Explaining the MSE program to the client, including penalties for failure to cooperate, and opportunity to claim good cause for not cooperating;
2. [Providing the parents with form CS-333, Facts about the Child Support Enforcement Program; ]
3. Securing information from the parent;
4. Securing copies of court orders, as appropriate;
5. Generating referral forms on KAMES and obtaining a signed KIM-125, NCP Fact/Information Sheet and Assignment of Rights, if:
  - a. There is a payee change in the Medicaid case; or
  - b. A child is placed back in a home from foster care.
6. Notifying CSE of subsequent changes by updating the client, absent parent or child's comments screens on KAMES.
7. Cooperating in completion of the court action upon request, including if necessary, appearing to give testimony; and
8. Taking other action by request of CSE, including responsibility for good cause determinations.

[Scan the signed KIM-125 into the Electronic Case File (ECF).]

MS 2270\*

GOOD CAUSE

Good cause for failing to cooperate exists only when one or more of the following criteria is met.

- A. Cooperation in support activities could result in physical or emotional harm of a serious nature to the child and/or custodial parent;
- B. Support action is not in the child's best interest due to incest;
- C. Support action is not in the child's best interest because the child was conceived as a result of forcible rape;
- D. Support action is not in the best interest of the child because legal proceedings for adoption of the child are pending; or
- E. Support action is not in the best interest of the child because the custodial parent is being assisted by a public or licensed private social agency to resolve whether to keep the child or release him/her for adoption AND discussion has not gone on for more than 3 months.

MS 2275\*

VERIFICATION OF GOOD CAUSE

Evidence must be provided by the individual within 20 calendar days of the date of the good cause claim (form PA-121) unless an extension is granted.

- A. Evidence which supports a determination of good cause includes, but is not limited to, the following:
1. Birth certificates, medical, or law enforcement records indicating that the child was conceived as a result of incest or forcible rape;
  2. Court documents or other records indicating legal proceedings for adoption of the child by a specific family are pending before a court of competent jurisdiction;
  3. Records (court, medical, criminal, child protective services, social services, psychological, or law enforcement) indicating the noncustodial parent or alleged father might inflict physical or emotional harm on the child or caretaker relative;
  4. A written statement from a public or licensed private social agency that assistance is being given to the custodial parent to resolve the issue of whether to keep the child or relinquish the child for adoption and the issue has not been pending more than 3 months; and
  5. Notarized statements from individuals, other than the custodial parent with knowledge of the circumstances which provide the basis for the good cause claim.

MS 2280

CSE RESPONSIBILITIES

(1)

Child Support Enforcement (CSE) secures medical support from absent parents and is responsible for:

- A. Initiating, reopening or intervening in paternity/medical support actions on behalf of a child;
- B. Reviewing all absent parent forms to determine appropriate action;
- C. Requesting additional information as needed;
- D. Requiring cooperation of the parent/legal guardian;
- E. Making all required contacts with absent parents;
- F. Initiating location efforts for all absent parents whose whereabouts are unknown;
- G. Advising field staff and the parent of progress in individual cases;
- H. Initiating location efforts at the request of other states;
- I. Establishing a CSE case on the absent parent based on the information provided by the parent on the absent parent forms;
- J. Referring cases for court action;
- K. Securing information as to the absent parent's name or location by subpoena or other means in instances of failure to cooperate, and applying penalties relating to fraud for deliberate withholding or falsifying of information;
- L. Enforcing medical support if health insurance coverage lapses; and
- M. [All aspects of medical support enforcement for SSI children.]

MS 2300

TECHNICALLY EXCLUDED INDIVIDUALS

The following are technically excluded individuals and are not included in the Family MA or AFDC Related MA case:

- A. SSI recipients;
- B. The member of a case not meeting enumeration requirements.

EXAMPLE: If a specified relative (SR) refuses to enumerate one child and the SR and other children in the assistance group meet all other MA eligibility requirements, the SR is included in the case and the un-enumerated child is technically excluded from the case.

A technically excluded un-enumerated member may be included in the MA family size, if advantageous to the assistance group.

- C. A child, 18 years of age not meeting the school attendance requirement;
- D. [A stepparent when the deprivation is anything other than incapacity. Incapacity is the only deprivation that qualifies a step parent with no common children in the home for benefits;]
- E. Aliens ineligible due to:
  - 1. Citizenship or alien requirements;
  - 2. Sponsor income; or
  - 3. Sponsorship by an agency or organization;
- F. Siblings who receive K-TAP;
- G. An individual who fails to comply with other technical eligibility requirements; and
- H. A non-responsible SR when the individual does not want to be included in the case.

MS 2310

SANCTIONED INDIVIDUALS

- A. The following are sanctioned individuals and cannot be included in the AFDC Related MA case, or as a Family MA individual in a K-TAP case.
  1. [A parent/legal guardian is sanctioned for refusing to cooperate with MSE.
    - a. The SR or minor parent sanctioned for MSE, other than an "I" pregnant/postpartum woman, if otherwise eligible, may receive MA provided the child in the home for whom the SR is being sanctioned does not receive MA.
    - b. The individual sanctioned for MSE may be included in the MA family size, if advantageous to the assistance group.]
  2. The qualifying unemployed parent sanctioned for refusing to register for work with the Office of Employment and Training (OET).
  3. Any individual sanctioned for refusal to comply with the requirements to receive statutory benefits, if potential entitlement exists. In the "N" case category, ONLY the individual who actually refuses to apply for or comply with the requirements is sanctioned.
  4. K-TAP recipients whose K-TAP case remains active and who are penalized for failing to participate in the Kentucky Works Program (KWP).
- B. Consider the income and resources of the sanctioned individual in determining financial eligibility of the AFDC Related MA case. Allow appropriate deductions for a sanctioned individual with earned income.
- C. An individual sanctioned from K-TAP for any reason other than failing to participate in KWP, may receive MA in the "I", "L", "N", or "Y" category, if all MA technical and financial eligibility requirements are met. The individual sanctioned from K-TAP for failing to participate in the KWP Program, if applying for or receiving MA as the qualifying parent in the "N" category, must register for work.
  1. The MA family size for the separate "I", "L", "N", or "Y" companion case must include the MA case member and the individual in the home responsible for the case member.
    - a. The MA family size may also include all other MA eligible children in the home.
    - b. When all individuals receiving an K-TAP payment are not included in the MA family size of the separate MA companion case for the K-TAP sanctioned individual, prorate the K-TAP payment to establish the amount for determining eligibility by

dividing the total amount of the K-TAP payment by the number of individuals for whom the check was intended.

2. If the individual sanctioned from K-TAP is MA eligible, establish a separate AFDC Related MA case in the "E" or "T" category or a Family MA case in the "I", "L", "N", or "Y" category.
  - a. If the companion K-TAP case remains active, no new application is required.
  - b. Document thoroughly in the separate MA case record and establish the same recertification date as the companion active K-TAP case.
  - c. The individual does not come in and file a new application.

MS 2320

STRIKERS

[Participants in a strike are not eligible to receive AFDC Related MA or Family MA except in the "I" category. ]

- A. A strike is defined as any work stoppage by employees including a stoppage due to the expiration of a collective bargaining agreement, and any concerted slow down or interruption of operations by employees.
- B. Participation in a strike is defined as the act of engaging in a concerted work stoppage or slowdown, and/or interruption of work operations.
  1. This definition includes persons not working as a result of honoring or refusing to cross picket lines set up by those on strike.
  2. This definition DOES NOT include persons:
    - a. Who are not part of the bargaining unit on strike who do not want to cross a picket line due to fear of personal injury or death;
    - b. Whose work place is closed by an employer in order to resist demands of employees, such as a lockout; or
    - c. Not working due to lack of work resulting from a strike situation, such as truck drivers who are not working because striking newspaper pressmen prevent newspapers from being printed.
- C. If an SR or SP in an MA case is participating in a strike as of the last day of a month, discontinue the entire MA group.
  - [1.] If the strike is not resolved within the 10 day timely notice period, discontinue the case.
  - [2.] Explore "I" eligibility for any appropriate individuals. The children or a pregnant woman may be eligible.]
- D. If an SR or SP is participating in a strike at the time of application for MA, deny the application on the last day of the month. Explore "I" eligibility for any appropriate individuals. [Consider the actual income for the month of application, not the household income before the strike.]
- E. If a nonresponsible SR included in the MA case is participating in a strike, do not include that individual in the case. [If the individual is participating in a strike as of the last day of the month, remove that

individual from the MA case the first work day of the next month.  
Explore eligibility in the "I" category for any appropriate members.]

- F. If a nonrelative who is acting as payee for an MA case is participating in a strike, eligibility of the case is not affected.

MS 2330\*

PRISONS/PUBLIC INSTITUTIONS

Eligibility for individuals in public institutions is limited or discontinued depending on what type of institution the person is in.

1. Eligibility for specified age groups in mental or psychiatric hospitals is determined according to LTC eligibility.
2. Inmates of a public institution such as a prison, a jail, a state-operated hospital for mental illness, or a similar facility, are not eligible for Medicaid benefits. For information on prison matches refer to Volume I, MS 0720.
3. Veterans Administration (VA) hospitals are not considered public institutions for Medicaid purposes. Individuals in a VA hospital, if otherwise eligible, may be approved for MA; however, the cost of care in the VA hospital is not covered.

MS 2400

RELATIONSHIP REQUIREMENTS

(1)

A CHILD meeting financial eligibility requirements may be technically eligible for Family MA or AFDC Related MA when living with:

- A. Both parents, married or unmarried and the qualifying parent is unemployed;
- [B. Both parents, married or unmarried and incapacity of either parent exists; ]
- C. Neither parent, since living in the home of a parent or other specified relative (SR) is NOT a technical eligibility requirement for "I" or "Y" children;
- D. One parent, and the other parent is dead or absent;
- E. Parent and stepparent, and deprived of support due to death or absence of the natural parent or adoptive parent;
- F. Other SR, and deprived of parental support due to death or absence of both parents; or
- G. One parent and a single parent adoption exists.

MS 2410 THE SPECIFIED RELATIVE (SR) AND THE SECOND PARENT (1)

The SR is the relative in whose home the MA child lives. If the SR is a relative other than a parent, they are considered a non-responsible SR. If both parents are in the home the second parent must be included in the case whether the parents are married (legally married or recognized as married through common-law by another state) or unmarried if paternity has been adjudicated by the court or administratively established.

A. The SR:

If the parent or minor parent is not in the home, the SR may be any blood relative of the child, including: a grandfather, grandmother, brother, sister, uncle, aunt, nephew, niece, first cousin. Also, relatives of the half-blood and preceding generations as denoted by prefixes of grand, great, or great-great. A second cousin or cousin further removed does not meet the definition of an SR.

1. The SR may also be any of the following:

- a. A stepfather, stepmother, stepbrother or stepsister;  
NOTE: A step-grandparent does not meet the definition of an SR.
- b. A legally adopted and/or natural child of the adoptive parent, and other relatives of such parents;
- c. The husband or wife of any persons listed above even if their marriage has been terminated; or
- d. The alleged parent or a relative of the alleged parent may be determined a blood relative through the administrative establishment of relationship.

2. For a minor parent/legal guardian living with an individual who is the minor's parent/legal guardian and the individual is:

- a. Applying for or receiving MA for children of the minor, the SR is the minor's parent/legal guardian meeting the definition of SR; and
- b. Applying for or receiving MA for siblings of the minor, the SR is the minor's parent/legal guardian, meeting the definition of SR.

B. The Second Parent:

The second parent can be either parent; however the common child must be deprived due to one or both of the parents being incapacitated, unemployed or underemployed. If both parents are in the home but not married, the father must be included in the case, if paternity has been adjudicated by the court or administratively established.

A second parent can also be any of the following:

1. The second parent may also be the incapacitated or unemployed step parent who is the parent of a sibling of a Family MA child, and living in the home.

2. An incapacitated step parent living in the home who is NOT a parent of a sibling of a Family MA child, BUT is legally married to the SR, or recognized as married to the SR through common-law by another state, is eligible in the "L" category ONLY.

Note: Incapacity is the only deprivation that qualifies a step parent with no common child in the home for benefits. If the step parent is NOT included in the case, then the system will test budget his/her income.

[C. Death of SR during pending application.

In order to provide MA coverage for the eligible SR who dies after application is made, but before it is processed, complete the following:

1. Deny the application;
2. Enter a reapplication with a new SR;
3. Backdate the application date to the original date; and
4. List the deceased parent as SP in the reapplication, with appropriate "from/to" dates.

The system approves the case for the new SR and the children. A medical card is issued for the deceased SP based on the "from/to" dates.]

MS 2420 ADMINISTRATIVE ESTABLISHMENT OF RELATIONSHIP

[Determine administrative establishment of relationship (AER) when either the alleged parent or his relative applies for Family MA or AFDC Related MA, or the alleged parent is in the home.]

- A. In order to make this determination, one of the following types of evidence must be provided. If determining AER on an alleged parent in the home, the evidence must be readily available in the case record to the worker.
1. A birth certificate listing the alleged parent;
  2. Legal documents such as hospital records, juvenile court records, wills, and other court records which clearly indicate the relationship of the alleged parent or relative;
  3. Receipt of statutory benefits as a result of the alleged parent's circumstances; or
  4. A notarized statement or affidavit of either parent acknowledging relationship PLUS one of the following:
    - a. School records;
    - b. Bible records;
    - c. Immigration records;
    - d. Naturalization records;
    - e. Church documents, such as baptismal certificates;
    - f. Passport;
    - g. Military records;
    - h. U.S. Census records; or
    - i. Sworn statement or affidavit from an individual having specific knowledge about the relationship between the alleged parent and child. The statement must include:
      - (1) Name of the child;
      - (2) Date of birth;
      - (3) Place of birth;
      - (4) Individual's relationship to the child; and
      - (5) Basis of the individual's knowledge.
- B. In cases in which the parent or, in the absence of the parent, the caretaker relative states the individual listed in items A1 or A2 is not the actual mother/father of the child:
1. The parent/caretaker relative may provide substantiating evidence that the information was erroneous and identify the alleged parent by providing a sworn statement or affidavit containing the following:

- a. The erroneous information originally provided; and
- b. The correct identity of the alleged parent.

EXAMPLE: The caretaker relative has proof that the parent named on the birth certificate was incarcerated for the 12 months prior to child's birth.

2. When the case record contains the above sworn statement or affidavit and substantiating evidence to refute the original information, do not administratively establish relationship for the individual listed on the birth certificate or legal documents. If AER has previously been established for the alleged parent now cited as being erroneous, consider it no longer valid.
3. Once a sworn statement or affidavit is submitted to change the parent, the rebuttal process cannot be used again to refute it.
4. Evidence of parentage as outlined in items A3 and A4 cannot be refuted or changed through this process.

MS 2440

VERIFICATION OF RELATIONSHIP

- A. Accept the child's birth verification and the statement of the parent, other than the alleged parent, as proof of relationship unless there is reason to doubt such statement.
- B. Verify the relationship of the relative, other than the parent

EXAMPLE: If the relative states she is an aunt, sister of child's mother, the documentation must verify the relative is a sister of the mother, and verify the relationship of the mother to the child.

- C. An alleged parent or relative of an alleged parent must provide proof of legal paternity or evidence for AEP. The relative of the alleged parent must also provide verification of relationship to the alleged parent.
  - 1. Exercise prudent judgement in determining reasonable verification of relationship for a relative other than a parent. Although a birth certificate is a primary source for verification of relationship, if other acceptable sources are available, these sources should be utilized.

EXAMPLE: Reasonable verification may be provided when a great aunt provides a court order giving her custody/guardianship and the court order states she is the great aunt. In a similar situation a grandmother provides a court order giving her custody/guardianship. However, the court order does not specify the relationship. This cannot be her sole source of verification.

- 2. When evidence is not provided or conflicting evidence, more than one affidavit, is provided for the same child, deny the application since relationship to the child cannot be established.
- D. Do NOT require verification of relationship for I and Y categories for which deprivation and living in the home of a parent or other SR are not technical eligibility requirements.
- E. Acceptable proof of relationship may be one item/document or a combination of items/documents. The following list is not intended to be all inclusive or to reflect any particular order of acceptance.
  - 1. State authorized/numbered birth certificate;
  - 2. Verification of birth registrations;
  - 3. Hospital record;
  - 4. Church documents including baptismal certificates;
  - 5. Statement from attending physician/midwife;

6. Adoption record;
7. INS records;
8. IMS Program E7, Birth Certificate Inquiries;
9. School record;
10. Insurance policy;
11. Medical records, including immunization record;
12. Passport/immigration/naturalization papers;
13. Driver's license;
14. Family Bible;
15. Military records;
16. Marriage and/or divorce records; or
17. If there is no other source of verification available, and ONLY AFTER the Field Services Supervisor provides approval, obtain a notarized statement from an individual having specific knowledge about the relationship between the applicant/recipient and child. The statement must include:
  - a. Name of the child;
  - b. Date of birth;
  - c. Place of birth;
  - d. Individual's relationship to the child; and
  - e. Basis of the individual's knowledge.

MS 2450

VERIFICATION OF "LIVING WITH"

Consider a child physically present in the home of applicant/recipient as living in the home.

- A. [For L and N categories which require that the child live with a specified relative, verify the household composition.] Use statement of landlord, school records or other collateral contacts for verification. [Verification is not required for I, U, P or Y cases.]
- B. Temporary absence from the home of either the specified relative or child for medical care, attendance at school, job corps, emergency foster care or short visits with friends or relatives, does not interrupt the "living with" requirement when it is intended that the SR or child will return to the home, AND if the parent continues to exercise control over the child.

MS 2500

INTRODUCTION TO DEPRIVATION

- A. [Children may qualify for Family MA, based on a deprivation factor of: ]
1. Death;
  2. Involuntary absence:
    - a. Single parent adoption;
    - b. Deportation;
    - c. Penal institutionalization; or
    - d. Hospitalization.
  3. Voluntary absence:
    - a. Divorce;
    - b. Legal separation;
    - c. Marriage annulment;
    - d. Desertion;
    - e. Forced separation; or
    - f. Birth out-of-wedlock.
  4. Incapacity; or
  5. Unemployment.
- B. [The following individuals may receive Family MA without a deprivation factor.]
1. A pregnant woman. A medical certification of pregnancy is required.
  2. Children in the I, P, U or Y category.]

Generally, accept the statement of the individual as proof of deprivation. Further documentation is required for specific deprivation factors, or if there is reason to doubt the statements of the individual.

MS 2510

DEATH

Death of the natural or adoptive parent constitutes deprivation.

The deprivation factor is changed to death if the divorced or absent parent dies. Send appropriate notification to the Division for Child Support Enforcement when the deprivation factor is CHANGED to death.

If the deceased parent was not married to the mother, the deprivation factor is birth out-of-wedlock, not death.

[Accept the statement of the recipient as evidence of death. Explore with the recipient any financial benefits accruing to the child as a result, e.g., RSDI, VA, etc.]

MS 2520

INVOLUNTARY ABSENCE

The following is a list of involuntary absence deprivations, their definitions and verification requirements.

- A. SINGLE PARENT ADOPTION automatically establishes deprivation for the child since there is only one parent.

Verify the single parent adoption by viewing the adoption papers or contact with the agency which handled the adoption. Document the type of verification used.

- B. DEPORTATION of a parent constitutes deprivation due to absence.

Verify deportation by viewing documents in recipient's possession or by contact with law enforcement officials.

- C. INCARCERATION constitutes deprivation due to absence when commitment of a parent to a penal institution is for a period in excess of 30 days.

1. Verify imprisonment and length of sentence by contacting law enforcement officials. Once the actual date the parent entered the correctional facility, or the date the facility expects the parent to be released has been verified enter the date in the field "Verified Date". Enter the three-digit maximum number of months the parent will be incarcerated in the field "Date parent is expected to be released". For example if the parent will remain incarcerated for 15 months enter 015. If the parent will be incarcerated for life, enter 999.

If the parent is never to be released, enter "12319999" in the field "Date parent is expected to be released".

Set up a spot check to review the case in the month of probable release.

2. The otherwise eligible child may continue to receive Family MA through the month the parent returns to the home from the correctional facility.
3. When the parent is released from the correctional facility, determine eligibility as follows:
  - a. If the parent returns to the home, discontinue the case effective the month following return.
  - b. If the parent is released to a half-way house, deprivation based on incarceration still exists even if the parent is permitted to spend some time at home.

- c. If the parent is allowed to live at home, but is not permitted to seek work for pay, deprivation based on incarceration still exists and the case remains eligible.
- D. HOSPITALIZATION constitutes deprivation due to absence when long term care of a parent is received in a hospital.
  - 1. Long term care is a period of 120 days or more. If hospitalization is anticipated to terminate in less than 120 days, work the case as a field determination, incapacity case.
  - 2. Verify hospitalization through contact with the appropriate hospital to secure the diagnosis, prognosis, and estimated length of stay.
  - 3. The otherwise eligible child may receive MA for the month the parent is released from the hospital.
  - 4. If the parent alleges continuing incapacity, eligibility continues during the period incapacity is being established.

MS 2530

VOLUNTARY ABSENCE

The following are types of voluntary absence. These types generally cause a child to be deprived of the support of at least one parent. However, if the court has ordered joint custody of the child, deprivation may not exist. Refer to [MS 2560](#) for specific information on joint custody.

- A. DIVORCE is a legal dissolution of a marriage by a court judgement. Divorce, unless specifically ordered by the court, does not terminate the parent's obligation to support the children. However, there may be situations in which the obligation to support the children is terminated, such as termination of parental rights when the child is adopted.
- B. LEGAL SEPARATION is the suspension of cohabitation by the two parties by court judgement. Unless specifically ordered by the court, it does not terminate the parent's obligation to support the children.
- C. [FORCED SEPARATION exists when:
  - 1. An applicant is in a spouse abuse center AND the children are with the individual or were temporarily absent prior to the forced separation. It is not necessary to verify a separate residence outside the spouse abuse center. Residence in a spouse abuse center does not, in and of itself, determine eligibility. All other technical and financial factors must be met.
  - 2. An abused spouse/applicant chooses not to reside in a spouse abuse center, but rather establishes a safe temporary shelter with family, friends or in a shelter for the homeless; AND
    - a. The children are with the individual or were temporarily absent prior to forced separation.
    - b. The applicant can provide one of the following as verification of a forced separation:
      - 1. A current restraining order issued due to the abusive situation; or
      - 2. A certification of the existence of an abusive situation made by a DCBS Division of Protection and Permanency (DPP) adult protective worker. All applicants alleging abuse should be referred to the Adult Stability and Safety Branch of DPP for assistance and for certification, if needed.]

NOTE: Do not verify a separate residence for the abusing spouse until the individual leaves the safe shelter and establishes a permanent residence. This may be a new residence or the former residence, if the abusing spouse has left.

Change the deprivation factor to desertion when the individual moves from the safe shelter or after 30 days have elapsed since separating from the absent parent, whichever comes first.

3. When force separation deprivation information is entered, KAMES deletes any previously entered information regarding emergency shelter.
- D. [MARRIAGE ANNULMENT is the legal proceeding declaring a marriage invalid from its inception. Children born to a marriage that was annulled: because of the minor age of the parties involved, or because it was obtained by force or fraud, or because the marriage was bigamous are considered legitimate children. Unless specifically ordered by the court, annulment does not terminate the parent's obligation to support.]
- E. DESERTION is:
1. The intentional severing of parental obligations, duties and rights on the part of the parent and:
    - a. Absence of the parent from the home for 30 days or more; or
    - b. Refusal on the part of the parent to accept the child into the home for a period of 30 days or more.
  2. The first day of desertion is the day the parent leaves the home. Consider desertion to exist beginning with the 31st day of absence.

EXAMPLE: If the parent leaves the home on 12/1, the deprivation exists as of 12/31.
  3. Desertion does not apply to children born out-of-wedlock, even if paternity is established either administratively or by adjudication.
  4. Desertion also exists when the following applies (the 30-day criteria does not apply to these situations):
    - a. The child leaves the parent because the parent was requiring the child to live under circumstances hazardous to the health or morals of the child;
    - b. The child is voluntarily placed with relatives following a finding by Protection and Permanency staff;
    - c. The child is placed by the court with an SR other than the parent;
    - d. [The child is eligible and receiving benefits in the "N" or "T" category and one of the parents subsequently leaves the home; or]
    - e. Absence of both parents.
  5. Deprivation does not exist if the only reason the parent is absent from the home is due to active duty in a uniformed service.

F. BIRTH OUT-OF-WEDLOCK exists if:

1. The parents are not married at the time of the child's birth;
2. The woman is married but states that the father is a man other than her husband and evidence shows that the marital relationship ceased at least ten months prior to the birth; or
3. The woman is divorced on the grounds that the child was conceived before or during their marriage by a man other than her husband and that she concealed the pregnancy from her husband.

MS 2560

JOINT CUSTODY

If the court has ordered joint custody of a child, determine if one parent has primary physical custody. Primary physical custody means the parent has physical custody of the child more than 50% of the time. If one parent meets this criteria, then that parent and the child may be MA eligible, if all other eligibility criteria is met. The MA case remains eligible during periods when the child is with the other parent (e.g., the child spends the summer break with the other parent).

If the joint custody agreement is 50/50 for physical custody and being adhered to, there is no deprivation for the child. The child may be MA eligible in the "I" or "Y" category, but both parents' incomes would then be counted.

[If the joint custody agreement is 50/50 for physical custody and is NOT being adhere to, both parents' incomes would not be considered if a written statement from both parent verifies this situation.]

MS 2570

INCAPACITY

(1)

Incapacity, for a Family Medicaid eligibility determination, is defined as any condition of the mind or body which makes a parent physically or mentally unable to work and provide the necessities of life for his/her child. Require documentary proof to substantiate deprivation based on incapacity of the parent. Guidelines for MA incapacity determinations are different from those used by the Social Security Administration (SSA) to determine eligibility for SSI and RSDI disability benefits. The fact that an individual is determined by SSA not disabled according to SSI and RSDI standards in no way affects that individual's right to apply for MA benefits based on incapacity. The processing of an individual's MA application is NOT delayed pending a determination of the individual's RSDI or SSI entitlement. However, an SSI determination of presumptive eligibility DOES NOT constitute a basis for a field determination.

A. Incapacity determinations are used to verify the deprivation factor for MA eligibility. The condition must have been present at the time of application and must have continued or be expected to continue for at least 30 days, and may be presumed to continue during a period in which the parent is undergoing diagnostic studies and/or evaluation of rehabilitation potential. The condition of incapacity must be such that it eliminates or substantially reduces the parent's ability to provide support and care, including homemaking and childcare functions, for the otherwise eligible child. Ability to provide support and care requires consideration of the parent's age, education, training, and work experience.

[B. For MA eligibility based on incapacity, there must be a two parent household with a common child. If the parents are married (legally married or recognized as married through common-law by another state) or unmarried, and, paternity has been adjudicated by the court or administratively established, the father must be included in the case. "Parent" includes the natural, adoptive, or the specified relative. The non-SSI incapacitated parent may apply under the Aged, Blind, or Disabled MA program or, if the definition of a second parent is met, be included in a Family MA case. An incapacitated stepparent (coded as a "M08") who meets the definition of a second parent may be included in a Family MA "L" case. An individual eligible under more than one category has the option to apply for the program desired.]

C. Incapacity is determined either by field determination or the Medical Review Team (MRT).

Note: If a non-SSI parent or a member of the assistance unit appears to have a disabling health condition, quadriplegia or head injury, refer the individual to the SSA utilizing form PAFS-5.1, Report or Referral to the District Social Security Office, to apply for SSI/Social Security benefits.

D. Make a field determination of incapacity if physical inability to work is alleged and:

1. SSI was received during any portion of the 12 months preceding application, provided the SSI discontinuance was due to income or resources and not an improvement in condition;

- a. Medical information must be submitted to MRT for a determination of incapacity prior to the next recertification, unless the SSI decision states that no reexamination is necessary.
  - b. If staff cannot determine the reexamination status, send a memorandum to the MRT at [medreview@ky.gov](mailto:medreview@ky.gov) asking if a reexamination is necessary. Include in the memorandum the name and SSN of the recipient and the date the recipient first received SSI.
2. The individual is age 65 or over; or
  3. RSDI, Black Lung or Railroad Retirement based on disability is received. An individual meets this requirement if the SSA has established disability but entitlement is pending due to the 5 months duration requirement. The official notification from SSA establishing entitlement at a later date, if provided, verifies incapacity; or
  4. By presenting, in the event of a hearing, a copy of the "Notice of Favorable Decision" from the Social Security Administration, Bureau of Hearings and Appeals. If benefits are not being received, complete a monthly spot check to establish receipt of benefits. If a check is not received within 6 months, send medical information to the MRT; or
  5. Incapacity or disability has been determined by the MRT, Hearing Officer, Appeal Board, or Circuit Court with the decision stating that no reexamination is necessary and that there is no visible improvement in the condition; or
  6. A determination of disability has been made by the Division of Disability Determination Services (DDS) which includes the MA application date and, if needed, retroactive months; or
  7. The individual is hospitalized or in an alcohol or substance abuse facility on the date of processing the application and a statement from the attending physician indicates the period of incapacity has or will exceed 30 days. If application was made prior to admission, the physician's statement MUST indicate if incapacity existed as of application date. ALL hospitalization cases are set up for a spot check as soon as the parent is released;  
  
Note: Following hospitalization or the discontinuance of SSI due to a determination that disability no longer exists, eligibility continues pending certification by the MRT if other field determination criteria are inappropriate and the parent continues to allege incapacity.
  8. Receipt of VA benefits based on 100% disability. 100% disability must be verified by a VA award letter; or
  9. An individual had surgery which requires a period of time for recovery as specified by a doctor's statement. A field determination can be made for up to six weeks from the date of surgery. Spot check the case at the

end of the six-week period and discontinue the case unless the individual still claims to be incapacitated. If so, a determination by MRT is required, with eligibility continuing pending the MRT incapacity decision; or

10. An individual is on approved sick leave from a job and the employer is holding the job for the individual's return. Verify this and the expected duration of the illness not to exceed six-weeks, through the employer; or
  11. An individual has an illness or injury which requires a period of time for recovery as specified by a doctor's statement. A field determination can be made for up to six weeks from the date of the doctor's statement. Spot check the case at the end of the six-week period. If the individual still claims to be incapacitated, a determination by MRT is required with eligibility continuing pending the MRT incapacity decision; or
  12. The individual has been diagnosed with end-stage renal disease and is on dialysis; or
  13. A woman is deemed to be in a high-risk pregnancy condition. This condition is verified by a doctor's statement and lasts for the duration of the pregnancy and through the postpartum period.
- E. In all other instances, determine resource eligibility before making a referral to the MRT.
1. If not resource eligible, DO NOT refer to the MRT.
  - [2. If resource eligible, complete form PA-601T, Referral for Determination of Incapacity/Disability, according to procedural instructions with the appropriate number of MRT-15's to the MRT. Form PA-601T, Sup. A, Supplemental for Additional Treating Sources for Determination of Incapacity/Disability, is used if additional information from doctors and facilities is needed. The MRT's certification is sent on form PA-6. When the MRT completes the determination a copy of the MRT decision will be mailed to the worker with indications of whether a re-determination is necessary. When a re-determination is required, complete form PA-601T, Referral for Determination of Incapacity/Disability.]

MS 2580

MRT REFERRAL PROCEDURES

[When a field determination of incapacity cannot be made, use the following procedure to establish incapacity.

1. Complete form PA-601T, Referral for Determination of Incapacity or Disability. This information should be completed in as much detail as possible. If additional information from doctor's or facilities is necessary use form PA-601T, Sup. A, Supplemental to Referral for Determination or Redetermination of Incapacity/Disability.

Note: Forms PA-601T with incomplete documentation will be returned to the caseworker for completion and this will delay the process.

2. Obtain the patient's signature on several MRT-15 forms (use the current version located on the forms website), Authorization for Information/Release of Information. Have at least one signed form for each medical source plus at least one extra. These forms must be signed and dated by the patient and a witness. The witness may be the Family Support worker.
3. Mail form PA-601T and the signed MRT-15 forms to MRT immediately upon completion. Include only the medical information the individual has provided. For redeterminations, include the prior form PA-6 and medical records used in making that determination, as well as form PA-601R, Referral for Redetermination of Incapacity/Disability and signed/witnessed MRT-15's with the current date.]

MS 2590

INCAPACITY CASE TREATMENT

Document a determination of incapacity by referring to form PA-6 or, for field determination, the specific method by which incapacity was established.

- A. [Field staff cannot make a field determination of “not incapacitated”. If the application cannot be approved using the criteria for field determinations, send a completed form PA-601T, Referral for Determination of Incapacity or Disability, and signed/witnessed MRT-15 forms (use the current version located on the forms website), Authorization for Information/Release of Information, to MRT for a decision. If additional information for doctors or facilities is required, use form PA-601T, Sup. A, Supplemental to Referral for Determination or Redetermination.
- B. If MRT determines that incapacity does not exist, use the comments and reasons on form PA-6 to explain to the applicant why the incapacity standard was not met and to help the applicant understand the basis for the determination.
- C. Incapacity continues unless there is a change in the physical condition of the applicant or the MRT requests a redetermination. For a redetermination use form 601R, Referral for Redetermination of Incapacity/Disability and signed/witnessed MRT-15’s with the current date.]
- D. If a case was denied or discontinued for reasons other than the deprivation factor, the prior MRT decision showing incapacity remains valid unless a redetermination was requested and the redetermination is due or past due.
- E. For Spend Down applications, DO NOT require verification of excess medical expenses prior to requesting a determination from MRT.

MS 2600

UNEMPLOYMENT

(1)

[Code cases with the deprivation factor of unemployment as "N" or "T". "N" and "T" cases must be two parent households with a common child. If the parents are married (legally married or recognized as married through common-law by another state) or unmarried and paternity has been adjudicated or relationship administratively established, the father must be included in the assistance group.]

Eligibility due to unemployment cannot be established until the qualifying parent has been unemployed for 30 days. The first day of the 30-day period begins the day the qualifying parent loses his/her job. Deprivation is met beginning with the 31st day of unemployment.

EXAMPLE: If the qualifying parent loses his/her job on 12/1, deprivation of unemployment exists as of 12/31.

- A. The qualifying parent can be either the mother or father, whichever is most beneficial to the case. The parents may also choose which one is the QP. EITHER parent may sign the application.
- B. Children and parents are included in MA cases when the natural, common-law, adjudicated, or adoptive parent who is the qualifying parent meets the following federal definition of unemployment:
  - 1. The qualifying parent is living with the child's mother/father; AND
  - 2. At the time of application, only the qualifying parent is totally unemployed or is employed less than 100 hours a month or 23 hours a week; OR
  - 3. At the time of application, employment exceeds 100 hours for a particular month but the work is intermittent and the excess is temporary in nature; that is, employment was under the 100 hour standard during 2 prior months and is expected to be under the 100 hour standard during the next month; AND
  - 4. Conditions generally applicable to the deprivation factor of unemployment are met.
- C. Unemployment DOES NOT exist when a qualifying parent is:
  - 1. On strike; or
  - 2. Temporarily unemployed due to weather conditions or lack of work if there is a job to return to and return can be anticipated within 30 days or at the end of a normal vacation period.
- D. Types of employment:

1. FARMERS The farm owner or tenant farmer must meet the definition of unemployment to be a qualifying parent. Hours involved in farming and farm income are annualized.
2. SELF-EMPLOYED A qualifying parent is considered unemployed if the conditions in item B are met.
3. STUDENTS who are qualifying parents are considered unemployed if all of the following are true:
  - a. Employed less than 23 hours a week; and
  - b. Registered for work.
4. PARTIALLY EMPLOYED qualifying parent who has only casual day work, works regularly less than 5 days a week, or regularly for only a few hours a day is considered unemployed if employment totals less than 100 hours per month at application.
5. CONTRACT EMPLOYMENT A qualifying parent who is under contract employment and works less than 23 hours per week is considered unemployed.
- [6. REGULAR EMPLOYMENT A qualifying parent is employed less than 100 hours a month or 23 hours a week.]

MS 2610 [UNEMPLOYMENT: UIB AND WORK REGISTRATION]

Application for Unemployment Insurance Benefits (UIB) must be made if potential eligibility exists. Document the case record clearly to show the verification used to establish application for benefits has been made. If the qualifying parent and/or any individual who is eligible for UIB benefits refuses to apply for or comply with the requirements of UIB, that individual is disqualified and not eligible to be included in the MA or in a K-TAP case.

A. Work Registration:

All adult MA applicants, ages 18 through 59, must register for work unless exempt from the work registration requirement. Work registration is accomplished by the signing of the application. If the work registration requirement is not met, the application is denied. Explore eligibility in another program category. Document comments thoroughly.

The individual is registered for work by answering "Y" to the question on KAMES "Is he/she required to register for work by completing DSI form?" and signing the KAMES application. Signing the application registers all members of the case who are required to work register unless they are exempt.

Individuals exempt from work registration requirements are individuals:

1. Under the age of 18;
2. Age 60 or older;
3. Age 18 or 19 and in full-time attendance at a secondary or elementary school;
4. Receiving benefits based on 100% disability;
5. Former recipients of benefits based on 100% disability within the past 12 months who lost benefits due to income or resources and not an improvement in the disability; or
6. Employed 30 hours or more weekly at minimum wage or higher.

B. Good Cause Determinations

Good cause is established for any qualifying parent terminating employment, reducing work hours or refusing an offer of work or training if one of the following conditions is met:

1. A definite bona fide offer of employment was NOT made at a minimum wage customary for such work in the community;
2. The parent is unable to engage in such employment or training for mental or physical health reasons;

3. The parent has no way to get to and from the work site or the site is so far away from the home that commuting time exceeds 2 hours daily; or
  4. Working conditions at such job or training are a risk to the parent's health or safety.
- C. Good cause determinations are NOT required for individuals losing employment due to being fired from a job.
  - D. If the qualifying parent, who is an applicant, terminates employment, reduces work hours, or refuses an offer of work or training without good cause, the application is denied unless 30 days have elapsed since the offer, or the work/training is no longer available.
  - E. If the qualifying parent in an active "N" or "T" case terminates employment, reduces work hours or refuses an offer of work or training without good cause, he or she is disqualified and the case remains active for the other case members.]

MS 2615

UNEMPLOYMENT AND INCAPACITY

- A. If a qualifying parent appears to have a disabling health condition, such as, quadriplegia, head injury, etc., refer the individual to the SSA utilizing form PAFS-5.1, Report or Referral to the District Social Security Office, to apply for SSI/Social Security benefits. Do not delay the individual's application pending a determination of Social Security or SSI entitlement.
- B. Either parent can be the qualifying parent.
- C. If the qualifying parent alleges incapacity, carry the application based on incapacity in pending status until a determination is made regarding incapacity. [If the qualifying parent is found not incapacitated, approve the case for "N" or "T" retroactive to the month of eligibility if:
  - 1. The parent registers for employment; and
  - 2. The parent agrees not to refuse employment or training without good cause; and
  - 3. The parent meets other eligibility criteria.]
- D. For an "N" or "T" qualifying parent requesting a program transfer to K-TAP based on unemployment, an application in the "W" category is required. If the "N" or "T" qualifying parent alleges incapacity, eligibility based on unemployment continues in the "N" or "T" category pending the incapacity determination, if the work registration remains active.
- E. [For a parent found no longer incapacitated, authorize a program transfer or program code change as appropriate to "N", "T" or "W" if:
  - 1. The parent registers for employment;
  - 2. The parent agrees not to refuse employment or training without good cause; and
  - 3. The parent meets other eligibility criteria.]

Eligibility for "N" or "T" status as shown above exists even though the individual is appealing the incapacity determination either to the Hearing Branch or the Appeal Board.

MS 2620

FOSTER CARE OVERVIEW

Consider children in foster care who are under the supervision of a Kentucky public or private child welfare agency as residents of Kentucky and eligible for MA if in medical need. Children must be in approved foster family care or in a licensed, private, nonprofit child caring institution.

Children residing in public institutions, including group homes in which the facility is owned or rented by a public agency and/or staffed and operated by public agency personnel, are ineligible unless the public facility is a community residence. A community residence is defined as a publicly operated facility serving no more than 16 people and providing any service, in addition to the basic necessities of food and shelter. Delinquent children may be eligible for MA if all other technical and financial eligibility criteria are met.

- A. Application for the child is made by the agency worker having responsibility for the child. Complete an application during an interview with the agency worker. If application is made for more than one child of the same family, complete separate applications for each child. When a child in foster care gives birth and requests assistance for the newborn, take a separate application in the appropriate category.
- B. The case name for a child in foster care is the child's legal name.
- C. The case number for all children in this classification consists of the program code prefix, P, followed by the 9 digit case number.
- D. [The Health Choices cards for children in this classification are sent to the child's residence unless the agency requests the card be mailed to the local office.]
- E. The county with case responsibility is the county where the P & P family services worker responsible for the individual child is located.

For a child placed in a prospective adoptive home, establish a new case with the adoptive home, establish a new case with the adoptive name for confidentiality. Carry the case in the county where the agency worker is located. Do not cross-reference the cases.

MS 2630

ELIGIBILITY OF FOSTER CARE CHILD

The "P" child must meet all Family MA technical eligibility requirements with the exception of deprivation.

- A. Establish technical and financial eligibility of the child through facts presented by the agency worker from the records of the children's agency or home, or facts presented by the social worker from the private facility or community residence.
- B. Children who are in foster care and qualify for Medicaid under the federal poverty levels will be placed in the "P" category. When the foster child is income or resource ineligible using the regular MA income scale, do not approve or complete a program code change to the "I" category.

If poverty level scales are used to establish eligibility for the foster child, all resources of the foster child are excluded. The child must meet the age requirement for the poverty level scale used. Spend down is an option if the foster child does not qualify under the regular MA scale or the poverty level income scales.

If the "P" case child is pregnant and becomes income or resource ineligible, the child remains active in the "P" case through the end of the postpartum period. Refer to MS 2850 for consideration of newborn children.

- [C. If a child(ren) is adopted in a private non-profit adoption, the child is considered the same as any other child in a parent's case and may receive MA benefits in the "I" category.

- D.] Consider each child individually in determining spend down if payment is available for medical care.

[E.] Eligibility of such children terminates when:

1. Child no longer meets technical eligibility requirement for age;
2. Child is released from foster care;
3. Child's income exceeds the MA standards for the "P" or "I" category, the child is age ineligible for poverty level income scales, and eligibility cannot be established through spend down;
4. Child's resources exceed limitation for family size of 1 and the child is age ineligible to have resources excluded using the financial eligibility

requirements of the "I" category;

5. Agency representative fails to keep appointment for interview; or
6. Agency representative fails to provide sufficient information or clarify information for a determination of eligibility.

[F.] Consider a foster care child placed with prospective adoptive parents in foster care until the adoption is finalized, unless the prospective parents request discontinuance of MA.

MS 2640

SUBSIDIZED ADOPTION OVERVIEW

- A. [The Division of Protection and Permanency (DPP) enters into subsidized adoption agreements for hard-to-place children.]
- B. [Children in subsidized adoptions may qualify for Medicaid. If DPP has responsibility for the child, they are to handle the case.]
- C. [A child in subsidized adoption may receive benefits under Title IV-E. This child is categorically eligible for Medicaid and receives under the "S" category. The Children's Benefits Worker (CBW) carries these cases.]
- D. A child in subsidized adoption may be non-IV-E. [When referred, this child may be eligible for Medicaid benefits under the "P" category. These cases are also handled by the CBW.]
- E. Vendor payments to a psychiatric facility, IMD, PRTF or EPSDT LTC facility may be authorized for a child in an "S" case depending on the child's length of stay. [Establish eligibility and authorize vendor payments in the "S" category. Use the following procedures.]
  - 1. There are two ways to process the vendor payments for "S" cases depending on the child's length of stay in the facility.
    - a. If a child Medicaid eligible in the "S" category enters a facility and is expected to stay or actually stayed for LESS than 30 days, the following steps are taken.
      - [(1) The CBW receives notification of the admission through the PRO Certification (see [MS 2720](#)).
      - (2) The CBW contacts the facility to ensure the child is in the facility.
      - (3) The CBW calculates the patient liability.
      - (4)] The vendor payment must be made by special circumstance on KAMES. To complete a vendor payment by special circumstance, see [Volume IV, MS 1520](#).
    - b. [If the child Medicaid eligible in the "S" category is in a facility and is expected to stay for MORE than 30 days, the CBW will:]
      - (1) Discontinue the "S" case; and
      - (2) [Process a "P" application.]
- F. Consider each child individually in terms of income and resource limitations.

- G. The MA effective date for the child in subsidized adoption is equal to the begin date of the subsidized adoption agreement. In this situation, the MA effective date may be further back than the 3 months retroactive date. However, if the child moves to Kentucky from another state with a subsidized adoption agreement, the MA effective date is not prior to the date residency was established in Kentucky.
- H. Situations may arise in which a child in a subsidized adoption may continue to receive MA while living with siblings who receive K-TAP. Refer to [Volume III, MS 2302](#).
- I. The application is signed by the adoptive parent. If the adoptive parents live in a state other than Kentucky and are unable to make application, the CBW responsible for the case signs the application on their behalf.
- J. Out-of-state subsidized adoption cases in the custody of the Cabinet, are handled by the CBW in the county where the CBW is responsible for the case.

MS 2645 PRIVATE NON-PROFIT ADOPTIONS OVERVIEW (1)

[Private non-profit adoption cases are processed the same as any other case with the following exceptions.

- A. **If** the private non-profit adoption agency **is not** registered with the Office of the Inspector General (OIG) during the adoption proceedings the expenses paid for any purpose related to the non-profit adoption shall be submitted to the court, supported by an affidavit, setting forth in detail a listing of expenses for the court's approval or modification. If the private non-profit adoption agency refuses to include reimbursement for medical expenses paid by Medicaid, the child is not technically eligible for medical assistance.
- B. **If** the private non-profit adoption agency **is** registered with the Office of the Inspector General (OIG) the affidavit and Medicaid reimbursement requirements do not apply. These agencies are exempt. To view a listing of the agencies registered with OIG refer to <http://chfs.ky.gov/os/oig/directories.htm>. Scroll to the bottom of the website and under the DRCC Directories section click on the Child Placing Agencies Directory.

If the criteria in item A above applies and the private non-profit adoption agency agrees to comply, process private non-profit adoption cases the same as any other case.

1. The child is in a "Y" or "I" case carried by the Family Support worker as he/she is not Title IV-E eligible.
2. The case is in the child's name.
3. Ask if parental rights are terminated. Annotate this information in case notes.
4. Ask if the adoption agency carries health insurance on the child. Annotate this information in case notes.
5. All required verification must be provided.

If the adoption is subsidized, the adoptive parents will have a copy of the subsidy agreement. Subsidized adoptions are handled through the Division for Protection and Permanency (DPP). Children in subsidized adoptions are "S" cases if they are Title IV-E eligible and "P" cases if not Title IV-E eligible. Both type cases are carried by the Children's Benefits Worker (CBW).

Once the adoption is final, a child in a private non-profit adoption is considered the same as any other children in a parent's case. The family may apply for medical assistance based on their financial situation for an "E", "T" or an "I" case just for the child. There are no special cases for private non-profit adoption children unless the adoption is subsidized by the state.]

MS 2650

OUT-OF-STATE ADOPTIONS

A child in a subsidized adoption case residing in another state may receive MA in the state where the child resides. The Interstate Compact on Adoption and Medical Assistance (ICAMA) was established to alleviate the problems encountered by children using an out-of-state Medicaid identification card. This agreement requires participating states to provide MA to children residing in their state even though the adoption is subsidized by another participating state.

A. The District of Columbia and the following states have signed the compact:

Alabama	Indiana	Nebraska	South Carolina
Alaska	Iowa	Nevada	South Dakota
Arizona	Kansas	New Hampshire	[Tennessee]
Arkansas	Kentucky	New Jersey	Texas
Colorado	Louisiana	New Mexico	Utah
Connecticut	Maine	[New York]	Virginia
Delaware	Maryland	North Carolina	Washington
Florida	Massachusetts	North Dakota	West Virginia
[District of Columbia]	Michigan	Ohio	Wisconsin
Georgia	Minnesota	Oklahoma	
Hawaii	Mississippi	Oregon	
Idaho	Missouri	[Pennsylvania]	
Illinois	Montana	Rhode Island	

- B. When a child in a subsidized adoption case moves from an ICAMA State to Kentucky, Protection and Permanency (P&P) staff verifies ICAMA eligibility and notifies the parents to apply for MA at the local Family Support office within 60 days. P & P provides notification to the local Family Support office. Discontinue the MA case from the previous State of residence once MA is approved in Kentucky.
- C. When a child in a Kentucky subsidized adoption case moves to an ICAMA State, the P & P worker will notify the local Family Support staff if MA is approved in the new state of residence. Discontinue the MA case once MA is approved in the new state of residence.
- D. Any changes affecting eligibility must be reported by the adoptive parents.
- E. The subsidy agreement between P & P and the adoptive parents or P & P notification is adequate proof of technical eligibility.

MS 2660

## SUBSIDIZED ADOPTION PROCEDURES

[Establish a new case record in the "S" category for each subsidized adoption case and discontinue the corresponding foster care "P" case.] Discontinuing these cases helps provide anonymity for the natural parents and assures that the contents of the original case record remain confidential. The new case record receives a new case number, which is different from the original case number. Subsidized adoption case records include the application and a copy of the subsidy agreement.

To preserve the anonymity of the natural parents and to assure the contents of the original case record remain confidential for children in subsidized adoption cases, follow enumeration procedures outlined in the Welfare Enumeration Manual, Section 00305.145.

MS 2670

"U" CHILDREN

(1)

A child that is in an approved psychiatric hospital, a Psychiatric Residential Treatment Facility (PRTF), or an Institution for Mental Disease (IMD) may be eligible to receive Medicaid in the "U" category. While Central Office is responsible for taking and processing "U" applications, the local DCBS office has limited responsibilities listed below.

A. Application Process

1. Local DCBS Office Responsibilities

- a. The local DCBS office must determine that the child is not eligible in any category of medical assistance through the application process on KAMES prior to referring the parent/representative to Central Office to make application for assistance in the "U" category.
- b. If the child is not eligible, the local office must give the parent/representative form MA-31, Facts about Medical Coverage for Children in Psychiatric Facilities, and advise them to contact Central Office at 1-866-229-0127 to make a "U" case application for the child.

2. Central Office Responsibilities – Applications are completed by the Medicaid Program Assistance Section in the Medical Support and Benefits Branch.

- a. The child is not eligible in the "U" category until the child has been institutionalized for 30 consecutive days. The 30 consecutive days can cover more than one facility. If the parent/representative makes contact prior to the 30<sup>th</sup> day, do not refuse to take the application. The system will pend the application until the 31<sup>st</sup> day. DO NOT ask the parent/representative to call back after the 30 days are up. For all applications, contact the facility prior to approval of the case to ensure the child is still institutionalized. No retroactive coverage is available for these cases.
- b. When the parent/representative contacts Central Office, inquire the system to see if an application was taken and denied.
  - (1) If a denied case is not found, ask if an application was made at the local office. If no, refer the parent/representative back to the local office.
  - (2) If the individual is a representative, form MAP-14, Kentucky Medicaid Authorized Representative, is required.
- c. Enter the application online immediately while talking with the parent/representative. The case name and number is the child's name and SSN. The parent/representative must be shown as payee for notices to generate to the appropriate individual. Answer "Y" to the question, "DOES HOUSEHOLD HAVE AN IM REPRESENTATIVE, PAYEE OR PROTECTIVE PAYEE?". Enter the representative's name and address. Answer "Y" to "PAYEE (TO RECEIVE NOTICES)". Ask all questions and complete the application online.

(1) The child's parent(s) and sibling(s) are entered on the case. They are coded as follows:

- (a) R57 – parent;
- (b) R58 – second parent; and
- (c) R59 – sibling.

(2) It is also possible to have the following individuals in the case record:

- (a) R42 – parent of a minor parent;
- (b) R47 – refugee second parent living in a separate household;
- (c) R49 – alien sponsor; or
- (d) R50 – alien sponsor's spouse.

(3) All other household members are coded as "T" non-members.

d. The income of the parent and siblings is entered and verified. If the parents do not return this verification, complete the case without it and comment in notes. If the child has income, it must be verified.

e. Immediately send a RFI to the parent/representative and allow 10 calendar days for return of any needed verification. Additional time may be granted at the request of the parent/representative if appropriate. Also send a copy of the application and any forms that require a signature.

The following forms are sent for signature. Highlight where the individual needs to sign and write on top of each document, "RETURN TO WORKER".

- (1) Application – system-generated at time of application / recertification;
- (2) Citizenship statement – system-generated at the time of application/recertification;
- (3) PA-7, Responsibilities for Reporting Changes; and
- (4) MA-36, Burial Designation (if the child owns a life insurance policy that has cash value).

f. Send the following forms to the parent/representative:

- (1) PA-3, Facts about EPSDT Services;
- (2) PAFS-4, Important Information for All Who Apply;
- (3) MAP-065, KY DMS Notice of Privacy Practices; and
- (4) MA-2, Medicaid Penalty Warning.

These forms are available in Spanish.

g. The case must have one of the following before it can be approved:

- (1) Pro Certification – these are automated (MS 2720); or
- (2) MAP-24, Memorandum for DCBS, for changes and discharges. If the child is transferred to a different facility, a new PRO Certification is needed.

**A child cannot be approved into EPSDT-LTC unless Medicaid eligibility exists prior to receipt of EPSDT services. No entry needed on KAMES.**

Once verification and signed forms are returned and the Pro Certification has been received, approve the case.

- h. If the child has income over the income limit for a "U" category, \$217, process an "I" case on the system. For an "I" case, parental income is not entered on the system. The application cannot be approved until the child has been living apart from the parents and in a facility a full 30 consecutive days. The initial 30 days of institutionalization must be shown on the LTC screen as private pay days with an explanation in case comments. Accept the application when the parent/representative contacts Central Office. Document in the case notes the reason for the "I" case and why parental income is not entered on KAMES.

## B. Recertification Process

Medicaid cases are certified for 1 year.

1. [When the case comes due for recertification, it appears on the worker's DCSR. The worker has until the 15<sup>th</sup> of the month to schedule an appointment. If the 15<sup>th</sup> falls on a weekend or a holiday, the last day to schedule recertification appointments is the last work day prior to the 15<sup>th</sup>. If appointments are not scheduled by the deadline, KAMES schedules them beginning at 8:00 a.m. on the first workday of the month at ½ hour intervals.]
2. To schedule appointments from KAMES Main Menu:
  - a. Select "D", Appointment Scheduling, and press enter. Your appointment calendar appears.
  - b. Input the appointment date and hit enter.
  - c. Enter the case number next to the time selected.
  - d. Under TYPE, enter RC for recert.
  - e. Under INT enter PI for phone interview.
3. The system sends an appointment letter to the client advising the worker will call on the date and time scheduled to recertify the case.
  - a. If the recert is not entered on the day of the appointment, a notice is system-generated advising the individual that the case will discontinue. It is very important if the parent/representative calls and states he/she will not be available at the scheduled time, to reschedule the appointment or complete the interview when he/she calls, if at all possible.
  - b. To reschedule, update the appointment calendar with the new date, the case number, and HR for change recertification interview. This schedules another appointment.
4. At the recertification interview, review all questions on KAMES, verify income, and send the following forms for signature and return:
  - a. Application; and
  - b. KIP-106, Attestation of Identity (if required).

MS 2690

X CHILDREN - SPECIAL PROCEDURES

Vendor payments to a psychiatric facility, IMD, PRTF or EPSDT LTC facility may be authorized for a child in an "X" case depending on the child's length of stay. [The Children's Benefits Worker (CBW) establishes eligibility and authorizes vendor payments in the "P" category using the following procedures.]

There are two ways to process the vendor payments for "X" cases depending on the child's length of stay in the facility.

- A. If a child MA eligible in this category enters a facility and is expected to stay or actually stayed for LESS than 30 days, the CBW takes the following steps.
  1. [The Peer Review Organization (PRO) issues the certification electronically. See [Volume IV, MS 2720](#)]
  2. The CBW contacts the facility to ensure the child is in the facility.
  3. The CBW calculates the patient liability, authorizes and processes the vendor payment.
  4. [The CBW can also make the vendor payment by special circumstance on KAMES by answering "Y" to "Do you want to add corrected patient liability?" on the 2<sup>nd</sup> page of the Special circumstance screen. Complete the Corrected Patient Liability screen using information from the case.]
- B. If the child MA eligible in this category is in a PRTF, IMD, psychiatric facility or EPSDT LTC facility and is expected to stay for MORE than 30 days, the CBW takes the following steps.
  1. Discontinue the "X" case.
  2. [Enter and process a "P" application including vendor payment.]

MS 2700      PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES

Psychiatric Residential Treatment Facilities (PRTF) residents consist of severely emotionally disturbed children and individuals up to age 21, or age 22 if receiving PRTF services at the age of 21.

A. Establish MA eligibility for PRTF residents according to the following guidelines.

1. For children age 17 or under, or age 18 if in regular full-time attendance in high school or the equivalent level of vocational school and expected to complete a course of study before age 19 or in the month of the 19th birthday, all other technical eligibility factors for Family MA except deprivation must be met.
2. PRTF residents over age 17 and not in school or in school and not expected to complete a course of study prior to or in the month of the 19th birthday may be eligible for a vendor payment if the following conditions are met:
  - a. Receiving MA in another category; or
  - b. Meets technical eligibility requirements for blind or disabled MA.
3. Patient status must be met.

B. [Establish financial eligibility according to [MS 3940](#).]

If a child is admitted to a PRTF directly from a mental hospital or psychiatric bed of an acute care general hospital, inpatient days count towards the 30 days of admission requirement for determining relative responsibility.

MS 2710

PRTF PROCEDURES

The following procedures are for children and individuals admitted to a PRTF facility:

A. Children in DCBS Custody

1. For active "P" cases, the Children's Benefits Worker (CBW) authorizes vendor payment from the "P" case.
2. If the child is in an active "S" or "X" case, vendor payments to a PRTF may be authorized depending on the child's length of stay.
  - a. If a child MA eligible in the "S" or "X" category enters a PRTF and is expected to stay or actually stayed for LESS than 30 days, the following steps are taken.
    - (1) [The Peer Review Organization (PRO) issues the certification electronically. See [Volume IVA, MS 3650](#)]
    - (2) The CBW contacts the facility to ensure the child is in the facility.
    - (3) The CBW calculates the patient liability and processes the vendor payment.
    - (4) The vendor payment may also be made by special circumstance on KAMES. To complete a vendor payment by special circumstance, answer "Y" to "Do you want to add Corrected Patient Liability" on the 2<sup>nd</sup> page of the Special Circumstance screen. Complete the Corrected Patient Liability screen using information from the case.
  - b. If a child MA eligible in the "S" or "X" category enters a PRTF and is expected to stay for MORE than 30 days, take the following steps.
    - (1) The CBW discontinues the "S" or "X" case.
    - (2) The CBW enters a "P" application including vendor payment.
    - (3) The case is carried in the county where the CBW is located.

B. [Long Term Care (LTC) is provided under the EPSDT Program for children who have special needs that cannot be met in a regular institution in-state or out-of-state. For a PRTF resident receiving EPSDT LTC services, in any category, see [Volume IV, MS 4170](#).]

C. All Other Children

1. If a child is receiving MA in another category, authorize a vendor payment from the existing case.
2. Establish an "I" case if a child meeting age requirements for Family MA is not receiving MA in any other category.

3. Establish MA eligibility in the B, D, K, or M category, as appropriate, for PRTF residents between the ages of 18 and 22 who do not meet age requirements for Family MA.

#### D. PRTF Resident Entering a Psychiatric Care Hospital

1. The PRTF may be reimbursed by MA for up to 14 bed reservation days per calendar year, per facility, for a resident who enters a psychiatric care hospital.
2. [Use form MAP-31 as follows, with regard to the MAP-552 process. Electronic certification from the PRO is issued when the individual enters the psychiatric care hospital.]
  - a. Form MAP-31 is received indicating availability of bed reservation days and the date the patient was released to a psychiatric care hospital. No action is required. If bed reservation days are exhausted during this period, a second form MAP-31 is sent to the local office showing the patient discharged from the PRTF. Complete system entries to discharge the individual from the PRTF and show admission to the psychiatric care hospital. The date of admission to the psychiatric care hospital is the day following the last bed reservation day.
  - b. Form MAP-31 is received and no bed reservation days are available. Complete system entries to discharge the individual from the PRTF and show admission to the psychiatric care hospital. The date of admission to the psychiatric care hospital is the day following the last bed reservation day.
  - c. Form MAP-31 is received officially discharging the individual from the PRTF. Complete form MAP-552 to discharge the individual from the PRTF and show admission to the psychiatric care hospital. The date of admission to the psychiatric care hospital is the day following the last bed reservation day.
  - d. [Following discharge from the PRTF, new forms MAP-31 and electronic certification from the PRO are required if the individual is readmitted to the PRTF.]
  - e. [Forms MAP-31 and electronic certification from the PRO are received showing readmission to the PRTF from the psychiatric care hospital.] No action is required if the patient has not been officially discharged from the PRTF. If officially discharged from the PRTF, complete form MAP-552 showing the discharge from the psychiatric care hospital and readmission to the PRTF.
3. When no notification of readmission to the PRTF has been received within 3 days after the last bed reservation day, contact the PRTF to determine if the individual was readmitted prior to the utilization of all available bed days. If the individual has not returned to the PRTF or all bed days were exhausted prior to readmission, complete a form MAP-552 discharging the

individual from the PRTF and show admission to the psychiatric care hospital.

4. The PRTF may reserve a bed and be reimbursed by MA for up to 14 days per admission to a regular or psychiatric bed in an acute care general hospital. In this situation, no action is required by field staff unless a discharge notice from the PRTF is received.
5. During the 14 bed reservation days, DMS continues vendor payments to the PRTF. However, any patient liability during bed reservation days continues to be paid to the PRTF by the individual. Collection of the patient liability payment from the individual is the responsibility of the PRTF.

MS 2720

LONG TERM CARE CERTIFICATION

(1)

Long Term Care (LTC) certifications from the Peer Review Organization (PRO) are issued electronically. The automated process includes a SSN matching function which searches KAMES for an active or pending member.

- A. If a match is found, the system posts a spot check to the worker's DCSR with the message "Pending PRO Certifications".
  1. Because ABI always has two providers, a case manager (C) and a primary care provider (P); workers may receive two PRO Certs for an individual. The PRO Cert indicates whether or not the provider is the case manager or the primary by display of a "C" or a "P" at the end of the provider number. If the same provider is providing both case management and primary care services a "B" will display at the end of the provider number. Workers enter the PRO Cert information twice, once for the primary and once for the case manager.
  2. The spot check appears on the worker's and supervisor's DCSR's if the worker is on probationary status.
  3. The spot check appears on the supervisor's DCSR for a non-probationary worker if no action is taken after 10 days.
  4. A menu item titled, "Pending PRO Certifications" is on the DCSR Menu as #10 under "Pending Case Actions" (C).
- B. Workers access the certification files for identified matches from item "P, PRO Certifications", on the KAMES Inquiry Menu. The certification is force-printed and filed or scanned in the case record.
- C. If no SSN match is found on KAMES, the member name, SSN and facility number appear on the RDS report HRKIPR94 titled, "PRO Certifications Not Matched to KAMES". This is the location of the certifications for SSI individuals and individuals that are not active Medicaid recipients on KAMES at the time the file is received.
  1. The member information is sorted by county code.
  2. Supervisors are responsible for monitoring this report daily and assuring that applications are completed for vendor payment approval for individuals active on SDX.
  3. Workers access the certification files for identified clients on item "P" on the KAMES Inquiry Menu.
  4. The certification is force-printed and filed or scanned in the case record.
- D. When a worker adds a new LTC segment to KAMES, matching the provider number and member number of a pending PRO Certification, the spot check disappears when the batch cycle is run.

1. Only supervisors can manually delete the PRO Spot Check.
  2. In order for a supervisor to manually delete the Pro Spot Check, select function K, delete PRO Spot Check, and hit enter.
    - a. The supervisor enters an "X" next to the spot check to be deleted and hit enter.
    - b. The "X" will be highlighted with a message that states "press enter to confirm deletion".
    - c. When enter is pressed again, the message stating "record deletion successful" displays.
    - d. The listing remains unchanged until batch is run.
- E. A verification source of "PR" is on the LTC screen of KAMES for the following types of care:
1. 01 (Nursing Facility);
  2. 02 (HCBS);
  3. 05 (SCL);
  4. 07 Model Waiver II;
  5. 08 (ICF/MR/DD);
  6. 09 (Mental Health/Psychiatric);
  7. 10 (PRTF);
  8. 11 (Adult Day Care);
  9. 12 (IMD);
  10. 13 (EPSDT);
  11. 16 (ABI);
  12. 17 (Michelle P); and
  13. 18 (ABI LTC Waiver).
- [F. If the individual currently receiving Medicaid in a Family MA category begins receiving waiver services, KAMES will calculate \$0 patient liability, regardless of the individual's income. This is because the individual was otherwise eligible for Medicaid and was admitted to waiver service after Medicaid eligibility was established.]

MS 2730

PATIENT LIABILITY FOR INDIVIDUALS  
OTHERWISE MEDICAID ELIGIBLE

(1)

Effective July 1, 2011, when an individual who is already Medicaid eligible begins receiving waiver services, the patient liability is \$0 regardless of the individual's income. This affects cases in the "C", "W", "E", "T", "L", "N", "Y", "P" and "I" Family MA categories. This applies to waiver admissions only, not to nursing facility admissions. The case remains in the original category. Do not alternate program to another category.

Example: A child is currently receiving Medicaid in the "I" category. He is admitted to HCBS and the worker receives a spot check that a PRO-Certification has been issued. The child receives \$750 a month in child support. Add the waiver information to the "I" case and KAMES calculates \$0 patient liability because the child was otherwise Medicaid eligible.

MS 2750

[PREGNANT WOMAN

(1)

Pregnant women with or without children in the home may qualify for MA. Review the applicant's income and resources and select the appropriate category of assistance.

A. Determine program code as follows:

1. Use "I" for a pregnant woman applying for herself and no one else.
2. If the pregnant woman with no other children in the home is living with the spouse who is the father of the unborn child and he is unemployed, take the application in the "I" category.

Following the birth of the baby, if assistance is requested for the spouse who is the father of the child, determine eligibility in the "N", "T", "L" or "E" category, as appropriate. The father must meet unemployment or incapacity criteria to receive medical assistance.

3. Use "L", "N", "Y" or "I" for a pregnant woman applying for herself and other children. If an application is taken in error as an "L" or "N" case for a pregnant woman applying for herself only, the application for the "L" or "N" case will deny and alternate program to the "I" category.
4. Enter the pregnant woman's name as SR. Do not enter the unborn child on KAMES as a member. For purposes of financial eligibility, the unborn child is included in the MA family size by the amount entered in "Number Births" on the member screen.
5. For applicants who state they, or another member of the assistance group, are pregnant and verification of any type is requested, indicate 30 day time standards for return of the verification on the request for information (RFI). When verification is provided, process the application due to the importance of accessing prenatal care at the earliest possible date. If verification is not provided, the application will deny on the 31st day.
6. Establish separate cases when more than one pregnant family member/group lives in the home.

EXAMPLE: A mother and minor daughter live in the home. Both are pregnant. Establish a separate case for each individual.

B. Determine financial eligibility, refer to [MS 3100](#) - [MS 3140](#) and [MS 3450](#) - [MS 3980](#) with the following exceptions:

1. A pregnant woman, who is resource ineligible in any other category may be eligible for MA in the "I" category during the pregnancy and through the end of the postpartum period. Eligibility determinations must begin with the "I" category if the applicant is a pregnant woman applying for herself only.
  - a. For active K-TAP and Family MA cases, if family resources exceed the resource limit for the family size, the pregnant woman is

eligible in the "I" category through the pregnancy and the end of the postpartum period.

- b. Following are special procedures for active cases which include a pregnant woman resource ineligible in any category.
  - (1) For K-TAP or Family MA cases, complete a program code change to the "I" category effective the first possible month.
  - (2) For "G", "H", "K" or "M" case, discontinue effective the first possible month. Process a new application in the "I" category for continued MA coverage. For an SSI pregnant woman resource ineligible for SSI, process a new application in the "I" category for continued MA coverage.
2. Determine retroactive eligibility according to [MS 1400](#) – [MS 1410](#).
3. The "I" pregnant woman, who is not deemed eligible, with family income exceeding the 133% or 185% of Poverty Level MA Scale for the appropriate family size, is considered for spend down eligibility in another MA category. Spend down eligibility is NOT appropriate for the "I" category.

C. Approve the application:

1. Verify pregnancy and the expected date of delivery by obtaining a written medical diagnosis. If the statement is unsigned, verify and document pregnancy and expected delivery date by calling the medical provider.
2. Consider the appropriate number of unborn children when determining the family size. If the pregnant woman provides verification of multiple births, enter the appropriate number of unborn children so the correct family size is considered in the income calculation.
3. Do not require the "I" eligible pregnant/postpartum woman to cooperate with Medical Support Enforcement (MSE) for children receiving MA in any category.
4. The L, N, or Y pregnant woman sanctioned for failure to comply with child support activities/MSE, is eligible if all other factors are met. If the mother requests MSE, provide those services. See [MS 2200](#).
5. KAMES sets the spot check in the case for the month following the month of the anticipated birth of the child to assure contact with the recipient. If no response is received, add the newborn to the case if information can be obtained by KVETS and change the pregnant woman to postpartum. Otherwise, change the pregnant woman to postpartum.
6. If the pregnant woman is eligible or becomes eligible for Long Term Care (LTC) services, add the coverage to the current case.
7. Applicants receiving Medicare can be dual eligible in the Family MA categories for QMB or SLMB. Complete the Medicare questions on the member screen and enter the Medicare information on the Health Insurance screen.]

MS 2780

DEEMED ELIGIBLE PREGNANT WOMAN

[A pregnant woman income ineligible in any other category may be eligible for MA in the "I" category during the pregnancy and through the end of the postpartum period in the following situations.]

- A. [For active K-TAP cases and active MA cases in any category, if reported family income exceeds the 185% of Poverty Level MA Scale for the appropriate family size, the pregnant woman is deemed income eligible in the "I" category during the pregnancy and through the end of the postpartum period.]

EXAMPLE: [A pregnant woman receiving MA in the "Y" category reports her husband has started working.] In the report month, her husband's income is over the 185% of Poverty Level MA Scale. [If the pregnant woman remains technically eligible, the pregnant woman is deemed income eligible in the "I" category.]

- B. Special procedures for active cases which include a pregnant woman income ineligible in any category are as follows:
1. [For K-TAP, Family MA or AFDC Related MA cases, complete a program transfer or program code change, as appropriate, to the "I" category effective the first administratively feasible month.]
  2. [For "G", "H", "K" or "M" cases, discontinue effective the first administratively feasible month. Require a new application in the "I" category for continued MA coverage. For an SSI pregnant woman income ineligible for SSI, require a new application in the "I" category for continued MA coverage.]
- C. [An "I" ineligible pregnant woman is Medicaid eligible in the "L" or "Y" category on a spend down basis. Document the case record regarding why the spend down was used.]

MS 2800

POSTPARTUM ELIGIBILITY

(1)

Postpartum MA eligibility continues as if the woman was pregnant through the end of the month in which the 60-day period following her pregnancy ends. The 60-day count begins on the day of the birth of the child. This ensures pregnancy related care and postpartum care are provided.

Example: A pregnant woman gives birth on 7/15/11. Her postpartum eligibility will continue until 9/30/11.

If a pregnant woman fails to keep a recertification appointment due prior to the end of the postpartum period, the KAMES will alternate program the case to the "I" category for the pregnant woman and the deemed eligible newborn, if previously reported. All other members are discontinued. KAMES will extend the certification period to end in the month the 60th day of postpartum eligibility falls, based on the expected or verified date of delivery. If the next recertification appointment is missed, the pregnant woman's MA coverage is discontinued. Eligibility for the deemed eligible newborn will continue if criteria for a deemed eligible newborn are met. Eligibility for the newborn will continue through the month of the newborn's first birthday even if the child does not reside with the mother, provided the mother is a Medicaid recipient for the month of the child's birth.

[When a deemed eligible newborn is added to the newborn database, KAMES automatically changes the pregnant woman to postpartum. At the end of the postpartum period KAMES discontinues the pregnant woman's case.]

- A. Pregnant women receiving MA in any category prior to the birth of the child are eligible for postpartum coverage.
- B. For active "I", "L", "N", and "Y" cases, which include a pregnant woman, DO NOT CONSIDER changes in financial and/or technical eligibility of the pregnant woman which occur during the postpartum period. However, if the recipient moves to another state before the end of the postpartum period, postpartum coverage ceases. Women who receive postpartum eligibility in another state do not qualify for those benefits in Kentucky.
- C. For applications filed after the birth of a child, determine postpartum eligibility in the "I" category unless ongoing eligibility exists in another category. Postpartum eligibility exists if all income and technical eligibility requirements are met.

The woman is deemed income eligible in the "I" category during the postpartum period if:

1. The woman is income ineligible for the "I" category in the application month; and
2. The family income does not exceed the 185% of Poverty Level MA Scale for the appropriate family size in any 1 of the 3 months prior to application.

- D. If income ineligible in the "I" category, determine postpartum eligibility in the "L", "N", or "Y" spend down category. Establish postpartum eligibility if:
1. The spend down excess is obligated by or on the last day of pregnancy; and
  2. The MA application is filed prior to and including the date the pregnancy ends.

Spend down is NOT appropriate for the "I" category.

- E. Procedures for determining continuing eligibility for the woman after the birth of the child are as follows:
1. If K-TAP criteria are met, complete appropriate forms and program transfer.
  2. For "L" or "N" cases, when the child is born, change from pregnant to postpartum.
  3. For "I" and "Y" cases, remove the SR after the postpartum period of eligibility.
  4. If the only child is committed to an authorized child welfare agency, discontinue the case after the postpartum period of eligibility. Accept an application for the child from the agency responsible for foster care.

MS 2810

REINSTATEMENT OF DISCONTINUED MEDICAID

[A woman who received MA due to pregnancy and whose case was subsequently discontinued for any reason, except no longer a resident of Kentucky, is entitled to MA benefits retroactive up to one year to the termination date and through the end of the postpartum period.

If a woman reports within one year of the effective month of case discontinuance that she was pregnant when the K-TAP, AFDC Related MA or Family MA case was discontinued, do the following: ]

- A. [Obtain medical verification that the woman was pregnant at the time the K-TAP, AFDC Related MA or Family MA case was discontinued.]
- B. Authorize MA benefits retroactive to the termination date from the report date, or the effective month of MA discontinuance, whichever is more recent. The retroactive period cannot exceed 12 months. Extend MA coverage through the end of the postpartum period.

The newborn is entitled to deemed eligible MA coverage for up to 12 months. Add the newborn for the appropriate months of eligibility beginning the first day of the birth month.

1. If the woman is no longer pregnant or in the postpartum period at the time of the report, authorize regular medical coverage by Special Circumstance Transaction to cover the retroactive period. The supervisor or principal worker must approve and sign off on any Special Circumstance Transaction.
2. If the woman is pregnant or in the postpartum period at the time of the report, and retroactive eligibility is three months or less prior to the report date, complete a reapplication on KAMES. [The application date is the date of report for medical coverage, AFDC Related MA or Family MA.] The effective MA date is the first day of the first month of entitlement for retroactive MA benefits.
3. If the woman is pregnant or in the postpartum period at the time of the report, and is entitled to retroactive MA benefits for more than three months:
  - a. Authorize medical coverage by Special Circumstance Transaction to cover the retroactive MA eligibility period. The supervisor or principal worker must approve and sign off on any Special Circumstance Transaction.
  - b. Reinstate the MA case on KAMES by completing the application process. Document case notes thoroughly to explain the reason for the reinstatement of benefits. The application date is the date of the report.

4. Annotate the case history folder and thoroughly document case comments.
5. For reinstatement purposes, eligibility for postpartum coverage ceases if the woman moves to another state before the end of the postpartum period. Women receiving postpartum coverage in another state does not qualify for those benefits in Kentucky.

MS 2850

NEWBORN CHILDREN

(1)

[A newborn baby born to a mother who received Medicaid in Kentucky, in any category, including Time-Limited, SSI or K-TAP, at the time of the newborn's birth, is deemed eligible. Once deemed eligible, the newborn is guaranteed Medicaid from the birth month through the 12th month even if the mother and/or other case members become financially or technically ineligible to receive Medicaid or even if the mother does not want the coverage.

After the newborn's first birthday, technical and financial eligibility requirements must be met in order for the child to continue to receive Medicaid. When a spot check advising of the newborn's first birthday is received request technical and financial eligibility verification to determine ongoing Medicaid eligibility. If the child's birthday is the first day of the month, deemed eligibility ends the prior month.

EXAMPLE: A deemed MA eligible newborn's birthday is 8/1/10. The newborn's deemed MA eligibility begins 8/1/10 and ends midnight 7/31/11.

- A. A child is considered a deemed eligible newborn even in situations where:
  - 1. The Medicaid application is made after the birth of the newborn, but the birth month is the month of application or one of the 3 retroactive months for which the mother is approved.
  - 2. The mother is approved for spend down eligibility and the excess is obligated on or before the newborn's date of birth.
- B. If the newborn is not deemed eligible, the Medicaid start date is the first day of the month up to three months prior to the month of the application. The start date cannot be prior to the first day of the month in which the child is born.
- C. When the deemed eligible newborn's birth is reported, a new application is not required. Inquire the newborn data base (see MS 2851) or check KAMES to see if the newborn has already been added to the case. If the newborn has not been added, take action to add the newborn.

If the child does not remain in the same household as the mother, set up a separate case for the child. Do not request technical or financial eligibility verification for the newborn if deemed eligible.

- 1. If the mother of a deemed eligible newborn requests assistance for herself after the postpartum coverage ends, determine eligibility in the appropriate Medicaid category.

2. Medical Support Enforcement (MSE), Third Party Liability (TPL) and enumeration are not required when determining eligibility for the deemed eligible newborn. However if the mother requests coverage for herself, as a condition of her ongoing eligibility, she is required to cooperate in MSE/TPL once her postpartum eligibility ends.

Note: To bypass the MSE referral on the deprivation screen, list the father as unknown and answer "N" to deprivation. On the KASES referral screen, indicate that you do not wish to update an existing referral or start a new referral.

3. If a child is born dead, a Medicaid case is not established for the child. Any charges related to delivery are billed under the mother's Medicaid number. If the deemed eligible newborn is born alive, but dies the same month of birth, check the Newborn database to see if the child was covered for the necessary time period. If not, the child is added to the Medicaid case and MA eligibility is issued for one month.
- D. A deemed eligible newborn may be included in the Medicaid family size when determining eligibility of the assistance group in other Family MA and/or AFDC-Related MA cases. The deemed eligible newborn's income and resources are considered when determining MA eligibility for the other case members.

Note: Resources are not considered in the "I" category.

- E. If the newborn's mother receives MA in an SSI case, a "G", "H", "K" or "M" case, or the Department for Protection and Permanency reports a newborn for a mother who receives MA in a "P", "S", or "X" case, set up a separate Family MA case in the "I" category for the newborn.
- F. In certain situations, the Medical Support and Benefits Branch staff forwards form MAP-221, Notice of Newborn Births, to the appropriate supervisor or designated representative when the birth is reported by the hospital or birthing clinic by form MAP-221. Upon receipt of form MAP-221, take action within 8 workdays to add the newborn to the case if appropriate. Deemed eligible criteria still applies.

Form MAP-221 not only indicates the birth of a newborn, but also if the newborn was stillborn or if the newborn died after birth. Use this information to help establish the mother's postpartum coverage or ongoing eligibility.

Follow K-TAP policy for adding a deemed eligible newborn child to the K-TAP case.]

MS 2851            AUTOMATED MEDICAID ISSUANCE FOR NEWBORNS            (1)

[Children born to a mother who is receiving Medicaid (MA) at the time of birth either on KAMES or SDX are deemed eligible for MA coverage through their first birthday. This applies to all newborns even if they do not go home with the mother. To guarantee deemed eligibility, most newborns born to a Medicaid mother are automatically issued Medicaid coverage through the newborn database.

A. Newborn on the Database

A spot check posts to the worker responsible for the mother's case and the supervisor's DCSR advising of the birth. The spot check states "Newborn added to NB database". Once the spot check posts, KAMES:

1. Updates the mother's member segment with the actual delivery date (the child's birth date);
2. Changes the pregnancy segment to "N";
3. Changes the number of births to "0"; and
4. Changes the postpartum to "Y".

The child must be added to the existing case or in a separate case within 10 calendar days of receiving the spot check. Once the child is approved in a case, the child's record on the Newborn Database is discontinued automatically by the system and the spot check is deleted from the DCSR.

B. Adding the Newborn to KAMES

1. Inquire the database before adding a newborn to KAMES to keep the newborn from being assigned two pseudo numbers. If it is discovered that the child is on both the database and KAMES, the supervisor or principal discontinues the newborn case from the database. If the child was added to KAMES with a different name than that on the database notify the Medical Support and Benefits Branch (MSBB) through the Regional office so the eligibility file can be corrected.
2. Access the database through inquiry on KAMES, option "S", Newborn Database. The information loaded to the database is the case number, the mother's name, the mother's SSN, mother's address, child's name, date of birth, sex, and race. The mother's race is used to determine the child's race. The database can be searched by the following:
  - a. The mother's SSN;
  - b. The mother's name; or
  - c. The child's name.
3. If the child has not been added to KAMES, add the child to the appropriate case. Use the same pseudo number the database assigned to the newborn.

Note: If the child's SSN is available, first add the child to KAMES with the pseudo number located in Newborn database and then complete a case change to correct the SSN.

- a. For "I" cases – inquire the database for the information on the child and add the child as an M02. No contact is needed with the parent.
- b. For all other MA categories – add the newborn as an M02. Generate an appointment and request information needed to determine ongoing eligibility. If the parent fails to keep the appointment, allow the case to discontinue and alternate program to the "I" category keeping the deemed eligible newborn active.

#### C. Newborns born to Alien Mothers

When an ineligible alien mother receives time limited Medicaid in the month of the child's birth the child is considered a deemed eligible newborn. The worker must establish a separate case from the mother for the deemed eligible newborn or add the newborn to a case with eligible siblings. The time limited Medicaid coverage is always issued on a separate case.]

MS 2860

"Y" CHILDREN

(1)

Children under age 18, or age 18 and in full-time attendance in high school or equivalent level of vocational or technical school, who will complete a course of study before the 19<sup>th</sup> birthday, may be eligible for MA in this category. Deprivation and living in the home of a parent or other specified relative (SR) are NOT requirements of this category.

- A. PROGRAM CODE IS "Y".
- B. CASE NAME is the name of the parent who signs the application. When an application is signed by an interested party for the parent, the case name may be the name of either parent. When an application is made by an interested party on behalf of a Y child not living in the home of a parent or other SR, the application is in the name of the interested party. If the child and interested party reside separately:
  - 1. Enter the interested party's name and address as the case name and address;
  - 2. Enter "c/o" and the child's name on the first line of the mailing address; and
  - 3. Enter the child's address as the mailing address.

This will ensure the KYHealth card and mail are sent to the address where the child resides.

[Note: If a child under the age of 18 does not live with his/her parents or other caretaker relative, then a case may be established in the child's name.]

- C. MEDICAL SUPPORT ENFORCEMENT (MSE). If a child in a "Y" case has a deprivation factor that requires a referral for MSE, a referral must be completed.
- D. FINANCIAL ELIGIBILITY is determined according to [MS 3140](#).

MS 2870

"I" CHILDREN

(1)

"I" child-only cases are for children not eligible in any other Family MA or KCHIP categories. Children receiving in this category will have the recipient status code of P1, P2 and P3. Applications for these categories can be made by:

- \* Completing and mailing the web-based application to PO Box 34090, Lexington, Kentucky 40588-4090;
- \* Completing the web-based application and returning it to the local DCBS Office for processing;
- \* Completing a face-to-face interview in the local DCBS office.

The eligibility criteria for these categories are as follows:

A. "I" categories

1. Children at least age 6, but under age 18, with family income that exceeds the regular MA Scale, but is not more than the 100% of Poverty Level MA Scale for the appropriate family size. (P1)
2. Children under age 6, with family income that exceeds the regular MA Scale, but is not more than the 133% of Poverty Level MA Scale for the appropriate family size. (P2)
3. Children under age 1, with family income that exceeds the regular MA Scale, but is not more than the 185% of Poverty Level MA Scale for the appropriate family size. (P3)

B. Create multiple "I" cases if income eligibility is not met when including all children in one single MA household. Example: The child support of one child with a different father causes the case to be over the income limit. Create a separate case for the child with the child support.

C. There is no resource limit for the "I" category.

D. Determine eligibility in the "I" category ONLY when the child is income and/or resource ineligible for ongoing MA in any other Family MA category, if technical eligibility requirements for the "I" category exist.

E. The KAMES system automatically applies the "I" income scale and eligibility criteria to any child who is ineligible for an "L", "N", "P", or "Y" Medicaid case. KAMES determines which income scale is appropriate by beginning with P1 and ending with the KCHIP 3/P7 category. Therefore, a child may apply for Family Medicaid but qualify for an "I" case or KCHIP instead.

F. Medical Support Enforcement (MSE) is not a technical eligibility requirement for "I" cases. A MSE referral must be completed at the request of parents, specified relatives or non-specified relatives.

- G. The case name is the name of the parent or relative who signs the application. When an application is signed by an interested party for the parent or relative with whom the child lives, the case name is the name of either of the parent or relative.

[Note: If a child under the age of 18 does not live with his/her parents or other caretaker relative, then a case may be established in the child's name.

EXAMPLE: Alice is a 17 yr. old, who lives by herself, and has come to the local office to apply for medical assistance. She is not pregnant and has no dependent children. She is currently working and is self-sufficient. Alice can apply for medical assistance as she is not living with her parents or other caretaker relative.]

- H. When an application is made by an interested party on behalf of an "I" child not living in the home of his/her parent or other SR, the application is in the name of the interested party unless it is a business agency that makes applications on behalf of a medical provider (such as Chamberlain Edmonds). If the child and interested party reside separately:

1. Enter the interested party's name and address as the case name and address. For agencies making an application, the case name is processed under the responsible party's name;
2. Enter care of (c/o) and the child's name on the first line of the mailing address; and
3. Enter the child's address as the mailing address. This will ensure the KYHealth card and mail are sent to the address where the child resides.
4. When processing the application, review the situation as far as whose income should be considered in the case.

EXAMPLE: If the child is only out of the home due to medical need but the parents are still responsible for the child their income is considered in the case. If the child is living with someone other than parents and those individuals are the responsible party then only income of the child would be considered. If the child has no income then none would be considered.

Note: Follow form MAP-14, Kentucky Medicaid Authorized Representative, procedures for those applying as an interested party.

- I. Deprivation and living in the home of a parent or other relative are NOT technical requirements for the "I" category.
- J. For employed "I" children, wages are excluded when calculating the household income if the child is in school.
- K. For "I" children approaching age ineligibility, a spot check is system-generated in the month preceding the "I" child's birthday.

MS 2871

KCHIP CHILDREN

(1)

KCHIP (Kentucky Children's Health Insurance Program) provides health insurance coverage for uninsured children who have income below the 200% federal poverty level and are not eligible in other Medicaid categories. Children receiving in this category have a recipient status code of P5, P6 or P7.

A. Applications for KCHIP can be made by:

1. Completing and mailing the web-based application to PO Box 34090, Lexington, Kentucky 40588-4090. For more information on the mail-in process refer to [MS 2890](#) on how to apply for KCHIP; or
2. Completing the web-based application and returning it to the local DCBS office for processing; or
3. Completing a face-to-face interview in the DCBS office.

B. KCHIP Categories

1. Children age 6 years to 19 years, with income 101% through 133% of the federal poverty level for the appropriate family size. (P5)
2. Children age 1 year to 19 years, with income 134% through 150% of the federal poverty level for the appropriate family size. (P6)
3. Children from birth to the 19<sup>th</sup> birthday, with income 151% through 200% of the federal poverty level for appropriate family size. (P7)

C. KCHIP 3/P7 category coverage:

KCHIP 3/P7 category coverage begins the date of application. The following applies:

1. There is no retroactive coverage for KCHIP 3/P7 members except by spend down coverage:
  - a. Explore eligibility in the L, N or Y category if the child has medical expenses in the current month or up to 3 calendar months prior to the date of application. If spend down coverage is approved for any portion of the prior quarter, manually calculate the income to determine the spend down amount and issue the eligibility as a special circumstance transaction. Document the case record;
  - b. [If a case is within the KCHIP 3 income scale, the application is filed after the first of the month and the child has unpaid medical bills, before approving the case explain the following:
    - 1) Because KCHIP 3 does not backdate to the first of the month, Medicaid benefits for that child will start on the date of application. Therefore, if the child has any unpaid medical bills for the current month KCHIP 3 will not cover those bills. A spend down may be more advantageous in this situation.

- 2) If the client chooses to apply for a spend down, the child will not receive ongoing Medicaid for the current month.

The worker must make the applicant aware of the advantages and disadvantages when coverage is needed prior to the application date. Advise the client of both options and allow them to make the decision.]

2. KCHIP 3/P7 category recipients are not eligible for:
  - a. Non-Emergency Medical Transportation (NEMT);
  - b. Early and Periodic Screening Diagnosis and Treatment (EPSDT) special services. EPSDT special services not covered by Medicaid include allergy shots, private pay nursing and substance abuse treatment; or
  - c. Kentucky Health Insurance Premium Payment (KHIPP).
- D. Create multiple "I" cases if income eligibility is not met when all children are included in one MA household. Example: The child support of one child with a different father causes the entire case to be over the income limit. Create a separate case for the child with the child support income.
- E. KAMES knows which income scale is appropriate when comparing the case income to determine which category of assistance best fits a household. A child may apply in a Family or AFDC Related category but may be approved in the "I" or KCHIP category.
- F. A Medical Support Enforcement (MSE) referral is not required in the KCHIP categories. Referrals are only completed at the request of the parent, other specified relative (SR) or non-specified relative.
- G. KCHIP technical eligibility matches the Family MA "I" category. The following are exceptions to KCHIP eligibility:
  1. A child who has existing comprehensive medical insurance, which is insurance coverage that covers both hospital and physician services, is not eligible for KCHIP.
  2. Children with the KCHIP member status code P7, who have no medical insurance, but were covered in the past 6 months, are not KCHIP eligible unless the loss of insurance was involuntary. Prior comprehensive medical insurance is considered as having both physician and hospitalization coverage. The 6-month count begins with the month coverage was lost.
  3. An application may be approved in cases where health insurance coverage ended less than 6 months prior to a determination of eligibility for KCHIP, if the coverage was terminated for reasons beyond the parent's control.

Reasons for involuntary loss of health insurance included:

- a. Loss of employment;

- b. Death of a parent;
  - c. Divorce, where a child's coverage had been provided by a non-parental adult;
  - d. Change of employment;
  - e. Change of address where no employment-sponsored coverage is available;
  - f. Discontinuation of health benefits to all employees of the applicant's employer;
  - g. Expiration of the coverage periods established by the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985;
  - h. Self-employment; or
  - i. Termination of health benefits due to long term disability.
- H. The 6-month waiting period does not apply to KCHIP children in categories P5 and P6 when private insurance has been lost or discontinued.
- I. For employed "KCHIP" children, their wages are excluded only if the child is in school when calculating the household's income.
- J. [When an application is made by an interested party on behalf of a KCHIP child not living in the home of a parent or other specified relative, the application is made in the name of the interested party unless it is a business agency that makes applications on behalf of a medical provider. When an agency makes an application, enter the case under the name of the person who is responsible for the child's care

If the child and interested party reside separately:

1. Enter the interested party's name and address as the case name and address;
2. Enter care of (c/o) and the child's name on the first line of the mailing address; and
3. Enter the child's address as the mailing address.
4. When a child is living with someone other than a parent or a non responsible specified relative wanting assistance, only the child's income is considered in the case.]

MS 2890

MAIL-IN APPLICATIONS FOR "I" AND KCHIP  
CATEGORIES

(1)

A face-to-face interview is **not** required of individuals applying for assistance in the "I" or KCHIP categories as these individuals can apply by mail. Applicants can obtain an application by:

1. Downloading a web-based mail-in application from the Governor's website or going to <http://kidshealth.ky.gov>;
2. Requesting an application at any Health Department, doctor's office, etc.; or
3. By calling toll free 1-877-524-7418.

Upon completion of an application it can be mailed to KCHIP, PO Box 55270, Lexington, Kentucky, 40555-5270. Applicants can also turn the application in to any local Department for Community Based Services (DCBS) office or to a benefits worker when completing a face-to-face interview.

Note: The mail-in application option is not available to pregnant women applying in the "I" category. A face-to-face interview is required for pregnant women. See item E below.

A. Taking applications in the "I" (children only) or KCHIP categories:

1. Once applications are entered on KAMES they pend for 30 days to allow for the return of mandatory verification. All other Family MA or AFDC Related MA categories pend for 10 days.
2. If the case is denied for failure to return mandatory verification, the applicant has a **30 day grace period** from the date the application was denied to provide the verification without having to complete a new application. The date the information is returned is the date used to enter the reapplication on KAMES.

[EXAMPLE 1: An application is taken April 1<sup>st</sup> with a request for additional information generated. The application denies April 30<sup>th</sup> for failure to return information. The applicant returns the requested information to the local office on May 3<sup>rd</sup>. The case is re-entered on KAMES and processed with the application date of May 3<sup>rd</sup>. If the individual has medical bills in March and/or April, retro coverage can start effective March 1, if eligible.]

3. Medical Support Enforcement (MSE) is not required, but is optional at the request of the parent/legal guardian.

MSE against the absent parent is addressed on the mail-in application with the following question: "Do you want us to help with Medical Support Enforcement for any child listed on this application? Y/N."

- a. If the question is answered "no" or left blank, MSE is not completed. The deprivation screen is completed as follows:
    - 1) Answer "Y" to unknown for the absent parent(s);
    - 2) Answer "N" to the question "Is this parent a basis of deprivation?" for both the father and the mother; and
    - 3) Answer "N" to "IS A REFERRAL TO DCSE/MSE REQUIRED?".
  - b. If the question is answered "yes", process the case as if they had answered "no". Send form PAFS-2, Application Letter or Notice of Expiration, scheduling an appointment for the client to complete the MSE referral during a face-to-face interview at the local office. During the interview, complete the MSE referral via case change.
- B. Mail-in or walk-in applications received in the local office are entered on KAMES and processed by local office staff. If additional information is required, an RFI is given to the applicant. The applicant has 30 days to return the requested information before the application is denied. If the application is denied, the 30 day grace period explained above is applied. The case record for the denied application is maintained in the local office that processed the action.

EXAMPLE: An application is taken April 1<sup>st</sup> with a request for additional information generated. The application denies April 30<sup>th</sup> for failure to return information. The applicant returns the requested information on May 3<sup>rd</sup>. The case is re-entered on KAMES and processed with the application date of May 3<sup>rd</sup>.

- C. If an applicant walks in and requests a face-to-face application proceed with normal application procedures. Do not refuse an applicant the right to a face-to-face interview.
- D. Mail-in applications are identified on KAMES by answering a "Y" to the question on the first screen, "KCHIP Mail-in App?" If the application is completed by a face-to-face interview the question is answered with an "N".
- E. Regular citizenship and identity requirements apply for all "I" and KCHIP cases as described in MS 2035.

Note: Mail-in applications are not pended for the return of form KIP-106, Attestation of Identity, as the applicant attests to the child's identity by signing the attestation on the mail-in application.

- F. For mail-in applications received on an active case or for a pregnant woman only, the following applies:
  1. If a mail-in application is received for individuals that are already receiving assistance, mail form MA-105, Notice of Eligibility or Ineligibility,

advising the applicant that no application is needed as they are currently active – indicate the type of case.

Example: "I" case, KCHIP case, "L" case, etc.

2. If the mail-in application is for a pregnant woman only, do not enter on KAMES. Send form PAFS-2 with an appointment for the individual to come in and complete a face-to-face interview. If they fail to keep the appointment, send form MA-105 and deny the application.

MS 2891 MAIL-IN RECERTIFICATION FOR 'I' AND K-CHIP CATEGORIES (1)

["I" and KCHIP cases coming due for recertification are identified on the coming due list with the message "Mail-In Recertification". KAMES generates form KIP-2SR, Renewal Form for Medical Coverage, for KCHIP and Medicaid "I" category cases.]

A 30 day grace period is given to all "I" and KCHIP cases discontinued for failure to complete and return forms KIP-2SR or KIP-2SRA, Renewal Form for Medical Coverage – Final Notice. KIP-2SR or KIP-2SRA recertification forms returned complete, with all required verification, **within 30 days from the effective date of discontinuance** (first day of Medicaid ineligibility) are entered as a reapplication **without** requiring a new mail-in application or face-to-face interview. The date the information is returned is used as the date of re-application on KAMES.

A. Renewal Form Due Dates

1. "I" and KCHIP cases coming due for recertification are identified on the coming due list with the message "Mail-In Recertification". At this time, no action is necessary on the part of the worker. They should, however, schedule time to complete these recertifications.
2. [Form KIP-2SR is generated on the 9<sup>th</sup> of the month prior to the recertification month. If the 9<sup>th</sup> falls on a weekend or holiday, the form is generated on the last workday prior to the 9<sup>th</sup> of the month.]
3. The completed form KIP-2SR is due in the local office on the last calendar day of the month prior to the recertification month.
4. The due date on form KIP-2SR is used to encourage recipients to return their forms prior to the KAMES system due date of the 5th workday of the recertification month. Workers must enter all forms KIP-2SR received prior to close of business on the 5th workday of the recertification month. Recertifications will process correctly if entered after IM cut-off in the month prior to the recertification month.
5. If the recipient fails to return form KIP-2SR by close of business on the 5th workday of the month, form KIP-2SRA is generated to the recipient the next workday and allows the recipient 10 calendar days to return the form. Form KIP-2SRA provides timely notice of negative action for failure to recertify benefits. The form notifies recipients the form must be completed and all required verification provided within 10 calendar days from the date form KIP-2SRA was generated or medical benefits will be discontinued. If the 10<sup>th</sup> falls on a weekend or holiday, the due date will be the next workday. The due date is printed on the form.

Example: Form KIP-2SR is not returned by close of business on Friday, July 5<sup>th</sup>. Form KIP-2SRA is generated and dated July 5<sup>th</sup>.

The form is not returned by close of business on Monday, July 15<sup>th</sup>.  
The case is discontinued effective August 1<sup>st</sup>.

6. If form KIP-2SRA is received after the due date, but before the close of business on the last day of the month, the case is reinstated and a recertification is completed whether the form is complete or incomplete. If complete, process the recertification. If incomplete, the recertification is entered on KAMES and the case is pended for mandatory verification.

If an incomplete and/or incorrect KIP-2SR or KIP-2SRA is received during the recertification month, enter it on KAMES and generate an RFI requesting the required information or verification.

**NOTE:** All incoming mail is scanned into ECF on the date received to assure that cases are not erroneously discontinued.

7. KIP-2SR or KIP-2SRA recertification forms returned complete with all required verification by the end of the 30 days from the first day of Medicaid ineligibility are entered as a reapplication without a new mail-in application or a face-to-face interview.

EXAMPLE: A recertification is discontinued at cut-off in September with an effective date of October 1<sup>st</sup>. The client returns all the required information on October 30<sup>th</sup>. The case is entered as an application using the date the client returned the information as the application date.

EXAMPLE: A recertification is discontinued at cut-off in September with an effective date of October 1. The client returned the KIP-2SRA on September 30<sup>st</sup> without verification. The case is reinstated and a RFI mailed to the client. Verification is not returned within 10 days, so the case denies. The 30 day grace period to return the requested information without making a new application begins with the date of case denial.

8. Individuals may choose to complete a face-to-face interview instead of recertifying through the mail-in recertification process.

#### B. Verification and Income Computation

1. As form KIP-2SR is due on the last workday of the month prior to the renewal month, the recipient may not have received all paychecks for the month that the form is due. Therefore, income received in the 2<sup>nd</sup> and 3<sup>rd</sup> months prior to the recertification month is used to determine financial eligibility (e.g., for the recertification month of October, income received in July and August is used to determine eligibility).
2. To compute income eligibility using the 2<sup>nd</sup> and 3<sup>rd</sup> prior months' income, enter the income as follows:

Form KIP-2SR is received on September 30<sup>th</sup> for the renewal month of October. The form requests verification of income for the months of July and August.

If the worker enters the recertification in September:

Answer "N" to the months of July and August and enter the calculation code "P2" for September.

If the worker enters the recertification in October:

Answer "N" to the months of July and August, "Y" to September and enter the calculation code "P2" for October.

MS 2896

JUVENILE JUSTICE CHILDREN

Children who are public offenders are committed to the Justice Cabinet, rather than to the Department for Community Based Services. As Juvenile Justice workers apply for Medicaid on behalf of these children, applications are accepted in the appropriate category and taken in the name of the child, not in the name of the Justice Cabinet worker. The cases are carried in the counties where the DJJ workers are located. The county of residence is the county in which the child is physically located. See [MS 2860](#) and [MS 2870](#).

[Because these children are committed to the Justice Cabinet, they are exempt from MSE.]

See [MS 1205](#) regarding county of residence and caseload code for these cases.

- A. Cases for children in Juvenile Justice Custody are entered in the child's name:
  1. Enter the child as the applicant;
  2. Answer "yes" to the IM representative question; and
  3. Enter the Juvenile Justice Worker as the IM representative who is responsible for the application.
- B. When you reach the deprivation screen for a child in Juvenile Justice custody:
  1. Leave both parents' names and SSN's blank;
  2. Answer "N" to "Is he/she in the home?";
  3. Answer "Y" to "Unknown"; and
  4. KAMES loads "Unknown" in the name fields and assigns a deprivation factor of "60", no deprivation. This bypasses the KASES Referral Screens.
- C. To transfer a DJJ case from one DCBS worker to another, do the following:
  1. The sending county must:
    - a. Contact the receiving county and advise them the case is coming;
    - b. Change the county number on the case address screen to the county where the receiving DCBS worker is located; and
    - c. Complete the case transfer.
  2. The receiving county must:
    - a. Reassign the case to the appropriate caseworker; and
    - b. Change the county code to match the child's county of residence. This must be done on the same day the case is received.

\*MS 2897

### EXCEPTION TO AGE REQUIREMENTS

A child technically ineligible due to age may remain eligible for MA in an "I" category if receiving inpatient hospitalization services. To receive continued MA coverage, the following requirements must be met.

- A. Inpatient services in a hospital must be received in the month the child becomes technically ineligible due to age. In addition, the child continues/continued, without being discharged and readmitted, to receive inpatient services through the first day of the month following the birthday month;

EXAMPLE: Child turns 19 on 11/10. The "I" case is discontinued effective 12/1. On 11/28, recipient reports the child entered the hospital on 11/27 and the verified date of release is 12/2. Authorize MA coverage for the month of December.

- B. Except for age, the child remains otherwise technically eligible under the "I" category. Changes in income must be considered; and
- C. Inpatient services have been verified by obtaining a written statement from the medical provider containing the date of admission to and the estimated length of stay in the facility.
- D. Case action procedures necessary to continue MA coverage for "I" child receiving inpatient services:
  - 1. Authorize MA coverage for one month by Special Circumstance Transaction;
  - 2. A system-generated notice is sent to the recipient for each Special Circumstance Transaction completed, notifying the recipient of the approval of the MA coverage and the automatic discontinuance of the MA coverage; and
  - 3. If the child has been/will be hospitalized continuously from the first day of the month of extended MA coverage through the first day of the second month, authorize MA coverage for the second month. Follow this procedure to issue MA coverage for any additional months the child is determined eligible.
- E. All special circumstance transactions require approval and sign off by the supervisor or a principal caseworker.

MS 2900

TMA INTRODUCTION

(1)

[Some K-TAP and E/T families receiving Medicaid issued by KAMES may receive up to 12 months of Transitional Medical Assistance (TMA) benefits after the K-TAP or E/T case is discontinued. Families receiving Medicaid issued by kynect do not receive TMA.]

- A. Families may be eligible for TMA if they lose K-TAP or E/T benefits solely because:
1. The caretaker relative becomes employed;
  2. The caretaker relative receives an increase in hours of employment or earnings; or
  3. A member of the family loses either the \$30 and 1/3 or the \$30 earned income disregard.
- B. TMA consists of two 6-month periods. The 12 months of TMA begins with the first month of K-TAP or E/T ineligibility. Consider months for which the entire month's benefits are recouped as TMA months.

[C. TMA recipients continue managed-care.]

- D. To be eligible for TMA benefits in the second six-month period, the caretaker relative must have been employed in each of the 3 months preceding the 7<sup>th</sup> and 10<sup>th</sup> report months. A determination of involuntary termination/loss or a good cause determination for voluntary quit of a job applies only to the report period in which the employment ended, not the entire remainder of the TMA period.

Example: Form PA-800, Transitional Medical Assistance Report Form, is received in March, the 7<sup>th</sup> report month. A caretaker relative reports termination of employment in January. Worker determines that good cause exists according to Vol. IV, MS 2990 and authorizes continuation of TMA coverage. Form PA-800 is received in June, the 10<sup>th</sup> report month. A caretaker relative reports no employment in March, April or May. The case does not meet criteria for continuation of TMA and the worker is to discontinue TMA coverage effective the 11<sup>th</sup> month.

- E. In the 12<sup>th</sup> month of TMA a recertification is completed for ongoing eligibility. Reference [Volume IV, MS 2960](#), H for process.

MS 2910

ELIGIBILITY REQUIREMENTS

(1)

[At the discontinuance of a K-TAP or "E/T" case in which the members received Medicaid issued by KAMES, if the following criteria are met, the case may be eligible for TMA.]

- A. A dependent child is in the home;
- B. K-TAP members were eligible for and received a K-TAP grant 3 out of the 6 prior months, including the month of discontinuance if recoupment is not required; and
- C. K-TAP case is discontinued due to increased earnings of the caretaker relative or increased hours of employment of the caretaker relative; or
- D. K-TAP or "E/T" case is discontinued due to expiration of the earned income disregards of \$30 and 1/3 or \$30 for any family member; or
- E. For "W" cases, the Qualifying Parent (QP) returned to work and is working 100 hours or more per month.
  - 1. If the QP is already working and another family member returns to work, the case would not be eligible for TMA, unless item C or D applies.
  - 2. If the second parent goes to work the case would meet the criteria in item "C".
- F. Do not require that all members of the family be included in the TMA case. Ongoing K-TAP eligibility may be continued or established for one or more members of the family.

EXAMPLE: A "W" case includes parents, one child in common and one child from the specified relative's previous marriage. The second parent starts working and the wages exceed the K-TAP limit. The second parent and child in common are removed from the K-TAP case and TMA eligibility is established in the "N" category in a separate case. Establish K-TAP eligibility in the "C" category for the specified relative and the child by the previous marriage. If the companion K-TAP case remains active, use a copy of the K-TAP case's current application. Document the "C" case thoroughly and establish the same recertification date as the previous "W" case.

MS 2920

TRANSFER TO TMA

(1)

[KAMES determines eligibility for Transitional Medical Assistance (TMA) at K-TAP, "E" or "T" discontinuance if the Medicaid is issued by KAMES, and establishes a TMA case. The K-TAP, "E" or "T" case discontinues and alternate programs to TMA "L" or "N".]

- A. Noncooperation with DCS has no effect on continuing eligibility. However, if an absent parent returns to the home and medical support enforcement has been initiated, update KASES.
- B. TMA cases are identified on the case General Information screen with "Y" in "Time Limited MA".
- C. The 12 months of TMA begin the first month the assistance group become ineligible for K-TAP or E/T.

EXAMPLE: Recipient reports in November that earnings exceeded the K-TAP scale in October for the appropriate family size. The K-TAP, "E" or "T" case is discontinued effective December. December is the first month of TMA eligibility. The MA end date will be December 1 of the following year.

- D. In the 12th month of TMA, the individual is required to complete a face-to-face recertification interview to determine ongoing eligibility.

MS 2930 TMA ELIGIBILITY AND REPORTING REQUIREMENTS

Transitional Medical Assistance (TMA) consists of two 6-month periods of eligibility. Each 6-month period has various reporting requirements. When the family no longer includes a dependent child, assistance for all remaining family members ends the last day of the month. Determine whether or not the former dependent child continues to be MA eligible.

- A. The TMA recipient is required to return a completed TMA report, form PA-800, in the 4th, 7th and 10th months of the 12-month TMA period. Form PA-800 captures information on the last three months earnings and actual child care costs. System-generated forms PA-802, PA-803 and PA-804, Important Reminder, are sent to TMA recipients in the 3rd, 6th and 9th months respectively, reminding them of the reporting requirements.
- B. KAMES generates form PA-800 to the individual in the appropriate months. The recipient must complete form PA-800 and return to the caseworker by the 10th calendar day in the 4th, 7th and 10th months respectively. If the 10th day falls on a weekend or holiday, form PA-800 must be returned by the next work day.
- C. If no report is acknowledged on KAMES by the 10th calendar day of the report month, KAMES sends a second form PA-800 to the individual along with form PA-801, to advise if the report form is not returned completed by the 21st day of the report month, the TMA benefits will be discontinued. If the 21st day of the report month falls on a weekend or holiday, the individual has until the next work day to return the form.

MS 2940                      TRANSITIONAL MEDICAL ASSISTANCE (TMA)  
GOOD CAUSE

A report is considered late if received after the 21st day of the report month. If the report form is late, make a good cause determination.

- A. Good cause exists for returning a late report if one of the following acceptable reasons is met:
  - 1. The SR is out-of-town for the entire filing period;
  - 2. An immediate family member living in the home is institutionalized or died during the reporting period;
  - 3. The assistance group was the victim of a natural disaster, such as a flood, storm, earthquake or serious fire; or
  - 4. The assistance group moved and reported the move timely, but the move resulted in a delay in receiving or failing to receive the report form.
- B. If good cause exists for the late return of the report and no action is taken in the report month, reinstate the case effective with the appropriate month.
- C. If the report is received late and good cause does not exist, KAMES discontinues the case effective with the appropriate month.

MS 2950

FIRST 6-MONTH PERIOD OF ELIGIBILITY

During the 4th month when the complete report is received, determine if a dependent child is in the home. If there is no dependent child, discontinue the case immediately.

- A. Only earned income and actual child care costs are reported. Do not consider other eligibility criteria. The amount of earnings DOES NOT affect TMA eligibility in the first 6-month period.
- B. If a recipient returns form PA-800, but fails to verify earnings and actual child care costs, DO NOT take action to discontinue the TMA case. The system automatically discontinues the TMA case effective the 7th month of TMA.
- C. [Acknowledge form PA-800 and complete a "TM" change in the report month to release the MAID card for the following 3 months. If no action is entered in the 4th month, or form PA-800 is acknowledged as incomplete, the case automatically discontinues effective the 7th month.
- D. If the report is received incomplete, enter the incomplete reason on the TMA screen. KAMES sends form PA-801, Notice of Decrease or Discontinuance, requesting the verification by the 21st of the month to avoid discontinuance.]

MS 2960

SECOND 6-MONTH PERIOD OF ELIGIBILITY

To be eligible for TMA benefits in the second six-month period, the caretaker relative must have been employed in each of the 3 months preceding the 7<sup>th</sup> and 10<sup>th</sup> report months. Form PA-800 is received in the 7<sup>th</sup> and 10<sup>th</sup> months. These reports verify the last 3 months earnings and actual child care costs.

- A. If no report is received by the 10th calendar day of the report month, KAMES sends a second form PA-800 to the recipient along with form PA-801, Notice of Discontinuance, advising the recipient that if the report form is not returned by the 21st of the month Transitional Medical Assistance (TMA) benefits are discontinued.
- B. During the second 6-month period, when the report is received, review the report to:
  1. Determine if complete. If the report is received incomplete, enter the incomplete reason code on the TMA screen. KAMES sends form PA-801 to request additional information/verification, and advises the recipient that if the necessary information is not received by the 21st that TMA benefits are discontinued.
  2. Determine if a dependent child lives in the home. If not, discontinue the case.
  3. Determine if the caretaker relative has been employed for each of the 3 months preceding the report month. If he/she has quit a job, determine if good cause existed. See [MS 2990](#) for good cause reasons. Enter the new information on KAMES and the TMA case will discontinue if appropriate; and
  4. Enter the gross earnings and actual child care expense for the previous 3 months and consider only earned income. Unearned income does not affect TMA eligibility.
- C. KAMES compares the net earned income to 185% of the poverty level for the appropriate family size. See [MS 3450](#) for Family MA income scales.
- D. [TMA cases exceeding the 185% income scale in the second 6-month period are processed as follows:
  1. KAMES will look at the 200% scale for the appropriate members;
  2. If the income is within the 200% scale, KAMES will alternate program the case to the "I" category, and issue the appropriate notice;
  3. If the income exceeds the 200% scale, KAMES will look for deemed eligible members;

4. If the case contains any deemed eligible members, it will remain active under the "I" category for the deemed member only and adjust the certification dates accordingly; or
5. If the case does not contain a deemed eligible member, KAMES will discontinue the case and issue the appropriate notices.

A spot check is issued informing the worker when a TMA case has alternate programmed to an "I" category Medical Assistance case.]

- E. [Acknowledge form PA-800 and complete a TMA case change in the report month, to release eligibility for the subsequent months.
  1. The TMA case change in the 7<sup>th</sup> month releases eligibility for the 8<sup>th</sup>, 9<sup>th</sup> and 10<sup>th</sup> months.
  2. The TMA case change in the 10<sup>th</sup> month releases eligibility for the 11<sup>th</sup> and 12<sup>th</sup> months.]
  3. Acknowledge receipt of form PA-800 and complete a TMA change by the end of the month or the TMA case discontinues.
- F. Do not act on the report if it is received after the 21<sup>st</sup> without good cause.
- [G. All TMA families with countable income (gross earnings minus child care expenses) of \$1,000 or more per month are required to pay a \$30 monthly premium per family.
- H. If a TMA case erroneously discontinues, reinstate the case using the effective date of the discontinuance and the original end date with the TMA case status code. KAMES counts the months and sends appropriate notices and reports.
- I. In the 12<sup>th</sup> month of TMA a mail-in recertification is completed for on going eligibility. A face-to-face interview may also be completed.
  1. In the 11<sup>th</sup> month of TMA, a KIP-2SR, Recertification Notice for KCHIP and Family MA, is system-generated to the recipient.]
  2. In the 12<sup>th</sup> month of TMA, if the recipient completes a face-to-face interview, the worker is to manually prescreen the income reported prior to entering a recertification action on KAMES. If the family is eligible in the E or T category, the worker must enter a program transfer. DO NOT enter a recertification action in this situation.
- [3. If the household does not qualify for ongoing medical coverage and contains a deemed eligible or postpartum member, the case remains active as an "I" case only. The certification is extended until the month the deemed-eligible member turns one year old or the month the 60-day postpartum period ends.]

MS 2980

TMA CHANGES REQUIRING ACTION

[Act on any changes reported during the 12-month period or reported on a Transitional Medical Assistance (TMA) report within 10 days. If a change results in discontinuance of TMA benefits, an advance 10-day notice is not required.

- A. If it is determined during the TMA benefit period that the only dependent child is no longer in the home, discontinue the TMA case.
  1. Assistance for all family members, except for the former dependent child, ends the last day of the month the family no longer includes a dependent child.
  2. Determine whether or not the former dependent child continues to be eligible in another category of assistance.
- B. If it is determined during the TMA benefit period that a dependent child no longer meets the definition of a Family MA child:
  1. Remove the ineligible child; or
  2. If this is the only child in the case, update the child's member information and allow the TMA case to discontinue.
- C. If the recipient reports the birth of a child and the mother of the child is included in the TMA case, consider the newborn a deemed eligible newborn and add the newborn to the TMA case.
- D. If the financial situation has changed, determine eligibility under other categories of assistance for the family unit.
- E. If a child or adult has moved into the home:
  1. Determine if the new member would have been eligible to receive benefits in the discontinued "E" or "T" case or is Family MA eligible now; and
  2. Add the new member to the TMA case if eligibility exists. Eligibility begins with the first day of the month the new member is reported to the Agency.
- F. TMA cases cannot be transferred during a report month as there is a system edit which prohibits any case changes until a "TM" action is complete on KAMES. See [MS 2930](#) for reporting procedures.
- G. Do the following when a TMA case discontinues in error:
  1. Use supervisory override if the discontinuance occurred that day;
  2. Correct the information in the case that caused the discontinuance action; or
  3. Process an "E" or "T" application, which will deny and reestablish TMA eligibility by answering yes to the question, "Is Time-Limited appropriate?" Correct the TMA dates as needed to match the original TMA period. This is completed on the last disposition screen.]

MS 2990

JOB QUIT GOOD CAUSE CRITERIA

Good cause criteria for quitting employment for the TMA program are:

- A. The individual is personally providing care for a child under age 6 and employment requires the individual to work more than 20 hours per week.
- B. [Child care is necessary for the individual to accept employment and such care is not available. Good cause also exists if the available child care does not meet the special needs of a physically or mentally disabled child.
- C. The individual is unable to engage in employment for mental or physical health reasons, including participation in drug and alcohol rehabilitation.] In instances of drug or alcohol rehabilitation, the employer must certify that they will not hold the position vacant pending the individual's return. Require a doctor's statement to verify the medical condition in all cases.
- D. Unavailability of transportation with no readily accessible alternative means of transportation available.
- E. Travel time to the work site exceeds 2 hours daily.
- F. Illness of the recipient or another household member which requires the presence of the recipient. Require a doctor's statement.
- G. Temporary incarceration. Require verification from employer that they will not hold the position vacant pending recipient's release is required.
- H. Discrimination by an employer based on age, race, sex, color, disability, religious beliefs, national origin or political beliefs.
  - 1. A formal discrimination complaint must be filed.
  - 2. Good cause also exists during the period of investigation of a formal discrimination complaint.
- I. [Work demands or conditions that render continued employment unreasonable, such as consistently not being paid on schedule or the presence of a risk to the individual's health or safety.]
- J. Wage rates are decreased subsequent to acceptance of employment. A reduction in hours scheduled does not qualify.
- K. Acceptance of a better job which, because of circumstances beyond the control of the recipient does not materialize. This situation must be verified by the employer who offered the position.

Obtain documentation to support the claim of good cause. Obtain written verification, if possible. If written verification is not obtainable, use collateral contacts.

MS 3000

TMA FAIR HEARING REQUEST

If the recipient is not satisfied with any action taken by the agency on TMA eligibility, a request for a fair hearing may be made. [Follow existing hearing procedures.] See Vol. I, MS [0550](#).

Continue assistance for the assistance group if the recipient requests continuation of benefits and:

- A. [The household is ineligible for any other eligibility group;]
- B. The basis of the hearing request is the accuracy of the agency determination; and
- C. The hearing is requested in a timely manner.

MS 3010

[SPEND DOWN PROCESS

(1)

Spend down provides time-limited Medicaid to an individual or family who meets all resource and technical requirements of eligibility but has income in excess of the MA Scale for the family size. Eligibility is determined on a quarterly basis using the month of application and two following months or some or all of the three months prior to the month of application.

A household that includes an aged, blind or disabled parent can choose spend down determination that includes their spouse and children in Family MA or Adult MA for themselves. The worker should review the situation and explain the option which would be to the applicant's best advantage.

- A. Spend down Medicaid eligibility begins on the day an individual meets the spend down obligation amount; i.e., the day medical expenses equal or exceed the excess income amount. Advise recipients the spend down obligated amount is met with medical bills incurred by any case member during the spend down time period. The household's obligated amount is met with the first providers who bill Medicaid. Use medical expenses that are incurred during the quarter or currently owed from a prior period that was not previously covered by spend down or regular Medicaid.

Example: The spend down obligation amount is \$100.00 for the spend down period of 3/23/11 through 5/31/11. The household is responsible for payment of bills prior to 3/23/11 used to meet the obligated spend down amount, as well as the \$100 spend down obligation. If the first bill received by DMS is for services on 4/6/11 for \$50.00, the amount of that bill is deducted from the obligated amount of \$100.00. The next bill received by DMS is \$25.00 for services on 3/23/11, and a bill is submitted the same day to DMS for \$25.00 for services on 5/1/11. These are deducted from the obligated amount, the client is responsible for paying them, and the spend-down obligated amount is met. Any subsequent bills paid by DMS as long as the date of service is within the spend down period of 3/23/11 through 5/31/11.

- B. Notices for spend downs show the case obligation amount rather than the individual's obligation amount. The obligation amount is the amount the client must pay for the spend down time period.
- C. For spend downs processed by special circumstance, enter the household's obligated amount by each member of the case. The worker enters each member's spend down liability amount in the "SPD/LIAB" field on the Special Circumstance - 1 screen. The member spend down liability amount is the amount the member is obligated to pay on the date the spend down eligibility is met. For instructions on processing a special circumstance, refer to [MS 1520](#).

Example: A household's spend-down obligation amount is \$100.00. For each member listed, enter \$100.00 as the spend-down obligation amount.

Tom	# Jones	xxx xx xxxx	07021989	100.00
Shirley	# Jones	000 00 0000	10101989	100.00
Cutie	# Jones	111 11 1111	06062007	100.00

Workers will receive an error message, "SPD LIAB AMTS MUST BE EQUAL", if the spend down obligated amount is not entered as shown above.

For individuals with an active QMB cases, use the recipient status code "HH". For active SLMB cases use "S2". These recipient status codes will prevent the recipients from losing their QMB/SLMB benefits with the issuance of the spend down special circumstance. Individuals eligible for buy-in under the Qualified Individuals Group 1 (QI1) and Qualified Disabled Working Individual (QDWI) programs are not dually eligible and are allowed a medical deduction for the SMI premium. QI1 and QDWI recipients are to be advised that the SMI premium will be recouped for the months that they are eligible for the spend down.

- D. If health insurance coverage other than Medicaid exists, that insurance provider's payment for the incurred services must be determined prior to approving the spend down application. Only the amount the individual is responsible to pay can be considered towards the spend down excess. Because of the time involved in determining the insured's liability from the other insurance, Medicaid may not be approved, in some situations, until the eligible quarter has expired. Inform applicants of this possibility.
- E. When quarterly excess income equals verified recognized incurred medical expenses, paid or owed, the application may be approved on a time limited basis. Effective dates of coverage begin on a specific day and end of the last month approved.
- F. A spend down application is approved as soon as possible, but not to exceed 30 days from the date of application unless additional time is requested by the applicant. If a spend down application cannot be processed within 30 days due to additional time being requested or if it is the beginning of the spend down quarter and client's obligation for payment of bills has not been met, the application is held pending receipt of incurred expenses up to 90 days. Refer to [MS 1320](#) for cases pending over 30 days with good cause. When the verification is received, the case must be worked WITHIN 5 WORK DAYS from receipt of the required verification.
- G. Advise recipients they need to wait until they receive a statement from the provider that DMS has been billed, and the bill was denied for use in meeting the obligated amount, before they make any payments for services during the spend down timeframe. This is necessary to establish which provider bills are adjusted based on the family/member's obligation amount.
- H. If, after a determination has been made, additional verification of medical expenses is provided by the recipient, a re-computation is completed.

1. If it is determined that the spend down liability was met earlier in the quarter, complete a Special Circumstance Transaction to authorize Medicaid eligibility for the earlier date.
  2. If the re-computation results in the determination that the applicant met the spend down liability later in the quarter, no action is required.
- I. Complete MSE referral for Family MA spend down cases in the "L" category. If a MSE referral exists due to the children already receiving Medicaid, update the referral in that case instead of completing a new referral. For those spend downs issued by special circumstance if no MSE referral exists, complete a KIM-125 and forward to Child Support Enforcement (CSE).
  - J. If Medical expenses for the quarter are less than the quarterly excess income; deny the application.]

MS 3015 ESTABLISHING THE RETROACTIVE SPEND DOWN QUARTER (1)

[KAMES reviews for regular Medicaid eligibility before it determines spend down eligibility. Months to which medical expenses can be applied are broken up into quarters. Eligibility established for a RETROACTIVE quarter may include any of the three prior months from the month of application during which an applicant incurred a medical expense. Which months are included in the retroactive quarter is a decision left up to the applicant as eligibility may be established for only one or two months of the RETROACTIVE quarter even if there are medical bills in the other months.]

A. To determine eligibility for the RETROACTIVE quarter spend down the following must be VERIFIED:

1. The applicant must verify that MEDICAL EXPENSES were incurred in any of the retroactive months for which the spend down application is made. The medical bills used must be currently owed. The bills can be owed by any member of the Medicaid household even if that member is not applying for or receiving Medicaid. However, if the medical bills have been turned over to a collection agency, the bills are no longer considered as owed and cannot be used. Any bills already used in a previous spend down approval cannot be used again for the current application; and
2. The applicant must verify INCOME received in any of the retroactive months for which the spend down application is made.

B. CONSIDERATION

The application may or may not be approved as a RETROACTIVE quarter spend down depending on the income.

- a. If the applicant meets technical and financial eligibility and has an incurred medical expense in any of the three months prior to the application month, regular MA coverage is approved for those months. Check each month separately.

Example 1: A retroactive quarter spend down is established for Susie who has a household of 2. She had medical expenses for the RETROACTIVE quarter but only had \$200 monthly income for those three months. She now grosses \$1500 per month. Susie is currently over the standard Family MA size for 2 (\$267) and has no current quarter medical expenses therefore she is denied for ongoing MA. She was under the MA scale for the retroactive months therefore MA coverage is approved for those months.

- b. If the applicant does NOT meet income eligibility for any of the three months prior to the application month but meets technical and resource eligibility and has incurred medical expenses for one, two or three months, a spend down determination is made.

Example 2: A retroactive quarter spend down is established for Mark. He had medical expenses for the retroactive quarter and had \$1200 monthly income for those three months. Mark was over the MA scale for the retroactive months therefore he has a spend down liability.

### C. SYSTEM ENTRY

Income and medical expenses are entered on KAMES for the RETROACTIVE quarter the same as it would be entered for a regular Medicaid application. However, the disposition screens display eligibility differently depending on whether the application is denied or approved and what months of eligibility are issued:

- a. If the applicant does not have enough medical bills to meet spend down eligibility for any of the months in the retro quarter the application is denied.
- b. If the applicant meets eligibility for one or two months due to not having enough medical expenses, the applicant has the choice to change the spend down to a one or two month spend down. This option must be explained in order to prevent the applicant from wasting a spend down month. Explain that the bills that would have been used in the month they were actually incurred will now be used for the months for which eligibility is met. If the applicant chooses to complete a one or two month spend down complete the following on KAMES:
  1. Revisit the medical expenses screen (screen HRKIMA1E) and change the dates for the bills that would have been used in the denied month to the first day of the month of spend down approval;
  2. Change the "type" of medical bill that was previously entered to "14-Prior Medical Exp" and navigate back through the application.

Example: Timmy applies in September and has a household size of 3. He pays \$100 monthly childcare for his two sons. He has medical bills for June, July and August. He grossed \$1200 in June, \$800 in July and \$800 in August. After the appropriate deductions Timmy's liability for June is \$702, \$302 for July and \$302 for August.

Timmy had \$200 in medical bills in June, \$900 in July and \$700 in August. He is denied for June as he does not have enough medical bills to meet the June liability. He meets his spend down liability on 7/15/11.

After the worker discusses the advantages of changing the spend down from a three month period to a two month period

the case is re-worked. The "type" and "dates" for all of June's medical expenses are adjusted:

"type 01-Medical/Dental for 6/5/11, 6/9/11" are changed to "type 14-Prior Medical Exp., with the July date of 7/1/11.

Timmy will meet his spend down on 7/5/11 as the June bills combined with the first few July bills help meet his spend down sooner.

- c. Once the system has determined which months of Medicaid will be issued the eligibility system calculations for the RETROACTIVE quarter will display as follows:
  1. On the first disposition screen HRKIPC14, a regular twelve month certification period, like a regular MA application, will upload;
  2. On the second disposition screen HRKIPC15, the "actual" months a spend down card will be issued for is displayed. Based on the example above KAMES would show 07/01/11 – 09/1/11.
  3. On the third disposition screen HRKIPC19, enter a "Y" for the spend down month. The actual income considered and the excess for that month will display.
  4. On the fourth disposition screen HRKIPC35, will display:
    - a. The type of medical bill used to meet the spend down liability (i.e. 01-Medical/Dental, 14-Prior Medical Exp., etc);
    - b. The medical bill used to meet the spend down liability;
    - c. The date the spend down liability was met; and
    - d. The amount of the bill used to meet the spend down liability.
- D. A retroactive and current quarter can be processed simultaneously. When all information is verified, the system approves both quarters and discontinues the case. If the spend down liability is met for the retroactive quarter, but not for the current quarter, KAMES processes the retroactive Medicaid and leaves the current quarter pending. KAMES generates a Request for Information (RFI) to request verification of additional medical expenses for the current quarter spend down.

MS 3016 ESTABLISHING THE CURRENT SPEND DOWN QUARTER (1)

[KAMES reviews for regular Medicaid eligibility before it determines spend down eligibility. Months to which medical expenses can be applied are broken up into quarters. Eligibility established for a CURRENT quarter includes the current month and the two following months. The spend down liability for the current month and the following two months must be met before the current quarter spend down application is approved. The applicant is allowed until the last day of the current quarter to meet the current quarter spend down liability.]

Before initiating the CURRENT quarter spend down it is important that the applicant understands all options. If the applicant has one large bill to be paid and does not expect to incur bills in the next two months a CURRENT quarter spend down is not advisable. Explain to the applicant it is to their advantage to complete a retro quarter spend down as their obligation amount will be less. Refer to MS 3015. If the applicant chooses to wait to apply provide the applicant with an appointment date and time for them to return to complete the application and complete form PA-97 Add/Inquiry on KAMES. Document the PA-97 the reasoning for not taking the application.

If payment of the bills is of lesser importance to the applicant then having Medicaid coverage for all three months in the current quarter proceed with the CURRENT quarter spend down application.]

A. VERIFICATION

To determine eligibility for the CURRENT quarter spend down, verify the following:

1. The applicant must verify they have enough unpaid medical expenses to meet the liability for the entire current quarter. The medical bills can be old bills incurred in previous months however they must be currently owed. The bills can be owed by any member of the Medicaid household even if that member is not applying for or receiving Medicaid. However, if the medical bills have been turned over to a collection agency, the bills are not considered owed and cannot be used. Any bills used in a previous spend down approval cannot be used again for the current application; and
2. The applicant must verify INCOME received in the prior two months. If the applicant states that income received for the prior two months is not representative of ongoing, verification from the employer of ongoing income must be provided.

B. CONSIDERATION

1. If the applicant meets technical and resource eligibility for the CURRENT quarter spend down, KAMES averages and converts income received in the previous two months to calculate the spend down liability.

EXAMPLE: Jake applies for a current quarter spend down in June and has a \$3,000 medical bill for surgery in June. He anticipates more medical expenses for July and August. He pays \$100 per month in child care for his two sons. He grosses \$3500 per month. After KAMES takes the average of the prior two months of wages (\$3500) and subtracts the standard for a Family MA size of 3 (\$308) it calculates an excess of \$3192. KAMES applies the appropriate income deductions, the \$90 work standard and \$100 child care expense. KAMES determines the current quarter spend down liability to be \$3002 per month. Since all three months must be considered for a current quarter spend down Jake must incur \$9006 (\$3002x3) in medical bills during the current quarter (June, July, August) before the current quarter spend down can be approved.

Note: Applicants are allowed the entire current quarter to meet the spend down liability.

### C. SYSTEM ENTRY

1. Income and medical expenses are entered on KAMES for the CURRENT quarter the same as for a regular Medicaid application however the disposition screens will display eligibility differently depending on whether the application is denied or approved:
  - a. If the applicant does not meet spend down eligibility due to a lack of medical bills, KAMES pends the application for 90 days from the month of application in order to allow the applicant time to meet the spend down obligation. After the 90 days, if the obligation is not met KAMES denies the application.
  - b. If the applicant meets the current quarter eligibility, when the spend down obligation is met, complete the following system entries on KAMES to calculate the CURRENT quarter spend down obligation:
    - 1) Insert "L" in the field next to question "If case is denied/disc, explore eligibility in the following category";
    - 2) Answer "Y" in the field next to question "Is spend down calculation needed for current quarter?"; and
    - 3) Navigate back through the case as if it was being programmed down. Once the case is recalculated it will either pend if the liability is not met or approve/deny as appropriate.

Note: The current quarter spend down excess and liability calculations will not be displayed until 1-3 above is completed.

2. Once the system has determined eligibility the system calculations for the CURRENT quarter will display as follows:

- a. On the first disposition screen HRKIPC14 – the three month current quarter spend down period will display to show the dates of eligibility.
  - b. On the second disposition screen HRKIPC15 – an “A” for approval will be displayed next to the applicant’s name with a “Y” uploaded under “MAID”.
  - c. On the third disposition screen HRKIPC19 – the averaged/converted countable income, the excess for the current month and the combined three month excess that must be met before the case can be approved will display.
  - d. On the fourth disposition screen HRKIPC35, the following is displayed:
    - 1) The type of medical bill used to meet the spend down liability (i.e. 01-Medical/Dental, 14-Prior Medical Exp., etc);
    - 2) The medical bill used to meet the spend down liability;
    - 3) The date the spend down liability was met; and
    - 4) The amount of the bill used to meet the spend down liability.
- D. A retro and current quarter can be processed simultaneously. When all information is verified, the system approves both quarters and discontinues the case. If the spend down liability is met for the retro quarter, but not for the current quarter, KAMES processes the retroactive Medicaid and leaves the current quarter pending. A Request for Information (RFI) is generated to request verification of additional medical expenses for the current quarter spend down.

MS 3020 [CONSIDERING MEDICAL EXPENSES IN SPEND DOWN (1)

Spend down medical expenses are expenses incurred by an individual, a spouse or dependent child under 21 in the home or away from home for school attendance. Unless already receiving MA, these expenses are allowed regardless of whether or not these family members are included in the case and/or regardless of whether or not their income is considered in the MA eligibility determination.

Consideration of Medical Expenses:

- A. Consider any verified recognized medical expense(s) incurred DURING the established quarter. Begin with the first day of the quarter and list daily expenses.
- B. Consider the unpaid balance of any verified recognized medical expense incurred PRIOR TO the established quarter.
  1. Consider the expense as incurred on the first day of the first month of the established quarter.
    - a. Medical expense type code "14 – PRIOR MEDICAL EXP" on the Application Medical Expense screen is used to identify allowable unpaid medical expenses incurred prior to the established quarter. When using prior medical expenses to meet the spend down amount, always show the date the expense was incurred as the first day of the spend down quarter. If the spend down amount is met with prior medical expenses only, the member spend down liability will be \$0.
    - b. Unpaid medical expenses from a prior quarter must be verified as still owed. If the bill has been written off or has been paid by a third party, it cannot be used. If verification cannot be provided that the bill is still owed, it cannot be used to meet the spend down liability. The "SPD LIAB" (spend down liability) field on the third General Member Information Inquiry screen is uploaded with the member's spend down liability amount.
  2. Consider only the portion of the expense needed to obligate the spend down excess.
    - a. If consideration of a portion of the expense obligates the spend down excess, then the remaining balance of the expense can be used to obligate a future spend down excess. For these situations, annotate the amount used to obligate the excess for the established quarter, and the amount remaining for future spend down use in case comments.
    - b. Review the case record to ensure the medical expense has not been considered in a previous quarter to establish MA eligibility.

EXAMPLE: An individual's spend down excess for the current quarter is \$1,200. Two years ago, the individual incurred a

\$1,600 hospital bill, made a payment of \$100 leaving an unpaid balance of \$1,500. The \$1,200 portion of the hospital bill is considered on the first day of the first month of the current quarter for spend down. The remaining \$300 of the bill can be used to obligate a future spend down excess.

- C. Verified payments on medical bills for services when MA was not received are deducted if paid during the quarter.

EXAMPLE: Two years ago, an individual purchased an \$800 hearing aid and charged the full amount. Every month a \$25 payment is made on the account. The individual applies for a MA spend down case. Consider the \$25 as a recognized medical expense and record as a spend down expense the day the \$25 payment is made.

- D. When all verified recognized medical expenses presented by the individual are recorded, determine if, on any day in the quarter, the total amount of expenses for the period is as much as the excess income.

Verification of Medical Expenses:

- A. Medical bills or statements;
- B. Receipts for payment of medical expenses;
- C. Medicare Summary Notices (MSN) which shows covered/uncovered and paid/unpaid medical expenses;
- D. Health insurance statements showing amount paid;
- E. Other appropriate means.

Medical Expense Restrictions:

- A. Do not list any expense to be paid by a third party, such as Medicare, health insurance, insurance settlement, family members, etc.

EXCEPTIONS:

1. DO NOT hold spend down applications pending for verification of payment of medical expenses as a result of an unforeseen accident which may be covered by liability insurance owned by another person. It is the responsibility of DMS to obtain reimbursements from third party liability sources.

This procedure does not apply to health insurance policies, such as, Medicare, Blue Cross/Blue Shield, Humana, etc. and Worker's Compensation. Spend down applications are held pending verification of payment of medical expenses by these third party liability sources.

2. For persons undergoing renal dialysis treatment, do not hold spend down applications pending for Medicare Summary Notices (MSN) if:

- a. They have Medicare but no other health insurance; and
- b. The renal dialysis clinic provides a statement verifying the date of service, cost of service and the anticipated amount of Medicare reimbursement for each date of service. The difference between the Medicare billed amount and the anticipated Medicare payment amount is allowed as the spend down medical expense.

Use this statement and any other verified medical expenses that will not be reimbursed by Medicaid, such as prescriptions. Other verified medical expenses subject to Medicare reimbursement cannot be used to meet the spend down liability as the application is to be processed prior to receipt of the MSN.

These cases are given priority and processed as soon as the spend down liability is met. When MSN's are received for other medical expenses, the case is reworked at the individual's request, to determine if an earlier date was met for the spend down program.

- B. Do not consider medical expenses for which individual is absolved from payment, such as a medical bill written off by provider as uncollectible. If the medical expense is more than 90 days old, OR if the individual's responsibility for payment of the medical expense is questionable, the appropriate provider MUST be contacted to determine whether or not the individual is liable for payment of the expense.
- C. Do not consider medical bills or payment on medical bills used to obligate the liability amount for any previous spend down quarter.

EXAMPLE: During the current quarter, an individual purchased eyeglasses costing \$129. The total amount was charged on the 6th day of the 1st month of the current quarter. The total amount is considered on the 6th for spend down. During the next quarter, \$25 a month has been paid on the \$129 charge. The \$25 payments cannot be used as the entire \$129 was used in the quarter the expense was incurred.

- D. Unpaid medical expenses are allowed as a spend down medical expense unless B or C of this section apply.
- E. For the child excluded from a K-TAP grant and for whom a separate spend down case has been established:
  1. Combine income and resources of the K-TAP group and the excluded child.
  2. Apply verified incurred medical expenses of the excluded child.
  3. Apply uncovered verified incurred medical expenses of the responsible relative to the spend down amount.
  4. Do not consider medical expenses of the K-TAP children.

- F. For a blind or disabled child living at home:
  - 1. Consider income and deductions of the parent and the blind or disabled child according to Vol. IVA, [MS 1810](#); and
  - 2. Apply uncovered, verified, incurred medical expenses of the parent, blind, or disabled child and siblings to the spend down amount.
- G. All bills, statements, and receipts, must show the actual date of service and daily charge to determine the day the excess is met.
- H. Deductions for prescription drug expenses incurred during a period of Medicaid eligibility may be allowed ONLY if the recipient verifies that Medicaid denied coverage of the drug at the time, and that a prior authorization request was also denied. A deduction can be given for a Medicare Part D premium if paid by the recipient.]

MS 3025 [ALLOWABLE SPEND DOWN MEDICAL EXPENSES (1)

The following are allowable recognized medical expenses used in determining spend down eligibility:

- A. Health insurance premiums including SMI, and specified disease policies such as cancer and/or any other policies paying for services within the scope of the program. Consider the entire amount when paid or prorated payment for months of actual coverage, to the benefit of the individual whichever they choose.

EXAMPLE: A \$90 premium is paid July 15 to cover August, September and October. Allow \$30 for August 1, September 1 and October 1 or use the entire \$90 on July 15.

- B. Insurance policies paying specific benefits per day to an individual while hospitalized or during recuperation. Premiums paid on these policies are considered a medical expense.
- C. Nursing facility insurance premiums.
- D. Transportation expenses for health care that are not available free of charge. Costs for use of the individual's own car are deductible at the state rate per mile;
- E. The actual amount paid for caretaker, Family Care or Personal Care services if the individual is paying the private pay rate.

If medical expenses of a spouse are being considered and the spouse is receiving state supplementation payments then consider the payment for caretaker services as a medical expense.

- F. In-patient hospital services including services in institutions for tuberculosis, mental disease or other specialty hospitals regardless of age;
- G. Laboratory and x-ray services;
- H. Nursing Facility services, including services in institutions for tuberculosis or mental disease, for all individuals regardless of age;
- I. Any physician's services;
- J. Medical care or any other type of remedial care recognized under state law furnished by licensed practitioners within the scope of their practice as defined by state law;
- K. Home health care services, including intermittent or part-time services of a nurse or home health aide according to a physician's plan of treatment;

- L. Private duty nursing services by a Licensed Practical Nurse or Registered Nurse;
- M. Clinic services;
- N. Dental services, including dentures prescribed by a licensed and practicing dentist;
- O. Physical therapy and related services including supplies such as hearing aids;
- P. Drugs prescribed by a licensed physician, osteopath or dentist;
- Q. Prosthetic devices, including braces, and artificial limbs;
- R. Eye glasses and other aids to vision, prescribed by an ophthalmologist or an optometrist;
- S. Ambulance services when medically indicated and/or other transportation costs necessary to secure a medical examination or treatment;
- T. X-ray, radium and radioactive isotope therapy;
- U. Surgical dressings, splints, casts and other devices used for reduction of fractures and dislocations, including surgical dressings and related items, used at the direction of a physician for continuing treatment of a health problem;
- V. If not available from a Home Health Agency, rental or purchase of durable medical equipment including, but not limited to iron lung, oxygen tents, hospital beds, wheelchairs, crutches, braces and artificial limbs including replacements if required because of change in the patient's condition;
- W. Purchase, care and maintenance costs of Seeing Eye dogs;
- X. Consider the cost of lodging, which may include the lodging cost of a nurse/attendant, a necessary medical expense if it can be determined lodging was necessary to secure required medical service or treatment.
  - 1. Question the individual to determine if circumstances necessitated lodging and explain in case comments.
  - 2. If the need for lodging cannot be determined, request a physician's statement to verify reported expenses were actually medically necessary.
  - 3. The allowable amount may not exceed commercial lodging costs prevalent in area.

- Y. Incurred medical expenses paid by a public program of the State or a political subdivision without federally designated funds. Political subdivisions include city, county, or local governments. These medical expenses are also allowed as deductions for LTC, waiver and Hospice cases if MA eligibility is determined by exceptional spend down, Step II process.
1. Examples of public programs of the State include;
    - a. Hospitals such as, UK Medical Center, Humana University Hospital;
    - b. Health departments;
    - c. Community Service Centers;
    - d. Primary Care Centers operated by local health departments; and
    - e. Comprehensive Care Centers.
  2. Medical expenses paid by programs of the federal government, including Medicare and VA. Bills that have been written off as uncollectible are not allowable as spend down deductions.
  3. Obtain a copy of the bill to verify that a medical expense was incurred and that the expense was paid by a State public program or political subdivision without federally designated funds prior to allowing the deduction.
- Z. Any item verified by a doctor's statement that is medically necessary for controlling a patient's allergy problem. Items may include:
1. The purchase of electrostatic air filters;
  2. Humidifiers;
  3. Air conditioner;
  4. Central heating systems;
  5. Hardwood floors;
  6. Payment for carpet/upholstered furniture cleaning; and
  7. Carpet removal.
- AA. Other items clearly identified as medical in nature.
1. This includes:
    - a. Aspirin;
    - b. Antacids;
    - c. Peroxide;
    - d. Band-aids;
    - e. Nutritional supplements such as Ensure; and
    - f. Incontinent care products.

2. Cash register receipts are acceptable verification of the expense. If the receipt does not specify the item, the individual's statement is accepted.
- BB. Consider charges from a physician who is not enrolled in the Medicaid program as a medical expense on the date of service in the spend down calculation. While the expenses can be deducted, Medicaid cannot make payments to a physician who is not an enrolled provider.]

MS 3050

K-TAP OR E/T CASES DISCONTINUED  
DUE TO CHILD OR SPOUSAL SUPPORT

If the receipt of new or increased child or spousal support causes K-TAP or E/T ineligibility, the group may be entitled to MA for UP TO 4 additional months. The 4 months of MA begin with the first month of K-TAP or E/T ineligibility due to new or increased child or spousal support. Consider months when recoupment is appropriate, due to new or increased child or spousal support, as MA months.

- A. Requirements for MA continuation are:
1. K-TAP or E/T members were eligible for and received a K-TAP grant or AFDC Related MA correctly for 3 of the 6 preceding months; and
  2. Discontinuance is due wholly or in part to increased child or spousal support received.
- B. [If adjusted income is more than the MA Scale for the family size, discontinue the K-TAP or E/T case and provide Family MA.]
- C. Consider any of the following changes occurring during the extended eligibility period. These changes affect the number of MA months:
1. Addition of a child born during this period;
  2. Removal of a member who becomes technically ineligible; or
  3. Entire assistance group becomes technically ineligible during the extended eligibility period, because deprivation no longer exists, increase in other income, or increase in resources.

MS 3100

["I" CATEGORY

Consider household composition as outlined below to determine how to consider income in the "I" category.]

- A. If the "I" child is living with:
  1. The parent, consider income of the parent and the "I" child in determining financial eligibility.
  2. The legal guardian who meets the definition of SR and is also included in the case, consider income of the legal guardian and the "I" child in determining financial eligibility.
- B. If a minor parent who is included in the case is living with his/her parent, determine the parent's surplus income and deem surplus of the parent to minor parent.
- C. If a pregnant woman including a minor pregnant woman, is living with her spouse, including spouse who is a minor, consider income of the pregnant woman and the spouse in determining financial eligibility.
- D. If living with anyone other than one or both parents, income of the child included in the "I" case must be considered in determining financial eligibility.
- E. Compare to the 100%, 133%, 150%, 185% or 200% of Poverty Level MA Scale for the appropriate MA family size. If advantageous to the assistance group, the MA family size may include individuals in the home such as:
  1. A sanctioned SR;
  2. Technically excluded children;
  3. Any or all other MA eligible children including deemed eligible newborns and/or potentially MA eligible children.
- F. An SSI recipient, parent or child, is a technically excluded individual but is not eligible to be included in the MA family size.
- G. Do not consider resources in determining MA eligibility in the "I" category.

MS 3110

["L" AND "N" CATEGORIES]

When determining MA eligibility in the "L" and "N" categories, follow the guidelines below:

- A. Consider resources and income of the following when living in the home:
  1. Children included in case;
  2. Responsible SR, natural or adoptive parent, even if sanctioned;
  3. Spouse of responsible SR;
  4. Spouse of child included in the case;
  5. Nonresponsible SR when included in the case; and
  6. Spouse of nonresponsible SR when the nonresponsible SR is included in the case.
- B. For a spend down on a pregnant woman with no other children, including a minor pregnant woman, and living with her spouse, including spouse who is a minor, consider income of the pregnant woman and the spouse in determining financial eligibility.
- C. If a minor parent included in the case is living with:
  1. His/her parent, determine the individual's surplus income and deem parental income to the minor parent.
  2. The legal guardian who meets the definition of SR and is not included in the case, determine the legal guardian's surplus income and deem legal guardian income to minor parent.
- D. If the spouse of a responsible SR is a stepparent and not included in the case, consider stepparent's income and resources to determine eligibility of the SR. DO NOT consider stepparent surplus available to the spouse's children.
  1. For households containing a member with income who is a parent to one child, and a stepparent to another child, and the result will be one case, the member's income is budgeted as parental income to all members in the case.
  2. For situations resulting in separate cases, consider the income as parental income in the case containing the member's child, and as stepparent income in the case containing the stepchild.

- E. If a child included in the case is living with the legal guardian who is also included in the case, consider income of the legal guardian and the child in determining financial eligibility.
- F. [For cases containing an SR only, consider only the resources and the income of the SR. The children's resources and income are not considered in determining eligibility of the parent since children are not financially responsible for their parents.]
- G. Compare to resources and income limits for MA family size. If advantageous to the assistance group, the MA family size may include individuals in the home such as:
  - 1. The sanctioned SR;
  - 2. Technically excluded member; and
  - 3. Any or all other MA eligible children including deemed eligible newborn and/or potentially MA eligible child.

MS 3120

"P" CATEGORY

[When determining Medicaid eligibility for children committed to the Cabinet for Health and Family Services, do not count parental income and resources against the child.] These children are considered to be in foster care and are not legally under the control of their parents. Consider only the income and resources of the committed child in the eligibility determination. This applies even if the child is living in the home of the parent, including the parent residing out-of-state during a trial placement or while awaiting an appropriate placement. [The Department for Community Based Services, Division of Protection and Permanency (DPP) designated worker is responsible for processing the Medicaid application.]

Allow appropriate income deductions according to policy for Family MA.

MS 3130

U CATEGORY

[A special category of assistance is available to children admitted to a psychiatric facility, Institute for Mental Diseases (IMD) or Psychiatric Residential Treatment Facility (PRTF) if not eligible under any other category of Medicaid. The first 30 days of the stay is not covered under the "U" category. [See MS 2670](#). Determination of eligibility for "U" cases is the responsibility of Central Office.]

MS 3140

"Y" CATEGORY

The following guidelines are to be used when determining financial eligibility in the "Y" category:

- A. Consider resources and income of the following individuals when living in the home and included in the case:
  1. Children; and
  2. An "I" ineligible pregnant woman, including a minor pregnant woman.
- B. If a "Y" child is living with the parent, consider income and resources of the parent and the "Y" child, in determining financial eligibility. If a "Y" child included in the case is living with the legal guardian who meets the definition of SR and is also included in the case, consider income of the legal guardian and the "Y" child in determining financial eligibility.
- C. [If a "Y" minor parent included in the case is living with: ]
  1. His/her parent, determine the parent's surplus income and deem surplus income to the minor parent. Consider the resources of the parent available to the minor parent.
  2. The legal guardian who also is included in the case, determine the legal guardian's surplus income and deem legal guardian income to minor parent.
- D. [If a "Y" child is living with anyone other than one or both parents, consider ONLY the income and resources of the "Y" child in determining financial eligibility.
- E. If an "I" ineligible pregnant woman, including a minor pregnant woman, is living with her spouse, including a spouse who is a minor, consider income and resources of the "I" ineligible pregnant woman and the spouse in determining financial eligibility.
- F. If a "Y" child is living with his/her spouse, including a spouse who is a minor, consider income of the spouse in determining the "Y" child's financial eligibility.]
- G. Compare to income and resource limits for MA family size. The MA family size may also include any or all other MA eligible children and/or other potentially MA eligible children in the home. Consider the income and resources of any individuals included in MA family size.

MS 3150

AGED, BLIND, OR DISABLED RECIPIENT  
WITH DEPENDENT CHILD

- A. Living together.
  - 1. Consider resources and income of MA family.
  - 2. Compare to resources and income limits for MA family size.
- B. Living apart due to reasons other than institutionalization of one spouse, both applying for or receiving MA.
  - 1. [For the Family MA case: ]
    - a. During the month of separation, consider the income and resources of the parent and dependents included in the case and income and resources of the aged, blind or disabled parent.
    - b. The month after the month of separation, consider only the income and resources actually made available to the family by the aged, blind or disabled parent.
  - 2. For the Aged, Blind or Disabled parent:
    - a. [Consider income and resources of the aged, blind or disabled parent and the income of the Family MA parent for the month of separation.]
    - b. The month after the month of separation, consider only the income and resources of the aged, blind or disabled parent.
- C. Living apart due to reasons other than institutionalization, one spouse applying for MA.
  - 1. For the month of separation, consider and compare resources and income in relation to MA family size, including the parent living apart.
  - 2. After the month of separation, consider and compare resources and income in relation to MA family size, excluding the parent living apart.
- D. Living apart due to institutionalization of one spouse with a community spouse and dependents.
  - 1. In the month of separation:

- a. Consider the gross income of the couple and dependents;
  - b. Consider the couple's resources as available to the institutionalized spouse; and
  - c. Include the institutionalized spouse in the MA family size.
2. The month after the separation month:
    - a. Consider the community spouse's income and dependent's gross income. Include the verified amount actually contributed by the institutionalized spouse;
    - b. Consider only the household's resources, including any actually contributed by the institutionalized spouse; and
    - c. Exclude the institutionalized spouse from the MA family size.
3. Refer to Volume IVA, MS [3550](#) to determine MA eligibility and patient liability for the institutionalized individual. For resource consideration for the institutionalized spouse, see Volume IVA, MS [2120](#).

MS 3160 [K-TAP/FAMILY MA PARENT OR CHILD IN LTC]

- A. [Consider resources and income in Family MA case for up to 1 year.]
- B. When it becomes apparent separation will last more than 1 year:
  - 1. Consider resources and income on basis of living apart.
  - 2. Determine technical eligibility for aged, blind or disabled individual.
  - 3. Establish a separate J, K, or M case for the aged, blind or disabled parent/child.
- C. [When separate cases are established, remove the aged, blind or disabled parent/child from the K-TAP/Family MA case.]

MS 3250

INTRODUCTION TO RESOURCES

Resources are generally defined as those assets which an individual or family own and are available, either directly or by sale or conversion, to meet basic needs of food, clothing, and shelter.

- A. Liquid resources are defined as:
  - 1. cash;
  - 2. checking and savings accounts;
  - 3. certificates of deposit;
  - 4. stocks/bonds; and
  - 5. money market accounts.
- B. A resource can be considered unavailable if the client cannot obtain, withdraw, sell, or liquefy it without third party action. Do not consider resources available when litigation is pending to determine to whom resources belong. Exclude resources as long as they are unavailable.
- C. For AFDC Related MA and Family MA cases, except "I" cases, consider the value of total combined liquid assets and compare to the appropriate resource limit listed below.

[RESOURCE LIMITS	
Family Size:	("L", "N", "P", "U", "Y" Cases)
1	\$ 2,000
2	\$ 4,000
3 or more	Add \$50 for each additional member.

If total countable resources are within or below the limits when the application or recertification is processed, the case is resource eligible. If total countable resources exceed the limits when the application or recertification is processed, the case is resource ineligible. If over the resource limit and the application is denied or, the recertification is discontinued, KAMES will send a timely notice of action. If, during the month of discontinuance or denial, resources are reduced to or below the appropriate limits without transferring resources to establish eligibility, take a reapplication when the recipient reports the decrease in resources. ]

- D. The "I" category does NOT have a resource limit.
- E. All IM cases with vendor payment are subject to a penalty for transfer of resources (Refer to OM Vol. IVA, [MS 2050](#)) except for the following levels of care:

1. Hospice Non-Institutionalized;
2. Hospice Institutionalized;
3. Mental Health/Psychiatric Facility;
4. PRTF; and
5. EPSDT.

MS 3260

RESOURCE PROCEDURES

- A. DO NOT consider transfer of resources unless the case includes an institutionalized individual. Refer to Vol. IVA, [MS 2050](#) for additional information.
- B. Do not count the current month's income as both income and a resource. For example, if income for the current month is deposited in a bank account, deduct that amount from the account balance to determine actual resources.
- C. If resources exceed the appropriate limits, reduce the countable resources by any verified liability against it, such as outstanding checks written against an account.
- D. If total countable resources are equal to or less than the appropriate limits when an application or recertification is processed, the case is resource eligible for that month.
- E. If total countable resources exceed the appropriate limits when an application or recertification is processed, the case is resource ineligible. In this situation, deny the application or send timely notice to discontinue an active case.
- F. If resources are reduced to the appropriate limit during the month of discontinuance or denial and there is no institutionalized individual or community spouse who transferred resources to establish eligibility, the case is resource eligible, as appropriate, for that month if reapplication has been made. [The following levels of care are exempt from transfer of resource policy in AFDC Related MA and Family MA cases: Institutionalized or Non-institutionalized Hospice; Mental Health/Psychiatric Facility; PRTF; and EPSDT.]
- G. If resources are near the maximum, verify and document resources each month for 3 months following approval. Inquire if an individual has medical bills in the 3 months before the month of application. If so, determine retroactive eligibility on a month-by-month basis for that period also.
- H. ALL resources MUST BE verified and documented before authorizing case action to assure the individual meets financial requirements. Verify and document resources in case record:
  1. At initial eligibility determination and for 3 months prior to application month;
  2. [At recertification the most current statement for a resource is required to assure resources were within the appropriate limits during that time;] and

3. Set up a monthly spot check for at least 3 months anytime resources are near the appropriate limits at approval or recertification.

MS 3290

JOINTLY HELD RESOURCES

These are resources owned or held by more than one individual. If the individual states that he/she does not contribute to or withdraw from a jointly held resource, allow the individual the opportunity to rebut ownership.

A. VERIFICATION OF JOINTLY HELD RESOURCES

Verify that the resource is not available or is no longer jointly held. Verification includes:

1. Statement from the other owners;
2. Statement from the business or financial institution;
3. Copy of contract governing the liquidation of the resource;
4. Copy of pending litigation affecting the availability of the resource;  
or
5. Copy of court order or agreement concerning the availability of the resources.

Document in case record the amount of the resource and type of verification used.

B. CONSIDERATION OF JOINTLY HELD RESOURCES

1. Total amount of joint checking/savings account is available to the individual when only one signature is required to withdraw funds.
2. When more than one signature is required to withdraw funds from joint checkings/savings account, only the individual's share is available. Establish the share by a signed statement from other parties as to the division. If the other owner refuses to cosign to make the resource available, do not count the resource. Obtain verification that the other owner refuses to sign.
3. If more than one of the account holders is an eligible individual, divide the funds equally among the eligible individuals when determining resources. Use this policy even if all the funds in the account were deposited by an ineligible individual and the eligible individuals have never made a withdrawal from the account.
4. Consider no resources available when the parties of the jointly held resource are not willing to release their portion of the resource or one party cannot be contacted for a release of their portion. Verify that litigation would be required or is pending, to

determine to whom a resource belongs. Spot check monthly or in the month litigation is expected to be completed.

- [5. For a Family MA case member who enters LTC, AIS/MR, ICF/MR/DD, HCBS or HCBS Model Waiver 2, apply policy outlined in Volume IVA, [MS 1820](#).]
6. Do not consider the resource available beginning with the month the individual's name is removed from the account.

C. VERIFICATION OF REBUTTAL OF JOINTLY HELD RESOURCES

In order for the individual to rebut the ownership of jointly held resources, individual must provide:

1. A written statement from the client regarding ownership, who deposits and withdraws; and
2. A written statement from each of the other account holder which corroborates the individual's statement, unless the account holder is a minor or is incompetent; and
3. Verification the individual's name has been removed from the joint account.

MS 3330

LIFETIME CARE AGREEMENT

This is an agreement entered into with another individual or organization for lifetime care of an individual or family in exchange for resources of the individual or family.

A. CONSIDERATION OF LIFETIME CARE AGREEMENT

1. If resources are still available to the individual or organization with whom the agreement is made, case is ineligible.
2. If individual or organization holding agreement provides written statement resources have been exhausted, compute current resources to determine if within the resource limit.

B. VERIFICATION OF LIFETIME CARE AGREEMENT – is a copy of agreement or statement from organization or individual providing care.

[C. The Department for Medicaid Services (DMS) will review all lifetime care agreements for the determination of Medicaid eligibility at applications and recertifications. DMS will advise how the agreements are to be considered in each determination. Please use the following procedures for forwarding a lifetime care agreement for consideration:

1. For all applications and recertifications, that include a lifetime care agreement, make two copies of the agreement document(s). Retain a copy of the agreement for the case record.

Note: For recertifications, do not send a lifetime care agreement that has been previously reviewed by DMS staff unless changes have been made to the agreement.

2. Ensure that any attachments listed in the lifetime care agreement have been provided. If any part of the agreement or attachments is missing, request the missing information from the client and submit the agreement when everything is in order.
3. Forward the complete lifetime care agreement even if the case is pending for additional information. Mail complete copies on a daily basis to assure processing timeframes are met.
4. MSBB forwards the copy of the lifetime care agreement to DMS for review. MSBB maintains a log of the documents received for tracking and response purposes.
5. Following completion of the review, DMS notifies MSBB staff regarding consideration of the agreement. MSBB staff will send this information in writing to the worker with a copy to the Program

Specialist. The copy of the lifetime care agreement will not be returned.

6. For applications, hold the application pending until response from DMS is received. DMS will give priority to lifetime care agreement reviews for applications.
7. For recertifications, do not hold a recertification pending for receipt of the agreement review response. Complete any case action necessary as a result of the review response with the next administratively feasible month.
8. Questions concerning the status of a lifetime care agreement review are to be directed to the supervisor, MSBB.]

MS 3340

LIQUID ASSETS

A. TYPES OF LIQUID ASSETS

1. Cash, checking accounts;
2. Savings accounts, certificates of deposits;
3. Stocks, mutual fund shares, bonds; and
4. [Money market accounts.]

B. CONSIDERATION OF LIQUID ASSETS

1. Deny or discontinue the case when resources are in excess of the maximum, when the case is processed.
2. Conversion or sale of any resource is not income but a change in type of resource.
3. The value of stocks, mutual fund shares, and bonds is based on market value on date verified.
- [4. Consider the portion of interest on interest-bearing checking and savings accounts remaining after the month of receipt, as a resource beginning the month after the receipt month.
- 5.] Consider as a countable resource the total value of a certificate of deposit (CD) including the interest which is posted to the CD and not paid directly to the individual owner of the CD.

C. VERIFICATION

If resources are declared, the applicant must make available the appropriate document, such as:

1. Statements from banks or other financial institutions;
2. Checking account statements;
3. [Savings account statements; or]
4. Stocks, bonds or certificates of deposit.

MS 3370

SSI ESSENTIAL PERSON RESOURCES

- A. Consider resources of SSI essential person, spouse or nonspouse.
- B. Document in case record the amount of the resource and type of verification used.

MS 3380

STEPPARENT RESOURCES

These relate only to eligibility of the parent as SR.

A. CONSIDERATION OF STEPPARENT RESOURCES

1. If the stepparent's countable resources exceed the resource limit for the stepparent family size plus SR, exclude the SR.
2. If resources are held jointly by the parent and stepparent, consider the parent's share, as determined according to MS [3330](#), as available to the assistance group regardless of whether the SR is included.

B. VERIFICATION OF STEPPARENT RESOURCES

Document in case record the amount of the resource and type of verification.

MS 3400

EXCLUDED RESOURCES

(1)

Excluded resources are assets, which are not counted in determining eligibility. Excluded resources are:

- A. Home. Proceeds from the sale of a home for 6 months from date of receipt of proceeds, if the intent is to use them to purchase another home.
- B. All vehicles.
- C. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.
- D. Household equipment and personal effects.
- E. Equity value of all equipment, including tools, machinery, livestock, or other inventory used in a farming or self-employment enterprise.
- F. All non home property.
- G. All resources of an SSI Individual.
- H. Burial space items including conventional gravesites, crypts, mausoleums, urns, vaults, caskets, headstones, and the cost of opening and closing the grave.
- I. Term and burial insurance policies
- J. Value of a prearranged funeral contract provided for through the purchase of life insurance policy with an irrevocable assignment of ownership of the insurance policy to the funeral home.
- K. The value, in an amount considered reasonable to cover burial costs, of prearranged funeral contracts with an irrevocable funeral trust agreement.
- L. All burial reserves.
- M. Cash, including interest accruing from cash, or an in kind item received to repair or replace a damaged, lost or stolen excluded resource. Allow 9 months to repair or replace the excluded item and an additional 9 months when the individual shows good cause.
- N. IRA's, KEOGH plans, deferred compensation, tax deferred retirement plans and other tax deferred assets. Consider amounts withdrawn as nonrecurring lump sums. If funds from the IRA are available for withdrawal due to age or disability, individuals must access the funds. In this situation the money received is other unearned income and payments are pro-rated over the period they are intended to cover. For example: the individual receives quarterly disbursements. The gross amount is divided by 3 to determine the monthly income.
- O. Property sold on a land contract being purchased by an individual.

- P. Loans. If a commercial loan contract, or form PAFS-73, Verification of Contributions - Loans - Roamer/Border Payments, is received, exclude the loan amount. If verification is not received, count the loan amount as a contribution.
- Q. Up to \$12,000 to Aleutians and up to \$20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardships experienced during World War II. All recipients of these payments are provided with written verification by the federal government.
- R. Life estate interest in real estate property or other property, such as an oil lease.
- [S. All payments received from Agent Orange.]
- T. Earned Income Credit (EIC) payments in the month of receipt and the following month.
- U. Victim compensation payments received from a fund established by a state to aid victims of crime. The individual must show that the amount was paid as compensation for expenses incurred or losses suffered as a result of a crime. Exclude these payments for nine months for pain and suffering purposes. Also, exclude payments received for losses and incurred expenses, such as lost wages or property, and medical treatment completely.
- V. State relocation assistance received for relocation assistance provided by a state or local government. This state assistance must be comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970 which is subject to the treatment required by section 216 of such Act.
- W. Any payments received from the Radiation Exposure Compensation Trust Fund.
- X. 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.
- Y. Interest on burial reserves.
- Z. With Self-Employment/Farming annualized income, exclude the balance of the yearly payment during each of the months the prorated amount is counted as self-employment income.

Example: A tobacco farmer, after all expenses, receives \$6,000 for his crop in January and deposits this sum in his bank account until needed for the next year's crop. The \$6,000 is prorated over a 12-month period and \$500 self-employment income is considered in the case. The yearly payment (\$6,000) is excluded as a resource during the period the prorated amount is counted as self-employment income.

- AA. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their

financial eligibility determined using SSI standards. This resource is NOT excluded by SSA, so these recipients should not be SSI eligible. If the hemophiliac is resource ineligible, pend the application and contact the Medical Support and Benefits Branch through your Regional office for further instructions.

- BB. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.

MS 3450

INCOME SCALES

(1)

INCOME is money received from sources including, but not limited to wages, self employment, child support, nonrecurring lump sums, and statutory benefits such as Unemployment Insurance Benefits (UIB), RSDI, and VA. Income may be earned or unearned, and must be verified and documented at each application, recertification, and when changes regarding income are reported.

- A. Gross countable income is compared to the appropriate MA Scale.
- B. MA SCALE FOR "L", "N", "P", "U", "Y" CASES EFFECTIVE 7/1/89:

Size of Family	Annual	Monthly	Individual Share
1	2,600	217	
2	3,200	267	134
3	3,700	308	103
4	4,600	383	96
5	5,400	450	90
6	6,100	508	85
7	6,800	567	81
8	7,520	627	78
9	8,240	687	76
10	8,960	747	75
Each Additional Member	+720	+60	Divide by Number of Members

[C. MA SCALES FOR "I" CASES EFFECTIVE 1/1/13

CHILDREN AT LEAST AGE 6  
BUT UNDER AGE 19: (P1)

PREGNANT WOMEN AND CHILDREN  
UNDER AGE 6: (P2)

100% of Poverty Level MA Scale

133% of Poverty Level MA Scale

Size of Family	Monthly Income Limit
1	\$ 958
2	\$1,293
3	\$1,628
4	\$1,963
5	\$2,298
6	\$2,633
7	\$2,968
8	\$3,303

Size of Family	Monthly Income Limit
1	\$1,274
2	\$1,720
3	\$2,165
4	\$2,611
5	\$3,056
6	\$3,502
7	\$3,947
8	\$4,393

Add \$335 for each additional member.

Add \$446 for each additional member.

TMA, PREGNANT WOMEN AND  
CHILDREN UNDER AGE 1: (P3)CHILDREN AGE 6 TO 19 YEARS:  
K-CHIP (P5)

185% Of Poverty Level MA Scale

133% of Poverty Level MA Scale

Size of Family	Monthly Income Limit
1	\$1,772
2	\$2,392
3	\$3,011
4	\$3,631
5	\$4,251
6	\$4,871
7	\$5,490
8	\$6,110

Size of Family	Monthly Income Limit
1	\$1,274
2	\$1,720
3	\$2,165
4	\$2,611
5	\$3,056
6	\$3,502
7	\$3,947
8	\$4,393

Add \$620 for each additional member.

Add \$446 for each additional member.

CHILDREN AT LEAST AGE 1  
AND UNDER AGE 19: K-CHIP (P6)CHILDREN UNDER AGE 19:  
K-CHIP III (P7)

150% Of Poverty Level MA Scale

200% of Poverty Level MA Scale

Size of Family	Monthly Income Limit
1	\$1,437
2	\$1,939
3	\$2,442
4	\$2,944
5	\$3,447
6	\$3,949
7	\$4,452
8	\$4,954

Size of Family	Monthly Income Limit
1	\$1,915
2	\$2,585
3	\$3,255
4	\$3,925
5	\$4,595
6	\$5,265
7	\$5,935
8	\$6,605

Add \$503 for each additional member.

Add \$670 for each additional member.]

- D. If total countable income is equal to or less than the appropriate MA scale, income eligibility is met.
- E. If total countable income is greater than the appropriate MA scale, the case is income ineligible. Explore spend down in the "L", "N", or "Y" categories. Spend down is NOT appropriate for the "I" category.

MS 3460

INCOME ROUNDING

Use the rounding procedures as follows.

A. For unearned income:

1. Use the gross **ROUNDED** amount of continuing, stable unearned income received on a monthly basis, such as statutory benefits.
2. For interest income, contributions or other types of nonstable unearned income, use the **ROUNDED** average of amounts received in the three prior months.
3. Complete all rounding before and after each calculation for income and deductions.
4. Round all cents before adding or multiplying weekly, biweekly, semi-monthly, monthly, quarterly or annual income. When rounding, \$.50 to \$.99 is rounded up to the next dollar.
5. [DO NOT round cents before adding or multiplying hourly or daily income.]

B. For earned income, determine gross monthly wages. When rounding, \$.50 to \$.99 is rounded up to the next dollar. DO NOT round cents before adding or multiplying hourly or daily earnings. Round before adding or multiplying weekly, bi-weekly, semi-monthly, monthly, quarterly or annual amounts, and round the results.

To obtain the monthly income amount for:

1. **HOURLY** - Multiply the number of hours in the pay period by the hourly rate and round to the nearest dollar.
2. **WEEKLY** - Round weekly income to nearest dollar. Combine rounded weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 3 and round result to nearest dollar.
3. **BI-WEEKLY** - Round to nearest dollar. Combine rounded bi-weekly amounts, average, and round to nearest dollar. Multiply by 13, divide by 6 and round result to nearest dollar.
4. **SEMI-MONTHLY** - Round to nearest dollar, average and round, and multiply by 2.
5. **MONTHLY** - Round to nearest dollar.

C. For self-employment:

1. Round actual dollar and cent amount of gross income to the nearest dollar (\$.01-.49, round down; \$.50-.99, round up) and divide by 3 or 12 months, or the number of months in operation, whichever is appropriate, to arrive at the gross monthly amount. Round the gross monthly amount to the nearest dollar.
2. Round actual dollar and cent amount of expenses to the nearest dollar and divide by 3 or 12 months, or the number of months in operation, whichever is appropriate, to arrive at the monthly amount. Round the monthly amount to the nearest dollar.

3. Subtract monthly expenses from monthly gross income. Round the result, which is the net profit, to the nearest dollar.

D. Round total of each type of other earned income to nearest dollar.

MS 3470

VERIFICATION OF ZERO INCOME

(1)

[Client statement of no income is accepted in all categories of Medicaid assistance. Verification of zero income is not required for any member of the household, including the head of household, unless questionable.]

For individuals whose statement of no income is accepted, enter "N" to the KAMES question "Is proof of no income required?" with no verification source needed. Document case comments that client statement of no income is acceptable.

If the client's statement of no income is questionable, enter "Y" to the KAMES question "Is proof of no income required?" and request verification by form PAFS-702, Proof of No Income, a signed statement, or a collateral contact. Document case comments thoroughly.]

\*MS 3471 ELECTRONIC INCOME VERIFICATION (EIV) (1)

Electronic Income Verification (EIV) is a method of obtaining verification of a client's earned income online. An online service may be used to assist clients when verification of earned income is not readily available and the client advises the worker that the income is available by a free on-line service. See Volume I, [MS 0131](#).

It remains the client's responsibility to provide verification of earned income if information from the online service is incorrect or incomplete.

Some online services may have gross wages and tip income combined, therefore, since the income is not separated, workers must request check stubs and a daily tip log. See Volume IV, [MS 3720](#).

If the client receives bonuses included in the gross amount that are not expected to continue, the client must provide check stubs to verify earned income.

If the client receives paid overtime included in the gross amount and which is not expected to continue, the client must provide check stubs to verify earned income.

MS 3500

INTRODUCTION TO UNEARNED INCOME

UNEARNED INCOME is money received, which does not involve direct physical activity by the individual.

Verify income at each application, recertification and interims involving an income change, before authorizing case action. Explore the possibility of withheld income information. Document amount and type of verification in case record.

[To verify zero income, see [Volume IV, MS 3470](#).]

MS 3520

## ANNUITIES

An annuity is an investment from which an individual receives fixed payments for a lifetime or a specified number of years. Payments received are considered unearned income. If the recipient has access to the principal of the annuity, regardless of penalty for early withdraw, the principal is a countable resource. All annuities are submitted to DMS by use of form MAP-4104, Annuity Transmittal. Please send the annuities, under cover of form MAP-4104, to the Medical Support and Benefits Branch (MSBB), 275 E. Main St., 3E-I, Frankfort, KY 40621. The documents may also be faxed to (502) 564-4021. DMS will advise how the annuity is to be considered in the MA case. MSBB will forward the DMS response to the worker. Refer to [MS 1320](#), for cases pending over 30 days with good cause.

[For more detailed procedures of how to submit an annuity to DMS, refer to [Vol. IVA, MS 1890](#). This manual section will also provide details regarding annuity beneficiary designation as a result of the Federal Deficit Reduction Act of 2005 (DRA).]

MS 3530

[FAMILY MA CHILD AND SPOUSAL SUPPORT

Child and/or spousal support income is the amount of legally established or voluntary child/spousal support regularly received by the applicant/recipient. Voluntary payments are payments made by a legal, alleged or adjudicated parent without a court order for support. If court ordered, the child support and spousal support may be in two separate orders. When child and/or spousal support is court ordered, it can be considered as non-continuing only if terminated by a court order and months of zero receipt are verified. Any amount of a military allotment designated as child/spousal support is considered as child/spousal support.

A. VERIFICATION

Verification includes court records, checks or statement from the Non-Custodial Parent (NCP), KASES etc. Use the column "DATE" on the KASES Benefit Summary Inquiry Screen to determine the month of receipt.

If child support is being paid through CSE:

1. Use the KASES Accounting Function, "05" to determine if child/spousal support is paid.
2. Select option "21", Benefit Summary to display the Benefit Selection Inquiry screen.
3. Select the appropriate IVD# to display the Benefit Summary Inquiry screen.
4. Use the column "DATE" on the KASES Benefit Summary Inquiry Screen to determine the month of receipt.
5. Access KASES during the interview, and review the amounts appearing on the KASES Benefit Summary Inquiry Screen with the individual. If the individual states they have not received a payment listed in the \$CSUP FAMILY or \$ARR FAMILY column, contact CSE staff or the contracting official to resolve the discrepancy.

B. CONSIDERATION

All child support is designated for a specific child. When calculating child support, deduct the \$50 disregard of support income received for a child applying for or receiving MA. If more than one case, divide by the number of cases in which child support income is received. If there is more than one child in a case receiving child support from more than one NCP, the \$50 disregard is divided per child.

Note: Sometimes it is more advantageous to place siblings into separate cases or to allow a larger share of the disregard amount in one case. However, only one disregard is given regardless of the number of cases. A portion of the disregard must be allowed in each case.

1. If the amount of child support is representative of ongoing income consider as follows:
  - a. Manually calculate the total amount of child support for the 3 prior months (do not round) and average the total to get the average monthly amount (do not round).
  - b. Deduct the \$50 disregard from the average monthly amount before entering the amount on KAMES.

EXAMPLE #1:

Two children in a case receive child support from the same NCP. KASES shows child support paid for both children as follows:

April	\$105
May	\$125
June	\$125
Total	\$355

The 3 months total (\$355) is divided by 3 which equal \$118.33. Subtract the \$50 disregard (\$118.33-\$50.00=\$68.33). The total (\$68.33) is divided by 2 children which equals \$34.16. \$34.16 is entered on KAMES for each child.

Example #2: Three children receive child support from three different NCP's. The \$50 disregard is divided per child. Calculate as follows:

	Child 1	Child 2	Child 3
April	\$ 50	\$ 25	\$ 60
May	\$ 50	\$ 40	\$ 50
June	\$ 75	\$ 55	\$ 50
Totals	\$175	\$120	\$160

$\$50 \text{ disregard} \div 3 = \$16.66$  round it up to \$17.

Child 1

$\$175 \div 3 = \$58.33$  monthly average - \$17 disregard = \$41.33 is considered.

Child 2

$\$120 \div 3 = \$40$  monthly average - \$17 disregard = \$23 is considered.

Child 3

$\$160 \div 3 = \$53.33$  monthly average - \$16 disregard = \$37.33 is considered.

2. If the amount of child support income is not representative of ongoing income due to a VERIFIED change in circumstances, consider the anticipated child support in the ongoing budget.

EXAMPLE: Alice applied in August. She received \$200 in the last 3 months; however, she provided a written statement from the NCP which verified that due to job loss he would only be paying \$75 a month until he regained employment. Anticipate that \$75 (less the \$50) in child support as the amount to be considered in the ongoing budget.

3. Support payments received for the child who is a specified relative are counted as contributions in the child's MA case, regardless of who receives the payment. Refer to [MS 3540](#).
4. Child Support received by SSI recipients:
  - a. If the specified relative, who is the only member of the MA case due to the only eligible child receiving SSI, receives child support for that child, the child support is excluded income as the support is for the SSI child. Medical Support Enforcement activity is pursued for this SSI child. Refer to [MS 2210](#).
  - b. If the specified relative is the SSI child's parent and receives spousal support, the spousal support is considered as a contribution. Refer to [MS 3540](#).

C. SYSTEM ENTRY

Enter the calculated monthly child support minus the \$50 disregard, on the child's IM Child Support unearned income screen. Do not round.

D. DOCUMENTATION

Document the verification source used, such as KASES, written statement from the NCP, check stubs, etc. Document the method used to calculate child support income. A calculator tape that shows the computations can be maintained in the case record as part of the documentation.]

MS 3540

FAMILY MEDICAID CONTRIBUTIONS

[Contributions are cash regularly received from any source which is anticipated to continue. Contributions received in the prior 3 calendar months are averaged to determine the best estimate of contribution income to be counted monthly.

A. CONSIDERATION:

1. Consider cash contributions received from the following sources:
  - a. Money from a parent involuntarily absent from the home;
  - b. Child support received by or for a child who is the specified relative in a case;
  - c. Spousal support received by a parent who is the only member of the case due to the only eligible child receiving SSI;
  - d. Any amount of a military allotment NOT designated by the absent parent as child/spousal support;
  - e. Any money received from a stepparent or a spouse of a non-responsible specified relative included in the case who is absent due to military service; and
  - f. undocumented loans.

Note: Any portion of military combat pay made available to a Family MA household is countable unearned income when establishing the household's eligibility.

B. VERIFICATION can include but is not limited to:

1. Statements from the individuals providing the contributions or the agency that has made the contribution;
2. Checks, if the contributions are received in that form;
3. By form PAFS-73, Verification of Contributions – Loans - Roomer/Boarder Payments.
4. Student loans/income must be verified through the student's educational account or a collateral contact to the institution. When verification is received exclude the loan amount. If verification is not provided consider the principal of the loan as a contribution in the month received and any remaining amount as a resource in subsequent months.

C. DOCUMENTATION:

Document in comments any unusual circumstance that conflicts with KAMES data.]

MS 3550

FARM/BUSINESS

[Farm/business income is unearned if there is no direct involvement in farm/business activities. In cases of divided ownership, divide profit between the owners, unless by mutual consent entire proceeds are available to the individual. If the Social Security Administration (SSA) considers all income as available to the SSI parent, do not enter income from this source in the AFDC Related MA case. If the SSA considers only part of the farm/business income available, consider appropriate shares available to the MA case.

- A. For verification use records maintained by the individual, current income tax returns, or a copy of a lease agreement.
- B. CONSIDERATION. To determine profit, deduct work expenses directly related to producing the goods or services without which the goods or services could not be produced. If the farming arrangements have changed, use anticipated income from the new arrangement.
  1. ALWAYS annualize farm and business income and the expenses; use the tax return, client accounts etc. for the past year to compute the countable income if available, otherwise average previous 3 months actual reported income and expenses.
  2. If the farming arrangement has changed, do not consider the income of the past year. Spot check the case for the month the new crop is to be sold. At that time, use the income received from the sale of the new crop to anticipate the income.
  3. If this is a new farm or farming activity AND:
    - a. The farm or farming activity has been in existence for less than a year and the individual has received income from the farm or farming activity, prorate the income over the period of time the farm or farming activity has been in operation. Use the monthly amount as the anticipated income for the next year.
    - b. The farm or farming activity has not been in existence long enough to receive income, no income is considered. Spot check the case for the month the income is to be received. At that time, use the income received to anticipate the income.
  4. If farming activities have been discontinued, no income is considered.
  5. Deduct the following:
    - a. Wages paid to employees;
    - b. Rent or interest on a mortgage and taxes, but only if the enterprise is carried on from a site other than the home;
    - c. Interest payments only on the purchase of capital assets, equipment, etc;

- d. Cost of stock offered for resale;
  - e. Cost of materials and supplies including seed, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
  - f. Mileage rate allowed as a deduction for business purposes if the vehicle expenses are directly related to the operation of the business enterprise – provided the person uses their private vehicle. The mileage deduction is equivalent to the amount shown on the federal tax return. If a tax return is not filed use the IRS mileage rate. This information can be accessed at: <http://www.irs.gov>. To access the current year's mileage rate enter the term "mileage rate" in the search box;
  - g. Other non-personal items directly related to producing the goods or services;
  - h. Repairs or maintenance of equipment and property used in the business. If the business is carried on from the home DO NOT allow a deduction for repairs to the home; and
  - i. Management fees incurred in managing property, including management fees charged by a relative.
6. Do not deduct the following:
- a. Personal work or business expenses such as taxes, FICA, lunches, etc;
  - b. Amounts claimed for depreciation;
  - c. Prior or current losses;
  - d. Purchase of capital equipment;
  - e. Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc;
  - f. Entertainment expenses;
  - g. Personal transportation;
  - h. Salary or commission paid to the individual by the self-employment enterprise; and
  - i. Rent, when the self-employment enterprise is based in the individual's residence.
7. Rental income is unearned if the individual is not actually involved in collecting the rent, making or supervising repairs, etc.
- a. For verification use a statement from a tenant, a current income tax return or other records.
  - b. Determine net profit by the same method used to determine Family MA earned rental income.

C. DOCUMENT how the income and expenses were calculated and verified.]

MS 3560\*

INCOME SUPPLEMENTATION

Income supplementation is money received by an individual from the Department for Rehabilitation Services, an income protection plan or hospital confinement policy, etc., not used to reimburse actual costs of care.

- A. Verify by one of the following:
  - 1. Statement from Department for Rehabilitation Services;
  - 2. Copy of income protection plan; or
  - 3. Hospital confinement policy, etc.
- B. Consider regular monthly income supplementation in determining initial and ongoing eligibility.

MS 3570\*

LIFE ESTATE INTEREST

- A. For verification use a copy of a written agreement.
- B. Consider all continuing unearned income regardless of whether the life estate interest is in real estate property, other property or any other asset.

MS 3580\*

## LOANS

Loans are amounts of money borrowed which require repayment.

A. Verify a loan by:

1. The loan agreement; or
2. Form PAFS-73, Verification of Contributions-Loans-Roomer/Boarder Payments, is completed and signed by the lender and borrower when the loan is not from a legal lending institution.

B. Consider the loan as follows:

1. Exclude a loan verified by form PAFS-73 or from a legal lending institution.
2. If a completed form PAFS-73 is not received, consider this income as:
  - a. A contribution if regularly received; or
  - b. A nonrecurring lump sum if received once.

MS 3590 OTHER UNEARNED INCOME (1)

MA recipients may receive unearned income from sources other than statutory benefits.

A. Other unearned income includes, but is not limited to:

1. Miner's benefits;
2. Pensions;

Note: Pensions received from the Department of Veteran Affairs under Chapter 31 Vocational Rehabilitation Benefits are called subsistence assistance and are designated to help with living expenses. This income is intended for food and/or shelter expenses and is countable.

3. Oil leases;
4. Mineral rights;
5. Trust income actually available other than from a Medicaid Qualifying trust;
6. JTPA income including Eastern Kentucky Concentrated Employment Program (EKCEP) paid to the specified relative or second parent;
7. Income from income indemnity policies;
8. Income from IRA's that are not received as non-recurring lump sum payments;
9. Any portion of military combat pay made available to a Family MA household is countable unearned income when establishing the household's eligibility.

B. Verify the income by:

1. Checks;
2. Award letters;
3. Written verification from company;
4. Contract;
- [5. Bank and other financial statements (for investments only); or]
6. Trust agreement.

C. Consider all continuing unearned income as follows:

1. Compute monthly amount if necessary.
2. If unearned income is received irregularly or in irregular amounts, average the prior 3 months actual income, even if some of the months have zero income, to arrive at the monthly amount. If the income is averaged, complete a spot check every 3 months for changes. Sixty dollars per quarter is excluded from the calculation of irregular and infrequent unearned income.

MS 3600\*

PROMISSORY NOTE, MORTGAGE,  
AND LAND CONTRACT

Promissory note, mortgage, or land contract is the sale of property for which an individual receives monthly payments over a period of time.

- A. Verify by the contract or other written agreement.
- B. Consider in the following manner.
  - 1. Count the interest portion of continuing payments as unearned income, if the principal is considered a resource; or
  - 2. Count both principal and interest parts of payments received as unearned income, if principal is not considered a resource. Deduct actual payments for mortgages, insurance and taxes.

MS 3610

STATUTORY BENEFITS

Statutory benefits include RSDI, Railroad Retirement, Black Lung, Veterans pension or compensation, Veterans Administration Improved Pension (VAIP), Agent Orange payments, Worker's Compensation, Unemployment Insurance or other pensions. If an individual is receiving statutory benefits at the time of application, verify entitlement amount of benefit, SMI charges, if appropriate, and amount of check. Document BEFORE approval.

A. VERIFICATION

1. Current benefit verification letters;
2. Checks if no SMI coverage;
3. SSA Verification Forms;
4. PA-1610A;
5. Railroad Retirement Board;
6. Any other documentation from the payor of benefits;
7. IMS program 39, New BENDEX, etc. NOTE: When accessing IMS Program 39, use the amount shown as "NET".

B. REQUIREMENT

1. Individuals must apply for statutory benefits if potential eligibility exists unless good cause is established. Good cause includes previous denial with no change in circumstances or inability to prove eligibility.
2. If applying for the VAIP reduces the total annual VA payment of the individual, he/she is not required to apply for the VAIP.
3. Verify application for statutory benefits. Refusal to explore entitlement results in ineligibility of the individual.
4. Do not withhold approval or discontinue an active case during the period entitlement is being determined.
5. Set up a monthly spot check to determine if statutory benefits are received or denied.

C. Count statutory benefits in determining income as follows:

1. Gross income as designated to a specified individual by benefit verification letter, benefit statement, PA-1610A, SSA verification, etc.

Count statutory benefits of responsible relatives or individuals included in the MA case.

If the payee of RSDI benefits IS NOT in the home, count the amount actually provided to the beneficiary.

2. Gross income not designated to a specified individual, e.g., VA or Black Lung benefits.

- a. When all individuals covered by benefit are in the MA case, count entire amount.

- b. When all individuals covered by benefit are not in the MA case, prorate the benefit to establish the amount for determining eligibility by dividing the total amount of statutory benefit by the number intended.

When a child is in the home and not in the MA case, subtract that child's prorated share.

If a family verifies paying a portion of the benefit to a covered individual outside the home, subtract only the prorated share. If the individual is in another MA or AFDC case and receives more than the prorated share, consider the actual verified amount as income in that case. If the individual receives less than the prorated share, consider the prorated amount as income.

3. Consider entitlement amount of statutory benefits. DO NOT deduct amounts withheld due to an overpayment.

MS 3620

TRUSTS

(1)

[The Department for Medicaid Services (DMS) reviews all trusts, other than funeral trusts, pertaining to the determination of Medicaid eligibility. DMS will advise how the trust should be considered in each eligibility determination.]

A. For applications, case changes and recertifications that include a trust, make two copies of the trust document. Retain a copy of the trust for the case record. Annotate on the front page of the copy whether it is an application, case change or recertification. Complete and attach form MA-33, DMS Review/Cover Sheet. To assure processing timeframes are met, the Service Region Program Specialist must forward all trusts to MSBB daily.

1. Review the trust to ensure all attachments listed in the trust have been provided. If any parts of the trust or attachments are missing, request the missing information from the client and DO NOT submit the trust until everything has been provided. The following information is needed when forwarding a trust for review:

- a. All pages of the trust;
- b. If the individual's home was placed in a trust, include a copy of form PA-16, Real Property Verification Request, and the deed placing the home in the trust;
- c. If an MRT is completed for the individual, include a copy of the front page of the MRT determination;
- d. Verification of funding of the trust (documentation of what is in the trust);
- e. If a guardian established the trust, include a copy of the guardianship court documents; and
- f. A list of all parties involved on the trust and what is the relationship to the member.

2. Scan all documents and send to MSBB by email at [DFS.Medicaid@ky.gov](mailto:DFS.Medicaid@ky.gov).

Note: For recertifications, do not send a trust that has been previously reviewed by DMS unless changes in the trust have occurred.

- B. MSBB is responsible for forwarding the copy of the trust to DMS for review.
- C. Following completion of the review, DMS notifies MSBB staff regarding consideration of the trust. MSBB staff will send this information in writing to the worker and the Service Region Program Specialist. The copy of the trust will not be returned.
- D. For an application, hold the application pending until a response from DMS is received. DMS will give priority to trust reviews for application. Refer to Volume IV, [MS 1320](#), for cases pending over 30 days with good cause.
- E. For recertifications, do not hold a recertification pending for receipt of the

trust review response. Complete any case action necessary as a result of the review response effective with the next administratively feasible month following receipt of the response.

- F. In some situations, DMS may need additional information to complete their review. The worker should promptly request the additional information upon notification from MSBB.
- G. Workers who have questions concerning the status of a trust review are directed to contact MSBB at [DFS.Medicaid@ky.gov](mailto:DFS.Medicaid@ky.gov) through their Regional Program Specialist.
- H. For recipients, representatives or attorneys who have questions about the regulations in establishing a trust, refer them to the following websites:
  - 1. The Center for Medicare and Medicaid Services Medicaid Manual refer to <http://www.cms.hhs.gov/medicaid/> for section 3259 the "Treatment of Trust";
  - 2. Kentucky Administrative Regulations refer to: <http://www.lrc.ky.gov> for title 907 KAR "Cabinet for Health Services, the Department for Medicaid Services"; and
  - 3. Department for Medicaid Member Services at 1-800-635-2570.

MS 3621\*      CONSIDERATION OF INCOME FROM A MEDICAID  
                         QUALIFYING TRUST ESTABLISHED ON OR BEFORE 8/10/93

The Department for Medicaid Services (DMS) reviews all trusts for Medicaid eligibility determinations. DMS will advise how the trust is to be considered in their response once the trust has been reviewed. Based on DMS determination on how the funds are to be considered in the case, the applicant/recipient could be considered for an undue hardship determination.

For Medicaid Qualifying Trusts established on or before 8/10/93, if DMS finds that there is a set monthly payment, that payment amount would be considered unearned income whether or not the individual actually receives the full payment amount.

If the individual alleges consideration of the full payment amount causes an undue hardship, the individual may request exemption from this requirement. An undue hardship is considered to exist if the trustee is legally unable to pay the maximum monthly payment allowed by the trust; for example, if the individual is obligated to pay court ordered child support or alimony.

Submit a memorandum to CHFS/DCBS Supervisor, MSBB, 275 East Main Street, 3E-1, Frankfort, Kentucky 40621, requesting an undue hardship determination for a Medicaid Qualifying Trust. Include in the memorandum the reason(s) the individual is alleging an undue hardship due to consideration of the total income from the Medicaid Qualifying Trust. Attach copies of verification of the reason(s) furnished by the individual.

MS 3700

## INTRODUCTION TO EARNED INCOME

Earned income is money derived from direct involvement in a work related activity. Earned income can be wages or self-employment.

Verify income at each application, recertification, and interim involving an income change before authorizing case action. Explore the possibility of withheld income information.

Self-declaration of income is not acceptable verification.

DOCUMENT type of verification and amount of earned income in case record.

[To verify zero income, see [Volume IV, MS 3470](#).]

MS 3710

[WAGES FOR FAMILY MA

(1)

WAGES consist of salaries received from full-time or part-time employment where taxes are withheld prior to the recipient receiving pay. Odd jobs, occasional, seasonal or contract employment are included when taxes are withheld prior to receipt of the income. Exclude from wages reimbursement for transportation in performance of duties, if identifiable.

Accumulated annual leave is considered as wages in the month the money is received with appropriate deductions allowed. If income is received as back payment from employment or severance pay, see [MS 3800](#).

Consider living allowances (stipends) paid by programs established under the National and Community Services Trust Act of 1993 (such as Americorps) as earned income and apply earned income disregards as appropriate.

Consider VISTA payments that equal or exceed the federal minimum wage or the state minimum wage, whichever is greater, as earned income. Allow deductions as appropriate. To determine if the VISTA payment equals or exceeds the applicable minimum wage, send a written request to: State Director of ACTION, 600 Federal Place, Room 372-D, Louisville, Ky. 40202.

#### A. VERIFICATION

1. Pay stubs;
2. Employer statement, either written or verbal; or
3. Electronic Income Verification (EIV). See Volume IV, [MS 3471](#).

Spot check within 1 week of anticipated receipt of first, check not to exceed 6 weeks from the individual's report of new employment.

#### B. CONSIDERATION

1. To determine the estimated monthly income, verify and use income from all pay periods in the last two calendar months. If the last two calendar months do not represent the ongoing situation (e.g., sick leave, holiday plant closing), use information available which best indicates the case member's ongoing income.
2. To calculate the estimated monthly earned income DO NOT round cents before adding or multiplying hourly or daily earnings. Round before adding or multiplying weekly, bi-weekly, semi-monthly, monthly, quarterly or annual amounts.
  - a. Add gross income from each pay period.
  - b. Divide the total by the number of pay periods considered.
  - c. Multiply by  $4 \frac{1}{3}$  for weekly amounts,  $2 \frac{1}{6}$  for bi-weekly amounts and 2 for semi-monthly. To manually convert by  $4 \frac{1}{3}$ ,

multiply by 13 and then divide by 3; for  $2\frac{1}{6}$ , multiply by 13 and divide by 6.

- d. Round up or down to the nearest dollar to determine the monthly amount to be counted in the administratively feasible month.

EXAMPLE 1: For Income Received Weekly

\$88.14	rounded to	\$88.00
70.40		70.00
75.63		76.00
69.11		69.00
71.00		71.00
87.50		88.00
83.23		83.00
69.77		70.00
	equals	\$615.00

\$615.00 divided by 8 equals \$76.88 average weekly rounded to \$77.  $\$77 \times 4\frac{1}{3}$  equals \$333.67 rounded to \$334.

EXAMPLE 2: For Earned Income Received Bi-weekly

\$153.50	rounded	\$154.00
165.75		166.00
169.35		169.00
158.00		158.00
	equals	\$647.00

\$647 divided by 4 equals \$161.75 average bi-weekly rounded to \$162.  $\$162 \times 2\frac{1}{6}$  equals \$351.00.

EXAMPLE 3: For Earned Income Received Semi-Monthly

\$158.45	rounded to	\$158.00
225.72		226.00
190.00		190.00
195.60		196.00
	equals	\$770.00

\$770 divided by 4 equals \$192.50 average semi-monthly rounded to \$193.  $\$193 \times 2$  equals \$386.

EXAMPLE 4: For Earned Income Received Monthly

\$351.55	rounded to	\$352.00
330.78		331.00
	equals	\$683.00

\$683 divided by 2 equals \$341.50 average monthly rounded to \$342.

3. Count gross income. Garnishments on salary ARE NOT deducted.

- C. If the income in the prior two months is NOT representative of the ongoing situation due to a change of circumstances which occurred or will occur, calculate the best estimate of the monthly income in the following manner:
1. If the change in circumstances results in change in the number of hours to be worked, multiply the number of estimated hours per pay period (use employer statement) by the current pay rate for the period and convert by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$ , 2 or 1, whichever is appropriate.
  2. If the change in circumstances results in a change in the pay rate, multiply the number of hours worked per pay period in the prior two months by the new pay rate. Divide the result by the number of pay periods in the prior two months and convert by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$ , 2 or 1, whichever is appropriate.
- D. If the income has recently begun or the recipient changed jobs and the recipient has not received two calendar months of income, anticipate the monthly income by computing an amount based on:
1. The hourly rate multiplied by the estimated number of hours to be worked during the pay period and convert; or
  2. The daily rate multiplied by the number of days to be worked in the pay period and convert.
- E. If the recipient reports that the income is ending:
1. Determine the last date the recipient will receive the income.
  2. Recalculate the case based on the income amount to be received.

EXAMPLE: The recipient reported in November that her job is ending and that she will receive one pay check in December. If the report is received before the November cutoff, count only the one paycheck anticipated for December and then remove the income for January.

If the report is received after the November cutoff, remove the income effective January.

- F. DOCUMENT in the case record the reason less than the last two calendar months of income was used in the calculation, method of verification, and how the monthly amount was calculated. If the estimated income DOES NOT accurately reflect the anticipated ongoing circumstances, spot check the case and recalculate the income utilizing verified income. However, if the estimated income accurately reflects the anticipated ongoing circumstances, recalculate the best estimate at recertification or six months, whichever comes first.]

MS 3720

[TIPS FOR FAMILY MA]

(1)

Countable tip income is money actually received in addition to wages for services performed by the employee. Countable tip income does not include the allocated or tip credit reported by the employer for tax purposes which may appear on the paycheck stub.

A. VERIFICATION

Verify tips by using the individual's daily tip log of actual tips received. A tip log is any record kept by the individual of tips received each day. Entries on the log must show date of receipt and amount. DO NOT use the allocated tip or tip credit amount shown on the paycheck stub.

1. For applications or new tip income when a daily tip log is not available, use the individual's statement of anticipated tips.
2. When tip income is reported, advise the individual of their responsibility of maintaining a daily tip log for verification purposes.
- [3. DO NOT use Electronic Income Verification (EIV) to verify earned income if tips are included in the gross amount. See Volume IV, [MS 3471](#).]

B. CONSIDERATION

1. To best estimate the monthly amount of tips, use the same time period used in determining the monthly amount of wages (i.e., if the best estimate of income is determined by using the prior 2 calendar months' wages, then use the prior 2 calendar months' amount of tips shown on the daily tip log). Convert the daily tips to weekly, bi-weekly, semi-monthly, etc.

Example: The recipient works at Jerry's Cafe and is paid each Friday. A daily tip log is kept by the recipient.

For September, the pay periods ended 9/3, 9/10, 9/17 and 9/24. Add the tips for each day in the pay period to obtain the weekly amount: 8/30 - \$6.00; 8/31 - \$6.55; 9/1 - \$9.75; 9/2 - \$9.10; 9/3 - \$10.50. Added together, they equal \$41.90 (round to \$42.00) for the 9/3 pay period. Average the tips for this weekly pay period and the other weekly pay periods and convert to a monthly amount.

2. Add the best estimate of monthly tips to the best estimate of monthly wages.

C. DOCUMENTATION

Document the method of verification and how the best estimate is computed.

MS 3730\*

CONTRACT EMPLOYMENT

Contract employment is income from jobs in which there is a signed contract; e.g., school teachers, bus drivers.

A. VERIFICATION

1. Contract stating salary and terms;
2. Employer contact to establish salary;
3. Employer statement or contact to verify termination of contract.

B. CONSIDERATION

1. When the individual has a contract/payment agreement compute gross monthly wages by dividing the contract amount by 12 and round to the nearest dollar, unless the contract/payment agreement states income will be paid for fewer months.
  - a. If the contract/payment agreement states the income is received in fewer than 12 months, divide the amount by the number of months in the contract/payment agreement and round to the nearest dollar.
  - b. If the contract/payment agreement states the income is received monthly for 12 months and the individual requests the remainder of the pay in a lump sum prior to the end of the 12-month period, continue to use the annualized figure for the remainder of the 12-month period.
2. If contract employment is self-employment, consider as self-employment.
3. Prorate other contract employment over the life of the contract.

MS 3740\* OCCASIONAL AND COMMISSIONED EMPLOYMENT

Occasional employment is income from working an irregular schedule that is not planned. Commissioned employment is income received as a percentage of the money received from sales.

A. VERIFICATION

Use pay stubs or employer contract.

B. CONSIDERATION

Compute anticipated monthly income by totaling actual amounts of income received in prior 3 months and divide by 3.

MS 3750\*

## SEASONAL EMPLOYMENT

Seasonal employment is income from employment during a limited period each year.

### A. VERIFICATION

1. Pay stubs;
2. Employer contact; or
3. Current income tax return or records maintained by individual.

### B. CONSIDERATIONS

1. Count anticipated earnings or actual earnings received in the month.
2. If employment has terminated before action can be effective, do not consider this income.
3. Spot check next year before anticipated seasonal employment.

MS 3760\*

SELF-EMPLOYMENT INCOME

Self employment income is derived from farming, small business enterprise, rental, roomers/boarders, etc., where taxes are NOT withheld PRIOR to the individual receiving pay.

A. Self-employment can be either ongoing or occasional.

1. Ongoing self-employment is where the client intends to work at the self-employment month after month.

EXAMPLE: Dolly operates a babysitting service. She intends to provide services throughout the year.

2. Occasional self-employment includes seasonal, temporary, sporadic or odd job income. Temporary or sporadic employment can include lawn mowing, house cleaning, babysitting, selling scrap metal, selling blood, etc., which is not continuous in nature.

EXAMPLE 1: Betty Lou baby-sits for a neighbor during the summer months. Sometimes she sits once a week and sometimes once a month.

EXAMPLE 2: Johnnie cuts grass for a neighbor when the neighbor cannot do it himself. Johnnie sometimes paints garages and sometimes cleans windows.

B. Recalculate the self-employment income at:

1. 12-month intervals, if the activity has been in operation for 12 months or more; or
2. The next IM or FS recertification, whichever comes first, if the activity has been in operation for less than 12 months.

C. DOCUMENT the method of verification and computation of the best estimate of the monthly income.

D. For verification, use records maintained by the individual or current income tax returns if it is representative of the current situation.

E. Consideration of Nonfarm Income

1. When using the annual U.S. Individual Income Tax Return or the individual's business records for the last 12 months:

- a. Round the gross income to the nearest dollar.
- b. Divide the rounded gross income by 12 and round to the nearest dollar to obtain the monthly gross income amount.

- c. Round the allowable expenses to the nearest dollar.
  - d. Divide the rounded allowable expenses by 12 and round to the nearest dollar to obtain the monthly allowable expenses.
  - e. Subtract rounded monthly allowable expenses from rounded monthly gross income to obtain the monthly profit.
2. When ongoing nonfarm self-employment income has been in operation for less than 12 months:
  - a. Round the gross income for the number of months the activity has been in operation to the nearest dollar.
  - b. Divide the rounded gross income by the number of months of operation and round to the nearest dollar to obtain the monthly gross income amount.
  - c. Round the allowable expenses for the number of months of operation and round to the nearest dollar.
  - d. Divide the rounded allowable expenses by the number of months of operation and round to the nearest dollar to obtain the monthly allowable expense.
  - e. Subtract the rounded monthly allowable expenses from the rounded monthly gross income to obtain the monthly profit.
3. For occasional or seasonal self-employment:
  - a. Round the gross income for the 3 previous months to the nearest dollar.
  - b. Divide the rounded gross income by 3 and round to the nearest dollar to obtain the monthly gross income amount.
  - c. Round the allowable expenses for the 3 previous months to the nearest dollar.
  - d. Divide the rounded allowable expenses by 3 and round to the nearest dollar to obtain the monthly allowable expenses.
  - e. Subtract the rounded monthly allowable expenses from the rounded monthly gross income to obtain the monthly profit.

#### F. FARM/BUSINESS

Farm income is earned if derived from active physical engagement or managerial responsibility in farming. In such instances, it is subject to earnings deductions. Consider profit as income to the family group if the farming is done by one or more of its members. If the farming is done in part by a household member not included in the assistance group, deduct his/her prorated share from profit.

In cases of divided ownership, divide profit between the owners, unless by mutual consent entire proceeds are available to the client. If the SSA considers all farm/business income available to an SSI individual, do not enter income from this source in the MA case. If the SSA considers only part of the farm/business income available,

consider appropriate shares available in the MA case. Consider farm income as follows:

1. If the individual's farming is a continuing business, use records such as tax return, individual accounts, etc. for the past year to compute the countable income.
2. If the farming arrangement has changed, do not consider the income of the past year. Spot check the case for the month the new crop is to be sold. At that time, use the income received from the sale of the new crop to anticipate the income.
3. If this is a new farm or farming activity:
  - a. If the farm or farming activity has been in existence for less than a year and the individual has received income from the farm or farming activity, prorate the income over the period of time the farm or farming activity has been in operation. Use the monthly amount as the anticipated income for the next year.
  - b. If the farm or farming activity has not been in existence long enough to receive income, consider no income. Spot check the case for the month the income is to be received. At that time, use the income received to anticipate the income.
4. If farming activities have been discontinued, do not consider the income.

MS 3770                      DEDUCTIONS FOR FARM/NONFARM INCOME

Deductions are subtracted from income to allow for specific expenses or allowances.

A. Deduct the following:

1. Wages paid to employees;
2. Rent or interest on a mortgage and, as appropriate, taxes but only if the enterprise is carried on from a site other than the home;
3. Interest payments only on the purchase of capital assets, equipment, etc;
4. Cost of stock offered for resale;
5. Cost of materials and supplies including seed, feed, crop insurance, fertilizer, and utilities required to carry on the enterprise;
6. [Mileage rate allowed as a deduction for business purposes if the vehicle expenses are directly related to the operation of the business enterprise – provided the person uses their private vehicle. The mileage deduction is equivalent to the amount shown on the federal tax return. If a tax return is not filed use the IRS mileage rate. This information can be accessed at: <http://www.irs.gov>. To access the current year's mileage rate enter the term "mileage rate" in the search box; ]
7. Other non-personal items directly related to producing the goods or services;
8. Repairs or maintenance of equipment and property.

B. DO NOT deduct the following:

1. Personal work or business expenses such as taxes, FICA, lunches, personal transportation, and entertainment expenses, etc;
2. Amounts claimed for depreciation, prior losses, or loss in one business from another;
3. Purchase of capital equipment;
4. Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc;
5. Improvements, such as paving drive, new roof, putting up a fence, etc.
6. Compensation paid to officers.

MS 3780

RENTAL/BOARDER INCOME

Rental/boarder income is earned if the individual personally collects the rent, makes or supervises repairs or gives other services in relation to the property. Consider profit from rental of property owned or being purchased by the individual.

- A. Rent from property, other than a home occupied by the individual, deduct the following:
1. Property taxes, state and local taxes on rental property;
  2. Interest on mortgages, debts, property improvement loans for rental property;
  3. Insurance on property;
  4. Repairs or maintenance to keep rental property in good operating condition; and
  5. Expenses for managing the property.
- B. Roomer or rent from renting or subrenting a portion of the home, determine deductions as follows:
1. Deduct a fraction of the expenses equal to the fraction of the home rented, e.g., if 2 rooms of a 6 room house are rented, then 1/3 of the expenses are used in calculating rental deductions.  
  
Halls, baths, etc., are not used in determining the number of rooms.
  2. Annualize cost of the home's utilities, property insurance, property taxes and interest on mortgage, if any. Divide by 12 to obtain the monthly expense. Multiply the monthly expenses by the fraction of the home rented to obtain the rental deduction.

EXAMPLE: Interest on mortgage	\$1,200
Utilities	800
Property Insurance	300
Property Taxes	<u>100</u>
	\$2,400 divided by 12 = \$200
	Monthly Cost
\$200 x 1/3 = \$66.67 monthly rental deduction	

- C. Boarder only, deduct an amount equal to the food stamp allotment for the number of boarders.

EXAMPLE: There are 3 boarders, the deduction equals the food stamp allotment of a 3-person household.

- D. Roomer/Boarder:

1. Food deductions. Deduct an amount equal to food stamp allotment. If roomer/boarder is a member of the food stamp case, do not allow a food deduction.
2. Rental deduction is computed the same as a roomer. Do not compute if the roomer/boarder payment is the same as, or less than, the food stamp allotment.

MS 3785

WORKFORCE INVESTMENT ACT (WIA)

(1)

[WIA funds job training and employment opportunities for economically disadvantaged, unemployed or underemployed individuals. WIA funds other programs such as Job Corps and JTPA.]

#### VERIFICATION

Pay stubs, WIA agency or employer contact.

#### CONSIDERATION

1. For the Medicaid specified relative or the second parent, only payments made for but not to the client and reimbursement for transportation are excluded. All other money received is considered as earned income.

Example 1: Joe is eligible for a clothing stipend. Job Corps writes a clothing voucher out to a retail store for Joe to get some work clothes. This income is excluded.

Example 2: Joe is eligible for a clothing stipend. Job Corps gives him \$300 to purchase some clothes for work. Since this money was given to Joe it is considered unearned income.

2. For the MA child, needs-based payments or money received through work experience, Job Corps or on-the-job training (OJT) is excluded. See [MS 3850](#), Excluded Income, for MA child and exclusion of other types of reimbursements.]

MS 3790

OTHER EARNED INCOME

- A. [OTHER EARNED INCOME sources may be accumulated annual leave, severance pay, incentive pay or cash benefits directly related to employment.]
1. VERIFICATION. Checks, employer statements or contacts or check stubs.
  2. CONSIDERATION. [Consider all continuing earned income as follows:
    - a. Compute monthly amount if necessary.
    - b. If earned income is received irregularly or in irregular amounts, average the prior 3 months actual income, even if some of the months had zero income, to arrive at the monthly amount. If the income is averaged, complete a spot check every 3 months for changes.]

MS 3800

NONRECURRING LUMP SUM INCOME

(1)

[A nonrecurring lump sum is money received at one time which is normally considered as income, but is not anticipated to continue. Common examples of nonrecurring lump sum income are accumulated back payments from unemployment insurance (UI), escrow child support money forwarded by CSE, child support received as a result of an IRS intercept, back payments from employment, severance payments, money received from insurance settlements, workers compensation settlements, gifts, inheritances, lottery winnings, etc.

Income from the sale of property, including initial or down payment from a land contract sale, IS NOT a nonrecurring lump sum but a change in type of resource.

- A. Income is considered when actually available and when the applicant or recipient has a legal interest in a nonrecurring lump sum and has the legal ability to make such sum available for support and maintenance.

Example 1: Emily receives MA in the "E" or "T" category for her two children, Janet and Joe. A \$5,000 settlement is received from an accident in which Janet was involved. Emily tells her attorney she wants \$2,500 set up in a trust and the rest to purchase certificates of deposits. In this example, Emily has control over the settlement and therefore a legal interest and ability to make this money available for maintenance. This lump sum would be countable.

Example 2: Paula receives MA in the "E" or "T" category for her child Susie. Susie was involved in an accident and received a \$5,000 insurance settlement. The court ordered the \$5,000 be set up in a trust for Susie until she reaches her 18th birthday. In this example, Paula has no control of the money and no legal interest. This lump sum would be excluded until the child's 18th birthday.

- B. Consider the non-recurring lump sum, minus any amount verified as earmarked and used for the purpose for which it was paid, as income in the month of receipt and a resource beginning with the following month.
1. If the non-recurring lump sum amount is for both "E" or "T" and non "E" or "T" children, prorate the amount between the individuals covered and count the prorated share of the E or T children as a nonrecurring lump sum amount in the "E" or "T" case.
  2. If a child included in the "E" or "T" assistance group receives the non-recurring lump sum income, the income is available to the "E" or "T" case, even if the child is excluded from the case AFTER receiving the money. If the child is removed from the "E" or "T" case, and the effective date of the removal is BEFORE the non-recurring lump sum income was received, the income is not available to the case.
  3. If the stepparent, spouse of a non-responsible SR included in the case, parent of a minor parent, or spouse of a dependent child receives the

non-recurring lump sum amount, use the following procedure to determine the net amount countable as surplus income in the month of receipt:

- a. Deduct back payments actually made from the nonrecurring lump sum amount
    - (1) For support or alimony payments to individuals not in the home; and/or
    - (2) To individuals out of the home who are or could be claimed as dependents for Federal Income Tax;
  - b. Deduct the "E" or "T" Standard of Assistance for the stepparent OR parent of a minor parent family size only if not deducted from earned and other unearned income.
  - c. The remainder is the net nonrecurring lump sum which is added to surplus income of the stepparent OR parent of a minor parent in the month of receipt.
  - d. Consider any amount remaining in subsequent months as a resource to the stepparent or parent only. Resources of the stepparent, parent, or spouse are not used to determine eligibility of the specified relative (SR) in the "E" or "T" assistance group.
- C. DETERMINE if any of the lump sum is earmarked and used for the purposes for which it is paid (e.g., money for back medical bills resulting from accidents or injury, funeral and burial costs, replacement or repair of lost or damaged resources, designated attorney fees, etc.).

Verify how the money is spent by receipts, court or insurance records, bills, etc.

D. EXCEPTIONS.

1. If the lump sum is from a federal or state income tax refund it is excluded as income for 12 months from the month of receipt.
2. If the lump sum is from a worker's compensation settlement and includes a one-time lump sum payment and continuing weekly or monthly benefits, consider the one-time payment as a nonrecurring lump sum payment and the continuing benefits as unearned income in the appropriate month.
3. If the lump sum is from accumulated annual leave or severance pay, it is considered continuing earned income in the month received, not a nonrecurring lump sum.
4. Tax rebates are considered as excluded in the month of receipt and the following two months. Any proceeds from the rebates after the third month are considered a countable resource.
5. If the lump sum is from an insurance settlement, inheritance, lottery winning, etc., it is countable income.

- a. Reduce insurance settlements by subtracting verified amounts used, or obligated, to repair or replace items damaged or destroyed and by any associated medical expenses not covered by MA.
  - b. Consider as countable income, the remainder of the insurance settlement or the actual amount of other windfall profit received by the individual.
6. Lump sums from accumulated back-payments of SSI and/or RSDI are excluded as a resource for the first 6 months following the month of receipt. If the back-payment includes current benefits for the month in which the payment is received, deduct that amount prior to determining the excluded resource amount. Set up a spot check for the end of the 6 month period. Consider any remaining amount as a countable resource.
- E. VERIFY the lump sum amount using a:
1. Statement from lawyer/trustee;
  2. Letters of award; or
  3. Check.]

MS 3810

CONSIDERATION OF LUMP SUM INCOME

- [A. Effective July 1, 2001, administrative regulations were changed for consideration of lump sum income in AFDC Related and Family Related Medicaid cases. Lump sum income is now considered as unearned income in the month of receipt and as a resource in the month after the receipt month.
- B. If there are remaining resources in the month after the receipt month, only resources that are liquid are considered.
- C. Liquid resources are defined as: cash, checking accounts, savings accounts, certificates of deposit, stocks, mutual fund shares, bonds and money market accounts.]

MS 3850 EXCLUDED INCOME (1)

Excluded income is income received but not considered in determining financial eligibility. Sources of excluded income are as follows:

- A. K-TAP and Kinship Care payments of an individual, other than a parent, not included in the MA family size for a separate case which includes a minor parent (SSI recipients are not included in the MA family size);
- B. SSI benefits and any other income of SSI beneficiaries in AFDC Related and Family MA cases;
- C. SSI essential person's portion of the SSI payment, if the person is included in the MA family size;
- D. Low Income Home Energy Assistance Program (LIHEAP) payments.
- E. Any payment made by the Division of Protection and Permanency (DPP) for child foster care, adult foster care, subsidized adoptions, or personal care assistance;
- F. In-kind income;
- G. Home produce for household consumption;
- H. Vendor payment income. Payments on behalf of or for the benefit of an individual, other than the SSP individual made DIRECTLY to a doctor, pharmacist, landlord, or utility company by another individual.
- I. Income of a child technically excluded from the MA case;
- J. MA child's earnings:
  - 1. Part-time earnings of a full-time or part-time student;
  - 2. Full-time earnings of a full-time student;
  - 3. Earnings received by a child, regardless of student status, from participation in any Workforce Investment Act (WIA) earned income activity for a period not to exceed 6 months within a calendar year. The 6 months are cumulative months. WIA activities from which earned income may be derived include, but are not limited to, On-the-Job Training (OJT), Internship, the Work Experience Program, Limited Work Experience Program, Tryout Employment Program or Summer Youth Employment Training Program (SYETP).
- K. All student work-study income, educational grants and loans to any undergraduate made or insured under any program administered by the U.S. Commissioner of Education or under the Bureau of Indian Affairs student assistance programs.

- L. Principal of loans, including educational loans. Verify the loan by a commercial loan contract, or form PAFS-73, Verification of Contributions - Loans - Roomer/Boarder Payments. Student income must be verified through the student's educational account or by a collateral contact to the educational institution. When verification is received exclude the loan amount.

If verification is not received, consider the principal of the loan as a contribution in the month received and any remaining amount as a resource in subsequent months.

- M. Veterans Administration payments of less than \$60 received no more frequently than one time in a quarter;
- N. Highway relocation assistance;
- O. Urban renewal assistance;
- P. Federal disaster assistance and State disaster grants;
- Q. Reparation payments from the Federal Republic of Germany.
- R. Experimental housing allowance program payments made under annual contributions contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended, and HUD Section 8 payments for existing housing under Title 24, Part 882;
- S. Public Law benefits and payments to:
1. Elderly persons under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;
  2. VISTA volunteers under Title I of PL 93-113 pursuant to Section 404(g);
  3. Individual volunteers for supportive services or reimbursement of out-of-pocket expenses while serving as foster grandparents, senior health aides or senior companions and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113;
  4. Indian tribe members under PL 92-524, PL 93-134, PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540.
  5. Natural children of women veterans who served in Vietnam during the Vietnam era who receive benefits based on Sec. 401 of the Veteran Benefits and Health Care Improvement Act of 2000, Public Law 106-419.
- T. Consider the income not available when the parties of jointly held income are not willing to release their portion of the income or one party cannot be contacted for a release of his/her portion. Verify that litigation would be required or is pending to determine to whom an income belongs. Spot-check monthly or in the month litigation is completed.

- U. Reimbursement for:
  - 1. Training-related expenses made by a manpower agency to recipients in institutional or work experience training;
  - 2. Transportation, lodging and meals in performance of employment duties, if identifiable; and
  - 3. Training-related expenses or other reimbursements by WIA to a MA child.
- V. Income excluded by the terms of a trust.
- W. Up to \$50 disregard per month, per family of child support income received by the applicant or responsible relative for children applying for or receiving MA.
- X. Small nonrecurring cash gifts, of \$30 or less, but not totaling more than \$30 per member of the assistance group per month. See [MS 4377](#).
- Y. The \$25 Employment and Training Program (ETP) payments.
- Z. Education related transportation payment and school supplies provided by a public agency or nonprofit organization.
- AA. Up to \$12,000 to Aleutians and \$20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardship experienced during World War II. All recipients of these payments are provided with written verification by the federal government.
- BB. Federal tax refunds are excluded as income for 12 months from the month of receipt. This includes advance Earned Income Tax Credit (EITC) payments.
- [CC. All payments received from Agent Orange.]
- DD. Interest on burial reserves if allowed to accrue.
- EE. Any payments received from the Radiation Exposure Compensation Trust Fund.
- FF. 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.
- GG. Educational grants and scholarships obtained and used, even if conditions do not preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill; educational payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:
  - 1. Tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, and including cost for rental or purchase of any equipment, materials or supplies required of all students in the same course of study; and

2. An allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.
- HH. AmeriCorps educational awards paid directly to the institution.
- II. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.
- JJ. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using SSI standards. This income is NOT excluded by SSA, so these recipients should not be SSI eligible. Enter the applications on KAMES as usual. If the hemophiliac is income ineligible for some other reason, pend the application and contact MSBB at [DFS.Medicaid@ky.gov](mailto:DFS.Medicaid@ky.gov) through your Regional Program Specialist for further instructions.
- KK. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.
- LL. Family Alternatives Diversion (FAD) payments.
- MM. Kentucky Works Program (KWP) supportive services and transportation payments.
- NN. Payments made from Crime Victim's Funds.
- OO. Income from interest and dividends.
- PP. Tobacco Settlement Income is excluded in the month of receipt and the month after receipt. It is considered a countable resource in the third month and thereafter.

MS 3870\*

WORK EXPENSE STANDARD

Deduct from earned income of each individual up to \$90 for full-time or part-time employment per month including stepparents and parents of a minor parent, who are not included in the case. If the earnings are less than \$90, deduct the amount of the earnings as the work expense standard.

MS 3880

MA DEPENDENT CARE

[An MA dependent care deduction is allowed for a child (13 years of age or younger) or an incapacitated individual who receives care; provided he/she is included in the MA case and lives in the home and the care is paid by the responsible or non-responsible SR, including sanctioned/excluded individuals, to retain employment.

A. The dependent care deduction is NOT allowed if:

1. The IM child is over age 13 (meaning through the month of the IM child's 14<sup>th</sup> birthday) unless the recipient requests such care, provides a statement of the reason this care is necessary and the worker concurs with the reason. Thoroughly document in the case record care for any child 14 years of age or older. Include the recipient's request, the recipient's statement as to the reason the care is requested, and the decision.
2. The person receiving payment is residing in the household and that person is either:
  - a. A member of the assistance group;
  - b. A parent of the child or incapacitated adult;
  - c. A stepparent of the child;
  - d. Any member considered in the stepparent's family size; or
  - e. An AFDC Related MA child in either of the above groups.

B. Allow the MA dependent care deduction in the case if it is paid to an individual in the household who is not listed above or paid to anyone outside the home.

C. VERIFICATION

1. To consider the cost of MA dependent care in the financial eligibility determination, verify the child or adult is being cared for by an allowable provider. Also, verify the actual amount the provider is paid by viewing payment receipts or contact the care provider.
2. The recipient is required to secure or assist in verifying, establishing or providing all necessary information which is pertinent to the case decision.

D. CONSIDERATION

Deduct monthly amount paid, rounded to the nearest dollar, for MA dependent care per child or incapacitated adult, not to exceed:

1. For an individual age 2 years or over:
  - a. \$150 for part-time employment, less than either 30 hours per week or 130 hours per month;

- b. \$175 for full-time employment, 30 or more hours per week or 130 or more hours per month.
- 2. For an individual under age 2 years; \$200 for full-time or part-time employment.]

MS 3900\*

OTHER SPECIFIED RELATIVE (SR)

A nonresponsible SR has the option of being included in the MA case with the child.

- A. If the nonresponsible SR does not want to be included, do not consider his/her income.
- B. If a nonresponsible SR wants to be included in the MA case, determine the countable income as follows:
  1. From the total income of spouse:
    - a. Deduct standard work expense for earned income.
    - b. Deduct any support payments made by spouse.
    - c. Deduct amount of MA Scale for family size, excluding SR.
    - d. Consider the remainder available to the SR.
  2. If the nonresponsible SR has income:
    - a. Deduct standard work expenses from earned income and dependent care, if appropriate.
    - b. Add countable earned income and unearned income to amount available from spouse.
    - c. Consider the result as income in the case.

If the case is ineligible due to income, the nonresponsible SR can still receive as a spend down.

MS 3910

DEPENDENT CHILD LIVING  
WITH PARENT/LEGAL GUARDIAN

When the parent/legal guardian is applying and requests one case be established for all MA eligible children in the home, the parent/legal guardian has the option of not being included in the case. The parent's income is always considered available to the dependent child. The legal guardian's income is considered available to the dependent child ONLY if the legal guardian meets the definition of SR (refer to Vol. IV, [MS 2410](#)) and is included in the case.

To determine the child's and parent/legal guardian eligibility:

- A. Combine the income of the parent/legal guardian and the child included in the case.
- B. Compare to the regular MA Scale for the parent/legal guardian and the child. If less than or equal to the MA Scale, the parent/legal guardian and the child are MA eligible.
- C. [If greater than the MA Scale, explore eligibility in the "I" category, if appropriate.
- D. If ineligible in the "I" category, determine if eligible as a spend down case and compare the income of the parent/legal guardian and the child's income to the regular MA Scale. The excess is the monthly excess that must be spent down to make the parent/legal guardian and the child eligible.]

MS 3920

DEPENDENT CHILD LIVING WITH PARENT  
AND STEPPARENT

Budget process for dependent child living with a parent and stepparent.

A. Child's Eligibility

1. Combine the income of the parent and the child.
2. Compare to the MA Scale for the parent and the child. If less than or equal to the regular MA Scale, the child is MA eligible.
3. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
4. [If ineligible in the "I" category, determine if eligible as a spend down and compare the parent's income and the child's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the child eligible. This is a separate spend down case for the child.

B. Parent's Eligibility

1. Combine the stepparent's surplus income deemed to the parent from form PA-30A, Test Budget, the parent's income and the child's income.
2. Compare to the regular MA Scale for the parent and the child. If less than or equal to the regular MA Scale, the parent is MA eligible.
3. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
4. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the stepparent's surplus income, the parent's income and the child's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the parent eligible. This is a separate spend down case for the parent.

MS 3930\*

INCAPACITATED STEPPARENT INCOME

If an incapacitated stepparent is included in the case with spouse and spouse's dependent child:

- A. Consider total income of the incapacitated stepparent, the spouse, and spouse's dependent child.
- B. Total countable income is the sum of:
  1. Earnings and profit less standard work expense deduction and dependent care deduction, if appropriate; and
  2. Unearned Income.
- C. Compare to the MA Scale for the appropriate family size.

MS 3940\*

PARENTAL INCOME DEDUCTIONS

Consider the gross income of the parent/legal guardian living in the home included in the case of a minor parent and child of minor parent as available to the minor parent.

- A. Reduce the gross income by the following:
  1. Actual self-employment expenses.
  2. The work expense standard.
  3. Child support or alimony payments actually made to persons not in the home. This amount does not have to be court ordered and may include medical bills or medical insurance.
  4. Actual amounts paid to an individual not in the home, other than children or an exspouse, who is or could be claimed by the parent/legal guardian of a minor parent as a dependent for federal income tax purposes.
  5. Appropriate MA scale for the parent/legal guardian family size. Family size includes the dependent of the parent/legal guardian living in the home and not in the MA case, who are or could be claimed for federal income tax purposes.
- B. After reducing the income of the parent/legal guardian, apply any surplus as specified in the specific budget procedure to the MA case.

MS 3950                      STEPPARENT OR PARENT OF A MINOR PARENT

[Income of a stepparent or parent is test budgeted and considered in different ways depending on the family living situation of a minor parent. The test budget determines what portion of the parent or stepparent's income is countable.

Note: For Family MA and AFDC Related MA, a minor parent is a parent under age 18, whose child is living with him/her. This also includes a minor pregnant woman under age 21.

A. Use form PA-30A, Test Budget, when appropriate, to compute the countable income of:

1. The stepparent if the specified relative (SR) wants to be included on the MA case of a minor parent. The stepparent's surplus income is ONLY considered available to the SR and may cause the SR to be ineligible for regular MA.
2. The SR of a minor parent:
  - a. When the SR is NOT included in the case of the minor parent and children of the minor parent;
  - b. When the SR is included in the case as SR for the minor parent and children of the minor parent and other dependents of the SR are living in the home but are not included in the MA case.

The surplus income of the SR is ONLY considered available to the minor parent and may cause the minor to be ineligible for regular MA.

3. The legal guardian when the legal guardian is included in the case as SR for the minor parent and children of the minor parent, and dependents of the legal guardian are living in the home but are not included in the MA case. The surplus income of the legal guardian is ONLY considered available to the minor parent.
4. The stepparent if SR of an adopted minor parent is included in the case as SR for the adopted minor parent and children of the minor parent. The stepparent's surplus income is ONLY considered available to the SR and may cause the SR to be ineligible for MA.

The adopting parent's spouse is considered a stepparent even if the adoption papers do not list the spouse as a parent.

B. Explore eligibility in the "I" category, if appropriate. If ineligible in the "I" category, the only way the SR or minor can be eligible is through spend down.

If individual spend down eligibility must be determined establish a separate spend down case. Appropriate material required to establish eligibility should be copied from the family case and placed in the separate case record.

Do NOT use form PA-30A, Test Budget, for an individual out of the home or for an individual included in another AFDC Related MA case.]

MS 3960

MINOR PARENT LIVING WITH PARENT

Budget process for a minor parent living with parent and siblings of the minor parent. In the budget process, parent refers to parent of minor parent and minor refers to minor parent. Minor's dependent refers to child of minor parent. Do not follow this section when living with both a parent and a stepparent.

A. If the parent/legal guardian is applying for MA as the SR for the minor and minor's dependent, the surplus income of the parent/legal guardian from form PA-30A, Test Budget, is ONLY considered in determining eligibility of the minor. Determine the surplus income of the parent/legal guardian by comparing countable income of the parent/legal guardian to regular MA Scale for the other dependent of the parent/legal guardian living in the home and not in the MA case excluding the parent/legal guardian and minor from consideration.

1. Minor's Dependent Eligibility

- a. Combine the income of the minor parent and the minor's dependent.
- b. Compare to the regular MA Scale for the minor and the minor's dependent. If less than or equal to the regular MA Scale, the minor's dependent is MA eligible.
- c. [If greater than the MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible, in the "I" category, determine if eligible as a spend down case and compare the minor's income and the income of the minor's dependent to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the dependent eligible. This is a separate spend down case for the minor's dependent.

2. Minor's and Parent's Eligibility

- a. Combine the surplus income of the parent/legal guardian from form PA-30A, Test Budget, the minor's income and the minor's dependent's income.
- b. Compare to the regular MA Scale for the parent/legal guardian, the minor and the minor's dependent. If less than or equal to the regular MA Scale, the parent/legal guardian and minor are MA eligible.
- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]

- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the surplus income of the parent/legal guardian, the minor's income and minor's dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the parent/legal guardian and minor eligible. This is a separate spend down case for the parent/legal guardian and minor.
- B. If the minor is applying for MA on a separate MA case for the minor and minor's dependent case, the parent's surplus income from form PA-30A, Test Budget, is only considered in determining eligibility of the minor.
1. Minor's Dependent Eligibility
    - a. Combine the income of the minor and the minor's dependent.
    - b. Compare to the regular MA Scale for the minor and the minor's dependent. If less than or equal to the regular MA Scale, the minor's dependent is MA eligible.
    - c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
    - d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the income of the minor and the minor's dependent to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the dependent eligible. This is a separate spend down case for the minor's dependent.
  2. Minor's Eligibility
    - a. Combine the parent's surplus income deemed to the minor from form PA-30A, Test Budget, the minor's income and the minor's dependent's income.
    - b. Compare to the regular MA Scale for the minor and minor's dependent. If less than or equal to the regular MA Scale, the minor is MA eligible.
    - c. If greater than the regular MA Scale, explore eligibility in the I category, if appropriate.
    - d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the parent's surplus income, the minor's income and the minor's dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the minor eligible. This is a separate spend down case for the minor.

C. If the parent is applying for MA on a separate MA case as the SR for the minor's dependent and MA is NOT requested by the minor, DO NOT consider the parent's income available to the minor's dependent.

1. Minor's Dependent Eligibility

- a. Combine the income of the minor and the minor's dependent.
- b. Compare to the regular MA Scale for the minor and the minor's dependent. If less than or equal to the regular MA Scale, minor's dependent are MA eligible.
- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the minor's income and the minor's dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the dependent eligible. This is a separate spend down case for the minor's dependent.

2. Parent's Eligibility

- a. Combine the income of the parent, the minor and the minor's dependent.
- b. Compare to the regular MA Scale for the parent, the minor and the minor's dependent. If less than or equal to the regular MA Scale, the parent is MA eligible.
- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the parent's income, the minor's income and the minor dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the parent eligible. This is a separate spend down case for the parent.

D. If the parent is applying for MA as the SR on 1 case for siblings of the minor, the minor and the minor's dependent, only consider the parent's income in determining eligibility of the minor and siblings of the minor.

1. Minor's Dependent Eligibility

- a. Combine the income of the minor parent and the minor's dependent.

- b. Compare to the regular MA Scale for the minor and the minor's dependent. If less than or equal to the regular MA Scale, the minor's dependent is MA eligible.
  - c. [If greater than the MA Scale, explore eligibility in the "I" category, if appropriate.]
  - d. [If ineligible in the "I" category, determine if eligible as a spend down and compare the minor's income and the minor's dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the dependent eligible. This is a separate spend down case for the minor's dependent.
2. Parent's, Minor's and Minor's Sibling Eligibility
- a. Combine income of the parent, the minor, the minor's dependent and the minor's sibling.
  - b. Compare to the regular MA Scale for the parent the minor, the minor's dependent and the minor's sibling. If less than or equal to the regular MA Scale, the parent minor and minor's sibling are MA eligible.
  - c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
  - d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the income of the parent, the minor's, the minor's dependent and the minor's sibling to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the parent, the minor and the minor's sibling eligible. This is a separate spend down case for the parent, the minor and the minor's sibling.

MS 3970

MINOR PARENT  
LIVING WITH PARENT AND STEPPARENT

Budget process for minor parent living with a parent and stepparent. In the budget process, parent refers to parent of minor parent and minor refers to minor parent, as appropriate. Minor's dependent refers to minor parent's child.

A. If the parent is applying for MA, consider stepparent surplus income from form PA-30A, Test Budget, in determining eligibility of the parent in Item A3.

1. Minor's Dependent Eligibility

- a. Combine the income of the minor and the minor's dependent.
- b. Compare to the regular MA Scale for the minor and the minor's dependent. If less than or equal to the regular MA Scale, the minor's dependent is MA eligible.
- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the parent's income, minor's dependent's income and the minor's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the minor's dependent eligible. This is a separate spend down case for the minor's dependent.

2. Minor's Eligibility

- a. Combine the income of the parent, the minor and the minor's dependent.
- b. Compare to the regular MA Scale for the parent, the minor and the minor's dependent. If less than or equal to the regular MA Scale, the minor is MA eligible.
- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the parent's income, minor's dependent's income and the minor's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the minor eligible. This is a separate spend down case for the minor.

### 3. Parent's Eligibility

- a. Combine the stepparent's surplus income deemed to the parent from form PA-30A, Test Budget, the parent's income, the minor's income and the minor's dependent's income.
- b. Compare to the regular MA Scale for the parent, the minor and the minor's dependent. If less than or equal to the regular MA Scale, the parent is MA eligible.
- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the stepparent's surplus income, the parent's income, the minor's income and the minor's dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the parent eligible. This is a separate spend down case for the parent.

B. If the parent is not applying, disregard the stepparent's income and consider the parent's income available to the minor. Complete the budget process for minor parent living with a parent not included in the case.

#### 1. Minor's Dependent Eligibility

- a. Combine the income of the minor and the minor's dependent.
- b. Compare to the regular MA Scale for the minor and the minor's dependent. If less than or equal to the regular MA Scale, minor's dependent is MA eligible.
- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the minor's income and the minor's dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the dependent eligible. This is a separate spend down case for the minor's dependent.

#### 2. Minor's Eligibility

- a. Combine the parent's surplus income deemed to the minor from form PA-30A, Test Budget, the minor's income and the minor's dependent's income.
- b. Compare to the regular MA Scale for the minor and minor's dependent. If less than or equal to the regular MA Scale, the minor is MA eligible.

- c. [If greater than the regular MA Scale, explore eligibility in the "I" category, if appropriate.]
- d. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the parent's surplus income, the minor's income and the minor's dependent's income to the regular MA Scale.] The excess is the monthly excess that must be spent down to make the minor eligible. This is a separate spend down case for the minor.

MS 3980

MINOR PARENT LIVING WITH STEPPARENT,  
NOT INCLUDED IN THE CASE

The following is the budget process for a minor parent living with a stepparent, not included in the case. In the budget process, minor refers to minor parent as appropriate. Minor's dependent refers to minor parent's child. Do not follow this section when living with both a parent and a stepparent.

- A. Disregard income of the stepparent who is not included in the case.
- B. Add the minor's income, and the minor's dependent's income.
  1. Compare to regular MA Scale for minor and minor's dependent. If less than or equal to the regular MA Scale, the minor and minor's dependent are MA eligible.
  2. [If greater than the regular MA Scale, explore eligibility in the "I" category.]
  3. [If ineligible in the "I" category, determine if eligible as a spend down case and compare the minor's income and the minor's dependent's income to regular MA Scale.] The excess is the monthly excess that must be spent down to make the minor and minor's dependent eligible.

MS 4100

## INTRODUCTION TO EPSDT

[Early and Periodic Screening, Diagnosis and Treatment (EPSDT) services are jointly administered by DFS and DMS. EPSDT makes available at periodic intervals, preventive health care services for all K-TAP, foster care, AFDC Related MA recipients, Family MA recipients and SSI recipients under 21 years of age.]

Form PA-3, Facts About the Early and Periodic Screening, Diagnosis and Treatment Services, is explained/reviewed at application/reapplication. Form PA-3 is also reviewed when an individual under age 21 is added to a household. The form is completed if the recipient requests assistance with scheduling EPSDT appointments.

MS 4110

EPSDT SERVICES

- A. The services are free health check-ups that include:
1. Health and developmental history.
  2. Unclothed physical examination.
  3. Developmental assessment.
  4. Immunizations which are appropriate for age and health history.
  5. Assessment of nutritional status.
  6. Vision testing.
  7. Hearing testing.
  8. Laboratory procedures appropriate for age and population groups, such as tests for tuberculosis, low blood and kidney problems.
- B. Additional services are:
1. Diagnosis and treatment if problems exist; and
  2. For children 3 years of age and over, dental services furnished by direct referral to a dentist for diagnosis and treatment.
  3. Long term care for children who have special needs that cannot be met in a regular institution in-state or out-of-state. See MS [4170](#).
- C. The periodic intervals are:

MEDICAL SCREENING		DENTAL SCREENING
0-1 month	9-10 years	3 years
2-3 months	11-12 years	6 years
4-5 months	13-14 years	7-8 years
6-8 months	15-16 years	9-10 years
9-11 months	17-19 years	11-12 years
12-13 months	20+ years	15-16 years
14-15 months		13-14 years
16-22 months		17-20 years
23-24 months		
3 years		
4 years		
5 years		
6 years		
7-8 years		

MS 4130\*

CENTRAL OFFICE RESPONSIBILITIES

- A. DFS:
  - 1. Sends quarterly EPSDT reminders to all AFDC recipients, Foster Care recipients, SSI recipients and AFDC Related MA Only recipients under 21 years of age; and
  - 2. Assists local DSI offices to meet program goals through site visits, technical assistance, training and/or other means that may be necessary.
  
- B. In addition, DMS:
  - 1. Assists in obtaining treatment of problems not covered by the Medicaid card;
  - 2. Assists in locating providers who are willing to furnish uncovered services at little or no expense to EPSDT recipients;
  - 3. Pays laboratory costs of frames and/or lenses and appropriate dispensing fee for EPSDT recipients with coverage for eye glasses limited to 2 pairs per person per year; and
  - 4. Pays a certified audiologist for hearing evaluations and hearing aid evaluations and for hearing aids if recommended by a physician and audiologist.
  
- C. Title V, federally funded and administered by the Department for Health Services offers:
  - 1. Various preventive health care services and treatment for existing health problems for children and prenatal/postnatal care for mothers; and
  - 2. Medical services for diagnosis, hospitalization, and follow-up care for children who are crippled or have problems leading to a crippling condition.
  
- D. When appropriate, the screening provider identifies, informs and refers eligible recipients to Title V services.

MS 4140 LOCAL OFFICE RESPONSIBILITIES FOR EPSDT (1)

Local Office staff must inform all AFDC-Related MA, Family MA and Foster applicants/re-applicants under the age of 21, by face-to-face contact and in writing of the availability of the Early and Periodic Screening, Diagnosis and Treatment Services (EPSDT).

- A. At the application/re-application interview:
  1. Explain services listed on form PA-3, Facts about the Early and Periodic Screening, Diagnosis and Treatment Services and complete the form if assistance with scheduling the services is requested;
  2. Explain the freedom of choice in selecting providers;
  3. Inform clients of available screening providers; and
  4. Explain appointment scheduling and medical transportation. See Volume IVA, MS 3800-3810.
- B. If the application is approved and EPSDT services are requested:
  1. Mail a copy of form PA-3 to the recipient;
  2. Complete form PA-3, page 2 according to procedural instructions;
  3. Record requests for scheduling assistance and/or medical transportation on form PA-3, page 2 if assistance is specifically requested; and
  4. Notify recipients of appointments by sending a copy of form PA-3, page 2.
- C. Inform recipients of available transportation through regional brokers. See Volume IVA, [MS 3810](#).
- D. Explain that a quarterly reminder will be received;
- E. Assist anyone who receives an incomplete screen to obtain the remaining screening services if requested;
- F. Assist SSI recipients to obtain EPSDT services, if requested.

MS 4150

SCHEDULING

[After a case is approved and for subsequent Early and Periodic Screening, Diagnosis and Treatment Services (EPDST) requests, page 2 of form PA-3, Early and Periodic Screening, Diagnosis and Treatment Services is sent to the designated staff who:

- A. Reports to the screening provider and/or dentist the names of children for whom EPSDT services are requested or to the designated person who;
  - 1. Obtains dates and appointment times of children from the provider;
  - 2. Enters identifying information on an office log;
  - 3. Posts dates appointment times of each child on the form PA-3; and
  - 4. Returns the completed form PA-3 to the worker.
- B. Worker or designated person responsibilities are to:
  - 1. Telephone a blind or illiterate recipient to advise them of their appointment time and date;
  - 2. Assist with medical transportation by informing recipients of available transportation from the Regional Broker; and
  - 3. Mail the completed form PA-3 to the recipient.
- C. Screening providers are responsible for referring recipients, if appropriate, to a diagnosis and treatment provider of the recipient's choice. If specifically requested to do so, the worker assists with medical transportation by referring recipients to the regional transportation broker. See Volume IVA, [MS 3810](#).]

MS 4160

LOCAL OFFICE RESPONSIBILITIES TO DMS

[Local Office responsibilities to DMS are to notify by calling, Division of Medical Management and Quality, (502) 564-9444 if:]

- A. Screening requests cannot be scheduled within 30 days of request;
- B. Individual reports dental appointments cannot be finalized within 120 days of request;
- C. A local DCBS office EPSDT capabilities will be seriously limited or discontinued; or
- D. Problems requiring treatment are not covered by the MA card.

MS 4170

EPSDT LONG TERM CARE

(1)

Long term care (LTC) is provided under the EPSDT Program for children who have special needs that cannot be met in a regular institution in-state or out-of-state.

A. To receive EPSDT LTC, a child must:

1. Be located in-state or placed by DMS out-of-state;
2. Need services not covered under regular Medicaid, such as drug treatment, if in-state; and
3. Apply for and be Medicaid eligible as an SSI (B or D), K-TAP (C or W), Kinship Care (KC), "L", "E", "N", "I", "P", "T", "Y", "U", "S", "X", "H", "K", "M", "HP" or "KP" recipient prior to the admission date for EPSDT LTC services. Medicaid eligibility must exist prior to receipt of services. To be eligible for EPSDT LTC, a child in custody /committed to the Cabinet must be Medicaid eligible prior to receipt of EPSDT LTC.

Example: An application for a child in need of psychiatric hospital level of care is pending. Medicaid eligibility exists, but lack of time has not permitted approval. Prior to approval, form MAP-24, Memorandum to DCBS, is received authorizing coverage under the EPSDT program. It is verified that the child remains institutionalized and the application is approved. This appears to be an approval for EPSDT LTC, but the initial application was for the psychiatric level of care. EPSDT LTC did not exist at original application, but was determined necessary for the child prior to approval. The eligibility was first based on other criteria, not receipt of EPSDT LTC. Medicaid eligibility must exist prior to approval for EPSDT LTC.

4. EPSDT LTC services are available to individuals under age 21 including those eligible for Pass Through and State Supplementation. The only exception is KCHIP 3 children who are not entitled to EPSDT LTC Services.
- B. EPSDT LTC children are not subject to transfer of resources, property check or estate recovery.
- C. See Volume I, [MS 0050](#), regarding county of residence and caseload coding for a child receiving MA in any category who enters an in-state or out-of-state EPSDT LTC facility.
- [D. The provider may notify the local office via form MAP-24, of those individuals receiving EPSDT LTC coverage. It is not necessary for

EPSDT LTC vendor payment to be added to the case for the provider to receive payment.]

- F. If adding the EPSDT LTC vendor payment only the child's income is considered in the patient liability determination.
1. If the child is a specified relative or case member in a K-TAP, KC, AFDC-related or Family MA case other than a "U" case, use current procedure for adding a vendor payment to active cases. Patient liability is zero for a specified relative or second parent who is K-TAP eligible. A child who is a member of a K-TAP case must have his/her patient liability calculated based on the child's income, excluding the K-TAP payment for the child. See Volume IVA, [MS 1800](#).
  2. If a K-TAP, AFDC-related or Family MA case containing an EPSDT LTC child is discontinued, or the EPSDT LTC child obtains a source of income such as RSDI that causes case ineligibility, refer the family or interested party to Central Office. See [MS 2670](#).
  3. If a child moves from a waiver program to EPSDT LTC, patient liability for the calendar month of the move to the EPSDT facility is zero.
  4. If the child moves from an EPSDT facility to a psychiatric hospital, PRTF, IMD or NF, the patient liability for the new institution is calculated based on the child's countable income.
- G. The MAP-24 is used to provide the admittance date, provider number and to:
1. Advise of placement in an EPSDT facility;
  2. Notify the local office when a child is released from a facility;
  3. Advise of a change when a child is moved from a regular institutional setting, e.g., a psychiatric hospital to an EPSDT LTC facility; and
  4. Advise of a change when a child is moved from an EPSDT facility to a regular covered service in a psychiatric hospital, PRTF, NF or waiver program.
- H. The Department for Medicaid Services (DMS) determines patient status for children in DCBS custody who are committed to the Cabinet and who require extended inpatient care in an EPSDT LTC facility. Payment for EPSDT LTC services for some of these DCBS children may be retroactive to July, 1995. The Children's Benefits Worker (CBW) receives documentation of the child's patient status and determines eligibility.
1. To receive extended EPSDT LTC, a child in DCBS custody must be:

- a. Medicaid eligible; and
  - b. Previously approved for placement in a psychiatric facility, IMD or PRTF by the Peer Review Organization; or
  - c. Approved for patient status in an EPSDT LTC facility.
2. The first two digits of the provider number for EPSDT LTC facilities are 45.
  3. Active cases are carried by the CBW in the county where the CBW responsible for the child is located.

MS 4200

[MEDICARE SAVINGS PROGRAM OVERVIEW]

(1)

Medicare Savings Programs can assist individuals/couples in paying for their Medicare Premiums. Medicare Savings Programs include: Qualified Medicare Beneficiaries (QMB), Specified Low-Income Medicare Beneficiaries (SLMB), Medicare Qualified Individuals Group 1 (QI1) and Qualified Disabled Working Individuals (QDWI). QMB, SLMB, QI1 and QDWI individuals must meet all technical eligibility requirements for Aged, Blind or Disabled MA.

Individuals receiving Family MA may receive benefits in the QMB or SLMB categories in addition to regular MA benefits. This is dual eligibility.

A. QMB

QMB recipients are eligible for limited MA and Buy-In. Coverage for QMB individuals provides for payment of Medicare Part A and Medicare Part B premiums, Medicare deductibles, and Medicare coinsurance amounts. Due to payment of coinsurance amounts, QMB coverage is extended to all Medicare services or items outside the scope of MA coverage except:

1. Prescription drugs;
2. Medical transportation;
3. Medicare deductibles and coinsurance for individuals age 21 (or age 22 if uninterrupted treatment began prior to age 21) through 64 in a psychiatric hospital.

B. SLMB

For individuals whose countable income is in excess of the QMB standard, determine eligibility for SLMB. SLMB recipients meet all of the technical and resource requirements for QMB benefits, except for having income in excess of the QMB standard but less than or equal to the SLMB scale maximum limit. Coverage for SLMB individuals provides for payment of the Medicare Part B premium only and may be effective three months prior to the SLMB application month. SLMB eligibility cannot be met through spend down.

C. QI1

For individuals whose countable income is in excess of the SLMB standard, determine eligibility for QI1. QI1 recipients meet all of the technical and resource requirements for QMB benefits, except for having income in excess of the SLMB standard but less than or equal to the QI1 scale maximum limit. Because the QI1 program has limited annual funding, applications can only be approved until funds are exhausted. DMS will advise when funding has been exhausted. QI1 recipients are not dually eligible for any category of Medicaid.

## D. QDWI

QDWI recipients are working individuals who do not meet the disability criteria for MA eligibility. If the QDWI recipient chooses to be included in another case with a dependent child, discontinue the "Z" case.

Since they are not entitled to dual benefits, do not include the QDWI individuals in a case for any month in which they receive QDWI benefits. For spend down approvals, the QDWI recipient will lose their buy-in for the months of spend down coverage and a medical deduction is allowed for the SMI premium for each spend down month. Advise the recipient that the SMI premium for those months may be recouped by the Centers for Medicare and Medicaid Services (CMS).

- E. KYHealth cards are ONLY issued for recipients receiving QMB, SLMB, and QI1. QDWI recipients do not receive a KYHealth card.
- F. For services requiring co-payments refer to VOL IVA, [MS 1065](#).

MS 4210 [TECHNICAL ELIGIBILITY FOR MEDICARE SAVINGS PROGRAM] (1)

The individual must meet all technical eligibility requirements for Aged, Blind, or Disabled MA, except Third Party Liability. The QMB individual must receive Medicare Part A. SLMB and QI1 individuals must receive both Medicare Part A and B. Receipt of Medicare may be verified by: making a copy of the Medicare card, written verification from SSA, or by viewing IMS Bendex file, Program 39 and SDX Inquiry under "INS CODE". These codes display A (Medicare Part A), B (Medicare Part B), C (Medicare Parts A and B) or M (No Medicare). Document in KAMES comments how Medicare receipt was verified.

A. Technical Eligibility for QMB:

Individuals applying for QMB must receive Medicare Part A. Open enrollment for Medicare Part A is January - March of each year. Individuals may enroll in Medicare Part A during the annual open enrollment period.

1. Annual Open Enrollment Period

- a. Individuals who do enroll in Medicare Part A during the annual open enrollment period do not become eligible for receipt of Part A until July. If these individuals request QMB benefits prior to becoming eligible for Medicare Part A, complete an Inquiry/Update PA-97, on KAMES. Specify on the KAMES PA-97 that the applicant has been advised to return to the local office in May or June to make application to determine QMB eligibility. Process the QMB application no later than the end of June to coincide with the first month of Medicare Part A receipt in July.
- b. Individuals who miss the open enrollment period in the current year cannot enroll in Medicare Part A until the open enrollment period in the following year.

2. Conditional Enrollment

Some individuals enroll in Medicare Part A with the condition that they are eligible for QMB benefits so that the incurred premium will be paid under the QMB program. These individuals still must meet all technical and financial eligibility requirements for the QMB program. SSA provides the names of conditional enrollees to the Medical Support and Benefits Branch (MSBB) which verifies eligibility and the effective date of Medicare Part A. For individuals not eligible for SSI, MSBB will forward to the field for action to be taken. Follow the steps below when notification is received:

- a. Send appointment letters to the individual to schedule a QMB application appointment.
- b. Schedule the appointment in a timely manner to allow the QMB application to be processed with a QMB effective date to coincide with the Medicare Part A effective date.

- c. Keep appointment letters for individuals who fail to keep a scheduled appointment in a designated local office file for a period of 1 year.
- d. As these individuals do not have Medicare cards, document the case record regarding conditional enrollment and verification of Medicare Part A eligibility by SSA.

B. Technical Eligibility for SLMB and QI1:

SLMB and QI1 individuals must receive both Medicare Part A and B. These individuals only receive buy-in for their Part B Medicare premium. SLMB and QI1 individuals do not receive limited MA for Medicare co-pays and deductibles.

MS 4300

[AFDC RELATED OVERVIEW

K-TAP recipients, K-TAP applicants and any individual who wishes to apply for Medical Assistance only may be eligible in either the "E" or "T" category. To be eligible in the "E" or "T" category a family must meet the AFDC Program criteria in effect on July 16, 1996. Spend down eligibility is not applicable in the "E" or "T" category. MA KWP disqualifications do not apply to "E" or "T" cases.]

MS 4305

STANDARD FILING UNIT

(1)

Include the parent and all children of that parent in the same AFDC Related MA (E/T) case, if technically eligible and living together, regardless of financial eligibility.

In the examples below "\$" indicates income and resources are counted.

- A. Single parent household. Deprivation is death, prison, hospitalization, divorce, desertion, birth out-of-wedlock, single parent adoption, legal separation, deportation, or marriage annulment.

<u>Household Member</u>	<u>IM ID Code</u>
Parent \$	M03
Child, age 10 \$	M05
Child, age 12 \$	M05
Child, age 4 \$	M05

Include everyone in the family size and consider all income and resources.

NOTE: If the parent refuses to add an eligible child to the AFDC Related MA case, the entire case is ineligible.

- B. No parent household.

1. Include all siblings living in the home in one E case.

Grandparent (not applying for self)	T
Daughter's child, age 6 \$	M05
Daughter's child, age 10 \$	M05

Only the children's income is considered in the case, since the grandmother is a non-responsible specified relative (SR), who is not included in the case.

OR

2. Children may have separate applications when there is no common parent in the home. The same non-responsible SR may apply for both MA groups, but may receive MA in only one case. Code the SR as a "T" member if not included in that case. Count income of case members only.

Case A	
Grandparent (applying) \$	M03
Daughter's child, age 9 \$	M05
Son's child, age 3	T

Case B	
Grandparent	T
Daughter's child, age 9	T
Son's child, age 3 \$	M05

[C. Two parent household, married or unmarried. Deprivation is incapacity (E) or unemployment (T) of either parent. Verification of legal marriage or paternity (adjudicated or administratively established) is required to include both parents in the case. An incapacitated parent is included as a member of the case unless receiving SSI. The income and resources of SSI recipients is excluded.]

1. E Case
 

Parent \$	M03
Parent (incapacitated) \$	M04
Child, age 13 \$	M05
  
2. E Case with SSI Parent
 

Parent (SSI)	R57
Parent \$	M04
Child, age 13 \$	M05
  
3. T Case
 

Parent (qualifying) \$	M03/M04
Parent \$	M04/M03
Child, age 13 \$	M05
  
4. E or T Case, Only Child is SSI/SSP Recipient
 

Parent (QP or incap.) \$	M03/M04
Parent \$	M04/M03
Child (SSI)	R52

D. Parent and stepparent household.

If there is a common child, establish one case containing the parent, stepparent and all children. Deprivation is incapacity (E) or unemployment (T) of either parent or stepparent.

Mother (incap.) \$	M03
Stepfather \$	M04
Her child, age 4 \$	M05
His child, age 6 \$	M05
Their child, age 2 \$	M05

E. Minor parents. A minor parent is any parent, married or not, under age 18.

1. Minor parent, minor parent's spouse, and the minor's child living with parents and siblings. The parents receive MA for themselves, the minor parent, and all other technically eligible siblings. The minor parent chooses whether to include the minor's child in the parent's case.

Mother \$	M03
Father \$	M04
Child, age 15 \$	M05
Minor parent \$	M07 (or M05 if minor's child not included)
Minor's child, age less than 1 year \$	M18 (or T if not included)
Minor parent's spouse \$	R58

In the examples below "TB" indicates Test Budget Income.

2. If there are no technically eligible siblings, the minor parent may receive MA for self, child, and spouse, if there is a deprivation factor of incapacity or unemployment for either minor parent or minor parent's spouse.

Mother TB \$	R42
Minor parent \$	M03/M04
Minor's spouse \$	M04/M03
Minor's child, age 3 \$	M05

Income from a parent, stepparent, spouse of a non-responsible SR, or minor's spouse may be counted in the E/T case, even when that person does not receive benefits. KAMES will "test budget" the income and determine eligibility. Form PA-30A, Test Budget, may be used to confirm that the "test budget" calculation is correct.

3. Minor parent living with parent, stepparent, spouse and child, and either minor parent or minor parent's spouse is incapacitated or unemployed.

Minor parent \$	M03/M04
Minor's spouse \$	M04/M03
Minor's child, age 3 \$	M05
Parent TB \$	R42
Stepparent TB \$	R41

MS 4308

TMA

E/T recipients may be eligible for TMA. Refer to MS [2900-3000](#). To be eligible for TMA, the recipient must have received either K-TAP or E/T, or a combination of both for at least 3 out of the prior 6 months.

MS 4309\* E/T DISCONTINUED DUE TO CHILD OR SPOUSAL SUPPORT

If the receipt of new or increased child or spousal support causes E/T ineligibility, the group may be entitled to MA up to 4 months. Refer to MS [3050](#).

MS 4310

INTRODUCTION TO RESOURCES

This subchapter defines and explains the method of determining if resources are within program limitations for Medicaid in the E or T category.

MS 4312                      RESOURCES – GENERAL INFORMATION                      (1)

Resources are money or other liquid assets to which the individual has access.

- A. Verify/document countable resources at the initial eligibility determination or recertification regardless of amount of the resources, at any time the family's holdings are close to the resource limit, or there is indication of receipt or transfer of resources. [Refer to Volume IV, [MS 1320](#), for cases pending over 30 days with good cause.]
- B. Document the case record as to type and amount of resource verified.
- C. Use the first appropriate verification:
  - 1. Savings book or bank statements;
  - 2. Stock statement or statement regarding bonds; or
  - 3. Wills, trustee statements.
- D. Consider countable resources when actually available to the specified relative (SR) or benefit group. Countable resources are added together to determine if they are within permitted limits. Funds in an IRA, trust fund, retirement or deferred compensation are EXCLUDED during periods of unavailability.
- E. All cases with vendor payments are subject to a penalty for transfer of resources and require a resource check prior to vendor payment approval. (Refer to Volume IVA, MS 2050) except for individuals in the following levels of care:
  - 1. Hospice Non-Institutionalized;
  - 2. Hospice Institutionalized;
  - 3. Mental Health/Psychiatric Facility;
  - 4. PRTF; and
  - 5. EPSDT.

Excluded resources are not considered in determining eligibility.

MS 4320

EXCLUDED RESOURCES

EXCLUDED RESOURCES are available money, real property, personal property or other assets not counted in determining eligibility.

- A. Owner-occupied home. This may include a motor vehicle if the recipient claims the family lives in the motor vehicle. If a motor vehicle is claimed as a home, the value of the motor vehicle is excluded until the recipient moves to another home.
- B. All motor vehicles;
- C. Basic household items essential for day-to-day living, e.g., furniture, appliances and clothing;
- D. Gifts or inheritance legally not available until a later date;
- E. All resources of an SSI or State Supplementation recipient;
- F. Equity value of all equipment, livestock or other inventory used in a farming or self-employment enterprise;
- G. Crops and animals raised for home consumption;
- H. Children's toys and bicycles;
- I. Household pets;
- J. Resources of a child technically excluded from the E or T case;
- K. Resources of the stepparent, parent or legal guardian of a minor parent, or the spouse of a non-responsible SR;
- L. Proceeds (sale price less indebtedness) from sale of home, including initial or down payment from land contract sale, for 6 months if recipient plans to invest in another home. If not reinvested in 6 months, the remaining amount is a countable resource;
- M. Non-home real property.
- N. Funds in an IRA, state retirement, deferred compensation, etc., during periods of unavailability. When these funds become available, count as a resource if the total amount is available. If not, count withdrawals as unearned income for the month of receipt and consider the fund an excluded resource.
- O. Excluded income is also an excluded resource, e.g., money received from urban renewal assistance;
- P. Principal and accrued interest of an irrevocable trust during periods of unavailability including irrevocable funeral trusts. See MS [4335](#);

- Q. All burial spaces;
- R. The entire value of prepaid burial funds and CSV of burial insurance policies;
- S. Up to \$5,000 is excluded in Individual Development Accounts (IDA's).
- T. Loans. Verify the loan by a commercial loan contract or form PAFS-73, Verification of Contributions – Loans – Roomer/Boarder Payments. When verification is received, consider the amount as a contribution;
- U. Up to \$12,000 to Aleutians and \$20,000 to individuals of Japanese ancestry for payments made by the United States Government to compensate for hardship experienced during World War II. All recipients of these payments are provided with written verification by the U.S. Government;
- V. Payments made from the Agent Orange Settlement Fund issued by Aetna Life and Casualty to veterans or their survivors in accordance with Public Law 101-201, which was retroactive to January 1, 1989;
- W. Earned Income Credit (EIC) payments in the month of receipt and the following month;
- X. Any payments received from the Radiation Exposure Compensation Trust Fund;
- Y. For Self-Employment/Farming annualized income, the balance of the yearly payment is excluded during each of the months the prorated amount is counted as self-employment income. Resources accumulated by a self-employed person, which are prorated as monthly income, are excluded.  
  
Example: A tobacco farmer, after all expenses, receives \$6,000 for her crop in January and deposits this sum in her bank account until needed for the next year's crop. The \$6,000 is then prorated over a 12-month period and \$500 as monthly self-employment income is considered in the case. The yearly payment (\$6,000) is excluded during the period the prorated amount is counted (12 months) as self-employment income; and
- Z. K-TAP or SSI back payments issued to an E or T recipient who is not ongoing eligible for SSI, are not counted as resources for the month of receipt and the following month. See MS [4325](#).
- AA. [Tax rebate checks are excluded in the month of receipt and the following two months. Any proceeds from the rebates retained after the third month are considered a countable resource.]



MS 4340

JOINTLY HELD RESOURCES

JOINTLY HELD RESOURCES are resources owned or held by more than 1 person.

- A. Document in the case record the amount of the resource and the type of verification used.
- B. Determine the amount of a jointly held resource and consider as follows:
  - 1. Total amount of joint checking/savings account is available to the recipient when only 1 signature is required to withdraw funds, unless the other individual is an SSI recipient.

If 1 or more of the other individuals on a joint account is a SSI recipient, divide the amount by the number of owners and count as available the money, which is not a SSI recipient's share.

- 2. When more than 1 signature is required to withdraw funds from a joint checking /savings account, only the recipient's share is available. Share is established by a signed statement from other parties as to the division.
  - [3.] If resources are held jointly, other than checking/savings accounts and business enterprises, determine recipient's share by dividing value by number of owners. The parent's share is available to the children for whom assistance is requested, regardless of whether the parent is included as specified relative.
  - [4.] If the recipient states that he/she does not contribute to or withdraw from a jointly held resource (i.e., checking, savings, certificates of deposit or savings bonds), allow the recipient the opportunity to rebut the ownership. To rebut, the recipient must provide:
    - a. A written statement regarding ownership, who deposits and withdraws;
    - b. A written statement from each of the other account holders which corroborates the recipient's statement, unless the account holder is a minor or is incompetent; and
    - c. Verification that the recipient's name has been removed from the account.
    - d. [Do not consider the resource effective with the month the recipient's name is removed from the account.
  - 5.] Consider non available when the parties of the jointly held resource are not willing to release their portion of the resource or one party cannot be contacted for a release of their portion. It must be verified that litigation would be required or is pending (E.g., divorce settlement, probate of will, etc.) to determine to whom a resource

belongs. Spot check monthly or in the month the litigation is expected to be completed.

MS 4348

[SALE OF PROPERTY]

[The sale of property includes the sale of land, the home, or another resource.] Proceeds (gross receipts minus indebtedness) from the sale of property are a countable resource.

- A. If negotiable or saleable, promissory notes, mortgages, and land contracts are considered resources to the holder in the amount of the equity (value minus indebtedness). Promissory notes, mortgages, and land contracts are considered saleable unless specifically prohibited in the agreement. Verify the amount using the contract or written agreement.
  1. If considered a resource, the interest portion of the continuing payment is income, the principal is a resource.
  2. If nonnegotiable or nonsaleable, continuing payments on promissory notes, mortgages and land contracts are considered unearned income. See MS [4395](#).
- B. If a home is sold and there is no intention to invest in another home, consider the proceeds as a countable resource in the month of sale or transfer and subsequent months when still available.
- C. If land is sold on a land contract, the initial or down payment is a countable resource and monthly payments are income, with the following exceptions:
  1. If a home is sold on land contract, the initial or down payment is an excluded resource for a period of 6 months to allow time to reinvest in another home; and
  2. If a home is sold or destroyed, the proceeds from the sale or insurance settlement is an excluded resource for a period of 6 months to allow time to reinvest in another home. If the proceeds have not been reinvested by the end of the 6-month period, the amount remaining is a countable resource.

MS 4350

LIFETIME CARE AGREEMENT

A LIFETIME CARE AGREEMENT is an agreement entered into with another individual or organization for lifetime care of an individual or family, in exchange for resources of the individual or family.

- A. Document in the case record the type of verification used.
  - 1. Copy of agreement; or
  - 2. Statement from organization or individual providing care.
  
- B. Consider the lifetime care agreement as follows:
  - 1. If resources are still available to the individual or organization with whom the agreement is made, case is ineligible.
  - 2. If individual or organization holding agreement provides a written statement that resources have been exhausted, compute current resources of the individual to determine if resources are within the resource limit.

MS 4360

INCOME – GENERAL INFORMATION

(1)

[INCOME may be earned or unearned money received from wages, statutory benefits, rental property, investments, business operations, child support, nonrecurring lump sums, etc., or for labor or services performed by a non-SSI responsible specified relative, second parent, "E" or "T" child, sanctioned or statutorily excluded or non-SSI technically excluded individual or a non-SSI stepparent. All income, earned or unearned, MUST be verified.

Earned and unearned income is divided into 3 general types: continuing, non-continuing, and anticipated. The type determines how the income will be counted in ongoing eligibility.

1. CONTINUING INCOME is income which will be received on a regular basis (i.e., weekly, monthly, quarterly, semi-annual, or annual). This income includes, but is not limited to, wages, statutory benefits, pensions, etc.
2. NON-CONTINUING INCOME is income which is or was intended to be a continuing type (i.e., wages, monthly RSDI) but has been terminated.
3. ANTICIPATED INCOME is money expected to be received in the future, (i.e., child support from CSE, wages).]

MS 4365 EXCLUDED INCOME (1)

EXCLUDED INCOME is income received by case members but is not considered when determining gross income.

Consider the income not available when the parties of the jointly held income are not willing to release their portion of the income or one party cannot be contacted for a release of their portion. It must be verified that litigation would be required or is pending to determine to whom income belongs. Spot-check monthly or in the month the litigation is completed.

The following is a list of excluded income.

- A. Reimbursement for transportation in performance of employment duties, if identifiable;
- B. KWP supportive services and transportation payments;
- C. Certain Workforce Investment Act (WIA) Income;
- D. Monies distributed to members of certain Indian tribes which are referred to in Section 5 of PL 94-114 that became effective October 17, 1975 or Section 9 of PL 96-420 that became effective October 10, 1980;
- [E. In-kind income; ]
- F. Nonemergency medical transportation payments;
- G. Principal of loans, including educational loans. Verify the loan by a commercial loan contract, or form PAFS-73, Verification of Contributions - Loans - Roomer/Boarder Payments. Student income must be verified through the student's educational account or a collateral contact to the institution. When verification is received exclude the loan amount.

If unable to obtain verification, consider the principal of the loan as a contribution in the month received and any remaining amount as a resource in subsequent months.

- H. Verified educational grants and scholarships obtained and used under conditions that preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill; Verified educational payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:
  - 1. Tuition and fees normally assessed a student carrying the same academic workload as determined by the institution, and including cost for rental or purchase of any equipment, materials or supplies required of all students in the same course of study; and

2. An allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution;
- I. All student work study income, educational grants and loans to any undergraduate verified to be made or insured under any program administered by the U.S. Commissioner of Education or under the Bureau of Indian Affairs student assistance programs;
  - J. Highway relocation assistance;
  - K. Urban renewal assistance;
  - L. Monies received from federal disaster and state disaster assistance;
  - M. Home produce utilized for household consumption;
  - N. Any funds distributed per capita to or held in trust for members of any Indian tribe under PL 92-524, PL 93-134, PL 94-540, PL 97-458, PL 98-64, PL 98-123, PL 98-124 or PL 100-241 (cash payment not exceeding \$2,000 per year);
  - O. Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;
  - P. Payments for supporting services or reimbursement of out-of-pocket expenses made to individual volunteers serving as foster grandparents, senior health aides or senior companions, and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113;
  - Q. Payments to volunteers under Title I (VISTA) of PL 93-113 pursuant to Section 404(g) if less than the federal or state minimum wage (whichever is greater);
  - R. Any payment made by the Division of Protection and Permanency for child foster care, or under certain circumstances subsidized adoptions, adult foster care, personal care assistance;
  - S. SSI or State Supplementation benefits including any other income of SSI or State Supplementation recipients and SSI back payments;
  - T. Cost of producing income for self-employment;
  - U. Any housing subsidies received from federal, state, or local governments even if paid directly to the recipient;
  - [V. Vendor payment income. Payments made DIRECTLY to a doctor, pharmacist, landlord, etc. by another individual. If this payment is for Home Energy Assistance Program (HEAP), see "W";

- W. Home Energy Assistance Program (HEAP) payments:
1. Vendor payment HEAP from a certified private nonprofit organization;
  2. Cash and vendor payment HEAP from a certified:
    - a. Supplier of home heating gas or oil;
    - b. Municipal utility providing home energy; or
    - c. Rate-of-return entity regulated by state and/or federal government; or
  3. Vendor payment assistance provided by an individual (e.g., friends, relatives, etc.).]
- X. Income of a technically excluded child;
- Y. Small nonrecurring cash gifts (e.g., Christmas, birthdays and graduation), of \$30 or less but not totaling more than \$30 per month for each member of the assistance group. See [MS 4377](#);
- Z. Income from complementary programs (i.e., ETP payment and education-related transportation and school supplies). See [MS 4368](#);
- AA. Up to \$12,000 to Aleutians and up to \$20,000 to individuals of Japanese ancestry for payments made by the U.S. Government to compensate for hardships experienced during World War II. All recipients of this income are provided with written verification by the U.S. Government;
- BB. Payments made from the Agent Orange Settlement Fund issued by Aetna Life and Casualty to veterans or their survivors in accordance to P.L. 101-201 retroactive to January 1, 1989;
- CC. K-TAP back payments;
- DD. Income of a legal guardian when determining eligibility for a minor parent and the minor parent's child. This does not include legal guardians that meet the definition of a specified relative (SR) and are included in the E or T case;
- [EE. Federal tax refunds are excluded as income for 12 months from the month of receipt. This includes advance Earned Income Tax Credit (EITC) payments.]
- FF. Any payments received from the Radiation Exposure Compensation Trust Fund;
- GG. Americorps educational awards. These awards are paid directly to the institutions;
- HH. Payments made to individuals because of their status as victims of Nazi persecution;

- II. Family Alternatives Diversion (FAD) payments;
- JJ. Wages from employment excluded for a 2 month period if the exclusion has not been allowed previously in the K-TAP or "E" or "T" case. This is a once in a lifetime exclusion.
- KK. Income from interest and dividends.
- [LL. The value of USDA donated foods, supplemental food assistance under the Child Nutrition Act of 1966, food assistance provided for children under the National School Lunch Act as amended, and the monthly SNAP allotment.
- MM. Tobacco Settlement Income is excluded in the month of receipt and the month after receipt. It is considered a countable resource in the third month and thereafter.]

MS 4367

EXCLUDED STUDENT INCOME

- A. [EARNED INCOME OF AN E OR T CHILD IN FULL-TIME SCHOOL ATTENDANCE may be excluded: 1) a student under 19 years old; 2) a child less than 18 years old who has graduated; 3) there is no time limits for these exclusions.
  
- B. Earned income received by a child from participation in a Workforce Investment Act (WIA) earned income activity, regardless of student status, is excluded for a period not to exceed 6 months within a calendar year.] The 6 months are cumulative months. See MS [4440](#).

MS 4368

COMPLEMENTARY PROGRAM INCOME

Certain assistance from complementary programs may be excluded. Assistance from complementary programs is money received from other public agencies and nonprofit organizations which does not duplicate items included in the E or T standard of assistance. [For WIA stipend income, see MS [4440](#). The E or T standard of assistance includes shelter, food, clothing and utilities.]

Complementary program assistance which may be excluded is the \$25 Employment and Training Program (ETP) payment to food stamp recipients and assistance for education related transportation and school supplies from other public agencies or nonprofit organizations.

MS 4370 INTRODUCTION TO UNEARNED INCOME (1)

UNEARNED INCOME is money not earned by direct activity by an individual. Examples are statutory benefits, miner's benefits, pensions, insurance, annuities, oil leases, minerals rights, spousal maintenance due to one member of the couple in an LTC facility, etc. The following are procedures for calculating the best estimate of the monthly unearned income.

A. CONSIDERATION.

1. Round the monthly amount of each unearned income type to the nearest dollar (1¢ - 49¢ round down and 50¢ - 99¢ round up).
  - a. If the income is received on a MONTHLY basis and:
    - (1) The income is reflective of ongoing, use the monthly amount of income.
    - (2) The income fluctuates, average the amounts received in the 3 prior calendar months to determine the best estimate of the monthly amount.
  - b. If the income is received MORE frequently (i.e., weekly, bi-weekly, semi-monthly), use the amounts received in the 3 prior calendar months, average and multiply the average by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$  or 2, whichever is appropriate, to determine the best estimate of the monthly amount of income.

If the income is received LESS frequently (i.e., quarterly), prorate over the period it is intended to cover. Consider the prorated amount as the best estimate of the monthly amount.

EXAMPLE: The recipient receives \$28 on a quarterly basis. Divide the \$28 by 3 and count \$9.33 as monthly income.

2. Profit from farm or rental income is considered unearned income if there is no direct activity on the part of the recipient in producing the income.
3. Consider payment received when employee's retirement contributions are withdrawn prior to retirement as a resource and not income. The retirement contribution was considered income in the month earned and withheld by the employer. Therefore, when it is withdrawn, it is not counted as income again.
4. Explore the possibility of withheld income information.
5. For cases pending over 30 days with good cause refer to Volume IV, [MS 1320](#).

**B. VERIFICATION.**

1. Verify the income at application, recertification and at the time of a reported change or an anticipation of a change in income.
2. Self-declaration of income is not acceptable verification. When income ceases, verify lack of income before removing it from the case. To verify zero income, see Volume IV, MS 3470.
3. The following are types of documents that may be used to verify unearned income:
  - a. Award letters from Social Security;
  - b. Job service card;
  - c. Company pension statement;
  - d. Internal Revenue Service records;
  - e. Veterans records;
  - f. Railroad Retirement records;
  - g. Support orders;
  - h. Union records;
  - i. PA-1610A;
  - j. SSA verification forms;
  - k. Bendex;
  - l. College financial aid award letter;
  - m. Contract on sale of property;
  - n. Bank and other financial statements (for investments only);
  - o. Statement or copy of checks from the absent parent for support payments; or
  - p. Statement from individual providing income to recipient.

**C. DOCUMENTATION.**

Document in comments any unusual circumstance that conflicts with KAMES data.]

MS 4372

## STATUTORY BENEFITS

STATUTORY BENEFITS are monies which are paid due to law and include RSDI, Railroad Retirement, Black Lung, Veterans pension or compensation, Agent Orange payments issued by the Department of Veterans Affairs, according to P.L. 102-4 enacted on February 6, 1991, Worker's Compensation, Unemployment Insurance (UI), or other pensions. SSI is not a statutory benefit.

ALL RECIPIENTS ARE REQUIRED to apply for or comply with the requirements to receive statutory benefits if potential entitlement exists and the appropriate agency allows the recipient to apply. Refusal to explore entitlement results in ineligibility of the individual. Do not withhold approval or discontinue an active case during the period entitlement is being determined.

[In a "T" case, ONLY the individual who actually refuses to apply for or comply with the requirements is statutorily excluded.]

Document in the case record the amount and type of verification or file a copy of the verification in case record.

Count statutory benefits in determining total income of the assistance group as follows:

- A. DESIGNATED BENEFITS. Gross income available only to a specified individual as designated by award letter, benefit statement, form PA-1610A, SSA verification forms, Bendex, etc., e.g., RSDI, UI, Worker's Compensation. EXCEPTION: If the benefits are being reduced due to an overpayment, only consider the amount of benefits actually received.

NOTE: When accessing Bendex (IMS program 39) to obtain the RSDI benefit amount, use the amount shown as "NET" in the calculation process. "NET" reflects the RSDI amount BEFORE the SMI deduction.

1. Count individual shares of all members of the assistance group.
  2. Exclude amount for individuals not in case, unless this individual is the natural or adoptive parent of an E or T child included in case. See MS [4379](#).
  3. If the payee of RSDI benefits IS NOT in the home, count only the amount actually provided to the beneficiary.
- B. NON-DESIGNATED BENEFITS. Gross income not assigned to a specified individual, e.g., VA or Black Lung benefits, etc. If the benefits are being reduced due to an overpayment, only consider the amount of benefits actually received.

1. When all individuals covered by the benefit are in the "E" or "T" case, count the entire amount.
2. When all individuals covered by the benefit are NOT in the "E" or "T" case, prorate the benefit to establish the amount for determining eligibility:
  - a. Divide the total amount of statutory benefit by the number of people for whom the payment is intended. Exclude amount for individuals not in case, unless this individual is the natural or adoptive parent of a child included in case.
  - b. When the family verifies paying a portion of the benefit to a covered individual outside the home, disregard only the prorated share. If the individual is in another K-TAP or MA case and receives more than the prorated share, consider the prorated amount as income.

C. CONSIDERATION. Determine the monthly amount of income to be considered in the case in the following manner.

1. If the income is received monthly, use the monthly amount of income.
2. If the income is received on more than a monthly basis (e.g., weekly, bi-weekly, semi-monthly), use the amounts received in the 3 prior calendar months. Average and multiply the average by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$  or 2 whichever is appropriate, to determine the best estimate of the monthly amount of income.

EXAMPLE: The recipient receives UIB bi-weekly and is part-time employed. The UIB payments are:

January	- \$ 150
	\$ 165
February	- \$ 145
	\$ 170
March	- \$ 180
	<u>\$ 130</u>
	\$ 940

\$940 divided by 6 equals \$156.67 average bi-weekly income.  
 \$156.67 multiplied by  $2 \frac{1}{6}$  equals \$339.45 monthly income.

D. DOCUMENT the method of verification and the computation of the best estimate of the monthly income.

MS 4374 AFDC RELATED MA: CHILD AND SPOUSAL SUPPORT

[Child and/or spousal support income is the amount of legally established or voluntary child/spousal support regularly received by the applicant/recipient. Voluntary payments are payments made by a legal, alleged or adjudicated parent without a court order for support. If court ordered, the child support and spousal support may be in two separate orders. When child and/or spousal support is court ordered, it can be considered as non-continuing only if terminated by a court order and months of zero receipt are verified. Any amount of a military allotment designated as child/spousal support is considered as child/spousal support.

A. VERIFICATION

Verification includes court records, checks or statement from the Non-Custodial Parent (NCP), KASES etc. Use the column "DATE" on the KASES Benefit Summary Inquiry Screen to determine the month of receipt.

If child support is being paid through CSE:

1. Use the KASES Accounting Function, "05" to determine if child/spousal support is paid.
2. Select option "21", Benefit Summary to display the Benefit Selection Inquiry screen.
3. Select the appropriate IVD# to display the Benefit Summary Inquiry screen.
4. Use the column "DATE" on the KASES Benefit Summary Inquiry Screen to determine the month of receipt.
5. Access KASES during the interview, and review the amounts appearing on the KASES Benefit Summary Inquiry Screen with the individual. If the individual states they have not received a payment listed in the \$CSUP FAMILY or \$ARR FAMILY column, contact CSE staff or the contracting official to resolve the discrepancy.

B. CONSIDERATION

All child support is designated for a specific child. When calculating child support, deduct the \$50 disregard of support income received for a child applying for or receiving MA. If more than one case, divide by the number of cases in which child support income is received.

Note: Sometimes it is more advantageous to place siblings into separate cases or to allow a larger share of the disregard amount in one

case. However, only one disregard is given regardless of the number of cases. A portion of the disregard must be allowed in each case.

1. If the amount of child support is representative of ongoing income consider as follows:
  - a. Manually calculate the total amount of child support for the 3 prior months (do not round) and average the total to get the average monthly amount (do not round).
  - b. Deduct the \$50 disregard from the average monthly amount before entering the amount on KAMES.

EXAMPLE #1:

Two children in a case receive child support from the same NCP. KASES shows child support paid for both children as follows:

April	\$105
May	\$125
June	\$125
Total	\$355

The 3 months total (\$355) is divided by 3 which equal \$118.33. Subtract the \$50 disregard (\$118.33-\$50.00=\$68.33). The total (\$68.33) is divided by 2 children which equals \$34.16. \$34.16 is entered on KAMES for each child.

Example #2: Three children receive child support from three different NCP's. Calculate as follows:

	Child 1	Child 2	Child 3
April	\$ 50	\$ 25	\$ 60
May	\$ 50	\$ 40	\$ 50
June	\$ 75	\$ 55	\$ 50
Totals	\$175	\$120	\$160

Child 1

$\$175 \div 3 = \$58.33$  monthly average - \$17 disregard = \$41.33 is considered.

Child 2

$\$120 \div 3 = \$40$  monthly average - \$17 disregard = \$23 is considered.

Child 3

$\$160 \div 3 = \$53.33$  monthly average - \$16 disregard = \$37.33 is considered.

2. If the amount of child support income is not representative of ongoing income due to a VERIFIED change in circumstances, consider the anticipated child support in the ongoing budget.

EXAMPLE: Alice applies in August. She received \$200 in the last 3 months, however a written statement from the NCP verifies that due to job loss he would only be paying \$75 a month until he regained employment. Anticipate \$75 (less the \$50) in child support as the amount to be considered in the ongoing budget.

3. If income cannot be reasonably anticipated to continue month after month, such as a tax intercept or back payment, consider as nonrecurring lump sum income.
4. Support payments received for the child who is a specified relative are counted as contributions in the child's "E" or "T" case, regardless of who receives the payment. Refer to [MS 4375](#).
5. Child Support received by SSI recipients:
  - a. If the specified relative, who is the only member of the MA case due to the only eligible child receiving SSI, receives child support for that child, the child support is excluded income as the support is for the SSI child. Medical Support Enforcement activity is pursued for this SSI child. Refer to [MS 2210](#).
  - b. If the specified relative is the SSI child's parent and receives spousal support, the spousal support is counted as a contribution. Refer to [MS 4375](#).

C. SYSTEM ENTRY

Enter the calculated monthly child support minus the \$50 disregard, on the child's IM Child Support unearned income screen. Do not round.

D. DOCUMENTATION

Document the verification source used, such as KASES, written statement from the NCP, check stubs, etc. Document the method used to calculate child support income. A calculator tape that shows the computations can be maintained in the case record as part of the documentation.]

MS 4375

[(E&T) CONTRIBUTIONS

Contributions are cash regularly received from any source which is anticipated to continue.

A. CONSIDERATION:

1. Average the amounts received in the prior 3 calendar months to determine the best estimate of contribution income to be counted monthly.
2. Consider cash contributions received from the following sources:
  - a. Money from a parent involuntarily absent from the home;
  - b. Child support received by or for a child who is the specified relative in a case;
  - c. Spousal support received by a parent who is the only member of the case due to the only eligible child receiving SSI;
  - d. Any amount of a military allotment NOT designated by the absent parent as child/spousal support;
  - e. Any money received from a stepparent or a spouse of a non-responsible specified relative included in the case who is absent due to military service; and
  - f. undocumented loans.

Note: Any portion of military combat pay made available to a Family MA household is countable unearned income when establishing the household's eligibility.

B. VERIFICATION can include but is not limited to:

1. Statements from the individuals providing the contributions or the agency that has made the contribution;
2. Checks, if the contributions are received in that form;
3. By form PAFS-73, Verification of Contributions – Loans - Roomer/Boarder Payments.
4. Student loans/income must be verified through the student's educational account or a collateral contact to the institution. When verification is received exclude the loan amount. If verification is not provided consider the principal of the loan as a contribution in the month received and any remaining amount as a resource in subsequent months.

C. DOCUMENTATION:

Document in comments any unusual circumstance that conflicts with KAMES data.]

MS 4377

CASH GIFTS

Small nonrecurring cash gifts of \$30 or less, but not totaling more than \$30 may be excluded per month for each member of the assistance group.

- A. Small nonrecurring cash gifts may include cash gifts for Christmas, birthdays, and graduations.
- B. When an E or T recipient reports receipt of a cash gift, take the following action.
  - 1. Determine the amount of the gift.
  - 2. If the amount of the gift exceeds \$30, the entire amount is considered as unearned income in the month of receipt.
  - 3. [If the amount of the gift does not exceed \$30 in a month, exclude the amount.]

EXAMPLE: The recipient receives \$40 in July. Since this gift exceeds \$30, count the entire \$40. The recipient receives \$20 in August. Exclude \$20.

- 4. Document in comments for tracking purposes.

MS 4379                   NON-SSI TECHNICALLY EXCLUDED INDIVIDUAL

Include all parents and minor siblings living in the same household of an E or T child in the E or T case, if technical requirements are met.

Income of the SSI individual, stepbrother, or stepsister is excluded from consideration.

Consider non-SSI EXCLUDED individuals in the following manner.

- A. When the parent or sibling is INCLUDED in the E or T assistance group, consider income according to current procedures for the specific type of income.
- B. If the sibling is technically excluded from the E or T assistance group, DO NOT consider the income and resources of the sibling and DO NOT count the sibling in the assistance group size.
- C. If the parent is technically EXCLUDED from the E or T assistance group, consider the parent's income but DO NOT count the parent in determining the assistance group size for either the Standard of Assistance or the Gross Income Test.

- 1. CONSIDER the technically excluded parent's gross income in the Gross Income Test.

If the Gross Income Test is passed and the parent has earnings, allow earned income deductions. DO NOT allow the \$30 and 1/3 or \$30 deduction.

[Consider the technically excluded parent's unearned income and net earnings in computing the grant.]

- 2. Resources of the technically excluded parent are considered in determining resource limits for the case.

MS 4380

TEST BUDGET INCOME

When a stepparent, spouse of a nonresponsible specified relative (SR) included in the case, parent of a minor parent or spouse of a dependent child is living in the home or is absent due to active duty in uniformed service and is not a member of a benefit group, consider income of the individual in determining the eligibility for the "E" or "T" case. EXCEPTION: If a stepparent or a spouse of a nonresponsible SR included in the case is absent due to active duty in a uniformed service, his/her income is NOT considered. However, if the stepparent or spouse of a nonresponsible SR gives money to the family, this is considered a contribution.

For the purpose of deeming income, a minor parent is considered any person married or unmarried under the age of 18. Income is first applied to the needs of the individual and his/her dependents. DO NOT include the minor parent as a dependent. Any surplus is considered available to the case.

- A. If a minor parent and his/her spouse are living in the home with the minor's parent, income of the parent or stepparent is deemed to the minor parent.
- B. If a dependent child included in an "E" or "T" case is married and the spouse is living with the dependent child and NOT included in the "E" or "T" case, the income of the spouse is considered in the "E" or "T" case in the same manner as stepparent income.
- C. For a stepparent, exclude any income received prior to the date of marriage or, if common law marriage as recognized by another state, the date the relationship was established.

[Do not consider a sanctioned or statutorily excluded individual in the stepparent family size when test budgeting income. DO NOT test budget income if the individual is not in the home or the individual is included in the "E" or "T" case.]

- 1. When a minor parent lives with a stepparent, the surplus of the stepparent's income is considered available to the "E" or "T" case.
- 2. [When a minor parent lives with a parent AND a stepparent and both have income, a test budget is completed to determine the stepparent's surplus income is considered available to the parent.] The surplus from the parent's test budget is then considered available to the E or T case of the minor parent.
- 3. If only the stepparent or parent has income, complete one test budget counting everyone except members of the minor parent's E or T assistance group in the family size. The surplus from the test budget is then considered available to the E or T case of the minor parent.

If the stepparent, spouse of a nonresponsible SR included in the case, parent of a minor parent, or spouse of a dependent child REFUSES to provide income verification, deny or discontinue the case.

- D. Consider a nonrecurring lump sum amount as income in the month of receipt when received by the stepparent, parent of a minor parent, or spouse of a dependent child. Consider any amount remaining in subsequent months as a resource to the stepparent or parent only. Resources of the stepparent, parent or spouse are not used to determine eligibility of the SR or E or T assistance group. For allowable deductions see MS [4385](#).
- E. Consider the gross income of the stepparent, spouse of a nonresponsible SR included in the case, parent of a minor parent, or spouse of a dependent child and reduce by the following. For a stepparent, spouse of a nonresponsible SR included in the case, or spouse of a dependent child the following amounts must have been paid on or after date of marriage.
1. The work expense standard deduction of up to \$90 for full-time and part-time employment. If the earnings are less than \$90, the amount of the earnings is the amount deducted as the work expense standard.
  2. Child support or alimony payments actually made to persons not in the home. This amount does not have to be court ordered and may include medical bills or medical insurance.
  3. Actual amount paid to an individual not in the home, other than children or an ex-spouse, who is or could be claimed by the stepparent, parent of a minor parent, or spouse of a dependent child as a dependent for federal income tax purposes.
  4. "E" or "T" standard of assistance for the stepparent, spouse of a nonresponsible SR included in the case, parent of a minor parent and/or spouse of a dependent child family size.
    - a. If both the stepparent and the parent of a minor parent have income, complete two test budgets. The family size on each parent's test budget would include the stepparent or parent plus his/her dependents living in the home and not in the minor parent's "E" or "T" case, who are or could be claimed for federal income tax purposes. If only the stepparent or parent has income, complete one test budget counting both parents plus all dependents living in the home not included in the minor parent's E or T case.
    - b. DO NOT include a sanctioned individual in the family size.
    - c. An SSI recipient is included in the stepparent family size, although his/her income is not counted.

For self-employment income, refer to MS [4450](#) and MS [4455](#) to determine the profit or net income. [After reducing the income of the stepparent, spouse of a nonresponsible SR included in the case, parent of a minor parent, or spouse of a dependent child, apply any surplus to the "E" or "T" case.]

MS 4390

INCOME SUPPLEMENTATION

Income supplementation is money received by the recipient from the Office of Vocational Rehabilitation, an income protection plan or hospital confinement policy, etc.

A. Verify the amount received using:

1. Statement from Office of Vocational Rehabilitation;
2. Copy of income protection plan; or
3. Hospital confinement policy, etc.

B. Consider regular monthly income supplementation in determining initial and ongoing eligibility.

1. If the income received monthly is stable, use the monthly amount of income.
2. If the income received monthly fluctuates average the amounts received in the 3 prior calendar months to determine the best estimate of the monthly income.

MS 4395 PROMISSORY NOTE/MORTGAGE/LAND CONTRACT SALE

Consider continuing payments on promissory notes, mortgages, and land contracts as unearned income to the holder if nonnegotiable/nonsaleable. Consider promissory notes, mortgages, and land contracts saleable unless specifically prohibited in the agreement. Verify the amount using the contract or written agreement.

- A. Both principal and interest parts of the continuing payments on promissory notes, mortgages and land contracts are unearned income, subject to the following deductions:
  1. Payments on mortgages, including interest; and
  2. Actual payments for insurance and taxes.
- B. [If negotiable or saleable a promissory note, mortgages, and land contracts are considered resources to the holder in the amount of the equity (value minus indebtedness).]

Example: Mr. Jones sold property to Mr. Smith on land contract for \$15,000 with down payment of \$5,000. Mr. Jones (the holder of the land contract) has no debt on the property. Mr. Jones has a resource (equity) in the saleable land contract of \$10,000. However, Mr. Smith, who bought the property for \$15,000 (value of the property), owes \$10,000. Mr. Smith has a resource (equity) of \$5,000. As payments are made Mr. Jones' equity in the land contract decreases while Mr. Smith's equity increases.

Example: Mr. Jones purchased property from Mr. Clark on land contract for \$25,000. MR. Jones still owes Mr. Clark \$5,000. Mr. Jones sold Mr. Smith the same property on land contract for \$25,000.

Mr. Clark is the holder of a land contract with an equity of \$5,000. Mr. Jones is the holder of a land contract with an equity of \$20,000 (value of \$25,000 minus indebtedness of \$5,000).

The initial or down payment must be an excluded or countable resource. See MS [4348](#).

MS 4400 HOME ENERGY ASSISTANCE PROGRAM (HEAP) (1)

[HOME ENERGY ASSISTANCE PROGRAM (HEAP) is any assistance related to home energy, (e.g., heating, cooling, home weatherization, blankets, storm doors, etc.). It does not include food or clothing.

A. CONSIDERATION.

1. EXCLUDE all benefits received from the Low Income Home Energy Assistance Program (LIHEAP).
2. EXCLUDE all vendor payment HEAP assistance.

Example 1: Grandmother pays \$50 directly to the electric company for the recipient. The \$50 is excluded income.

Example 2: A local church issues a \$100 check to pay for heating oil directly to the provider. The \$100 is excluded income.

3. All cash HEAP paid to the recipient by a noncertified provider, an individual (e.g., relatives, friends, etc.), or private non-profit organization is considered as unearned income. When the assistance is received on a regular basis, but in irregular amounts, average the amounts received in the 3 prior months. Annotate the case record with the amount or value of assistance received, and the type of verification used.

Example 1: Grandmother gives recipient \$50 to pay electric bill. Consider the \$50 as unearned income.

Example 2: A local church gives recipient \$100 to pay for heating oil. Consider the \$100 as unearned income.

4. When a vendor pays an expense which includes costs for utilities (e.g., utilities included in rent, etc.), DO NOT consider this as home energy assistance.

B. VERIFICATION.

VERIFY the amount of cash HEAP assistance received by checks, award letters, or statements from the assistance provider. Verify vendor payment HEAP assistance, by a statement from the provider that no cash was paid to the recipient, (i.e., payments were made directly to an energy provider).]

MS 4405 OTHER UNEARNED INCOME (1)

Other sources of unearned income may be miner's benefits, pensions, insurance, annuities, oil leases, mineral rights, spousal maintenance due to one member of a couple being in LTC facility, etc. Consider payment received when employee's retirement contributions are withdrawn prior to retirement a resource, not income.

A. VERIFY amounts of other unearned income using:

1. Checks;
2. Award letters;
3. Written verification from insurance company;
4. Contract; or

[5. Bank and other financial statements (for investments only).]

B. Determine the monthly amount of income to be considered in the case in the following manner.

1. If the income is received on a MONTHLY basis and:
  - a. The income is stable, use the monthly amount of income.
  - b. The income fluctuates, average the amounts received in the 3 prior calendar months to determine the best estimate of the monthly amount.
2. If the income is received MORE frequently (e.g., weekly, bi-weekly, semi-monthly), use the amounts received in the 3 prior calendar months, average, and multiple the average by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$  or 2, whichever is appropriate, to determine the best estimate of the monthly amount of income.
3. If the income is received LESS frequently (e.g., quarterly), prorate over the period intended to cover. Consider the prorated amount as the best estimate of the monthly amount.

EXAMPLE: The recipient receives income on a quarterly basis in the amount of \$28. Divide the \$28 by 3 and count \$9.33 as monthly income.

C. DOCUMENT the method of verification and the computation of the best estimate of the monthly income.

[EARNED INCOME is wages derived from direct involvement in a work related activity. The sections in this subchapter provide the specific procedures for calculating the best estimate of the monthly income. Information specific to prospective budgeting is found in [MS 4512](#).

A. CONSIDERATION.

1. For earned income, other than self-employment:

- a. Determine the monthly amount of each earned income type;
- b. Use actual or anticipated monthly earned income, whichever is more reflective of ongoing. Determine monthly income by multiplying weekly, bi-weekly or semi-monthly amounts by  $4\frac{1}{3}$ ,  $2\frac{1}{6}$  or 2. Do NOT round cents before adding or multiplying hourly or daily earnings. Round before adding or multiplying weekly, bi-weekly, semi-monthly, monthly, quarterly or annual amounts, and round the results.

Example: The recipient works 25 hours per week at \$4.50 per hour. He/she is paid weekly. 25 hours per week multiplied by \$4.50 per hour equals \$112.50 per week. Round to \$113. \$113 per week multiplied by  $4\frac{1}{3}$  equals \$489.67 (rounded to \$490).

- c. Round the monthly amount of each earned income type to the nearest dollar (1¢ - 49¢ round down and 50¢ - 99¢ round up to the next dollar).
2. For self-employment income, request a copy of the applicant's income tax return. If the applicant does not have income tax returns, request business records maintained by the individual. Give all allowable deductions on the federal IRS Schedule C (Form 1040). For more information see [MS 4450](#).

Note: If the self-employment income has recently begun and a Schedule C (Form 1040) or business records are not available, calculate the income the following way:

- a. Round the actual dollar and cent amount of gross income to the nearest dollar. Divide by the number of months in operation, and round the result to the nearest dollar to obtain a monthly amount.
- b. Round the actual dollar and cent amount of expenses to the nearest dollar. Divide by the number of months in operation, and round the result to the nearest dollar to obtain a monthly amount.
- c. Subtract the rounded monthly expenses from the rounded monthly income. The difference between the two amounts is considered profit.

NOTE: The mileage deduction claimed on the income tax return is given at the federal rate.

3. For sick pay received consider as earned income if the person is still considered an employee by the employer and the sick pay is received for time off, such as a short term illness. However, sick pay from an outside source, such as an insurance company, is considered unearned income whether or not the recipient is still considered an employee by the employer.

NOTE: Employers may use different sources of funds to compensate employees for their approved time off; therefore the appearance or information on their pay stubs may change. In order for the income to be counted correctly, check if the income is still received from the employer or if it is from an outside source not affiliated with the employer.

Example: Jane broke her arm and is off work for six weeks. During this time she applies for AFDC-Related MA for a household of 2. She works for McDonald's and earns \$1200 per month. She is currently on paid family medical leave but the check stubs she receives state "Employee Compensation Inc.", not "McDonald's". This company is used by McDonald's to handle their medical leave funds that are used to compensate employees that are off on approved sick leave. Although the funds come from another income source these wages would still be considered as sick pay as it is the company McDonald's uses to compensate Jane for her sick time.

4. Two-Month Exclusion: Members who obtain employment while receiving AFDC Related MA may chose to exclude their new wages for the first two months of employment. This exclusion is called the two-month exclusion and it is allowed once in a lifetime per active adult member in a case. The following applies when considering the two-month exclusion:
  - a. It is not allowed for new approvals or new members added to a case with wages;
  - b. To allow the exclusion, wages must be reported and verified timely within 10 days. If the member does not verify wages, the case is discontinued however, if verification is provided during adverse action, the case is reinstated and the exclusion is allowed;
  - c. The count begins in the 2<sup>nd</sup> month of new employment and the months are consecutive. Example: An individual reports she started working on 10/16/09. The two-month exclusion begins with 11/09 and ends with 12/09;
  - d. The recipient chooses whether to use the exclusion for the new job or save it for a future job; and
  - e. The two full months' earnings are excluded regardless of amount of income, hours or the type of work. The two-month exclusion is tracked manually on form PAFS-116, Supplement A, Tracking Log.

#### B. VERIFICATION.

1. Verify unearned income at application, recertification and at the time of a reported change or an anticipation of a change in income.
2. Explore the possibility of withheld income information and DO NOT deduct garnishments on salary.

3. Use the following types of documentation to verify income:
  - a. Pay stubs;
  - b. Employer statement;
  - c. Contract;
  - d. Records maintained by the individual of self-employment income;
  - e. Current income tax returns; or
  - f. Form PAFS-700, Verification of Employment and Wages.
4. A change in circumstances is defined in [MS 4307](#). Refer to Volume IV, [MS 1320](#), for cases pending over 30 days with good cause.
5. Profit from farm or rental income is considered unearned income if there is no direct activity on the part of the recipient in producing the income.
6. Self-declaration of income is not acceptable verification. When income ceases, verify lack of income before removing it from the case. To verify zero income, see Volume IV, [MS 3470](#).

C. DOCUMENTATION.

Document in comments any unusual circumstance that conflicts with KAMES data.]

MS 4420

[WAGES FOR AFDC RELATED MA]

(1)

WAGES consist of salaries received from full-time or part-time employment where taxes are withheld prior to the recipient receiving pay. Odd jobs, occasional, seasonal or contract employment are included when taxes are withheld prior to receipt of the income. Exclude from wages reimbursement for transportation in performance of duties, if identifiable.

Accumulated annual leave is considered as wages in the month the money is received with appropriate deductions allowed. If income is received as back payment from employment or severance pay, see [MS 3800](#).

Consider living allowances (stipends) paid by programs established under the National and Community Services Trust Act of 1993 (such as Americorp) as earned income and apply earned income disregards as appropriate.

Consider VISTA payments that equal or exceed the federal minimum wage or the state minimum wage, whichever is greater, as earned income. Allow deductions as appropriate. To determine if the VISTA payment equals or exceeds the applicable minimum wage, send a written request to: State Director of ACTION, 600 Federal Place, Room 372-D, Louisville, KY. 40202.

A. VERIFICATION

1. Pay stubs;
2. Employer statement, either written or verbal; or
- [3. Electronic Income Verification (EIV). See Volume IV, [MS 3471](#).]

If new employment is report, spot check within 1 week of anticipated receipt of first check, not to exceed 6 weeks.

B. CONSIDERATION

1. To determine the estimated monthly income, verify and use income from all pay periods in the last two calendar months. If the last two calendar months do not represent the ongoing situation (e.g., sick leave, holiday plant closing), use information available which best indicates the case members' ongoing income.
2. To calculate the estimated monthly earned income DO NOT round cents before adding or multiplying hourly or daily earnings. Round before adding or multiplying weekly, bi-weekly, semi-monthly, monthly, quarterly or annual amounts.
  - a. Add gross income from each pay period.
  - b. Divide the total by the number of pay periods considered.
  - c. Multiply by  $4 \frac{1}{3}$  for weekly amounts,  $2 \frac{1}{6}$  for bi-weekly amounts and 2 for semi-monthly. To manually convert by  $4 \frac{1}{3}$ , multiply by 13 and then divide by 3; for  $2 \frac{1}{6}$ , multiply by 13 and divide by 6.

- d. Round up or down to the nearest dollar to determine the monthly amount to be counted in the administratively feasible month.

EXAMPLE 1: For Income Received Weekly

\$88.14	rounded to	\$88.00
70.40		70.00
75.63		76.00
69.11		69.00
71.00		71.00
87.50		88.00
83.23		83.00
69.77		70.00
	equals	\$615.00

\$615.00 divided by 8 equals \$76.88 average weekly rounded to \$77. \$77 x 4 1/3 equals \$333.67 rounded to \$334.

EXAMPLE 2: For Earned Income Received Bi-weekly

\$153.50	rounded to	\$154.00
165.75		166.00
169.35		169.00
158.00		158.00
	equals	\$647.00

\$647 divided by 4 equals \$161.75 average bi-weekly rounded to \$162.

\$162 x 2 1/6 equals \$351.00.

EXAMPLE 3: For Earned Income Received Semi-Monthly

\$158.45	rounded to	\$158.00
225.72		226.00
190.00		190.00
195.60		196.00
	equals	\$770.00

\$770 divided by 4 equals \$192.50 average semi-monthly rounded to \$193.

\$193 x 2 equals \$386.

EXAMPLE 4: For Earned Income Received Monthly

\$351.55	rounded to	\$352.00
330.78		331.00
	equals	\$683.00

\$683 divided by 2 equals \$341.50 average monthly rounded to \$342.

3. Count gross income. Garnishments on salary ARE NOT deducted.
- C. If the income in the prior two months is NOT representative of the ongoing situation due to a change of circumstances which occurred or

will occur, calculate the best estimate of the monthly income in the following manner:

1. If the change in circumstances results in change in the number of hours to be worked, multiply the number of estimated hours per pay period (use employer statement) by the current pay rate for the period and convert by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$ , 2 or 1, whichever is appropriate.
  2. If the change in circumstances results in a change in the pay rate, multiply the number of hours worked per pay period in the prior two months by the new pay rate. Divide the result by the number of pay periods in the prior two months and convert by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$ , 2 or 1, whichever is appropriate.
- D. If the income has recently begun or the recipient changed jobs and the recipient has not received two calendar months of income, anticipate the monthly income by computing an amount based on:
1. The hourly rate multiplied by the estimated number of hours to be worked during the pay period and convert; or
  2. The daily rate multiplied by the number of days to be worked in the pay period and convert.
- E. If the recipient reports that the income is ending:
1. Determine the last date the recipient will receive the income.
  2. Recalculate the case based on the income amount to be received.
- EXAMPLE: The recipient reported in November that her job is ending and that she will receive one pay check in December. If the report is received before the November cutoff, count only the one paycheck anticipated for December and then remove the income for January.
- If the report is received after the November cutoff, remove the income effective January.
- F. DOCUMENT in the case record the reason less than the last two calendar months of income was used in the calculation, method of verification, and how the monthly amount was calculated. If the estimated income DOES NOT accurately reflect the anticipated ongoing circumstances, spot check the case and recalculate the income utilizing verified income. However, if the estimated income accurately reflects the anticipated ongoing circumstances, recalculate the best estimate at recertification or six months, whichever comes first.

MS 4425

[TIPS FOR AFDC RELATED MA]

(1)

Countable tip income is money actually received in addition to wages for services performed by the employee. Countable tip income does not include the allocated or tip credit reported by the employer for tax purposes which may appear on the paycheck stub.

A. VERIFICATION

Verify tips by using the recipient's daily tip log of actual tips received. A tip log is any record kept by the recipient of tips received each day. Entries on the log must show date of receipt and amount. DO NOT use the allocated tip or tip credit amount shown on the paycheck stub.

1. For applications or new tip income when a daily tip log is not available, use the recipient's statement of anticipated tips.
2. When tip income is reported, advise the recipient of their responsibility of maintaining a daily tip log for verification purposes.
- [3. DO NOT use Electronic Income Verification (EIV) to verify earned income if tips are included in the gross amount. See Volume IV, [MS 3471](#).]

B. CONSIDERATION

1. To best estimate the monthly amount of tips, use the same time period used in determining the monthly amount of wages (i.e., if the best estimate of income is determined by using the prior 2 calendar months' wages, then use the prior 2 calendar months' amount of tips shown on the daily tip log). Convert the daily tips to weekly, bi-weekly, semi-weekly, etc.

Example: The recipient works at Jerry's Cafe and is paid each Friday. A daily tip log is kept by the recipient.

For September, the pay periods ended 9/3, 9/10, 9/17 and 9/24. Add the tips for each day in the pay period to obtain the weekly amount: 8/30 - \$6.00; 8/31 - \$6.55; 9/1 - \$9.75; 9/2 - \$9.10; 9/3 - \$10.50. Added together, they equal \$41.90 (round to \$42.00) for the 9/3 pay period. Average the tips for this weekly pay period and the other weekly pay periods and convert to a monthly amount.

2. Add the best estimate of amount of monthly tips to the best estimate of the monthly wages.

C. DOCUMENTATION

Document the method of verification and how the best estimate is computed.

MS 4430

CONTRACT EMPLOYMENT

CONTRACT EMPLOYMENT is income from jobs in which there is a contract/payment agreement, e.g., school teachers, bus drivers, house painters, etc.

A. VERIFICATION:

1. Copy of contract/payment agreement stating salary and terms;
2. Employer contact to establish salary and terms; or
3. Employer statement or contact to verify termination of contract.

B. CONSIDERATION:

1. When the recipient has a contract/payment agreement, compute gross monthly wages by dividing the contracted/agreed upon amount by 12, and round to the nearest dollar, unless the contract/payment agreement states income will be paid for fewer months.
  - a. If the contract/payment agreement states the income will be received in fewer than 12 months, divide the contracted agreed upon amount by the number of months in the contract/payment agreement and round to the nearest dollar.
  - b. If the contract/payment agreement states the income will be received monthly for 12 months and the recipient requests the remainder of their pay in a lump sum prior to the end of the 12 month period, continue using the annualized figure for the remainder of the 12 month period.
  - c. DO NOT recompute based on monthly fluctuations in income. However, reported losses in income due to unpaid sick leave or snow days that are not made up and that lasted 30 days or more, are taken into account by reducing the annualized monthly income over the remaining months of the contract by the reported income loss due to unpaid leave.

EXAMPLE: \$2400 was the original contract amount and the monthly income was \$200. The recipient lost \$200 due to sick leave which lasted 34 days. There are 5 months left on the contract. Reduce the \$1000 ( $\$200 \times 5$ ) by \$200, leaving \$800. Divide \$800 by the remaining months, 5. \$160 is counted per month for the remainder of the contract.

2. If contract employment is self-employment, consider as self-employment income (e.g., contract to paint house, install roof, etc.).

3. Prorate other contract employment over the life of the contract (e.g., individual does work on a contract basis for a company).
4. [Spot check the case for the last month of the contract. Remove the income for the next administratively feasible month.]

EXAMPLE: A recipient is contracted to paint a building over a 4-month period starting in January and ending in April. The income from the job would be counted starting January and would be removed effective May.

- C. DOCUMENT the method of verification and computation of the monthly income.

MS 4435

OCCASIONAL/SEASONAL EMPLOYMENT

OCCASIONAL EMPLOYMENT is income from working an irregular schedule (e.g., odd jobs, jury duty, temporary or sporadic employment). For jury duty pay, exclude any reimbursement for related expenses (e.g., lunch and transportation). Odd jobs could include mowing lawns, housecleaning, baby-sitting, etc.

SEASONAL EMPLOYMENT is income from employment during a limited period each year (e.g., working at race track or tobacco warehouse).

Income from both occasional and seasonal employment can be either wages, if taxes are withheld by the employer, or self-employment if no taxes are withheld.

- A. VERIFY occasional/seasonal employment using pay stubs, or an employer contact, either written or verbal, such as form PAFS-700, Verification of Income, or form PAFS-121, Irregular Work Form.
- B. CONSIDERATION:
  1. For occasional or seasonal income which is considered wages, refer to MS [4420](#) in determining the best estimate of earnings for the payment month.
  2. For occasional or seasonal income which is considered self-employment, refer to MS [4450](#) in determining the best estimate of earnings for the payment month.
  3. For seasonal employment income which is considered wages, spot check next year before anticipated period of seasonal employment.
- C. Document the method of verification and computation of the best estimate of the monthly income.

MS 4440 [WORKFORCE INVESTMENT ACT (WIA) INCOME

WIA INCOME is payment received through participation in WIA and includes such programs as Summer Youth Employment and Training Program (SYETP) and Job Corps.

VERIFY WIA participation with appropriate agency and document the agency contacted.

CONSIDER WIA income as follows: ]

A. For E or T Children:

1. [Exclude ALL UNEARNED WIA income.
2. Exclude earnings received by a child, regardless of student status, from participation in any WIA earned income activity for a period not to exceed 6 months within a calendar year. The 6 months are cumulative months. WIA activities from which earned income may be derived include, but are not limited to, On-the-Job Training (OJT), Internship, the Work Experience Program, Limited Work Experience Program, Tryout Employment Program, SYETP, or BRITE.]

If the child remains in the program longer than 6 months, spot check the case in the 6th month. The income would then be considered in the 7th month by using income averaged from the prior two calendar months (if representative of ongoing income).

3. Exclude "needs-based payments", (e.g., money provided to cover lunch and transportation).
4. [Exclude emergency type assistance provided by WIA, (e.g., payment to provider or child to replace glasses).]
5. Exclude reimbursement for transportation.
6. Exclude payments made for but not to child, (e.g., books for vocational school, bus fare).

B. For E or T specified relative or second parent:

1. Exclude payments made for but not to the recipient, (e.g., emergency type assistance, books provided for vocational school, bus fare).
2. Exclude reimbursement for transportation.
3. Count all payments received from Job Corps as earned income.

4. [Count WIA stipend income as unearned income.]
5. Count money received through employment or OJT as earned income.
6. [Count all other WIA income according to income policy.]

C. Determining the Amount of Countable WIA Income:

1. WIA earnings are considered as specified above.
2. For WIA stipend income, to determine the amount of countable income, an additional calculation is necessary.
  - a. Determine the best estimate of the WIA stipend income.]
  - b. Determine the difference between the Standard of Need and the Maximum Payment.
  - c. [Subtract the difference between the Standard of Need and the Maximum Payment from the best estimate of the WIA income.
  - d. The result is the countable amount of WIA income which is entered as unearned WIA income.]

EXAMPLE: A recipient and her 2 children receive MA in the E or T category. [The recipient attends a WIA training and is paid a \$3 per hour stipend. The recipient receives \$90 per week.] After conversion, the best estimate is determined to be \$390 per month.

The maximum payment for 3 members is \$228. The Standard of Need is \$526. The difference is \$298. The \$298 is subtracted from \$390 (total stipend) resulting in a \$92 remainder. [The amount of countable unearned income from the WIA stipend is \$92.

No income other than a WIA stipend is treated in this manner.]

MS 4445

COMMISSIONED EMPLOYMENT

COMMISSIONED EMPLOYMENT is income received as a percentage of the money taken in on sales (e.g., real estate, Avon, Tupperware, etc.). This income may be either wages or self-employment.

- A. VERIFY commissioned employment using pay stubs, an employer contact either verbal or written, such as form PAFS-700, Verification of Income, or an income statement.
- B. CONSIDERATION.
  - 1. If the commissioned income is wages, refer to MS [4420](#) for the computation of the monthly income.
  - 2. For self-employment income, to compute the best estimate refer to MS [4450](#).
- C. DOCUMENT the method of verification and computation of the best estimate of the monthly income.

MS 4450

SELF-EMPLOYMENT INCOME

SELF-EMPLOYMENT INCOME is income derived from farming, small business enterprise, rental, roomer/boarders, selling blood etc., where taxes are NOT withheld PRIOR to recipient receiving pay. When taxes are withheld prior to the recipient receiving pay, the income is considered wages.

A. Self-employment can be either ongoing or occasional.

1. Ongoing self-employment is where the recipient intends to work at the self-employment month after month.

EXAMPLE: Dolly operates a babysitting service. She intends to provide services throughout the year.

2. Occasional self-employment includes seasonal, temporary, sporadic or odd job income. Temporary or sporadic employment can include lawn mowing, house cleaning, babysitting, selling scrap metal, selling blood, etc. which is not continuous in nature.

EXAMPLE 1: Betty Lou babysits for a neighbor during the summer months. Sometimes she sits once a week and sometimes once a month.

EXAMPLE 2: Johnnie cuts grass for a neighbor when the neighbor cannot do it himself. Johnnie sometimes paints garages and sometimes cleans windows.

B. VERIFICATION.

1. Quarterly estimated tax returns, if filed;
2. Most recent annual income tax return if quarterly return is not filed; or
3. Records maintained by individual if self-employment income is not reported on income tax return.

C. CONSIDER profit (net income) from self-employment and enter in the assistance plan. To determine profit, deduct actual work expenses directly related to producing the goods or services and without which the goods or services could not be produced.

1. Farm or rental self-employment income may be either unearned or earned.
  - a. Unearned.

- (1) Profit from farm income is unearned income if there is no direct involvement in farming activities. In cases of divided ownership, divide total profit (net income) between the owners, unless by mutual consent entire proceeds are available to the recipient. If the Social Security Administration considers all farm income as available to the SSI parent, do not enter income from this source in the assistance plan.
  - (2) Profit from rental income is unearned income if all activity is performed by someone other than the recipient.
- b. Earned.
- (1) Farm income is earned self-employment income if derived from active physical engagement or managerial responsibility in farming. In such instances, it is subject to earnings deductions. Consider profit as income to the family group if the farming is done by one or more of its members. If the farming is done in part by a household member not included in the assistance plan, deduct his/her prorated share from profit.
  - (2) Rental income is earned self-employment income if the recipient personally collects the rent, makes, supervises or authorizes repairs, manages the property, is responsible for renting property or gives other services in relation to the property. Consider profit from rental property owned or being purchased by the recipient.
  - (3) The sale of blood or plasma is earned self-employment income.

#### D. COMPUTING MONTHLY INCOME.

1. When using the annual U.S. Individual Income Tax Return (if one is filed and representative of the current situation) or the recipient's business records for the last 12 months:
  - a. Round the gross income to the nearest dollar.
  - b. Divide the rounded gross income by 12 and round to the nearest dollar to obtain the monthly gross income amount.
  - c. Round the allowable expenses to the nearest dollar.
  - d. Divide the rounded allowable expenses by 12 and round to the nearest dollar to obtain the monthly allowable expenses.
  - e. Subtract the rounded monthly allowable expenses from the rounded monthly gross income to obtain the monthly profit.
2. When ongoing nonfarm self-employment income has been in operation for less than 12 months:
  - a. Round the gross income for the number of months the activity has been in operation to the nearest dollar.
  - b. Divide the rounded gross income by the number of months of operation and round to the nearest dollar to obtain the monthly gross income amount.

- c. Round the allowable expenses for the number of months of operation and round to the nearest dollar.
  - d. Divide the rounded allowable expenses by the number of months of operation and round to the nearest dollar to obtain the monthly allowable expenses.
  - e. Subtract the rounded monthly allowable expenses from the rounded monthly gross income to obtain the monthly profit.
3. For occasional or seasonal self-employment:
  - a. Round the gross income for the 3 previous months to the nearest dollar.
  - b. Divide the rounded gross income by 3 and round to the nearest dollar to obtain the monthly gross income amount.
  - c. Round the allowable expenses for the 3 previous months to the nearest dollar.
  - d. Divide the rounded allowable expenses by 3 and round to the nearest dollar to obtain the monthly allowable expenses.
  - e. Subtract the rounded monthly allowable expenses from the rounded monthly gross income to obtain the monthly profit.
4. Recalculate self-employment income at:
  - a. 12-month intervals if the activity has been in operation for 12 months or more; or
  - b. The next IM or FS recertification, whichever comes first, if the activity has been in operation for less than 12 months.
5. If income from self-employment fluctuates, continue using the averaged amount based on tax return. If self-employment income changes from one type to another, the prior tax return is no longer used.
6. [When a recipient reports he/she is no longer self-employed, the income is removed in the next administratively feasible month.]

EXAMPLE: Self-employment terminated in March. The income would be removed effective April.

- E. DOCUMENT the method of verification and computation of the best estimate of the monthly income.

MS 4455                    FARM BUSINESS/SELF-EMPLOYMENT INCOME

FARM/BUSINESS INCOME is income obtained from farming activities or from a small business enterprise.

A. CONSIDER farm income as follows:

1. If the recipient's farming is a continuing business, use records (e.g., tax return, recipient accounts, etc.) for the past year to compute the countable income.
2. If the farming arrangement has changed (e.g. had grown corn, then switched to soy beans), do not consider the income of the past year. Spot check the case for the month the new crop is to be sold. At that time, use the income received from the sale of the new crop to anticipate the income.
3. If this is a new farm or farming activity:
  - a. If the farm or farming activity has been in existence for less than a year and the recipient has received income from the farm or farming activity, prorate the income over the period of time the farm or farming activity has been in operation. Use the monthly amount as the anticipated income for the next year.
  - b. If the farm or farming activity has not been in existence long enough to receive income, consider no income. Spot check the case for the month the income is to be received. At that time, use the income received to anticipate the income.
4. If farming activities have been discontinued, no income is considered.

B. DEDUCT the following from gross income to determine profit:

1. Wages paid to employees;
2. Rent when the enterprise is carried on from a site other than where the recipient lives;
3. Interest on a mortgage and taxes, when the enterprise is carried on from a site other than the home;
4. Interest payments on the purchase of capital assets, equipment, etc;
5. Cost of stock offered for resale;
6. Cost of supplies (including seed, feed, fertilizer, crop insurance), utilities required to carry on the enterprise;

7. [Mileage rate allowed as a deduction for business purposes if the vehicle expenses are directly related to the operation of the business enterprise – provided the person uses their private vehicle. The mileage deduction is equivalent to the amount shown on the federal tax return. If a tax return is not filed use the IRS mileage rate. This information can be accessed at: <http://www.irs.gov>. To access the current year's mileage rate enter the term "mileage rate" in the search box; ]
8. Repair or maintenance of equipment and property used in business. DO NOT allow deduction for repairs to home.
9. Other non-personal items directly related to producing the goods or services (e.g., fuel to operate equipment).

C. DO NOT DEDUCT the following:

1. Personal work or business expenses (taxes, FICA, lunches, etc.);
2. Amounts claimed for depreciation;
3. Prior or current losses;
4. Purchase of capital equipment;
5. Payments on principal for the purchase of property, durable goods, capital assets, equipment, etc;
6. Entertainment expenses;
7. Personal transportation;
8. Salary or commission paid to the recipient by the self-employment enterprise;
9. Rent, when self-employment enterprise is based in recipient's residence.

D. DOCUMENT the type of verification used for the income and expenses.

MS 4465

RENTAL/ROOMER/BOARDER INCOME

RENTAL/ROOMER/BOARDER INCOME is received from renting a home, a portion of a home, or providing food only to an individual.

A. For RENT FROM NONHOME PROPERTY (even from houses which are an excluded resource), deduct the following from gross income to determine profit, if identifiable:

1. Property taxes;
2. Interest on mortgages;
3. House or building insurance (liability);
4. Advertising; and
5. Other valid expenses such as repairs.

B. For RENT FROM RENTING OR SUB-RENTING A PORTION OF THE HOME, (or place of residence) determine deductions as follows:

1. Divide the square footage of the room or portion of the home being rented by the square footage of the home to obtain the rented percentage. Recipient's statement is acceptable verification of square footage. For example, square footage of rented room = 500; square footage of home = 1500; 500 divided by 1500 = 1/3 or 33 1/3% (rented percentage).
2. Annualize cost of the home's utilities, home insurance, property taxes, interest on mortgage, and if appropriate, rent paid for home, if any. Divide by 12 to obtain the monthly expense. Multiply the monthly expense by the rented percentage to obtain the sub-rental deductions. For example:

Interest on mortgage	\$1,200
Utilities	800
Home Insurance	300
Property Taxes	+100
	\$2,400 divided by 12 = \$200 monthly costs

$\$200 \times 33 \frac{1}{3}\% = \$66.67$  monthly sub-rental deductions

C. Roomer only, determine sub-rental deduction as in item "B" of this section.

- D. Boarder only, deduct an amount equal to the food stamp coupon allotment for the number of boarders. EXAMPLE: There are 3 boarders. The deduction equals the food stamp allotment of a 3-person household.
- E. Roomer/boarder:
  - 1. Food Deductions:
    - a. Deduct an amount equal to food stamp allotment.
    - b. If roomer/boarder is a member of the food stamp case, do not allow food deduction.
  - 2. Sub-rental Deduction:
    - a. Compute sub-rental deduction as in item "B" of this section.
    - b. DO NOT compute the sub-rental deduction if the roomer/boarder payment is the same as, or less than, the food stamp allotment.

MS 4475

STANDARD OF NEED

The Standard of Need is an established amount based on the number of eligible persons included in the case and used in the ratable reduction calculation. The standard includes amounts for food, clothing, shelter, and utilities.

Do not count the technically excluded/statutorily excluded/sanctioned member in determining the number of eligible persons.

Standard of Need

Number of Eligible Persons	1	2	3	4	5	6	7 or more
Standard	\$394	\$460	\$526	\$592	\$658	\$724	\$790

MS 4480

[GROSS INCOME FOR AFDC-RELATED MA

Countable income in AFDC Related Medicaid cases consists of the sum of unearned or earned income for each member in the MA household. Countable income is determined by completing the gross income test at application, recertification and interim changes (which require re-computing eligibility).

- A. Gross income is the sum of non-excluded income, both unearned and earned, before disregards and deductions and includes:
1. Surplus income of the stepparent OR parent of a minor SR (Exclude SSI income);
  2. Nonrecurring lump sum income. [MS 3810](#);
  3. Child support;
  4. Income of children included in the case (both unearned and earned);
  5. Wages before deductions;
  6. Profit from self-employment;
  7. Gross income of non-SSI technically excluded parents of an "E" or "T" child; or
  8. Gross income of a sanctioned/statutorily excluded and/or technically excluded individual.

Consider gross income of non-SSI parents in the home even if the parent of an "E" or "T" child is excluded from the case. The technically excluded member, and the sanctioned/statutorily excluded individual, is not counted when determining the number of eligible members.

- B. The gross income scale is as follows:

1 person	\$ 742
2 persons	\$ 851
3 persons	\$ 974
4 persons	\$1,096
5 persons	\$1,218
6 persons	\$1,340
7 persons or more	\$1,462

- C. If gross income exceeds the appropriate amount on the Gross Income Scale at application, recertification or interim change, the case is ineligible. Determine eligibility in another MA category.]

MS 4485

DISREGARDED INCOME

Disregarded income is income considered in the Gross Income Test but NOT CONSIDERED in the Applicant Eligibility Test or in determining on-going eligibility.]

The following income is disregarded:

- A. Earnings of an E or T child in full-time school attendance or earnings of a child in part-time school attendance, if not a full-time employee.
- B. Earnings received from participation in Jobs Corps by an E or T child.
- C. [Apply the child support disregard by reducing each monthly amount of countable child support by up to \$50 and count remaining support, if any, in computing gross income.] The disregard applies only to child support, not spousal support.

MS 4495

## DEDUCTIONS

[If the gross income test is passed, deduct work expense standard, dependent care (except for a month for which a child care payment is made), \$30 and 1/3 or \$30 deduction from the earned income of each individual, including sanctioned or statutorily excluded individuals, if appropriate.] Deduct child care only if individual has these costs. The \$30 and 1/3 or \$30 deduction is deducted only when certain circumstances exist.

MS 4498

GENERAL RESTRICTIONS

Do not allow any deductions from earned income for the month(s) in which any of the following conditions exist:

- A. The income is earned from illegal activities (those prohibited and criminalized under Federal and State law).
- B. The individual voluntarily requests discontinuance of the case and states this request is primarily to avoid receiving the \$30 and 1/3 deduction for 4 consecutive months or the \$30 deduction for 8 consecutive months.
- C. Employment is REFUSED, REDUCED, or TERMINATED without good cause within prior 30 days.

GOOD CAUSE exists only if one of the following conditions is met:

- 1. A definite bona fide offer of employment was NOT made at a minimum wage customary for such work in the community.
- 2. The individual is unable to engage in such employment or training for mental or physical health reasons.
- 3. The individual has no way to get to and from the work site or the site is so far removed from the home that commuting time exceeds 3 hours daily.
- 4. Working conditions at such job or training are a risk to the individual's health or safety.
- 5. The child care arrangement is terminated through no fault of the recipient.
- 6. The available child care does not meet the special needs of the child, e.g., physically or mentally disabled child.
- 7. The parent is temporarily absent from work on approved educational leave.
- 8. A KWP participant leaves employment in an attempt to improve skills or become self-sufficient by participating in KWP.
- 9. The individual is needed in the home to care for another household member who is ill or incapacitated, and there is no other household member available to provide the care.

Verify good cause only if there is reason to doubt the recipient's statement. A good cause determination is not required for an individual fired from a job. Document the case record whether good cause exists and why.

- D. The individual FAILED to REPORT new or increased earnings without good cause within 10 calendar days of the day the change in circumstances becomes known to the recipient. Changes are considered known to the recipient at the earliest point the change can be verified. Example: If the recipient started a job December 1, the recipient must report by December 11 to be considered timely and receive earned income deductions.

1. Good cause exists only if one of the following conditions is met within the 10 calendar days:
  - a. The E or T assistance group was the victim of a natural disaster, such as a flood, storm, tornado, earthquake or fire;
  - b. An immediate family member living in the home was institutionalized or died; or
  - c. The responsible relative and, if different, individual who is employed is out of town the entire timely reporting period.
2. If good cause EXISTS, allow the appropriate earnings disregards.
3. If good cause does NOT EXIST:
  - a. Apply the deduction for the ongoing months.
  - b. DO NOT apply the deductions for the report month or prior months.

EXAMPLE: The recipient reports on April 15, that her wages increased effective March 1. She had no good cause as she just forgot to report the change. Recompute the ongoing eligibility, allowing the appropriate deductions, effective the next possible month, May.

If the next possible month is June, allow the deductions for May.

Only verify good cause if there is reason to doubt recipient's statement. Document the case record whether good cause exists and why.

MS 4500

WORK EXPENSE STANDARD

The work expense standard is deducted from the earnings of each individual, including sanctioned or statutorily excluded individuals or technically excluded parents, if eligible to receive deductions. Deduct up to \$90 for either full-time or part-time employment including stepparent and parents of a minor parent, who are not included in the case. If the earnings are less than \$90, the amount of the earnings is the amount deducted as the work expense standard.

MS 4502

DEPENDENT CARE DEDUCTION

Allow E or T dependent care paid by the responsible or nonresponsible SR, including sanctioned or statutorily excluded individuals, to retain employment if paid for children or an incapacitated adult receiving care, living in the home, dependent does not have to be included in the case, AND meeting the relationship requirements in MS [2400](#).

If a recipient is starting a job or a new dependent care arrangement, consider the anticipated dependent care expense as a deduction in the budget unless the recipient is eligible for child care payment.

A. Restrictions.

1. E or T dependent care for a child 13 years of age or older is not allowed unless the recipient requests such care, provides a statement of the reason this care is necessary, and the worker's determination concurs with the reason. Care for any child 13 years of age or older is to be thoroughly documented in the case record. This documentation includes the recipient's request, the recipient's statement as to the reason the care is requested, and the decision.
2. DO NOT consider the amount paid for E or T dependent care as a deduction if paid to a person residing in the household and that person is:
  - a. A member of the E or T assistance group;
  - b. A parent of the child or incapacitated adult; or
  - c. A stepparent of the child.
3. Consider E or T dependent care as a deduction in the budget if paid to an individual in the household who is not listed above or paid to anyone outside the home.
4. [If both parents in a "T" case are employed, a child care deduction may be given for only one parent's income.]
5. If one parent is participating in KWP while the other parent is employed, child care is allowed as a deduction from the employed parent's wages, not to exceed the maximum allowable deduction.
6. A dependent care deduction for a child may not be given for a month for which a child care payment is made for the same child.

B. Verification.

1. To consider the cost of E or T dependent care in the computation of the ongoing payment, accept the recipient's statement that the child or adult is being cared for by a provider and the amount paid for that care. Verify the actual amount the provider is paid by

viewing payment receipts or contracting the care provider if there is reason to doubt the recipient's statement.

- a. If the recipient is starting a job or a new dependent care arrangement, verify the anticipated expenses through a statement from the provider who will be caring for the individual. Allow the deduction for the dependent care based on the statement of anticipated expenses. If there is reason to doubt the recipient's statement, verify the anticipated expenses through a statement from the provider who will be caring for the individual.
  - b. If child care eligibility ends and the dependent care deduction is to be allowed in the E or T eligibility calculation, use the child care payment for the prior two months, if representative of the ongoing expense. Compare the child care payments to the dependent care deduction limits.
2. The recipient is required to secure or assist in verifying, establishing, or providing all necessary information which is pertinent to the case decision, and the amount paid for that care.
  3. If verification is requested and the recipient fails to provide verification of dependent care expenses, the case is processed without the deduction.
- C. Limits. Deduct the best estimate of the monthly amount paid for E or T dependent care per child or incapacitated adult rounded to the nearest dollar, not to exceed per individual:
1. For an individual age 2 years and over:
    - a. \$150 for part-time employment, less than either 30 hours per week or 130 hours per month or not employed throughout the month; or
    - b. \$175 for full-time employment, 30 or more hours per week or 130 or more hours per month.
  2. For an individual under age 2 years, \$200 for full-time or part-time employment.
- D. Consideration. Determine the best estimate of the monthly amount, as follows:
1. If the dependent care costs and provider have not or are not anticipated to change, use the amount of the costs for the prior 2 months for wages, or 3 months, or 12 months for annualized when an income tax return is used, for self-employment income.

EXAMPLE 1: The recipient works at her beauty salon 4 days a week and pays child care for a 3 year old. Her tax return shows \$1,800 child care costs for the year. Divide \$1,800 by 12 which equals \$150 a month.

EXAMPLE 2: The recipient worked at a drugstore and paid child care of \$135 and \$145 in the prior 2 months. She pays child care

on a monthly basis. Average the prior 2 months (\$280 divided by 2 equals \$140) for the best estimate of the monthly cost.

2. If the dependent care costs in the prior months do not reflect the ongoing costs due to a change in the dependent care arrangement:
  - a. Estimate the new costs on the new provider's statement; or
  - b. If only the rate changed, estimate the dependent care costs using the prior 2 months' number of hours, days or weeks, whichever is appropriate, dependent care was required multiplied by the new rate. Convert to a monthly amount.

EXAMPLE: The recipient had paid \$8 per day for child care. The child care is increasing to \$9 per day. The recipient pays the child care weekly and her wages are paid weekly. She worked the following days in the prior two months.

Month 1 - 4 days	Month 2 - 4 days
3	5
4	3
<u>5</u>	<u>3</u>
16 days	15 days

31 total days multiplied by \$9 per day equals \$279. Divided \$279 by 8 weeks which equals \$34.88 average weekly cost. Multiply \$35 by 4 1/3 to obtain the best estimate of the monthly costs, which is \$152.

- E. Document the method of verification and the computation of the best estimate of the monthly dependent care costs.

MS 4505

TIME-LIMITED DEDUCTIONS

Two distinct time-limited deductions are allowed if appropriate. The \$30 and 1/3 deduction is given for a maximum of 4 consecutive months unless otherwise stated; the \$30 deduction is given for a maximum of 8 consecutive months.

The recipient is eligible to receive 4 consecutive months of the \$30 and 1/3 deduction (e.g., May, June, July, and August). The 4 consecutive months are accrued without breaks. The \$30 and 1/3 and \$30 deductions are only one set of deductions. If the recipient is receiving one of these deductions while receiving K-TAP, the count carries over to the E or T case; the count does not start over. Once the recipient has received the \$30 and 1/3 deduction for 4 consecutive months, the deduction cannot be allowed again until the recipient has not received K-TAP or E or T benefits for at least 12 consecutive months.

If the K-TAP or E or T case becomes ineligible due to the expiration of the \$30 and 1/3 deduction or the \$30 deduction, explore eligibility for Transitional Medical Assistance (TMA). Refer to Volume IV, MS [2900](#).

Subtract the \$30 and 1/3 deduction or the \$30 deduction from the earned income of each individual included in the K-TAP or E or T case, if appropriate.

The \$30 and 1/3 or \$30 deduction is NOT transferable between states.

A. RESTRICTIONS. DO NOT allow the \$30 and 1/3 deduction or \$30 deduction for:

1. A technically excluded parent;
2. Any situations listed in General Restrictions; and
3. [A case where the time-limited deductions have expired or have been used due to penalties.]

B. REAPPLICATIONS.

1. If more than 12 months have elapsed and the Gross Income Test is passed and applicant eligibility exists, begin 4 consecutive months of considering the \$30 and 1/3 deduction.
2. If the recipient REAPPLIES and the K-TAP or MA in the E or T category case was closed for reasons other than those listed in Deductions, General Restrictions before the \$30 and 1/3 deduction is applied for the appropriate number of months, determine the number of months the individual has not received K-TAP or Medicaid in the E or T category.
  - a. [If more than 4 months but less than 12 months have elapsed and the Gross Income Test passed, recalculate the month

following any break in the count allowing the \$30 and 1/3 deduction and start the count at one or continue the \$30 deduction to 8 consecutive months from the effective date of discontinuance.

- b. If 4 months or less have elapsed, determine if appropriate to begin the \$30 and 1/3 deduction or to continue the \$30 deduction months to 8 consecutive months from the effective date of discontinuance.]

#### C. RECERTIFICATIONS AND INTERIMS.

1. For active cases in which earnings are considered currently, review the case to determine if the \$30 and 1/3 deduction has been received for 4 consecutive months without any breaks. If a break occurred, the 4 consecutive month count starts over and the month following the break is counted as month one.

This review may span multiple years and the original approval and any subsequent reapprovals depending on when the earnings were considered initially. [It may be necessary to request additional income verification if it is not available in the K-TAP, E, T, Food Stamp case record, if applicable.]

2. If it is determined the \$30 and 1/3 deduction was not received for 4 consecutive months and:
  - a. The case remained active and earnings were still considered, recalculate the month following the break allowing the deduction and start the count at one. Recalculate the subsequent months until the \$30 and 1/3 deduction is allowed for 4 consecutive months or the case became inactive.

EXAMPLE: A recipient received MA in the E or T category since March. She started work in May and is currently employed. After reviewing the case, it was determined she received the \$30 and 1/3 deduction for May, June and July. In August, there was not enough income to use the \$30 and 1/3 deduction.

The count would start over with September being month one. Recalculate October and subsequent months until the \$30 and 1/3 deduction is allowed for 4 consecutive months. In this example, the 4 consecutive month count started with September and ended with December being month four. The recipient is not eligible again for the \$30 and 1/3 deduction until she has not received K-TAP or MA in the E or T category for 12 consecutive months since the \$30 and 1/3 deduction was received for 4 consecutive months.

- b. The case was discontinued and reapproved before 12 consecutive months had elapsed, recalculate the month following any break in the count allowing the deduction and start the count at one.

EXAMPLE 1: A recipient began to receive MA in the E or T category in July. She began work in October. She received the \$30 and 1/3 deduction for November and December. Her MA in the E or T category case was discontinued for January. She reapplied in April and passed the Applicant Eligibility Test. She was still working. The \$30 and 1/3 deduction was allowed for April and May and removed for June.

Recalculate the case allowing the deduction for June and July.

EXAMPLE 2: Same situation as EXAMPLE 1, except the case was discontinued for a second time for July of the following year. The recipient was reapproved in September for MA in the E or T category. In October, she began a new job.

Recalculate June allowing the \$30 and 1/3 deduction. Calculate October allowing the deduction. Start the count over with October as month one and continue until the deduction is allowed for 4 consecutive months.

MS 4507

\$30 AND 1/3 DEDUCTION

A. CONSIDERATION.

1. BEGINNING MONTH OF DEDUCTION. A \$30 and 1/3 deduction month is any month where \$1 or more income remains after allowing the work expense standard. If no income remains after the work standard expense is deducted, the month is NOT a \$30 and 1/3 month. The \$30 and 1/3 deduction is applied for each individual with earned income.
  - a. The first month of the \$30 and 1/3 deduction for an eligible case is the month earnings should have been considered but were not, due to those circumstances in which restrictions apply even though no \$30 and 1/3 deduction is allowed.
  - b. The first month of the \$30 and 1/3 deduction for an ineligible case is the first month earnings were received, even if no \$30 and 1/3 deduction is allowed.
  - c. Each additional month of the \$30 and 1/3 deduction for an eligible case is a month in which the \$30 and 1/3 deduction is allowed or a month in which the \$30 and 1/3 deduction is not allowed due to circumstances for which restrictions in this section apply.
  - d. A recipient is eligible to receive 4 consecutive months of \$30 and 1/3 deduction without breaks.
    - (1) A break in the count includes an inability to benefit from the disregard (e.g., the wages are totally disregarded as work expenses before the consideration of the \$30 and 1/3 deduction, or the recipient quits the job with good cause or is fired).

EXAMPLE: The recipient receives a gross month wage of \$90 for July. She received the \$30 and 1/3 deduction for May and June.

\$ 90	Gross wage for July
- 90	Work expense standard
= 0	No wage left for \$30 and 1/3 deduction

The recipient received \$30 and 1/3 for 2 consecutive months, May and June. The month of July would not count as a \$30 and 1/3 month; therefore, the count would start over.

- (2) The following DO NOT constitute a break in the \$30 and 1/3 count.
  - (a) If the recipient requests discontinuance of the K-TAP or E or T case or voluntarily reduces the wages

in order to break the \$30 and 1/3 count, the count continues for one month even though the \$30 and 1/3 deduction is not given.

EXAMPLE: The recipient is in the 3rd month of the \$30 and 1/3 count. She requests the discontinuance of the case because she knows she is about to lose the \$30 and 1/3 deduction. The discontinuance month is counted as the fourth month even though the deduction is not given.

- (b) If the recipient fails without good cause, to report the earnings timely, the \$30 and 1/3 is not allowed for one month; however, it is counted as a month used.

EXAMPLE: The recipient started a job June 10 and reported it on June 28. The report was untimely. The \$30 and 1/3 is not allowed for June; however, June is counted as the first month of the 4 consecutive months. The \$30 and 1/3 is applied for July, as appropriate.

- (c) If the earnings are not reported at all, or the report was untimely, without good cause, for more than one month, the \$30 and 1/3 count starts with the month the job began; however, the deduction is not allowed.

EXAMPLE 1: In July, the worker discovers the recipient started to work in April. The \$30 and 1/3 count starts with April and ends with July; however, no \$30 and 1/3 deduction is allowed for these months.

EXAMPLE 2: The recipient reports in July that she started work in May. The \$30 and 1/3 starts with May. No \$30 and 1/3 deduction is given for May, June or July. The deduction can be given for August, if appropriate.

- 2. LOSS OF EMPLOYMENT. When the individual loses employment, the 4-month period of the \$30 and 1/3 deduction starts over again when the individual regains employment if 4 consecutive months of \$30 and 1/3 were not received and at least one K-TAP check or E/T MA card without the \$30 and 1/3 deduction being applied was received.

Example: An individual quits his/her job without good cause in the 3rd month of \$30 1/3. The last paycheck is received in the same month. Deductions are not allowed for the month of job quit, but the 3rd month of \$30 1/3 is still considered as received. The individual receives K-TAP or MA in the E or T category for 3 months

without income from employment. The individual begins a new job. The count for 4 consecutive months of \$30 1/3 are started over.

3. EXPIRATION OF DEDUCTION TIME LIMITS. If the individual has received the \$30 and 1/3 deduction for the appropriate time period, remove the deduction and do not allow again until the individual has not received K-TAP or MA in the E or T category for at least 12 consecutive months.
4. TRACKING. Indicate on form PAFS-116, Supplement A, Monthly Tracking Log, each month in which the \$30 and 1/3 deduction is applied.
5. SPOT CHECKS. KAMES will post a spot check on the worker's DCSR for the case for the fourth month of the \$30 and 1/3 deduction to ensure the deduction is removed timely.

MS 4509

\$30 DEDUCTION

Following removal of the \$30 and 1/3 deduction, each of the next 8 consecutive months is counted as a \$30 month, even if there is no earned income in the case or the case becomes inactive. If the case is discontinued during the 8-month period, see MS [4505](#). The \$30 deduction is applied for each individual with earned income.

A. RESTRICTIONS. See MS [4505](#).

B. CONSIDERATION.

1. BEGINNING MONTH OF DEDUCTION. The first month of the \$30 deduction is the first month the \$30 and 1/3 deduction is no longer applied, even if no earned income is considered in determining the grant amount.
2. EXPIRATION OF DEDUCTION TIME LIMIT. [If the case remains active for the 8 months following removal of the \$30 and 1/3 deduction, KAMES will remove the \$30 deduction (if being allowed) and the worker is not to allow the \$30 deduction again until the individual has not received K-TAP or MA in the "E" or "T" category for at least 12 consecutive months.]
3. TRACKING. Indicate on form PAFS-116, Supplement A each month the \$30 deduction is applied.
4. SPOT CHECKS. Spot check the case during the eighth month of the \$30 deduction to ensure the deduction is removed timely.

MS 4512

PROSPECTIVE BUDGETING

Prospective budgeting is the method by which a best estimate of income is used to anticipate the amount of income to be received by the E or T assistance unit.

- A. The best estimate is based on the Agency's knowledge of past and current circumstances and accurately reflects the anticipated ongoing circumstances. Determination of the best estimate is dependent on the type of income (e.g., wages, self-employment, interest, contributions). In general, the actual income for a specified time period is averaged and/or converted by  $4 \frac{1}{3}$ ,  $2 \frac{1}{6}$ , 2 or 1, as appropriate, based on the type of income.

Determine the dependent care deduction by using a best estimate to anticipate the ongoing monthly expense. Derive the best estimate by computing dependent care expenses for the same time period used in the computation of the best estimate of earnings.

- B. Redetermine the best estimate at recertification or if there is a change in circumstances which will affect ongoing eligibility.
1. A change in circumstances requires a recomputation of the best estimate. A change in circumstances is defined as a change in income and/or dependent care expenses which affect ongoing eligibility. This includes:
    - a. Beginning or ending employment;
    - b. Change in employers or obtaining additional employment;
    - c. Increase or decrease in the number of work hours;
    - d. Increase or decrease in the rate of pay;
    - e. Increase or decrease in the dependent care expense due to a change in provider, number of hours of care, number of individuals for whom care is given, or amount charged; or
    - f. Change in cropping arrangements or type of self-employment activities.
  2. Normal fluctuations in the income amounts are not considered as a change in circumstances and do not require a recomputation of the best estimate. Normal fluctuations include:
    - a. A change in work hours which will not exceed 30 days;
    - b. A 5th or periodic paycheck; or
    - c. Holidays, vacation days or sick leave not to exceed 30 days.
- C. Process the case in the following manner for applications, recertifications or interims:

1. If the income is representative of the ongoing situation, use the income from all pay periods in the prior 2 calendar months. Apply the procedures found in MS [4360](#) and MS [4420](#).  
EXAMPLE: The recipient applied in March. She has worked since November and continues to work. Use the income from the pay periods in January and February (the 2 months prior to the application month of March) to determine the monthly income to be counted in March and ongoing. January and February are used regardless whether the case is worked in March or April.
2. If the income is NOT representative of the ongoing situation, do the following:
  - a. For the recently employed who have not received 2 calendar months of earned income, calculate the monthly amount as follows:
    - (1) Multiply the hourly rate by the estimated number of hours to be worked in a pay period. Round the results;  
or
    - (2) Multiply the daily rate by the estimated number of days to be worked in a pay period. Round the results; and
    - (3) Convert the estimated pay period amount by multiplying:
      - a) The weekly amount by  $4 \frac{1}{3}$ ;
      - b) The bi-weekly amount by  $2 \frac{1}{6}$ ; or
      - c) The semi-monthly amount by 2.

Apply current rounding procedures found in MS [4360](#).

EXAMPLE: The recipient applies in March and begins work in March. The employer verification indicated the recipient would work 10 hours a week at \$5 per hour and would be paid weekly. Use this information to calculate the estimated monthly amount. This amount is used to determine benefits for March and ongoing whether the case is worked in March or April.

- b. For cases of new employment, where the employer verifies the recipient will be paid for only a partial month, use the estimated weekly amount times the number of checks the recipient will receive for the month of application. To determine ongoing eligibility, convert the weekly estimated amount by  $4 \frac{1}{3}$  or  $2 \frac{1}{6}$ .  
EXAMPLE: The recipient applies in March, and started a job in March. The employer verifies the recipient will only receive 2 pay checks in March. Use the estimated amount for the pay period multiplied by 2 for the month of March and convert the weekly estimated amount for the ongoing eligibility.
3. For cases where the hours of employment or the rate of pay changes and the recipient has not received 2 calendar months of earned income at the changed hours or rate, calculate the monthly amount using the steps outlined in C.2, a.

EXAMPLE: The recipient received a pay raise in the middle of February. She applies for K-TAP or E or T in March. Since the January and February income does not represent the ongoing income, calculate the anticipated income using the new rate of pay multiplied by the number of hours estimated for the pay period and convert accordingly.

Document HOW the income is calculated and WHAT verification was used. If less than 2 calendar months was used, document WHY.