January-April 2015 Summary of Changes

Chapter	Passage	Summary
0200	**0230.0001**	Corrected the name of Emergency Medical Assistance for Noncitizens (EMA) Coverage.
	0230.0102	Updated passage to change age group for individuals 19-21 from 18-21, corrected the name of EMA coverage and corrected the name of Former Foster Care for Children (FFC) coverage.
	0230.0104	Deleted extra space.
	0230.0105	Corrected the name of EMA coverage.
400	**0440.0610**	Removing the Notice of Review Case Action, denying the eligibility on FLORIDA and notifying the individual of hearing rights.
	0440.0612	Correct the acronym for Minimum Monthly Maintenance Needs Allowance (MMMNA).
0600	**0630.0100**	Corrected previously stricken space between “at” and “reapplication”.
	0630.0101, 0630.0109	Deleted extra space.
	0630.0111	Added parentheses to dates to state date(s) and corrected the name of EMA coverage.
	0630.0112	Deleted extra space and changed “include” to “includes”.
	0630.0502	Corrected the name of EMA coverage.
600	**0640.0100**	Financial Release Form must be submitted when applying or receiving Medicaid on the basis of age 65 or older, blind or disabled.
800	**0840.0601**	Clarify language explaining Exparte when SSI is terminated.
1410	**1410.2200**	Corrected the effective date for conviction for felony drug trafficking for imposing disqualification from on or after 8/22/96 to after 8/22/96

	1420.2200	Corrected the effective date for conviction for felony drug trafficking for imposing disqualification from on or after 8/22/96 to after 8/22/96
1430	**1440.0008**	Correct language for number 3 and 4 of the Cystic Fibrosis section.
	1440.0200	Changes didn't cross over from the last policy update.
1600	**1640.0205**	Updated passage to correct the asset limit for the Working Disabled (WD) program. Updated passage to remove Assisted Living Waiver and Long Term Care Diversion Waiver and added iBidget and SMMC-LTC
	1640.0206	Added statement about the financial release.
	1640.0302.01	Grammatical correction.
	1640.0315	Updated passage to remove Assisted Living Waiver and Long Term Care Diversion Waiver and added iBudget and SMMC-LTC.
	1640.0543.02	Deleted the language that pertains to interstate residency agreements. Amended the language to explain the criteria for excluding an out-of-state home based on intent to return.
	1640.0551	Updated passage to correct the transfer of assets period to 60 months.
	1640.0572	Updated passage to correct the address to request a hardship exemption for US Savings Bonds by series.
	1640.0608	Updated the passage to remove the language.
	1640.0609.01	Grammatical correction.
1800	**1810.0209**	Revised passage to clarify collateral contact verification requirements apply to both income and benefits received
	1820.0209.02	Revised passage to clarify collateral contact verification requirements apply to both income and benefits received
	1850.0209.02	Revised passage to clarify collateral contact verification requirements apply to both income and benefits received
	1860.0209.02	Revised passage to clarify collateral contact verification requirements apply to both income and benefits received

2000	**2030.0200**	Updated passages to include the age limit for children's Medicaid categories, corrected the name of EMA coverage and corrected the name of FFC coverage.
	2030.0201	Added language to specify to include the spouse of a parent or other caretaker relative.
	2030.0202	Deleted extra space.
	2030.0203	Corrected the spelling of Medicaid, and modified text to clarify eligibility policy for Transitional Medicaid.
	2030.0600	Added the acronym for Qualified Hospital and capitalized the first word of each item in a number list and corrected the name of FFC coverage.
	2030.0700	Updated passage to explain the period of eligibility for pregnant women and removed Medically Needy from the list of exceptions and corrected the name of EMA coverage.
	2030.0702	Deleted language that does not apply.
	2030.0704	Corrected spelling of eligibility.
	2030.0901	Corrected the name of EMA coverage.
	2030.0902	Added clarifying language to explain referrals to the Children's Health Insurance Program or the Federally Facilitated Marketplace.
	2030.1100	Corrected the name of EMA coverage.
	2030.1100.01	Added clarifying language regarding the emergency date(s) of service.
	2030.1100.02	Numbered a list and corrected the name of EMA coverage.
	2030.1200	Added language to explain the eligibility requirements for individuals that aged out of foster care and corrected the name of FFC coverage.

	2030.1400	Corrected the name of the Medically Needy Program and to explain an individual eligible for Medically Needy must met the technical requirements of one of the Medicaid categories.
	2040.0107	SSI-Related Medicaid Category Codes that were being retired were deleted, they include MT-A, MH-P, MW-C
	2040.0800	SSI-Related Medicaid Coverage Groups , deleted Disabled Widow(er) I Protected Medicaid, and Protected Medicaid for SSI Children, Channeling Waiver, Assisted Living Waiver, Long-Term Care Diversion Waiver and Developmental Services Waiver, added Familiar Dysautonomia and Statewide Medicaid Managed Care Programs
	2040.0815.01	Changed reference passage from 0240.0810 to 0240.0111.
	2040.0815.02	Deleted Additional Criteria HCBS Channeling Waiver and renumbered to state Additional Criteria –HCBS cystic Fibrosis Waiver
	2040.0815.03	Deleted Additional Criteria – HCBS Project AIDS Care and renumbered to state Familial Dysautonomia Waiver
	2040.0815.04	Deleted Additional Criteria – HCBS Aged/Disabled Adult Waiver and renumbered to state Additional Criteria- HCBS Individual Budgeting Florida (iBudget) Developmental Disabilities
	2040.0815.05	Deleted Additional Criteria - HCBS Individual Budgeting Florida (iBudget) Developmental Disabilities Services Waiver and renumbered to state Additional Criteria – HCBS Model Waiver
	2040.0815.06	Deleted Additional Criteria - HCBS Assisted Living Waiver and renumbered to state Additional Criteria - HCBS Project AIDS Care
	2040.0815.07	Deleted Additional Criteria – HCBS Model Waiver and renumbered to state Additional Criteria HCBS Statewide Managed Medical Care Long Term Care (SMMC LTC)
	2040.0815.09	Deleted entire section Additional Criteria – Long – Term Care Comm. Diversion Waiver
	2040.0815.10	Deleted and renumbered to 2040.0815.02
	2040.0815.11	Deleted and renumbered to 2040.0815.03
	2040.0816	#3. Deleted $5,000 asset limit and changed it to $4,000

	2040.0819	Added abbreviation for Qualifying Individuals,
	2040.0821	Changed DOH phone number.
2200	**2210.0302.02**	Changed language of the passage from “two parents” to “parent(s).
2400	**2420.0300**	Deleted reference to work expenses for the blind as an income disregard for TCA. This is an SSI related Medicaid expense deduction
	2420.0406	Corrected the effective date for conviction for felony drug trafficking for imposing disqualification from on or after 8/22/96 to after 8/22/96
	2440.0100	Removed Appendix A-7
	2440.0102	Revised passage to clarify the Medically Needy Income limits.
	2440.0103	Deleted the word “the”
	2440.0113	Added the abbreviation (WD) for Working disabled.
	2440.0115	Added the abbreviation for Qualifying individuals
	2440.0118	Added the word (PACE)
	2440.0211	Added the words “the new and the word “periods”
	2440.0212, 2440.0321, 2440.0322, 2440.0367, 2440.0368, 2440.0369	Added the abbreviation (WD)for Working disabled
	2460.0300	Deleted reference to work expenses for the blind as an income disregard for RAP. This is an SSI related Medicaid expense deduction
2600	**2610.0410**	Corrected the effective date for conviction for felony drug trafficking for imposing disqualification from on or after 8/22/96 to after 8/22/96
3200	**3230.0303**	Adding reference to MyAccess Account and remove the word Emergency.
	3240.0303	Adding reference to MyAccess Account and remove the word Emergency.
	3250.0303	Adding reference to MyAccess Account and remove the word Emergency.
3400	**3430.0100** **3430.0102**	Corrected the referenced passage number and removed a comma. Removed language regarding notices for Medically Needy with an estimated share of cost.

3600	**3610.0902**	Corrected the effective date for conviction for felony drug trafficking for imposing disqualification from on or after 8/22/96 to after 8/22/96
	3620.0902	Corrected the effective date for conviction for felony drug trafficking for imposing disqualification from on or after 7/1/97 to after 8/22/96

0230.0001 Caseload Distribution (MFAM)

Caseload assignments are frequently made according to the characteristics of a given assistance group and the type of assistance received. These breakdowns are called Temporary Cash Assistance cases, Family-Related Medicaid cases or SSI-Related Medicaid cases. Each type may include food stamps.

A Temporary Cash Assistance case or Family-Related Medicaid case may contain one or more of the following types of assistance: Temporary Cash Assistance (TCA), Refugee Assistance Program (RAP), food stamps, Family-Related Medicaid or Medically Needy.

An SSI-Related Medicaid case may contain one or more of the following types of assistance: Institutional Care Program (ICP), MEDS-AD, Protected Medicaid (PM), Medically Needy, Emergency Medical Assistance for Noncitizens ~~Medicaid for Aliens~~ (EMA), Hospice, Home and Community Based Services (HCBS), Refugee Assistance Program (RAP), Qualified Medicare Beneficiaries (QMB), Working Disabled (WD), Special Low Income Medicare Beneficiary (SLMB), Optional State Supplementation (OSS), Part B Medicare Only (PBMO), Home Care for Disabled Adults (HCDA), or food stamps. All programs are Medicaid Programs except OSS, HCDA and food stamps. The Department of Elder Affairs currently handles Home Care for the Elderly (HCE).

A mixed caseload contains one or more Temporary Cash Assistance or Family-Related Medicaid and SSI-Related types of assistance, with or without food stamps.

Child in Care cases are frequently specialized due to the special confidentiality requirements and unique policy. Therefore, they are not considered part of the Temporary Cash Assistance or Family-Related Medicaid caseload and the information about the case is limited to eligibility specialists with special confidential security profiles.

0230.0102 Program Overview (MFAM)

Family-Related Medicaid contains the following coverage groups:

1. Parents and other caretaker relatives
2. Pregnant women
3. Infants and children under age 19
4. Children Ages 19~~18~~-21
5. Emergency Medical ~~Medicaid~~ Assistance for ~~to~~ Noncitizens
6. Former Foster Care Children~~Individual aged out of Foster Care up to age 26~~

0230.0104 Medically Needy (MFAM)

The Medically Needy Program provides coverage for individuals who meet the technical requirements for the above coverage groups, but whose income exceeds the group's

income -standard. Medically Needy has no income limit. Individuals are enrolled in the program with a Share of Cost (SOC). SOC refers to the amount of medical bills which an individual enrolled in the Medically Needy Program must incur in any given month before Medicaid coverage may be authorized.

0230.0105 Emergency Medical Assistance ~~Medicaid~~ for Noncitizens (MFAM)

This program provides emergency Medicaid coverage for noncitizens who would otherwise be eligible for Medicaid except for their noncitizen status. They must meet all technical requirements except for citizenship, child support enforcement cooperation, and welfare enumeration.

To be eligible for emergency Medicaid benefits, the noncitizen must meet the income requirements for whichever Medicaid coverage group the noncitizen is determined to be eligible.

Medicaid coverage is for the duration of the emergency medical situation only, as certified by a health professional. This includes emergency labor and delivery.

0440.0610 Reevaluating Medicaid Adverse Actions (MSSI, SFP)

The Department must reevaluate any Medicaid determination where there is evidence of good cause that the previous determination was incorrect.
The request for reevaluation applies to the following situations:
1. benefits terminated or denied in error;
2. an overstated patient responsibility/share of cost; and
3. an error in the calculation of the level of benefits.

If a participant requests a reevaluation:
1. Within 90 days of the mailing date of the notice, follow hearing policy and continue to work on resolution.

2. After 90 days from the mailing date of the notice but no more than 12 months following the effective date of the adverse action, review the request to determine if good cause exists.

3. After 12 months from the effective date of the notice, deny the eligibility on FLORIDA and inform the individual of hearing rights on the electronic notice ~~complete the Notice of Review of Case Action to deny the reevaluation and inform the participant of hearing rights~~.

Good cause exists when:
1. The Department made mistakes in mathematical computations.
2. The Department made an error in the determination.

3. The participant presents new information that was not considered when the previous determination was completed and it may result in a different conclusion. The information must have been unavailable due to circumstances beyond the participant's control.

Once good cause is established, determine eligibility, authorize benefits as appropriate and send a new notice of case action. Notify the participant of the decision for all months as required below.
For applications: Review eligibility each month and authorize as appropriate back to the month of application, including any requested retroactive months.
For active cases: Review eligibility each month and authorize as appropriate back to the effective date of the action under review.
When good cause does not exist:
~~Send the Notice of Review of Case Action notifying the participant~~ Notify the individual of the reevaluation denial and hearing rights. The determination that good cause does not exist cannot be reevaluated.

0440.0612 Community Spouse Resource Allowance (MSSI)

If an applicant is denied eligibility due to excess assets, a hearings officer may increase the Community Spouse Resource Allowance (CSRA) to an amount that would generate income to bring the community spouse's income up to the Minimum Monthly Maintenance Needs ~~Income~~ Allowance (MMMNA~~MMMIA~~).

During a fair hearing when the spouse requests an increase in the CSRA, the amount of resources adequate to provide the community spouse the MMMNA MMMIA shall be based on the cost of a single premium lifetime annuity with monthly payments equal to the difference between the MMMNA ~~MMMIA~~ and the amount the community spouse's income is expected to be upon approval of institutional care benefits for the institutional spouse.

In making this determination, the hearing officer considers the community spouse's actual income at the time of the fair hearing and any income that would be available from the institutional spouse upon approval of institutional care benefits, less income produced by the couple's assets. This ensures that all income that will actually be available to the community spouse, excluding income generated by the couple's actual assets, is considered before the CSRA is revised.

0630.0100 APPLICATION FOR ASSISTANCE (MFAM)

Individuals may apply for public assistance in person, by phone, mail or by web-based or facsimile application. An acceptable application must have the applicant's name, address and signature on the form. Upon request from an applicant, provide necessary assistance in completing the application.

The application must be the Department's web-based application, which is the Self Service Portal, or the application used by the Department and Florida KidCare (Family-Related Medical Assistance Application), or a single streamlined application for all insurance affordability programs developed by the federal department of Health and Human Services.

~~Applicants for Family-Related Medicaid may not apply using the ACCESS Florida Application (CF-ES 2337).~~

Provide the individual or the individual's designated representative the right to file an application the same day the individual or designated representative contacts the office and expresses interest in obtaining assistance. Only the PIP or designated representative must sign the application. Unless signed in the presence of Department staff, an application signed with a mark must have two witness' signatures.

An individual must submit a Family-Related Medicaid application at initial application and at reapplication.

0630.0101 Date of Application (MFAM)

For all households in which the PIP is a member (except sponsors), or is acting as a designated representative, the date of application is the date the Department receives a signed application. When an applicant submits a paper application or verification, the scan/fax date is the date of receipt and the application date. If the Department receives a web-based or facsimile application after normal business hours, establish the first business day following receipt as the application date.

The date the federally qualified health center or disproportionate share hospital receives and date -stamps a signed application is the official date of application for Medicaid. In the absence of a date stamp, the application date is the date the applicant signs and dates it.

0630.0109 Designated Representatives (MFAM)

A representative may be designated by an applicant or recipient to act responsibly on their behalf in assisting with the application and redetermination of eligibility and other ongoing communication with the Department. An applicant must authorize designated representatives prior to eligibility determination or anytime during the review period.

If the household member or a designated representative is not responsible, that member may not represent the household and may not designate a representative. Record the information that supports this decision.

Designated representatives assume responsibility for the accuracy of the information provided and are subject to the same disqualification penalties and possible prosecution as responsible household members.

0630.0111 Medical Provider Referrals (MFAM)

Hospitals and other Medicaid providers refer individuals who are potentially eligible for Medicaid to the Department for the purpose of making application. Upon receipt of a referral, contact the individual to obtain an application, determine eligibility status and notify the provider of the disposition.

If a medical assistance referral is received on an Emergency Medical Assistance for Noncitizens ~~Medicaid for Aliens~~ case during their 12-month eligibility period, Medicaid benefits should be opened for the new date(s) ~~dates~~ of emergency using the information supplied on the referral. The individual does not need to be contacted for an eligibility determination.

0630.0112 —Certified Application Counselors (MFAM)

The staff and volunteers of state-designated organizations may act as application assisters, authorized to provide assistance to applicants and recipients with the application and redetermination process. Certified Application Counselors (CAC) are trained in the Medicaid eligibility policies and adhere to all rules and regulations relating to safeguarding and confidentiality of customer information.

The assistance provided by CAC's includes ~~include~~: providing information on Medicaid programs, helping individuals complete an application/redetermination, assisting the individuals to provide required documentation, submitting documents to the Department, making inquiries as to the status of the applications and redeterminations, assisting individuals with responding to Department requests.

0630.0502 Date of Medicaid Eligibility (MFAM)

For eligible individuals, the date of eligibility for Medicaid is the first day of the month of application receipt regardless of the date of disposition. If eligible for Medicaid for one day in the month, an applicant is eligible for the entire month, regardless of changes in circumstances.

For these programs, the date of initial eligibility begins the date the AG is determined eligible:

1. Emergency Medical ~~Medicaid~~ Assistance for Noncitizens ~~Aliens~~ cases,
2. Presumptively eligible individuals, and
3. Medically Needy SOC cases.

0640.0100 APPLICATION FOR ASSISTANCE (MSSI, SFP)

Individuals may apply for public assistance in person, by mail or by web-based or facsimile application. An acceptable application must have the applicant's name, address and signature on the form. Upon request from an applicant, provide necessary assistance in completing the application.

Encourage the individual or the individual's designated representative to exercise the right to file an application the same day the individual or designated representative contacts the office and expresses interest in obtaining assistance. Only the PIP or designated representative must sign the application. Unless signed in the presence of the eligibility specialist, an application signed with a mark must have two witness' signatures. If the eligibility specialist signs as the witness, no other witness is required.

A signed Financial Information Release Form (CF-ES 2613) or a written permission to release financial records to the Department is required in the determination of eligibility for individuals applying for or receiving Medicaid, including those individuals whose assets are deemed to evaluate eligibility on the basis of age (65 or older), blindness or disability.

An individual must submit an application at initial application, reapplication, and requests for additional types of assistance.

0840.0601 SSI Ex Parte (MSSI)

Upon termination of an individual's SSI cash benefits, AHCA mails the Medicaid redetermination letter informing the individual that the Department will review their eligibility to determine ~~see~~ if they continue to qualify for Medicaid. There is no requirement~~t~~ for the individual to contact the Department to initiate the ex parte determination. If necessary, the Department will contact the individual for additional information and extend eligibility until the review is completed. Complete the review within 30 days from the date the Department is notified that the individual's SSI was terminated, unless an extension is needed~~,~~. ~~and s~~Send the individual a notice of case action advising of their eligibility when the determination is complete.

1410.2200 INDIVIDUAL CONVICTED OF FELONY DRUG TRAFFICKING (FS)

Food stamp benefits shall be denied to an individual who has been convicted of a felony for drug trafficking including agreeing, conspiring, combining, or confederating with another person to commit the act committed ~~on or~~ after 8/22/1996. This disqualification is a lifetime disqualification. Only the individual who was convicted will be penalized. If the illegal behavior that lead to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is not subject to the disqualification. The individual must provide proof of the expungement.

Since felony conviction for drug trafficking is not considered noncompliance with specific program requirements, “Riverside” policy would not be applied.

1420.2200 INDIVIDUAL CONVICTED OF FELONY DRUG TRAFFICKING (TCA)

Temporary Cash Assistance benefits shall be denied to an individual who has been convicted of a felony for drug trafficking including agreeing, conspiring, combining, or confederating with another person to commit the act committed ~~on or~~ after 8/22/1996. This disqualification is a lifetime disqualification. Only the individual who was convicted will be penalized. If the illegal behavior that lead to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is not subject to the disqualification. The individual must provide proof of the expungement.

Since felony conviction for drug trafficking is not considered noncompliance with specific program requirements, “Riverside” policy would not be applied.

1440.0008 Additional Criteria - HCBS Waivers (MSSI)

The individual must also meet additional program specific criteria that vary according to the Home and Community Based Services (HCBS) Program waiver type.

For the Cystic Fibrosis Waiver (CF/HCBS) individuals must:

1. be 18 years of age or older (must meet disability criteria if under age 65);
2. meet a level of care for being at risk of hospitalization as determined by CARES;
3. have a diagnosis of Cystic Fibrosis and a need for medically necessary services provided by the waiver as determined by Adult Services; and
4. be enrolled in the Cystic Fibrosis waiver as documented by form CF-ES 2515.

5. ~~have a diagnosis of Familial Dysautonomia and a need for medically necessary services provided by the waiver as determined by CARES; and~~
6. ~~be enrolled in the Familial Dysautonomia waiver as documented by form CF-ES 2515~~

For Familial Dysautonomia Waiver FD/HCBS) individuals must:

1. be age three or older (must meet disability criteria if under age 65);
2. meet a level of care of being at risk of hospitalization as determined by CARES;
3. have a diagnosis of Familial Dysautonomia and a need for medically necessary services provided by the waiver as determined by CARES, and
4. be enrolled in the Familial Dysautonomia waiver as documented by form CF-ES 2515.

For the iBudget Florida Waiver individuals must:

1. be aged three or older (must meet disability criteria if under 65),
2. meet level of care requirements as determined by the Agency for Persons with Disabilities; and
3. be enrolled in the iBudget Florida waiver as documented by form CF-ES 2515

The iBudget Florida waiver is targeted to develop mentally disabled individuals and allows the customer more choice and control over his or her services.

For the Model Waiver, individuals must:

1. be under 21 years of age
2. be diagnosed as having a degenerative spinocerebeller disease; and
3. meet the appropriate level of care for inpatient hospital care as determined by Children's Medical services as documented by form CF-ES 2515.

Florida can only serve five children at any one time under this program. The Agency for Health Care Administration evaluates each case and authorizes slots.

For Project AIDS Care (PAC/HCBS), individuals must:

1. be disabled with AIDS (this also applies to an aged individual);
2. meet level of care requirements as determined by CARES, and
3. be enrolled in the PAC waiver as documented by form CF-ES 2515.

For the Statewide Managed Medical Care Long Term Care Waiver (SMMC LTC) individuals must:

1. be enrolled in the SMMC-LTC waiver as documented by form CF-ES 2515;
2. meet the appropriate level of care requirement as determined by CARES; and
3. be 18 years of age or older (must meet disability criteria if under 65).

For Traumatic Brain and Spinal Cord Injury Waiver, individuals must:

1. be between the ages of 18 and 64;
2. be disabled due to Traumatic Brain Injury or Spinal Cord Injury;
3. meet a nursing facility level of care as determined by Cares; and
4. be enrolled in the waiver as documented by form CF-ES 2515.

1440.0200 SOCIAL SECURITY NUMBER (MSSI, SFP)

The eligibility specialist must obtain a Social Security number (SSN) for each individual or verify that the individual has applied for an SSN as a condition of eligibility. This requirement does not apply for the Emergency Medical Assistance for Noncitizens

Program. The purpose of the SSN is to identify income and assets held by an individual.

A verbal statement providing the SSN is sufficient as the SSN is validated through data exchange. If the SSN is unknown or has never been obtained, the individual must:

1. apply for an SSN through the welfare enumeration system at the local DCF office. (Original evidence of age, identification and citizenship or noncitizen status must be sent by the eligibility specialist to the local Social Security Administration (SSA) office with the completed SS-5.); or
2. apply for an SSN through the local SSA office (The SSA filing receipt for application must be presented to the eligibility specialist as evidence that the individual has applied.); or
3. apply for an SSN through the Florida enumeration at birth process.

Evidence that the individual has applied includes:

1. an SSA 2853 indicating that an SSN was requested at the hospital,
2. the child's birth certificate with "yes" annotated in Section 11d, or
3. a screen print from BVS with a "y" indicator in the child issue field.

The eligibility specialist must request that SFU members whose income and/or assets are included in the budget, but who are not members of the assistance group, provide their SSN for purposes of data exchange. These individuals are not required to comply with this request. The agency must not deny or delay services to an otherwise eligible individual pending issuance or verification of the individual's SSN by SSA.

Refer to the FLORIDA Desk Guide for procedures for routing the SS-5.

1640.0205 Asset Limits (MSSI, SFP)

Total countable assets for an individual or a couple must not exceed the following limits:

1. For MEDS-AD and Medically Needy ~~and Working Disabled~~, the asset limit is $5,000 for an individual and $6,000 for a couple.

2. For the Working Disabled (WD), the asset limit is $4,000 for an individual and $6,000 for a couple.

3. For ICP, PACE, all HCBS Waivers and Hospice, the asset limit is $2,000 for an individual ($3,000 for eligible couple) or $5,000 if the individual's income is within the MEDS-AD limit ($6,000 for eligible couple).

4. For QMB, SLMB, and QI1 the asset limit is three times the SSI resource limit with annual increases based on the yearly Consumer Price Index. Refer to Appendix A-9.

Community spouse resource allowance policy applies to ICP, Institutional ~~institutional~~ Hospice, Cystic Fibrosis Waiver, iBudget, ~~Assisted Living Waiver, Long Term Care Diversion Waiver~~ SMMC-LTC and PACE. Applicants who have spouses residing in the community or spouses who are not enrolled in HCBS, have a Community Spouse Resource Allowance (CSRA) subtracted from the couple's total countable assets before comparing the institutionalized spouse's countable assets to the $2,000 or $5,000 asset limit. The CSRA is an established amount that increases annually.

1640.0206 Verification of Assets (MSSI, SFP)

Verification of all assets, except cash, is required when the total assets of the SFU are within $100 of the asset limit. The individual's statement of the amount of cash is accepted. If it is clear from the individual's statement that total assets exceed the limitation or if the individual is ineligible on another factor, assets need not be verified. A signed Financial Information Release Form (CF-ES 2613) or a written permission to release financial records to the Department is required in the determination of eligibility for individuals applying for or receiving Medicaid, including those individuals whose assets are deemed to evaluate eligibility on the basis of age (65 or older), blindness or disability.

The exceptions to this are:

1. persons requesting ICP, Hospice, or HCBS (you must always verify except for the value of the first vehicle and any vehicle over seven years old); and
2. cases that receive an IRS hit. Verification in these cases must be handled in accordance with current policy, which requires a review of these hits. If there is a discrepancy, verification must be secured through a third party.

1640.0302.01 Joint Ownership of Bank Accounts (MSSI, SFP)

When an individual is a joint account holder who has unrestricted access to the funds in the account, you must presume all of the funds in the account are owned by the individual. This presumption is made regardless of the source of the funds.

If the individual alleges the funds in the account belong to someone else, you must allow the individual to submit evidence to challenge this presumption. If the challenge is successful, do not count the funds in the account as an asset to the individual for any month. ~~(If the individual never owned the funds, they were never his.)~~ If the challenge to the presumption of ownership is not successful, you must consider the funds as an asset to the individual. This policy applies to checking accounts, savings accounts, certificates of deposit and other jointly owned financial accounts.

1640.0315 Assets Available to Spouse after Approval (MSSI)

The following policy applies to ICP, ICP/MEDS, PACE, Institutionalized Hospice Programs, iBudget and Statewide Medicaid Managed Care-Long Term Care ~~the Assisted Living, Long term-Care Community Diversion~~ and Cystic Fibrosis waivers.

Following approval, none of the assets solely owned by the community spouse are included as available to the institutional spouse. The amount of assets allocated to the community spouse which belong to the institutional spouse and are available to the institutional spouse must be transferred to the community spouse. The eligibility specialist must work with the individual to assure that the assets are transferred to the community spouse; however, the assets will not be counted as available to the institutional spouse until the first scheduled complete redetermination is conducted. In no instance should the failure to transfer the assets to the community spouse within the prescribed time limits result in overpayment.

Any assets received by the institutionalized spouse after approval, which cause the total assets to exceed the asset standard, will not affect the individual's eligibility if they are transferred to an allowable person (see Section 1640.0600) within the month of receipt or if the individual receives equitable value. If the assets are still available to the institutionalized spouse the month after receipt, the value of the new assets is considered a countable asset to the institutionalized spouse the month after the assets are received.

If the individual returns home and the case is closed, the couple's assets must be reevaluated if the individual reapplies after a 30 day absence from the institutional facility. This policy does not apply if the individual returns to the institutional facility within 30 days.

1640.0543.02 Individuals with Homes in Another State (MSSI)

Individuals who meet Florida residency requirements solely because they are institutionalized in a Title XIX Medicaid facility in Florida, but who have a home in another state, may have that home excluded as an asset if:

1. the individual’s spouse or dependent relative resides in the home; or

2. the individual expresses an intent to return to that home (that is, the home continues to be the individual’s principal place of residence). ~~and the State of Florida has an interstate agreement with the individual’s home state to provide reciprocal care to Florida residents needing institutional care while in that state.~~

Statements of intent to return or allegations of dependency are accepted without further development (unless questionable) from the individual, designated representative, and the dependent relative if the individual is incapable of providing such information.

~~Alabama, Arkansas, California, Georgia, Idaho, Iowa, Kansas, Kentucky, Louisiana, Maryland, Minnesota, Mississippi, New Jersey, New Mexico, North Dakota, Ohio, South Dakota, Tennessee, Texas and West Virginia have interstate agreements with Florida.~~

1640.0551 Life Estate Interest (MSSI, SFP)

Any life estate interest held by an individual, the individual's spouse, a child or specified relative is excluded as an asset to the individual. Also, transfers of life estates need not be examined for potential penalties.

Life estate received as a result of a transfer within 60 ~~36~~ months of application for institutional care or HCBS must be evaluated under the transfer of assets policies.

Although individuals owning life estates have the right to obtain profits from the estate property they do not have exclusive rights to the benefits of the property. Therefore, only that portion of the income made available to the individual will be counted as income to the individual.

1640.0572 Savings Bonds (MSSI, SFP)

U.S. Savings Bonds are an obligation of the federal government, but unlike other government bonds, they are not transferable; that is, they can only be sold back to the government.

U.S. Savings Bonds are usually registered in the name of the owner(s) shown on the front of the bond and may be redeemed by the owner by completing a form on the back of the bond. If ownership of a bond is shared, each person's share is equal. All owners must agree to liquidate the bond.

Several series of U.S. Savings Bonds (for example, Series EE, HH, E, I, J, and H) can normally be quickly converted into cash at local banks. These bonds are defined as liquid assets and are counted as resources. Do not use the table sometimes provided on the back of the bond to determine its value. The tables often do not reflect changes in interest rates. A bank must be contacted to determine the current value. The face value of Series H bonds does not change. No further verification of value is necessary for that series; however, interest is paid rather than accrued on these bonds.

Some bonds must be held for a specific period of time from the date of issue before they can be converted to cash. Examples of bonds with retention periods are indicated below:

1. Series EE and I bonds issued prior to February 1, 2003 can be converted to cash at any time after six months from the issue date.
2. Series EE and I bonds issued on or after February 1, 2003 can be converted to cash at any time after twelve months from the issue date.

3. Series HH bonds can be converted to cash at any time after six months from the issue date.

Although there are mandatory retention periods for the bonds referenced above, they may be converted to cash early if the owner requests a waiver of the retention period claiming hardship circumstances. A hardship exemption request must be in writing, accompanied by the bond that is still within the mandatory retention period, to the following address:

~~Bureau of the Public Debt~~
~~Savings Bonds~~
~~Parkersburg, West Virginia 26106-1328.~~
Treasury Direct Address:
Series EE and Series I
Bureau of the Fiscal Service
Division of Customer Assistance
PO BOX 7015
Parkersburg, WV 26106-7015

For Paper Savings Bonds:
Series EE and Series I
Treasury Retail Securities Site
PO Box 214
Minneapolis, MN 55480-0214

Series HH and Series H
Bureau of the Fiscal Service
Division of Customer Assistance
P.O. Box 2186
Parkersburg, WV 26106-2186

When the value of a bond will affect eligibility, the bond's owner must request a waiver of the retention period due to hardship (for example, need to receive public assistance or enter a nursing home). If evidence indicates the waiver was denied, the value of the bond is considered unavailable and not counted as a resource until the month after the mandatory retention period expires. If the waiver is granted, the amount of funds an owner receives or can receive by cashing in the bond early is considered as a countable resource.

1640.0608 Transfer Look-Back Period (MSSI)

You must consider any transfer that occurred within the transfer look-back period prior to the date of application or anytime after applying. The look-back period begins with the month of application, counting backwards. Each transfer must be evaluated to

determine if fair compensation was received and if not, to evaluate if a period of ineligibility must apply.

The look-back period for non-trust transfers is 60 months. ~~The 60-month look-back period will be phased in over time.~~

~~For applications received prior to January 1, 2013, look back 36 months prior to the month of application to determine if a transfer of an asset or income occurred. For applications received during January 2013 and for each month following, the look-back period will be phased in by one-month increments. The full look-back period for non-trust transfers will not be realized until December 2014.~~

~~For trusts, which are considered transfers of assets, the look-back period remains 60 months and is not phased in over time.~~

1640.0609.01 Identifying Potential Transfers of Assets or Income (MSSI)

Applicants may declare transfers on the application and unreported transfers may be discovered during application processing or the annual review. At application for ICP, ICP-Hospice, HCBS or PACE, ask all applicants if they (or their spouses if applicable) have transferred any assets within the look-back period preceding the month of application. At review, explore transfers that may ~~my~~ have occurred over the course of the year, such as a homestead that was excluded at application.

The following list indicates the most common clues to potential transfers of assets:

1. unidentified withdrawals from bank accounts;
2. tax assessor online pages showing change in ownership of property;
3. quit claim deed to property with recent signature date;
4. unidentified deposits on financial statements;
5. data exchange responses for sources not on record;
6. purchase of annuities;
7. promissory notes and mortgages received in exchange for cash or property;
8. formal and informal loans made to others;
9. purchase of personal services or care contract;
10. purchase life estate interest;
11. assets declared at application not included on the Interim Contact Letter; and
12. funds placed in a trust.

Evaluate all the above situations and all other transactions that change an asset from potentially countable to excluded, including transfer of ownership interest in a home that was previously excluded as an asset. A homestead is still subject to a transfer of asset penalty, even if it could be/have been excluded prior to the transfer.

1810.0209 Collateral Contact Verification (FS)

Verification must be obtained regarding the source and amount of incomebenefits received. When other sourceswritten evidence of verification areis unavailable, the following information provided by a collateral contact must be recorded:

1. date verbal verification is received,
2. name and title of person providing verification,
3. source of the income or benefit,
4. date(s) received and amount,
5. benefit claim or identification number for each individual receiving a benefit (ex. SSI, SSDI, VA), and
6. the reason the individual is eligible for the benefit if receiving a benefit (ex. SSI, SSDI, VA).

1820.0209.02 Collateral Contact Verification (TCA)

Verification must be obtained regarding the source and amount of incomebenefits received. When other sourceswritten evidence of verification areis unavailable, the following information provided by a collateral contact must be recorded:

1. date verbal verification is received,
2. name and title of person providing verification,
3. source of the income or benefit,
4. date(s) received and amount,
5. benefit claim or identification number for each individual receiving a benefit (ex. SSI, SSDI, VA), and
6. the reason the individual is eligible for the benefit if receiving a benefit (ex. SSI, SSDI, VA).

1850.0209.02 Collateral Contact Verification (CIC)

Verification must be obtained regarding the source and amount of incomebenefits received. When other sourceswritten evidence of verification areis unavailable, the following information provided by a collateral contact must be recorded:

1. date verbal verification is received,
2. name and title of person providing verification,
3. source of the income or benefit,
4. date(s) received and amount,
5. benefit claim or identification number for each individual receiving a benefit (ex. SSI, SSDI, VA), and
6. the reason the individual is eligible for the benefit if receiving a benefit (ex. SSI, SSDI, VA).

1860.0209.02 Collateral Contact Verification (RAP)

Verification must be obtained regarding the source and amount of income~~benefits~~ received. When other sources~~written evidence~~ of verification are~~is~~ unavailable, the following information provided by a collateral contact must be recorded:

1. date ~~verbal~~ verification is received,
2. name and title of person providing verification,
3. source of the income or benefit,
4. date(s) received and amount,
5. benefit claim or identification number for each individual receiving a benefit (ex. SSI, SSDI, VA), and
6. the reason the individual is eligible for the benefit if receiving a benefit (ex. SSI, SSDI, VA).

2030.0200 COVERAGE GROUPS (MFAM)

The following are the Medicaid coverage groups:

6. Parents and other caretaker relatives
7. Pregnant women
8. Infants and children under age 19
9. Children Ages 19~~18~~-21
10. Emergency Medical ~~Medicaid~~ Assistance to Noncitizens
11. Former Foster Care Children~~Individuals that aged out of Foster Care up to age 26~~

2030.0201 Parents and Other Caretaker Relatives (MFAM)

Parents (including step-parents), caretaker relatives, and their spouses living together may receive Medicaid coverage when household income is equal to or below the appropriate income limit.

2030.0202 Extended Medicaid (MFAM)

Medicaid must be extended for up to four months if the conditions below are met:

1. The parents and other caretaker relatives and their dependent children become ineligible for Medicaid due solely or in part to the receipt of, or increase in, spousal support for an individual whose needs are included in the assistance group.

2. The parents and other caretaker relatives assistance group was eligible for and received Medicaid as a parent or other caretaker relative in at least three of the six months preceding the month of ineligibility. The three months can include months in which Medicaid was received in another state.

3. Only those members included in the benefit computation for the month prior to cancellation are entitled to extended Medicaid.

2030.0203 Transitional Coverage (MFAM)

Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid ~~Medicail~~ period. An ex parte determination must be completed prior to cancellation at the end of the transitional period.~~and a notice sent when the parents and other caretaker relatives and/or children included in the assistance group becomes ineligible due to the following reasons:~~

~~1. initial receipt of earned income of the parent or caretaker relative, or~~
~~2. receipt of increased earned income of the parent or caretaker relative.~~

Conditions that must be met:

1. The parents and other caretaker relatives' ~~relatives~~ assistance group must be ineligible for Medicaid ~~as parents and other caretaker relatives~~ based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative. If more than one budget change is being acted on at the same time, a test budget(s) will be necessary to determine if the change in earned income is the sole cause of ineligibility.

2. At least one member of the assistance group was eligible for and received Medicaid in at least three of the preceding six months. The three months can include one month in which Medicaid was received in another state, or a retroactive month. All SFU members are eligible, even if they were not a part of the original assistance group.

   Note: While all SFU members are eligible for Transitional Medicaid, it is not necessary to change a child's coverage group to Transitional Medicaid if they remain eligible for Medicaid as a child. If the initial receipt or increase in earned income does not cause ineligibility for other SFU members, do not change those individuals' Medicaid coverage.

   Example: A parent reports increased income over the Parent and Other Caretaker Relative income limit (19% federal poverty level (FPL)), but the increased earned income does not go over the income limit for Children Under Age 19 (133% FPL).

2030.0600 PRESUMPTIVE ELIGIBILITY COVERAGE (MFAM)

Presumptive eligibility is a determination of eligibility made by a Qualified Hospital (QH) based on the applicant's verbal statements about the SFU's income. The income must

be equal to or below the income limit. Citizenship status is not a factor of eligibility for this coverage group.

The following are presumptive eligibility coverage groups:

1. Pparents and other caretaker relatives
2. Ppregnant women
3. Iinfants and children under age 19
4. Former Foster Care Childrenindividuals that aged out of Foster Care up to age 26

This is temporary coverage that begins with the date the presumptive eligibility determination is completed by the Qualified Hospital (QH) and ends on the date of the Medicaid determination if an application for regular Medicaid is filed by the last day of the month after the presumptive eligibility determination. If an application for regular Medicaid is not filed by then, presumptive eligibility ends on the last day of the month after the presumptive eligibility determination. Only one presumptive period per 12 months is allowed. For the individual to receive coverage beyond the presumptive period, a regular Medicaid application is necessary and the QH is expected to assist with this application process.

2030.0700 PREGNANT WOMEN (MFAM)

Medical assistance for the pregnant woman will be under one coverage group. The coverage group under which the pregnant woman receives benefits is determined by the household composition and income.

The following are coverage groups for pregnant women who:

1. have SFU income under the income limit and may have no other children 185% of the FPL (no asset test),
2. are Medically Needy,
3. are presumptively eligible.

A pregnant woman who is eligible for regular Medicaid for at least one month, including a retroactive month, is eligible to receive Medicaid through her pregnancy and until the end of the second month after the birth (postpartum period), regardless of any changes except for Medically Needy, Presumptive Eligibility for Pregnant Women and Emergency Medical Assistance for NoncitizensMedicaid for Aliens.

2030.0702 Pregnancy Verification (MFAM)

Self attestation of pregnancy, the anticipated due date, and the number of unborns (if multiple births are expected) is acceptable.

2030.0704 Presumptively Eligible Pregnant Women (MFAM)

Presumptive eligibility is a determination of eligibility made by a designated provider based on the applicant's verbal statements about the SFU's income. The income must be equal to or below the income limit. Citizenship status is not a factor of eligibility ~~eligilibity~~ for this coverage group.

This is temporary coverage that begins with the date the presumptive eligibility determination is completed by the Qualified Designated Provider (QDP) and ends on the date of the Medicaid determination if an application for full Medicaid is filed by the last day of the month after the presumptive eligibility determination. If an application for full Medicaid is not filed by then, presumptive eligibility ends on the last day of the month after the presumptive eligibility determination. Only one presumptive period per pregnancy is allowed and these benefits cover only ambulatory prenatal services. It does not cover inpatient hospital services or delivery. For the pregnant woman to get coverage beyond the presumptive period, a full Medicaid application is necessary and the QDP is expected to assist with this application process.

2030.0901 Infants Under Age One (MFAM)

A newborn is presumed eligible for Medicaid through the birth month of the following year when born to a mother eligible for Medicaid on the date of the child's birth, including a mother on Emergency Medical Assistance for Noncitizens~~Medicaid for Aliens~~. The child remains eligible for Presumptively Eligible Newborn (PEN) coverage as long as the child remains a resident of Florida or until the child's death. If the child was born on the first of the month, PEN eligibility ceases effective the birth month. All newborns are considered to be living with the mother the month of birth.

Eligibility for PEN does not apply to a child born to a parent receiving Presumptively Eligible Pregnant Woman (PEPW) coverage only. If a PEPW woman is later determined eligible for regular Medicaid for the month of delivery, the child will be PEN eligible.

If the mother is Medically Needy and meets her share of cost on or before the date of birth, the child is eligible for presumptive coverage.

Notification of birth may be received from the Medicaid provider or from the parent(s). All PENs must be added to Medicaid within five days of notification of their birth. No application or face-to-face interview is required for PEN coverage.

A Medicaid notice of case action must be sent with the newborn's Medicaid number to the parent stating the following information: "Medicaid is being authorized for up to one year from the date of the child's birth". This will serve as the 10-day advance notice unless the case is canceled prior to the end of one year.

No verification of U.S. citizenship or identity will be needed for these children, even after the presumptive period ends.

2030.0902 Children Under Age 19 (MFAM)

When a child who meets the technical criteria for residency, age, identity and citizenship/noncitizen and the tax household's income is at or below the income limit for the coverage group, the child is eligible for Medicaid. If the income is higher than the income limit, the child may be enrolled in Medically Needy and/or referred to ~~eligible for~~ the Children's Health Insurance Program (CHIP) ~~(Kidcare)~~ or the Federally Facilitated Marketplace (FFM).

2030.1100 EMA TO INELIGIBLE NONCITIZENS (MFAM)

To be eligible for Emergency Medical ~~Medicaid~~ Assistance for Noncitizens (EMA) benefits, the noncitizen must meet all technical (including residency) and financial requirements for a Medicaid coverage group, except: citizenship, child support enforcement cooperation, and Social Security number requirement.

2030.1100.01 Coverage of Emergency Only (MFAM)

Medicaid benefits will only be authorized to cover the emergency medical situation. An emergency medical condition is a medical condition of sufficient severity (including severe pain) that could result in placing the individual's health in serious jeopardy. This includes emergency labor and delivery. Accept the medical provider's statement regarding the emergency and date(s) ~~dates~~ of service.

A medical provider or Utilization Review Committee (URC) will determine if an emergency medical condition exists. The URC is a group affiliated with a hospital which determines an individual's need for emergency treatment. The provider or URC will also determine the length of time the emergency situation is expected to exist.

An applicant may receive retroactive Medicaid and posthumous Medicaid for a deceased individual under the EMA coverage group if eligible.

2030.1100.02 Exceptions to Medicaid Policy and Procedures (MFAM)

The following Medicaid exceptions to policy and procedures apply to Emergency Medical ~~Medicaid~~ Assistance for Noncitizens:

1. An ex parte determination is not required. ~~Ten days advance notice of termination is not required.~~
2. Dates of eligibility will be for the time period of the emergency only.
3. There is no postpartum coverage for pregnant women.
4. Ten days advance notice of termination is not required.

2030.1200 Former Foster Care Children ~~INDIVIDUALS THAT AGED OUT OF FOSTER CARE UP TO AGE 26~~ (MFAM)

Individuals ~~Individual~~ may ~~continue to~~ receive Medicaid up to age 26 if they were in foster care and receiving Medicaid when they aged out of foster care in Florida. There is no income limit for eligibility.

To be eligible, an individual must:

1. Be under age 26,
2. Be enrolled in or received Medicaid when they aged out of Florida's Foster Care Program at age 18 (or 21 as appropriate), and
3. Not otherwise eligible for or enrolled in mandatory Medicaid coverage.

2030.1400 MEDICALLY NEEDY COVERAGE (MFAM)

The Medically ~~Medical~~ Needy Program ~~coverage~~ is for individuals who meet the technical requirements of one of the above coverage groups but whose income exceeds the income limit. If the household's income is greater than the income limit, the exceeding amount is determined as the share of cost. The individual is enrolled but is not eligible until the share of cost is met. Medically Needy provides month-to-month coverage when individuals have incurred medical bills that meet their share of c

2040.0107 SSI-Related Medicaid Category Codes (MSSI)

1. MS = SSI Medicaid for SSI direct assistance recipients
2. Protected SSI Medicaid
   a. MT-C = Regular COLA
   ~~b. MT-A = Widows I~~
   c. MT-W = Widows II
   d. MT-D = Disabled Adult Children
3. MM-S = MEDS for aged or disabled
4. ML-S or NL-S for Medically Needy = Emergency Medical Assistance for Noncitizens
5. NS = SSI-Related Medically Needy
6. Institutional Care Program (ICP)
   a. MI-S = SSI eligible
   b. MI-I = Regular
   c. MI-T = Transfer of Assets
   d. MI-M = MEDS
7. Hospice Services
   a. MH-S = SSI eligible
   b. MH-H = Regular
   c. MH-M = MEDS
   ~~d. MH-P = Protected Medicaid~~
8. Home and Community Based Services (HCBS)

~~a. MW-C = Channeling~~
a. MW-A = All HCBS waivers ~~other than Channeling~~. For PACE individuals in the community, the category will be MWA. If the PACE individual is placed in a nursing home, the code will change to the appropriate ICP code.

9. Medicare Savings Programs
   a. QMB = Qualified Medicare Beneficiaries (QMB)
   b. WD = Working Disabled
   c. SLMB = Special Low Income Medicare Beneficiary (SLMB)
   d. QI-1 = Qualifying Individual 1 (QI-1)

2040.0800 SSI-RELATED MEDICAID COVERAGE GROUPS (MSSI)

1. Aged, Blind and/or Disabled Medicaid for SSI eligible individuals (could be ICP, Hospice or HCBS);
2. Protected SSI Medicaid, including Regular COLA Protected Medicaid, ~~Disabled Widow(er) I Protected Medicaid~~, Disabled Widow(er) II Protected Medicaid, Disabled Widow(er) III Protected Medicaid, Disabled Adult Child Protected Medicaid, and ~~Protected Medicaid for SSI children~~;
3. SSI-Related MEDS for Aged or Disabled (Medicaid Expansion designated by SOBRA - Aged or Disabled);
4. Emergency Medical Assistance for Noncitizens, from an SSI-Related Medicaid category;
5. Medically Needy from an SSI-Related Medicaid category;
6. SSI Eligible ICP (includes Hospice);
7. SSI-EEI ICP (includes Hospice);
8. SSI-Related ICP except for transfer of assets (not eligible for ICP due solely to transfer of assets, cannot receive vendor payments for institutional services, but is eligible for all other services);
9. SSI MEDS ICP for Aged and Disabled;
10. SSI Medically Needy in a Long Term Care Facility;
11. Hospice Services Medicaid, including SSI Eligible Hospice Services, SSI-EEI Hospice Services, SSI MEDS Hospice Services for Aged and Disabled, and SSI Medically Needy Hospice Services;
12. Home and Community Based Services (HCBS) Medicaid waivers, including ~~Channeling Waiver,~~ Project AIDS Care ~~Waiver, Aged and Disabled Adults Waiver, Developmental Services Waiver, Assisted Living Waiver,~~ Traumatic Brain and Spinal Cord Injury Waiver, Model Waiver, ~~Long-Term Care Diversion Waiver,~~ Familiar Dysautonomia, Cystic Fibrosis Waiver and Individual budget (iBudget) program ~~Florida Waiver~~; and Statewide Medicaid Managed Care Programs;
13. Qualified Medicare Beneficiaries Medicaid for all categorical Medicaid where the individual is Part A Medicare eligible;
14. Special Low Income Medicare Beneficiary Medicaid;

15. Qualified Individuals 1;
16. Working Disabled entitled to payment of Part A Medicare premium only (cannot receive other coverage);
17. Retroactive Medicaid;
18. Posthumous Medicaid;
19. Breast and Cervical Cancer Treatment; and
20. Program of All-Inclusive Care for the Elderly (PACE).

2040.0815.01 Home and Community Based Services (MSSI)

Home and Community Based Services (HCBS) Programs are considered Medicaid Waiver Programs. Their purpose is to prevent institutionalization of the individual by providing care in the community with specific providers. Refer to 0240.0111 ~~0240.0810~~ for a list of Medicaid Waiver Programs.

To be eligible for HCBS, the individual must meet all SSI-Related technical criteria and have income and assets within the limits for ICP or MEDS-AD. Individuals cannot qualify for HCBS under the Medically Needy Program.

2040.0815.02 Additional Criteria - HCBS Cystic Fibrosis Waiver (MSSI)

For the Cystic Fibrosis Waiver, individuals must:

1. be at least 18 years of age, but no older than 59;
2. meet a level of care for being at risk of hospitalization as determined by CARES;
3. have a diagnosis of cystic fibrosis and a need for medically ~~medially~~ necessary services provided by the waiver as determined by Adult Services; and
4. be enrolled in the Cystic Fibrosis waiver as documented by form CF-ES 2515.

2040.0815.03 Additional Criteria - HCBS Familial Dysautonomia Waiver (MSSI)

For the Familial Dysautonomia (FD/HCBS) waiver individuals must:

1. be aged three or older (must meet disability criteria if under age 65);
2. meet a level of care for being at risk of hospitalization as determined by CARES;
3. have a diagnosis of Familial Dysautonomia and a need for medically necessary services provided by the waiver as determined by CARES; and
4. be enrolled in the Familial Dysautonomia waiver as documented by form CF-ES 2515

2040.0815.04 Additional Criteria - HCBS Individual Budgeting Florida (iBudget) Developmental Disabilities ~~Services Waiver~~ (MSSI)

For the (iBudget) Developmental Services program ~~waiver (DS/HCBS),~~ individuals must:

1. be disabled or aged;
2. meet the appropriate level of care for an ICF/DD as determined by the Agency for Persons with Disabilities, ~~Developmental Disabilities~~ and
3. be enrolled in the waiver as documented by form CF-ES 2515.

2040.0815.05 Additional Criteria - HCBS Model Waiver (MSSI)

For the Model waiver, individuals must:

1. be under 21 years of age,
2. be diagnosed as having a degenerative spinocerebeller disease,
3. meet the appropriate level of care for inpatient hospital care as determined by Children's Medical Services; and
4. be enrolled in the waiver through Children's Medical Services as documented by form CF-ES 2515.

~~**2040.0815.02 Additional Criteria - HCBS Channeling Waiver (MSSI)**~~

~~For HCBS Channeling, individuals must:~~

~~1. live in either Dade or Broward counties only;~~
~~2. be aged (65 years old or older);~~
~~3. be enrolled in the Channeling waiver as documented by form CF-ES 2515 (revised October 2002), and~~
~~4. meet the level of care requirement as determined by CARES.~~

2040.0815.06 ~~2040.0815.03~~ Additional Criteria - HCBS Project AIDS Care (MSSI)

For Project AIDS Care (PAC), individuals must:

1. be disabled with AIDS (this also applies to an aged individual);
2. meet level of care requirement as determined by CARES, and
3. be enrolled in the PAC waiver as documented by form CF-ES 2515.

2040.0815.07 Additional Criteria HCBS Statewide Managed Medical Care Long Term Care (SMMC LTC)

For Statewide Managed Medical Care Long Term Care (SMMC LTC), an individual must

1. be aged 65 years of age or older
2. be 18 years of age or older
3. meet level of care requirement as determined by CARES

4. be enrolled in the waiver with specific managed care providers as documented by form CF-ES 2515.

~~**2040.0815.04 Additional Criteria - HCBS Aged/Disabled Adult Waiver (MSSI)**~~

~~For the Aged and Disabled Adult Waiver (ADA/HCBS) individuals must:~~

~~1. be 18 years of age or older (must meet disability criteria if under 65);~~
~~2. meet the appropriate level of care as determined by CARES; and~~
~~3. be enrolled in the waiver as documented by form CF-ES 2515 HCBS services.~~

~~**2040.0815.05 Additional Criteria - HCBS Individual Budgeting Florida (iBudget) Developmental Disabilities Services Waiver (MSSI)**~~

~~For the (iBudget) Developmental Services program waiver (DS/HCBS), individuals must:~~

~~4. be disabled or aged;~~
~~5. meet the appropriate level of care for an ICF/DD as determined by the Agency for Persons with Disabilities, Developmental Disabilities and~~
6. be enrolled in the waiver as documented by form CF-ES 2515.

~~**2040.0815.06 Additional Criteria - HCBS Assisted Living Waiver (MSSI)**~~

~~For the Assisted Living waiver (AL/HCBS), individuals must:~~

~~1. reside in a specially licensed Assisted Living Facility (ALF);~~
~~2. be 60 years of age or older (must meet disability criteria if under 65);~~
~~3. meet the appropriate level of care and special functional criteria as determined by CARES; and~~
~~4. be enrolled in the wavier as documented by form CF-ES 2515.~~

~~**2040.0815.07 Additional Criteria - HCBS Model Waiver (MSSI)**~~

~~For the Model waiver, individuals must:~~

~~5. be under 21 years of age,~~
~~6. be diagnosed as having a degenerative spinocerebeller disease,~~
~~7. meet the appropriate level of care for inpatient hospital care as determined by Children's Medical Services; and~~
~~8. be enrolled in the waiver through Children's Medical Services as documented by form CF-ES 2515.~~

2040.0815.08 Add. Criteria - HCBS Traumatic Brain/Spinal Cord Injury Waiver (MSSI)

For the Traumatic Brain and Spinal Cord Injury Waiver, individuals must:

1. be between the ages of 18 and 64;
2. have one of the following medical conditions: traumatic brain injury or spinal cord injury;
3. meet a nursing facility level of care as determined by CARES; and
4. be enrolled in the waiver as documented by form CF-ES 2515.

~~**2040.0815.09 Additional Criteria - Long-Term Care Comm. Diversion Waiver (MSSI)**~~

~~For the Long-Term Care Community Diversion (LTCCD) waiver, individuals must:~~

~~1. be age 65 or older,~~
~~2. meet the nursing facility level of care requirement as determined by CARES, and~~
~~3. be enrolled in the waiver with specific managed care providers as documented by form CF-ES 2515.~~

~~**2040.0815.10 Additional Criteria - HCBS Cystic Fibrosis Waiver (MSSI)**~~

~~For the Cystic Fibrosis Waiver, individuals must:~~

~~5. be at least 18 years of age, but no older than 59;~~
~~6. meet a level of care for being at risk of hospitalization as determined by CARES;~~
~~7. have a diagnosis of cystic fibrosis and a need for medially necessary services provided by the waiver as determined by Adult Services; and~~
~~8. be enrolled in the Cystic Fibrosis waiver as documented by form CF-ES 2515.~~

~~**2040.0815.11 Additional Criteria - HCBS Familial Dysautonomia Waiver (MSSI)**~~

~~For the Familial Dysautonomia (FD/HCBS) waiver individuals must:~~

~~5. be aged three or older (must meet disability criteria if under age 65);~~
~~6. meet a level of care for being at risk of hospitalization as determined by CARES;~~
~~7. have a diagnosis of familial dysautonomia and a need for medically necessary services provided by the waiver as determined by CARES; and~~
~~8. be enrolled in the Familial Dysautonomia waiver as documented by form CF-ES 2515.~~

2040.0816 Working Disabled (MSSI)

Most individuals with disabilities who work will continue to receive at least 93 consecutive months of hospital (Part A) and medical (Part B) insurance under Medicare.

They pay no premium for Part A. After premium-free Medicare Part A coverage ends, they can continue receiving Medicare, as long as they remain medically disabled and continue to work, but must pay a premium for Part A. The state can pay the Medicare Part A premium for qualified individuals who meet all of the following eligibility criteria:

1. Are enrolled in Medicare Part A under this special extended coverage (as confirmed by SSA)
2. Are under age 65,
3. Have assets at or below $4,000 ~~5,000~~ for an individual and $6,000 for a couple,
4. Have income at or below 200% of the federal poverty level (individual or couple),
5. Are U.S. citizens or qualified noncitizens,
6. Take necessary steps to access any other benefits to which they may be entitled.

2040.0819 Qualifying Individuals 1 (QI1) (MSSI)

This mandatory federal program pays the monthly Medicare Part B premium for individuals who would be, QMB or SLMB eligible except for the fact that their income exceeds those program limits. This is not an open entitlement program as funding is limited to an annual federal allocation.

To qualify as a Qualifying Individuals 1 beneficiary, an individual must meet all the following eligibility criteria:

1. Be enrolled in Medicare Part A;
2. Have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level;
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9);
4. Be a U.S. citizen or qualified noncitizen;
5. Take necessary steps to access any other benefits to which they may be entitled; and
6. Does not qualify for Medicaid under any other Medicaid coverage group, except Medically Needy.

Note: Cross reference passage 1440.1504.

2040.0821 Breast and Cervical Cancer Treatment Program (MSSI)

A special Medicaid Program is available for women needing treatment for breast and cervical cancer.

To be eligible, a woman must:

1. be screened and diagnosed for breast or cervical cancer by the Department of Health (DOH) under the Center for Disease Control (CDC) Screening Program in Florida,

2. need treatment for the disease,
3. be uninsured or have health coverage that does not cover the necessary treatment,
4. not be eligible under a Medicaid group (excluding Medically Needy),
5. be under age 65, and
6. be a citizen or qualified noncitizen.

   Exception: Apply EMA policy for noncitizens who meet all technical requirements, except citizenship.

Do an ex parte when a woman becomes ineligible, unless she moves out of state or dies.

Refer women who do not meet the above qualifications to the toll-free the American Cancer Society National Hotline ~~DOH information line~~ at 800 227-2345 ~~800-451-2229~~.

2210.0320.02 Student Eligibility Test (FS)

Complete the student eligibility test for students in institutions of higher education to determine if they meet a student exemption. Testing for student eligibility does not apply to individuals attending high school, individuals not attending school at least half-time, or individuals enrolled full-time in schools and training programs that are not institutions of higher education. Individuals pass the student eligibility test and are eligible to participate in the Food Stamp Program if they are:

1. age 17 or under or 50 or older. or

2. physically or mentally unfit. Individuals are physically or mentally unfit if they are receiving temporary or permanent disability benefits from government or private sources or are obviously physically or mentally unfit. Individuals meet the obviously unfit criteria if the impairment is so severe that they are not only unable to do their previous work but cannot, considering their education and experience, hold any other kind of job in the national, state, or local economy. If the unfitness is not obvious, get written or verbal verification from a physician, physician's assistant, nurse, nurse practitioner, designated representative of the physician's office, licensed or certified psychologist, social worker, or other medical personnel. Assist the individual in providing the verification. or

3. responsible for the care of a dependent standard filing unit (SFU) member under age six. or

4. households with parent(s) ~~two parents~~ or members acting as the parents responsible for the care of a dependent SFU member age six but under the age of 12, for whom adequate child care is not available to allow the student to attend class and comply with the requirements of working an average number of work

hours that total 80 hours per month or attend class and participate in a state or federally financed work study. or

5. receiving Temporary Cash Assistance benefits. or

6. assigned to or placed in an institution of higher learning through the Job Training Partnership Act, the Food Stamp Employment and Training Program (FSET), Regional Workforce Board coalition/contract provider, the Trade Act, or state or local government employment and training program where components are the same as required components in the FSET Program. or

7. participating in an on-the-job training program. The exemption applies only while the employer is training the individual. or

8. enrolled in the school because of participation in the JOBS Program or its successor programs through the Agency for Workforce Innovation under Title IV of the Social Security Act. or

9. single parents enrolled in school full-time and responsible for care of a dependent child under age 12 when there is only one natural, adoptive, or step-parent in the same food stamp SFU. or

10. working average work hours that total 80 hours per month and be paid for the work (with no allowance for substitution of wages equal to 80 times the federal minimum wage), or self-employed average work hours that total 80 hours per month and receiving payment for the work at least equal to the federal minimum wage multiplied by 80 hours per month. or

11. participating in a state or federally financed work-study program during the regular school term. The student must have approval for the work-study when they apply for food stamp benefits and anticipate actually participating in work-study during the school term. This exemption does not apply to students working in hospitals or as student teachers who must get actual experience as part of their course work or cooperative education students who attend classes full-time one semester and work at curriculum related jobs full-time the next semester. This work-study exemption does not continue during term breaks of more than a full month unless the student participates in work-study during the break.

2420.0300 INCOME DISREGARDS (TCA)

Income disregards are amounts subtracted from the gross earned income. Some examples are:

1. earned income disregard,

2. standard disregard,
3. student earned income,
~~4. work expenses of the blind,~~
4. ordinary and necessary expenses,
5. optional deduction, ~~and~~or
6. unearned income overpayment.

2420.0406 Disqualification for Felony Drug Trafficking (TCA)

An individual who has been convicted of felony drug trafficking including agreeing, conspiring, combining, or confederating with another person to commit the act committed ~~on or~~ after 8/22/1996 pursuant to 893.135 F.S. shall be permanently disqualified from the Temporary Cash Assistance Program. If the illegal behavior that lead to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is not subject to the disqualification. The individual must provide proof of the expungement.

2440.0100 INCOME LIMITS (MSSI, SFP)

The income limits compared to the SFU's countable income to determine eligibility for assistance vary by coverage group. Refer to Appendix ~~A-7~~, A-9 and A-12 for the standard tables.

2440.0102 Medically Needy Income Limits (MSSI)

When the standard filing unit ~~assistance group~~ has met the technical eligibility criteria and the asset limits, the assistance group ~~it~~ is enrolled. There is no income limit for enrollment. The assistance group is ~~income~~ eligible (entitled to Medicaid) once income is less than or equal to the Medically Needy Income Level (MNIL) or medical bills equal the amount by which ~~his~~ income exceeds the MNIL. Once medical bills are equal to the ~~this surplus income, referred to as~~ share of cost, the assistance group is eligible.

The eligibility specialist must determine eligibility for Medically Needy when an ~~any time the~~ assistance group's income exceeds the income limits for another full Medicaid Program~~. Refer to Appendix A-7 for the Medically Needy income limits.~~

2440.0103 Income Limits (MSSI)

For ~~the~~ ICP, HCBS, Hospice, HCDA, and PACE monthly income cannot exceed the state income standard for the appropriate coverage group.

The standard for these programs is equal to the ICP income standard, which represents 300% of the SSI Federal Benefit Rate (FBR).

In ICP institutional hospice, HCBS, or PACE applicants or recipients whose income exceeds 300% of the SSI Federal Benefit Rate may establish an income trust in order to qualify for Medicaid. This policy does not apply to Community Hospice or HCDA. (Refer to Chapter 1800 for policy on qualified income trusts.)

2440.0113 Working Disabled (MSSI)

~~Working disabled~~ WD individuals' income cannot exceed 200% of the federal poverty level.

2440.0115 Qualifying Individuals 1 (QI 1) (MSSI)

~~Qualifying Individual(s) 1~~ QI 1 recipients must be enrolled or conditionally enrolled in Medicare Part A and their income must fall between 120% and 135% of the federal poverty level. This is a program with limited funding.

2440.0118 Program for All Inclusive Care for the Elderly (PACE) (MSSI)

The standard for this program is equal to the ICP income standard, which represents 300% of the SSI Federal Benefit Rate (FBR). Individuals with income in excess of this amount may qualify through the implementation of an income trust. (See passage 1040.0815 for applicable policies).

2440.0211 Retrospective Budgeting - SSI Direct Assistance (MSSI, SFP)

SSA uses retrospective budgeting for SSI cash assistance. (Retrospective budgeting is not used for MSSI or SFP.) In the following situations, SSI does not use retrospective budgeting.

When the individual initially becomes eligible for SSI, the benefit amounts for the first and second months are computed using the income from the first month of eligibility.

After a period of ineligibility the benefit amounts for the first and second months of the new ~~re~~eligibility periods are computed using the income from the first month of ~~re~~eligibility. This is to avoid using income from a period of ineligibility to determine the benefit amount.

2440.0212 Deeming Eligibility Determinations (MSSI)

The following policy is applicable only to MEDS-AD, Medically Needy, Protected Medicaid, ~~Working Disabled~~, QMB, SLMB, QI-1, WD and EMA.

For eligibility determinations when there are beginning and ending deeming situations, the effective month of change is the month following the month of change.

Example: If a spouse left the assistance group in April and is not expected to return, the effective month of change is May. For the May eligibility determination, there would be no deeming of income.

2440.0321 Earned Income Disregard (MSSI, SFP)

This policy applies to MEDS-AD, MN, QMB, SLMB, QI-1, WD ~~Working Disabled~~, Protected Medicaid, EMA and OSS.

The earned income disregard is only applied to earned income. The amount of the disregard is $65 plus one half of the remaining earned income. The amount of the disregard remains $65 plus one half of the remaining earned income when an individual and his spouse both have earned income.

2440.0322 Standard Disregard (MSSI)

This policy applies to MEDS-AD, MN, QMB, SLMB, QI-1, WD ~~Working Disabled~~, Protected Medicaid and EMA.

A $20 per month standard disregard applies to any type (earned or unearned) of income other than income which is provided on the basis of need. The amount of the disregard is not increased for a couple, regardless of whether one or both individuals have income. If there is only earned income then apply the entire amount of the disregard to the earned income. If there is only unearned income then apply the entire amount of the disregard to the unearned income. If there is both earned and unearned income then apply the disregard first toward the unearned income and apply any amount of the disregard remaining toward the earned income. This is done due to the effect of the earned income disregard. (Refer to passage 2440.0321 for policy on the earned income disregard.)

2440.0367 Work Expenses of the Blind (MSSI, SFP)

The following policy applies to MEDS-AD (if the blind person has been determined disabled), MN, QMB, SLMB, QI1, WD ~~Working Disabled~~, Protected Medicaid, Emergency Medicaid to Noncitizens and OSS.

An individual eligible on the basis of blindness and who is working, may have the amount of his ordinary and necessary work related expenses deducted. If a blind individual has a spouse who is also eligible on the basis of blindness and both are working, then the amounts of ordinary and necessary work related expenses for each may be deducted. Though there is no limit on the dollar amount of expenses to be deducted, the amount must be reasonable and not exceed the amount of each individual's respective earnings from work in the month involved.

This exclusion does not apply to a blind individual who is 65 or older unless the individual was receiving Medicaid assistance on the basis of blindness in the month before the individual became 65.

2440.0368 Types of Work Expenses of the Blind (MSSI, SFP)

The following policy applies to MEDS-AD, MN, QMB, SLMB, WD ~~Working Disabled~~, Protected Medicaid, EMA and OSS.

To be deductible, an expense need not relate directly to the blindness of the individual; it need only be an ordinary and necessary work expense of the blind individual. Examples of such expenses follow.

Transportation Expenses To and From Work - This includes the actual cost of a cab or bus, cane travel instruction, a guide dog and his upkeep, and a private automobile (15 cents per mile).

Job Performance Expenses - This would include Braille instruction, child care costs, equipment needed on the job, instruction in grammar, licenses, lunches, work related professional association dues, prostheses needed for work, optical aids, readers, safety shoes, taxes (income, FICA, and self-employment), tools used on the job, translation of material to Braille, uniforms and their care, union dues, and wheelchairs if necessary due to another disability.

Job Improvement Expenses - This would include stenotype instruction for blind typists, keypunch training, and computer program training courses.

Expenses for life maintenance is not work related and cannot be deducted. These include food, self-care items (items of cosmetic rather than work required nature), general educational development and life insurance.

If necessary items are furnished by some other individual or organization, and consequently permit the individual to avoid incurring a work related expense which would be deductible, the value of such items is not considered income.

2440.0369 Verification of Work Expenses of the Blind (MSSI, SFP)

The following policy applies to MEDS-AD, MN, SLMB, QI 1, QMB, WD ~~Working Disabled~~, Protected Medicaid, EMA and OSS.

Verification such as receipts, bills, and the like must be requested to substantiate expenses. Allegations regarding transportation expenses and lunches may be accepted without verification if they appear to be reasonable.

2460.0300 INCOME DISREGARDS (RAP)

This section presents policy on the following:

1. earned income disregard,

2. standard disregard,
3. student earned income,
~~4. work expenses of the blind,~~
4. ordinary and necessary expenses,
5. optional deduction, ~~and~~or
6. unearned income overpayment.

2610.0410 Ineligible/Disqualified Members (FS)

Disqualified individuals may not participate in the Food Stamp Program. A disqualified individual is identified as one who is:

1. found to have committed an intentional program violation by an administrative disqualification hearing, found guilty by a court, or the individual has signed either a waiver of the right to an administrative disqualification hearing, or a consent agreement in cases referred for prosecution;
2. a fleeing felon or is in violation of probation or parole;
3. sanctioned for failing to meet work or workfare requirements;
4. convicted of felony drug trafficking including agreeing, conspiring, combining, or confederating with another person to commit the act committed ~~on or~~ after 8/22/1996; or
5. guilty of receiving multiple state benefits.

The disqualified individual may not be included in the household size when benefit amounts are determined. Treat the income, assets and expenses of the disqualified individual as follows:

1. The income will continue to count in its entirety but the 20% earned income deduction is allowed;
2. The assets will count in their entirety; and
3. The medical expenses, if appropriate, the dependent care deduction, child support deduction and the excess shelter deduction continue to be allowed in full in the household's budget even if paid by or billed to the disqualified member.

Technically ineligible individuals may not participate in the Food Stamp Program. A technically ineligible individual is one who:

1. fails to meet the SSN requirements;
2. fails due to being an ineligible noncitizen;
3. fails due to serving a child support sanction; or
4. fails due to not meeting ABAWD requirements.

The technically ineligible individual may not be included in the household when food stamp benefits are determined. Treat the income, assets and expenses of technically ineligible individuals as follows:

1. Prorate the income of the ineligible individual and count all but the ineligible member's share toward the eligibility of the remaining household members for individuals who fail to meet SSN requirements, are ineligible noncitizens, are serving child support sanctions, or have received all time limited months as an ABAWD. Exclude the income of the ineligible student;
2. Count the assets in their entirety for all technically ineligible individuals except the ineligible student. Exclude the assets of the ineligible student;
3. The 20% earned income deduction is allowed;
4. Expenses billed to the technically ineligible member but paid entirely with the eligible member's income because the ineligible member has no income, count in full in the budget. If the expense is billed to the technically ineligible member, but paid for with the eligible member's income and the ineligible member's income, prorate the expense in the budget. If the expense is billed to and paid entirely by the technically ineligible member, prorate the expense in the budget; and
5. When the SFU contains a technically ineligible member, do not prorate the appropriate utility standard in the budget. Allow the full SUA, BUA, or Phone Standard if the dwelling is eligible for a standard.

3230.0303 ~~Emergency~~ Proof of Medicaid (MFAM)

When an individual requests ~~requires~~ ~~emergency~~ proof of Medicaid eligibility ~~for the current month~~, the eligibility specialist will first verify Medicaid eligibility through FLORIDA and the Florida Medicaid Management Information System (FMMIS) ~~Recipient Eligibility Subsystem~~. If eligible, the individual will generate proof of their Medicaid eligibility coverage by accessing their online MyACCESS Account.~~the eligibility specialist must issue a proof of eligibility through FLORIDA. When a Medicaid eligible individual requests proof of eligibility for the current month, t~~The eligibility specialist ~~will~~ can generate ~~an Emergency~~ a Medicaid Identification Card through FLORIDA.

3240.0303 ~~Emergency~~ Proof of Medicaid (MSSI)

When an individual requests ~~requires~~ ~~emergency~~ proof of Medicaid eligibility ~~for the current month~~, the eligibility specialist will first verify Medicaid eligibility through FLORIDA and the Florida Medicaid Management Information System (FMMIS) ~~Recipient Eligibility Subsystem~~. If eligible, the individual will generate proof of their Medicaid eligibility coverage by accessing their online MyACCESS Account.~~the eligibility specialist must issue a proof of eligibility through FLORIDA. When a Medicaid eligible individual requests proof of eligibility for the current month, t~~The eligibility specialist ~~will~~ can generate ~~an Emergency~~ a Medicaid Identification Card through FLORIDA.

3250.0303 ~~Emergency~~ Proof of Medicaid (CIC)

When an individual requests ~~requires~~ ~~emergency~~ proof of Medicaid eligibility ~~for the current month~~, the eligibility specialist will first verify Medicaid eligibility through FLORIDA and the Florida Medicaid Management Information System (FMMIS) ~~Recipient Eligibility Subsystem~~. If eligible, the individual will generate proof of their Medicaid eligibility coverage by accessing their online MyACCESS Account.~~the eligibility specialist must issue a proof of eligibility through FLORIDA. When a Medicaid eligible individual requests proof of eligibility for the current month, t~~The eligibility specialist ~~will~~ can generate ~~an Emergency~~ a Medicaid Identification Card through FLORIDA.

3430.0100 WRITTEN NOTICE REQUIREMENT (MFAM)

The individual must be informed in writing or electronically of all DCF decisions affecting eligibility, appointment times, or any request for information.

All requests for information from the individual must be given in writing or electronically and must specify the date on which the information must be returned.

Except in situations indicated in passages 3430.0102 through 3430.0103~~3430.0104~~, written notice must be given, mailed~~,~~ or electronically posted, at least 10 days prior to the effective month of the action if action is being taken to terminate or reduce benefits (adverse action).

In addition, the individual must be notified in writing or electronically when data exchange from a federal source indicates a discrepancy between the information provided and information contained in FLORIDA or the case record. The individual must be provided an opportunity to dispute the findings.

3430.0102 Exceptions to Written Notice (MFAM)

When DCF is unable to locate an individual, the written or electronic notice requirement is waived. Inability to locate an individual may be evidenced by the return of a letter of recent date indicating that the letter could not be delivered because the individual has moved, there is no forwarding address, and no additional information is available to locate the individual. The reason for not giving advance notice must be recorded and the returned correspondence, including the envelope, must be retained in the case record.

~~In Medically Needy cases, if an assistance group is assigned an estimated rather than actual SOC, notice is given at the time the Share Of Cost is assigned that it is subject to change without notice. If the assistance group later provides verification of actual income, and a higher Share Of Cost is determined, the assistance group is informed of the higher SOC. Ten days advance notice is not required.~~

3610.0902 Disqualification Periods and Implementation (FS)

The disqualification period for an eligible assistance group member will begin with the first month following the date the agency receives written notification of the hearings decision or within 45 calendar days from the date of receipt of a state attorney/court disposition. There is no requirement for notification through certified mail. The agency

is not required to give the assistance group notice of adverse action prior to imposing the disqualification.

Disqualification periods, when specified in a court order, must be followed as defined by the court. In the absence of court ordered specifications, use the following program specific policies to determine disqualification periods.

FS disqualification periods:

In the Food Stamp Program there are several program violations, which have very stringent disqualification periods; these include the sale of controlled substances (illegal drugs), firearms, ammunition and/or explosives.

For program violations related to the use or receipt of food stamps in a transaction involving the sale of a controlled substance, the disqualification periods are:

1. 24 months for the first violation, and
2. permanent disqualification for the second violation.

For program violations related to the use or receipt of food stamps in a transaction involving the sale of firearms, ammunition, or explosives, the disqualification period is permanent for the first violation.

For program violations involving trafficking of food stamps in the amount of $500 or more, the disqualification period is permanent for the first violation.

For program violations involving fraudulent statements or representations regarding identity or residence in order to receive multiple benefits, the disqualification period is 10 years for each violation.

In addition to these specific program violations there are two situations where an individual is automatically disqualified due to their status as a fleeing felon or probation violator or having a felony drug trafficking conviction.

An individual, who is a fleeing felon or probation violator, is disqualified from participation in the Food Stamp Program as long as they are a fleeing felon or probation violator.

An individual who was convicted of a drug trafficking felony including agreeing, conspiring, combining, or confederating with another person to commit the act committed ~~on or~~ after 8/22/1996 is permanently disqualified from participation in the Food Stamp Program. If the illegal behavior that lead to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is

not subject to the disqualification. The individual must provide proof of the expungement.

For all other Food Stamp Program violations, the disqualification periods are:

1. 12 months for the first violation,
2. 24 months for the second violation, and
3. permanent disqualification for the third violation

Note: In instances where the food stamp fraud occurred prior to April 1, 1983, a three month disqualification period is applied, regardless of the type of violation.

3620.0902 Disqualification Periods and Implementation (TCA)

The disqualification period for an eligible assistance group member must begin no later that the first day of the second month, which follows the date of the decision. There is no requirement for notification through certified mail. The agency is not required to give the assistance group notice of adverse action prior to imposing the disqualification.

Disqualification periods, when specified in a court order, must be followed as defined by the court. In the absence of court ordered specifications, use the following program specific policies to determine disqualification periods:

TCA disqualification periods:

1. 12 months for the first violation,
2. 24 months for the second violation, and
3. permanent disqualification for the third violation.

For program violations involving trafficking of Temporary Cash Assistance benefits in the amount of $500 or more, the disqualification period is permanent for the first violation.

For program violations involving fraudulent statements or representations regarding identity or residence in order to receive multiple benefits, the disqualification period is 10 years for each violation.

In addition to these specific program violations there are two situations where an individual is automatically disqualified due to their status as a fleeing felon or probation violator or having a felony drug trafficking conviction.

An individual, who is a fleeing felon or probation violator, is disqualified from participation in the Temporary Cash Assistance Program as long as they are a fleeing felon or probation violator.

An individual, who was convicted of a drug trafficking felony ~~on or~~ after 8/22/96~~7/1/97~~, is permanently disqualified from participation in the Temporary Cash Assistance Program. If the illegal behavior that lead to the conviction occurred on or before 8/22/96, the disqualification does not apply regardless of the date of the conviction. If a court expunges the felony drug trafficking conviction, the individual is not subject to the disqualification. The individual must provide proof of the expungement.

For all other Temporary Cash Assistance Program violations the disqualification periods are:

1. 12 months for the first violation,
2. 24 months for the second violation, and
3. permanent disqualification for the third violation.