November 03, 2010 Summary of Changes

Chapter	Passage	Summary
0200	**0210.0103**	Added information about broad-based categorically eligible standard filing units (SFU).
	0240.0111	Removed obsolete information related to Alzheimer's Disease (ALZ) waiver.
0600	**0610.0501**	Added felony drug trafficking and fleeing felon to the list of disqualifications that will preclude a standard filing unit from categorical or broad-based categorical eligibility.
	0610.0600	Added information indicating Puerto Rico Nutritional Assistance Program benefits are not duplicate benefits in the United States.
	0630.0111, 0640.0111, 0660.0111	Clarified medical referrals for Emergency Medicaid for Aliens.
	0630.1500	Clarified verification requirements for Simplified Eligibility for Pregnant Women.
0800	**0830.100, 0840.0100**	Defined a Medicaid eligibility review and clarified assigning a review period.
1400	**1410.0103, 1420.0103, 1430.0103, 1440.0103, 1450.0103, 1460.0103**	Added exception indicating a voided Puerto Rican birth certificate must not be used for proof of citizenship after September 30, 2010.
	1410.0109, 1420.0109, 1430.0109	Added eligibility information on potential child trafficking victims.
	1410.0115, 1420.0115, 1430.0115, 1440.0115, 1450.0115, 1460.0115	Changed the VIS-CPS requirement for all programs.
	1410.0204	Added language indicating good cause must be evaluated at each recertification.
	1410.0400, 1430.0400, 1440.0400	Added exception indicating a voided Puerto Rican birth certificate must not be used for proof of citizenship after September 30, 2010.
	1420.1001	Clarified the third trimester of pregnancy.
	1440.0008	Removed obsolete information related to Alzheimer's Disease (ALZ) waiver.
	1440.0109	Added eligibility information on potential child trafficking victims.
	1440.1302	Removed obsolete information related to Alzheimer's Disease (ALZ) waiver.
	1450.0109, 1460.0109	Added eligibility information on potential child trafficking victims.

Chapter	Passage	Summary
1600	**1610.0000**	Added information to indicate asset policies only apply to SFUs that are not categorically or broad-based categorically eligible.
	1640.0300	Added disclosure of annuities language.
	1640.0307.04	Deleted the criteria for an estimate of current market value and language pertaining to impact of legal impediments on current market value.
	1640.0561.03	Removed the DRA promissory notes, loans and mortgages transfer policy from this section. Refer to new passage 1640.0609.08.
	1640.0594	Deleted the phrase, individuals applying for, in the first paragraph and now using resource instead of asset in reference to the disregard.
	1640.0609.03	Deleted the parenthetical definitions of irrevocable and nonassignable.
	1640.0609.08	Added passage for DRA transfer policy regarding promissory notes, loans and mortgages.
	1640.0614.03	Deleted passage, Compensation in Property.
1800	**1820.0315,1830.0315, 1840.0315, 1850.0315, 1860.0315**	Removes the requirement for staff to request an exception to the verification requirement for self employment income from the Region or Circuit Program Office; exception can be granted by a supervisor.
	1860.0827	Added exclusion of cash grants received under the Department of State's Reception and Placement Program for both RAP Cash Assistance and Refugee Medical Assistance.
2000	**2010.0201**	Added information how a SFU becomes broad-based categorically eligible for food assistance and must meet the gross and net income limits unless the SFU contains an elderly or disabled member.
	2010.0202	Added information on SFUs that are not broad-based categorically eligible.
	2030.0900	Entered the full program name of Emergency Medicaid for Aliens in the text and clarified eligibility for a child born on the first of the month.
2200	**2210.0308**	Removed "or" from the passage title since the 165% limit test applies to individuals who are both elderly and disabled.

Chapter	Passage	Summary
	2210.0318.04	Added language to further explain how to determine the shelter cost of elderly and/or disabled individuals in a blind or disabled group living arrangement.
2600	**2610.0103**	Added information that broad-based categorically eligible SFUs must meet the gross and net income limits unless the SFU contains an elderly or disabled member.
	2610.0106.02	Added information about broad-based categorical eligibility.
	2640.0117, 2640.0118	Removed obsolete information related to Alzheimer's Disease (ALZ) waiver.
3200	**3210.0213.02**	Updated passage and removed outdated language.
3600	**3610.0711**	Added new passage for compromising claims.

0210.0103 Eligibility Criteria (FS)

Individuals who purchase and prepare food together will be considered an assistance group for food stamp purposes and will have their eligibility determined together. Individuals who apply for food stamps must qualify on the basis of income and assets. Almost all types of income are counted. After adding all the assistance group's countable income, the eligibility specialist must allow certain adjustments. In order to be eligible, the total income must fall below certain limits, depending on the assistance group's size.

In addition, families and individuals must meet work registration requirements as well as certain citizenship and residency requirements. Eligibility criteria are established by USDA and are uniform throughout the United States.

Any assistance group in which all members are recipients of TCA, RAP and/or SSI benefits are considered categorically eligible because of their status. Eligibility factors accepted for FS eligibility, TCA, RAP, and/or SSI eligibility are:

1. gross and net income limits,
2. assets,
3. SSN information,
4. sponsored noncitizen information, and
5. residency.

Broad-based categorically eligible standard filing units are categorically eligible because they received information about Temporary Assistance for Needy Families or Maintenance of Effort funded services or benefits in an ACCESS Florida notice. Broad-based categorically eligible standard filing units must meet the gross income limit, which is 200% of the federal poverty level and net income limit which is 100% of the federal poverty level unless the standard filing unit contains an elderly or disabled member. Standard filing units with an elderly or disabled member must pass only the net income limit.

0240.0111 Home and Community Based Services (MSSI)

The purpose of the Home and Community Based Services (HCBS) Programs is to prevent institutionalization of individuals by providing for care in the community. These programs are considered Medicaid waiver programs because they waive certain Medicaid eligibility criteria and allow individuals to be eligible who would not otherwise be eligible, and they allow additional services that are not usually available under Medicaid.

Following are HCBS waivers for which you must determine eligibility:

1. Channeling,
2. Project AIDS Care (PAC),
3. Aged and Disabled Adult (ADA),
4. Developmental Disabilities (DD),
5. Assisted Living Waiver (AL),
6. Traumatic Brain and Spinal Cord Injury (BSCIP),
7. Model Waiver,
8. Long-Term Care Community Diversion (LTCCD),
9. Cystic Fibrosis (CF),
10. ~~Alzheimer's Disease (ALZ),~~
11. Comprehensive Adult Day Health Care, and
12. Family and Supported Living (FSL).

~~Refer to Chapter 1400 for technical criteria for these programs.~~

The individual must meet all technical criteria, have income and assets within the limits for ICP or MEDS-AD, meet the level of care for the particular program involved and be enrolled in the waiver as documented by form CF-ES 2515. (Individuals cannot qualify for HCBS under the Medically Needy Program).

Note: With the exception of the Long-Term Care Community Diversion, the Cystic Fibrosis, and the Assisted Living Waiver Programs, spousal impoverishment policies do not apply to HCBS Programs. However, the transfer of assets policy does apply to all HCBS Programs.

0610.0501 Categorical Eligibility (FS)

Standard filing units are categorically eligible if they:

1. file a joint application for food stamps and TCA,
2. file for SSI benefits,
3. file for FS and SSI benefits,
4. have a TCA or SSI application pending and are denied food stamps but are later determined categorically eligible, or
5. are SFUs in which all members receive income from TCA, RAP, or SSI.

These SFUs are eligible for food stamps without separate verification of assets, gross and net income limits, social security number, residency, and sponsored noncitizen status.

Standard filing units are not categorically eligible or broad-based categorically eligible if:

1. a member is disqualified for IPV.
2. a member is disqualified for employment and training requirements.
3. a member is disqualified for felony drug trafficking ~~an ineligible noncitizen~~. or
4. a member is a fleeing felon ~~an ineligible student~~.

Prorate the food stamps for the initial month for AGs that file joint applications and are determined categorically eligible after a prior denial of food stamps. Begin the prorated period on the date of TCA eligibility or the date of the original food stamp application whichever is later.

Provide retroactive food stamps prorated from the application date to any potentially categorically eligible food stamp AG determined TCA eligible within the 30-day food stamp processing time. Reevaluate the original application at the SFU's request or when the Department becomes aware of the SFU's TCA and/or SSI eligibility.

0610.0600 NON-DUPLICATION OF ASSISTANCE (FS)

Recipients may not receive benefits from more than one state or be included in more than one AG in any month.

Nutritional Assistance Program (NAP) benefits from Puerto Rico are the same as food stamp benefits in the United States. However, if the customer moves to the United States, the NAP benefits do not count as income to the household and the household is not receiving duplicate benefits. It is not necessary to attempt to contact Puerto Rico to confirm the closure of the NAP case prior to approval of food stamp benefits.

Exception: Battered spouse AGs temporarily residing in a shelter for battered woman and children, may receive benefits beginning the month they enter the shelter even though they were included in the allotment of the former AG containing the individual who subjected them to abuse.

0630.0111 Medical Provider Referrals (MFAM)

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

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

0640.0111 Medical Provider Referrals (MSSI)

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

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

0660.0111 Medical Provider Referrals (RAP)

Hospitals and other Medicaid providers refer individuals when potential eligibility for Medicaid exists. Upon receipt of a referral, contact the individual, determine whether eligibility exists, and notify the provider of the disposition.

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

0630.1500 SIMPLIFIED ELIGIBILITY FOR PREGNANT WOMEN (MFAM)

Pregnant women may apply for Simplified Eligibility for Pregnant Women (SEPW) coverage (MEDS for P~~p~~regnant W~~w~~omen) ~~coverage~~ by completing a Health Insurance Application for Pregnant Women ~~Woman~~ (Form CF-ES 2700). Coverage is limited to pregnant women with filing unit income equal to or below 185 percent of the federal poverty level. If the individual is seeking other program services, such as food stamps, provide an appropriate application and process it according to current procedures.

Obtain the social security number and date of birth of the pregnant woman for income verification purposes (data matching).

Verification: Prior to approval of the SEPW Medicaid the following items must be verified:

1. pregnancy,
2. citizenship or noncitizen status, and
3. questionable information on the application.

Verification of income is not required prior to disposition of the application unless there is reason to question the reported income. If income is not verified prior to approval, it must be verified following approval, using electronic data exchange whenever possible. If no data exchange is received, verify the income using standard verification procedures, no later than the next eligibility review. Document CLRC with the type of verification used. ~~Confirm the applicant's income~~

~~information through data exchange or computer matching to the extent possible. Verify self-employment income as well as any inconsistencies. Do not delay Medicaid unless the information on the application is inconsistent. If the applicant's statement of income or the data exchange income from the same source does not exceed 185% of the poverty level, consider income verified. Verify the pregnancy and noncitizen status prior to approving these Medicaid benefits.~~

0830.0100 ELIGIBILITY REVIEWS (MFAM)

An eligibility review reestablishes eligibility on all factors, resolves discrepancies and ensures correct benefits. If there are multiple AGs in the case, use the earliest review date of any AG in the case to review all AGs.

An eligibility review for Medicaid is defined as an application, or any time all applicable items addressed in the interim contact letter are evaluated.

If it becomes necessary to close TCA or food stamps, evaluate the Medicaid portion of the case separately to determine if closure is appropriate. If the eligibility determination was completed within the last 12 months, do not close the Medicaid AGs, but close the other programs as appropriate. Keep the Medicaid AGs open, and schedule the eligibility review 12 months from the month Medicaid eligibility was last determined.

For applications assign a 12-month review period from the month of disposition, unless eligibility does not begin until a future month. At review assign a 12-month review period from the month following disposition. ~~Assign a 12-month review period from the month of disposition of an application or review~~. For Medically Needy cases, evaluate the individual for reenrollment prior to the expiration of the current enrollment period.

If the eligibility review is denied due to not providing requested verification(s) following an interview or when no interview is required reapprove Medicaid:

1. without a new application if an interim contact letter was submitted the month the eligibility review was due, and
2. the individual provides the verification within 60 days from the date the Department received the interim contact letter.

The new application date is the date the Department receives all requested information. If eligible, approve Medicaid using the date of Medicaid entitlement policy.

Explore retroactive Medicaid for any lost months, if the applicant indicates they have unpaid medical bills for that period and all information needed to determine eligibility for that month is received.

0840.0100 ELIGIBILITY REVIEWS (MSSI, SFP)

An eligibility review reestablishes eligibility on all factors, resolves discrepancies and ensures correct benefits. If there are multiple AGs in the case, use the earliest review date of any AG in the case to review all AGs.

An eligibility review for Medicaid is defined as an application, or any time all applicable items addressed in the interim contact letter are evaluated.

If it becomes necessary to close TCA or food stamps, evaluate the Medicaid portion of the case separately to determine if closure is appropriate. If the eligibility determination was completed

within the last 12 months, do not close the Medicaid AGs, but close the other programs as appropriate. Keep the Medicaid AGs open and schedule the eligibility review 12 months from the month Medicaid eligibility was last determined.

For applications assign a 12-month review period from the month of disposition, unless eligibility does not begin until a future month. At review assign a 12-month review period from the month following disposition. ~~Assign a 12-month review period from the month of disposition of an application or review~~. For Medically Needy cases, evaluate the individual for reenrollment prior to the expiration of the current enrollment period.

If the eligibility review is denied due to not providing requested verification(s) following an interview or when no interview is required reapprove Medicaid:

1. without a new application if an interim contact letter was submitted the month the eligibility review was due, and
2. the individual provides the verification within 60 days from the date the Department received the interim contact letter.

The new application date is the date the Department receives all requested information. If eligible, approve Medicaid using the date of Medicaid entitlement policy.

Explore retroactive Medicaid for any lost months, if the applicant indicates they have unpaid medical bills for that period and all information needed to determine eligibility for that month is received.

1410.0103 Verification Sources for U.S. Citizens (FS)

The individual's verbal or written statement of date and place of birth must be accepted if they were born in the United States (U.S.) unless the information is questionable. This policy applies to all individuals claiming U.S. citizenship, including those who are naturalized and those born abroad to U.S. citizens.

If questioned, U.S. citizenship must be verified. Sources of verification include:

1. Birth or hospital certificates showing U.S. birth (except for voided Puerto Rican birth certificates after September 30, 2010),
2. Form I-197 (U.S. Citizen I.D. card),
3. Religious documents recorded in the U.S. shortly after birth,
4. SSA records,
5. U.S. passport,
6. Certificate of Citizenship or Naturalization.

1420.0103 Verification Sources for U.S. Citizens (TCA)

The individual's verbal or written statement of date and place of birth must be accepted if they were born in the United States (U.S.) unless the information is questionable. This policy applies to all individuals claiming U.S. citizenship, including those who are naturalized and those born abroad to U.S. citizens.

If questioned, U.S. citizenship must be verified. Sources of verification include:

1. Birth or hospital certificates showing U.S. birth (except for voided Puerto Rican birth certificates after September 30, 2010),
2. Form I-197 (U.S. Citizen I.D. card),
3. Religious documents recorded in the U.S. shortly after birth,

4. SSA records,
5. U.S. passport,
6. Certificate of Citizenship or Naturalization.

1430.0103 Verification Sources for U.S. Citizens (MFAM)

United States citizenship must be verified for all individuals who claim to be citizens, including those who are naturalized and those born abroad to U.S. citizens. If we have verification in our records, do not ask for it again, unless it appears fraudulent.

Exceptions: Presumptively eligible newborns (even after the first year), individuals who receive SSI, any part of Medicare, Social Security Disability based on their work history and children in the care of the Department are exempt from this requirement.

The following sections discuss what documents may be accepted as verification of U.S. citizenship and identity.

The following can be used to document U.S. citizenship and identity:

1. A U.S. passport (can be expired),
2. A Certificate of Naturalization (DHS form N-550 or N-570),
3. A Certificate of Citizenship (DHS form N-560 or N-561) or,
4. Data from the Driver's And Vehicle Express (DAVE) system.

The following can only be used to verify citizenship (must show a U.S. place of birth):

1. BVS record (MNOV or DEBP) if born in Florida,
2. VIS-CPS (SAVE) for naturalized citizens (must have their A#),
3. Verification of eligibility under the Child Citizenship Act of 2000, including the U.S. citizenship of the parent,
4. A U.S. birth certificate (originally issued prior to age five) (except for voided Puerto Rican birth certificates after September 30, 2010),
5. A final adoption decree, or if the adoption is pending and no birth certificate can be issued, a statement from the state adoption agency (U.S. born children),
6. A Report of Birth Abroad of a U.S. citizen (forms FS-240, FS-545 or DS1350),
7. A U.S. Citizen I.D. card (DHS form I-197 or I-179),
8. A Northern Mariana ID card (I-873),
9. An American Indian card (I-872, with "KIC" code),
10. Proof of civil service employment before 6/1/76, or
11. Official military record of service (ex.DD-214).

If none of the above documents exist or can be located, the following documents can be used to verify U.S. citizenship if they show a U.S. place of birth and are dated five years prior to the Medicaid application (unless for a child under age five):

1. Extract of hospital birth record on hospital letterhead (not a souvenir birth certificate),
2. Life or health insurance record with a U.S. place of birth,
3. Early school record, or
4. Religious record (ex baptism) within three months of birth.

If none of the above documents exist or can be located, the following documents can be used to verify U.S. citizenship if they show a U.S. place of birth and are dated five years prior to the Medicaid application (unless for a child under age five):

1. Federal census records from 1900-1950 showing the age and place of birth (the five year rule does not apply),
2. Tribal census records,
3. An amended birth certificate, after age five,
4. A signed statement from the doctor or midwife who was present at the birth,
5. Nursing home institution records that contain biographical information,
6. Medical records with biographical information,
7. Listed on the roll of Alaskan natives, or
8. A written statement signed under penalty of perjury by at least two people who have personal knowledge of the event(s) – (One cannot be related.). They must also prove their own citizenship and identity. A separate statement by the applicant/recipient/representative, signed under penalty of perjury, must also be completed stating why the documentation could not be obtained.

1440.0103 Verification Sources for U.S. Citizens (MSSI, SFP)

United States citizenship must be verified for all individuals who claim to be citizens, including those who are naturalized and those born abroad to U.S. citizens.

Exceptions: Individuals who receive SSI, any part of Medicare, Social Security Disability based on their work history and children in the care of the Department are exempt from this requirement. If we have verification in our records, do not ask for it again, unless it appears fraudulent.

The following sections discuss what documents may be accepted as verification of U.S. citizenship and identity.

The following can be used to document U.S. citizenship and identity:

1. A U.S. passport (can be expired),
2. A Certificate of Naturalization (DHS form N-550 or N-570),
3. A Certificate of Citizenship (DHS form N-560 or N-561) or,
4. Data from the Driver's And Vehicle Express (DAVE) system.

The following can only be used to verify citizenship (must show a U.S. place of birth):

1. BVS record (MNOV or DEBP) if born in Florida,
2. VIS-CPS (SAVE) for naturalized citizens (must have their A#),
3. Verification of eligibility under the Child Citizenship Act of 2000, including the U.S. citizenship of the parent,
4. A U.S. birth certificate (originally issued prior to age five) (except for voided Puerto Rican birth certificates after September 30, 2010),
5. A final adoption decree, or if the adoption is pending and no birth certificate can be issued, a statement from the state adoption agency (U.S. born children),
6. A Report of Birth Abroad of a U.S. citizen (forms FS-240, FS-545 or DS1350),
7. A U.S. Citizen I.D. card (DHS form I-197 or I-179),
8. A Northern Mariana ID card (I-873),
9. An American Indian card (I-872, with "KIC" code),
10. Proof of civil service employment before 6/1/76, or
11. Official military record of service (ex.DD-214).

If none of the above documents exist or can be located, the following documents can be used to verify U.S. citizenship if they show a U.S. place of birth and are dated five years prior to the Medicaid application (unless for a child under age five):

1. Extract of hospital birth record on hospital letterhead (not a souvenir birth certificate),

2. Life or health insurance record with a U.S. place of birth,
3. Early school record, or
4. Religious record (ex baptism) within three months of birth.

If none of the above documents exist or can be located, the following documents can be used to verify U.S. citizenship if they show a U.S. place of birth and are dated five years prior to the Medicaid application (unless for a child under age five):

1. Federal census records from 1900-1950 showing the age and place of birth (the five year rule does not apply),
2. Tribal census records,
3. An amended birth certificate, after age five,
4. A signed statement from the doctor or midwife who was present at the birth,
5. Nursing home institution records that contain biographical information,
6. Medical records with biographical information,
7. Listed on the roll of Alaskan natives, or
8. A written statement signed under penalty of perjury by at least two people who have personal knowledge of the event(s) – (One cannot be related.). They must also prove their own citizenship and identity. A separate statement by the applicant/recipient/representative, signed under penalty of perjury, must also be completed stating why the documentation could not be obtained.

1450.0103 Verification Sources for U.S. Citizens (CIC)

The individual's verbal or written statement of date and place of birth must be accepted if they were born in the United States (U.S.) unless the information is questionable.

For all programs, the individual's verbal statement attesting to U.S. citizenship and the signature of one adult household member on the Declaration of Citizenship form must be accepted, unless questioned. This policy applies to all individuals claiming U.S. citizenship, including those who are naturalized and those born abroad to U.S. citizens. Staff must not use a voided Puerto Rican birth certificate for proof of citizenship after September 30, 2010.

Note: Only one signature from an adult household member is needed on the Declaration of Citizenship form.

1460.0103 Verification Sources for U.S. Citizens (RAP)

The individual's verbal or written statement of date and place of birth must be accepted if they were born in the United States (U.S.) unless the information is questionable. This policy applies to all individuals claiming U.S. citizenship, including those who are naturalized and those born abroad to U.S. citizens.

If questioned, U.S. citizenship must be verified. Sources of verification include:

1. Birth or hospital certificates showing U.S. birth (except for voided Puerto Rican birth certificates after September 30, 2010),
2. Form I-197 (U.S. Citizen I.D. card),
3. Religious documents recorded in the U.S. shortly after birth,
4. SSA records,
5. U.S. passport,
6. Certificate of Citizenship or Naturalization.

1410.0109 Victims of Human Trafficking (FS)

Victims of severe forms of human trafficking are eligible for benefits to the same extent as a noncitizen who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. The only exception is the human trafficking victim will not provide USCIS documents. Adult victims will provide a certification letter from the Department of HHS. Children under 18 years old are not required to be certified and will instead be provided an eligibility letter. The agency will accept the certification letter for adults or the eligibility letter for children in place of USCIS documentation.

Before approving these individuals, the validity of the certification or eligibility letter must be confirmed by calling the HHS' Office of Refugee Resettlement (ORR) at (866) 401-5510. The call will advise ORR of the benefits for which the individual has applied and at the same time ORR will verify whether or not the individual is a trafficking victim.

Certain family members of the Victims of Human Trafficking are now potentially eligible for food stamps. This includes the spouse and children of a trafficking victim 21 years of age or older. If the severe trafficking victim is under 21 years of age, parents, spouses, children, and unmarried siblings under 18 on the date of the "T" visa's application, are eligible, if they meet all other program criteria. These family members will have a nonimmigrant "T" Visa, with no additional USCIS documentation.

Note: These individuals are not subject to the five-year ban.

Note: Do not use the Verification Information System - Customer Processing System (VIS-CPS) for these individuals, as VIS-CPS does not contain information about them.

Potential Child Trafficking Victims: Potential child trafficking victims are eligible for federally funded benefits and services for up to 90 days pending a final trafficking eligibility decision. An "Interim Assistance Letter" issued to potential child victims by the Department of HHS, Office of Refugee Services (ORR) will certify this status. These children are eligible for benefits beginning with the eligibility began date on the interim assistance letter. ORR will issue a final trafficking determination on the child within this interim period. If denied a final trafficking status, terminate benefits at the end of the month in which the 90th day falls.

1420.0109 Victims of Human Trafficking (TCA)

Victims of severe forms of human trafficking are eligible for benefits to the same extent as a noncitizen who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. The only exception is the human trafficking victim will not provide USCIS documents. Adult victims will provide a certification letter from the Department of HHS. Children under 18 years old are not required to be certified and will instead be provided an eligibility letter. The agency will accept the certification letter for adults or the eligibility letter for children in place of USCIS documentation.

Before approving these individuals for benefits, the validity of the certification or eligibility letter must be confirmed by calling the HHS' Office of Refugee Resettlement (ORR) at (866) 401-5510. The call will advise ORR of the benefits for which the individual has applied and at the same time ORR will verify whether or not the individual is a trafficking victim.

Certain family members of victims of human trafficking are potentially eligible for TCA. This includes the spouse and children of a trafficking victim 21 years of age or older. If the severe trafficking victim is under 21 years of age, parents, spouses, children, and unmarried siblings under age 18 on the date of the "T" visa application are eligible, if they meet all other eligibility requirements. These family members will have a nonimmigrant T Visa, with no additional USCIS documentation.

Note: These individuals are not subject to the five-year ban.

Note: Do not use the Verification Information System - Customer Processing System (VIS-CPS) for these individuals, as VIS-CPS does not contain information about them.

Potential Child Trafficking Victims: Potential child trafficking victims are eligible for federally funded benefits and services for up to 90 days pending a final trafficking eligibility decision. An "Interim Assistance Letter" issued to potential child victims by the Department of HHS, Office of Refugee Services (ORR) will certify this status. These children are eligible for benefits beginning with the eligibility began date on the interim assistance letter. ORR will issue a final trafficking determination on the child within this interim period. If denied a final trafficking status, terminate benefits at the end of the month in which the 90th day falls.

1430.0109 Victims of Human Trafficking (MFAM)

Victims of severe forms of human trafficking are eligible for benefits to the same extent as a noncitizen who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. The only exception is the human trafficking victim will not provide USCIS documents. Adult victims will provide a certification letter from the Department of HHS. Children under 18 years old are not required to be certified and will instead be provided an eligibility letter. The agency will accept the certification letter for adults or the eligibility letter for children in place of USCIS documentation.

Before approving these individuals for benefits, the validity of the certification or eligibility letter must be confirmed by calling the HHS' Office of Refugee Resettlement (ORR) at (866) 401-5510. The call will advise ORR of the benefits for which the individual has applied and ORR will verify whether or not the individual is a trafficking victim.

Certain family members of victims of human trafficking are now potentially eligible for Medicaid. This includes the spouse and children of a trafficking victim 21 years of age or older. If the severe trafficking victim is under 21 years of age, parents, spouses, children, and unmarried siblings under 18 on the date of the "T" visa's application are eligible, if they meet all other program criteria. These family members will have a nonimmigrant "T" Visa, with no additional USCIS documentation.

Note: These individuals are not subject to the five-year ban.

Note: Do not use the Verification Information System - Customer Processing System (VIS-CPS) for these individuals, as VIS-CPS does not contain information about them.

Potential Child Trafficking Victims: Potential child trafficking victims are eligible for federally funded benefits and services for up to 90 days pending a final trafficking eligibility decision. An "Interim Assistance Letter" issued to potential child victims by the Department of HHS, Office of Refugee Services (ORR) will certify this status. These children are eligible for benefits beginning with the eligibility began date on the interim assistance letter. ORR will issue a final trafficking determination on the child within this interim period. If denied a final trafficking status, terminate benefits at the end of the month in which the 90th day falls.

1410.0115 VIS-CPS (FS)

VIS-CPS must be completed for noncitizens:

1. at application or reapplication,
2. when adding a noncitizen individual, and

3. any time there is a change to alien status ~~recertifications for individuals who have not received Permanent Residence status~~.

A noncitizen who has what appears to be a “good” USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1420.0115 VIS-CPS (TCA)

VIS-CPS must be completed for noncitizens:

1. at application or reapplication,
2. when adding a noncitizen individual, and
3. any time there is a change to alien status ~~at eligibility reviews for individuals who have not received Permanent Residence status~~.

A noncitizen who has what appears to be a “good” USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1430.0115 VIS-CPS (MFAM)

VIS-CPS must be completed for noncitizens:

1. at application or reapplication,
2. when adding a noncitizen individual, and
3. any time there is a change to alien status ~~at eligibility reviews for individuals who have not received Permanent Residence status~~.

A noncitizen who has what appears to be a "good" USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1440.0115 VIS-CPS (MSSI, SFP)

VIS-CPS must be completed for noncitizens:

1. at application or reapplication,
2. when adding a noncitizen individual, and
3. any time there is a change to alien status ~~at eligibility reviews for individuals who have not received Permanent Residence status~~.

A noncitizen who has what appears to be a "good" USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1450.0115 VIS-CPS (CIC)

VIS-CPS must be completed for noncitizens:

1. at application or reapplication,
2. when adding a noncitizen individual, and

3. any time there is a change to alien status ~~at eligibility reviews for individuals who have not received Permanent Residence status~~.

A noncitizen who has what appears to be a "good" USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1460.0115 VIS-CPS (RAP)

VIS-CPS must be completed for noncitizens:

1. at application or reapplication,
2. when adding a noncitizen individual, and
3. any time there is a change to alien status ~~at eligibility reviews for individuals who have not received Permanent Residence status~~.

A noncitizen who has what appears to be a “good” USCIS document, when VIS-CPS indicates contradictory information, will be considered potentially eligible until secondary verification is returned confirming the status. Do not hold, deny or terminate benefits waiting for the secondary verification.

1410.0204 When SSN is not Provided/Refusal to Apply (FS)

The needs of the individual or child without an SSN must be excluded from the assistance group if an individual fails without good cause to provide or apply for an SSN on his own behalf or on the behalf of the individual’s child(ren) or nonrelative child(ren).

Eligibility under this factor ~~for one month in addition to the month of application~~ is determined if good cause exists. Good cause must be evaluated ~~each month~~ at each recertification in order for the individual to retain continued eligibility. Expedited households must apply for or provide an SSN prior to the first full month of eligibility unless good cause exists.

To determine if good cause exists, documentary evidence or collateral information indicating that the individual has applied for an SSN or made every effort to supply information to complete the application must be considered.

1410.0400 IDENTITY (FS)

The identity of the individual making application must be established as a condition of eligibility. Use any available documentation as proof of identity, but if unavailable, make a collateral contact. If an authorized representative applies on behalf of a household, the identity of both the authorized representative and the individual making application must be established. If the individual(s) is known to the interviewer, this information must be recorded in order for the identity to be considered established.

Examples of acceptable documentation include but are not limited to:

1. driver’s license,
2. data from the Driver’s And Vehicle Express (DAVE) system,
3. work or school ID,
4. ID for health benefits or for any assistance or social services program,
5. voter registration card,
6. wage stubs, or

7. birth certificate (except for voided Puerto Rican birth certificates after September 30, 2010).

1430.0400 IDENTITY (MFAM)

The identity of each U.S. citizen applying for, or receiving Medicaid must be documented.

Exceptions: Presumptively eligible newborns (even after the first year), individuals who receive SSI, Medicare (any part), Social Security Disability based on their work history and children in the care of the Department are exempt from this requirement.

The following documents are acceptable as proof of identity:

1. State driver's license with photo or other identifying information;
2. State ID card with photo or other identifying information;
3. School ID card with photo (for children under 16, includes nursery, daycare records, or school records, including school conference records and no photo is required);
4. Clinic, doctor, or hospital record for children under 16 (except for voided Puerto Rican birth certificates after September 30, 2010);
5. U.S. military card or draft record;
6. A military dependent's ID card;
7. Federal, state, or local government ID card with photo;
8. A certificate of Indian blood;
9. Native American tribal document;
10. Three or more of the following documents unless a fourth tier verification of citizenship was used:
    a. Marriage license,
    b. Divorce decree,
    c. High school diploma,
    d. Employer ID card, or
    e. Any other document from a similar source.
11. Food Stamp, CSE, Department of Corrections, child protection and DJJ data records,
12. U.S. Coast Guard merchant mariner card; or
13. Attestation (a written, signed statement under penalty of perjury) for children under age 16, or a disabled adult living in a residential facility, stating the date and place of birth. (Cannot be used if statement was used for citizenship verification.)

Do not accept a Social Security card, birth certificate, voter's registration card or Canadian driver's license for identity verification.

1440.0400 IDENTITY (MSSI)

The identity of each U.S. citizen applying for, or receiving Medicaid must be documented.

Exceptions: Individuals who receive SSI, Medicare (any part), Social Security Disability based on their work history and children in the care of the Department are exempt from this requirement.

The following documents are acceptable as proof of identity:

1. State driver's license with photo or other identifying information;
2. State ID card with photo or other identifying information;
3. School ID card with photo (for children under 16, includes nursery, daycare records, or school records, including school conference records and no photo is required);

4. Clinic, doctor, or hospital record for children under 16 (except for voided Puerto Rican birth certificates after September 30, 2010);
5. U.S. military card or draft record;
6. A military dependent's ID card;
7. Federal, state, or local government ID card with photo;
8. A certificate of Indian blood;
9. Native American tribal document;
10. Three or more of the following documents unless a fourth tier verification of citizenship was used:
    a. Marriage license,
    b. Divorce decree,
    c. High school diploma,
    d. Employer ID card, or
    e. Any other document from a similar source.
11. Food Stamp, CSE, Department of Corrections, child protection and DJJ data records,
12. U.S. Coast Guard merchant mariner card; or
13. Attestation (a written, signed statement under penalty of perjury) for children under age 16, or a disabled adult living in a residential facility, stating the date and place of birth. (Cannot be used if statement was used for citizenship verification.)

Do not accept a Social Security card, birth certificate, voter's registration card or Canadian driver's license for identity verification.

1420.1001 Pregnancy Policy (TCA)

A pregnant woman may be eligible for Temporary Cash Assistance (TCA) due to pregnancy if:

1. she has no other children for whom assistance is requested,
2. the unborn is deprived, and
3. she is in her ninth month of pregnancy, or is in her third trimester and unable to participate in work activities.

    Note: The ninth month is defined as the calendar month in which the due date falls. The third trimester begins three months prior to the month the baby is due ~~with the seventh month of pregnancy~~.

    Example: If a woman is pregnant and due June 14, the eligibility specialist would count back three months from June (May, April and March) to determine when the third trimester begins ~~the seventh month of pregnancy~~, which would be March.

Note: Pregnant women residing in the home with deprived children applying for assistance will have their application for temporary cash and determined on the needs of the assistance group regardless of their stage of pregnancy.

The father of the unborn child living in the home with no other children may not receive TCA ~~Temporary Cash Assistance~~ under the two-parent policy until after the baby is born.

Pregnant women eligible for TCA ~~Temporary Cash Assistance~~ must still work register unless they meet an exemption from work registration.

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 HCBS Channeling, individuals must:

1. live within the project area (Dade or Broward county);
2. be aged (65 years old or older);
3. meet level of care requirement as determined by CARES, and
4. be enrolled in the Channeling waiver as documented by form CF-ES 2515.

Channeling is a program for aged individuals only.

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 requirement as determined by CARES, and
3. be enrolled in the PAC waiver as documented by form CF-ES 2515.

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.

For the Developmental Disabilities waiver (DD/HCBS), individuals must:

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

Eligible participants in the DD waiver must be developmentally disabled.

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.

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.

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 the 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.

For the Long-Term Care Community Diversion (LTCCD/HCBS) 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.

Eligible participants in LTCCD receive services through specific managed care providers and are not restricted to a specific living arrangement. Services may be provided at home, in an assisted living facility or in a nursing facility.

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 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.

~~For the Alzheimer's Disease wavier (ALZ/HCBS) individuals must:~~

~~1. be aged 60 or older (must meet disability criteria if under age 65);~~
~~2. reside within the project area (Miami-Dade, Broward, Palm Beach or Pinellas county);~~
~~3. meet level of care requirement and special criteria as determined by CARES; and~~
~~4. be enrolled in the ALZ waiver as documented by form CF-ES 2515.~~

~~Eligible participants in the ALZ waiver must have a diagnosis of Alzheimer's disease and live in a private home or apartment with a caregiver.~~

For the Comprehensive Adult Day Health Care waiver individuals must:

1. be aged 75 or older;
2. live within in the project area (Lee or Palm Beach county);
3. meet level of care requirement and special criteria as determined by CARES; and
4. be enrolled in the waiver as documented by form CF-ES 2515.

Eligible participants in the Comprehensive Adult Day Health Care waiver must live with a caregiver.

For the Family and Supported Living waiver (FSL/HCBS) individuals must:

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

The FSL waiver is targeted to individuals waiting to enroll in the Developmental Disabilities waiver.

1440.0109 Victims of Human Trafficking (MSSI, SFP)

Victims of severe forms of human trafficking are eligible for benefits to the same extent as an alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. The only exception is the human trafficking victim will not provide USCIS documents. Adult victims will provide a certification letter from the Department of HHS. Children under 18 years old are not required to be certified and will instead be provided an eligibility letter. The agency will accept the certification letter for adults or the eligibility letter for children in place of USCIS documentation.

Before approving these individuals for benefits, the validity of the certification or eligibility letter must be confirmed by calling the HHS' Office of Refugee Resettlement (ORR) at (866) 401-5510. The call will advise ORR of the benefits for which the individual has applied and ORR will verify whether or not the individual is a trafficking victim.

Certain family members of victims of human trafficking are now potentially eligible for Medicaid. This includes the spouse and children of a trafficking victim 21 years of age or older. If the severe trafficking victim is under 21 years of age, parents, spouses, children, and unmarried siblings under 18 on the date of the T visa's application are eligible, if they meet all other program criteria. These family members will have a nonimmigrant T Visa, with no additional USCIS documentation.

Note: These individuals are not subject to the five-year ban.

Note: Do not use the Verification Information System - Customer Processing System (VIS-CPS) ~~VIS-CPS~~ for these individuals, as VIS-CPS does not contain information about them.

Potential Child Trafficking Victims: Potential child trafficking victims are eligible for federally funded benefits and services for up to 90 days pending a final trafficking eligibility decision. An "Interim Assistance Letter" issued to potential child victims by the Department of HHS, Office of Refugee Services (ORR) will certify this status. These children are eligible for benefits beginning with the eligibility began date on the interim assistance letter. ORR will issue a final trafficking determination on the child within this interim period. If denied a final trafficking status, terminate benefits at the end of the month in which the 90th day falls.

1440.1302 Who Determines Need for Placement (MSSI)

The agency or office responsible for determining the need for care depends on the applicant's age and what kind of facility or program is needed. After the eligibility specialist requests a determination, he must receive DOEA CARES Form 603 (Notification of Level of Care) from the responsible office to document the specific need in the case record.

Note: The eligibility specialist does not request level of care decisions for HCBS waivers but must receive documentation of decisions from case managers or CARES.

The determination will be obtained from one of the following offices:

CARES (Comprehensive Assessment and Review for Long Term Care Services), Department of Elder Affairs:

1. For ICP: determines Level of Care for applicant/recipients over age 21 in nursing facilities, swing beds or hospital based nursing facility beds.
2. For HCBS: determines if applicant/recipient meets waiver requirements for a specific HCBS waiver, including Channeling, Aged and Disabled Adult, Project AIDS Care, Assisted Living, Traumatic Brain and Spinal Cord Injury, Long-Term Care Community Diversion, Cystic Fibrosis~~, Alzheimer's~~ or Comprehensive Adult Day Health Care.

3. For PACE: determines if the applicant/recipient meets the level of care.

CMAT (Children's Multidisciplinary Assessment Team), Children's Medical Services in the Department of Health:

1. For ICP: determines Level of Care for children under age 21, unless they are applicants for Project AIDS Care or Developmental Disabilities.
2. For HCBS: determines if applicants meet waiver requirements for the Model waiver.

APD (Agency for Persons with Disabilities:

1. For Intermediate Care Facility for Developmental Disabilities: determines Level of Care for ICF/DD placement.
2. For HCBS: determines if applicant meets waiver requirements for the Developmental Disabilities and Family and Supported Living waivers.

If the eligibility specialist is not sure who is handling this determination, or whether a determination has been requested, he should request assistance from his supervisor.

1450.0109 Victims of Human Trafficking (CIC)

Victims of severe forms of human trafficking are eligible for benefits to the same extent as a noncitizen who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. The only exception is the human trafficking victim will not provide USCIS documents. Adult victims will provide a certification letter from the Department of HHS. Children under 18 years old are not required to be certified and will instead be provided an eligibility letter. The agency will accept the certification letter for adults or the eligibility letter for children in place of USCIS documentation.

Before approving these individuals for benefits, the validity of the certification or eligibility letter must be confirmed by calling the HHS' Office of Refugee Resettlement (ORR) at (866) 401-5510. The call will advise ORR of the benefits for which the individual has applied and ORR will verify whether or not the individual is a trafficking victim.

Certain family members of victims of human trafficking are now potentially eligible for Medicaid. This includes the spouse and children of a trafficking victim 21 years of age or older. If the severe trafficking victim is under 21 years of age, parents, spouses, children, and unmarried siblings under 18 on the date of the "T" visa's application are eligible, if they meet all other program criteria. These family members will have a nonimmigrant "T" Visa, with no additional USCIS documentation.

Note: These individuals are not subject to the five-year ban.

Note: Do not use the Verification Information System - Customer Processing System (VIS-CPS) for these individuals, as VIS-CPS does not contain information about them.

Potential Child Trafficking Victims: Potential child trafficking victims are eligible for federally funded benefits and services for up to 90 days pending a final trafficking eligibility decision. An "Interim Assistance Letter" issued to potential child victims by the Department of HHS, Office of Refugee Services (ORR) will certify this status. These children are eligible for benefits beginning with the eligibility began date on the interim assistance letter. ORR will issue a final trafficking determination on the child within this interim period. If denied a final trafficking status, terminate benefits at the end of the month in which the 90th day falls.

1460.0109 Victims of Human Trafficking (RAP)

Victims of severe forms of human trafficking are eligible for benefits to the same extent as an alien who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act. The only exception is that the human trafficking victim will not provide USCIS documents. Adult victims will provide a certification letter from the Department of HHS. Children under 18 years old are not required to be certified and will instead be provided an eligibility letter. The agency will accept the certification letter for adults or the eligibility letter for children in place of USCIS documentation.

Before approving these individuals for benefits, the validity of the certification or eligibility letter must be confirmed by calling the HHS' Office of Refugee Resettlement (ORR) at (866) 401-5510. The call will advise ORR of the benefits for which the individual has applied and at the same time ORR will verify whether or not the individual is a trafficking victim.

Certain family members of victims of human trafficking are now potentially eligible for refugee assistance payments. This includes the spouse and children of a trafficking victim 21 years of age or older. If the severe trafficking victim is under 21 years of age, parents, spouses, children, and unmarried siblings under 18 on the date of the T Visa's application are eligible, if they meet all other program criteria. These family members will have a nonimmigrant T Visa, with no additional USCIS documentation. Trafficking victims and certain family members are potentially eligible for refugee assistance payments for eight months from the date of the trafficking certification letter.

Note: Do not use Verification Information System - Customer Processing System (VIS-CPS) for these individuals as VIS-CPS does not contain information about them.

Potential Child Trafficking Victims: Potential child trafficking victims are eligible for federally funded benefits and services for up to 90 days pending a final trafficking eligibility decision. An "Interim Assistance Letter" issued to potential child victims by the Department of HHS, Office of Refugee Services (ORR) will certify this status. These children are eligible for benefits beginning with the eligibility began date on the interim assistance letter. ORR will issue a final trafficking determination on the child within this interim period. If denied a final trafficking status, terminate benefits at the end of the month in which the 90th day falls.

Proof of this status includes:

1. ORR certification letter,
2. T-2, T-3, T-4, or T-5 visa, also called a "Derivative T Visa",
3. telephone call to verification line at (202) 401-5510, or
4. victims that are minors are eligible on the basis of a similar ORR letter of eligibility, which is not a certification letter.

1610.0000 Food Stamps

The policies in this chapter apply only to standard filing units that are not categorically or broad-based categorically eligible. ~~Each individual's assets must be considered to determine eligibility for public assistance.~~

1640.0300 ASSET OWNERSHIP AND AVAILABILITY (MSSI, SFP)

Any individual who has the legal ability to dispose of an asset is considered the owner of the asset. The type of ownership (single or joint) of an asset determines to whom the asset is available and the value that is counted to the individual.

Individuals and their spouses must disclose their ownership interest in any annuity, including annuities that are not subject to the transfer of assets provision discussed in passage 1640.0609.03.

1640.0307.04 Home Equity (MSSI, SFP)

Apply the following policy to individuals who file an initial application or reapplication for ICP, institutionalized MEDS-AD, Institutional Hospice, Home and Community Based Services Programs or PACE on or after November 1, 2007. Do not apply the policy to individuals who were determined eligible for the above programs prior to November 1, 2007 and have had no break in eligibility.

Individuals with an equity interest in their home greater than $500,000 are ineligible for nursing facility or other long-term care services, unless one of the following relatives of the institutionalized individual is residing in the home:

1. spouse;
2. child under age 21; or
3. blind or disabled child, regardless of age or marital status.

Home equity is not an asset test. This does not change the policy that excludes a home of any value from countable assets.

Individuals ineligible solely due to their home equity will not qualify for nursing home care or other long term care services but will be eligible for general Medicaid benefits.

If an individual shares ownership interest in the home with other persons, only consider the equity value of the individual's shared fractional interest.

The equity value of the home is the current market value minus any indebtedness. Current market value is the price for which the home can reasonably be expected to sell on the open market in the particular geographic area involved.

Unless questionable, accept the individual or designated representative's statement as to equity value of a home that is less than $450,000. For equity value of $450,000 or more, the individual or designated representative must provide verification of current market value and indebtedness.

Verification of the current market value must be obtained from a knowledgeable source commonly involved in the housing industry such as a real estate broker, mortgage broker, property appraiser, or builder. The statement must include:

1. the current market value, ~~.~~
2. the name of the person providing the estimate ,~~.~~ and
3. contact information of the business or agency for whom the person providing the estimate works. ~~and~~
4. ~~the basis for the estimate, to include such things as a description of the property and its condition and, where appropriate, the value of similar property in the same area.~~

~~Legal impediments to the sale of the home do not impact the calculation of home equity. The amount of the individual's equity interest in the home is based solely on the current market value of the home, minus any debt. (In instances of shared ownership, only count the equity of the individual's fractional portion.)~~

The home equity provision may be waived when denial of long term care services would result in demonstrated hardship to the individual.

1640.0561.03 Promissory Notes Signed On or After 03/1/05 (MSSI, SFP)

Promissory notes, loans and mortgages signed on or after March 1, 2005 are included as assets for an individual (lender) who has the legal right to sell the loan or owns an interest in the loan that can be converted to cash. The asset value of the promissory note, loan, or mortgage is the equity value. Equity value is the outstanding balance minus indebtedness. When there is no indebtedness the equity value is the outstanding balance shown in payment records unless the individual can provide evidence that the value is less.

Absent evidence to the contrary, a promissory note, loan, or mortgage is bona fide and negotiable. A bona fide agreement is an agreement that is legally valid and made in good faith. A negotiable agreement is an agreement whereby the ownership of the instrument itself and the whole amount of money expressed on its face can be transferred from one person to another.

If the note, loan or mortgage is determined to be bona fide and negotiable, it is an asset. When payments consist of both principal and interest, the interest portion of the payment is excluded as unearned income in eligibility determination, but is counted as unearned income in patient responsibility calculations. The principal portion of the payment is conversion of an asset, not income.

If the note, loan or mortgage is not bona fide or not negotiable, the instrument cannot be converted to cash (sold) and is not an asset.

If the note, loan or mortgage is determined not to be an asset, the total payments received (principal or interest) is considered unearned income.

~~All promissory notes, loans and mortgages purchased on or after November 1, 2007 must also:~~

1. ~~have a repayment term that is actuarially sound;~~
2. ~~have payments made in equal amounts during the term of the loan with no deferral and no balloon payments made; and~~
3. ~~not allow debt forgiveness.~~

~~If all of the above criteria are not met, the purchase of the promissory note, loan or mortgage must be considered a transfer of assets. For transfer purposes, the value of the promissory note, loan or mortgage is the outstanding balance due as the date of application for long-term care services.~~

1640.0594 Long-Term Care Insurance Partnership Payments (MSSI)

This policy applies to the ~~individuals applying for~~ Medicaid Institutional Care Program (ICP), Home and Community Based Services, Hospice, and Program for All-inclusive Care for the Elderly.

An individual who is a beneficiary of a qualified state Long-Term Care (LTC) Insurance Partnership Policy will have a portion of their total countable resources ~~assets~~ disregarded when evaluating their Medicaid eligibility for the programs listed above. The disregarded portion is equal to the actual amount of LTC insurance partnership benefits paid out to or on behalf of the individual by the company. The resource disregard ~~asset exclusion~~ will continue to apply for the duration of the individual's Medicaid coverage.

For example, an individual has countable resources ~~assets~~ of $61,000 and reports that his LTC Insurance Partnership Policy paid out $60,000 toward his nursing home bill. The individual's countable resources ~~assets~~ are reduced by $60,000 and the remaining $1,000 is considered countable in the eligibility determination.

The resource ~~asset~~ disregard is protected from estate recovery. Complete and send a Third Party Recovery Transmittal (CF-ES 2356) to notify ACS Recovery Services of the amount to be disregarded for estate recovery purposes.

If the individual will continue to receive the LTC insurance benefits, determine if the payments will be considered income to the individual or a third party source. If the recipient directly receives the insurance payments, follow instructions in manual passage 1840.1007 to determine if the payments are considered income to the individual. If the insurance benefits are paid to the nursing home, exclude the payments under 1840.0118 as a third party source that the provider must bill prior to billing Medicaid.

Verification Requirements:

Not all long-term care insurance policies are a qualified LTC Insurance Partnership Policy. Eligibility staff must request documentation at the time of application to verify the:

1. policy is a qualified LTC Insurance Partnership Policy, and
2. total amount of long term care benefits paid out to or for the applicant.

The insurance company may use the approved Office of Insurance Regulation Form (OIR-B2-1781) or a similar form developed by the insurance company.

1640.0609.03 Transfers to Annuities on or After 11/1/07 (MSSI)

This policy applies to ICP, institutionalized MEDS-AD, institutionalized Hospice, HCBS Programs and PACE.

Applicant's or Recipient's Annuity

The purchase of an annuity on or after 11/01/2007, and within the look-back period, by an individual (or his representative) will be considered a transfer of assets for less than fair compensation unless the annuity meets all of the following requirements:

1. Names the state of Florida, Agency for Health Care Administration (AHCA), as the primary beneficiary, for the total amount of medical assistance paid on behalf of the individual, except for when the individual has a spouse or minor or disabled adult child. In this case, the state shall be named as secondary beneficiary after the spouse and/or the minor or disabled child.

   Note: If the spouse or minor/disabled child disposes of their primary remainder beneficiary interest for less than fair market value (for example, transferred their interest to someone who does not meet the criteria), AHCA must be named primary beneficiary or the individual will be subject to a transfer of asset penalty.

2. Is irrevocable ~~(cannot be cashed in)~~ and nonassignable ~~(cannot be sold or transferred to a third party)~~.

3. Makes payments (that include both principal and interest) to the individual in equal amounts during the term of the annuity, with no balloon or deferred payments.

4. Is actuarially sound based on the actuarial tables used by the Social Security Administration, (refer to Appendix A-14).

If the annuity meets all of the above criteria, funds in the annuity are excluded as a resource and the periodic payments are counted as income in the eligibility determination and patient responsibility.

If all of the requirements above are not met, the total amount of funds transferred into the annuity is considered a transfer without fair compensation, except when the annuity is revocable or assignable. When the annuity is revocable, count as an asset the amount the purchaser would receive from the annuity issuer if the annuity is cancelled. When the annuity is assignable, count as an asset the amount the annuity can be sold for on the secondary market.

Certain transactions that occur on or after 11/01/2007 make an annuity (including an annuity purchased before 11/01/2007) subject to the transfer of assets provisions. The transactions include such actions as additions of principal to an existing annuity or electing to annuitize an existing annuity.

Exception: Certain Individual Retirement Accounts (IRAs) or annuities that were established by an employee or their employer are not considered under the transfer of assets provisions and do not have to meet the above criteria. These include such financial vehicles as an individual retirement annuity, a simplified employee pension or a Roth IRA.

Community Spouse's Annuity

The purchase of an annuity on or after 11/01/2007 (and within the look-back period) by the community spouse of an applicant of ICP, institutionalized MEDS-AD, institutionalized Hospice, HCBS Programs and PACE will be considered a transfer of assets for less than fair compensation unless the annuity meets the criteria below:

1. Names AHCA as the primary beneficiary for the total amount of medical assistance paid on behalf of the applicant/recipient spouse, except for when the spouse has a minor or disabled child. In this case, AHCA shall be name as secondary after the minor or disabled child.

2. Is actuarially sound based on the spouse's age on the actuarial table used by the Social Security Administration (Refer to Appendix A-14).

Community spouse annuities that are revocable or assignable shall count as an asset, in the same manner as an applicant's/recipient's annuity counts, as indicated above.

Annuities purchased by the community spouse after approval of long-term care Medicaid for the applicant spouse are not evaluated for transfer of assets provisions.

Evaluating Annuities

At application, when an individual indicates ownership interest in an annuity, request a copy of the annuity contract and evaluate the annuity using the Evaluating Annuities job aid (Appendix A-34) to determine if the annuity will be subject to transfer of asset provisions. For annuities that name AHCA as beneficiary, send a copy of CF-ES 2355, Letter to Annuity Issuers (along with a copy of the contract) to the annuity company. At each annual review, send form CF-ES 2355 to the annuity issuer to solicit information about any changes that might have occurred during the year. Any time an issuer reports a change to the individual's (or spouse's) annuity, evaluate the change to determine if it subjects the annuity to transfer of asset provisions.

AHCA Notification

The Agency for Health Care Administration must be notified of annuities that name the state as beneficiary. Using Form CF-ES 2356, eligibility staff must forward a copy of each annuity that names the state as beneficiary to the following address:

ACS Recovery Services
Post Office Box 12188
Tallahassee, FL 32317-2188

When eligibility staff becomes aware of the death of an individual whose annuity was forwarded to ACS Recovery Services, eligibility staff must notify ACS of the individual's death to assist them in collecting beneficiary proceeds from the annuity.

1640.0609.08 Promissory Notes Signed On or After 11/1/07 (MSSI, SFP)

Promissory notes, loans and mortgages signed on or after November 1, 2007 will be considered transfers of assets without fair market compensation to become Medicaid eligible unless the promissory notes, loans, or mortgages meet all of the following criteria:

1. the repayment term is actuarially sound in accordance with the Life Expectancy Tables used by the Social Security Administration (Refer to Appendix A-14).
2. payments must be made in equal amounts during the term of the loan with no deferral and no balloon payments being possible; and
3. debt forgiveness is not allowed.

If the above criteria are not met, for purposes of transfer of assets, the value of the promissory notes, loans or mortgages will be the outstanding balance due as of the date of application for long-term care services.

1820.0315 Verification of Self Employment Income (TCA)

Self-employed individuals must verify earned income at application and review. In addition, these individuals must make all business records available to the eligibility specialist. Examples of business records include documentation on:

1. income tax records necessary to determine gross income and deductible expenses;
2. purchases;
3. sales;
4. salaries;
5. capital improvements; and
6. utility, transportation, and other operating costs.

If the individual claims to have no business records, or that the records are inaccurate, the eligibility specialist may request their supervisor to grant an exception to the verification requirements. The exception and supervisor's approval must be documented in CLRC. ~~must submit a request for a temporary exception to the verification requirements to the Region or Circuit Program Office. At the Region or Circuit's option, a temporary exception may be granted by the supervisor.~~

1830.0315 Verification of Self-Employment Income (MFAM)

Self-employed individuals must verify earned income at application and review. In addition, these individuals must make all business records available to the eligibility specialist. Examples of business records include documentation on:

1. income tax records necessary to determine gross income and deductible expenses;
2. purchases;
3. sales;
4. salaries;
5. capital improvements; and
6. utility, transportation, and other operating costs.

If the individual claims to have no business records, or that the records are inaccurate, the eligibility specialist may request their supervisor to grant an exception to the verification requirements. The exception and supervisor's approval must be documented in CLRC. ~~must submit a request for a temporary exception to the verification requirements to the Region or Circuit Program Office. At the Region or Circuit's option, a temporary exception may be granted by the supervisor.~~

1840.0315 Verification of Self-Employment Income (MSSI, SFP)

Self-employed individuals must verify earned income at application and review. In addition, these individuals must make all business records available to the eligibility specialist. Examples of business records include documentation on:

1. income tax records necessary to determine gross income and deductible expenses;
2. purchases;
3. sales;
4. salaries;
5. capital improvements; and
6. utility, transportation, and other operating costs.

If the individual claims to have no business records, or that the records are inaccurate, the eligibility specialist may request their supervisor to grant an exception to the verification requirements. The exception and supervisor's approval must be documented in CLRC. ~~must submit a request for a temporary exception to the verification requirements to the Region or Circuit Program Office. At the Region or Circuit's option, a temporary exception may be granted by the supervisor.~~

1850.0315 Verification of Self-Employment Income (CIC)

Self-employed individuals must verify earned income at application and review. In addition, these individuals must make all business records available to the eligibility specialist. Examples of business records include documentation on:

1. income tax records necessary to determine gross income and deductible expenses;
2. purchases;
3. sales;
4. salaries;
5. capital improvements; and
6. utility, transportation, and other operating costs.

If the individual claims to have no business records, or that the records are inaccurate, the eligibility specialist may request their supervisor to grant an exception to the verification requirements. The exception and supervisor's approval must be documented in CLRC. ~~must submit a request for a temporary exception to the verification requirements to the Region or Circuit Program Office. At the Region or Circuit's option, a temporary exception may be granted by the supervisor.~~

1860.0315 Verification of Self-Employment Income (RAP)

Self-employed individuals must verify earned income at application and review. In addition, these individuals must make all business records available to the eligibility specialist. Examples of business records include documentation on:

1. income tax records necessary to determine gross income and deductible expenses;
2. purchases;
3. sales;
4. salaries;
5. capital improvements; and
6. utility, transportation, and other operating costs.

If the individual claims to have no business records, or that the records are inaccurate, the eligibility specialist may request their supervisor to grant an exception to the verification requirements. The exception and supervisor's approval must be documented in CLRC. ~~must submit a request for a temporary exception to the verification requirements to the Region or Circuit Program Office. At the Region or Circuit's option, a temporary exception may be granted by the supervisor.~~

1860.0827 Assistance Payments (RAP)

Monthly cash payments from another agency (minus training expenses) to meet ongoing maintenance needs as defined by DCF are unearned income unless specifically excluded ~~as such~~.

Documentation or verification from the agency as to the amount received, frequency, purpose, and type of program is required.

Income Exclusions:

1. Emergency payments made by another agency or a nonprofit organization prior to the date the first Temporary Cash Assistance (TCA) ~~TCA~~ benefits are received.
2. Assistance payments under the Refugee Resettlement Match Grant Program when determining eligibility for Refugee Medical Assistance.

   Match Grant recipients may not receive TCA or RAP Cash Assistance.

3. Cash grants received under the Department of State's Reception and Placement Program for both RAP Cash Assistance and Refugee Medical Assistance.

2010.0201 Categorically Eligible Assistance Groups (FS)

A categorically eligible assistance group is one in which all members are receiving or are authorized to receive Temporary Cash Assistance or Supplemental Security Income (SSI) benefits or a combination of Temporary Cash Assistance and SSI. A broad-based categorically eligible standard filing unit (SFU) is one that receives information about Temporary Assistance for Needy Families or Maintenance of Effort funded services or benefits on an ACCESS Florida notice and does not contain a disqualified member. An individual is considered a recipient of Temporary Cash Assistance or SSI if the benefits have been authorized but not received, if the benefits are suspended or recouped, or if the benefits are not paid because they are less than a minimum amount.

Families that are receiving or are authorized to receive services through Healthy Families Florida are considered categorically eligible.

The assistance group cannot be considered categorically eligible for months in which an individual opts not to receive Temporary Cash Assistance, months that a SFU ~~standard filing unit~~ contains an ineligible or disqualified member or receives medical assistance only.

Individuals who are categorically eligible for food stamps are considered to have met gross and net income limits, asset limits, SSN requirements, and residency.

Broad-based categorically eligible SFUs must meet the 200% gross and the 100% net income limits unless the SFU contains an elderly or disabled member. These SFUs must pass only the net income limit.

2010.0202 Noncategorically Eligible Assistance Groups ~~AGs~~ (FS)

If the standard filing unit does not contain all individuals who receive or are authorized to receive Temporary Cash Assistance, SSI, or services through Healthy Families Florida, the assistance group is not considered categorically eligible. Standard filing units that contain any disqualified members due to IPV, felony drug trafficking, fleeing felon, or employment and training requirements are not broad-based categorically eligible. These assistance groups are referred to as noncategorical assistance groups (NA). Medical assistance only assistance groups, except for under $10 Temporary Cash Assistance cases, are considered NA assistance groups.

2030.0900 PRESUMPTIVELY ELIGIBLE NEWBORNS (MFAM)

A newborn is 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 E~~e~~mergency Medicaid for Aliens ~~benefits~~. The child remains eligible for Presumptive Eligibility for Newborn (PEN) coverage as long as the child remains a resident of Florida. If the child was born on the first of the month, ~~the~~ PEN eligibility ceases effective the birth month ~~coverage would end when the child turns one~~. 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.

An ex parte determination must be completed prior to the end of the child's presumptive eligibility. No verification of U.S. citizenship or identity will be needed for these children, even after the presumptive period ends.

2210.0308 Elderly and~~/or~~ Disabled Individuals Living with Others (FS)

A group of individuals living together and who purchase and prepare meals together generally constitute a single SFU. The exception to this policy involves an individual who is age 60 or older, disabled, and unable to purchase and prepare his/her own meals. In such a case, the

individual eats with others because he is unable to purchase and prepare meals for himself. If this occurs, the individual must verify that he is unable to purchase and prepare meals himself. This may be accomplished with a doctor's statement. If visibly obvious to the eligibility specialist, no written statement is required. The eligibility specialist will document CLRC with evidence of this determination.

If the income of the others with whom the individual resides, excluding the income of the spouse of the elderly and disabled individual, does not exceed 165% of the gross monthly income standard, then the individual, along with their spouse, qualifies as a separate food stamp assistance group. When applying the 165% limit test, the elderly and disabled person and spouse are not to be considered SFU members. Refer to Chapter 2600 for policy on the 165% limit test.

2210.0318.04 Determining Shelter Costs – Blind or Disabled Living Arrangement (FS)

A resident of a blind or disabled group home can only receive a shelter deduction for the portion of the shelter payment that they pay from their own funds. Any portion of a payment for shelter or meals paid by vendor payment, or from funds that do not belong to the resident, cannot be an allowable food stamp deduction. Special budgeting procedures are required to determine what portion of the resident's own income is used for room and meals.

Three methods are used to determine the allowable shelter costs that may be deducted for a resident. One calculation is used when a resident is billed only one fee that includes meals and room. The second calculation is used when the resident is billed separately for meals and room. Use the third method when the group home does not provide a specific amount for the Personal Needs Allowance (PNA) but considers any money that exceeds the room and board rate to use for the resident's personal needs. The PNA for food stamp purposes does not have to be one of the standard amounts from the SSI-Related Programs. Examples of these calculations are as follows:

1. If the resident is charged for room and meals in one amount, and the charges cannot be separately identified, the following example will be used:

   $674 SSI resident income - $54 PNA (allowance will vary) = $620 remainder of income - $200 one-person maximum food stamp benefit (meals portion) = $420 total rent expense (room portion).

2. If the resident is charged for room and meals separately and these expenses are identified separately, then the amount actually paid for meals will be deducted from the remaining income as the meals portion. The actual amount the resident pays for rent is determined as follows:

   $674 SSI resident income - $54 PNA (allowance will vary) = $620 remainder of income - $100 meals charge (meals portion) = $520 total rent expense (shelter portion).

3. If the group home considers any money that exceeds the room and board rate to use for the resident's personal needs, then this is the PNA.

   $1048 Social Security income - $543.42 room and board rate = $504.58 PNA. $1048 Social Security income - $507.58 (PNA) = $543.42 - $200 one-person maximum food stamp benefit = $343.42 shelter deduction.

The three examples cited above will assist the eligibility specialist in determining the amount of the rent expenses to be included for a resident of a blind or disabled group home.

Note: If none of the individual's own income is used to pay for room and meals, then a shelter deduction cannot be allowed. If the room and board is more than the income, only use the amount of income as the room and board amount.

Room and medical costs that can be separately identified are allowable shelter and medical expenses. However, if the amount the resident pays for room and medical care cannot be separately identified, no deduction is allowed for either shelter or medical expenses.

The portion of income used for the cost of nursing care, medical treatment, etc., cannot be used as a shelter expense. When determining the amount the resident pays for shelter, the cost of care would be deducted as shown in the following example:

$563 SSA resident income + $68 OSS resident income = $631 total income - $54 PNA (allowance will vary) = $577 remainder of income - $200 one-person maximum benefit (medical portion) = $377 net income - $250 cost of care (medical expense) = $127 total rent expense (shelter portion).

2610.0103 Budgets and Tests (FS)

Assistance groups must meet both the gross and net income standards to be eligible for food stamps with the following exceptions:

1. assistance groups that contain an elderly or disabled member and are not categorically eligible must meet the net income limits; ~~and~~
2. assistance groups in which all members are categorically eligible are not required to meet either gross or net income limits;~~.~~and
3. standard filing units (SFUs) that are broad-based categorically eligible must meet the 200% gross and the 100% net income limits unless the SFU contains an elderly or disabled member. These SFUs must pass only the net income limit.

2610.0106.02 Minimum Benefit (FS)

Initial month: Issue no benefits less than $10.

Recurring months:

1. Issue a minimum of eight percent of the maximum benefit for a one-person assistance group to one or two person assistance groups who meet the net income test, or are categorically eligible.
2. Issue a benefit less than the minimum benefit to assistance groups of three or more that is not categorically eligible. $1, $3, or $5 benefits will round to $2, $4, or $6.

2640.0117 Patient Responsibility Computation (MSSI)

The following policy applies to ICP, institutionalized MEDS, institutionalized Hospice, Community Hospice, PACE and the following HCBS Waiver Programs:

1. Assisted Living,
2. Long-Term Care Diversion,
3. Cystic Fibrosis,
4. ~~Alzheimer's Disease,~~
5. Comprehensive Adult Day Health Care, and
6. Family and Supported Living.

After the individual is determined eligible, the amount of monthly income to be applied to the cost of care (patient responsibility) is computed as follows:

Step 1 - Deduct the personal needs allowance and one half of the gross therapeutic wages up to the maximum of $111 if applicable. Refer to 2640.0118 for information regarding the personal needs allowance.

Step 2 - Deduct the community spouse income allowance, family member allowance, or the dependent's allowance, if applicable.

Step 3 - Consider protection of income policies for the month of admission or the month of discharge, if appropriate (refer to 2640.0123) for the following programs:

1. Institutional Care Programs, (including institutionalized MEDS and institutionalized Hospice) - the month of admission to and discharge from a nursing facility,
2. Assisted Living Waiver - the month of admission to and discharge from an ALF,
3. PACE and Long-Term Care Diversion - the month of admission or discharge from a nursing home facility or from an assisted living facility.

Step 4 - Deduct uncovered medical expenses as discussed in passages 2640.0125.01 through 2640.0125.04.

The balance is the amount of the patient responsibility.

Note: The following individuals have no patient responsibility:

1. ICP children (aged 3-17 years) in ICF/DDs.
2. QMB individuals (with income 100% or less of the federal poverty level) while in a nursing home under Medicare coinsurance period, and
3. SSI recipients who have no other source of income and are only entitled to a $30 SSI payment.

2640.0118 Personal Needs Allowance (MSSI)

The amount of the individual's income which is designated as a personal needs allowance (PNA) varies by program.

For ICP and institutionalized MEDS-AD, the personal needs allowance is $35 as follows:

1. If the individual has less than $35 total countable income, a supplemental payment must be authorized through the Supplemental Payment System (SPS). The personal needs allowance supplement (PNAS) cannot exceed $5 a month.

2. Single veterans (and surviving spouses) in nursing homes who receive a VA $90 pension (disregarded as income in both eligibility and patient responsibility computations) are also entitled to the $35 PNA.

3. Single veterans (and surviving spouses) with no dependents who reside in state Veterans Administration nursing homes may keep $90 of their veterans payments, including payments received for aid and attendance and unreimbursed medical expenses, for their personal needs. Any amount exceeding $90 will be part of their patient responsibility to the facility. These individuals are also entitled to the $35 PNA.

For community Hospice, the PNA is equal to the Federal Poverty Level.

For institutionalized Hospice, the PNA is $35. There is no provision to supplement this PNA.

For the Assisted Living waiver, the PNA is equal to the current OSS rate plus OSS personal needs allowance.

For the Cystic Fibrosis, ~~Alzheimer's disease,~~ Comprehensive Adult Day Health Care and Family Supported Living waivers, the PNA is equal to 300% of the federal benefit rate. Because the PNA is the same as the HCBS income limit, only those individuals who become eligible using an income trust will have a patient responsibility.

For the Long Term Care Community Diversion Waiver and the Program for All-Inclusive Care for the Elderly (PACE), the personal needs allowance is as follows:

1. For an individual residing in the community (not an ALF), the PNA is 300% of the Federal Benefit Rate.
2. For an individual residing in an ALF, the PNA is computed using the ALF basic monthly rate (three meals per day and a semi-private room), plus 20% of the Federal Poverty Level. The ALF basic monthly rate will vary depending on the facility's actual room and board charges.
3. For an individual residing in a nursing home, the PNA is $35.

For individuals in the above programs who earn therapeutic wages, an additional amount equal to one half of the therapeutic wages, up to $111, can be deducted or protected for personal needs. The total amount of income to be protected as therapeutic wages cannot exceed $111. (This is in addition to the $35 personal needs allowance.)

3210.0213.02 ~~Statement of~~ Nonreceipt Affidavit/Replacement Authorization ~~(Affidavit)~~ (FS)

A statement attesting to the assistance group's (AG's) loss in a household misfortune or disaster must be obtained prior to issuance of the replacement benefit. Form CF-ES 3515, Nonreceipt Affidavit/Replacement Authorization, can ~~(Benefit Books/Nonreceipt Affidavit/Replacement Authorization) is to~~ be used for this purpose. ~~CF-ES 3515 is to be used for household disaster replacements.~~ The form can ~~is~~ either be mailed to the AG ~~assistance group~~ or completed in person at ~~the~~ an ACCESS service center. The signed form must be returned to the Department within 10 days of the date of the report of the loss or no replacement will be made. If the 10th day falls on a weekend or holiday, it will be considered timely if received the next work day after the weekend or holiday. The supervisor must verify the information on the form for completeness and accuracy. The statement must then be signed by the supervisor and retained in the case file ~~and a copy submitted to the Headquarters Management Information and Systems support office~~.

3610.0711 Compromising Claims (FS)

A claim or any portion of a claim may be compromised with the exception of court ordered restitutions or intentional program violations. Individuals with an overpayment claim may request a compromise of their claim at any time after they are notified of the claim. The Department will determine the economic household circumstances reasonably demonstrate the overpayment claim will not be paid within three years of being notified of the overpayment claim and will compromise to zero dollars when at least one of the following is present:

1. The death or prognosis of death of any liable individual within three years of being notified;
2. Pending litigation in a court, including a bankruptcy court, that involves any liable individual's obligation to repay the overpayment within three years of being notified;
3. Any liable individual is sentenced to a period of incarceration that will expire after the three-year period the overpayment is expected to be paid; or

4. The liable individual(s) sole household's income is based only on either age or disability projecting a fixed, limited economic potential to repay the overpayment within three years.

Verification of the above criteria is required.

Note: Liable individual(s) can request a compromise even if they do not meet the above criteria. The request and any other related information provided must clearly show the overpayment claim will not be paid within the three-year period. The Department will not speculate about the liable individual's ability to repay the overpayment.