June 24, 2009 Summary of Changes

Chapter	Passage	Summary
1400	**1420.1914.08**	Removed full-time care requirement and need to obtain documentation of the child's age.
	1420.1914.13	Removed the definition and references to full-time care and removed requirements to demonstrate attempts to obtain alternative care of a disabled family member.
	1430.0400	Added PENs as an exemption for verification of identity.
1600	**1640.0576.09**	Changed the payee name for reimbursements.
2200	**2210.0318.04**	Added a third method to determine shelter costs for residents of a blind or disabled group home.
3200	**3230.0402**	Changed the payee name for reimbursements.
	3230.0403	Updated the address where to submit reimbursements.
Appendix	**A-22**	Updated the address where to refer questions regarding settlements of balances in approved qualified Medicaid trusts.

1420.1914.08 Child Under Three Months (TCA)

One custodial parent of a child under three months ~~old personally providing full-time care for the child~~ is exempt.

~~Documentation~~ The individual's statement of the child's age is sufficient, unless questionable ~~must be obtained~~. When there is more than one child in the home who meets this criterion, the age of the youngest child should be used ~~documented~~ for this exemption.

~~Absences of the parent to attend school full-time, including college, high school, vocational, or technical schools, does not constitute brief and infrequent absences. Written proof from an official of the educational institution that the parent is registered and attending part-time and not full-time (as defined by the educational institution) is required in order for the individual to be exempt.~~

1420.1914.13 Care of a Disabled Family Member (TCA)

An individual is exempt from participation in work activities when the individual is required to be in the home ~~a minimum of eight hours per day~~ to provide for the personal care of a family member with a disability. The individual is not subject to time limits during the allowed exemption period.

The care given may include such things as supervision, arranging services, transportation and such tasks that are typically completed during the family member's waking hours. Verification of the family member's disability and the need for personal care is required. Statement of Need for Care, CF-ES 2094, can be used to verify both disability and need for care. A verbal statement from the caregiver to the questions in Part A of this form may substitute for the caregiver completing this section. A disabled family member is any person related by blood or marriage and who resides in the home with the caregiver. The individual in need of care need not be a member of the assistance group/standard filing unit (AG/SFU) ~~AG/SFU~~ and may be either an adult or child. The caregiver may self-declare to the lack of alternative care, including lack of alternative care from other family members, for the disabled individual.

~~The applicant must demonstrate he/she has attempted to obtain alternative care from all available sources for the family member with a disability. Documentation should be submitted to verify the attempts to obtain alternative care and that none is available. (There may be a lack of available services in the community or the cost may be prohibitive.) The individual may self-attest that there are no other family members to provide care for the disabled individual.~~

A family member is considered disabled if receiving temporary or permanent disability benefits issued by a government or a private source, or if a statement from a physician or licensed certified psychologist indicates that the family member is disabled. The age of the family member is not a factor in the need for care.~~; however, verification to substantiate that the disabled family member needs care for a minimum of eight hours per day is required.~~

The need for care of the disabled individual must be reviewed annually to evaluate whether or not the TCA recipient still qualifies for this exemption. When the family member requiring care is temporarily disabled, the disability verification is valid until the temporary disability is expected to end or one year, whichever is earlier. If the disability is "total and permanent", there is no need to re-verify the family member's disability. ~~However,~~ In either case, the department ~~agency~~ must annually require verification the caregiver provides ~~to show that a minimum of eight hours of~~ personal care for the disabled individual in their home. ~~per day is needed.~~

When one disabled individual lives in a two-parent AG ~~assistance group~~, only one parent may be exempted from work requirements due to caring for the disabled individual. Unless otherwise

exempt, the other adult in the two-parent AG ~~two-parent assistance group~~ is required to participate in employment and training activities. The responsibility for the caregiver of a disabled family member may be moved from one adult in the case to another adult in the case at any time, if requested by the AG ~~assistance group~~. If this occurs, verbal statement from the new caregiver or an updated Part A section on the Statement of Need for Care (CF-ES-2094) is required. The request should be granted unless the adult who was required to comply with work activities is facing penalties for noncompliance. When more than one disabled member lives in a two-parent AG ~~two-parent assistance group~~, both parents may meet the need for care exemption, provided no alternative care exists and a physician indicates that each parent is responsible ~~"totally responsible"~~ for the care of a different disabled household member. The physician's statement regarding the need for care should be included on the "Statement of Need for Care" (CF-ES 2094).

~~**Note:** "Totally responsible" is defined as being responsible for providing personal care for a disabled household member for a minimum of eight hours per day during the disabled individual's waking hours.~~

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), i~~I~~ndividuals 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;
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 4th 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.

1640.0576.09 Treatment of Qualified Disabled Trusts (MSSI, SFP)

After the trust is approved by the District Legal Counsel as meeting the criteria of a qualified trust for the disabled under age 65 or a pooled trust, apply the following policies to determine the individual's eligibility for Medicaid benefits:

1. Do not consider the corpus of the exempt trust as an asset to the individual beginning with the month the assets are placed into an executed qualified disabled trust or pooled trust;
2. Do not consider the funding of a qualified disabled or pooled trust as a transfer of assets or income subject to imposition of a penalty period, provided the trust purchases items and services at fair market value for the sole benefit of the disabled individual (refer to 1640.0609.06);
3. Do not count any income deposited into the trust as income to the individual when determining the individual's eligibility;
4. Do not consider disbursements from the trust to third parties as income to the individual;
5. Do not consider any income earned by the trust which remains in the trust as income to the individual;
6. Count any payments made directly to the individual as income to the individual;
7. Count all income placed into the trust (along with countable income outside the trust) when computing patient responsibility. Standard spousal impoverishment policies apply.

If income is deposited into the trust, the trustee must provide quarterly statements identifying the deposits (and disbursements) made to the trust for each month.

Any funds paid directly to the individual from the trust must be counted as income to the individual. Disbursements not paid to the individual are not counted as income to the individual.

Fax or send a copy of the approved qualified disabled or pooled trust to:

ACS Recovery Services
Post Office Box 12188
Tallahassee, Florida 32317-2188
Fax: (866) 443-5559

When you receive inquiries regarding the settlement of remaining funds in the trust after a recipient's death, tell them to make checks payable to Agency for Health Care Administration ~~Florida Medicaid~~ and send to the above address. Also advise them to clearly identify the individual by including a note with the individual's full name and social security number or Medicaid number. If there are further questions, refer callers to ACS Recovery Services (866) 357-3268.

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

A resident of a blind or disabled group home ~~for the blind/disabled~~ can only receive a shelter deduction for the portion of the shelter payment that they pay ~~he pays~~ from their ~~his~~ 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 ~~FS~~ deduction. Special budgeting procedures are required to determine what portion of the resident's own income is used for room and meals. ~~First, obtain the total income of the resident. Second, subtract the resident's personal need allowance from the total income.~~

~~**Note:** This calculation is done prior to calculating the portion of the resident's income paid for meals and rent.~~

Three ~~Two~~ 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 ~~$637~~ SSI resident income - $54 PNA ~~personal needs allowance~~ (allowance will vary) = $620 ~~$583~~ remainder of income - $200 one-person ~~$162 one person~~ maximum food stamp benefit (meals portion) = $420 ~~$421~~ total rent expense (room portion).

   ~~**Note:** The one person maximum benefit changes every year in October. The SSI amount changes every year in January.~~

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. ~~Then~~ T~~t~~he actual amount the resident pays for rent is determined as follows:

   $674 ~~$637~~ SSI resident income - $54 PNA ~~personal needs allowance~~ (allowance will vary) = $620 ~~$583~~ remainder of income - $100 meals charge (meals portion) = $520 ~~$483~~ 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 ~~two~~ 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.

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. ~~However,~~ W~~w~~hen 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 ~~personal needs allowance~~ (allowance will vary) = $577 remainder of income - $200 one-person ~~$162 one person~~ maximum benefit (medical portion) = $377 ~~$415~~ net income - $250 cost of care (medical expense) = $127 ~~$165~~ total rent expense (shelter portion).

3230.0402 Reimbursement (MFAM)

If an individual receives medical care that is not covered by Medicaid, the state does not have the right to third party payment for that care.

If an individual receives medical care that is paid or will be paid by Medicaid, any third party payment received by the Medicaid provider is to be reimbursed to the state up to the amount paid by Medicaid.

If an individual receives direct reimbursement for medical care paid by Medicaid, the individual is required to reimburse the state. This is done by endorsing the check from the insurance company to Agency for Health Care Administration ~~Florida Medicaid~~ or by sending a check or money order to Agency for Health Care Administration ~~Florida Medicaid~~.

3230.0403 Eligibility Specialist Given Reimbursement (MFAM)

Support for administration of other federally funded programs (food stamps, social services, etc.).

If the individual gives the reimbursement to the eligibility specialist, the eligibility specialist must submit the reimbursement to:

ACS Recovery Services ~~Agency for Health Care Administration (AHCA)~~
~~Division of Health Purchasing~~
~~Medicaid - Third Party Recovery~~
P.O. Box 12188 ~~12900~~
Tallahassee, FL 32317-2188 ~~2900~~, and

Attach a cover memo that includes the following information: the individual's name, Medicaid identification number, and hospital admission date or date of service(s) if outpatient case.