
RHODE ISLAND DEPARTMENT OF HUMAN SERVICES MANUAL

MEDICAL ASSISTANCE

OVERVIEW OF MA

SECTION 0326**MANUAL ORGANIZATION****0326.05**

REV:01/2002

Sections 0326 through 0348 of this manual set forth the policies and procedures which govern Medical Assistance eligibility for families with dependent children, poverty level children, pregnant women and children in foster care:

- o The remainder of this section, OVERVIEW OF MA, briefly summarizes eligibility requirements and lists coverage groups applicable to family cases;
- o Section 0328, CHARACTERISTIC REQUIREMENTS, describes the characteristic requirements for family cases and the process of verification;
- o Section 0330, INCOME GENERALLY, contains general provisions which apply to the consideration of an applicant's income, e.g., income limits, definitions, what income is counted;
- o Section 0332, BUDGET PERIODS, defines a budget period and describes the budget periods for Categorically Needy, Medically Needy and Flex-Test cases;
- o Section 0334, DETERMINING INCOME ELIGIBILITY, sets out the provisions governing whose income is counted for determining income eligibility;
- o Section 0336, FLEXIBLE TEST OF INCOME, contains the policies governing the spend down of excess income to achieve Medically Needy eligibility;
- o Section 0338, RESOURCES GENERALLY, contains general provisions which apply to the evaluation of an applicant/recipient's income - resource limits, definitions, excluded resources and provisions governing the reduction of excess resources;
- o Section 0340, EVALUATION OF RESOURCES, contains the policies for evaluating specific types of resources;
- o Section 0342, CATEGORICALLY NEEDY COVERAGE GROUPS, describes the eligibility requirements and other specific provisions of family categorically needy coverage groups, including Section 1931 families and Extended Benefits;

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- o Section 0344, POVERTY LEVEL COVERAGE GROUPS, describes the coverage provisions for pregnant women and children born after September 30, 1983 with income within a certain percentage of the Federal Poverty Level;
- o Section 0346, MEDICALLY NEEDED COVERAGE GROUPS, describes the eligibility requirements and other specific provisions of family Medically Needed coverage groups;
- o Section 0348, THE RITE CARE PROGRAM, describes the statewide managed care demonstration project to provide medical, dental and mental health services to certain categories of under-insured pregnant women and children who meet the program's eligibility requirements;
- o Section 0349, THE RITE SHARE PROGRAM, describes the requirements for enrolling MA eligible individuals and families in DHS approved employer sponsored health insurance plans.

0326.10 ELIGIBILITY REQUIREMENTS FOR FAMILIES

REV:09/2001

To be eligible for Medical Assistance (MA), a family must meet the program's technical, characteristic, financial and cooperation requirements.

SECTION 1931 ELIGIBILITY

There are two distinct groups of families eligible for MA under Section 1931: Family Independence Program (FIP) cash assistance families (CATEGORICALLY NEEDED ELIGIBLE); and MA Only families with income at or below one hundred ten percent (110%) of the federal poverty level income guidelines (FPL). The eligibility criteria for each group are outlined below:

1. SECTION 1931 MA AND ELIGIBILITY FOR FIP CASH ASSISTANCE

The eligibility profile of families who qualify for cash assistance through the Family Independence Program (FIP) falls within the parameters of Section 1931 eligibility. Consequently, all FIP eligible families are eligible for coverage under Section 1931 irrespective of whether they receive cash assistance.

Families who receive FIP cash assistance are categorically

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eligible for MA. The family's eligibility for MA is concurrent with receipt of their cash assistance. Countable family income is calculated using FIP income disregards, e.g., the earned income disregard of one hundred seventy dollars (\$170) plus one-half of the balance). Countable resources are determined using FIP resource rules. Families who apply for FIP and the concurrent MA benefits complete the DHS-1 and DHS-2 when filing an application.

FIP eligible families who are not receiving cash assistance are also Section 1931 eligible. This includes families participating in the Job Development Incentive Program (WSUP), as well as those who decline cash assistance for any reason and at any point during their period of eligibility. However, all Section 1931 families are NOT eligible for FIP.

2. SECTION 1931 MEDICAL ASSISTANCE ONLY

Section 1931 MA only families are those who: 1) meet the characteristics of age and relationship (a child living with at least one parent or caretaker relative); and 2) when using the MA income methodology, e.g., the \$90 earned income disregard, have countable family income not exceeding one hundred ten percent (110%) of poverty. There are no resource tests for any members of Section 1931 families. Families who apply for MA Only under Section 1931 may use the MARC-1 (mail-in application) when requesting benefits.

Both FIP families and Section 1931 MA only families must enroll in either Rite Care managed care (Section 0348) or in Rite Share employer-based group health insurance (Section 0349), as determined by the Department.

To illustrate the major similarities and differences:

FIP FAMILY	SECTION 1931 FAMILY
Must meet age and relationship requirements;	Must meet age and relationship requirements;
FIP Earned Income Disregard (\$170 plus one-half of balance)	MA Earned Income Disregard (\$90);
FIP Income Standard;	110% FPL Income Standard;
Must meet FIP resource limits;	No resource test (parents or

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children);

Must file DHS-1 and DHS-2;

May file DHS 1&2 or MARC-1
(mail-in application with
relaxed verification rules);

Must enroll in Rite Care
or Rite Share;

Must enroll in Rite Care
or Rite Share

Twelve month recertification.

Twelve month recertification.

MA FAMILY WAIVER ELIGIBILITY

Families with income greater than one hundred ten percent (110%) of the federal poverty level income guidelines (FPL), but less than or equal to one hundred eighty-five percent (185%) of FPL, may qualify for MA under the MA Family Waiver, if they meet all other eligibility criteria for Section 1931.

MEDICALLY NEEDY ELIGIBILITY

Families ineligible for MA under Section 1931 or the MA Family Waiver may attain Medically Needy eligibility status if the family has:

1. an AFDC characteristic;
2. countable resources within the Medically Needy resource limit; and
3. either countable income within the Medically Needy Income limit or spent down excess income on allowable medical expenses to within the Medically Needy Income Limit.

Medically Needy families, with the exception of those qualify through the spend down excess income, must enroll in Rite Care managed care or Rite Share employer-based group health insurance. Families who spend down excess income receive the Medically Needy scope of services through fee-for-services providers.

POVERTY LEVEL PREGNANT WOMEN AND CHILDREN

Pregnant women and children may be eligible under special Title XIX and Rite Care waiver poverty level coverage groups. Poverty level coverage groups require the applicant to have income to within a certain percentage of the Federal Poverty Level and to meet the eligibility requirements of the particular coverage

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group. There are no resource tests for poverty level coverage groups. After enrollment, pregnant women and children receive their medical care either through Rite Care or Rite Share.

Family Categories - Eligibility Tests**0326.10.05**

REV:09/2001

Some eligibility tests (e.g., citizenship/alienage, cooperation, residency) are applied to all categories of MA, whereas others are applied only to certain coverage groups. The chart below identifies the income, resource, relationship and deprivation tests applicable to each of the family categories.

**FAMILY MA COVERAGE GROUPS
ELIGIBILITY TESTS**

	INCOME TEST	RESOURCE TEST	RELATIONSHIP TEST	DEPRIVATION TEST
SECTION 1931	Y	N	Y	N
CAT NEEDY	Y	Y	Y	Y
MED NEEDY	Y	Y	Y	Y
PREGNANT WOMAN	Y	N	N	N
POVERTY LEVEL/ RITE CARE CHILD	Y	N	N	N
FAMILY WAIVER	Y	N	Y	N

COVERAGE GROUPS**0326.15**

REV:09/2001

The following is a summary listing of the Medical Assistance coverage groups applicable to families. Following each listing is a reference to the specific section where the requirements of that particular coverage group may be found.

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Categorically Needy Coverage Groups are:

- o FIP Recipients and Section 1931 Families (0342.05)
- o Deemed FIP Recipients, Less than \$10 in Monthly Benefits (0342.10)
- o Deemed FIP Recipients, Zero Benefits Due to Work Support Program (0342.10)
- o Deemed FIP Recipients, Zero Benefits Due to Recoupment (0342.10)
- o FIP Closures Due To Increased Child Support (0342.15)
- o Persons Who Would be Eligible for AFDC Except for RSDI Benefit Increase (0342.20)
- o Qualified Pregnant Women - No Deprivation Factor (0342.25)
- o Qualified Pregnant Women (0342.30)
- o Qualified Post Partum Women (0342.35)
- o Post Partum Women - Family Planning Services (0342.35.05)
- o Newborn Children of MA Eligible Mother (0342.40)
- o Ribicoff Child (0342.45)
- o Extended Benefits - FIP Closure Due to Employment (0342.50)
- o Individuals Receiving DHS Day Care Subsidy (0342.55)
- o FIP Eligible Institutionalized Individual (0342.65)
- o Adoption Subsidy or IV-E Foster Child (0342.70)
- o Non IV-E Foster Child Under Age 18 (0342.75)
- o Non IV-E Foster Child Older Than Age 18, But Not Yet 21 (0342.80)

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- o Non IV-E Foster Child With State Subsidized Adoption Assistance (0342.85)
- o Refugee Medical Assistance (0342.90)
- o Closed FIP Case - HMO Enrollee (0342.95)

Poverty Level Family Coverage Groups are:

- o Pregnant Women - Poverty Level (0344.05)
- o Child Younger than Six (6) Years of Age - Poverty Level (0344.10)
- o Children Who Have Attained Age Six (6) But not Age Nineteen (19) - Poverty Level (0344.15)
- o Title XIX Waiver Group for Families, Pregnant Women, Extended Family Planning and Children under Nineteen (19) - (0348.10.05)
- o State-Funded Pregnant Women (0348.10.10)
- o State-Funded Extended Family Planning (0348.10.10.10)
- o State-Funded Non-Citizen Children (0348.10.10.15)
- o Other Non-Title XIX Rite Care Groups (0348.10.15)

Medically Needy Family Coverage Groups are:

- o Families With AFDC Characteristics (0346.05)
- o Qualified Pregnant Women - No Deprivation Factor (0346.10)
- o Qualified Pregnant Women (0346.15)
- o Qualified Post Partum Women (0346.20)
- o Newborn Children of MA Eligible Mother (0346.25)
- o Ribicoff Child (0346.30)
- o Non IV-E Foster Child Under Age 18 (0346.35)

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- o Non IV-E Foster Child Age 18 But Not Yet 21 (0346.40)
- o Non IV-E Child With State Subsidized Adoption Agreement (0346.45)
- o Refugee Medical Assistance (0346.50)

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AGE REQUIREMENT**0328.05**

REV:11/2000

To qualify for MA under the Rite Care (section 0348) or poverty level coverage groups (0344.10 and 0344.15), an otherwise eligible child must be under the age of nineteen (19).

To qualify for MA under all other family-related coverage groups (such as Section 1931 or Medically Needy), an otherwise eligible child must be under the age of eighteen (18). If the child is eighteen (18) s/he must be a full time student in secondary school, or in the equivalent level of technical or vocational training. In addition, the student must reasonably be expected to complete the program before or in the month of his/her nineteenth (19th) birthday.

To be MA eligible, a parent (or other caretaker relative) must maintain a home for a needy child under the age of eighteen (18) without regard to whether the child is attending school or achieving passing grades. If the child is eighteen (18), s/he must be a full time student in secondary school, or in the equivalent level of technical or vocational training. The student must reasonably be expected to complete the program before or in the month of his/her nineteenth (19th) birthday.

Medical Assistance coverage is also available to certain groups of children up to age twenty-one (21). These groups are:

- o Children receiving foster care services, whether through DCYF or private, non-profit agencies;
- o Children for whom there is a State adoption subsidy agreement (hard to place children with special needs who are not eligible under the criteria of the IV-E program);
- o Individuals in Nursing Facilities and ICFs/MR.

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0328.05.05**Verification of Age**

REV:07/1994

The birth certificate is the primary source of verification of age. If not available, the following documents are satisfactory:

Baptismal Certificate	Voter Registration Card
Confirmation Papers	Family Bible
Marriage License	State/Federal Census Record
Driver's License	Life Insurance Policy
Immigration Papers	School Records
Military Service Papers	Physician Records
Hospital Birth Records	RSDI Award Letter if DOB of child is included
Adoption Records	
Passport	Affidavit of Third Party (see 328.10.05)

0328.10**RELATIONSHIP REQUIREMENT**

REV:11/2000

The relationship requirement must be met by Section 1931 families (including FIP families), and Medically Needy Families. There is no MA relationship requirement for pregnant women or poverty level/Rite Care children.

To satisfy the MA requirement of relationship, a child meeting the age requirement must be living with a relative of an acceptable degree of relationship in a home maintained by such relative. When the relative with whom the child lives is not the natural or adoptive parent, the term caretaker relative or loco parentis ("in place of the parent") is used. Although both parents of an eligible dependent child may qualify under the family related Section 1931 and Medically Needy coverage groups, only one caretaker relative may qualify under these groups. For purposes of determining MA eligibility, a relative does not

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qualify as a caretaker relative for a foster child when DCYF foster care payments are provided.

A child meets the relationship requirement if his/her home is with any of the following relatives:

- o Father, adoptive father, mother, adoptive mother;
- o Stepfather, stepmother (but not the parent of either);
- o Grandfather, great grandfather, great-great grandfather, great-great-great grandfather;
- o Grandmother, great grandmother, great-great grandmother, great-great-great grandmother;
- o Adoptive grandparent if the grandchild is the natural child of a parent who was adoptive, or if the grandchild is the adopted child of a parent, who was the natural child of the grandparent;
- o Brother, half brother, adoptive brother, stepbrother, sister, half sister, adoptive sister, stepsister;
- o Uncle or aunt (including uncle or aunt of whole or half blood), great uncle or aunt, great-great uncle or great-great aunt;
- o First cousin (including first cousin of whole or half blood), first cousin once removed;
- o Nephew, great nephew, great-great nephew or niece, great niece, great-great niece including nephew or niece of whole or half blood.

Spouses of any of the persons in the above groups meet the relationship requirement and continue to meet it even after the marriage is terminated by death or divorce.

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0328.10.05

Verification of Relationship

REV:07/1994

The degree of kinship between the parent or caretaker relative and the child must be established. The following evidence serves to substantiate the parent's statement of relationship:

o Vital Statistics Records

For natural or adoptive parents, relationship is determined by examination of the child's birth certificate on which the parents' names are recorded.

For other relatives, a combination of vital statistics records must be reviewed in order to establish the required degree of relationship.

o Other Records

When vital statistics records are unavailable for review, insurance policies, RSDI awards, or written statements by doctors, clergymen, school authorities, or others who have previous knowledge of the relationship constitute acceptable evidence.

o Third Party Affidavit

When verification of age and/or relationship is unobtainable from any other source, a third party affidavit may be acceptable evidence.

An affidavit is the signed and sworn statement of a third person based upon the third person's personal knowledge of the facts which would indicate the probable age and relationship of the child. It is not merely a statement of belief based on the applicant's appearance. It should contain a statement of the circumstances upon which the third party's knowledge is based. The facts attested to must be consistent with the information provided on the DHS-2 and must not be contradictory of other records or evidence in the case record.

The eligibility technician determines with the applicant who is the person in the best position to attest to the facts, and the person who is readily available should be the first choice.

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The affidavit from the third party must be notarized and must contain the following:

- o Name, address, occupation and length of time the third party has been at the address;
- o Relationship to the applicant (e.g., friend, cousin, doctor, employer, teacher);
- o How long he has known the applicant;
- o The approximate age, number and sex of the child(ren);
- o Circumstances in establishing the connection with the applicant. This might include statements such as: I grew up with the applicant and his brothers and sisters. We went to school together. I know that the child(ren) (name(s)) was born on (date) and is his/her child(ren).

An affidavit of a third person shall not be the first source of verification. The applicant, together with the eligibility technician must explore the availability of other sources to establish age and relationship. S/He must demonstrate that s/he has tried to obtain appropriate records (e.g., letter has been written to a city or state registry).

An affidavit is acceptable verification while awaiting replies from other sources, and it may be accepted if no other record is obtainable.

Verif Relationship Unwed Father

0328.10.05.05

REV:07/1994

An unwed natural father is defined as a child's biological father who was not married to the child's mother at the time of the child's birth.

The primary sources of verification for an unwed natural father are the child's birth certificate on which the man's name is recorded, or an adjudication of paternity by the RI Family Court or any other

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court of competent jurisdiction. When paternity has been established through adjudication a copy of the court order or decree must be retained as part of the case record. If either of these sources of verification is available, no further documentation of paternity is required.

0328.10.10**Establishment of Home/Temporary Absence**

REV:11/2000

A home is the family setting maintained or in the process of being established, as evidenced by assumption, continuation, and exercise of responsibility for day-to-day care and control of the child by the relative with whom the child is living, regardless of who has legal custody.

A home exists while the parent exercises responsibility for the child even though circumstances may require the temporary absence of either the child or caretaker from the customary family setting. Examples of allowable temporary physical separations between parent and child include but are not limited to the following:

- 0 Hospitalization of the child or parent, when the illness is such that a return to the family can be expected AND parental responsibility continues.
- 0 Attendance at school for the primary purpose of obtaining an education or vocational training while the parent retains full responsibility for the child.
- 0 Visiting or similar situations in which the child or parent is away from the home for a temporary period of time.

In general, allowable temporary absences of the child or parent from the home are limited to ninety (90) days per episode, with a second ninety (90) day renewal authorized only through supervisory approval. If a child is attending school or vocational training outside the home community, a temporary absence may exist as long as the child was living in the home before leaving for education, the parent retains full responsibility and supervision of the child, and the child returns to the home periodically, such as during vacation

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periods.

In determining whether a separation is allowable, the Regional Manager considers such factors as:

- o the extent to which the parent retains custodial, legal, and/or financial responsibility for the child;
- o the degree to which the parent's functioning as a provider of maintenance, physical care, or guidance is interrupted or terminated;
- o whether the municipality in which the parent resides pays tuition to the municipality where the child attends public school; and,
- o frequency of contact between parent and child.

DEPRIVATION OF PARENT SUPPORT**0328.15**

REV:07/1994

To satisfy the eligibility factor of deprivation, a child must be deprived of support or care by the natural or adoptive parents due to:

- o The continued absence of a parent from the home; or,
- o The death of a parent; or,
- o The physical or mental incapacity of one natural (or adoptive) parent; or,
- o The unemployment of the natural (or adoptive) father or mother.

In situations where a parent(s) is separated from the child because a parent has placed him/her with a relative (or agreed to placement with a relative), it is necessary to determine that the child and the child's primary family is eligible based on one of the deprivation factors.

Also, when a child who does not have a poverty level characteristic is living with both of his/her natural or adoptive parents, whether or not they are married to each other, the child is not eligible,

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except if s/he meets the definition of incapacity of a parent or unemployment of a parent.

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Deprivation, Continued Absence

REV:07/1994

A child is considered eligible on the basis of continued absence, when either or both the natural or adoptive father or mother is absent from the home, and this absence interrupts or terminates the parent's functioning as a provider of maintenance, physical care and/or guidance for the child. This absence, furthermore, precludes counting on the parent's performance of this function in planning for the present support or care of the child for a known or indefinite period. If these conditions exist, the parent may have left only recently or sometime previously. Absence of the parent may be due to any of the following:

- o Divorce;
- o Divorce action in progress;
- o Legal separation;
- o Imprisonment;
- o Unmarried parent;
- o Agreement to live apart;
- o Search for employment;
- o Employment away from home;
- o Desertion or abandonment, which may also be present in other absence reasons such as a search for employment, employment away from home or an agreement to live apart.

A parent whose absence is occasioned solely by reason of the performance of active duty in a uniformed service of the United States is not considered absent from the home. (Uniformed Service means Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration and the Public Health Service of the United States).

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In addition, a child is considered deprived of parental support by continued absence of a parent when:

- o A parent has been convicted of an offense and is under sentence of a court;
- o The sentence requires and the parent is performing unpaid public work or unpaid community service during working hours; and,
- o The parent is permitted by the court to live at home while serving the sentence because of crowded jail conditions or for other reasons in the public interest.

The continuing existence of the factor of absence must be determined whenever there is an indication of change and at least once in every six-month period.

Evidence of Parental Absence**0328.15.05.05**

REV:07/1994

The eligibility technician has the responsibility through observation and evaluation of the facts submitted to determine that the parent is in fact absent. When there has been a divorce or legal separation, or if divorce action is in process, the eligibility technician examines any documents, such as current court decree, letter from attorney, etc. as substantiating evidence. In other situations, a letter from the absent parent, information about the absent parent's address, employment, or other pertinent information is used.

Referral to Child Support**0328.15.05.10**

REV:01/2002

With the exception of pregnant women, the eligibility technician will refer the family with an absent parent via InRHODES to Rhode Island Child Support Enforcement (CSE). As a condition of eligibility, the individual is required to cooperate in establishing the paternity of a child born out of wedlock for whom the individual can legally assign rights and in obtaining medical care support and medical care payments for himself/herself, as well as for any other person for whom the

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individual can legally assign rights. The individual is also required to cooperate in identifying and providing information to assist CSE in pursuing any third party which may be liable to pay for care and services provided by MA.

0328.15.10**Deprivation by Death**

REV:07/1994

For a child to be eligible on the basis of death, either or both the natural or adoptive father or mother of the child must be deceased. This information is specified on the DHS-2.

Verification of this factor can be made through the death certificate, a newspaper obituary, an RSDI award letter, VA death payment letter, insurance death settlement letter, funeral director records, hospital records, military service records, GPA burial payment, lodge, club or fraternal organization record, or police record.

0328.15.15**Deprivation, Phy/Mental Incap**

REV:07/1994

A child satisfies the parental incapacity requirement when one parent (natural or adoptive) has a physical or mental defect, illness, or impairment which is substantiated by competent medical authority. An existing physical or mental condition that precludes a parent (father or mother) from employment or from providing care to the child(ren) establishes deprivation without regard to whether such parent was supporting the family or caring for the child(ren) prior to becoming incapacitated. The incapacity must be of such a debilitating nature as to reduce substantially or eliminate the parent's present ability to support or care for the child(ren). The incapacity must be expected to last for a minimum of 30 days.

When at least one child in a family is eligible due to the incapacity of the natural or adoptive parent in the home, eligibility exists for all eligible children, the parent, and the child's other parent with whom the child is living, or the incapacitated parent's spouse with whom the child is living. The term "natural parent" means natural or adoptive parent. The term "spouse" means an individual who is the husband or wife of the child's own parent by reason of a ceremonial or other legal marriage. The wife or husband need not be the natural or adoptive mother or father, but

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the eligibility factor of incapacity must exist for the natural or adoptive parent.

In making the determination of ability to support the child, the eligibility technician should take into account the limited employment opportunities of handicapped individuals.

A parent must accept medical treatment likely to enable him or her to work or to care for the child(ren).

Evidence of Parental Incapacity

0328.15.15.05

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The medical evidence of incapacity can be either oral or in writing but must be identified as to the source of information and the date. The information must be recorded on a C1-b and filed in the case record.

The statement must indicate what the incapacity is (diagnosis), what effect it has on the ability of the parent to provide support or to care for the needy child, how long the condition is expected to continue, and any recommendations for care or treatment.

Evidence for RSDI or SSI Beneficiaries:

A finding of eligibility for RSDI or SSI benefits based on disability or blindness is acceptable proof of the parent's incapacity for AFDC purposes.

Evidence for mental retardation as Incapacity Factor:

An individual psychometric examination showing an I.Q. of 70 or less is evidence that a parent is mentally retarded. This evidence must be substantiated by the use of the C1-b.

Previous examination reports, available from school records, court and probation records, state schools, or from files of other agencies, may be used as evidence, provided the examination was an individual one given within five (5) years.

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Continuing Elig, Parental Incap

REV:01/2002

The eligibility technician has the responsibility to determine that incapacity continues to exist:

- o At least once in every six (6) months or twelve (12) months; or,
- o At the time the previous medical report showed that a potential change might occur.

The review of incapacity for continuing eligibility includes a current medical report giving the diagnosis and all the information for initial eligibility.

A period of eligibility up to three (3) months after recovery from an incapacity is provided, if needed, and if the need exists in order to enable the parent to re-establish himself/herself in assuming responsibility for his/her family. A need would exist if the parent does not have the present ability to provide support or care for the child(ren).

0328.15.20

Deprivation by Parent Unemployment

REV:01/2002

A child satisfies the unemployment of parent requirement only if s/he is not eligible on the basis of any other deprivation factor and if the person who is unemployed is the natural or adoptive parent (mother or father) of the child.

When at least one child in a family is eligible due to the unemployment of the natural or adoptive parent in the home, eligibility exists for all eligible children, the natural or adoptive qualifying unemployed parent, and the child's other parent with whom the child is living or the unemployed parent's spouse with whom the child is living. The term "spouse" means the husband or wife of the child's natural or adoptive father/mother, by reason of a ceremonial or other legal marriage. The wife (spouse) need not be the natural or adoptive mother. The husband (spouse) need not be the natural or adoptive father.

The information given by the applicant on the DHS-2 regarding the employment history of the child's natural or adoptive parent must be verified to establish the unemployment factor.

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For the child(ren) to be eligible for this program, the qualifying unemployed parent must be the principal earner and must meet the definition of unemployment specified in Section 0328.15.20.05.

The principal earner is the parent, in a home in which both parents of the child(ren) are living, who earned the greater amount of gross income in the 24-month period the last month of which immediately precedes the month in which an application is filed on the basis of unemployment of a parent. The parent who is determined to be the principal earner remains the principal earner for each consecutive month for which the family receives assistance on the basis of such application.

If the agency cannot secure primary evidence of earnings for this period, the eligibility technician shall designate the principal earner based on the best evidence available.

If both parents earned an identical amount of income in the twenty-four month period, the eligibility technician designates which parent shall be the principal earner.

Definition of Unemployment

0328.15.20.05

REV:01/2002

To meet the definition of unemployment, the parent who is the principal earner must be:

- o Unemployed for at least thirty days prior to the effective date of the payment; or,
- o Employed but working less than 100 hours a month, prior to the effective date of the payment.

If the parent worked fewer than 100 hours during the 30-day period prior to acceptance, eligibility exists even though, during part of the time, s/he may have worked full-time.

The definition of unemployment may also be met if the parent is employed more than 100 hours during a particular month, but the work is intermittent and the excess is of a temporary nature, shown by the fact that s/he has worked fewer than 100 hours for the two prior months and is expected to work fewer than 100 hours a month during the next month.

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In determining eligibility under this definition, vacation or sick pay is not counted as hours of work in determining the total monthly hours.

An exception to the above is a parent whose unemployment results from participation in a strike. A strike does not meet the definition of unemployment for MA eligibility purposes.

0328.20**EXCEPTIONS TO CHARACTERISTICS**

REV:01/2002

Federal law provides for several family MA coverage groups whose eligibility is based on rules which depart from the requirement of dependency due to deprivation (absence, death, incapacity, unemployment) or receipt of cash assistance (SSI or FIP).

These family coverage groups include:

- 1) pregnant women (including Rite Care waiver pregnant women;
- 2) poverty level children (including Rite Care waiver children;
- 3) FIP families;
- 4) Section 1931 families (up to 110% FPL); and
- 5) MA Waiver families (up to 185% FPL).

0328.20.05**Children Under 19**

REV:07/1999

In general, eligibility for Medical Assistance may exist for:

- o a child under nineteen (19) years of age whose family income does not exceed 250% of the federal poverty level (FPL), as categorically needy;
- o a child under eighteen (18) years of age whose family income exceeds 250% of the federal poverty level (FPL), as medically needy after meeting the requirements of the flexible test of income policy (see section 0336);

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- o a child under one year of age, born to and living with a woman who was eligible and receiving Medical Assistance at the time of the child's birth, as categorically needy or medically needy depending on the mother's category of Medical Assistance.

See Section 0348 for detailed information regarding Medical Assistance for children.

Pregnant Women

0328.20.10

REV:05/1997

In general, eligibility for Medical Assistance may exist for the duration of the pregnancy and for 60 days postpartum for:

- o a pregnant woman whose family's countable income does not exceed 350% of the federal poverty level (FPL), as categorically needy;
- o a pregnant woman whose family's countable income exceeds 350% (250-350% is a state funded group) of the federal poverty level (FPL), as medically needy after meeting the spenddown requirements of the medically needy flexible test of income policy (see section 0336).

See Section 0348 for detailed information regarding Medical Assistance for pregnant women.

Section 1931 and MA Waiver Families

0328.20.15

REV:01/2002

In general, eligibility for family Medical Assistance Only may exist without regard to deprivation for:

- o a pregnant woman;
- o a child under eighteen years of age* whose family's countable income does not exceed 185% of poverty;
- o a parent, or parents, of an eligible child (SSI or family-related MA) whose countable income does not

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exceed 185% of poverty;

- o a caretaker relative of an eligible child (FIP, SSI, or family-related MA) whose countable income does not exceed 185% of poverty.

* See "in-school extension" as defined in Section 0328.20.05.

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INCOME STANDARDS - FAMILIES**0330.05**

REV:04/2002

FAMILY INCOME ELIGIBILITY STANDARDS

Income eligibility will exist if the family's countable monthly income does not exceed the appropriate limit for the family size. Family size includes an unborn; if medical documentation shows multiple births are expected, add as documented.

FAMILY CATEGORICALLY NEEDY MONTHLY INCOME LIMITS

1 Person	\$ 327.00	5 Persons	\$ 714.00
2 Persons	449.00	6 Persons	794.00
3 Persons	554.00	7 Persons	874.00
4 Persons	634.00	8 Persons	954.00

MEDICALLY NEEDY MONTHLY INCOME LIMITS

1 Person	\$ 641.67	5 Persons	\$1,075.00
2 Persons	683.33	6 Persons	1,216.67
3 Persons	841.67	7 Persons	1,333.33
4 Persons	958.33	8 Persons	1,466.67

2002 FEDERAL POVERTY LEVEL MONTHLY INCOME GUIDELINES

100% OF FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR TITLE XIX CHILDREN BORN AFTER SEPTEMBER 30, 1983, WHO HAVE ATTAINED THEIR SIXTH (6TH) BIRTHDAY, BUT HAVE NOT ATTAINED THEIR NINETEENTH (19TH) BIRTHDAY.

1 Person	\$ 738.33	5 Persons	\$1,765.00
2 Persons	995.00	6 Persons	2,021.67
3 Persons	1,251.67	7 Persons	2,278.33
4 Persons	1,508.33	8 Persons	2,535.00

110% of FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR SECTION 1931 FAMILIES AND FOR RETROACTIVE ELIGIBILITY FOR CERTAIN FAMILIES (See Section 0310.05)

1 Person	\$ 812.17	5 Persons	\$1,941.50
2 Persons	1,094.50	6 Persons	2,223.83
3 Persons	1,376.83	7 Persons	2,506.17
4 Persons	1,659.17	8 Persons	2,788.50

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133% OF FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR TITLE XIX CHILDREN WHO HAVE ATTAINED THEIR FIRST (1ST) BIRTHDAY, BUT HAVE NOT ATTAINED THEIR SIXTH (6TH) BIRTHDAY.

1 Person	\$ 981.98	5 Persons	\$2,347.45
2 Persons	1,323.35	6 Persons	2,688.82
3 Persons	1,664.72	7 Persons	3,030.18
4 Persons	2,006.08	8 Persons	3,371.55

150% OF THE FEDERAL POVERTY INCOME GUIDELINES - RELATED TO COST SHARING REQUIREMENTS FOR RITE CARE AND RITE SHARE FAMILIES (See Section 0348.40 and 0349.10.20.15)

1 Person	N/A	5 Persons	\$2,647.50
2 Persons	\$1,492.50	6 Persons	3,032.50
3 Persons	1,877.50	7 Persons	3,417.50
4 Persons	2,262.50	8 Persons	3,802.50

185% OF FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR TITLE XIX WAIVER FAMILIES, CHILDREN UNDER ONE (1) YEAR OF AGE, AND PREGNANT WOMEN.

1 Person	\$1,365.92	5 Persons	\$3,265.25
2 Persons	1,840.75	6 Persons	3,740.08
3 Persons	2,315.58	7 Persons	4,214.92
4 Persons	2,790.42	8 Persons	4,689.75

250% OF FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR RITE CARE PREGNANT WOMEN, NEWBORNS AND CHILDREN UNDER NINETEEN (19) YEARS OF AGE.

1 Person	\$1,845.83	5 Persons	\$4,412.50
2 Persons	2,487.50	6 Persons	5,054.17
3 Persons	3,129.17	7 Persons	5,695.83
4 Persons	3,770.83	8 Persons	6,337.50

350% OF FEDERAL POVERTY LEVEL INCOME GUIDELINES FOR STATE FUNDED RITE CARE PREGNANT WOMEN.

1 Person	\$2,584.17	5 Persons	\$6,177.50
2 Persons	3,482.50	6 Persons	7,075.83
3 Persons	4,380.83	7 Persons	7,974.17
4 Persons	5,279.17	8 Persons	8,872.50

0330.10**INCOME DEFINITIONS**

REV:07/1994

INCOME is the receipt of money, goods, or services to meet need. It must be both available and computable. Income is considered available when it is actually available, or when the applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and mainte-

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nance. The income must be under the control of the individual during the period for which need is being determined, or can be available, should action be taken by the individual to obtain it.

Certain types of income are EXCLUDED, i.e. not considered, under Medical Assistance rules. (See section 0330.20). Furthermore, portions of income may be DISREGARDED (deducted) before arriving at the family's COUNTABLE income. Once it is determined, the family's countable income is compared to the appropriate standard. If countable income is equal to or less than the standard, eligibility exists. If countable income exceeds the standard, eligibility is not established for Poverty Level and Categorically Needy, but Medically Needy eligibility may be possible via a spend down.

DOCUMENTATION OF INCOME**0330.15**

REV:07/1994

The income information provided by the applicant on the DHS-2 must be verified. Documentation sources are business records, wage stubs, income tax returns, award letters, reports from Social Security, Veterans' Administration, and other agencies. In some instances, when the applicant is unable to obtain the information requested, Departmental forms (Wage Report, AP-50; Bank Clearance, AP-91; Clearance with VA, AP-150 and AP-151) are used. When an applicant appears potentially eligible for another program such as RSDI, ESB, TDI or VA benefits, s/he is required to file for such ben

EXCLUDED INCOME**0330.20**

REV:01/2002

In determining eligibility for family-related MA coverage, the following kinds of income are excluded:

- o The value of U.S. Department of Agriculture donated foods;
- o Any payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;
- o Any grant or loan for an undergraduate student for educational purposes made or insured under any programs administered by the U.S. Commissioner of Education;

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- o Payments distributed per capita to, or held in trust for, members of any Indian tribe under Public Law 92-254, Public law 93-134 or Public law 94-540;
- o Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;
- o Payments for supportive services or reimbursement of out-of-pocket foster grandparents, senior health aides or senior companions, and to persons serving in the Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) and any other program under Title II and Title III of the Domestic Volunteer Service Act of 1973;
- o Payments to individual volunteers under Public Law 96-143, the Domestic Volunteer Service Act of 1979, which governs the Volunteers in Service to America (VISTA) Program, unless the total of said payments, when the number of hours served is considered, equals or exceeds the Federal minimum wage. (Implementation of the qualified VISTA exclusion is on abeyance pending clarification of Federal regulations. Therefore, until further notice, all VISTA payments are totally excluded);
- o The value of supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Fund Act, as amended, (Public Law 92-433 and Public Law 93-150);
- o Payments of Experimental Housing Allowance Program made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended;
- o Receipts distributed to members of certain Indian tribes which are referred to in Section 5 of Public Law 94-114 that became effective October 17, 1975;
- o Tax exempt portions of payments made pursuant to the Alaska Native Claims Settlement Act, Public Law 92-203;
- o Foster care payment paid by the Department for Children, Youth and Families;
- o The value of food stamp benefits;

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- o The value of government rent and/or housing subsidies;
- o Income from college work study programs;
- o Funds awarded under PL 98-123 to the Red Lake Band of Chippewa Indians;
- o Funds awarded under PL 98-124 to the Assiniboine Tribe of the Fort Belknap Indian Community, and the Assiniboine Tribe of the Fort Peck Indian Reservation;
- o Up to the first \$50 per calendar month collected for or received by an assistance unit and representing either payment on a current monthly support obligation or a voluntary support payment;
- o The earned income of a dependent child who is a full-time student; if the child is a part time student, earnings will be disregarded as long as the child is not a full time employee;
- o For six (6) months per calendar year, a dependent child's earned income derived from a JTPA program;
- o A transportation allowance paid under the auspices of a work or training program, such as Pathways program, Employment Search, or a JTPA program;
- o In accordance with PL 100-485, the refund of taxes under the earned income tax credit (EITC), or the advance payment of the EITC;
- o Loans and grants, such as scholarships, obtained and used under conditions that preclude their use for current living costs.

EARNED INCOME**0330.25**

REV:01/2002

Earned income is the receipt of wages, salary, commissions, or profit from activities in which the applicant is engaged as a self-when it is received (or would have been received except for the decision of the recipient to postpone receipt) rather than when earned. It includes earnings over a period of time for which settlement is made at one given time. Income which the individual

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produces as a result of service, including managerial responsibilities, is classified as earned income. (Examples are income from a lodger or boarder and income from real estate property).

Earned income does not include returns from capital investment with respect to which the individual is not actively engaged, such as dividends and interest. It also does not include benefits such as individual pensions, RSDI, UCB, TDI or Veterans' Benefits.

0330.25.05**Earned Income From Wages**

REV:01/2002

Any legal attachment on wages is considered unavailable and not counted. Under current law, the first \$50 of any pay is exempt from attachment, and no attachment can be placed on the wage of a current or former Family Independence Program (FIP) recipient for one (1) year following the termination of assistance. If an attachment exists, the recipient is referred to Rhode Island Legal Services.

0330.25.10**Earned Income From Self-Employment**

REV:07/1994

When a business is carried on at home, no part of the overhead is considered as a business expense, except as specified in Section 0330.25.10.05. Those self-employed work expenses directly related to producing the goods or services and without which the goods or services could not be produced shall be excluded.

However, items such as depreciation, personal business and entertainment expenses, personal transportation, purchase of capital equipment, and payments on the principal of loans for capital assets or durable goods are not excluded.

Income considered from self-employment is the difference between the amount of gross receipts and the amount of allowable operating expenses incurred in producing the income.

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Payment for Providing Child Care Services

0330.25.10.05

REV:07/1994

Income received by providing child care services is considered earned income from self-employment. The income must be verified from information provided by the applicant/recipient.

For purposes of this section, child care services are defined as any care of a child or incapacitated adult for which the provider receives payment, whether by a public or private agency or a private party. The provider need not be a licensed Day Care Mother. Casual baby-sitting, for which the baby sitter is paid, qualifies as "child care services".

Expenses of earning such income are deductible. Such expenses include household items, wear and tear on household furnishings, and the increased cost of utilities if the service is provided in the provider's home. Special equipment needed by the person receiving care, and furnished by the provider is also deductible regardless of where the service is provided. The average total expense of providing child care is \$32.00 per week per child. (If the household can document cost in excess of the applicable average amount, the actual cost can be considered).

Earned Income From Roomer/Boarder

0330.25.15

REV:01/2002

When an applicant/recipient receives income from a roomer or boarder, the amount considered as income is computed by subtracting from the amount paid the following cost of maintaining such lodger or boarder. However, if the household can document cost in excess of the amount indicated, the actual cost can be considered as follows:

**Monthly Cost
of Maintenance**

Roomer:	\$ 25.00
Boarder:	134.00

Board Payment for a foster child paid by the Department for Children and their Families to a FIP or MA applicant/recipient parent is disregarded.

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Earned Income From Real Property

REV:07/1994

When the applicant owns and lives in the rental property, the tenant's share of the following property expenses is deducted from gross rental income to determine the amount of money to be applied as net income of the applicant:

- o Mortgage, including principal and interest, taxes, insurance, water, sewer charges and special monthly assessments for sewer installation; and,
- o The cost of the tenant's heat, gas and electric if provided in the rent by the homeowner.

To determine the net income of a property owner-applicant living in a two-family dwelling, one-half (1/2) of the expenses in (a) plus the expenses in (b) are deducted from the gross rental; in a three-family dwelling, two-thirds (2/3) of the expenses in (a) plus the expenses in (b) are deducted; in a four-family dwelling, three-fourths (3/4) of the expenses in (a) plus the expenses in (b) are deducted.

When the applicant does not live in the rental property (which is within the \$1,000 Resource Limit) the income is determined by subtracting from the gross rental income the expenses of maintaining the property outlined above.

0330.30

EARNED INCOME DISREGARDS

REV:11/1998

When determining financial eligibility for all non-cash categories of family MA, the following earned income is disregarded:

- o Exclusion of Earnings of a Dependent Child
Disregard all the monthly earned income of each dependent child from the financial unit's income.
- o Work Expense Disregard
Ninety (\$90) dollars from the monthly gross income for each person employed is disregarded.

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o Dependent Care Disregard

After the work expense disregard is applied, the dependent care disregard is applied. The dependent care disregard (DHS Day Care Subsidy plus the individual's copayment) allows a disregard not to exceed \$175 per month per child age two (2) years and older or an incapacitated adult. For a child under the age of two (2) years, this disregard may not exceed \$200 per month. Payments actually made for dependent care must be verified. Consideration of the dependent care expense is only given when the care is provided by a person not living in the child's or incapacitated adult's household.

o \$50.00 Child Support Disregard

A \$50.00 child support disregard is applied to the gross amount of the family's total child support income from all sources.

OTHER SOURCES OF INCOME**0330.35**

REV:07/1994

Income may come from many sources beyond employment. The eligibility technician needs to be aware of the possible sources of income described in the following sections.

Fed/State Insurance, UCB, TDI**0330.35.05**

REV:01/2002

An applicant or recipient of MA who has worked in the past 52 weeks is required to file a claim for either Unemployment Compensation Benefits (UCB) or Temporary Disability Insurance (TDI) and advise the eligibility technician of the results. An AP-152 is used to verify the amount of or the receipt of benefits. UCB and TDI reports are funneled through InRHODES and will be reflected on the eligibility technician's daily reports.

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0330.35.05.05 Unemployment Compensation Benefits (UCB)

REV:01/2002

Unemployment Compensation benefits are available to unemployed persons who satisfy certain work history and minimum earnings criteria. The individual's benefit level depends on his or her wage history. To qualify for employment security benefits, a person must be able to, and be available for, work. In addition to eligible former employees of private employers, civilian employees of the federal government, ex-servicemen and most ex-stat

A claimant is entitled to a dependent's allowance for each dependent child under the age of 18 years (or over 18, if the child is mentally or physically handicapped) up to a maximum of five (5) children.

0330.35.05.10 Temporary Disability Insurance

REV:07/1994

To be eligible for TDI benefits, a claimant must be unable to work because of illness and meet certain work history and wage requirements.

The actual number of weeks a claimant may collect benefits is based not only on work history and prior earnings, but also on the specific length of time that the claimant's physician certifies that s/he is unable to work (up to a maximum of 30 weeks in any benefit year). The benefit year is the 52 weeks following the effective date of an initial claim.

A claimant is entitled to a dependent's allowance for each dependent child, including an adopted or stepchild under the age of 18 years (or over 18 if the child is mentally or physically incapacitated) up to a maximum of five (5) children. An otherwise eligible individual who is unemployed due to sickness resulting from pregnancy is entitled to receive benefits in the same manner as any other non-work related illness.

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Workforce Investment Act

0330.35.10

REV:01/2002

The Workforce Investment Act (WIA) is a program funded by the United States Department of Labor to provide employment and training programs for eligible individuals and dislocated workers.

Earned income under the auspices of a WIA program is subject to the MA income disregard provisions. Accordingly, after the appropriate disregards, income is counted in determining MA income eligibility.

Incentives are considered in the same manner as earnings.

An allowance provided by WIA is excluded if it is provided for specific goods or services not included in the FIP standard of need. For example, a transportation allowance to meet an expense resulting from participation in a WIA program is totally disregarded.

For minor participants, income derived from a WIA program is disregarded when earned by a dependent child on FIP. Such income is excluded from consideration relative to determining the family's eligibility and the amount of assistance grant for a period not to exceed six (6) months per calendar year. However, if the child is a full-time student or a part-time student but not a full-time employee, policy relative to disregard of a student's earning applies.

RSDI Income

0330.35.15

REV:07/1994

The total amount of benefits received from RSDI by a member of the assistance unit is considered as income. When a child receives RSDI, the caretaker relative does not have the option of excluding that child from the financial unit.

A person or a specific relative must have been a wage earner or a self-employed person for a certain length of time in employment covered by the Social Security Act. Referral to SSA must be made for determination of eligibility and continued MA eligibility is dependent upon acceptance of this income. Sections 0330.35.15.05 through 0330.35.15.20 are a guide for identifying those who may be

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eligible. Persons eligible for specific benefits are listed.

0330.35.15.05 Retirement Benefits

REV:01/2002

Retirement benefits can be paid to:

- o The insured wage earner or self-employed person who is eligible or can elect to receive actually reduced benefits at age 62. Although the Social Security Act makes this provision elective (receipt of benefits age 62), eligibility for FIP or MA benefits is dependent upon acceptance of this source of income at age 62.
- o The spouse of a retired or disabled worker who:
 - Is age 62 or over; or,
 - Has in care a child under age 16 or over age 16 and dis-abled, who is entitled to benefits on the worker's Social Security record.

A spouse is eligible, if the marriage has been in effect for one year and in some instances, less than a year. Spouses of defective ceremonial marriages entered into in good faith are also eligible.

- o The divorced spouse of a retired or disabled worker if age 62 or over and married to the worker for at least ten years.
- o The divorced spouse of a fully insured worker who has not yet filed a claim for benefits if both are age 62 or over and have been finally divorced for at least two continuous years.
- o The dependent, unmarried child of a retired or disabled worker entitled to benefits, if the child is:
 - Under age 18;
 - Age 18 or over but under a disability which began before age 22.

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This includes children born of natural parents, adopted children, step-children or children born out of wedlock.

Survivorship Benefits

0330.35.15.10

REV:07/1994

Relatives of a deceased insured wage earner or self-employed person who may be eligible to receive monthly benefits include:

- o The surviving spouse, (including a surviving divorced spouse) if the widow(er) is age 60 or over;
- o The disabled surviving spouse, (including a surviving divorced spouse in some cases) if the widow(er) is age 50-59 and becomes disabled not later than seven (7) years after the worker's death, or in case of a widow(er), within seven (7) years after s/he stops getting checks as a widow(er) caring for a worker's children;
- o The surviving spouse, or surviving divorced spouse if caring for an entitled child (under age 16 or disabled) of the deceased;
- o The dependent, unmarried child of a deceased insured worker if the child is:
 - Under age 18; or,
 - Age 18 or over but under a disability which began before age 22.
- o The dependent parents of a deceased worker at age 62 or over.

Lump Sum Death Benefits

0330.35.15.15

REV:07/1994

A lump sum death benefit of \$255 is payable upon the death of an insured worker to certain relatives. This payment is made in the following order of priority:

- o To the spouse who was living in the same household with the worker at the time of death;

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- o To the spouse (excluding a divorced spouse) who is eligible for a widow(er)'s benefits for the month of death;
- o To children who are eligible for benefits on the worker's record for the month of death.

0330.35.15.20 Disability Benefits

REV:07/1994

A worker who becomes severely disabled before age 65 can get disability checks. The disability must be a severe physical or mental condition which prevents employment and is expected to last (or has lasted) for at least 12 months, or is expected to result in death.

Benefits may begin as early as the 6th full month of disability and continue as long as the disability exists. If a person is severely disabled, benefits can be paid even though the person can do some work.

Dependent's benefits may be paid to certain members of a disabled worker's family as in the case of a retired worker.

0330.35.15.25 Requesting Info from Social Sec

REV:07/1994

The SSA-1610 is used for claim development, for information on pending claims or for determining information relative to the type of SSA benefit which cannot otherwise be ascertained.

The form is always sent in duplicate to the appropriate SSA district office servicing the area. The eligibility worker initiates the form by completing page 1, signing it, and entering his/her name and return address in the space provided on the reverse side.

If the claim is pending, the second copy of the SSA-1610 is used to acknowledge the referral and the original is returned with the completed information, when the claim is adjudicated. If there is

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no record of a claim or recent inquiry, the SSA processes the referral as a claim lead, develops the claim and arranges for a personal interview with the person, if necessary. When the claim is adjudicated, the completed form is returned to the agency. If adjudication is to be delayed more than thirty (30) days, the agency is so advised on the second copy of the SSA-1610. If the person does not contact SSA within thirty (30) days after a personal interview, the SSA office returns the original SSA-1610 to the agency with the notation that no application was filed and that SSA will take no follow-up action with the person. SSA retains the person's record in the pending file for an additional thirty (30) days to give the agency time to follow up with the person as to why s/he has not applied for benefits.

Employment Pensions**0330.35.20**

REV:07/1994

Many employers provide for retirement or disability pensions for their employees under specific conditions. Among them are local governments, industrial plants, stores, and railroad and steamship companies. If an applicant/recipient has had employment of ten (10) or more years with any one employer, the possibility of eligibility for a pension exists and must be explored.

Veterans Administration Benefits**0330.35.25**

REV:07/1994

All applicants and recipients who have been other than dishonorably discharged from any branch of the armed services should apply for VA benefits and/or services. An individual may be eligible as a veteran who served during wartime or specific periods of qualifying peacetime, who is disabled or non-disabled, or who has a disability that is service connected or not. Dependents and survivors of the veteran may also be eligible. Stepchildren, if living with the stepparent, may receive an allowance based on the stepparent's benefits.

Potentially eligible individuals may be referred directly to:

Veterans Regional Office
380 Westminster Street
Providence, RI 02903

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Telephone: 273-4910

If the individual questions whether there is eligibility for a specific program or benefit, or needs help in completing the application, referral may be made to:

Veterans Affairs
Metacom Avenue
Bristol, RI 02809
Telephone: 277-2488

An AP-150 is used to verify benefits for the veteran and an AP-151 is used to verify benefits for the dependent.

When payments are received under a Veterans Educational Assistance Program by recipients who are otherwise eligible for MA, consideration can be given to certain educational expenses. That part of the assistance which is the verified amount that is used for tuition, books, fees, equipment, special clothing needs and transportation for school purposes is not considered as income in the determination of income eligibility.

0330.35.30

Workers' Compensation

REV:07/1994

Under the Workers' Compensation Act, benefits are payable if an employee sustains a personal injury arising out of or in the course of employment or develops an occupational disease. The possibility of this resource should be discussed with the injured applicant/recipient and follow-up made if this is potential income. Based on third party liability, Workers' Compensation benefits are subject to the assignment by the injured worker and receipt by DHS of Medical Assistance payments which are related to the accident, injury or illness for which a third party may be liable. (See section 0308.10.10, Cooperation Requirements).

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Insurance Settlement**0330.35.35**

REV:07/1994

Money received from an insurance settlement is considered as a lump sum resource. If the insurance settlement is a result of fire, flood, lightning or severe wind, and if it is used to repair or replace the property lost because of the fire, flood, lightning or severe wind, it is not considered as a resource.

Money/Goods From Other Agencies**0330.35.40**

REV:07/1994

When another agency provides money or goods to an applicant or recipient on an irregular basis, it is not considered as income to be applied to the applicant unit.

Relative Contribution**0330.35.45**

REV:07/1994

Regular and/or substantial contributions by relatives or friends living with or apart from the MA family is considered income. Gifts and contributions of small value and occurring infrequently for special occasions or as expressions of affection are not related to support and are not considered income.

Child Support Income**0330.35.50**

REV:07/1994

For purposes of this section, child support is defined as financial support, voluntary or court ordered, paid by an absent parent on behalf of his/her natural or adopted child(ren).

The Child Support Disregard (sometimes called a bonus) is defined as a dollar amount not counted for purposes of the MA Program. The Child Support Disregard is a disregard of up to \$50 per family total, per calendar month, collected for or received by the child and representing payment on a current monthly support obligation or a voluntary support payment. The remainder of the monthly support is counted as unearned income. (Note: That portion of a child support payment that exceeds the current

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monthly support obligation is not subject to disregard).

0330.35.55**Inc for Ind Pursuing an Educ**

REV:07/1994

Grants and loans to any undergraduate student for educational purposes made or insured under any program administered by the Commissioner of Education under the Higher Education Act must be totally disregarded. There are four programs of student assistance in the form of loans and grants supported by the U.S. Office of Education. These are Basic Education Opportunity Grant Program (BEOG) or Basic Grants; Supplemental Educational Opportunity Grants (SEOG); National Direct Student Loans (NDSL); and Guaranteed Student Loans.

University Year for Action is a service-learning program authorized under Title I of the Domestic Volunteer Service Act of 1973. It is a program of full-time volunteer service by students enrolled in institutions of higher education. Payments to volunteers shall not be counted in the determination of need and amount of assistance to be paid.

0330.35.55.05**Treatment of VA Educ Assis**

REV:07/1994

The Veterans Administration sponsors several different educational assistance programs. One does not have to be a veteran to qualify for assistance under some of the programs. Anyone receiving educational assistance receives an award letter indicating the amount to be received and the period of time for which it will be received.

In determining MA eligibility, that part of the VA educational assistance payment that is for the individual's dependents is counted as available income. The verified amount from the student's portion that is used for tuition, books, fees, equipment, special clothing needs, and transportation for school purposes is not considered as income.

The total amount of the approved educational expenses is deducted, up to the amount of the individual's benefit. Only the balance, if any, is entered as income.

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Fed or Non-Fed Supported Source**0330.35.55.10**

REV:07/1994

Individuals may receive scholarships, grants and awards from federally supported sources such as the Bureau of Indian Affairs (BIA); state sources; civic, fraternal and alumni/alumnae organizations; from relatives; or because of verified needs, achievements or a combination of such reasons. That portion of the scholarship, grant or award which is used for tuition, books, fees, equipment or transportation for school purposes is disregarded as income in the determination of MA eligibility.

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MEDICAL ASSISTANCE**BUDGET PERIODS****SECTION 0332**

DEFINITION OF A BUDGET PERIOD**0332.05**

REV:07/1994

A BUDGET PERIOD is the period of time against which the applicant's income is measured for the purpose of determining income eligibility. Categorically Needy cases have a one-month budget period. Medically Needy cases have a six-month budget period.

When a change in circumstances occurs within a 6-month budget period, the current budget period is shortened and a new budget period begun.

MEDICALLY NEEDEY BUDGET PERIODS**0332.10**

REV:01/2002

An applicant who meets all other eligibility requirements, but has income in excess of the Medically Needy income limits for the size of his/her family may be eligible for MA in accordance with the Flexible Test of Income (See Section 0336 - Flexible Test of Income).

Flex Test cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) receipts for medical services incurred during the period of determination and/or 2) unpaid bills incurred either during the current period of determination and/or prior to application for which the individual is still liable equal to the amount of such excess income. If the applicant is determined eligible via spenddown, the applicant is certified for six months or for the balance of the six (6) month budget period remaining when the excess income is absorbed.

FLEX CASES - Cases achieving Medically Needy eligibility because of having met a spenddown are initially approved for the balance of the original six-month budget period. Such case will automatically close on the last day of this six-month certification period. The new flex test six-month budget period will begin the next day.

For example, a case's original flex test 6-month budget period is January 1 through June 30th. The case meets spenddown on March 22nd. The case is approved eligible beginning March 22nd and the certification period is for the balance of the six month period (March 22nd to June 30th). The case auto closes June 30th. The

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case begins new flex test 6-month budget period July 1st.

FIP CASE WITH CURRENT MONTH CLOSING - When a FIP case is closed due to excess income only, the FIP portion of the case is discontinued and eligibility for continued Medical Assistance is redetermined. If the income is in excess of Medically Assistance Income Limits, the MA case is closed. The first month of the new flex test six month budget period begins the month of the MA closure.

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DETERMINING INCOME ELIGIBILITY

SECTION 0334

INTRODUCTION

0334.05

REV:01/2002

Families applying for Medical Assistance are treated as financial units. Treating a family as a financial unit recognizes the reality that families do indeed function as a single economic unit. While not required to apply, an individual family member **MUST** be included when determining Medical Assistance eligibility for other family members if the individual has financial responsibility for another Medical Assistance applicant.

Certain types of income are excluded, i.e., not considered, under the rules of the Medical Assistance Program. For a list of the types of income excluded from Medical Assistance financial determinations, see Section 0330.20 of the Rhode Island Department of Human Services Manual.

In addition to excludable income, a portion of an individual's income may be disregarded (deducted). The Medical Assistance Program recognizes the \$90 work expense disregard, the dependent care disregard, and the \$50 child support disregard. The dependent care disregard (DHS Day Care Subsidy plus the individual's copayment) allows a disregard not to exceed \$175 per month per child, age two years and older or an incapacitated adult. For a child under the age of two years, this disregard may not exceed \$200 per month. Payments actually made for dependent care must be verified. Consideration of the dependent care expense is only given when the care is provided by a person not living in the child's or incapacitated adult's household.

When determining countable income, first eliminate excludable income. Next apply the \$90 work expense disregard to the earned income of each employed individual. If applicable, next apply the dependent care disregard to the family's income and finally, apply the \$50.00 child support disregard to the family's income. The balance of the earned income together with any unearned income is the countable income.

In Medical Assistance family-related income eligibility determinations, the amount of countable income must first be determined and then compared to the appropriate income standard. If countable income is equal to or less than the standard, eligibility exists. Eligibility for Medical Assistance cannot be established if the countable income is greater than the standard.

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SECTION 0334

DETERMINING INCOME ELIGIBILITY

0334.10

DEFINITIONS

REV:07/1994

To make a Medical Assistance financial determination, the following three components must be identified:

- o Household unit;
- o Applicant unit;
- o Financial unit.

0334.10.05

Household Unit

REV:01/2002

The Household Unit is comprised of ALL individuals listed on the MARC-1 Application or DHS-2 Statement of Need as living in the household. The Household Unit is used to:

- o Identify Medical Assistance applicants;
- o Evaluate members according to the FIP rules of relationship;
- o Assess financial responsibility; and,
- o When necessary, establish the characteristics of absence, unemployment, death and incapacity.

Each individual must be evaluated to determine if the individual:

- o Is a Medical Assistance applicant;
- o Is a relative of acceptable degree under the FIP rules of relationship;
- o Is financially responsible for another individual in the Household Unit who is a Medical Assistance applicant;
- o Requires a characteristic of program eligibility.

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MA Applicant Unit

0334.10.10

REV:07/1994

The Applicant Unit is used to identify those members of the Household Unit who are applying for Medical Assistance. The members of the Applicant Unit will form the foundation on which the third component, the Financial Unit, will be constructed.

Financial Unit

0334.10.15

REV:01/2002

The Financial Unit has two elements; the TOTAL NUMBER OF INDIVIDUALS in the financial unit and the TOTAL AMOUNT OF COUNTABLE INCOME those individuals bring to the financial unit. The Financial Unit is used to determine the amount of the family's countable income and the size of the Medical Assistance standard against which that income will be tested.

The Financial Unit draws its members only from the Household Unit. No consideration is given for support for individuals who do not live in the applicant household. A referral to Child Support Enforcement(CSE) initiates the process of obtaining support from absent members.

When constructing the Financial Unit, include the following household members and their countable income.

FIRST include:

- o All Medical Assistance applicants; and,
- o All household members for whom an applicant has financial responsibility.

NEXT include:

- o All household members who have financial responsibility for an applicant;
- o Any other household member for whom such individual has financial responsibility.

FINALLY, include, if not already included:

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DETERMINING INCOME ELIGIBILITY

- o The step-parent of an applicant minor child; and,
- o Any other household members for whom such individual has financial responsibility.

Therefore, when determining the Financial Unit, INCLUDE THE FOLLOWING INDIVIDUALS AND THEIR COUNTABLE INCOME:

- o IF THE APPLICANT IS A CHILD, include the applicant child. Also include the child's natural or adoptive parent(s) and minor siblings, and the child's step-parent and minor step-siblings (if any), if living in the household and whether or not they are applying.
- o IF THE APPLICANT IS A PARENT, include the applicant parent. Also include the parent's minor natural or adoptive children, the parent's spouse, and the parent's minor step-child(ren) (if any), if living in the household and whether or not they are applying.
- o IF THE APPLICANT IS A STEP-PARENT, include the applicant step-parent. Also include the step-parent's minor natural or adoptive children, the step-parent's spouse, and the step-parent's minor step-child(ren) (if any), if living in the household and whether or not they are applying.

0334.15

GROUP SIZE AND COUNTABLE INCOME

REV:07/1994

Once the financial unit has been constructed, determine:

- o The total number of individuals in the financial unit; and,
- o The total amount of countable income in the financial unit.

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STANDARD OF ELIGIBILITY**0334.20**

REV:07/1994

When the total number of individuals and the total amount of countable income of the Financial Unit has been determined, establish eligibility for each applicant as follows:

For EACH applicant:

- o Determine the individual's APPROPRIATE Medical Assistance income standard, e.g., one of the federal poverty level standards if the applicant is a poverty level pregnant woman or a poverty level child, or the categorically needy standard, or the medically needy standard;
- o Determine the amount of the standard to be tested based on a group size comparable to the TOTAL number of individuals in the Financial Unit;
- o Compare the TOTAL amount of countable income of the Financial Unit to the MA standard for the group size comparable to the total number of individuals in the Financial Unit.
- o Certify each ELIGIBLE APPLICANT for the correct scope of Medical Assistance benefits.

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USE OF EXCESS INCOME

0336.05

REV:01/2002

An applicant who meets the other eligibility requirements, but has income in excess of the Medically Needy income limits may be eligible for Medical Assistance in accordance with the Flexible Test of Income.

Flexible Test cases are determined for a six (6) month period beginning with the first day of the month in which the application is received. Eligibility as Medically Needy is not established, however, until the applicant has presented 1) RECEIPTS FOR MEDICAL SERVICES INCURRED DURING THE PERIOD OF DETERMINATION and/or 2) UNPAID BILLS incurred either during the CURRENT PERIOD of determination AND/OR PRIOR TO APPLICATION for which the individual is STILL LIABLE equal to the amount of such excess income. The only exception to the requirement of applicant liability for the medical expenses is in the case of medical expenses which are paid by or are the liability of other medical care programs that are funded 100% with State funds. For example, an applicant's medical expenses that have been paid (or are to be paid) by the RIPAE program are considered to be the liability of the applicant, and if otherwise allowable, are deducted from the spenddown liability. Medical expenses that are subject to payment by any other third party payer are not considered the liability of the applicant and are not deducted from the excess income.

In some cases, current payments ON THE PRINCIPAL BALANCES of loans to pay off old medical bills (i.e., bills incurred prior to the current budget period) are incurred health care expenses if certain conditions are met.

The Flexible Test of Income may be used to establish eligibility in a retroactive period.

If the applicant is determined eligible under a flexible test of income, the applicant is certified for SIX (6) MONTHS OR FOR THE BALANCE OF THE SIX (6) MONTH BUDGET PERIOD remaining when the excess income is absorbed.

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0336.05.05**When Eligibility Begins**

REV:07/1994

The date of eligibility is the actual day of the month on which the applicant incurs a medical expense which reduces income to the income standard. THEREFORE, THE DATE OF ELIGIBILITY IS THE DAY THAT THE MEDICAL SERVICE IS PROVIDED AND NOT THE DATE OF THE BILLING, which may be a later date. The expense is incurred on the day of the service.

When an incurred medical expense is a hospital bill, the date of eligibility is the first day of hospitalization. An AP-758 is required to establish the amount of the hospital bill for which the individual is liable. The individual's liability is his/her excess income on the first day of hospitalization, providing there is no expense subsequently incurred which reduces such excess income to a lesser amount.

If the applicant has excess income and there is no indication of medical expenses by which the excess can be absorbed, the case is rejected. However, if the applicant should present medical expenses within the same six (6) month period, the original application is used in determining whether the excess income for this same six-month period has been reduced to the income standard.

0336.05.10**Whose Expenses Are Used**

REV:07/1994

The construction of the Financial Unit provides the basis for determining the applicable Medically Needy standards for a family case and the amount of excess income, if any, to be absorbed via a spenddown. The Financial Unit may include persons who are not applying for MA. Medical expenses incurred by non-applicant members of the Financial Unit may be counted toward the applicant's spenddown liability. However, once the excess income is absorbed, only the applicant is MA eligible.

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DEDUCT LOANS TO PAY BILLS

0336.10

REV:07/1994

A loan can be an incurred health care expense and, in some circumstances, may be applied against the CURRENT spenddown liability when the applicant has a CURRENT obligation under the loan. The objective of the policy is to allow the recipient to use his or her liability to the lender in place of his or her liability to the provider. However, since the applicant may apply only the amount that would have been deducted had the provider's bill been used, the deduction of interest paid or payable on the loan is precluded.

A loan taken out in the current period or a preceding period to pay a provider's bill incurred in a PRECEDING PERIOD may be applied against current spenddown liability to the extent of any unpaid balance in certain cases. Current principal payments and any remaining unpaid principal balance on the loan may be applied against the spenddown liability to the extent that:

- o The proceeds from the loan WERE actually used to pay the provider's bill (i.e., the loan payments are not deductible until after the proceeds have been paid to the provider); and,
- o Neither the provider's charges nor the loan payments and the unpaid balance were previously applied against spenddown liability or deducted from income.

Loan proceeds that will not be used until after the current eligibility period may not be applied against the spenddown liability in the current period because only loan proceeds THAT HAVE BEEN USED to pay for health care expenses may be applied. However, such proceeds could be used against any spenddown liability for the subsequent period in which they actually are used.

This policy gives the recipient the relief intended by the spenddown (i.e., application of the remaining liability for old medical expenses against the person's spenddown liability). The policy does not change the treatment of old bills that remain unpaid -- i.e., they are still deductible in the spenddown to the extent that a current liability continues to exist and the bills have not been previously deducted.

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0336.15

DEDUCTING RECOGNIZED MEDICAL EXPENSES

REV:04/1995

In establishing financial eligibility, excess income is applied toward reasonable incurred medical expenses that are not subject to payment by a third party (other than those medical expenses which are the liability of or paid for by 100% State funded medical care programs).

Recognized medical expenses include medical insurance premiums, co-payments, deductibles and certain medical and remedial care expenses recognized under state law (See section 0336.15.05 for recognized medical/remedial care expenses that are not provided within MA scope of services and which may be used to offset excess income). Incurred medical expenses may also include current payments on the principal of loans used to pay off old medical bills.

A loan that is taken out in the current eligibility period to pay a health care provider for services rendered in the same period (or, in the case of a new application, for services rendered in the month of application or within the 3 preceding months) may be applied against the spenddown liability for the current period IN PLACE of the provider's bill. (The loan expense and the provider's bill may not BOTH be applied against the spenddown liability.)

Determine the available excess income for the six (6) month period beginning with the month of application. Excess income can then be applied to recognized medical expenses incurred PRIOR to application and unpaid. If a medical expense is more than one (1) year old, it is necessary to ensure that the applicant is still liable for the payment. This can be done by presentation of a current billing. Apply the excess income to the medical expenses in the appropriate order.

Excess income is applied to the medical expenses in the following order:

FIRST: Deduct incurred medical insurance premiums, including any enrollment fee, Medicare premiums, capitation fees for enrollment in prepaid health care programs, and premiums for any other health insurance program which is primarily established for payment of medical costs. With the exception of Medicare premiums, the cost of such medical insurance must be actually incurred and

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MAY NOT BE PROJECTED over the six (6) months of the application period; Deduct any co-payments, co-insurance or deductibles under any health insurance program as they are incurred.

SECOND: Deduct necessary medical or remedial care recognized under state law but not provided within the Medical Assistance scope of services, such as chiropractic services, adult day care, respite care, or Home Health Aide/Homemaker services.

THIRD: Deduct necessary medical or remedial care provided within the Medical Assistance scope of services.

FOURTH: Deduct current payments on the principal balances of loans used to pay off medical bills incurred prior to the current budget period.

Deducting Recognized Medical/Remedial Care

0336.15.05

REV:04/1995

Care which is not being provided within the MA scope of services and which may be used to offset excess income includes:

- o Adult Day Care;
- o Respite Care; and,
- o Home Health Aide/Homemaker Services.

Adult Day Care

0336.15.05.05

REV:07/1994

The cost of adult day care services may be used to offset a flexible-test spenddown liability. In order to be considered a cost of "medical or remedial care", these conditions must be met:

- o The service must have been rendered by a provider agency approved by the Department of Elderly Affairs (DEA); and,
- o The service was required to assist an individual, who because of severe disability related to age or chronic illness, encountered special problems resulting in physical and/or social isolation detrimental to his/her

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well- being, or required close monitoring and supervision for health reasons.

0336.15.05.10

Respite Care

REV:07/1994

The cost of respite care may be used to offset a flexible-test spenddown liability if the applicant receives overnight respite care at a licensed nursing/convalescent facility or in-home respite care as provided by the Department of Elderly Affairs (DEA).

0336.15.05.15

Home Health Aide/Homemaker Services

REV:07/1994

The cost of Home Health Aide services or Homemaker services may be used to offset a flexible-test spenddown liability under certain circumstances. In order to be considered a cost of "medical or remedial care", the following three conditions must be met:

- o The service must have been rendered by an agency licensed by the Rhode Island Department of Health, and recognized as a service provider by DHS under the Homemaker Program (see Section 0530.35 for list); and,
- o At least a portion of the service provided each month MUST be for personal care services (assistance with bathing, dressing, grooming, etc.). If the client does not (or did not) receive assistance with personal care during a month, no part of that month's cost of service may be used to offset the flexible-test spenddown liability; and,
- o A physician must certify the client's need for personal care services, in writing, at least once in each flexible-test period (six (6) months). The certification must indicate the patient's diagnosis(es), and the type of services required.

If the foregoing three criteria are met, eligibility staff may recognize, without further review, the cost of up to 65 hours per month in Home Health Aide/Homemaker services to offset a flexible-test spenddown liability. Deductions in excess of this amount must

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be approved in writing by the Nurse/Consultant for Homemaker Services located at C.O. The referral to the Nurse/Consultant is comprised of a brief cover memo prepared by the eligibility technician, a copy of the individual's Plan of Service obtained from the provider agency, and a copy of the physician's certification of need for services. The Nurse/Consultant reviews the material to determine the extent to which the costs of service in excess of 65 hours per month may be recognized as a deduction from excess income. Only the cost of substantive services may be allowed as a deduction from excess income.

EXAMPLES

0336.20

REV:07/1994

EXAMPLE: The applicant has verified unpaid medical expenses for which the applicant is liable that were incurred prior to application but are still unpaid at the time of application. If the medical expenses absorb all the excess income, the applicant is eligible and is certified for a six (6) month period beginning with the month of application. The case must be redetermined at the end of the six (6) month period.

When the excess income is not absorbed by applying it to medical expenses incurred prior to the application and unpaid, the applicant must present receipts or bills for medical expenses incurred during the six (6) month period beginning with the month of application. The excess is then applied to those expenses. When the excess income is absorbed, ELIGIBILITY BEGINS ON THAT DAY WHICH IS THE DAY THE MEDICAL SERVICE WAS PROVIDED. The case is certified for the balance of that six (6) month period. At the end of this period, a new application must be submitted.

EXAMPLE: An applicant applies in July with countable income of \$7,200 a year (\$500 excess per year or \$250 excess for six (6) months). The applicant cannot be certified as eligible until bills or receipts for incurred medical expenses totalling \$250 are presented. If a receipt of \$50 is presented in July, and a bill for \$200 is presented in August, the applicant is then certified from the day in August that the medical service was provided, through December, the end of that six (6) month period.

If on the final day of the six (6) month period, the applicant has (1) no receipts or bills for incurred medical expenses; or (2) if the receipts and/or bills presented do not absorb the excess

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income; or (3) if the absorption of excess income in the exact amount of the excess income occurs on that final day, there is no eligibility.

EXAMPLE: An applicant applies in July with income of \$7,200 a year (\$500 excess per year or \$250 excess for six (6) months). The applicant cannot be certified as eligible until bills and/or receipts for incurred medical expenses totalling \$250 are presented. No bills or receipts for incurred medical expenses are presented.

EXAMPLE: An applicant applies in July with income of \$7,200 a year (\$500 excess per year or \$250 excess for six months). A receipt for \$50 is presented in July, \$100 in September, and \$50 in November - total \$200. No further bills or receipts are presented.

EXAMPLE: An applicant applies in July with income of \$7,200 a year (\$500 excess per year or \$250 excess for six months). A receipt for \$50 is presented in July, \$100 in September, \$50 in November, and \$50 on December 31 - total \$250. However, the excess income is absorbed on the final day of the six (6) month period. There is no eligibility for that period since there is no medical coverage to be met.

Had the receipts and/or bills totaled more than \$250, eligibility would have existed for MA coverage of the amount of any unpaid bills over \$250. Also, had the applicant been hospitalized on December 31, eligibility would have existed for any expenses on December 31 which exceeded \$250.

0336.25**CERT OF FLEXIBLE TEST CASES**

REV:07/1994

Each individual determined to be ineligible for MA will receive notice of the basis of ineligibility. Those individuals ineligible on the basis of excess income will be informed of the amount of his/her spenddown liability.

When a recipient's case is discontinued on the basis of income exceeding the Medically Needy income standard, a review of the recipient's situation is completed under the Flex Test policy. Such recipient is advised of the amount of excess income and the eligibility period during which such excess must be absorbed.

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When such applicant/recipient presents unpaid bills (for which the individual remains liable) incurred at any time through the final day of the six (6) month period and/or receipts for bills incurred during the period for which eligibility is being determined which total or exceed the amount of the excess income, eligibility exists for the balance of the six (6) month period. A new application is not needed for that six (6) month period.

Any case certified, whether for a full six (6) month period or a balance of even only one (1) month, needs a new application at the end of each six (6) month period. The InRHODES system will trigger the mailing of a redetermination packet by sending a notice to the field office. Each six (6) month period is determined separately. Medical bills recognized in a previous Flexible Test period to reduce excess income must not be applied to reduce the excess income for the new application period. However, if the bills did not establish eligibility, then they were not used for spenddown and can be considered in a subsequent six (6) month period.

To certify a case where the recipient and Medical Assistance must share the expense, the InRHODES eligibility system will notify MMIS of the bills that were used to meet the spenddown. These bills will not be paid by MMIS and are the applicant's responsibility.

Controlling Flexible Test Cases**0336.25.05**

REV:07/1994

The InRHODES on-line redetermination report lists all cases due for redetermination with flex-test cases highlighted. The system notifies workers two months before the month that certification ends that re-determination packets need to be sent out.

Flex-test cases by their nature are ineligible at the end of the certification period and will automatically close, and eligibility must be redetermined. The redetermination activities should be completed by the end of the six-month (or less) flex-test period.

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RESOURCE LIMITS**0338.05**

REV:11/1998

A determination of eligibility requires a review of the family's resources only for those coverage groups which require that resources be tested. In addition to the evaluation of resources at the time of MA application, resources are reviewed when a change occurs, or when information is received which indicates that unreported resources may exist.

CATEGORICALLY NEEDY MA ONLY (Non-Cash Eligibility)

When determining family MA Only Categorically Needy eligibility, resources are not tested for:

- o pregnant women;
- o children; or,
- o the parent(s) or caretaker relative of MA Only eligible children whose countable income does not exceed 185% of poverty.

With regard to family-related MA Only coverage groups that require countable resources be within program limits, the amount of non-exempt, available resources (real and personal property) that a family unit can possess and maintain Categorically Needy MA eligibility is one thousand (\$1,000) dollars:

TABLE OF CATEGORICALLY NEEDY RESOURCE UNITS

RESOURCE	LIMITS
Real Property and Personal Property	\$1,000
Home (in which family is living)	Excluded
Automobile	See Sec. 0338.25.20 and Sec. 0338.25.20.05
One burial plot or space	Excluded for each member of family
Funeral agreement	Not to exceed \$1,000 of equity value for each member of family

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Household furnishing and appliances, Excluded
clothing, personal effects and
keepsakes of limited value

MEDICALLY NEEDY MA

Determination of eligibility for medically needy eligibility requires a review of the family's resources. In addition to the evaluation of resources at the time of MA application, resources are reviewed when a change occurs, or when information is received which indicates that unreported resources may exist.

The resource limits for eligibility as Medically Needy are the following:

TABLE OF MEDICALLY NEEDY RESOURCE LIMITS

Resource	One Person	Two Persons	Additional Persons
Real Property and Personal Property	\$4,000	\$6,000	\$100 Each
Life Insurance	\$4,000 Each Adult	\$4,000 Each Parent	\$1,500 Each Dependent Child Under 18
Burial Set-Aside	\$1,500 Each		
Tangible Personal Property (automobile, personal valuables, boat, etc.)	\$5,000 per Household (See Exclusions)		
Home and Adjoining Land	Excluded if Applicant is living in the home		
Burial Spaces	Excluded		
RSDI Retroactive Payments	Excluded for 6 Months		

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DEFINITION OF RESOURCE

0338.10

REV:07/1994

A RESOURCE may be either real or personal property:

- o REAL PROPERTY is land, including houses or objects permanently attached to the land;
- o PERSONAL PROPERTY in a broad sense is everything that is subject to ownership that is not real property. Personal property includes liquid resources, such as cash, stocks, bonds, bank accounts, cash value of life insurance, automobiles and non-essential items.

Countable/Excluded Resources

0338.10.05

REV:07/1994

Resources are further defined based on whether they are countable or excluded in the process of determining eligibility for Medical Assistance.

- o COUNTABLE RESOURCE: A resource, whether real or personal property, that is counted toward a resource limit. They are those resources that are available to the client, and that are not excluded. Resources are considered available both when actually available, and when the applicant/recipient has a legal interest in a liquidated sum and has the legal ability to make such sum available for support and maintenance. The determination of resource eligibility follows the same methodology set forth in Section 0334 - Determining Income Eligibility. Certain resources are excluded with the value of the remaining resources compared to the appropriate resource standard.
- o EXCLUDED RESOURCE: A resource that is not counted toward the resource limit because of a specific exclusion in policy. Some resources are totally excluded regardless of value (e.g., the home). Some resources are excluded to the extent they do not exceed a specific threshold amount (e.g., \$1,500 exclusion limit for automobile).

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0338.15**DOCUMENTATION OF RESOURCES**

REV:07/1994

The information the individual supplies on the DHS-2, both at application and redetermination is documented through insurance policies, bank books, property records and similar documentary sources. The source used for verification of the resource is recorded in the appropriate area of the DHS-2. Photocopies of the documentation must be kept for the case file.

0338.20**TIMING OF RESOURCE EVALUATION**

REV:07/1994

If, at the time of the resource evaluation, countable resources exceed the resource limit, resources are assumed to be in excess of the limit for the entire month. Resources are evaluated at the point in time at which the application or redetermination is completed.

0338.25**EXCLUDED RESOURCES**

REV:06/1998

MA policy allows the exclusion of certain resources when counting the value of the family's resources to determine eligibility. The exclusion of certain resources takes into account the Current Fair Market Value (CFMV) and/or the Equity Value defined as:

- o Current Fair Market Value (CFMV): The amount for which the property (real and personal) can be expected to sell on the open market in the geographic area involved, under existing economic conditions at the time of the determination.
- o Equity Value: The CFMV of the resource less the amount of its legal encumbrances.

The following resources may be excluded in the determination of MA resource eligibility:

- o Real property that is the home;
- o Real property owned by a husband and wife (under

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certain limited conditions);

- o Real property other than the home (six months, pending sale);
- o Income-producing property other than real estate;
- o Automobile (See Sec.0338.25.20 and Sec. 0338.25.20.05);
- o Burial plot;
- o Funeral agreement, not to exceed \$1,000 equity value;
- o Household furnishings, appliances, clothing, personal effects and keepsakes of limited value.

The Home**0338.25.05**

REV:07/1994

The home is excluded. The home exclusion applies to any land that appertains to the home and any other buildings located on such land, for example, a barn or shed. To appertain to the home, the real property must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others. (An AP-5A is completed on excluded property and filed in the case record.);

The home exclusion applies when the applicant/recipient is only temporarily absent from the usual residence. The home exclusion applies, for example, to the marital domicile when a parent and child(ren) leave to reside in a shelter, with relatives, or elsewhere, pending issuance of a restraining order against the spouse, and with the intention of returning to the home as soon as possible;

Property that is not the home and is owned by a husband and wife may be excluded if (1) the deed indicates the property is held by them as tenants by the entirety, and (2) the property is not the home of the applicant/recipient, and (3) the spouse of the applicant/recipient refuses to sell his/her interest in the property. To ascertain if these conditions are met, the eligibility technician must verify, by examination of the deed, that the parties own the property as tenants by the entirety and determine if the parties are still married because a divorce (but not a legal separation) automatically dissolves a tenancy by the entirety. If the three

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conditions specified above appear to be met, the eligibility technician must refer the case, through the Regional Manager, to the Department's Office of Legal Counsel for a determination of the property's excludability. The referral should include copies of the deed to the property and any other relevant documents.

0338.25.10**Real Property Other Than Home**

REV:07/1994

Real property, except for the home in which the assistance unit is living or otherwise excludable as specified in Section 0338.25.05, is excludable for up to a maximum of six (6) months. The exclusion of real property is subject to the following provisions:

- o The family must make a good-faith effort to sell the property, generally by listing it with a licensed realtor. The realtor must indicate in a signed statement that the asking price is consistent with the property's Current Fair Market Value (CFMV). If the family chooses to sell the property independently, they must demonstrate a good-faith effort, for example, by adequate newspaper advertising of the property for sale. Any method of disposal other than listing with a realtor is subject to review and approval by the Regional Manager before it can be excluded.
- o The family must notify the agency upon executing a purchase and sale agreement, a copy of which is submitted to the eligibility technician. Further, within five (5) days of the closing, the family must provide the eligibility technician with a copy of the closing or settlement sheet.
- o If the net proceeds from the sale of the property, together with all other resources at the beginning of the disposal period, are within the allowable resource limit, no repayment is warranted.
- o If the property is not sold within six (6) months, eligibility ceases, and the entire amount of assistance paid during the period is treated as an overpayment and subject to repayment by the recipient. This provision also applies if eligibility ceases for any other reason.

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Income-Producing Property

0338.25.15

REV:07/1994

Income-producing property other than real estate is excluded. Equipment such as farm tools, carpenter's tool and vehicles used in the production of goods and services as a means of earning a living may be excluded from consideration as resources in certain circumstances. If the property has been used by the applicant/recipient to generate income and the reasonable expectation exists that it will be used for that purpose in the foreseeable future, the property is not subject to the \$1,000 resource limitation.

In making the determination that the income-producing property is excluded, the eligibility technician evaluates such factors as:

- o The applicant's present and future capacity to utilize the property to become self-supporting;
- o The suitability of the property to serve as one of the means to this goal; and,
- o The length of time expected to elapse before the property might be put to use in a self-support plan.

Appropriate medical, psychological and social service assessments are used to reach the determination.

Automobile

0338.25.20

REV:06/1998

Automobile means a passenger car or other motor vehicle used to provide transportation of persons or goods.

In determining eligibility, count toward the resource limit only that part of the fair market value of any vehicle not otherwise excluded which exceeds \$4,600, or the portion of the family's equity in a vehicle which exceeds \$1,500 value, whichever is less.

Equity value is the difference between wholesale/average trade-in value of the automobile and the amount of total encumbrances (legal debts).

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To assess the equity value of an automobile, determine the wholesale/average trade-in value of the car (truck, van, motorcycle), as listed in the Used Car Guide (NADA "Blue Book") minus any encumbrances. Encumbrances are verified from documents submitted by the applicant/recipient or from contact with collateral sources. (If a motor vehicle not excluded under Section 0338.25.20.05 is specially equipped with apparatus for the handicapped, the value of the apparatus is excluded from the assessment in applying the resource policy.)

If the automobile is not listed in the Blue Book, or the recipient disputes the value as stated because of physical damage, the appraisal of a registered automobile dealer is accepted as evidence of the average trade-in/wholesale value.

Family with Two or More Automobiles

For a family with two or more automobiles, calculate the portion of the value of each vehicle which exceeds \$4,600, or the portion of the family's equity which exceeds \$1,500 value, whichever is less. The total of those computations is countable towards the resource limit.

If the value of automobiles, when combined with other countable resources, exceeds the \$1,000 resource limit, eligibility does not exist.

0338.25.20.05**Special Use Vehicles**

REV:06/1998

The value of vehicles used primarily for income-producing purposes is excluded. Such vehicles include but are not limited to:

- o a taxi, truck, or fishing boat;
- o a vehicle which annually produces income consistent with its fair market value, even if only used on a seasonal basis;
- o a vehicle used for long distance travel, other than daily commuting, which is essential to the employment of a family member;

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- o a vehicle necessary to transport a physically disabled family member where the vehicle is specially equipped to meet the specific needs of the disabled person or is the vehicle is a special type of vehicle that makes it possible to transport the disabled person; and,
- o a vehicle used as a family's home.

Burial Plot

0338.25.25

REV:07/1994

One (1) burial plot or space for each member of the assistance unit is excluded. A burial space is any conventional gravesite, crypt, mausoleum, urn, or other repository customarily used for the remains of a deceased person.

Funeral Agreement

0338.25.30

REV:07/1994

A bona fide funeral agreement, not to exceed \$1,000 of equity value for each member of the assistance unit, is excluded. A bona fide or good-faith funeral agreement is a cash resource reserved authentically and solely to meet the funeral expenses of the beneficiary. It must not constitute a mere shelter for funds that would otherwise count toward the \$1,000 resource limit.

Evidence that funds in a purported funeral agreement are being tapped for other than their avowed purpose is a contraindication that the agreement is bona fide. Every funeral agreement must be submitted to and, if appropriate, approved by the Regional Manager before it can be excluded as a resource. Further, at each recertification, the eligibility technician must review each excluded funeral agreement. Any new, significant information bearing on the agreement is submitted to the Regional Manager for evaluation and determination of its continued excludability.

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0338.25.35**Resources Excluded by Law**

REV:07/1994

Resources excluded by law in determining need and the amount of assistance include:

- o Funds awarded under PL 98-123 to the Red Lake Band of Chippewa Indians.
- o Funds awarded under PL 98-124 to the Assiniboine Tribe of the Fort Belknap Indian Community, and the Assiniboine Tribe of the Fort Belknap Indian Reservation.

0338.30**RESOURCE REDUCTION**

REV:07/1994

If an applicant or recipient is found to be ineligible due to excess countable resources, s/he is notified that eligibility does not exist via the InRHODES Eligibility Notice. Included with the Notice is an attachment describing the possibility of resource reduction (form MA-6). The applicant/recipient may establish eligibility if the excess resource amount is expended on allowable medical, legal, or guardianship/conservatorship expenses. Eligibility may be established as of the date the allowable expense equals or exceeds the excess resource. (However the date of eligibility achieved via resource reduction can never be earlier than the first day of the month of application). To reduce resources under this provision, the applicant must verify the asset reduction within 30 calendar days of the date of the notification.

An applicant whose countable resources exceed the basic resource limitation may establish eligibility on the basis of resources if:

- o S/he incurs (or has incurred) outstanding allowable medical bills or other allowable expenses that equal or exceed his/her excess resources; and,
- o S/he reduces the excess resources to the appropriate resource limit by actually paying the allowable expenses or fees, and submitting verification thereof within thirty days of the date of the rejection or closing notice. Both the expenditure of the resource and submission of verification of the expenditure must occur within the thirty day time period.

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Medical Assistance is not responsible for payment of that portion of the medical bills equal to the amount of the excess assets. The bills used to establish eligibility cannot be incurred earlier than the first day of the third month prior to the date of an application that is eventually approved. Allowable bills, which the applicant has paid and used to reduce resources, may not be the same bills that have been used to meet an income spenddown.

The agency representative must see the bills that have been actually paid in order to verify that resources have been properly reduced.

Date of Eligibility**0338.30.05**

REV:07/1994

An individual who meets the requirements for resource reduction and is otherwise eligible will be eligible as of the date his or her incurred allowable expenses equalled or exceeded the amount of his or her excess assets, subject to verification that the excess resource was actually expended on the allowable expense. In no event shall the first day of eligibility be earlier than the first day of the month of application. Although an applicant may use medical bills incurred up to three months prior to his/her application to reduce resources, an applicant cannot achieve retroactive eligibility via resource reduction.

The client will be required to verify that:

- o S/he incurred the necessary amount of expenses; and,
- o His or her excess resources were reduced to the allowable resource limit by expenditure of the excess resource on the allowed expense.

Allowable Expenses**0338.30.10**

REV:04/2001

Only certain expenses may be used to establish eligibility by reduction of excess resources. These expenses are as follows:

- o Medical Expenses that would be allowed under the policy

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on the Flexible-test of income. See Section 0336, FLEXIBLE TEST OF INCOME.

- o Certain fees required for: a) an individual to make income or resources available; or b) for an incompetent individual, who needs a court-appointed guardian, to access or consent to necessary medical treatment, including applying for Medical Assistance. Only the fees indicated in Sections 0338.30.10.05 through 0338.30.10.15 are allowable under this provision.

0338.30.10.05**Guardian/Conservatorship Costs**

REV:04/2001

Applicants who have court-appointed guardians or conservators are generally required to pay court-approved guardian/conservator's fees. Such fees include but are not limited to court filing fees, the cost of a Probate Bond, court-approved guardianship/conservatorship fees, and court-approved legal fees.

Allowable court-approved expenses not covered by other sources for items listed in Section 0338.30.10, subject to the Rhode Island Supreme Court approved fee schedule (currently \$30 per hour for guardians under "Executive Order" Number 95-01), up to \$125 monthly may be considered. When such guardianship fees have been approved by Probate Courts, related guardian ad litem fees not exceeding \$250 may also be recognized. The applicant must submit a copy of the Probate Court Order and any supporting documentation, including an itemized bill for any allowable guardianship/conservatorship expenses.

The case is referred to the Office of Legal Counsel by the Regional Manager for a decision on the amount of the allowable deduction. The total amount allowed must be reasonable and shall be based on the hours approved by the particular Probate Court for items listed in Section 0338.30.10 at the rate of compensation paid for guardians-ad-litem in Family Court as specified in the then-current Rhode Island Supreme Court Executive Order on fee schedules.

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Legal Fees

0338.30.10.10

REV:07/1994

Individuals who incur legal fees resulting from legal action to obtain income or resources for their support may expend excess resources to pay such fees.

Tax Assessments

0338.30.10.15

REV:07/1994

Individuals ordered by the Internal Revenue Service, the Rhode Island Division of Taxation, or other State or municipal taxing authority to pay income taxes may expend excess resources to pay the taxes.

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MEDICAL ASSISTANCE**EVALUATION OF RESOURCES****SECTION 0340**

EVALUATION OF REAL PROPERTY**0340.05**

REV:07/1994

Real property is land, including houses or objects permanently attached to the land. The equity value of any non-excluded real property owned by the family must be counted toward the \$1,000 Categorically Needy or \$4,000 Medically Needy resource limit.

In determining the value of the resource, equity value is defined as the Current Fair Market Value (CFMV) minus encumbrances.

Evidence of ownership includes the deed, current mortgage statement, assessment notice, the recent tax bill, or a report of title search. If not available, the eligibility technician must obtain the information from the Recorder of Deeds, by telephone or other means.

The Regional Manager is available to the supervisor for consultation in assessing the value of property if the value is questionable in relation to the appropriate resource limit.

EVALUATION OF PERSONAL PROPERTY**0340.10**

REV:07/1994

Personal property in a broad sense is everything that is subject to ownership that is not real property. Personal property includes liquid resources.

Liquid resources are those properties in the form of cash or other financial instruments which are convertible to cash and include savings accounts, checking accounts, stocks, bonds, mutual fund shares, time deposits shares, money market certificates, promissory notes, mortgages, cash value of insurance policies and similar properties.

The value of any liquid resources must be counted toward the \$1,000 Categorically Needy or \$4,000 Medically Needy resource limit.

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SECTION 0340

EVALUATION OF RESOURCES

0340.10.05

Life Insurance

REV:07/1994

In determining eligibility as Categorically Needy, the cash surrender value of all life insurance policies of the assistance unit is counted toward the \$1,000 resource limit. Each assistance unit may retain insurance where the total cash surrender value of all the policies, when combined with all other countable resources, does not exceed \$1,000.

Medically Needy resource limits allow up to \$4,000 cash surrender value in life insurance policies for each adult, and up to \$1,500 cash surrender value in life insurance policies for each dependent child under 18.

Term insurance and group insurance have no cash surrender provisions and are, therefore, not counted as resources.

Procedures to determine eligibility include the following:

- o Determine the cash value of each policy that has a cash surrender provision;
- o If the total cash surrender value is under the \$1,000 limit, this amount must be added to all other countable resources to determine whether the total resources are within the \$1,000 limit;
- o If the total cash surrender value, when added, exceeds the \$1,000 limit, the applicant does not meet Categorically Needy eligibility and eligibility under the Medically Needy limit should be determined.
- o If the total cash surrender value, when added, exceeds \$4,000 for an adult or \$1,500 for a dependent child under 18, the applicant is ineligible for Medically Needy MA.

The specific information required on the insurance policies is identified on the Statement of Need for each member in the family. The information is obtained from the applicant or recipient by examining the insurance policies or premium books. The insurance information is reviewed and the value updated for purposes of continuing eligibility at each redetermination. If insurance coverage changes by adjustment, termination or purchase, the Statement of Need is updated.

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Life insurance held on any or all assistance unit members by an individual outside the assistance unit shall not be counted as a resource.

Medical Insurance**0340.10.10**

REV:07/1994

If a family has any medical insurance, such as Blue Cross/Blue Shield, Major Medical, Federal Medicare (Part A, Part B), Harvard Community Health Plan, Ocean State, Delta Dental or other medical insurance, this is identified as a resource for medical payment on the DHS-2 and on the InRHODES Insurance (INSU) panel. The insurance information is transferred from InRHODES to the MMIS at eligibility approval and with each change.

Automobiles**0340.10.15**

REV:07/1994

Automobile means a passenger car or other motor vehicle used to provide transportation of persons or goods.

In determining eligibility, one automobile, valued at \$1,500 or less, is excluded. However, the equity value over \$1,500 of the one excluded automobile and any other automobile(s) owned by the assistance unit must be added to the value of all other resources owned by the assistance unit, and counted toward the \$1,000 resource limit for Categorically Needy eligibility or the appropriate resource limit for Medically Needy eligibility.

Equity value is the wholesale/average trade-in value of the automobile less the amount of total encumbrances (legal debts).

- o To assess the equity value of an automobile, the eligibility technician determines the wholesale/average trade-in value of the car (truck, van, motorcycle), as listed in the Used Car Guide Book (NADA "Blue Book") minus any encumbrances.

Encumbrances are verified from documents submitted by the applicant/recipient or from contact with collateral sources. (If a motor vehicle is specially equipped with apparatus for the handicapped, the value of the apparatus

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is excluded from the assessment in applying the resource policy);

- o If the automobile is not listed in the Blue Book, or the recipient disputes the value as stated because of physical damage, the appraisal of a registered automobile dealer is accepted as evidence of the average trade-in/wholesale value.

Assistance Unit With One Automobile

For assistance units with one automobile, the first \$1,500 of the automobile's equity value is excluded. If the automobile's equity value is \$1,500 or less, then no further determination is needed.

The equity value in excess of \$1,500 is counted toward the Categorically Needy or Medically Needy resource limit.

Assistance Unit With Two or More Automobiles

For assistance units with two or more automobiles, exclude up to the first \$1,500 of equity value from the first automobile. The recipient/applicant can choose which automobile is to be excluded.

Count the amount of equity value in excess of \$1,500 of the first automobile plus the total equity value of all other automobiles owned by the assistance unit toward the Categorically Needy or Medically Needy resource limit.

0340.10.20

Non-Essential Items

REV:07/1994

Usually accepted household items are excluded. However, when there is evidence that the applicant possesses household or personal items of unusual or exceptional value, there should be verification of this resource by establishing its fair market price and equity value. Items of unusual value are those not normally used to maintain an adequate standard of comfort and convenience for the household.

The value of recreational boats, art objects or valuable collec-

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tions of luxury items of unusual value represent resources that must be added to all other total resources to determine whether the resources are within the appropriate limit. It is the current fair market value of the item rather than the item itself that determines the unusual value.

The statement on the DHS-2 (indicating the applicant does not own items of unusual value) referring to other resources owned by the applicant/recipient will be accepted without further development unless there is evidence to the contrary (e.g., information from other sources, or answers to other questions on the application that cast doubt on the validity of the response).

If the applicant/recipient owns a valuable resource, then the CFMV must be determined. Any reliable and reasonable method may be used to establish and verify the CFMV, e.g., sales slips, insurance, prior appraisals, or contacts with local merchants.

If the total equity is under the resource limit, this amount must be added to all other countable resources to determine whether the total resources are within the resource limit.

If the total equity exceeds the resource limit, eligibility is not established.

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CAT NEEDY AFDC-RELATED COVERAGE

SECTION 0342

FIP FAMILIES AND SECTION 1931 FAMILIES

0342.05

REV:09/2001

FAMILY INDEPENDENCE PROGRAM (FIP)

In Rhode Island, eligible families receive temporary cash assistance through the Family Independence Program (FIP) and are automatically certified for MA concurrent with the determination of FIP eligibility.

Eligible recipients include:

- o FIP families which include children under 18 and their parent(s) or caretaker relative;

Includes FIP children age 18 who are full time students in a secondary school or in the equivalent level of vocational or technical training, and who will complete school before or in the month of their 19th birthday.

- o FIP pregnant women with no other eligible children.

All FIP closures and denials must be reviewed for continuing eligibility under Section 1931 using Medical Assistance (i.e., non FIP) income and resource counting rules (see DHS Manual, sections 0330.30 and 0338.05). For example, a review of continuing MA eligibility should take place when:

- A family found eligible for FIP cash assistance decides to decline the cash benefit;
- A family applying or being recertified for FIP and fails to provide sufficient verification for FIP, but has met the 1931 verification requirements (proof of income, alien status, pregnancy); or
- An eligible FIP family decides to close their cash assistance.

All FIP families receiving cash assistance are categorically needy and must enroll in Rite Care or Rite Share, as determined by the Department. FIP families qualify for extended Medical Assistance if their Medical Assistance is closed for reasons related to increased child support or income from employment.

SECTION 1931 MEDICAL ASSISTANCE ONLY

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SECTION 0342

Section 1931 refers to a family category of MA Only, i.e, there is no cash assistance attached to the receipt of the Medical Assistance.

Section 1931 MA Only recipients include:

- o Families with children under age eighteen* (18) whose countable income does not exceed one hundred ten percent (110%) of the federal poverty level income guidelines (FPL) and without regard to deprivation or resources.

*Includes children age eighteen (18) who are full time students in a secondary school, or an equivalent level of vocational or technical training program, and who will complete school before or in the month of their 19th birthday.

All MA Section 1931 families are categorically needy and must enroll in Rite Care or Rite Share.

Families who do not qualify for Section 1931 MA because of excess income are evaluated for MA under the Family Waiver Group.

Both FIP and Section 1931 MA only families may qualify for Extended Medical Assistance when Section 1931 MA eligibility is lost due to reasons related to increased income from child support or employment. If the family is eligible for both extended MA coverage and Family Waiver coverage, Extended MA coverage is granted first.

0342.10 DEEMED FAMILY INDEPENDENCE PROGRAM RECIPIENT

REV:06/1998

Deemed Family Independence Program (FIP) recipients include:

- o FIP eligible persons who receive no FIP payment because the monthly grant would be less than \$10 (InRHODES Category Code 48);
- o Individuals who would be eligible for FIP except for the fact that a member of the FIP filing unit is participating in the Work Supplementation Program (InRHODES Category Code 49);

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MEDICAL ASSISTANCE**CAT NEEDY AFDC-RELATED COVERAGE****SECTION 0342**

- o Individuals whose FIP payments are reduced to zero by reason of recovery of overpayment of FIP funds (InRHODES Category Code 50).

FIP CLOSURES DUE TO INCREASED CHILD SUPPORT**0342.15**

REV:06/1998

This coverage group is families who become ineligible for the Family Independence Program (FIP) due to an initial collection or an increase in the collection of child support payments. The family continues to be eligible for Medical Assistance as Categorically Needy for four (4) additional months following FIP closure due to increased child support. The family must have received FIP in at least three (3) of the six (6) months preceding the month of FIP ineligibility (InRHODES Category Code 53).

When the FIP case is closed due to the receipt of child support, InRhodes determines potential eligibility and identifies the case as eligible for extended benefits. The eligibility technician verifies and approves eligibility. InRhodes generates the appropriate notice, notifies MMIS and tracks the period of Extended Medical Assistance eligibility.

In the third month of the 4-month extension, InRhodes notifies the eligibility technician and a redetermination packet is sent to the Extended Medical Assistance recipient.

AFDC-ELIGIBLE, EXCEPT RSDI BEN INCR**0342.20**

REV:07/1994

This coverage group is individuals who, for any month, would have been eligible for AFDC if the August, 1972 increase in RSDI benefits, under Title II of the Social Security Act, had not been applicable to him/her (InRHODES Category Code 64).

Eligibility exists provided that:

- o The recipient was AFDC-eligible for the month of August, 1972; and,
- o The recipient was entitled to RSDI benefits; and,

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- o The receipt of AFDC was discontinued solely due to the August, 1972 increase in RSDI benefits.

0342.25

QUALIFIED PREGNANT WOMAN, NO DEPRIVATION

REV:01/2002

A pregnant woman in a one or two parent family whose income and resources are within appropriate limits at the time of the eligibility determination, is eligible for Medical Assistance as an individual for the duration of the pregnancy.

Eligibility exists provided that:

- o The pregnancy has been medically verified; and,
- o The family's income and resources do not exceed the Family Independence Program (FIP) income and resource standards for the size of the family including the newborn.

Once the pregnant woman has been determined eligible, she remains eligible throughout the pregnancy and post-partum period regardless of changes in family income.

0342.30

QUALIFIED PREGNANT WOMEN

REV:01/2002

This coverage group is women whose pregnancy has been medically verified, and who would be eligible for a Family Independence Program (FIP) cash payment if the child had been born and living with her. (Family size includes the unborn). Once the pregnant woman is determined eligible, she remains eligible regardless of any change in family income.

0342.35

QUALIFIED POST PARTUM WOMEN

REV:07/1994

This coverage group is women who, while pregnant, were eligible for and received MA. The woman continues to be eligible, as though she were pregnant, for all pregnancy-related and post partum medical assistance for a 60-day period beginning with the last day of her pregnancy (InRHODES Category Code 68).

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Eligibility for this coverage extends to the last day of the month in which the 60th post partum day falls.

Post Partum Women--Family Plan**0342.35.05**

REV:07/1994

This special coverage group (i.e. not Categorically Needy or Medically Needy) is post partum women who received categorical MA at the time the child was born and who are otherwise ineligible. (69) Coverage for FAMILY PLANNING SERVICES ONLY extends for twenty-four (24) months after the post partum period. It is provided to all women after the post partum period even if they have become ineligible for Medical Assistance.

NEWBORN CHILD OF MA ELIGIBLE MOTHER**0342.40**

REV:01/2002

This coverage group consists of children born to a woman who is eligible for and receiving MA as Categorically Needy on the date of the child's birth. The mother's basis of eligibility may be cash assistance-related or MA Only. The child is deemed eligible for one year from birth as long as:

- o The child resides continuously in the mother's household;
- o The mother remains eligible for MA, or would have remained eligible if she were still pregnant; and,
- o Reasonable effort is made to fulfill the newborn enumeration requirement.

To determine if the newborn is living in the mother's household, the eligibility technician will use the rules of the cash assistance program (FIP or SSI) related to the mother's eligibility.

Changes in the mother's family income never effect the newborn's deemed eligibility because, if still pregnant, the mother would remain eligible regardless of changes in income. If the mother loses eligibility because of changes other than income, the

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eligibility technician must determine whether she would have remained eligible on any basis if she were still pregnant.

An infant born to an eligible pregnant woman has automatic MA enrollment for the first year of life whether the mother qualifies through a cash assistance program (FIP or SSI) or through Medical Assistance only. The eligibility exists even if the mother becomes ineligible for FIP or SSI, provided the mother is currently eligible for MA or would be if she were pregnant.

Eligibility under this coverage group remains until one of the following occurs:

- o One year from the child's date of birth; or,
- o The infant is determined eligible for the equivalent scope of Medical Assistance services under another coverage group; or,
- o The mother loses MA eligibility based on the application of criteria as if she were pregnant. As a result, the child is determined to be ineligible.

EXAMPLE OF NEWBORN ELIGIBILITY

A pregnant woman in one-parent family is determined eligible for FIP cash-assistance. After the birth of the child the mother refuses to cooperate with the Family Independence Program's requirement that she assist Child Support Enforcement (CSE) to establish paternity and seek support from the father of the child. As a result of non-cooperation, mother is ineligible for FIP and cash-related Medical Assistance benefits cease at the end of the post-partum period. Although mother is no longer eligible for FIP, cooperation with CSE is not a requirement of the Medical Assistance Program if she were pregnant. Since mother would be eligible for Medical Assistance if she were pregnant, the newborn is automatically enrolled and eligible for Medical Assistance benefits for the first year of life.

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Newborn Enumeration Requirement**0342.40.05**

REV:01/2002

Although the mother need not file a separate application for coverage for the newborn, she is required to cooperate with the agency in the enumeration process. Enumeration is a requirement of eligibility for the newborn. However, failure to enumerate the child results in a sanction against the mother, not the child. The child will remain eligible even if lacking a social security number because of the mother's failure to cooperate.

Medical Assistance coverage under this group is the "last resort" for newborns. Whenever possible, staff should determine a child eligible as part of the mother's FIP or Medical Assistance case or under another MA coverage group before certifying the child for MA as a newborn.

Newborn Case Processing**0342.40.10**

REV:01/2002

Although the newborn is deemed eligible at birth, the birth itself is a change in household composition which has substantial eligibility ramifications. The introduction of a new household member(s) requires the worker to redetermine eligibility for the family unit as a whole, as well as the newborn. The redetermination process is completed within thirty (30) days from the date the district office receives notification of the birth.

Operating procedures vary, depending on how the district office becomes aware of the birth and on whether the mother is enrolled in managed care. In some instances the hospital or HMO may inform DHS of the birth, or the mother, or guardian of the infant, may inform the district office of the birth directly.

For a newborn child born to a mother not enrolled in managed care, the district office will receive a copy of the hospital birth record from the hospital where the birth occurs. Subsection 0342.40.10.05, below, describes the function of the hospital birth record.

For a newborn born to a mother enrolled in managed care, the hospital will notify the mother's HMO through their billing process and the HMO will subsequently send a Health Plan Status Change Reporting Form (RC-80HP) to the Center for Child and Family Health. The birth hospital may also issue a hospital

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birth record to the mother which will allow the mother to report the birth to DHS directly. Refer to section 0348.75.10 for guidance relative to newborn enrollment into managed care.

Either the Health Plan Status Change Reporting Form or the hospital birth record is acceptable verification of the birth. Upon notification, the worker evaluates the change in circumstances brought about by the birth by redetermining eligibility for the family unit.

0342.40.10.05**Hospital Record of Birth**

REV:01/2002

Certain in-state hospitals with maternity units have agreed to assist DHS in establishing eligibility for newborns (for Medical Assistance Only, or FIP/MA) by completing a hospital birth record form. The hospital record of birth contains:

- o Newborn's name, date of birth and sex;
- o Mother's name; and,
- o Information regarding whether the child was discharged in the mother's care.

The document must bear the original signature of the hospital's representative authorized to sign the hospital record of birth. The authorized representative must be an individual designated as keeper of the facility's official records.

The original of the hospital birth record is given to the mother at the point of discharge from the hospital, and a copy is attached to the hospital bill for the newborn that is sent to the Division of Health Care Quality, Financing and Purchasing.

This document is reliable alternate evidence of:

- o The age of the child;
- o The relationship of the child to the mother; and,
- o The U.S. citizenship of the child.

The birth record serves as initial documentation for the field staff to add a child to the FIP and/or Medical Assistance case.

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Note: This document does not establish paternity for a child born out of wedlock. Paternity for eligibility determination purposes is established only when an adjudication is made by Family Court, or when the official birth certificate issued by the Division of Vital Statistics lists the father's name.

Determination of Newborn Eligibility

0342.40.15

REV:06/1998

When the eligibility technician determines if the child is eligible for inclusion in the mother's Family Independence Program (FIP) or Medical Assistance case, there are three possible outcomes:

- o The child is eligible for inclusion in the mother's case; or,
- o The child cannot be included in the mother's case, but is eligible as a "Poverty Level" or "Ribicoff" child; or,
- o The child remains eligible as a newborn.

Elig Remains As a Newborn

0342.40.15.05

REV:07/1994

If eligibility cannot be determined to exist in any other group, it continues to exist for the child as a newborn for as long as the mother:

- o Remains eligible for and receiving Medical Assistance, or would be eligible for Medical Assistance if she were pregnant;
- o The child remains living with her; and,
- o A reasonable effort is made to meet newborn enumeration requirements.

At minimum, the child must be authorized Medical Assistance coverage for the period from the date of birth until the expiration of the ten-day notice period.

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When the mother becomes ineligible, and/or eligibility for the newborn terminates, the client must be given a ten-day notice of impending termination.

0342.40.15.10

Examples of Newborn Elig

REV:07/1994

EXAMPLE: Mother is eligible at the child's birth as a "Poverty Level" pregnant woman. Her eligibility continues to the end of the month in which the 60th postpartum day falls. The mother takes no action to secure continuing assistance for herself and/or the child, ignoring a contact letter sent to her by the district office upon receipt of the hospital notification of birth. Because the mother takes no action the child cannot be determined eligible in his/her own right under any provision other than as a newborn. Medical Assistance eligibility for the mother continues only until the end of the month in which the 60th postpartum day falls.

Notice of impending termination must be sent to the mother at least ten days prior to the date eligibility for the mother terminates.

However, failure of the mother to cooperate does not result in termination of coverage of the newborn since an infant eligible under the newborn provision is eligible for the first year of life. If recertification is unsuccessful, or if recertification is successful and eligibility under another provision is not found, eligibility remains for the newborn until the first birthday.

EXAMPLE: Mother, an SSI recipient, gives birth on November 11, 1994. The agency becomes aware of the birth from the hospital bill, accompanied by a hospital birth record. The hospital birth record is forwarded to the district office attached to the MA-526NB. The eligibility technician contacts the mother, who declines to file a formal application on behalf of the child. The mother does not cooperate in the enumeration process by completing an SS-5 for a Social Security Number for the child. The child remains Categorically Needy for Medical Assistance as long as s/he remains living with the mother and the mother remains Categorically Needy by virtue of being an SSI recipient. The child is certified for Medical Assistance via InRHODES. An interim redetermination must be conducted after six months to ascertain that the mother is still eligible for MA, or would be eligible if pregnant, and the child is still living with the mother.

Newborn children are considered to be eligible under the same

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category as the mother. Thus, if the mother is eligible as Categorically Needy, the child is Categorically Needy. If the mother is Medically Needy, the child is Medically Needy.

Newborn's Loss of Eligibility**0342.40.20**

REV:07/1994

Events which result in the child's loss of eligibility under the newborn provision are:

- o The mother loses eligibility for a reason that would result in her ineligibility even if she were pregnant, or there is a break in her eligibility;
- o The child moves from the mother's house;
- o The child is placed with potential adoptive parents either directly from the hospital or subsequent to discharge;
- o The child attains one year of age.

RIBICOFF CHILD**0342.45**

REV:01/2002

This coverage group is children who are born after September 30, 1983, are under age 19, and whose family meets FIP resource and income requirements. A deprivation factor does not exist. However, if the income and resource limits are met, only the child may be eligible. A Ribicoff child does NOT qualify the caretaker relative for Medical Assistance.

EXTENDED MEDICAL ASSISTANCE**0342.50**

REV:06/1998

The Family Support Act of 1988 created a special Medical Assistance program for families in which parents are making the transition from welfare to work. The program was established because of an extraordinary lack of health insurance coverage among employed former welfare beneficiaries. These families are most likely to be uninsured and least able to pay out-of-pocket for medical services. Continuing categorically needy Medical

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Assistance for up to 18 months provides a greater period of health care protection to families with newly employed parents.

Under welfare reform, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) severed the historical link between eligibility for cash assistance -- formerly called Aid to Families with Dependent Children (AFDC) -- and automatic Medical Assistance eligibility. However, Congress also created a new Medical Assistance eligibility category referred to as Section 1931 families. Rhode Island state law mandates that people eligible for cash assistance under the Family Independence Program (FIP) are also eligible for Medical Assistance. While the link between cash assistance and Medical Assistance is broken at the federal level, the income and resource limits for FIP cash assistance and the new MA only category of Section 1931 families are such that family cash assistance remains an automatic door to Medical Assistance eligibility.

Extended MA may be accessed directly from either Section 1931 eligibility or from the cash assistance Family Independence Program (FIP) eligibility.

Families who are eligible for cash assistance and who choose to forgo cash benefits for whatever reason, remain eligible for Medical Assistance under the Section 1931 category. If the family subsequently loses eligibility for reasons related to employment, family members may qualify for extended MA.

0342.50.05**Extending MA When FIP/Section 1931 MA Ends**

REV:06/1998

Extended MA may be provided to families for up to eighteen (18) months following the loss of eligibility for medical coverage provided through eligibility for the Family Independence Program (FIP) or for Section 1931 families MA Only. Receipt of benefits through either of these programs with a subsequent loss of eligibility because of events related to employment may result in continuing categorically needy Medical Assistance coverage.

Medical Assistance eligibility may continue under certain circumstances if a Family Independence Program case or Section 1931 MA case is closed because of increased earned income due to:

- o employment; or,

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- o increased hours from employment; or,
- o an increase in wages.

Initial Criteria for Extending MA

0342.50.10

REV:06/1998

At the time a family becomes ineligible for the Family Independence Program or Section 1931 Medical Assistance benefits, InRhodes examines the case for potential eligibility for extended MA and provides an MAXT pop-up window accordingly. The eligibility technician must verify and confirm, whether:

- o the family has a child living in the home who is under the age of eighteen (18) or between the age of eighteen (18) and nineteen (19) if the child is a full-time student in a secondary school, or at the equivalent level of vocational or technical training, and is reasonably expected to complete the program before or in the month of his/her nineteenth (19th) birthday. A student attending summer school full time, as defined by school authorities, is considered a full-time student for these purposes; and,
- o eligibility for the Family Independence Program or Section 1931 Medical Assistance coverage was discontinued because of earned income of a caretaker relative or other member of the family due to:
 - employment;
 - increased hours of employment; or,
 - an increase in wages.

NOTE: Extended Medical Assistance is not provided to any individual who has been legally determined to be ineligible for the Family Independence Program because of fraud at any time during the last prior six months in which the family received benefits.

Families who meet this initial criteria are eligible to receive Medical Assistance beyond the loss of health coverage provided through the Family Independence Program or Section 1931 MA

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eligibility provided they continue to meet the additional requirements described in Section 0342.50.15.

0342.50.15**Additional Requirements**

REV:06/1998

When earned income contributes to the loss of eligibility for the Family Independence Program or for Section 1931 MA, InRhodes generates a notice informing the family of the right to continue to receive categorically needy medical coverage under extended Medical Assistance for up to the maximum of 18 months allowable under the program, and of the requirements to:

- o submit two (2) reports which include an accounting of the family's earned income and the "necessary child care" expenses;
- o enroll in an employer's health plan (whether individual or family coverage) if it is offered at no cost to the caretaker relative; and,
- o report circumstances which could result in the discontinuance of extended benefits, e.g., no age appropriate child in the family or a move out of state.

0342.50.20**Loss of Benefits Due to Employment**

REV:06/1998

A required element for eligibility to receive extended Medical Assistance is employment of a caretaker relative or other member(s) of the family whose earned income contributes to the family's loss of eligibility for cash assistance or Section 1931 Medical Assistance.

Often employment linked with other changes, such as a parent returning to the home or a child turning eighteen, may combine to cause the loss of eligibility. While there must be a relationship between earned income and the loss of eligibility for cash benefits or Section 1931 MA to qualify for extended MA, the advent or increase in earned income need not be the only factor causing the loss.

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Determining Employment is a Causative Factor 0342.50.20.05

REV:06/1998

Sometimes it is difficult to determine if the relationship between earned income and the loss of Family Independence Program or Section 1931 Medical Assistance eligibility is present. Follow the steps below to determine if a change in earned income had a causative effect.

- 1) Determine if the change in earned income (starting employment, increase in wages, or an increase in hours of work) would have resulted in the loss of eligibility if all other factors in the case remained the same (e.g., no other change in income, no change in family composition, no change in income standards, etc.).

If yes, the family is eligible to receive extended Medical Assistance.

If no, proceed to step 2;

- 2) Determine if events other than the change due to earned income would have resulted in the loss of eligibility if the earned income had stayed the same.

If yes, the family is not eligible to receive extended Medical Assistance.

If no, proceed to step 3;

- 3) Determine if the family is ineligible when all changes are considered.

If yes, the family is eligible for extended Medical Assistance. The change in earnings was essential to the loss of eligibility. Without the change related to earned income, the family would not have lost eligibility.

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0342.50.25**Individuals Eligible to be Included**

REV:06/1998

The first month of extended Medical Assistance is the first full or partial month in which the family loses the medical coverage received concurrently with their Family Independence Program eligibility or after the loss of their Section 1931 Medical Assistance coverage. Extended MA is provided to those individuals:

- who are living in the household, and whose needs and income were included in determining the Family Independence Program or Section 1931 eligibility of the assistance unit at the time such benefits were discontinued;
- who are under Family Independence Program sanction and whose income but not needs were included in determining the Family Independence Program eligibility of the assistance unit at the time such benefits were discontinued; and,
- whose needs and income would be taken into account in determining the Family Independence Program or Section 1931 MA eligibility of the assistance unit if the family were applying for either of these programs in the current month.

Under the above definition, a child born after Family Independence Program or Section 1931 benefits are discontinued, or a child, parent or step-parent who returns home after the Family Independence Program or Section 1931 benefits are discontinued, is included as a member of the family for purposes of providing extended MA.

0342.50.30**Initial Receipt of Extended MA**

REV:06/1998

Extended Medical Assistance continues throughout the first seven months following the loss of Family Independence Program or Section 1931 MA eligibility as described in Section 0342.50.05, unless:

- o no age-appropriate child is living in the family; or,

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- o the caretaker relative refuses to apply for free health coverage offered by the employer.

When it is determined that a family no longer has a child who meets the age requirements living in the home, Medical Assistance for all family members ends the last day of the month in which the family no longer includes such child.

The Medical Assistance program requires recipients to utilize all resources available to them to pay for all or part of their medical care before using Medical Assistance. If the caretaker relative fails to avail her/himself of an employment related health plan (either individual or family membership) offered at no cost to the employee, extended benefits must be discontinued.

Continuing Receipt of Extended MA

0342.50.35

REV:06/1998

To continue to receive the remaining months of extended Medical Assistance, up to the limit of the full eighteen months of the transitional medical program, families must:

- o include a child who meets the age requirement living in the household (see Sec. 0342.50.10); and,
- o timely file the earned income report when due in the seventh (7th) and thirteenth (13th) months; and,
- o pass the 185% FPL earned income test; and,
- o pass the caretaker relative employment test.

Additionally,

- o an employed caretaker relative must enroll in an employment-related health plan, if such plan is offered at no cost to the employee.

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0342.50.40

Earned Income Report - Requirement

REV:06/1998

During the period of extended MA, the family is required to file two (2) reports due in the seventh (7th) and thirteenth (13th) months of extended MA.

The first report is filed in the seventh month of extended MA coverage and is an accounting of the family's total earnings and necessary child care expenses incurred during month six (6) of extended Medical Assistance.

The second report is filed in the thirteenth month of extended MA coverage and is an accounting of the family's total earnings and necessary child care expenses incurred during month twelve (12) of extended Medical Assistance.

The following information is reported.

- o the family's gross monthly earnings received in the specified month, including the earnings of any individual who is eligible to be included in the coverage, but who may not be included in the coverage because of a statutory exclusion (e.g., an individual who fails to comply with child support requirements); and,
- o the necessary child care expense for the specified month. Necessary child care is defined as the child care expenses which allow a caretaker relative to be employed.

0342.50.40.05

The Family Defined

REV:06/1998

A family receiving extended MA is defined as:

- those individuals living in the household whose needs and income were included in determining the eligibility of the family unit at the time that the Family Independence Program (FIP) or Section 1931 MA benefits were discontinued; and,
- those individuals under sanction or who are statutorily barred from participation whose income but not needs were included in the family unit.

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It also includes:

- those individuals whose needs and income would be taken into account in determining the eligibility of the family unit if the family were applying for FIP or Section 1931 MA in the current month.

Under this definition, a child born after the FIP or Section 1931 MA coverage is discontinued or a child or parent who returns home after the benefits are discontinued is included in the family for purposes of extended MA eligibility.

Family's Total Gross Earnings Defined**0342.50.40.10**REV:06/1998

The total gross earned income of family receiving extended MA is defined as the total countable earned income of all the members of the family without the application of any earned income disregards.

Necessary Child Care Expenses Defined**0342.50.40.15**REV:02/1997

For an extended MA family, necessary child care expense is defined as a reasonable child care expense necessary for the employment of a caretaker relative.

'Reasonable' refers to a child of an age or of a dependency plausibly needing child care. Additionally, child care expenses paid by DHS or another third-party are not recognized as an allowable deduction. A necessary child care expense can be incurred, it need not be paid.

Submitting the Earned Income Report**0342.50.45**REV:06/1998

The extended MA earned income reports are:

- an accounting of the family's total gross earned income and a caretaker relative's necessary child care expenses for months 6 and 12 of extended benefits;

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- due by the 5th day of months 7 and 13 respectively of extended benefits.

On the 15th of each month, a reporting form is sent to any family who has reached month six or month twelve of extended MA. Such a family must report the required income and necessary child care information by the 5th day of the following month.

On the 7th day of each month, a reminder notice is sent to all extended MA cases scheduled to report in the month. This is to encourage compliance by any family that has neglected to return the report by the due date (5th of the month). Instructions direct those who have complied to disregard the reminder notice.

All reports due in the month must be received by DHS prior to the close of business on the 21st day of the month. Medical Assistance is discontinued on the last day of the month for any family who fails to submit the report by the 21st of the month.

0342.50.45.05

Employment Test for the Caretaker Relative

REV:06/1998

For families to remain eligible beyond the seventh month of extended benefits, a caretaker relative must meet an employment test. Unless there is good cause, a caretaker relative must be employed. The caretaker relative must claim good cause on the income report form in order to have the circumstances of a lack of employment considered. (See Section 0342.50.60.10 for Good Cause.)

A caretaker relative must have earnings under the employment test even if the loss of benefits from the Family Independence Program or Section 1931 MA was caused by the earnings of another family member.

If a caretaker relative fails the employment test without good cause, InRhodes will discontinue extended benefits on the last day of the 7th month of extended MA. InRhodes will generate a notice of discontinuance to the recipient. Since the caretaker relative is required to be employed unless there is good cause, the caretaker relative must also meet the employment test when the second earned income report is filed in month thirteen (13). Failure to do so, without good cause, will result in the discontinuance of extended MA on the last day of month thirteen (13).

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Income Test - Family's Gross Earned Income 0342.50.45.10

REV:06/1998

A family's total gross earnings consist of the countable earned income of all employed family members prior to the application earned income disregards. The family's gross earnings include the earnings of any financially liable relative who returns to the unit after the loss of Family Independence Program or Section 1931 eligibility.

The family's UNEARNED income is NOT a reporting requirement and is NOT included in the income test.

Necessary child care expenses are those incurred or paid child care expenses which allowed a caretaker relative to be employed.

InRhodes applies the income test in the following manner:

- Step 1. The gross countable earnings of all employed members of the family are totaled.
- Step 2. The totaled earnings are divided by the number of pay dates and the result is multiplied by 4.33 to determine the average monthly earnings.
- Step 3. The caretaker relative's necessary child care expenses are totaled.
- Step 4. The totaled necessary child care expense is divided by the number of pay dates (same as above) and the result is multiplied by 4.33 to determine the average necessary child care monthly expense.
- Step 5. The child care expense from Step 4 is deducted from the earned income from Step 2 to determine the countable earned income.
- Step 6. The countable earned income is then compared to 185% of the federal poverty level for the current family size.

Family size will take into account any individual living in the household whose income is being considered whether or not the individual is included in extended MA.

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0342.50.50**Failure to Meet Requirements**

REV:06/1998

If the family fails to pass the income test, InRhodes will discontinue extended benefits on the last day of a reporting month. In addition to failure to pass the employment and income tests in months seven (7) and thirteen (13) of extended benefits, eligibility will end any month during extended MA when it is determined that:

- o the family ceases to include a child who meets the age requirement (see section 0342.50.10) living in the household; or,
- o an employed caretaker relative failed to enroll in a employment-related health plan which is offered at no-cost to the employee.

The maximum amount of time under the extended MA program is limited to 18 months. InRhodes will generate a notice of closing if eligibility is discontinued prior to the receipt of the maximum time allowed under the program's 18 months time-limited benefits. Eligibility is always discontinued on the last day of a month.

For a family nearing the end of the maximum period allowed under extended MA, a Medical Assistance application packet will be mailed to the family at the beginning of month seventeen (17). Failure to reapply by the specified return date will result in a discontinuance of coverage under extended MA.

Eligibility may continue for those family members for whom InRhodes has sufficient data to determine eligibility pursuant to another MA coverage group, e.g., poverty level child. If InRhodes is able to determine eligibility based on data in hand, Medical Assistance will be reauthorized in a timely manner to avoid interruption of medical coverage.

0342.50.60**Good Cause**

REV:06/1998

A family may have reason to claim good cause for failure to comply with required action.

- Good cause may exist for a failure to timely submit an

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earned income report;

- Good cause may exist for a failure of the caretaker relative to be employed.

Good cause for failure to comply with the above requirements is discussed further in subsections 0342.50.60.05 and 0342.50.60.10.

Good cause may not be claimed for failure to comply with any extended MA requirements other than the above.

Failure to Submit Earned Income Report**0342.50.60.05**

REV:02/1997

Good cause for failure to submit the earned income report or to include appropriate verifications, may exist if circumstances beyond the recipient's control prevent the requirement from being met when due. Circumstances in which good cause may exist include, but are not limited to, the following:

- o hospitalization or documented serious illness of the recipient or a member of the recipient's family;
- o lost or stolen mail confirmed by the Postal Service;
- o a catastrophe caused by fire, flood, or a severe weather condition.

Caretaker Relative Failure to be Employed**0342.50.60.10**

REV:06/1998

The caretaker relative may have good cause for lack of employment if loss of employment was caused by illness or other factors beyond the caretaker relative's control. Extended MA may continue if the caretaker relative can show good cause for being unemployed. Good cause includes circumstances beyond the recipient's control, such as, but not limited to:

- o involuntary loss of employment;
- o illness or incapacity;
- o unanticipated household emergency;

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- o work demands or conditions that render continued employment unreasonable, such as working without being paid on schedule.

0342.50.70**Discontinuing Extended MA - Notice Required**

REV:06/1998

When a family becomes ineligible for the Family Independence Program or Section 1931 MA for reasons related to employment, the family is advised in writing of their continuing eligibility for medical coverage. InRhodes generates a notice informing the family of the extended MA program's eligibility requirements, the time-limited nature of the program (18 months maximum), and the exact date coverage will end when the maximum period of benefits has passed. The notice also explains that family members may qualify for Medical Assistance under other provisions of the program when eligibility for extended MA ceases.

When extended MA is discontinued for any reason prior to the end of the maximum eighteen month period, separate notice is sent.

0342.55**IND RECEIV DHS DAY CARE SUBSID**

REV:01/2002

This coverage group consists of individuals in a family unit who would be FIP eligible if the individual's work-related child care costs were paid directly from his/her earnings, rather than by the DHS Child Care Assistance Program.

Eligibility for this coverage group exists if the family's countable income is within the FIP standard for the unit size. The family's income is determined by the same methodology used for determining FIP eligibility. However, the Dependent Care Disregard used in these cases is equal to the amount of DHS Child Care Assistance plus the individual's co-payment, not to exceed \$200 per month for a child under two (2) or \$175 per month for a child age two (2) and older or an incapacitated adult. The dependent care expense is only disregarded when the dependent's care is rendered by a person not living in the child's or incapacitated adult's household.

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FIP ELIG, NO CASH PAYMENT

0342.60

REV:01/2002

This coverage group is composed of individuals who meet Family Independence Program (FIP) requirements, but do not want a cash payment.

FIP ELIGIBLE BUT FOR INSTITUTIONALIZATION

0342.65

REV:06/1998

This coverage group is individuals in a medical or nursing facility who, if they left the facility, would be eligible for the Family Independence Program (FIP) (InRhodes Category Code 62).

ADOPTION SUBSIDY/IV-E FOSTER CHILD

0342.70

REV:07/1994

This coverage group includes foster children and adopted children whose MA eligibility is based on eligibility for the Title IV-E Foster Care Maintenance Program or Adoption Assistance Program (InRHODES Category Code 54).

The Foster Care Maintenance Program provides federally funded foster care payments on behalf of the following children:

- o Children previously eligible under the Title IV-A Foster Care Maintenance Program;
- o Certain children voluntarily placed or involuntarily removed from their homes;
- o Children in public non-detention type facilities housing no more than 25 children.

Children for whom a cash payment is made under the foster care program are deemed AFDC recipients and thus eligible for Medical Assistance as Categorically Needy. MA eligibility for children in the Foster Care Maintenance program exists as long as the Title IV-E payment continues to be made for them.

The Adoption Assistance Program provides Federal funding for continuing payments for hard to place children with special needs. The special needs adoptive children must be SSI-

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recipients or AFDC eligible at the time of adoption. A cash payment is not an MA eligibility requirement for Title IV adoption assistance children. These children continue to be eligible for Medical Assistance as long as a Title IV-E adoption assistance agreement is in effect. An interlocutory order or final decree need not exist.

0342.70.05 Eligibility Considerations

REV:07/1994

To be eligible for Title IV-E foster care payments, and therefore eligible for MA, the child must be an SSI recipient or AFDC eligible. The child's AFDC eligibility must be based on deprivation of parental support independent of the fact that the child is out of the home. The deprivation of parental support and need must exist on the basis of the child remaining in the parent or caretaker relative's home.

Once initial eligibility based on parental deprivation is established, only the income and resources actually available to the child are considered for financial eligibility.

0342.70.05.05 MA Elig, State of Residence

REV:07/1994

Title IV-E adoption assistance children and Title IV-E foster care children are eligible for Medical Assistance in their state of residence. The maintenance payment or adoption assistance payment need not have originated in Rhode Island.

0342.70.05.10 DCYF Certification Responsibility

REV:07/1994

Primary certification responsibility for Title IV-E children resides with the Department of Children, Youth and Families. When a parent or guardian of a IV-E foster or adopted child, who is now residing in Rhode Island contacts a local district office to apply for MA for his/her child, referral is made to the IV-E Unit at the DCYF.

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Closing MA Case

0342.70.05.15

REV:07/1994

Since the child's MA eligibility is contingent upon Title IV-E eligibility, the MA case is closed when the child becomes ineligible for any reason, including:

- o Child returns home;
- o Child is age 18 (and will not complete school before 19th birthday);
- o No deprivation of parental support exists;
- o Income exceeds eligibility limit;
- o Resources exceed eligibility limit.

NON IV-E FOSTER CHILD UNDER 18

0342.75

REV:07/1994

This coverage group is children under age 18, or if 18, will complete high school before his/her 19th birthday, who are in foster family care and are not eligible for Title IV-E (InRHODES Category Code 55). The basis of eligibility for Medical Assistance is deprivation of parental support by the child's separation from his/her family.

This coverage group includes:

- o Children placed in foster care by the Department of Children, Youth and Families (DCYF);
- o Children placed in foster care by private, non-profit child caring agencies; and,
- o Children in group care serviced by private, non-profit child caring agencies.

The determination of financial need of a child not living in a home maintained by the child's parents or other relatives considers only the child's own income and resources. A child is determined to be Categorically Needy if his/her non-excluded resources are within the AFDC resource limit of \$1000 and income

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is less than the AFDC Consolidated Standard for a Plan size of one.

0342.75.05**MA Foster Care Case Processing**

REV:07/1994

Within ten days of the child's placement in foster/group care, DCYF Medical Benefits Unit completes the Statement of Need for subsequent referral to the MA Foster Care Unit.

The MA FOSTER CARE UNIT located in the Regional Office at 111 Fountain Street, Providence, Rhode Island 02903 is responsible for:

- o Processing MA applications for children placed in foster family care or group care by DCYF or private, non-profit child caring agencies;
- o Determining the basis for MA eligibility (Categorically Needy or Medically Needy);
- o Maintaining records, files, controls and reports for this coverage group.

Prior to the final determination of eligibility, the MA Foster Care Unit will transmit a temporary id for medical benefits to DCYF Medical and Benefits Unit.

0342.75.10**Responsibility of DCYF**

REV:01/2002

DCYF has the continuing responsibility to notify the MA Foster Care Unit of any change in circumstance for the Foster or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, notification and return of the medical identification card is made to the Division of Health Care Quality, Financing and Purchasing, 600 New London Avenue, Cranston, RI 02920.

If a child is returned to his/her family, the agency worker informs the family about Medical Assistance. If the family is

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potentially eligible, the worker helps the family apply for MA coverage.

NON IV-E, OLDER THAN 18 BUT NOT 21**0342.80**

REV:07/1994

This coverage group is children older than age 18, but not yet 21 who are in foster family care and are not eligible for Title IV-E (InRHODES Category Code 56). The basis of eligibility for Medical Assistance is deprivation of parental support occasioned by the child's separation from his/her family.

This coverage group includes:

- o Children placed in foster care by the Department of Children, Youth and Families (DCYF);
- o Children placed in foster care by private, non-profit child-caring agencies; and,
- o Children in group care serviced by private, non-profit child-caring agencies.

The determination of financial need of a child not living in a home maintained by the child's parents or other relatives considers only the child's own income and resources. A child is determined to be Categorically Needy if his/her non-excluded resources are within the AFDC resource limit of \$1000 and income is less than the AFDC Consolidated Standard for a Plan size of one.

Cont Respon, DCYF**0342.80.05**

REV:01/2002

Within ten days of the child's placement in foster/group care, DCYF Medical Benefits Unit completes the Medical Assistance application for subsequent referral to the MA Foster Care Unit.

The MA FOSTER CARE UNIT, located in the Regional Office at 206 Elmwood Avenue, Providence, Rhode Island 02907 is responsible for:

- o Processing MA applications for children placed in

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foster family care or group care by DCYF or private, non-profit child caring agencies;

- o Determining the basis of MA eligibility;
- o Maintaining records, files, controls and reports for this coverage group.

0342.80.10**Contin Respon, DCYF**

REV:01/2002

DCYF has the continuing responsibility to notify the MA Foster Care Unit of any change in circumstances for the Foster or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, notification and return of the medical identification card is made to the Division of Health Care Quality, Financing and Purchasing, 600 New London Avenue, Cranston, RI 02920.

If a child is returned to his family, the agency worker informs the family about Medical Assistance. If the family is potentially eligible, the worker helps the family apply for MA coverage.

0342.85**NON IV-E, STATE SUB ADOPT ASSIS**

REV:01/2002

This coverage group is hard-to-place children for whom the state provides adoption assistance and who are not eligible for Title IV-E. The basis of eligibility for Medical Assistance is deprivation of parental support occasioned by the child's separation from his/her family.

The determination of financial need of a child not living in a home maintained by the child's parents or other relatives considers only the child's own income and resources. A child is determined to be Categorically Needy if the value of his/her non-ex Consolidated Standard for a Plan size of one.

Medical Assistance under this coverage group may be provided

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until the child reaches age 21.

REFUGEE MEDICAL ASSISTANCE**0342.90**

REV:01/2002

This coverage group is refugees who have resided in the United States for eight (8) months or less, and who are ineligible for one of the categorical programs due to lack of a characteristic.

To be eligible for Refugee Medical Assistance (RMA), a refugee must:

- o Meet the refugee immigration and identification requirements or be the dependent child of such refugees;
- o Meet the non-financial requirements and conditions of eligibility for Refugee Cash Assistance (RCA). (Receipt of RCA is not an RMA eligibility requirement);
- o Not have been denied or terminated from RCA due to voluntary termination from a job or a refusal of employment;
- o Not be full-time students except as allowed in Section 0906.20;
- o Be recipients of RCA or, for certain refugees prohibited from receiving a cash payment for a limited period of time, be eligible for some form of RCA;
- o Have income and resources within the Categorically Needy limits.

Treatment of Income**0342.90.05**

REV:07/1994

In-kind services and shelter provided by a sponsor or resettlement agency are not considered as income to the refugee when determining financial eligibility for RMA.

Direct cash payments to the refugee from a sponsor or resettlement agency are counted as unearned income.

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0342.90.10**Eight Month Limitation for RMA**

REV:07/1994

Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months in the United States, beginning with the month the refugee initially entered the United States, or the entrant was issued documentation of eligible status by the Immigration and Naturalization Service.

0342.90.15**Extended RMA Coverage**

REV:07/1994

If a refugee receiving Refugee Cash Assistance becomes ineligible solely due to increased earnings from employment, the refugee's RMA is extended, at the same level of care, for four months or until the end of the eight month limitation, whichever comes first.

0342.90.20**Termination of Elig for RMA**

REV:07/1994

A refugee who is terminated from RCA because of failure or refusal to participate in the employment-related requirements (Sections 0906.10 and 0906.20) is also terminated from RMA. The RMA termination applies only to the sanctioned individual.

0342.95**CLOSED FAMILY-RELATED MA-HMO ENROLL**

REV:01/2002

This coverage group is individuals who would be ineligible if not enrolled in an HMO. These individuals are closed family-related recipients locked in for the enrollment period by managed care.

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PREGNANT WOMEN - POVERTY LEVEL**0344.05**

REV:01/2002

This coverage group is pregnant women in a one or two parent family whose countable income does not exceed 185% of the Federal Poverty Level (FPL) for the family size, including the unborn.

Eligibility considerations are:

- o The pregnancy must be medically verified;
- o Only the pregnant woman is eligible. No other family member qualifies for coverage under this provision;
- o A deprivation characteristic (Section 0306.10.15) need not exist;
- o There is no resource test;
- o Countable income is determined by the MA family-related treatment methodology (See Section 0334 - Determining Income Methodology);
- o There is no spenddown. Costs incurred for medical care are not deducted from the family's income when determining eligibility for this coverage group;
- o Once eligibility is established, the pregnant woman remains Categorically Needy until the end of the month in which the 60th post partum day occurs. Any subsequent change in income does not effect the woman's eligibility status.

If a pregnant woman is ineligible under this coverage group and there are very high medical expenses, eligibility as Medically Needy may be found under the flexible test of income policy (Section 0336). A deprivation characteristic need not exist for the pregnant woman, but there is a resource test coverage as a Medically Needy Pregnant Woman.

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0344.05.05**Example of Poverty Level Eligibility**

REV:05/1996

A pregnant woman, living in a family with four members, including the unborn, applies for Medical Assistance for herself. The family's countable income is \$2,360 monthly. Since the income is within the FPL for the family size, the pregnant woman is eligible for Medical Assistance as Categorically Needy.

0344.10**CHILD YOUNGER THAN 6, POVERTY LEVEL**

REV:11/2000

These coverage groups consist of children up to one (1) year of age with family countable income is less than one hundred eighty five percent (185%) of the Federal Poverty Level (fpl); and children older than one (1) year of age and younger than six (6) years of age with family countable income is less than one hundred thirty three percent (133%) of the Federal Poverty Level (fpl).

Eligibility considerations are:

- o An eligibility factor of deprivation need not exist;
- o There is no relationship requirement. The child may be living with a non-relative caretaker or in a licensed foster care home;
- o There is no resource test;
- o Countable income is determined by the MA family-related treatment methodology (See Section 0334 - Determining Income Methodology);
- o There is no spenddown. Costs incurred for medical care are not deducted from the family's income when determining eligibility;
- o Once eligibility is established, the child is entitled to the full scope of services as a Categorically Needy individual, from the first of the month of application through the end of the month in which the child's first birthday occurs. If the child is hospitalized on his/her first birthday, coverage will be extended until

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the child is discharged from the facility.

- o If the child is hospitalized in a hospital or long term care facility when s/he reaches age six (6), coverage is extended until the child is discharged from the facility.

If the child is ineligible under this coverage group or under a corresponding Rite Care coverage group (Section 0348) because countable income exceeds the appropriate fpl, eligibility as a Medically Needy Ribicoff child may be available based on a flexible test of income. An eligibility factor of deprivation need not exist, but the family must meet the Medically Needy resources limits.

CHILD OLDER THAN 6, NOT 19**0344.15**

REV:11/2000

This coverage group consists of children born after September 30, 1983 who have attained six (6) years of age but have not attained nineteen (19) years of age with family countable income within one hundred percent (100%) of the Federal Poverty Level (fpl).

Eligibility considerations are:

- o An eligibility factor of deprivation need not exist;
- o There is no relationship requirement. The child may be living independently, with a non-relative caretaker, or in a licensed foster care home;
- o There is no resource test;
- o Countable income is determined by the MA family-related treatment methodology (See Section 0334 - Determining Income Methodology);
- o There is no spenddown. Costs incurred for medical care are not deducted from the family's income when determining eligibility for this coverage group;
- o If the child is hospitalized in a hospital or long term care facility when s/he reaches age nineteen (19), coverage is extended until the child is discharged from

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the facility.

If a child is ineligible for this coverage group or under a corresponding Rite Care coverage group (Section 0348) because countable income exceeds the appropriate FPL, eligibility as a Medically Needy "Ribicoff" child may be available based on a flexible test of income. An eligibility factor of deprivation need not exist, but the family must meet the Medically Needy resource limits.

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FAMILIES WITH AFDC CHARACTERISTICS

0346.05

REV:07/1994

Families with characteristics of AFDC and income and resources within the limits established for the Medically Needy (InRHODES Category Code 80)include:

- o AFDC-related families to include children under 18 and their caretakers;
- o AFDC-related pregnant women with no other eligible children;
- o AFDC-related children age 18 who are full time students in a secondary school or in the equivalent level of vocational or technical training, and who will complete school before their 19th birthday.

QUAL PREG WOMEN--NO DEPRIV FACTOR

0346.10

REV:01/2002

A pregnant woman in a one or two parent family, without regard to the existence of a deprivation characteristic, whose income and resources are within appropriate limits at the time of the eligibility determination, is eligible for Medical Assistance as an individual for the duration of the pregnancy.

Eligibility exists provided that:

- o The pregnancy has been medically verified; and,
- o The family income and standards do not exceed the Medically Needy standards for the size of the family including the newborn.

Once the pregnant woman has been determined eligible, she remains eligible throughout the pregnancy and post partum period regardless of changes in family income.

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0346.15

QUALIFIED PREGNANT WOMEN

REV:01/2002

This coverage group is women whose pregnancy has been medically verified, and who would be eligible for FIP cash payment if the child had been born and living with her. Family size includes the unborn. Once the pregnant woman is determined eligible, she remains eligible regardless of any change in family income.

0346.20

QUALIFIED POST PARTUM WOMEN

REV:01/2002

This coverage group is women who, while pregnant, were eligible for and received MA. The woman continues to be eligible, as though she were pregnant, for all pregnancy related and post partum medical assistance for a 60 day period beginning with the last day of her pregnancy.

Eligibility for this coverage extends to the last day of the month in which the 60th post partum day falls.

0346.25

NEWBORN CHILD OF MA ELIG MOTHER

REV:01/2002

This coverage group is children born to a woman who is eligible and receiving MA as Medically Needy on the date of the child's birth (InRHODES Category Code 90). The mother's basis of eligibility may be family or SSI-related.

The child is deemed eligible for one year from birth as long as:

- o The child resides continually in the mother's household;
- o The mother remains eligible for MA, or would have remained eligible if she were pregnant.

To determine if the newborn is living in the mother's household, the eligibility technician will use the rules of the cash assistance program related to the mother's eligibility.

Changes in the mother's family income never effect the newborn's deemed eligibility because, if still pregnant, the mother would remain eligible regardless of changes in income. If the mother

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loses eligibility because of changes other than income, the eligibility technician must determine whether she would have remained eligible on any basis if she were still pregnant.

An infant born to an eligible pregnant woman has automatic MA enrollment for the first year of life whether the mother qualifies through a cash assistance program (FIP or SSI) or through Medical Assistance only. This eligibility exists even if the mother becomes ineligible for FIP or SSI, provided the mother is currently eligible for MA or would be if she were still pregnant.

Newborn Enumeration Requirement**0346.25.05**

REV:01/2002

Although the mother need not file a separate application for coverage for the newborn, she is required to cooperate with the agency in the enumeration process. Enumeration is a requirement of eligibility for the newborn. However, failure to enumerate the child results in a sanction against the mother, not the child. The child will remain eligible even if lacking a social security number because of mother's failure to cooperate.

Medical Assistance coverage under this group is the "last resort" for newborns. Whenever possible, staff should determine a child eligible under the Section 1931 or under another coverage group before certifying the child for Medical Assistance as a newborn.

Newborn Case Processing**0346.25.10**

REV:01/2002

Although the newborn is deemed eligible at birth, the birth itself is a change in household composition which has substantial eligibility ramifications. The introduction of a new household member(s) requires the worker to redetermine eligibility for the family unit as a whole, as well as the newborn. The redetermination process is completed within thirty (30) days from the date the district office receives notification of the birth.

Operating procedures vary, depending on how the district office becomes aware of the birth and on whether the mother is enrolled in managed care. In some instances the hospital or HMO may inform DHS of the birth, or the mother, or guardian of the infant, may

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inform the district office of the birth directly.

For a newborn child born to a mother not enrolled in managed care, the district office will receive a copy of the hospital birth record from the hospital where the birth occurs. Subsection 0346.25.10.05, below, describes the function of the hospital birth record.

For a newborn born to a mother enrolled in managed care, the hospital will notify the mother's HMO through their billing process and the HMO will subsequently send a Health Plan Status Change Reporting Form (RC-80HP) to the Center for Child and Family Health (CCFH). The birth hospital may also issue a hospital birth record to the mother which will allow the mother to report the birth to DHS directly. Refer to section 0348.75.10 for guidance relative to newborn enrollment into managed care.

Either the Health Plan Status Change Reporting Form or the hospital birth record is acceptable verification of the birth. Upon notification, the worker evaluates the change in circumstances brought about by the birth by redetermining eligibility for the family unit.

0346.25.10.05 Hospital Record of Birth

REV:01/2002

Certain in-state hospitals with maternity units have agreed to assist DHS in establishing MA eligibility for newborns by completing a hospital birth record form.

The hospital record of birth contains:

- o Newborn's name, date of birth and sex;
- o Mother's name; and,
- o Information regarding whether the child was discharged in the mother's care.

The document must bear the original signature of the hospital's representative authorized to sign the hospital record of birth. The authorized representative must be an individual designated as keeper of the facility's official records.

The original of the hospital birth record is given to the mother

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at the point of discharge from the hospital, and a copy is attached to the hospital bill for the newborn that is sent to the Division of Medical Services.

This document is reliable alternate evidence of:

- o The age of the child;
- o The relationship of the child to the mother; and,
- o The U.S. citizenship of the child.

The birth record serves as initial documentation for the field staff to add a child to the Medical Assistance case.

Note: This document does not establish paternity for a child born out of wedlock. Paternity for eligibility determination purposes is established only when an adjudication is made by Family Court, or when the official birth certificate issued by the Division of Vital Statistics lists the father's name.

Determination of Newborn Elig**0346.25.15**

REV:07/1994

When the eligibility technician determines if the child is eligible for inclusion in the mother's Medical Assistance case, there are two possible resolutions:

- o The child is eligible as a "Poverty Level" child; or,
- o The child remains eligible as a newborn.

Newborn Inclusion in Mother's Case**0346.25.15.05**

REV:01/2002

The newborn is added via InRHODES for Medical Assistance Only recipients. The fiscal unit will be notified electronically by InRHODES of the inclusion of the newborn in the mother's FIP case.

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0346.25.15.10 Newborn not in Mother's Case

REV:07/1994

The eligibility technician determines eligibility for the child as a "Poverty Level" or "Ribicoff" child (Section 0344). If eligibility under one of these groups exists for the child, Medical Assistance is authorized via InRHODES in the normal manner.

0346.25.15.15 Elig Remains as a Newborn

REV:07/1994

If eligibility cannot be determined to exist in any other group, it continues to exist for the child as a newborn for as long as the mother:

- o Remains eligible for and receiving Medical Assistance, or would be eligible for Medical Assistance if she were pregnant;
- o The child remains living with her; and,
- o A reasonable effort is made to fulfill newborn enumeration requirements.

At a minimum, the child must be authorized Medical Assistance coverage for the period from the date of birth until the expiration of the ten-day notice period.

When the mother becomes ineligible, and/or eligibility for the newborn terminates, the client must be given a ten-day notice of impending termination.

0346.25.15.20 Example of Newborn Elig

REV:01/2002

Example: Mother is eligible at the child's birth as a Medically Needy pregnant woman. Her eligibility continues to the end of the month in which the 60th postpartum day falls. The mother takes no action to secure continuing assistance for herself and/or the child, ignoring a contact letter sent to there by the district office upon receipt of the hospital notification of birth. Because the mother takes no action the child cannot be determined eligible in his/her own right under any provision other than as a

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newborn. Medical Assistance eligibility for the mother continues only until the end of the month in which the 60th postpartum day falls.

A notice of impending termination must be sent to the mother at least ten days prior to the date eligibility for mother terminates.

Failure of the mother to cooperate does not result in termination of coverage of the newborn since an infant eligible under the newborn provision is eligible for the first year of life. If recertification is unsuccessful, or if recertification is successful and eligibility under another provision is not found, eligibility remains for the newborn until the first birthday.

Example: Mother, a MA only Medically Needy recipient, gives birth on November 11, 1994. The agency becomes aware of the birth from the hospital bill, accompanied by a hospital birth record. The hospital birth record is forwarded to the district office attached to the MA-526NB. The eligibility technician contacts the mother, who declines to file a formal application on behalf of the child. The mother does cooperate in the enumeration process by completing an application for a Social Security Number for the child. The child remains Medically Needy for Medical Assistance as long as s/he remains living with the mother and the mother remains Medically Needy. An interim redetermination must be conducted after six months to ascertain that the mother is still eligible for MA, or would be eligible if pregnant, and the child is still living with the mother.

Newborn's Loss of Eligibility**0346.25.20**

REV:07/1994

Events which result in the child's loss of eligibility under the newborn provision are:

- o The mother loses eligibility for a reason that would result in her ineligibility even if she were pregnant, or there is a break in her eligibility;
- o The child moves from the mother's house;
- o The child is placed with potential adoptive parents either directly from the hospital or subsequent to

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discharge;

- o The child attains one year of age.

Notification must be sent to the mother ten days prior to terminating Medical Assistance for the newborn.

0346.30

RIBICOFF CHILD

REV:01/2002

This coverage group is children who are born after September 30, 1983, are under age 19, and whose family meets Medically Needy resource and income standards. A deprivation characteristic does not exist. Ribicoff coverage does not qualify the child's caretaker relative for Medical Assistance.

0346.35

NON IV-E FOSTER CHILD UNDER 18

REV:01/2002

This Medically Needy coverage group is children under age 18 or if 18, will complete high school or technical training before their 19th birthday, who are in foster family care and are not eligible for Title IV-E. The basis of eligibility for Medical Assistance is deprivation of parental support by the child's separation from his/her family.

This coverage group includes:

- o Children placed in foster care by the Department of Children, Youth and Families (DCYF);
- o Children placed in foster care by private, non-profit child caring agencies; and,
- o Children in group care serviced by private, non-profit child caring agencies.

The determination of financial need of a child not living in a home maintained by the child's parents or other relatives considers only the child's own income and resources. A child is determined to be Medically Needy if his/her non-excluded resources are within the Medically Needy resource limit and income is less than the Medically Needy limit for one.

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MA Foster Care Case Processing

0346.35.05

REV:01/2002

Within ten days of the child's placement in foster/group care, DCYF Medical Benefits Unit completes the MA application for subsequent referral to the MA Foster Care Unit.

The MA FOSTER CARE UNIT located in the DHS Regional Office in Providence, is responsible for:

- o Processing MA applications for children placed in foster family care or group care by DCYF or private, non-profit child caring agencies;
- o Determining the basis for MA eligibility (Categorically Needy or Medically Needy);
- o Maintaining records, files, controls and reports for this coverage group.

Responsibility of Child Care Agency

0346.35.10

REV:07/1994

The child care agency has the continuing responsibility to notify the MA Foster Care Unit of any change in circumstance for the Foster or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, notification and return of the medical identification card is made to the Division of Medical Services, 600 New London Avenue, Cranston, RI 02920.

If a child is returned to his/her family, the agency worker informs the family about Medical Assistance. If the family is potentially eligible, the worker helps the family apply at the appropriate district office.

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0346.40**NON IV-E AGE 18 BUT NOT YET 21**

REV:07/1994

This coverage group is children age 18 but not yet 21 who are in foster family care and are not eligible for Title IV-E (InRHODES Category Code 88). The basis of eligibility for Medical Assistance is deprivation of parental support by the child's separation from his/her family.

This coverage group includes:

- o Children placed in foster care by the Department of Children, Youth and Families (DCYF);
- o Children placed in foster care by private, non-profit child-caring agencies; and,
- o Children in group care serviced by private, non-profit child-caring agencies.

The determination of financial need of a child not living in a home maintained by the child's parents or other relatives considers only the child's own income and resources. A child is determined to be Medically Needy if his/her non-excluded resources are within the Medically Needy resource and income limits.

0346.40.05**MA Foster Care Case Processing**

REV:07/1994

Within ten days of the child's placement in foster/group care, DCYF Medical Benefits Unit completes the Statement of Need for subsequent referral to the MA Foster Care Unit.

The MA FOSTER CARE UNIT, located in the Regional Office at 111 Fountain Street, Providence, Rhode Island 02903 is responsible for:

- o Processing MA applications for children placed in foster family care or group care by DCYF or private, non-profit child caring agencies;
- o Determining the basis of MA eligibility (Categorically Needy or Medically Needy);
- o Maintaining records, files, controls and reports for this

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coverage group.

Prior to the final determination of eligibility, the MA Foster Care Unit will transmit a temporary ID for medical benefits to DCYF Medical and Benefits Unit.

Responsibility, Child Care Agency **0346.40.10**

REV:07/1994

The child care agency has the continuing responsibility to notify the MA Foster Care Unit of any change in circumstances for the Foster or Group Care child. The change in circumstance could be a change in placement or a change in the child's income or resources.

When a child is no longer in the agency's care, notification and return of the medical identification card is made to the Division of Medical Services, 600 New London Avenue, Cranston, RI 02920.

If a child is returned to his family, the agency worker informs the family about Medical Assistance. If the family is potentially eligible, the worker helps the family apply at the appropriate district office.

NON IV-E, STATE SUB ADOPT ASSIS **0346.45**

REV:07/1994

This coverage group is hard-to-place children for whom the State provides adoption assistance and who are not eligible for Title IV-E (InRHODES Category Code 89). The basis of eligibility for Medical Assistance is deprivation of parental support by the child's separation from his/her family.

The determination of financial eligibility of a child not living in a home maintained by the child's parents considers only the child's own income and resources. A child is determined to be Medically Needy if the value of his non-excluded resources and income are within Medically Needy limits.

Under this coverage group, Medical Assistance is available until the child reaches age 21.

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0346.50

REFUGEE ASSISTANCE

REV:07/1994

This coverage group is refugees who have resided in the United States for eight (8) months or less, and who are ineligible for one of the categorical programs due to lack of a characteristic (InRHODES Category Code 92).

To be eligible for Refugee Medical Assistance (RMA), a refugee must:

- o Meet the refugee immigration and identification requirements or be the dependent child of such refugees;
- o Meet the non-financial requirements and conditions of eligibility for Refugee Cash Assistance (RCA). (Receipt of RCA is not an RMA eligibility requirement);
- o Not have been denied or terminated from RCA due to voluntary termination from a job or a refusal of employment;
- o Not be full-time students except as allowed in Section 0906.20;
- o Have income and resources within the Medically Needy limits.

0346.50.05

Treatment of Income

REV:07/1994

In-kind services and shelter provided by a sponsor or resettlement agency are not considered as income to the refugee when determining financial eligibility for RMA.

Direct cash payments to the refugee from a sponsor or resettlement agency are counted as unearned income.

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Eight Month Limitation for RMA**0346.50.10**

REV:07/1994

Receipt of RMA under the characteristic of "refugee" is limited to the first eight (8) months in the United States, beginning with the month the refugee initially entered the United States, or the entrant was issued documentation of eligible status by the Immigration and Naturalization Service. (See 0908.10.05)

Extended RMA Coverage**0346.50.15**

REV:07/1994

If a refugee receiving Refugee Cash Assistance becomes ineligible solely due to increased earnings from employment, the refugee's RMA is extended, at the same level of care, for four months or until the end of the eight month limitation, whichever comes first.

Termination of Elig for RMA**0346.50.20**

REV:07/1994

A refugee who is terminated from RCA because of failure or refusal to participate in the employment-related requirements (Sections 0906.10 ad 0906.20) is also terminated from RMA. The RMA termination applies only to the sanctioned individual.