Family Independence

An Office of the
Department of Health and Human Services

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Department of
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Office for Family Independence

Eligibility Rules

MAINECARE
And
State-funded Services

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PART 1
GENERAL INFORMATION

SECTION 1 INTRODUCTION

The Maine Department of Health and Human Services is responsible for administering the MaineCare Program in compliance with Federal and State statutes and administrative policies. It is also responsible for state funded assistance programs found within this manual. Within the Department, the Office of Integrated Access and Support (OIAS) establishes and applies written policies and procedures for taking applications and determining eligibility for assistance, consistent with the objectives of the Program. It also respects the rights of individuals under the United States Constitution, the Social Security Act, Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act and all other relevant provisions of Federal and State laws which do not result in practices that violate the individual's privacy or personal dignity. The Department further holds any policies or procedures developed at the regional level to be consistent.

Title VI of the Civil Rights Act of 1964 and the Americans with Disabilities Act states that no person shall be excluded from participation, be denied benefits, or be subjected to discrimination on the grounds of race, color, national origin, sex, gender orientation, religion or handicap under any program or activity receiving federal financial assistance. Therefore, the programs of the Department, like every program or activity receiving financial assistance from the Federal Department of Health and Human Services, must be operated in compliance with the law.

In accordance with the Americans with Disabilities Act, no qualified individual with a disability will, by reason of such disability, be subjected to discrimination; or be excluded from participation or be denied the benefits of the services, programs or activities of the Maine Department of Health and Human Services.

SECTION 2 CONFIDENTIALITY

The Department of Health and Human Services, in accordance with Federal Regulation (42 CFR 431.306) and State statutes, must maintain the individual's information in a manner which will ensure that this information is restricted to persons or agency representatives who are subject to standards of confidentiality comparable to those of the Department.

Section 2.1 Release of Information

Information from the case record will be released under the following circumstances:

I. The individual has the right to review information in their case record at any time. When the medical source requests that the medical information be kept confidential, that information may not be reviewed by the individual.

II. All information pertaining to a decision of eligibility for assistance, including medical and social data for preparation of an Administrative Hearing will be made available to the individual or the individual's representative. If the individual is being represented by an attorney, permission to release information to the attorney must be obtained in writing from the individual.

III. Financial information relating to eligibility will be given to general assistance administrators if necessary for making a determination of granting general assistance.

IV. Information relating to whether an individual is a recipient in a particular month will be given to hospitals, physicians, pharmacists, and other medical providers inquiring in order to determine whether to provide their service under MaineCare. The address of the individual is not to be released.

V. Information necessary for other Offices within the Department to administer their programs may be given. These Offices include Office of Child and Family Services (OCFS) – Child Protective Services, Office of Elder Services (OES) – Adult Protective Services, Division of Support Enforcement and Recovery (DSER), Fraud Investigation and Recovery (FIR), the Preventive Health Program (PHP), and the Division of Administrative Hearings. Information may also be provided to other Offices within DHHS if there is a written Memorandum of Understanding between OIAS and that Office.

VI. For those agencies having a contract with the Department information may be released that is needed for the agency to fulfill the terms of the contract. Agencies include Home and Community Based Waiver agencies and Community Action Programs.

VII. In the event of the issuance of a subpoena or order from the court for the case record or for any agency representative to testify concerning an applicant or recipient, the Department's attorneys will call the Court's attention to the statutory provisions and the regulations against disclosure of information. The decision in regard to release of information will be with the presiding judge.

Section 2.2 Written Release of Information

With all other requests, a written release from the individual is required prior to sharing the information. Unless otherwise specified any written release of information is valid for one year from the date of signature by the individual. The release of information must specify the information to be released and to whom.

I. Release of medical reports to general assistance administrators will be made only if the individual has signed a written release.

II. Information will be made available upon receipt of written authorization from the individual (or adult family head in the case of children) giving the Department authorization to release information to the following:
   A. Federal and State legislators;
   B. attorneys;
   C. social or financial service agencies requesting information beyond eligibility dates, or, if under contract with the Department, information beyond that necessary to administer their program.

III. Information about whether the individual is receiving MaineCare, the number of children in the assistance unit and the address of the children will be made available to absent parents inquiring about the status of the family only with written permission of the caretaker relative.

Section 2.3 Information from an external source

For DHHS to obtain information:

I. the Eligibility Specialists must inform the individual of the Department's need for collateral information; and

II. receive a signed release form from the individual identifying the information being requested and from whom.

Information in case records and computer files will be used only for Department business, never for obtaining information about friends, relatives or neighbors. Employees of the Department are not permitted to determine their own eligibility or that of their immediate family.

The names of individuals supplying information who wish to remain anonymous will not be kept in the case record.

SECTION 3 REFERRALS

Under certain circumstances referral to other Offices and Divisions within the Department of Health and Human Services are to be made. These include the Office of Child and Family Services (OCFS), the Office of Elder Services (OES) and the Division of Fraud Investigation and Recovery (FIR) within OIAS.

Section 3.1 Referrals to Child and Adult Protective Services

In compliance with Federal and State statutes, when information is brought to the attention of a staff member or there is reasonable cause to suspect abuse, neglect or exploitation, an immediate referral will be made to the Child or Adult Protective Unit which will investigate the suspected abuse.

Section 3.2 Referral to the Fraud Investigation and Recovery Unit (FIR) from the Eligibility Unit

If it appears that a recipient has purposely misrepresented actual circumstances (such as living arrangement, income, or assets) in order to receive MaineCare, and the individual would not have been eligible had the proper information been available at the time of application, re-determination of eligibility, or within ten days of the change in circumstances, a referral to the Fraud Investigation Unit will be made.

The report will include:

I. a detailed explanation of the misrepresentation and the effect it had on eligibility.
II. a claims history indicating the services that should not have been paid.

Section 3.3 Referrals to the Fraud Investigation and Recovery Unit (FIR) from an outside source

Complaints received directly by the Fraud Investigation and Recovery Unit may be referred to the Attorney General's Office if it is determined that:

I. the individual was enrolled in MaineCare at the time alleged fraud occurred;

II. it appears that the individual has purposely misrepresented actual circumstances to receive MaineCare;

III. the individual would not have remained eligible if the complaint is valid; and

IV. MaineCare paid for services during the time period in question.

The name of individuals supplying information who wish to remain anonymous will not be kept in the case record.

SECTION 4 REPLACEMENT OF MEDICAL IDENTIFICATION CARDS

In those instances when an individual reports the loss or non-receipt of a medical identification card, the Department will issue a replacement card.

Requests may be made by telephone, in writing, or in person.

OIAS will issue replacement cards for those individuals for whom they maintain case records or for SSI recipients. Child welfare recipients will be referred to Office of Child and Family Services (OCFS).

SECTION 5 OUT OF STATE COVERAGE

Medical Services provided outside of the State of Maine are coverable under the following circumstances:

I. Individuals are eligible for payment of services to qualified providers as long as the provider is located within fifteen miles of the Maine-New Hampshire border or within five miles of the Maine-Canada border.

II. Individuals absent from the State are eligible for coverage of emergency services. Routine medical services usually require prior authorization from the Office of MaineCare Services (OMS). In both circumstances the provider will need to enroll as a MaineCare provider.

SECTION 6 OUTREACH

State law (22 MRSA §3173) requires the Department of Health and Human Services to inform low-income households of the availability and benefits of MaineCare and provide reasonable and convenient access to the program. The Department publishes information explaining covered services and eligibility.

SECTION 7 ADMINISTRATIVE HEARINGS

An Administrative Hearing (Hearing) is an informal conference held by the Commissioner of the Department, or a Hearing Officer, to review the action taken by the Department in order to ensure that Federal and State policy have been applied correctly. This right is basic throughout all of the public assistance programs. (Administrative Hearings regulations for all of DHHS is found at 10-144 in the Code of Maine Regulations Chapter 1). If the Commissioner authorizes another agent to handle the hearing, the Hearing Officer must be:

I. impartial and not have participated in the action causing dissatisfaction;

II. sufficiently skilled in interviewing to obtain evidence and the facts necessary for a fair determination; and

III. qualified to evaluate all evidence fairly and realistically, to explain to the individual the policies under which the Department operated and to interpret and inform the Department of any evidence of unsound, unclear or inequitable policies or practices.

Written notification of the right to a hearing is given to all interested parties through the use of pamphlets and informational materials.

Every written notification of Department action on eligibility will include:

I. the right to a hearing;

II. the method by which a hearing can be obtained; and

III. the right to be represented by legal counsel, relative, friends, or other persons. The Department cannot pay for legal services.

Section 7.1 Requesting an Administrative Hearing

Federal and State laws assure that any individual or the individual's representative who believes that proper consideration has not been given to circumstances surrounding a request for assistance may request a hearing. Any oral or written request made by the individual or their representative to the Department that they want an opportunity to present the case to a higher authority is a request for a hearing.

All complaints which are not clear requests for a hearing will be answered by a personal contact or in writing by the Eligibility Specialist, Supervisor, or member of Central Office staff and will explain the individual's right to a hearing. If the individual is satisfied with the adjustment or explanation, activity on the complaint will end. If not, the individual will be offered the opportunity for a hearing.

The Department must assure that the individual understands the process. When a request is made, the Department will not limit or interfere with the individual's rights in any way. In fact, the emphasis of the Department will be on helping the individual submit the request and prepare the case. The Department's regional office will provide information regarding legal services available in the community to assist the individual in representation at hearings.

The Department may request that the Division of Administrative Hearings deny or dismiss a request for a hearing when:

I. the request is withdrawn in writing by the individual or individual's representative;

II. the sole issue is one of State or Federal law requiring automatic adjustment for groups of individuals unless the reason for an individual's appeal is disagreement of facts affecting eligibility (such as incorrect computation); or

III. the hearing is abandoned. Abandonment occurs when the individual or the individual's representative fails to appear at the hearing without a reason acceptable to the Hearing Officer.

The Department may respond to a series of individual requests for hearings by requesting the Division of Administrative Hearings conduct a single group hearing. The Department will consolidate only cases in which the sole issue involved is one of a single policy issue. If individuals request a group hearing on such an issue, the Department will grant it. In all group hearings, the policies governing hearings will be followed. Thus, individuals will be permitted to present their own cases and to be represented. If, at any time, an individual scheduled for a group hearing wants to withdraw and have an individual hearing, the request must be made to the Division of Administrative Hearings.

Any request for a hearing must be received by the local office or the Division of Administrative Hearings within thirty days (plus two days for mail) starting with the date on the written notice of eligibility unless the Department decides to grant an extension of time.

The hearing process will take no longer than sixty days from the date of the initial request for the hearing except when the individual requests a delay. If the request for a delay is granted, additional time may be added to the sixty days.

A request for a hearing will be acknowledged in writing within five days of its receipt by the local office or the Division of Administrative Hearings. If the Eligibility Specialist has not prepared a hearing report, a request for a hearing will be forwarded to the Division of Administrative Hearings with a note that a report will follow. On receipt of the request, the Division of Administrative Hearings will send a written acknowledgment to the individual. A written report of the actions taken which resulted in the request for the hearing will be forwarded to the Division of Administrative Hearings by the Eligibility Specialist within ten days of the request for the hearing. The Division of Administrative Hearings will then send a hearing notice to the individual and the individual's representative. The hearing notice will contain the date, time and place of the hearing. The hearing will be scheduled after considering the convenience of the individual. The notice will be sent at least ten days prior to the hearing to allow for preparation of the case.

A copy of the hearing request and acknowledgment letter will be forwarded to the regional office. The Eligibility Specialist will review the circumstances prior to the hearing and will submit a report to the Hearing Officer. The person who had primary responsibility for the decision will furnish the required reports. If the review results in a satisfactory adjustment or explanation, the individual may make written withdrawal of the request for a hearing which will be forwarded immediately to the Hearing Officer.

When additional medical information is requested by the individual, it will be obtained at Department expense from a medical source satisfactory to the individual. The Hearing Officer can also consider the physician's report or can request additional evidence. The medical report will be made in writing or by personal testimony for the hearing record. When the hearing involves medical issues, a medical assessment other than that of the persons involved in making the original decision will be obtained and made a part of the record if the Hearing Officer or the individual considers it necessary.

Section 7.2 Continuation of Benefits

If the individual requests a hearing at any time during the Adverse Action Notice Period, assistance will be continued until the written hearing decision is rendered. The Adverse Action Notice Period is the twelve day period (ten days for notice plus two days for mail), starting with the date of the written notice of eligibility.

If a hearing is requested after the twelve day period, assistance will not be continued or reinstated at its previous level pending a decision.

Closure of temporary coverage is a denial and continuation of benefits cannot be made.

Section 7.3 Conducting an Administrative Hearing

The Eligibility Specialist and other Department representatives involved in the decision will participate in the hearing. All participants will testify under oath.

Either party may subpoena witnesses and evidence by request through the Division of Administrative Hearings Office. The party requesting the subpoena will bear any expenses of issuance and costs of reimbursement to witnesses.

All hearings will:

I. be conducted privately and be open only to the individual, anyone present at the individual's request, and members of the Department's staff, or others selected by the Hearing Officer for their participation in the hearing;

II. be conducted informally without technical rules of evidence. Hearings will be subject to the requirement of due process, the regulations of the Division of Administrative Hearings and the Administrative Procedure Act. All witnesses will testify under oath;

III. be opened by the Hearing Officer who will make a statement of points in issue, give all participants an opportunity to present relevant oral or written testimony or documentary evidence, offer rebuttal, question witnesses, examine all evidence presented at the hearing, and establish competency of witnesses offering subjective or technical opinions;

IV. be recorded to be available to members of the Department and to the individual or individual's representative. All documentary evidence submitted as exhibits at the hearing will be available;

V. be concluded when the Hearing Officer and the individual or individual's representative are satisfied that all available relevant evidence has been introduced and properly examined; and

VI. result in a decision based exclusively on evidence or testimony presented at the hearing.

Section 7.3.1 The Hearing Officer's review of the Department's decision shall include consideration of:

I. the Agency's failure to act with reasonable promptness. This includes undue delay in reaching a decision about eligibility or refusal to consider a request for assistance and termination or reduction of assistance.

II. an Agency decision regarding:
   A. eligibility for assistance in both initial and subsequent determinations;
   B. the level of coverage granted.

Section 7.3.2 The individual or the individual's representative will have the opportunity to:

I. examine all documents and records pertinent to the hearing;

II. present the case with or without the aid of others;

III. bring witnesses;

IV. establish all pertinent facts and circumstances;

V. present any relevant arguments without interference;

VI. question or refute any testimony or evidence; and

VII. confront and cross examine adverse witnesses.

Any information shared with the Hearing Officer must also be shared with the individual or the individual's representative.

Section 7.3.3 Following the Hearing, a written decision will be prepared by the Hearing Officer.

The decision will contain:

I. a statement of the issue;

II. a list of participants;

III. relevant facts brought out at the hearing and items introduced into evidence;

IV. pertinent provisions in Department's policy governing the decision; and

V. the decision and the basis for the decision.

A copy of the hearing decision will be sent to the individual, the individual's representative, the regional office and the MaineCare Program Manager.

The Department is bound by the hearing decision. The decision is applied to the case in question only.

Section 7.4 Implementing Results

The hearing decision will be implemented upon receipt of the written decision.

If the individual files an appeal to Superior Court benefits will continue if directed by the Attorney General or the court.

Section 7.5 Judicial Review

Within five days of the written decision by the Hearing Officer, the copy of the decision and notice of the individual's rights to judicial review under Maine Administrative Procedure Act 5 M.R.S.A., Sec. 11001 et seq. will be mailed to the individual and the individual's representative. The notice will also advise the individual that to take advantage of this right, a petition for review with the Superior Court must be filed within thirty days of the receipt of the decision.

For additional information on the preparation of a hearing, see Appendix I - Preparation for the Hearing Process.

SECTION 8 RECORD RETENTION

Material is kept for auditing purposes for three years. Material over three years old may be destroyed except for the first application which should be kept even if it is over three years old.

Individual case records are not to be filed in Archives for historical preservation and future review by historians or anyone else. Such retention has no bearing on the administration of MaineCare.

The only exception to this procedure is a case which has been referred to the Fraud Investigation and Recovery Unit (FIR) or Attorney General for collection or prosecution purposes. These case records shall be clearly marked "Do Not Destroy".

PART 2
BASIC ELIGIBILITY CRITERIA

SECTION 1 SCOPE OF THE PROGRAM

The purpose of MaineCare is to provide Maine residents with access to health care. It is the goal of the Department to assist Maine residents in obtaining all of the benefits to which they are entitled under MaineCare.

MaineCare is the name used by the State of Maine to encompass a number of programs that help individuals pay for health care costs. The programs are:

Medicaid (Title XIX of the Social Security Act). To be enrolled in Medicaid an individual must be eligible under one of the Medicaid categories listed below. Each category has its own eligibility rules.

Categorically Needy – This Medicaid category is made up of different coverage groups. An individual qualifies for Medicaid in this category if they meet the requirements of one of the Categorically Needy coverage groups. There are a number of Family - Related and SSI - Related Categorically Needy coverage groups.

Medically Needy – This Medicaid category provides coverage for individuals whose income or assets are too high to qualify for any of the coverage groups in Categorically Needy. Usually coverage is gained by meeting a deductible or “spend-down”.

Medicare Buy-In (Medicare Savings Program (MSP)) – This Medicaid category is a benefit for those who are entitled to Medicare Part A and who meet certain income criteria. Depending on income, the benefit is payment of Medicare Part B premium or payment of Medicare Part A and B premiums as well as coinsurance and deductibles.

Medicaid Waiver Groups – These are special categories approved by the Center for Medicare and Medicaid Services (CMS) under which an individual can become enrolled in Medicaid who might not otherwise be eligible. Examples are the Home and Community Based Waivers, the HIV Waiver and the Non-Categorical Waiver.

Cub Care (Children’s Health Insurance Program [CHIP], Title XXI of the Social Security Act) – This program provides coverage for children under the age of 19 with higher income guidelines and different eligibility rules than Medicaid.

In addition to MaineCare, OIAS administers five State funded benefits found in this manual:

Health Insurance Purchase Option (HIPO) – This is State program that provides 18 months of extended health coverage to children under the age of 19 who are no longer eligible due to changes in income. (See 10-144 Code of Maine Regulations Chapter 335)

Low Cost Drugs for the Elderly and Disabled (DEL) – This is a State program that assists elderly or disabled individuals with the cost of their medications. (See 10-144 CMR Chapter 333)

Maine Rx Plus – This is a State program that assists Maine residents with the cost of their medications. Income guidelines are higher than under DEL and the benefit is less. See 10-144 CMR Chapter 334

State Supplement to SSI – This is a cash payment to SSI recipients and individuals who would otherwise be eligible for SSI except for income and citizenship criteria.

Spousal Living Allowance – This is a cash payment to a spouse of a resident of a Residential Care Facility or Cost Reimbursed Boarding Home. The spouse must meet income and asset criteria.

SECTION 2 COVERAGE GROUPS AND ASSISTANCE UNITS

In order to be eligible for MaineCare an individual must fall within a category. Unless an individual qualifies for Medicaid under a Waiver Group or for the Medicare Buy-In, they must fall into one of the Categorically Needy/Medically Needy coverage groups. Each coverage group has specific eligibility criteria. Individuals can meet the eligibility criteria of more than one coverage group at the same time. Criteria can include age, pregnancy, responsibility for minor children, or disability, depending on the particular coverage group.

Once it has been determined that an individual meets the criteria of one or more coverage groups possible assistance units for each coverage group are identified.

An assistance unit is an individual or group enrolled in or applying for MaineCare. The assistance unit also includes individuals who are not covered or not applying for coverage but whose income and assets are considered in determining eligibility.

Individuals should be covered in the coverage group and assistance unit which is most beneficial for them. An individual can be included in more than one assistance unit at the same time in order to make sure that everyone who wants coverage gets coverage. When everyone who wants coverage cannot be covered and a decision needs to be made as to which family members will be covered, the individual must be informed of the coverage options and given the opportunity to choose which coverage is preferred.

Choosing a coverage group:

In a family with a parent claiming disability, the parent could be covered as SSI - Related (based on disability) or included with the rest of the family as Family - Related coverage if it provides the quickest decision.

Choosing an assistance unit:

In a family in which a child has countable income which would affect the eligibility of other family members, the child may be removed from the assistance unit. The child and any responsible relatives may then become members of a separate assistance unit. The responsible relative is also a member of the original assistance unit.

Example:

The family consists of a parent and two children. One of the children receives two hundred dollars a month in child support. The other child has

no income. The parent's earned income, in combination with the child support puts the assistance unit of the parent and the two children into a large deductible. However, an assistance unit of the parent and the child with no income can be considered. Only the earned income of the parent is used and the assistance unit size is two. The coverage group for the child with income is an assistance unit size of three (parent and both children) with the parent's earnings and the child support counted as income.

If an individual under age 21 wants coverage and the legal parents are on Temporary Assistance for Needy Families (TANF) that member's legal parent(s) must be included in the assistance unit with the individual. The parent's share of the TANF grant is countable income.

Example:
Ms. Soma gets a TANF benefit for herself and her 16 year old son. Her 19 year old also wants coverage. Ms. Soma, her income and her share of the TANF grant must be included in the assistance unit with the 19 year old. Alternatively, all three family members and their income including the TANF grant may be considered as one assistance unit.

If a family is getting the maximum grant, the share of the TANF grant attributed to the adult is the maximum grant amount for one adult. The share of the TANF grant attributed to the other members of the TANF filing unit including a second adult is determined by dividing the remaining grant amount by the number of other individuals in the TANF filing unit.

If the family has a TANF grant that is less than the maximum, the share attributed to each member of the TANF filing unit is the grant amount divided among the members of the filing unit.

SECTION 3 CITIZENSHIP

To receive MaineCare benefits, an individual must be either a citizen of the United States or be a qualified alien in one of the groups listed in the charts below.

I. Citizens -

The citizenship and identity of all members of a household applying for Medicaid and Cub Care (CHIP) must be verified. The following individuals are exempt from Citizenship and Identity requirements:

A. Medicaid and Cub Care applicants who receive either Supplemental Security Income (SSI) or Social Security benefits on the basis of disability, or Medicare.
B. People who receive child welfare assistance under IV-B of the Social Security Act or foster care assistance under IV-E of the Social Security Act. This exemption is for the child not the family providing the care.
C. A newborn whose mother receives Medicaid at the time of birth.
D. Pregnant women while covered under Presumptive Eligibility.

Failure to comply with this requirement will cause Medicaid and Cub Care ineligibility for any applicant for whom proof of citizenship and identity cannot

be provided. A reasonable opportunity will be given to those who can not provide documentation when filing their initial application. Eligibility will be granted if all other eligibility factors are met. The applicant will then be given 90 days from the date of application to obtain the needed information or benefits will be closed. This opportunity will not be provided on subsequent applications submitted by the applicant.

II. Non-Citizens -

An individual who is not a citizen of the United States must be an alien lawfully admitted for permanent residence or otherwise permanently residing in the United States. A lawfully admitted alien will include, either:

A. an individual who has resided in the United States continuously from any date before 1/1/72; or
B. an individual who meets the requirements and characteristics of the groups named in the charts below.

An individual must also provide documentation from the United States Citizen and Immigration Services (USCIS) to prove his or her immigration status.

If an individual admits to being an illegal alien, this information will not be shared with USCIS. All information is held confidential in accordance with Part 1, Section 2.

III. Failure to prove citizenship or alien status -

A. Emergency Benefits only can be provided to an applicant unable to prove alien status. No Medicaid or Cub Care benefits can be provided to a citizen applicant unable to prove citizenship.
B. If an individual in a household is not eligible due to inability to prove citizenship, identity or alien status, the individual will still be counted as part of the household and that person's income and assets will be included in determining eligibility of the rest of the household.

Below is a listing of non-citizen groups eligible for Full Benefits.

NON-CITIZEN STATUS	ACCEPTABLE CHARACTERISTICS
1. **Non-Citizen veteran or active duty personnel**	○ Lawfully residing in U.S.; and ○ A veteran of the U.S. Armed Forces with an honorable discharge or on active duty (not training) in the U.S. Armed Forces; or ○ A spouse or unmarried child of the veteran described above. "Unmarried child": child is or could be claimed as dependent on veteran's tax return and meets MaineCare requirements for a dependent child.

2. **Legal permanent resident**	○ Legal permanent resident status granted ○ Prior to adjustment to legal resident status regardless of the LPR status-granted date, the non-citizen's status was refugee under section 207, asylee under section 208 or deportee under section 243(h). This non-citizen is eligible as refugee, asylee, or deportee.
3. **Refugee**	○ refugee status granted under section 207 of the INA
4. **Asylee**	○ asylee status granted under section 208 of the INA
5. **Deportation withheld**	○ deportee status granted under section 243(h) of the INA
6. **Parolee**	○ Parolee status granted under section 212(d) (5) of the INA.
7. **Conditional entrant**	○ Conditional entrant status granted under section 203(a)(7) of the INA
8. **Battered non-citizens OR Non-citizen's minor child**	○ While lawfully residing in the U.S. the non-citizen or the minor child was battered or subjected to extreme cruelty by a spouse, a parent, or a member of the spouse's or parent's family residing in the same household as the non-citizen; and ○ Batterer no longer lives in same household, and ○ Approved or pending petition for status as spouse or child under clause (i), (ii), or (iv) of section 204(a)(1)(A) or classification per clause (i), (ii) or (iii) of section 204(a)(1)(B) of the INA or suspension of deportation and adjustment of status per section 244(a)(3), 244(a)(1)(A) or 244(a)(1)(B) of the INA.
9. **Trafficking Victims Project**	○ Aliens certified as a trafficking victim (TV) under 107(b) (1) of the TV Protection Act of 2000.
10. **Amerasians or Cuban Haitian Entrants**	○ Amerasians or Cuban/Haitian entrants granted under 212 of INA or 501(e) Refugee Education Act 1980.
11. **App for adjustment or status to LPR (Legal Permanent Resident)**	○ Aliens who have filed applications for adjustment of status pursuant to section 245 of the INA. See #19 for Asylee Apps.
12. **Voluntary departure & non-enforce**	○ Aliens granted voluntary departure pursuant to section 242(b) of the INA whose departure the INS does not contemplate enforcing.

13. **Deferred departure**	○ Aliens granted a deferred departure.
14. **Supervision**	○ Aliens residing in the US under orders of supervision pursuant to section 242(d) of INA
15. **Residing in U.S. prior to 1/72**	○ Aliens who have entered and continuously resided in the US since before 1/1/72, section 249.
16. **Suspended deportation or indefinite voluntary departure**	○ Aliens granted suspension of deportation pursuant to Section 244 of the INA and whose departure the INS does not contemplate enforcing or ○ Aliens granted indefinite voluntary departure under Section 44.
17. **Stay of deportation or deportation withheld**	○ Aliens granted stay or deportation by court order, stature, or regulation, or by individual determination of the INS, whose departure the agency does not contemplate enforcing.
18. **Temporary parolee status**	○ Aliens granted temporary parolee status pursuant to Section 212(d) (5) of INS. See page 2 and 5 for other parolee statuses.
19. **Applicants for Asylum**	○ Prior to application for Asylum, individuals may have been an undocumented or ineligible alien covered for Emergency Benefits only.
20. **American Indian born in Canada**	○ Considered to be lawfully admitted for permanent residence if he/she is of at least one half American Indian blood.
21 **Iraqi Special Immigrants eligible under Public Law 110-161 and 110-181, Section 1244.** Expires 9/30/12.	○ Beginning no sooner than 12/26/07, for a period not to exceed eight months from the date granted special immigrant status.
22. **Afghani Special Immigrants eligible under Public Law 110-161.**	○ Beginning no sooner than 12/26/07, for a period not to exceed eight months from the date granted special immigrant status.

Section 3.1 Citizenship and Identity Requirements

I. Definition of Citizen. A citizen of the United States is:

A. an individual born in the United States or its territories, including Puerto Rico, the Virgin Islands, Guam, and the Northern Mariana Islands, except those born to a foreign diplomat, and who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].

B. an individual born of a parent who is a U.S. citizen or who otherwise qualifies for U.S. citizenship under §301 *et seq*. of the Immigration and Nationality Act; [8 U.S.C. §§ 1401-1409].
C. a naturalized citizen.
D. a national (both citizen and non-citizen national):
   1. Citizen National. A citizen national is an individual who otherwise qualifies as a U.S. citizen under §301 *et seq*. of the Immigration and Nationality Act. [8 U.S.C. §§ 1401-1409].
   2. Non-Citizen National. A non-citizen national is an individual who was born in one of the outlying possessions of the United States, including America Samoa and Swain's Island, to a parent who is a non-citizen national.

II. Acceptable Proof of Citizenship and Identity (Primary evidence of citizenship and identity) -

The following documents may be accepted as proof of both citizenship and identity because each contains a photograph of the individual named in the document, and the citizenship and identity of the individual have been established by either the U.S. or a state government. Primary verifications satisfy both citizenship and identity requirements:

A. U.S. passport; The Department of State issues this. A U.S. passport need not be currently valid to be accepted as evidence of U.S. citizenship, as long as it was originally issued without limitation. However, a passport that was issued with limitation and is not currently valid may be used as proof of identity only. U.S. passports issued after 1980 show only one person. However, spouses and children were sometimes included on one passport through 1980. Consequently, the citizenship and identity of the included person can be established when one of these passports is presented.
B. Certificate of Naturalization (Department of Homeland Security form N - 550 or N-570); or
C. Certificate of U.S. Citizenship (Department of Homeland Security form N-560 or N-561). The Department of Homeland Security issues certificates of citizenship to individuals who derive citizenship through a parent.
D. Tribal enrollment documents, evidencing membership or affiliation with a Federally-recognized tribe.

III. Secondary Verifications of Citizenship -

If Primary verification from the list in previous paragraph (II.) is unavailable, the person should provide satisfactory documentary verification from paragraph (VI.) of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. A U.S. public birth certificate showing birth in one of the 50 States, the District of Columbia, Puerto Rico (if born on or after 1/13/41), Guam, the Virgin Islands of the U.S., American Samoa, Swain's Island, or the orthern Mariana Islands (after 11/4/86 (NMI local time)). The birth record document may be issued by the state, commonwealth, territory or local jurisdiction. It must have been recorded before the person was 5 years of age. (A delayed birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship) see section V, paragraph B.

B. If the document shows the individual was born in Puerto Rico, Guam, the Virgin Islands of the U.S., or the Northern Mariana Islands before these areas became part of the U.S., the individual may be a collectively naturalized citizen. Collective naturalization occurred on the dates listed for each of the Territories. The following will establish U.S. citizenship for collectively naturalized individuals:

1. Puerto Rico:
   a. evidence of birth in Puerto Rico and the person's statement that he or she was residing in the U.S., a U.S. possession, or Puerto Rico on 1/13/41; or
   b. evidence that the person was a Puerto Rican citizen and the person's statement that he or she was residing in Puerto Rico on 3/1/17 and that he or she did not take an oath of allegiance to Spain.
2. U.S. Virgin Islands:
   a. evidence of birth in the U.S. Virgin Islands, and the person's statement of residence in the U.S., a U.S. possession or the U.S. Virgin Islands on 2/25/27; or
   b. the person's statement indicating residence in the U.S. Virgin Islands as a Danish citizen on 1/17/17 and residence in the U.S., a U.S. possession, or the U.S. Virgin Islands on 2/25/27, and that the person did not make a declaration to maintain Danish citizenship; or
   c. evidence of birth in the U.S. Virgin Islands and the person's statement indicating residence in the U.S., a U.S. possession, or Territory or the Canal Zone on 6/28/32.
3. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands):
   a. evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the U.S., or a U.S. Territory or possession on 11/3/86 (NMI local time) and the person's statement that s/he did not owe allegiance to a foreign state on 11/4/86 (NMI local time); or
   b. evidence of TTPI citizenship, continuous residence in the NMI since before 11/3/81 (NMI local time), voter registration prior to 1/1/75 and the person's statement that s/he did not owe allegiance to a foreign state on 11/4/86 (NMI local time); or
   c. evidence of continuous domicile in the NMI since before 1/1/74 and the applicant's statement that s/he did not owe allegiance to a foreign state on11/4/86 (NMI local time).
   d. If a person entered the NMI as a nonimmigrant and lived in the NMI since 1/1/74, this does not constitute continuous domicile and the person is not a U.S. citizen.

C. A Certification of Report of Birth (DS-1350) -

The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth, based on the information shown on the FS-240. When the birth was recorded as a Consular Report of Birth (FS-240), certified copies of the Certification of Report of Birth Abroad (DS-1350) can be issued by

the Department of State in Washington, D.C. The DS-1350 contains the same information as that on the current version of Consular Report of Birth FS-240. The DS-1350 is not issued outside the U.S.

D. A Report of Birth Abroad of a U.S. Citizen (Form FS-240) -

The Department of State consular office prepares and issues this. A Consular Report of Birth can be prepared only at an American consular office overseas while the child is under the age of 18. Children born outside the U.S. to U.S. military personnel usually have one of these.

E. A Certification of Birth Issued by the Department of State (Form FS-545 or DS-1350) -

Before 11/1/90, Department of State consulates also issued Form FS-545 along with the prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

F. A U.S. Citizen I.D. Card -

This form was issued as Form I-197 until the 1980s by INS. INS issued the I-179 from 1960 until 1973. It revised the form and renumbered it as Form I-197. INS issued the I-197 from 1973 until 4/7/83. INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican border who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

G. A Northern Mariana Identification Card (I-873) -

(Issued by the Department of Homeland Security (DHS) to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before 11/4/86.) The former Immigration and Naturalization Service (INS) issued the I-873 to a collectively naturalized citizen of the U.S. who was born in the NMI before 11/4/86. The card is no longer issued, but those previously issued are still valid.

H. An American Indian Card (I-872) issued by the Department of Homeland Security with the classification code “KIC”. (Issued by DHS to identify U.S. citizen members of the Texas Band of Kickapoos living near the United States/Mexican border) -

DHS issues this card to identify a member of the Texas Band of Kickapoos living near the U.S. / Mexican border. A classification code “KIC” and a statement on the back denote U.S. citizenship.

I. A final adoption decree showing the child's name and U.S. place of birth -

In situations where an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final

adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

J. Evidence of U.S. Civil Service employment before 6/1/76 -

The document must show employment by the U.S. government before 6/1/76. Individuals employed by the U.S. Civil Service prior to 6/1/76 had to be U.S. citizens.

K. U.S. Military Record showing a U.S. place of birth -

The document must show a U.S. place of birth (for example a DD-214 or similar official document showing a U.S. place of birth.)

L. A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database. Inclusion in this database could prove citizenship through naturalization.

M. Evidence of meeting the automatic criteria for U.S. Citizenship outlined in the Child Citizenship Act of 2000.

IV. Third-Level Verification of Citizenship.
If verification from the lists in Section 3.1 (II and III) is unavailable and the person claims a U.S. place of birth, the person should provide satisfactory verification from paragraph (VI.) of this section to establish identity, and satisfactory verification of citizenship from the list below:

A. Extract of a hospital record on hospital letterhead, indicating a U.S. place of birth. The hospital record must have been established at the time of the person's birth and created five years before the initial application date for Medicaid or Cub Care. (For children under age 16 the document must have been created near the time of birth or five years before the date of application.) A souvenir "birth certificate" issued by a hospital does not satisfy this requirement.

B. Life, health, or other insurance record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care.

C. Religious record recorded in the U.S. within three months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. (Entries in a family bible are not considered religious records).

D. Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of the admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of the birth of the applicant's parents.

V. Fourth-Level Verification of Citizenship -
If verification from the lists in previous paragraphs (II.,III.,and IV.) of this

section is unavailable and the person claims a U.S. place of birth, the person should provide verification from paragraph (VI.) of this section to establish identity, and satisfactory documentary evidence of citizenship from the list below:

A. Federal or State census record showing U.S. citizenship or a U.S. place of birth. The census record must also show the applicant's age.

   Census records from 1900 through 1950 contain certain citizenship information. To secure this information, complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested". Also add that the purpose is for Medicaid and Cub Care eligibility.

B. One of the following documents that show a U.S. place of birth and was created at least five years before the application for Medicaid and Cub Care:
   1. Seneca Indian tribal census record;
   2. Bureau of Indian Affairs tribal census records of the Navajo Indians;
   3. U.S. State Vital Statistics official notification of birth registration;
   4. A delayed U.S. public birth record that is recorded more than five years after the person's birth;
   5. Statement signed by the physician or midwife who was in attendance at the time of birth; or
   6. Bureau of Indian Affairs Roll of Alaska Natives.

C. Institutional admission papers from a nursing facility, skilled care facility or other institution, showing a U.S. place of birth, created at least five years before the initial application.

D. Medical (clinic, doctor, or hospital) record showing a U.S. place of birth. The record must have been created at least five years before the initial application date for Medicaid or Cub Care . (For children under age 16 the document must have been created near the time of birth or five years before the date of application).

   An immunization record alone is not considered a medical record for purposes of establishing U.S. citizenship.

E. Written Affidavits of Citizenship.

F. Declarations should only be used in rare circumstances. If the documentation requirement needs to be met through affidavits, the following rules apply:
   1. There must be at least two affidavits by two people who have personal knowledge of the event(s) establishing the individual's claim of citizenship (the two affidavits could be combined in a joint declaration).
   2. At least one of the people making the affidavits cannot be related to the applicant or recipient. Neither of the two individuals can be the applicant or recipient.

3. In order for the affidavits to be acceptable, the people making them must be able to provide proof of their own citizenship and identity.
4. If the people making the affidavits have information that explains why documentary evidence establishing the individual's claim of citizenship does not exist or cannot be readily obtained, the declaration should contain this information as well.
5. The applicant or recipient or other knowledgeable person (guardian or representative) must also provide an affidavit explaining why the evidence does not exist or cannot be obtained
6. The affidavits must be signed under penalty of perjury.

VI. Evidence of Identity -

The following documents, even if expired, may be accepted as proof of identity and must be submitted when the person uses as proof of citizenship, the documents listed in paragraphs (II.) through (V.) of the previous section. (A separate document proving identity need not be submitted when the person submits Primary evidence of citizenship and identity as outlined in II. of this section):

A. A driver's license issued by a state or territory. The license must either have a photograph of the individual or other identifying information such as name, age, sex, race, height, weight, or eye color.

   Note: Individuals may not rely upon a Canadian driver's license, as the Centers for Medicare and Medicaid Services does not view this as a reliable form of identification.

B. School identification card. The card must have a photograph of the individual.
C. U.S. military card or draft record.
D. Identification card issued by the federal, state, or local government. The card must have the same information that is required for driver's licenses.
E. Military dependents identification card.
F. Native American tribal document.
G. U.S. Coast Guard Merchant Mariner card.
H. Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native Tribal document. The document must have a photograph or other personal identifying information relating to the individual.

   Note: Individuals may not rely upon a voter's registration card, as Centers for Medicare and Medicaid Services (CMS) does not view this as a reliable form of identification.

I. Three or more corroborating documents such as marriage licenses, divorce decrees, high school and college diplomas from accredited institutions, including general education and high school equivalency

diplomas, property deeds or titles, and employer ID cards can be used to verify the identity of an individual.

Note: If the individual submitted fourth level verification of citizenship, three or more corroborating documents can not be used to verify identity of the individual.

VII. Special Identity Rules for Children and some Disabled Individuals -

A disabled individual in a residential care or institutional facility may have their identity attested to by the facility director or administrator when the individual does not have or cannot get any document on the preceding lists. Again, the affidavit is signed under the penalty of perjury, but need not be notarized.

Children under age 16 may have their identity documented using the following:

A. school record including report card, daycare or nursery school record, verified by the Department with the issuing school; or
B. clinic, doctor or hospital record.
C. If none of the documents in paragraph (VI.) are available, an affidavit of identity may be used to prove the identity of the child. An affidavit of identity is only acceptable if it is signed under penalty of perjury by a parent, guardian, or caretaker relative stating the date and place of the birth of the child and cannot be used if affidavits were used to establish citizenship.
D. Identity affidavits may be used for children under age 18 in limited circumstances, when the child is from an area where a school ID with picture is not provided or a driver's license with a picture is not available.

VIII. Documentary Evidence -

A. All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies may not be accepted. Originals or certified copies presented by the applicant or recipient will be returned.
B. Copies of citizenship and identification documents shall be maintained in the case record or electronic data base.
C. Individuals may submit documentary evidence without appearing in person at an OIAS office. Documents may be tendered in person, by mail, or by a guardian or authorized representative.
D. Presentation of documentary evidence of citizenship is a one-time activity; once a person's citizenship is documented and recorded in a state database, subsequent changes in eligibility should not require repeating the documentation of citizenship unless later evidence raises a question of the person's citizenship.
E. The requirement to provide documentary evidence is the responsibility of the applicant. If documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation.

Section 3.2 Emergency Benefits

A non-citizen who has no USCIS documents regarding their alien status or is an ineligible alien as defined below, can get Emergency Benefits only. They must still

meet income and asset tests, and must be in a coverable group. These individuals must meet all basic eligibility requirements (including Maine residency) with the exception of citizenship or alien status and providing a Social Security number.

I. Undocumented alien – aliens who do not have USCIS documentation of their citizenship status.

II. Ineligible alien - aliens legally admitted on a temporary basis. The following are examples of individuals who are ineligible aliens:
   A. foreign government representatives on official business and their families and employees;
   B. visitors for business or pleasure, including exchange visitors;
   C. aliens in travel status while traveling directly through the United States;
   D. crewmen on shore leave;
   E. treaty traders and investors and their families;
   F. foreign students;
   G. international organization personnel and their families and servants;
   H. temporary workers, including agricultural contract workers;
   I. members of foreign press, radio, film or other information media and their families.

      Note: These aliens should have one of the following types of documents: I-94, Arrival-Departure Record; I-185, Canadian Border Crossing Card; I-186, Mexican Border Crossing Card; SW-434, Mexican Border Visitor's Permit; I-95A, Crewman's Landing Permit; or I-184, Crewman's Landing Permit and Identification Card.

   J. Parolee in the U.S. under Section 212(d) (5) for less than one year unless they are granted "temporary parolee status."

If it is determined that any of the above individuals intend to remain in Maine at the time of application they will be considered Maine residents.

Section 3.3 Documentation and Verification for Non-Citizens

An individual who is not a citizen or national of the United States must present alien registration documentation, other proof of immigration registration from the U.S. Citizenship and Immigration Services (USCIS), or other documents indicating the individual's satisfactory immigration status. If documentation is not presented at application, the individual will be given a reasonable opportunity to provide the documentation. Temporary Medicaid coverage will not be provided if the applicant cannot provide satisfactory documentation of non-citizen status.

The Systematic Alien Verification for Entitlements Program (SAVE) is the U.S. Citizenship and Immigration Services (USCIS) operative system for verification of immigration status of aliens applying for MaineCare. Primary verification will be obtained through touch-tone access to the INS-ASVI system. If no record is found, secondary verification procedures will be necessary. No eligible documented alien will be denied benefits based solely on information from the ASVI system. Ineligibility can be determined only following the secondary verification procedures in which a written request for verification is mailed to USCIS.

SECTION 4 RESIDENCY

Each individual must be a resident of Maine. A resident is an individual living in the State of Maine with the intent to remain indefinitely.

An individual who is visiting or in Maine temporarily is not a resident. The individual should apply to the actual state of residence for Medicaid. However, if the individual is living in Maine and has entered the State with a job commitment or seeking a job (even if only a temporary job, e.g., migrant workers), the individual is a resident of Maine.

When two or more states cannot resolve which state is the state of residence, the state where the individual is physically located is the state of residence for Medicaid purposes.

Eligibility cannot be denied or terminated because:

I. an individual has not resided in the State for a specified period;

II. the individual did not establish residence before entering a medical institution; or

III. an individual is temporarily or involuntarily absent from the State, provided the individual intends to return once the purpose of the absence has been accomplished, unless another state has determined the individual is a resident there.

Eligible individuals who move out of Maine and intend to remain out of state and are making application for assistance in that state remain eligible until the other state determines eligibility or ineligibility.

Section 4.1 Children

For purposes of residency a child is any individual under the age of 21. A dependent child is a resident of the state where the caretaker relative resides. An independent child is a resident of the state where they reside with an intent to remain indefinitely.

Section 4.2 Title IV-E of the Social Security Act

In any situation where a child is eligible for a Title IV-E payment (including the Federal Adoption Assistance Program) from another state, the state of residency, for Medicaid purposes, is the state in which the child is physically living (See Part 3, Section 4.5.2). Children who are receiving services under the Interstate Compact for the Placement of Children (ICPC) who are not receiving Title IV-E payments from another state are not considered residents of the State of Maine.

Section 4.3 Residents of Medical Institutions

I. If a state arranges for an individual to be placed in an institution located in another state, the state making the placement is the individual's state of residence, regardless of the individual's indicated intent or ability to indicate intent.

II. For any institutionalized individual who became incapable of indicating intent before age 21, the state of residence is that of the individual's parents, or legal guardian. If the parents reside in separate states and there is no

appointed legal guardian, the state of residence is that of the parent applying for Medicaid on the individual's behalf.

III. For an institutionalized individual who became incapable of indicating intent on or after age 21, the state of residence is the state in which the individual was living when the individual became incapable of indicating intent.

IV. The state where the institution is located is the individual's state of residence unless that state determines that the individual is a resident of another state by applying the rules under (I.) or (II.) above.

V. For any other institutionalized individual, age 21 or over, the state of residence is the state where the individual is living with the intention to remain for an indefinite period of time.

An individual is considered incapable of indicating intent if:

I. the individual has an I.Q. of 49 or less or has a mental age of 7 or less based on tests acceptable to the Office of Adults with Cognitive and Physical Disabilities (OACPD);
II. the individual has been judged legally incompetent; or

III. medical or other acceptable documentation supports a finding that the individual is incapable of indicating intent.

Section 4.4 SSI and State Supplement Recipients

An individual who is receiving SSI or State Supplemental payments is considered a resident of the state making the payment.

SECTION 5 SOCIAL SECURITY NUMBERS

All individuals are asked to provide their Social Security Number.

All individuals are required to have a Social Security number or proof of application with the exception of:

I. undocumented non-citizens; or

II. a child who is born to a mother covered by Medicaid at the time of their birth. By the time the child turns one an application for or proof of a Social Security number must be provided.

The individual is required to furnish the Department with a Social Security number. If the individual has a Social Security number but is unable to provide it, the Department must contact the Social Security Administration in order to obtain the number.

The individual is required to apply to the Social Security Administration for a Social Security number if the individual does not have a Social Security number. The applicant or recipient must provide the Department with verification that the application for a Social Security number has been made. The Social Security number will be provided by the Social Security Administration.

For a child born to a mother not covered by Medicaid at the time of the child's birth, the Social Security number requirement must be met by the first day of the second month following the month in which the child's mother is discharged from the hospital.

Examples:

1. A child is born on July 3rd. Mother leaves the hospital on July 6th. Application for a Social Security number for the child must be completed by September 1st.
2. A child born on July 31st. Mother leaves the hospital on August 2nd. Application for a Social Security number for the child must be completed by October 1st.

The Eligibility Specialist should explain that the Social Security Administration requires the individual to provide a valid birth certificate or other proof of age and verification of identity.

The Department must assist the individual in obtaining verification necessary to apply for a Social Security number. This includes obtaining documents to prove date of birth, citizenship or identity if these materials cannot be provided by the individual. The Department cannot pay any costs incurred in obtaining this information.

MaineCare will not be withheld or terminated for lack of a Social Security number as long as an individual provides verification of application for a Social Security number for those requesting assistance. MaineCare will not be withheld or terminated while verification of the individual's Social Security number is being obtained from the Social Security Administration.

Section 5.1 Non-Compliance/Sanctions/Good Cause

For any individual who fails to provide or apply for a Social Security number as required, Medicaid and/or Cub Care must be denied or terminated.

When the Social Security number requirements for a dependent child are not met the parent or specified relative as well as the child must be denied or terminated for Medicaid and/or Cub Care.

I. When an individual is not eligible for Medicaid and/or Cub Care the individual is included in the assistance unit size and the individual's income and assets are used to determine eligibility for the assistance unit.

II. When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Levels (See Chart 6).

III. When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's. However, such sanctioned specified relative may choose to be excluded from the assistance unit.

An individual may request good cause for not providing a Social Security number. See Section 8 of this Part for specific information regarding good cause.

Section 5.2 Retroactive Coverage

If otherwise eligible, retroactive coverage will be granted if the Social Security number requirements are met during the application process. If the Social Security number requirements are not met, but at a later date the individual cooperates with these requirements, the retroactive coverage cannot be granted.

Examples:

1. A parent refuses to apply for a Social Security number for a child. The parent and the child are denied coverage. One month later, the parent agrees to comply. The parent and child are eligible, effective the first day of the month in which the application for a number is made. Retroactive coverage cannot be granted.

2. A parent refuses to apply for a Social Security number. Coverage for the parent only must be denied. A year later, the person reapplies and gives a Social Security number proving application for the number was made six months previously. Eligibility may be authorized with up to three months' retroactive coverage because the applicant complied with the Social Security number requirements prior to the retroactive period.

Individuals must be informed that the Social Security number will be utilized in the administration of MaineCare and will be used for verification of information such as wages, unemployment benefits and bank accounts.

SECTION 6 ASSIGNMENT OF RIGHTS TO MEDICAL PAYMENTS (referral to the Third Party Liability Unit (TPL))

As a condition of eligibility for Medicaid and Cub Care, certain individuals must assign to the Department of Health and Human Services their rights to payment for medical care from any third party and cooperate in obtaining these medical payments. This is done by a referral to TPL.

Section 6.1 Who must comply:

I. Parents or other specified relatives applying on behalf of themselves and their children;

II. individuals age 18 or over who are applying on their own behalf; and

III. individuals under age 18 who are applying on their own behalf who are married or in the military.

This provision does not apply to pregnant women.

Section 6.2 What is required:

I. Assign rights to payment for medical care;

II. cooperate with the Third Party Liability Unit in obtaining medical payments; or

III. relinquish medical payments received directly from a third party resource which were intended to cover services paid by Medicaid.

IV. Items for both prospective and retroactive periods, which must be reported include:
   A. any court ordered responsibility to pay medical bills by a parent, unless it can be demonstrated that contact with the parent by the Third Party Liability Unit (TPL) or Division of Support Enforcement and Recovery (DSER) could cause harm;
   B. medical insurance (except Medicare) covering the applicant or recipient. This includes private medical group insurance, TRICARE (formerly CHAMPUS), and supplemental policies such as companion plans from Blue Cross/Blue Shield, Major Medical and indemnity insurance. Reporting is required whether the cost of premiums is paid by the individual, employer, or another person;
   C. the portion of Worker's Compensation benefits for medical services for which the recipient is applying, receiving, or which terminated during the retroactive eligibility period; and
   D. information regarding settled or pending lawsuits involving personal injury.

Section 6.3 Non-compliance:

I. If an individual who is required to do so fails to comply with these provisions, Medicaid is denied or terminated. An individual who does not comply with this requirement is not eligible for Medicaid. When parents or other specified relatives are applying on behalf of themselves and their children, it is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

II. When an individual is not eligible for Medicaid because they do not comply with the provisions to apply for a Social Security Number, cooperate with the Division of Support Enforcement and Recovery (DSER) or cooperate in a referral to TPL, the individual is counted in the assistance unit size and the individual's income and assets are used to determine eligibility for the assistance unit.

III. When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level (See Chart 6).

IV. When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's. However, such sanctioned specified relative may choose to be excluded from the unit.

An individual may request good cause for non-compliance with TPL. See Section 8 of this Part for specific information regarding good cause.

SECTION 7 COOPERATION IN OBTAINING MEDICAL SUPPORT FROM THE NON-CUSTODIAL LEGAL PARENT AND ESTABLISHING PATERNITY

Section 7.1 Who Must Comply

Certain individuals must cooperate in obtaining medical benefits from the non-custodial parent of a dependent child (See Part 3, Section 1) and in establishing paternity. If the individual can show that good cause for not cooperating exists, no referral will be made.

These individuals are parents or other specified relatives applying on behalf of themselves and their children unless the assistance unit is being covered under Transitional Medicaid.

This provision does not apply to pregnant women or individuals covered under Transitional Medicaid. An individual who does not comply with this requirement is not eligible for Medicaid. It is the parent or other specified relative applying on behalf of the child under age 18 who is not eligible, not the child.

Section 7.2 What is Required:

I. Identify and help locate those parents of a dependent child for whom Medicaid is requested.

II. Cooperation includes responding to requests for information from DSER and appearing as a witness at a judicial or other hearing or proceeding.

Section 7.3 Non-Compliance:

I. If an individual who is required to do so fails to comply with these provisions, Medicaid is denied or terminated.

II. When an individual is not eligible for Medicaid because they do not cooperate with DSER the individual is included in the assistance unit size and the individual's income and assets are used to determine eligibility for the assistance unit.

III. When a stepparent must be sanctioned, the stepparent's income will be considered as if the stepparent chose to be excluded from the assistance unit. The assets owned solely by the stepparent are not considered available to the assistance unit. The stepparent is not considered a member of the assistance unit when determining eligibility under the appropriate Federal Poverty Level (See Chart 6).

IV. When a specified relative other than a parent or stepparent must be sanctioned, the specified relative's income and assets are considered in the same manner as a sanctioned parent's. However, such sanctioned specified relative may choose to be excluded from the assistance unit.

An individual may request good cause (See Section 8 of this Part) for non-compliance with TPL.

SECTION 8 GOOD CAUSE

Every Medicaid or Cub Care applicant or recipient will have the opportunity to claim good cause for refusing to cooperate. When the individual claims good cause,

sanctions will not be implemented unless it is finally determined that good cause does not exist.

Cooperation requirements, sanctions, and the right to claim good cause must be explained to the individual. The Eligibility Specialist must inform the individual that DSER may attempt to establish paternity and collect medical support in cases where there is no risk to the individual or children.

If the individual thinks that attempts to establish paternity or collect support would pose a risk to the individual or children, the individual must provide evidence to substantiate the claim of good cause not to cooperate.

The Eligibility Specialist must document the reasons for granting or denying the claim of good cause and must notify the individual of the decision in writing. If the decision is not to grant good cause, the individual must be given the opportunity to withdraw from the Program or provide additional information to substantiate the claim. The Eligibility Specialist makes the final determination of good cause.

The individual's eligibility will be determined prior to granting or denying good cause. Referral of the parent who is not in the home to TPL will not be made while the decision is pending. If good cause is granted, no referral will be made.

If good cause is not granted and the individual continues to refuse to cooperate, sanctions will be applied and the TPL unit and DSER will proceed without the individual's cooperation.

The Eligibility Specialist must discuss the above with the individual at the time of the application.

Good cause for not cooperating may be claimed by the individual if the individual can demonstrate that:

I. cooperation may reasonably be anticipated to result in physical or emotional harm to the child or physical or emotional harm to the caretaker relative which would hinder the ability to care for the child.

II. legal proceedings for adoption of the child are pending before a court or the individual has been working with a social agency to decide whether to relinquish the child for adoption.

III. the child was conceived as the result of rape or incest.

Documents from court records, law enforcement agencies, medical sources, social service agencies and any other legal document may be used to substantiate rape, adoption and physical or emotional harm to the child or caretaker relative. If such documents are unavailable, information may be secured from other sources familiar with the claims of the individual. The Agency should assist the individual in obtaining the required evidence, but no contact with collateral sources will be made without the individual's knowledge and consent.

A contact with the absent parent or putative father should be made only if it is essential to the claim for good cause. Contact should not be made until the applicant or recipient has the opportunity to:

I. present additional evidence or information which makes contact with the absent parent or putative father unnecessary;

II. withdraw the application for assistance, or have the case closed; and

III. have the good cause claim denied.

SECTION 9 INDIVIDUALS RESIDING IN PUBLIC INSTITUTIONS

I. Medicaid coverage is authorized for inmates of state prisons, Mountain View Youth Development Center, Long Creek Youth Development Center, local or county jails, if the individual meets financial and non-financial criteria applicable to non-inmates. Medicaid will only pay for any coverable in-patient service provided to the inmate while they are an in-patient in a hospital, nursing home, intermediate care facility for the mentally retarded (ICF/MR) or juvenile psychiatric facility.

II. Individuals admitted to reside in a public (or private) medical institution classified as an IMD (Institution for Mental Disease) for over thirty days: Spring Harbor, Acadia, Riverview Psychiatric Center, and the Dorothea Dix Psychiatric Center. The following applies:
   A. if over age 20 and under age 65, these individuals are not Medicaid eligible until they are conditionally or unconditionally released or are on convalescent leave from the facility. Individuals may apply prior to discharge, but eligibility is not granted until they are released or are on convalescent leave.
   B. if under age 21 (through age 20) or age 65 or over, coverage is available for all Medicaid coverable services.

SECTION 10 APPLICATION FOR OTHER BENEFITS

Individuals must take all appropriate steps to obtain benefits to which they are entitled. This includes applying for the benefit and providing the other benefit source with necessary information to determine eligibility for the benefit.

I. Other benefits for which the individual must file include Social Security, Railroad Retirement, Veteran's Pension/ Compensation, Worker's Compensation, and Unemployment Insurance. This provision does not apply to SSI, State Supplement, TANF cash benefits and other Federal, State, local or private programs which make payments based on need.

II. Individuals who apply for Medicaid and DEL and who are eligible for Medicare Parts A, B and/or D must be enrolled in or take action to enroll in these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

III. Individuals who are enrolled in Medicaid and DEL and subsequently become eligible for Medicare Parts A, B and/or D must be enrolled in or take action to enroll in these programs and a Medicare Part D Prescription Drug Plan at the next available opportunity to do so.

IV. There is good cause for not enrolling in Medicare and/or Medicare Part D Prescription Drug Plan if:

A. the individual is not eligible for Medicaid and DEL to pay any premiums and cost sharing for Medicare Parts A and/or B as described in Part 8.
B. the individual is denied enrollment by Medicare or by a Medicare Prescription Drug Plan due to circumstances beyond his/her control or,
C. the individual has prescription drug coverage which is determined by the insurer to be creditable coverage. Creditable coverage means that the coverage on the average is at least as good as the standard Medicare Prescription drug plan.
D. enrollment is not cost effective as determined by the Pharmacy Benefits Manager.

V. Do not require an individual:
A. to file for other benefits when applying for them would result in no additional benefit which affects the individual's eligibility.
B. to pursue a claim for other program benefits through the appeals process.
C. who is not applying for or covered by Medicaid to pursue a claim for other program benefits, for example, an ineligible spouse, parent or child.

SECTION 11 APPLICATION PROCESS

An application is a signed request for MaineCare coverage. This request must be made on a document approved by OIAS as an application form.

The individual or someone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

The date of application is the date the signed application form is received in any OIAS office. For presumptive eligibility for pregnant women, the date the form is signed and dated by both the applicant and the designated person at specified provider sites is considered the date of application (See Part 3, Section 4.3.1).

All signed applications will be acknowledged in writing. A written decision of eligibility will be sent to the applicant.

An application which is denied is valid for the month of application and the following month.

Example:
An individual applies in January seeking prospective coverage. They exceed the asset limit for January. The application is denied for prospective coverage. In February, the individual verifies that assets are below the asset limit and requests prospective coverage. Prospective coverage may be granted beginning February 1st. It is not necessary for the individual to complete another application form.

Section 11.1 Subsequent requests for eligibility

Once eligible for MaineCare, the Food Supplement Program, or TANF/PaS an individual does not need to complete a new application form if:

I. open for the Food Supplement Program (FSP) and wants MaineCare. In this situation the application date is the date that the request is made, either orally or in writing. Additional information may still be needed to determine eligibility.

II. open MaineCare and requesting eligibility for new members orally or in writing. The application date for the new member is the date the request is made. Additional information may still be needed to determine eligibility.

III. open under one MaineCare program (for example Medicaid) and requesting coverage under another MaineCare program (for example Buy-in). In this situation the application date is the date that the request is made, either orally or in writing. Additional information may still be needed to determine eligibility.

IV. open MaineCare and now requesting coverage in a facility or Home and Community Based Waiver services. Additional information may still be needed to determine eligibility.

V. SSI recipients moving to a residential care facility where SSI benefits continue. Additional information may still be needed to determine eligibility.

SSI Individuals who move to a nursing facility need to complete an application. Community coverage is to be kept open while determining eligibility in the facility.

All applicants or re-applicants for MaineCare will be given information in writing, or verbally if appropriate, about the following:

I. services covered under MaineCare;

II. conditions of eligibility;

III. the individual's rights, including the right to an Administrative Hearing;

IV. responsibilities of recipients, including reporting changes within ten days (See Section 12.2 of this Part); and

V. the 45-day application processing standard (See Section 12.3.1 of this Part).

A reapplication is any signed application form received after the Adverse Action Notice Period. This includes review forms returned after that period.

Section 11.2 Recipients of SSI or State Supplement

Aged, blind or disabled individuals and couples who are recipients of SSI or State Supplement are automatically covered as Categorically Needy unless they refuse to assign their rights to payments for medical care. A separate application for Medicaid (including coverage for any Home and Community Based Waiver program) is not needed for these groups.

SECTION 12 CLIENT AND AGENCY RESPONSIBILITIES

Section 12.1 Verification of Eligibility Factors

The individual or the individual's representative is responsible for supplying verification of information for all persons in the household whose circumstances

affect eligibility. If this information is not provided, eligibility does not exist. It is the responsibility of the Department to assist the individual in establishing eligibility for MaineCare**.**

Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If collateral contacts are necessary to determine eligibility and the individual does not give consent, denial or closure must occur because the Department is unable to determine eligibility.

When a decision cannot be made due to inconclusive or conflicting information, the individual will be notified what questions remain and what needs to be resolved. If the Department cannot determine that eligibility exists after contacting the individual or collateral contacts, assistance will be denied or closed.

Section 12.2 Reporting Responsibilities

Changes which are expected to occur before the next review must be explored by the Eligibility Specialist.

The Eligibility Specialist should discuss any potential changes in family size, assets, residency, income (for example, unemployment, Social Security, Worker's Compensation or a new job), school attendance, disability, and ages of covered members (to determine if changes in coverage will occur because of age).

It is the responsibility of the individual to report changes of income, assets, household composition and any other change in circumstances which affect eligibility for MaineCare. Such change is to be reported within ten days from occurrence. For income purposes, "occurrence" will be considered the date the increased income was received. For all other purposes, "occurrence" will be considered the date the change took place. Applicants and recipients are informed of reporting responsibilities in the notice of eligibility.

Eligibility will be recalculated within thirty days of the receipt of new information which may affect the level of MaineCare coverage or cause ineligibility

Section 12.3 Temporary Coverage

Section 12.3.1 Forty Five (45) Day Processing Standard

The applicant must be sent a notice of eligibility no later than forty-five days after the date of application. The 45-day processing standard is the result of the settlement of a court case, Polk et al. vs. Longley. The consent decree stated that all applications must be acted upon and a decision made as quickly as possible.

Temporary Coverage is Medicaid coverage that is authorized because an application has not been processed timely.

If the individual is over income guidelines a deductible needs to be met prior to temporary coverage being granted.

I. Temporary Coverage is authorized when:
   A. a decision is not made within forty-five days. The Department must authorize temporary coverage. This provides Medicaid coverage from day forty-six until a final decision is made on the application.

B. it is necessary to obtain medical reports from physicians, hospitals, or other medical sources and such medical information is not requested from all necessary sources within five days after the date of application. If the reports are not received within fifteen days of the first request, a second request must be sent. The applicant is to be notified whenever a second request is made to inform the individual that the necessary medical reports have not been received.
C. a deductible is met. Temporary Coverage will be authorized the later of the 46th day or the date the deductible is met.

II. Temporary Coverage will not be authorized if:
A. there is documentation that the applicant or the applicant's source of medical information has not cooperated in obtaining information necessary to make a decision. Documented non-cooperation by the applicant or the source of the applicant's medical information means that the case record must contain sufficient information to show that the applicant or the source of the applicant's medical information was requested to provide specific information or verification, or carry out particular activities necessary to establish eligibility and that the applicant or medical source failed or delayed in doing so within a reasonable period of time.
B. the individual must meet a deductible and the deductible has not yet been met.

Section 12.3.2 Ten (10) day processing standard for deductibles

The consent decree filed as a result of Polk et al. vs. Longley also mandates that the Department issue a medical card no later than ten days after the applicant furnishes adequate information about incurred medical expenses in order to meet the deductible. Adequate information includes the date, cost, type of service and amounts payable by insurance and other third parties for submitted bills.

If the person is not issued a medical card within ten days of submitting the information, the Eligibility Specialist must issue temporary coverage, effective on the 11th day unless there is documentation that the individual is not cooperating.

Section 12.3.3 Ending of Temporary Coverage

If the individual is found to be eligible, Medicaid coverage will go back to the first month of eligibility. This could be a retroactive month, the month of application or the first day of eligibility when a deductible to met.

If the applicant is found to be ineligible after temporary coverage has been issued, the applicant is to be sent a notice of denial. There is no Adverse Action Notice Period. The applicant becomes ineligible upon the receipt of the denial notice (three days from the day the notice is mailed). In no instance may the dates of temporary coverage be eliminated. The individual may request a hearing regarding the denial, but coverage will not continue pending the hearing decision. If the decision of the Hearing Officer is to remand the case back to the regional office for a new decision, temporary coverage is reinstated back to the date that the coverage stopped.

No payment for medical services provided to the individual during the period when the applicant was eligible for temporary coverage is recoverable from the applicant.

SECTION 13 ELIGIBILITY PERIODS/REVIEWS

An individual's eligibility period is based on the month the application is received. Eligibility for the prospective period is determined for twelve months for all MaineCare programs with the exception of:

- six months for Medically Needy
- twenty-four months for DEL and Maine Rx

The eligibility period begins on the 1st day of the month of application unless temporary coverage is being given. (See "45 Day Processing Standard", Section 12.3.1 of this Part). In some instances, the individual is not eligible for coverage during the month of application but is eligible for the following month (See Section 11 of this Part). In this situation, the length of the eligibility period remains the same (six, twelve or twenty-four months), depending on the type of coverage.

A review is a re-determination of eligibility. Appropriate review forms must be used. If the recipient is no longer eligible an Advance Notice must be sent. If the review form is not received in a regional office by the end of the month in which the Adverse Action Period ends, (See Section 15 of this Part) it is considered a reapplication.

Section 13.1 Changes within the Eligibility Period

Changes reported by recipients during the eligibility period must be reviewed by the Eligibility Specialist to determine the effect of the change on the individual's eligibility.

If the new information results in a change in the level of coverage, the Eligibility Specialist must give the recipient timely and adequate notice of the change of level or termination in coverage (See Section 15 of this Part).

Certain categorically eligible individuals have a continuous period of eligibility even if changes occur. These groups are:

I. Newborns -

If the newborn's mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible regardless of the income of the assistance unit. The mother must be fully covered by Medicaid on the day of the baby's birth. In other words, if mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year. This means that the baby is eligible without regard to changes in income or composition of the assistance unit.

II. Children under age 19 -

Any categorically eligible child (including a newborn) who is;

A. not in the Katie Beckett group; and
B. under the age of 19 (through the end of the month of his or her 19th birthday) is continuously eligible for full benefits for twelve months after eligibility is determined by application or review (beginning with the month of application or review) without regard to changes in

income or composition of the assistance unit. Eligibility within the twelve month period will end if:

1. at the end of the month the child turns 19;
2. when the child ceases to be a state resident; or
3. when mail addressed to the child or child's household is returned as undeliverable.

A child who becomes eligible for Transitional Medicaid at the time of annual review does not get twelve months of continuous eligibility.

Examples:

1. Family reviewed 1/08 and is found eligible for Transitional Medicaid effective 2/08. Based on their TM report they are over income for the second 6-month period. The children do not have continuous eligibility through 1/09.

2. Family reviewed 1/08 and found eligible Family -Related Section 1931 effective 2/08. A change moves the family into Transitional Medicaid effective 4/08. Based on their TM report they are over income for the second 6-month period. The children have continuous eligibility through 1/09.

If a child is receiving coverage based on eligibility for SSI or State Supplement benefits or under an SSI - Related coverage group, the child's Medicaid coverage continues for twelve months even if the SSI, or State Supplement benefit ends.

When SSI or State Supplement benefits end before the conclusion of the twelve month eligibility period, the child's coverage continues and a review is done for month twelve.

The Medicaid review after an SSI closing is the start of a twelve month eligibility period.

Example:
A child is eligible as SSI - Related in 12/07. The child is found to not meet the disability criteria in 7/08. Medicaid continues through 11/08 when a review of eligibility is completed.

III. Pregnant women -

Once granted, pregnant women are continuously eligible for sixty days beyond the date the pregnancy ends and through the last day of the month in which the 60th day falls.

Section 13.2 Medically Needy Eligibility Periods

Medically Needy recipients have a six month eligibility period. Most have to meet a deductible to gain eligibility. The only time the six month deductible period is shortened is in situations when:

I. the individual, age 20, will turn 21 in less than six months;

II. the individual dies;

III. the individual becomes eligible for coverage in nursing care status; or

IV. the individual voluntarily withdraws from the program. If the individual voluntarily withdraws and reapplies, new deductible periods (both retroactive and prospective) are established based on the new application. Some months of the retroactive coverage possible from the first application may not be included in the new retroactive period which is established with the reapplication.

Medically Needy coverage begins on the day of the month that the deductible is met. The individual may have some responsibility for bills for medical services incurred on that day. If there is no deductible or the deductible is met with uncovered items, coverage begins on the first day of the month of eligibility.

Once the date of eligibility is established, unless there is a change in income which changes the deductible amount or the individual becomes ineligible for Medicaid, coverage continues to the end of the deductible period. These individuals are entitled to review and advanced notice as described in Section13 above.

Although individuals who are eligible for Medically Needy coverage are in a deductible for six months, if their income is stable and is between the Categorically Needy income levels and the Protected Income Level (PIL) – (See Chart 5), a complete review is necessary once every twelve months rather than once every six months.

Section 13.3 Changes within the Medically Needy Eligibility Period

All changes reported by the recipient during the six month eligibility period must be reviewed by the Eligibility Specialist to determine the effect of the change on the individual's eligibility.

If the new information results in a change in the level of coverage, the Eligibility Specialist must:

I. give the recipient timely and adequate notice of the change of level or termination in coverage (See Section 15 of this Part);

II. determine the effect of the new information on the amount of the deductible; and

III. allow the individual to withdraw and reapply if the information would result in a change of coverage to Categorically Needy.

Section 13.4 Retroactive Period

An applicant for Medicaid may receive retroactive coverage of up to three months prior to the month of application. The exception to this rule is when the individual is only eligible for the Non-Categorical coverage group or Qualified Medicare Beneficiary (QMB) Buy-In group for the retroactive period.

I. Eligibility for retroactive coverage must be determined separately from prospective coverage. It is possible for an individual to be covered as Medically Needy during the retroactive period and Categorically Needy prospectively or vice versa.

II. The individual must meet basic eligibility requirements for any month during which coverage is received. For example, a person who turned age 65 in the month of application cannot be covered retroactively unless SSI - Related disability criteria are met during the retroactive period. (For persons who are eligible for SSI payments based on a disabling condition see Part 6, Section 4.3). The individual does not have to be eligible in the month of application in order to be eligible for retroactive coverage.

The entire three months period may be covered if the individual is eligible for all three months. Medicaid will not cover the third month prior to the application month without including the first and second months unless the individual is ineligible due to basic eligibility requirements or excess assets during the intervening months.

Examples:

1. The individual applies in August and has medical expenses incurred in May. There are no bills for June and July. The individual has a deductible of $300 per month. In order to cover the bills incurred in May, the deductible is $900, not $300. June and July could be covered with a deductible of $600 or July only with a deductible of $300, but coverage must be continuously retroactive from the application month.

2. The individual applies in March and incurred medical expenses in December, January and February. The person had assets of $1500 in December, $2500 in January and $700 in February. Bills incurred in the month of January cannot be covered by Medicaid as the assets exceeded the asset limit that month. The person's deductible for December and February are added together. The bills incurred in January for which the individual is still responsible can be used as non-covered items toward meeting the deductible (See Part 10).

The individual who has a deductible period may withdraw from the program and reapply for retroactive coverage. If an individual voluntarily withdraws, a new prospective period begins with the month of the new application and retroactive eligibility can be determined for up to three months prior to the month of the new application.

In determining eligibility for the retroactive period, income actually received during that period is used.

Individuals who are determined to be eligible for SSI benefits and who indicate on their SSI application that they have medical expenses for the three months prior to their application for SSI do not need to make a separate application for retroactive Medicaid coverage.

If the individual meets the non-financial criteria and the Department has sufficient information in the case record about the individual's financial situation to determine eligibility for the retroactive period, the individual will be sent a notice of eligibility for Medicaid. If there is not sufficient information in the case record or no case record exists, the individual should be contacted in writing and verification of specific information requested. Due to the length of time involved in establishing SSI eligibility, especially if a disability decision is involved, requests for information should be reasonable and lenient.

Individuals who are determined to be eligible for SSI and who indicate on the application for SSI that they do not have medical expenses for the three months prior to their application for SSI will be sent a notice of denial for the three month period.

SECTION 14 CLOSINGS AND DENIALS

Before MaineCare coverage is ended or denied, it must be determined that the individual is not eligible under any coverage group. This includes:

- doing a disability determination when there is information that the individual can potentially meet the disability criteria;
- determining medical and financial eligibility for a Wavier, Nursing Home Care, or Katie Beckett coverage groups when there is information that the individual can potentially meet these criteria;
- determining continuing coverage when SSI/State Supplement cash benefits end;
- determining eligibility under Cub Care and Maine Rx.

Example:
Cathi and her 17 year old daughter are eligible under Family - Related Section 1931 coverage group. Her daughter leaves the home. Cathi claims to have a significant disability and is being assessed by the Medical Review Team to determine if she meets the criteria for SSI - Related Medicaid coverage. Cathi's eligiblity under Family – Related Section 1931 continues until a decision is made by the Medical review Team (MRT).

When individuals lose eligibility for SSI/State Supplement payments and a review for continued MaineCare is needed, existing information in the case record is used to determine continuing eligibility for MaineCare. If there is insufficient information in the case record to determine eligibility or a disability determination is necessary, coverage must be continued until ineligibility is determined. If a review form is necessary, it must be sent to the individual within ten days of the date SSI/State Supplement coverage has ended.

SECTION 15 NOTICES

Individuals will be notified in writing as soon as eligibility is determined. If some of the individuals applying for MaineCare are eligible and some are not, the notice must specify who is and who is not eligible and the reasons for each individual's ineligibility.

Individuals whose eligibility begins after the month of application must be sent a denial notice for the months of ineligibility.

All individuals who apply for Medicaid must be notified of their eligibility for retroactive coverage. Such notification must indicate the months of eligibility or ineligibility.

When an individual is determined to be ineligible, the notification will contain:

I. a statement that the application has been denied;

II. the specific reason(s) for the denial;

III. the manual citations which support the decisions; and

IV. an explanation of the individual's right to request a hearing.

In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient.

I. “Timely” means that the notice must be mailed twelve days before the intended change would be effective (ten days for notice plus two days for mail).

   Timely actions resulting from computer matching mass changes to Social Security and other Federal benefits require an advance notice of thirty days prior to the effective date of the action.

   The only situations in which the timely notice guarantee is not required are as follows:
   A. factual information is received confirming the death of the recipient;
   B. a written statement that assistance is no longer wanted is received by the Department. Such statement must be signed by the recipient or the recipient's representative;
   C. the recipient has been committed to a public institution (See Section 9 of this Part);
   D. the recipient's cost of care changes (See Part 12, Sections 4.3.4 and 4.4.1; Part 13, Section 6; and Part 14, Section 6.2);
   E. the recipient's whereabouts are unknown and Departmental mail directed to the recipient has been returned;
   F. an applicant for Medicaid has been covered temporarily due to the Department's failure to determine eligibility within the forty-five day time limit and is later found to be ineligible. The applicant's temporary coverage is to end three days from the date the denial notice is sent; and
   G. documentation is obtained that the individual is currently receiving Medicaid in another state.

II. “Adequate” means a written notice which includes a statement of:
   A. the action the Department intends to take;
   B. the reasons for the intended action;
   C. the regulations supporting such action;
   D. an explanation of the rights to request a hearing; and
   E. a statement explaining that if a hearing is requested within the notice period, the intended action will not become effective until after a hearing Decision is rendered.

SECTION 16 UNFUNDED CHECKS

An unfunded or bounced check is considered non-payment of a premium.

Upon notice from State Treasury that a check has bounced, the household will be sent a notice of non-payment including the amount now due.

If no payment is received within thirty days of the 1st notice, a 2nd notice is sent.

If no payment is received, the penalty will take effect the month following the month in which the 2nd notice is sent as long as the client has received twelve days advance notice.

> **Example:**
> The family is sent a second notice of non-payment on May 10th. No payment is received within twelve days. The penalty starts in June 1st. If the notice was not sent until May 30th, the penalty would take effect in July.

The penalty is a period of time during which the client cannot get coverage under the option for which there is a non-payment. How long this lasts depends on the coverage option involved.

For **Cub Care**, there is a month of ineligibility for each month of non-payment up to a maximum of three months.

> **Note:** A family's twelve month enrollment period cannot be ended in order to impose this penalty. The penalty starts at the end of any current enrollment period.

In the example above, if the family's enrollment period was January through June, the penalty would take effect in July rather than May.

For **Transitional Medicaid** (TM), coverage under TM ends and cannot be reinstated for any remaining months in the TM period for which a bounced check is received unless overdue premiums are paid. Unpaid premiums from one period of TM do not affect eligibility for subsequent periods of TM.

For **Working Disabled**, coverage cannot continue after the end of the current or last enrollment period unless the unpaid premiums are paid.

For **Katie Beckett**, coverage cannot continue after the end of the current three month premium period unless all outstanding premiums are paid.

> **Note:** A family's three month enrollment period cannot be ended in order to impose this penalty.

PART 3
CATEGORICALLY NEEDY FAMILIES WITH CHILDREN - RELATED COVERAGE

This Medicaid category includes families with children and individuals under the age of 21 (through age 20). The eligibility criteria follows Aid to Families with Dependent Children (AFDC) regulations in effect 7/16/96, as amended by Medicaid. Recipients of TANF, including Alternative Aide, are eligible for Medicaid under this category if they meet these requirements.

Individuals who are ineligible as Categorically Needy due to income or assets may be eligible as Medically Needy (See Part 10).

To be eligible as Categorically Needy Families with Children - Related Coverage an individual must:

I. be a covered individual;

II. have a coverage group;

III. meet basic eligibility criteria in this Part and in Part 2; and

IV. meet income and asset criteria.

SECTION 1 COVERED INDIVIDUALS

In order to get Medicaid coverage under the Families with Children - Related category an individual must meet the criteria of at least one of the following:

I. Individuals under age 21:
   A. Dependent child: A person who lives with parents, with foster parents or with caretaker relatives who are maintaining a home for the individual.

      Note: A “Dependent Child” under a Section 1931 (See Section 2 of this Part) group must be under the age of 18 (through age 17) or age 18 and expects to graduate from high school before age 19.

   B. Independent child: A person who lives alone or with other individuals who are not their parent(s) or caretaker relative(s) or an 18 to 21 year old who is pregnant or is a parent.

   School attendance does not affect eligibility for Medicaid except in the determination of countable income (see Part 4, Section 3.4.1 and Part 17, Section 4.54) and whether the specified relative can be covered (Section 4.1.1 of this Part).

II. Specified Relatives:
   A. Legal parent(s); and
   B. other relatives specified below have the option of being covered by Medicaid and being included with the dependent child in the assistance unit. These are "caretaker relatives". They are:

1. brother or sister, including those of half-blood relationship;
2. stepbrother, or stepsister;
3. legal grandfather, grandmother, uncle or aunt or the same relatives of preceding generations as denoted by prefixes of great and great-great, or first cousin, nephew or niece;
4. the spouse of any persons in the above groups, though the marriage is terminated by death or divorce; or
5. stepparents and the spouse of a caretaker relative.

   Stepparents and the spouse of a caretaker relative have the option of being covered by Medicaid and being included with the dependent child in the assistance unit as long as this does not cause ineligibility for the stepchild or caretaker relative's child.

Note: A parent or caretaker relative whose only child receives SSI is potentially eligible under Section 1931 criteria.

SECTION 2 COVERED GROUPS OVERVIEW

A covered individual must meet the criteria of at least one of the coverage groups below. An individual may meet the criteria of more than one group at the same time in which case they should be enrolled with the group which is the easiest way for them to get the best coverage. An individual may be included in more than one coverage group at the same time in order to get coverage for another family member.

I. Section 1931 eligibles - this group meets the 7/16/96 AFDC rules as amended by Medicaid. These rules include criteria for income, assets and maintenance of a home. “Section 1931” refers to the section of the Social Security Act under which they are covered;

II. Transitional Medicaid includes those who become ineligible for Medicaid coverage under Section 1931 due to an increase in their earnings, hours of employment or child support;

III. individuals under age 21 include those who live on their own, with one or both parents or with unrelated others;

IV. pregnant women, regardless of age;

V. specified relatives who meet all the criteria of the Section 1931 coverage group except for income and whose dependent children may not be enrolled in Medicaid or Cub Care; or

VI. other special coverage groups refers to various special groupings created by federal and/or state legislation.
   A. Refugee/Asylees
   B. IV-E Eligibles and State Adoption assistance

SECTION 3 FINANCIAL RESPONSIBILITY OF RELATIVES

For all Families with Children - Related groups: the following rules apply. See Section 4.1.2 of this Part for a definition of when a child is “living with” the relative.

The financial responsibility of relatives is limited to spouse for spouse (living together) and parents for children (under age 21 and living with parents). Financial responsibility does not exist between siblings nor is there financial responsibility of children for their parent(s) or caretaker relatives.

I. Special Circumstances -
   A. When one parent or caretaker relative is an SSI or State Supplement recipient, that parent/relative's income, assets and needs are not considered in determining the eligibility of the remainder of the assistance unit.
   B. When a child is in state custody and the state has placed the child back with the parent on a trial basis, the parent’s income, assets and needs are not considered unless the parent is requesting medical coverage as well.
   C. Since financial responsibility does not exist between siblings, or from children to parents, those children with either income or assets which affect eligibility may be removed from the assistance unit. Such children are to be considered self-sufficient and no allocation of the parent's income may be made. These children may, however, be considered as a separate assistance unit (See Part 2, Section 2).
   D. Stepparents have financial responsibility for their spouse but not for their stepchildren (See Part 4, Section 3.6.1 for stepparent budgeting rules.)
   E. Caretaker Relatives of individuals under age 18 (or expected to graduate high school before their 19th birthday) (See Section 1 of this Part.)

      The relatives may choose to get coverage. If the caretaker relative elects to get coverage, the relative's and the spouse's income and assets will be included in the determination of eligibility.

      Note: If this results in Medicaid coverage for the caretaker relative but not the child, the child may still be eligible under another coverage group such as an individual under age 21. The caretaker relative’s income and assets are then excluded because they are not financially responsible for the child.

      If the relative elects not to get coverage, that relative's income and assets, as well as those of the spouse will be excluded in determining the needs of the child.

      If the excluded caretaker relative claims the child as a dependent on their income tax, a minimum of 50% of the full need standard is budgeted as income for the child.

II. Circumstances involving individuals under age 21:
   A. An individual under 21 years of age living with parent(s): the parental income and assets must be used in establishing eligibility and the parent(s) included in the appropriate income and asset standards and assistance unit size.

B. An individual under age 21 who is not living with parents: the parental income and assets are not counted. Any actual contributions made by the parents are counted as income, but the parents are not included to determine the appropriate income and asset standard and assistance unit size.

C. An individual under age 21 who is living with their parents or caretaker relative, is not married and is pregnant or a parent:
   1. age 18 to 21 - This individual is an "independent child". The income and assets of the parents or caretaker relatives are not counted. The parent or caretaker relative is not counted in the assistance unit size.
   2. under age 18 (through age 17) - Financial responsibility of relatives is limited to available income from the grandparents to the minor parent or pregnant minor only, not to the grandchild. Refer to Part 4, Section 3.6.2 for budgeting.

   If the grandparents want coverage or it is to the advantage of those wanting coverage, everyone can be included as one assistance unit.

D. an individual under age 21 who is living with their parents or caretaker relative, is married and is not pregnant or a parent: the spouse's income is counted and the spouse is included to determine the appropriate income and asset standards and assistance unit size.

   The parents' income and assets are counted for their child's eligibility but are not counted for their child's spouse.

SECTION 4 COVERAGE GROUPS DETAIL

Section 4.1 Section 1931 of the Social Security Act

Individuals are potentially eligible under this group if they meet all of the following criteria:

Section 4.1.1 Maintenance of a Home

A specified relative is potentially eligible only if they are living with a dependent child for whom a home is maintained and that child is also covered by Medicaid. The child must be under age 18 or is age 18 and expects to graduate from high school prior to their 19th birthday.

The specified relative does not need to have legal custody as a result of court action in order to be considered to be maintaining a home for the child.

If the child lives part of the time with each parent, the parent with whom the child resides over 50% of the time must apply for the child. The applying parent and the child are the assistance unit.

- The countable income of the applying parent is considered in determining eligibility of the child.
- The only income of the non-applying parent that is counted is that which paid to the assistance unit and is countable.

If the child lives 50% of the time with each parent, either parent can apply for the child but not both. The applying parent and child are the assistance unit.

- The countable income of the applying parent is considered in determining eligibility of the child.
- The only income of the non-applying parent that is counted is that which paid to the assistance unit and is countable.

If a child is living with his/her legal parents but the parents are not married, all three have a coverable group and are potentially eligible. The parents have a coverable group because they are residing with their child under age 18 (or 18 and expects to graduate from high school by age 19).

If the only child is between the ages of 19 and 21, (or is age 18 and does not expect to graduate from high school prior to the 19th birthday), the parent or caretaker relative cannot receive Medicaid coverage unless the parent or caretaker relative is eligible in another category.

Examples:

1. The unit consists of a single mother and her 18 year old son. In June, the boy graduates from high school. The boy may remain eligible for Medicaid since he has a coverable group (under age 21). The mother is no longer eligible. She has no coverable group since she is not living with a dependent child covered by Medicaid and does not meet SSI disability criteria.

2. The unit consists of a mother, father, and their 19 year old daughter. The daughter may be eligible, depending on the income and assets of the group, however, the parents cannot be covered.

3. The unit consists of a mother, father, and 17 year old girl who is a sophomore in high school. On the child's eighteenth birthday, the parents' coverage is due to end. Discussion with the family prior to terminating the parents' coverage reveals that the mother has a condition which might meet disability criteria under the SSI program. Coverage for the girl continues. Coverage for the father is terminated. Coverage for the mother continues pending a decision from the Medical Review Team on her disability. If she does not meet criteria for SSI - Related disability (see Part 6, Section 4.3), her coverage must also end.

4. The unit consists of a brother, age 20, who is the caretaker relative of his 18 year old sister. When she graduates from high school, both can continue to receive Medicaid as both are in the under 21 year old group.

Section 4.1.2 Physical Separation

A child may be separated physically from the specified relative and still be considered to be living with the relative provided the relative retains full and exclusive responsibility for the supervision and guidance of the child, offers a home during vacations, and any other delegation of authority to another by the relative is temporary, voluntary, and revocable. When separation occurs, it is expected that the child or parent will return home at the completion of the reason for the separation. The following criteria meet these conditions when a child or parent is away from the home.

I. To secure education when high school facilities are not maintained in the place of residence or if existing facilities do not meet the child's educational or social needs. In this later instance, the assessment of needs and the development of a responsible plan must be made through the parent and a recognized social service agency.

II. To secure planned supervised therapy in a private, organized treatment center such as Sweetser Home when such is necessitated by special needs of a physical or emotional nature.

III. To attend Governor Baxter State School for the Deaf, providing no adequate resource for therapy can be found or developed in the child's own community.

IV. To attend a vocational or technical school or college or university.

V. For care for a terminal illness which probably will prohibit eventual return to the home, although if possible the individual would do so.

VI. For other purposes, such as visiting or moving to another community and similar situations where temporary separation occurs. In such situations, the separation may not exceed four months unless the individual can demonstrate that there is a good reason and that the separation will end as soon as possible.

Section 4.2 Transitional Medicaid

When eligibility under Section 1931 ceases due to increased earnings of a specified relative or due to increased receipt of child support, Transitional Medicaid may be available. Covered individuals described in Sections 2, V and 4.5.3 of this Part are not eligible for Transitional Medicaid, because their eligibility did not come from Social Security Act, Section 1931.

Section 4.2.1 Families with Earnings who Become Ineligible for Coverage under Section 1931 (TM)

Definitions:

Family - a family consists of individuals whose needs and income were included in determining eligibility under Section 1931 at the time coverage under Section 1931 ended. It also includes those individuals whose needs and income would be taken into consideration in determining coverage under Section 1931 if the family were applying in the current month.

Included in the definition is:

- a parent or stepparent who returns home; who is included for coverage with the Section 1931 coverage group and whose earnings, either alone or added to other income of the assistance unit, result in the family losing coverage under Section 1931;
- a child or parent/stepparent who moves into the home after TM has started; or
- a child who is born after TM has started.

Families who lose eligibility under the Section 1931 coverage group due to the earnings of a specified relative remain eligible for Medicaid for up to a year.

These families may receive up to twelve additional months of medical coverage known as Transitional Medicaid (TM). The twelve months are divided into two separate eligibility periods, each consisting of six months. There are different requirements for each extension. Families receiving TM must continue to assign their rights to payment for medical care from any third party. There is not a requirement to cooperate in obtaining medical support or payments from the non-custodial parent (See Part 2, Sections 6 and 7).

The twelve month count starts with the first month of ineligibility, which may not necessarily be the effective month of the loss of coverage under Section 1931.

Example:
A family reports an increase in the parent's earnings on April 5th. The case is now ineligible in April. The first month for TM is April, the first month of ineligibility, and not May which would be the effective month for the closing under Section 1931 coverage.

Section 4.2.2 Initial Six Month Extension (Months One - Six):

I. Conditions of Eligibility -

At least one member must have been eligible for and receiving coverage under Section 1931 in one of the prior three months immediately preceding ineligibility. Retroactive coverage under Section 1931 will be counted for this purpose even if there is only one month of retroactive coverage and no current eligibility under Section 1931.

For example, the family applies in July. Eligibility exists only for June. The family gets coverage under Section 1931 for June and TM starting in July.

Exception:

A. A family is not eligible for the extension if there has been a determination by the State's legal system that any family members collected Medicaid under Section 1931 fraudulently at any time during the last six months.

B. The closing of coverage under Section 1931 must be due to the earnings of a specified relative.

Examples:

1. Mother and one child are covered under Section 1931. Father or stepfather returns to the home. When eligibility is determined including the father or stepfather and his earnings, the family is over income for Section 1931. All three are eligible for TM.

2. Mother, father and two children are covered under Section 1931. Mother and father have earnings. One child leaves the home or turns age 18 resulting the family being over income for Section 1931. Mother, father, and child under age 18 are eligible for TM.

3. Mother and two children are covered under Section 1931. The 17 year old (not attending school) has earnings, which result in the family being over income under Section 1931. The family is not eligible for TM because it is not the earnings of the specified relative that resulted in ineligibility under Section 1931.

4. Family of four are covered under Section 1931. Mother has earnings and father, who is employed, starts to get unemployment benefits putting the family over the Section 1931 income limit. This family is not eligible for TM since it was the change in UIB that resulted in being over the Section 1931 income limit.

C. It is not a condition of eligibility that the specified relative remain employed during the first six months of the initial extension or that included individuals cooperate in establishing paternity and in obtaining medical support and payments. Individuals in the assistance unit must comply with rules on assigning rights to medical support (through Third Party Liability (TPL)).
D. There is no income or asset test for the initial six month extension.
E. Failure to file the income and child care report required in the fourth month does not affect the coverage provided in the initial extension.
F. The coverage group must include a child, under the age of eighteen or between the ages of 18 and 19 and a student regularly attending a secondary school on a full-time basis (or in the equivalent level of vocational or technical training at the high school level) and reasonably expected to complete the program prior to his or her 19th birthday, residing within the household.

II. Covered Individuals -
A. All family members who were members of the Section 1931 assistance unit at the time of closing and/or whose needs and income were taken into account in determining coverage under Section 1931 (for example a parent returned to the home).
B. Anyone who moves into the home after TM has started as long as that person would have been covered under Section 1931 if the family were applying in the current month.

For example:
- a newborn
- a non-custodial parent returns
- a child moves into the home
- a stepparent moves into the home.

III. Client Reporting Responsibilities -
A. Each family must report when a child no longer resides within its household or when there are any other changes in the family composition.
B. Each family must file its report of gross earnings and child care expenses necessary for the employment of the specified relative by

the 21st of the fourth month. The report will contain verified information for months one, two, and three of the initial extension.

Good cause for failure to file an income and child care report on time or failure to file a completed report is established by the eligibility specialist. Some reasons for good cause include but are not limited to:

1. mail delay;
2. reported change of address too late in preceding month for data processing changes for mailings;
3. the 21st falls on a weekend or holiday, in this instance the due date becomes the next working day;
4. planned absences previously reported;
5. death or illness of a family member or responsible relative;
6. circumstances beyond the control of the responsible relative.

All other changes must be reported within the time frames outlined in Part 2, Section 12.2, unless otherwise specified.

IV. Agency Notice Requirements -

A. At the time of the closing under Section 1931 rules, a determination must be made for the initial Transitional Medicaid extension and a notice sent informing the family of the following:
   1. the family's eligibility for the extension and a medical card which lists all eligible members; and
   2. the requirement to report the family's gross monthly earnings and necessary child care expenses by the 21st of the fourth month within the initial extension as a condition of eligibility for the additional extension (months seven - twelve); and
   3. the availability of a second six month extension; and
   4. the conditions under which the initial extension may be terminated.

B. In the third month of the initial extension, a notice (which is due in the 4th month) will be sent informing the family of the following:
   1. the requirement to report their gross earnings and child care expenses for each of the three prior months;
   2. the optional availability of a second six month extension (months seven - twelve);
   3. a description of when a premium is required, how it is calculated, and when payments are due; and
   4. a description of the scope of services provided within the second six months.

C. In the sixth month of the initial extension, a notice (which is due in the 7th month) is required informing the family of the following:
   1. the family's option to continue into the second six month extension; the requirement for the family to file a report in the seventh month of its gross earnings and child care for the fourth, fifth, and sixth months of the extension;
   2. the amount of any premium, if any, due for the seventh, eighth, and ninth months of the extension;

3. a description of the scope of services provided in the second extension; and
4. a description of reinstatement for any remaining months of this extension.

V. Termination of Initial TM (Months one - six) -

A. TM will be terminated with adequate notice when a child no longer resides within the household.
B. A determination for any other potential MaineCare must be done prior to terminating extended coverage.
C. In situations when the intended agency action is to terminate coverage, adequate and timely notice must be given to the recipient as described in Part 2, Section 15.

Section 4.2.3 Second Six Month Extension (Months seven - twelve):

I. Conditions of Eligibility -

A. Families must have received TM for all six of the months within the initial extension to be offered the second extension.
B. Families must have filed a timely report of income and child care expenses in the fourth month as required.
C. The scope of services will be the same as those provided to those eligible under Section 1931.
D. The specified relative must remain employed in each month of the second six months. Families are only required to report a period of being unemployed at the time of filing an income report form. Good cause provisions will be considered for lack of employment and established by the Eligibility Specialist. Some reasons for good cause for lack of employment include but are not limited to:
   1. dismissal;
   2. illness of employed individual;
   3. care of other ill family members who are residing within the household;
   4. loss of transportation;
   5. harassment;
   6. risk to health and safety;
   7. loss of child care if there is not any other adequate replacement; or
   8. other reasons which indicate the action was not deliberate or willful.

E. Countable income is defined as gross earnings minus child care expenses. A family's countable income must be less than 185% of the Federal Poverty Level (See Chart 6) to be eligible. The countable income is tested for 185% upon receipt of the required income reports. Unearned income is not counted in the 185% FPL test.
F. Premiums will be charged for families whose countable income is greater than 150% of the Federal Poverty Level (See Chart 6) but less than 185%. The premium will be three per cent (3%) of the family's net income (see IV. E below).
G. There is no asset limit in the second six months of TM. Included individuals do not have to cooperate in establishing paternity or in

obtaining medical support and payments. Included individuals must comply with the rules on assigning rights to medical support (through Third Party Liability (TPL)).

Note: If after the initial six months extension, parents or caretaker relatives have income between 150 - 200% FPL, they could be eligible for coverage under the expanded coverage group for caretaker relatives (See Part 4, Section 2).

II. Covered Individuals -

A. All family members who were members of the assistance unit under Section 1931 coverage at the time of closing and/or whose needs and income were taken into account in determining coverage under Section 1931 (for example a parent returned to the home).

B. Anyone who moves into the home after TM has started as long as that person would have been covered under Section 1931 if the family were applying in the current month.

For example:
- a newborn
- a non-custodial parent returns
- a child moves into the home
- a stepparent moves into the home.

III. Budget Computations -

A. The only income used to determine if a family remains eligible for TM is gross earnings of financially responsible adults, living within the household, and the gross earnings of any caretaker relative and their spouse or stepparent who is getting coverage.

B. The actual cost for child care is an income deduction. Only that amount of child care costs necessary for the employment of the specified relative, will be allowed as a deduction as long as the family is liable for this expense.

C. Countable income for use in TM is defined as gross earnings minus allowable child care deductions in meeting the 185% FPL test. Unearned income is not counted in the 185% FPL test.

D. The family's countable income is determined from the two required reports for gross earnings and child care expenses. These reports are required in the fourth and seventh months during the extension.

A review is due in the 12th month in order to determine continuing eligibility for Medical coverage.

Countable income is determined as follows:

1. Determine the family's total gross earnings for the required three month period.
2. Deduct from gross wages the allowable child care costs necessary for the specified relative's employment.
3. Divide by three to obtain the average monthly income.
4. Compare the average monthly income to 185% of the Federal Poverty Level (See Chart 6) for the family unit size. If the income is equal to or less than the limit, the family remains

eligible. If the income is greater than the limit, benefits are terminated with adequate notice.

E. Premiums are required for families whose countable income is equal to or greater than 150% but less than 185% of the Federal Poverty Level (See Chart 6) for that family unit size.

Monthly premiums will equal 3% of the family's net income (rounded down to the nearest dollar) and are to be paid by the 21st of the month following the month for which coverage is being granted.

Example:
June coverage requires premium payment no later than July 21st.

Net income for the purpose of establishing a premium is defined as gross earnings of financially responsible adults and caretaker relatives and their spouse/ stepparents who are being covered minus allowable tax and child care limited to only those amounts required by law. Allowable child care deductions are defined earlier in IV. B above.

For a premium to be considered timely, it must be paid by the 21st of the month in which it is due. Good cause for failure to pay a premium on time can be looked at for late payments that are received no later than the last day of the month in which the payment is due. Good cause is established by the Eligibility Specialist. Some reasons for good cause include but are not limited to:

1. mail delay;
2. planned absences previously reported;
3. death or illness of a family member or responsible relative;
4. other unanticipated emergencies; or
5. circumstances beyond the control of the responsible relative.

F. Premium Base Periods -

The premium charged, if applicable, for months seven, eight, and nine is based on the report filed in the fourth month of the initial extension. This report contains income and child care information from months one, two, and three of the initial extension.

The premium charged, if applicable, for months ten, eleven, and twelve is based on the report filed in the seventh month of the extension. This report contains income and child care information from months four, five, and six of the initial extension.

When coverage of the parent ends due to non-payment, TM is possible for any remaining months of the extension. Prior to reinstatement any overdue premiums must be paid.

Example:
A parent receives coverage for June but fails to pay the required premium due no later than July 21st, therefore, coverage is closed August 31st. (June is the 7th month of the extension). In October the parent wants reinstatement for October (11th month). Since the family already received coverage for June,

July and August the premiums for these three months are required before current coverage can be granted for October. Upon payment for June, July and August coverage, the parent can be reinstated beginning with October coverage. The October premium is due no later than November 21st. Since coverage was not provided in September, no premiums are due for that month.

Note: When a parent has been closed for TM and there is an unpaid premium due, the Eligibility Specialist will refer the case to Third Party Liability (TPL) for possible collection.

IV. Client Reporting Responsibilities -

A. There are two reports required during the TM extension. They are due by the 21st of the fourth and seventh months of the extension. Verification of income and child care must be provided. Once child care has been verified, additional verification will only be needed if there is a change. In month twelve a review is due to determine continuing eligibility for Medical coverage.

B. Each family must report in the same month when a child no longer resides within its household or when there are any other changes in the family composition.

C. Each family must report if the specified relative is no longer employed. Families are only required to report this information at the time of filing an income report form.

All other changes must be reported within the time frames outlined in Part 2, Section 12.2.

V. Agency Notice Requirements -

A review is due in the 12th month. It is used to determine continuing eligibility for MaineCare coverage when TM ends.

VI. Termination of Benefits for the Second Six Month Extension -

TM will be closed with adequate notice when:

A. a child no longer resides within the household; This means there must be a child, under the age of eighteen or between age 18 and 19 and a student regularly attending a secondary school on a full-time basis (or in the equivalent level of vocational or technical training at the high school level) and reasonably expected to complete the program prior to his or her 19th birthday, residing within the household.

B. a required income and child care report is not filed.

C. the specified relative is no longer employed.

D. when income increases above 185% of the FPL (See Chart 6).

E. a required premium is not paid timely nor good cause granted.

A determination must be made for any other possible MaineCare coverage prior to the closing of TM.

In situations when the intended Agency action is to terminate coverage, adequate and timely notice must be given to the recipient as described in Part 2, Section 15.

Section 4.2.4 Families who Become Ineligible for Coverage Under Section 1931 Due to Increased Child Support

Coverage under Section 1931 must have been closed solely because of an increase in the amount of child support or alimony being received by the family.

The family must have been eligible under Section 1931 for three of the six months prior to the month of ineligibility. Once eligibility for the four month period has been determined, it continues regardless of whether the family meets other conditions of eligibility.

At the end of the four month period, the family's coverage is to be reviewed for potential future coverage. If eligibility does not exist, coverage is to be ended following advance notice procedures.

The four month count for extended Medicaid begins with the first month of ineligibility even though the closing under Section 1931 is later.

Example:
A client reports in May that her child support has increased and now the countable income exceeds program standards. The four month extension begins in May, even though the case cannot be closed for May.

Section 4.3 Pregnant Women

Pregnancy and the expected delivery date must be verified by a medical source.

Pregnant women whose countable income is equal to or below 200% of the Federal Poverty Level (See Chart 6) are eligible. The assistance unit size is increased by one (or by two if the woman is expecting twins). Assets and cooperation with Third Party Liability (TPL) and Division of Support Enforcement and Recovery (DSER) are not factors in determining eligibility.

Retroactive coverage may be granted for up to three months if the woman was pregnant and financially eligible.

If a woman is eligible as a pregnant woman in the month of application, or the retroactive period, or due to a change in ongoing eligibility, she continues to be eligible for sixty days beyond the date her pregnancy ends and through the last day of the month in which the 60th day falls.

In the case of unmarried parents, acknowledgment of paternity cannot be made prior to the baby's birth. Therefore, the father's income and assets, as well as his needs, would not be used in the determination of eligibility for the pregnant woman even if the needs of the unborn child were included in the budget.

For additional financial factors affecting pregnant women under the age of 21 see Section 3 of this Part and Part 4, Section 3.6.2.

Only the pregnant woman is eligible under this income limit. Other family members must be in another coverable group.

If the individual is receiving inpatient hospital services on the last day of the month in which coverage as a pregnant woman occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

Section 4.3.1 Presumptive Eligibility for Pregnant women

A pregnant woman is eligible to receive ambulatory prenatal care beginning on the day that a qualified Medicaid provider determines that the pregnant woman's family income is less than the 200% of the Federal Poverty Level (See Chart 6). This coverage is called "presumptive eligibility".

The qualified Medicaid provider will use a presumptive eligibility application to establish the family size and income for the presumptive determination. Assets are not a factor in the presumptive eligibility determination. The Medicaid provider must contact the regional office of Medicaid within five working days after the date the presumptive determination is made to report the name, date of birth, and Social Security number of each woman determined eligible under the presumptive eligibility standards.

Once the Medicaid provider has made a presumptive determination, the woman is eligible through the last day of the month following the month in which a presumptive determination is made. If the woman applies for Medicaid during this presumptive eligibility period, presumptive eligibility continues through the day that the Medicaid application is granted or denied.

> **Example:**
> A pregnant woman is determined presumptively eligible by the Medicaid provider on September 14th. She receives coverage under presumptive eligibility through October 31st. On October 31st she files an application for Medicaid. Because she applied for Medicaid within the presumptive eligibility period, the individual continues to be presumptively eligible through the day the application is granted or denied.

The Eligibility Specialist is required to provide appropriate notices based on the Medicaid application itself, but is not required to send any notice regarding the discontinuance of the presumptive eligibility period and the individual has no rights of appeal.

It is the responsibility of the Medicaid provider to inform the pregnant woman requesting presumptive eligibility whether she is eligible or not eligible for presumptive eligibility.

Section 4.4 Individuals Under Age 21 (Through age 20)

I. Newborns -

If the newborn’s mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible regardless of the income of the assistance unit. The mother must be fully covered by Medicaid on the day of the baby’s birth. In other words, if mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year. This means that the baby is eligible without regard to changes in income or composition of the assistance unit.

II. Other children under age 1 -

Individuals under the age of one who are living with specified relatives or with unrelated others are eligible if they meet other applicable eligibility rules.

Countable income must be equal to or less than 185% of the Federal Poverty Level (See Chart 6).

There is no asset limit for this group.

If the individual is receiving inpatient hospital services on the last day of the month in which the first birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

III. Age 1 through Age 18 -

Individuals age 1 up to and including age 18 (under age 19) who are living with specified relatives or who are living alone or with unrelated others are eligible for Medicaid if they meet other applicable eligibility rules.

Countable income must be equal to or less than 150% of Federal Poverty Level (See Chart 6).

There is no asset limit.

If the individual is receiving inpatient hospital services on the last day of the month in which the 19th birthday occurs, eligibility continues until the last day of the inpatient stay if the individual continues to meet all other eligibility criteria.

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IV. Age 19 or 20 -

Individuals age 19 or 20 who are living with specified relatives or who are living alone or with unrelated others are eligible for Medicaid if they meet other applicable eligibility rules.

Countable income must be equal to or less than 150% of Federal Poverty Level (See Chart 6) and countable assets must be less than $2,000.

If the individual is receiving inpatient hospital services on the last day of the month in which the 21st birthday occurs, eligibility continues until the last day of the in-patient stay if the individual continues to meet all other eligibility criteria.

Section 4.5 Other Special Groups

Section 4.5.1 Refugees/Asylees

Persons who are eligible for services under the Refugee Resettlement Program (RRP) are eligible for Medicaid provided that financial and basic eligibility

requirements are met. Eligibility is determined on the basis of need without regard to family composition or the presence of children. Age is not considered. Financial eligibility follows Section 1931 budgeting.

I. Special Eligibility Factors:
   A. Each applicant must have a Form I-94, I-151, or I-551 indicating that the individual has been admitted under Section 212(d)(5) of the Immigration and Naturalization Act (INA) or granted asylum under Section 208 of the INA.
   B. Any funds received through the RRP are counted as unearned income and used in determining eligibility.
   C. The following guideline should be used for documentation:

      1. Form I-94 may be accepted as proof of age.
      2. Any documents that the refugees brought with them when they emigrated showing the relationship among family members is acceptable evidence of relationship.
      3. School records and medical records established since arrival in the United States may be used as methods of verification.
      4. Information recorded in the refugee assistance case folder may be used as supporting evidence.
      5. If there are no written records of any kind, the refugee's statement is acceptable unless the statement appears unreasonable.

   D. Only the assets which are available on the date of application are considered for the eight month eligibility period. Assets which are unavailable to the refugee (including assets which were left behind when emigrating) are not considered. Only the income the individual is receiving on the date of application is used in determining eligibility for the eight month period.
   E. The income and assets of sponsors and any income-in-kind they provide is not used in determining eligibility.
   F. Children born to refugees in this country are considered United States citizens. They are issued alien registration numbers which are the same as their mother's with the suffix 01, 02, 03, etc. These children are considered a part of the refugee family for eligibility purposes.
   G. Individuals who are dependents of repatriated United States citizens may be eligible during the first ninety days after their arrival in the United States if the individuals qualify as refugees under the RRP.

II. Limitation -
   A. An individual can receive Medicaid as a refugee for only the eight month period including the month that the refugee enters the United States.

      Example:
      The individual enters the United States as a refugee on July 1st. She is potentially eligible to receive Medicaid as a refugee from July 1st through February of the following year.

   B. An individual can receive Medicaid as an asylee for only eight months beginning in the month they are granted asylum.

Example:
An individual enters the United States in January, but is not granted asylum until November. November is the first month of the eight month period.

C. This limitation applies on an individual basis.
D. At the end of the 8th month period, eligibility is reviewed for other program categories. If none exists, Medicaid ends with timely and adequate notice.

This limitation does not apply to individuals who meet age factors for Family - Related or SSI - Related coverage. If eligible under other programs, the individual should first be covered under those programs. The refugee program is one of last resort.

Section 4.5.2 IV-E Eligibles and State Adoption Assistance

I. Move-In from Out of State -

An individual under the age of 21, who is receiving Title IV-E funds from another state or is covered by a State Adoption Agreement from another state and moves to Maine, is eligible to enroll in Medicaid. The income and assets of the child and parents are not considered to determine eligibility for this child.

There must be an assignment of rights to medical support and the Department must be provided with a Social Security number for the child.

There are three groups of children who fall into this category:

A. children whose medical and financial circumstances qualify them for federal IV-E adoption assistance;
B. children whose medical and financial circumstances qualify them for federal IV-E foster care assistance; and
C. children whose medical and financial circumstances quality them for state adoption assistance.

The foster or adoptive parents in Maine are provided with a written explanation of their status by the state of origin which usually serves as verification of their status.

II. Maine Residents

A. Coverage is usually determined by the Office of Child and Family Services (OCFS) for:
   - a foster child eligible for Maine IV-E funds, or
   - a child covered under a Federal (IV-E) or Maine State Adoption Assistance agreement.

B. Coverage is determined by OIAS for:
   - a foster child that is not eligible for IV-E funds;
   - a child is not eligible under a Federal or Maine State Adoption Assistance agreement; or

- a child who is placed in Permanency Guardianship by the State of Maine.

Section 4.5.3 Parents and Caretaker Relatives with income between 150% - 200% FPL

Medicaid coverage can be provided to parents and caretaker relatives who meet all other Section 1931 coverage group criteria, except the following:

I. countable income is greater than 150% FPL and equal to or less than 200% FPL (See Chart 6).
II. the dependent child does not need to be covered by Medicaid.

Parents and Caretaker Relatives in this Section are not eligible for Transitional Medicaid as described in Section 4.2 of this Part because their eligibility did not come from Social Security Act, Section 1931.

PART 4
FAMILY - RELATED BUDGETING

SECTION 1 FAMILY - RELATED ASSET LIMIT

If the assistance unit is below the maximum asset limit any day of the month, the unit is potentially eligible for coverage for that month.

I. The countable asset limit for the following Categorically Needy groups is $2000:
   A. Section 1931 eligibles;
   B. individuals age 19 and 20;
   C. Refugees/Asylees; or
   D. parents and caretaker relatives with income between 150% - 200% of the FPL (See Chart 6).

II. There is no asset limit for the following Categorically Needy coverage groups:
   A. pregnant women;
   B. children up to and including age 18 who are ineligible under Section 1931 of the Social Security Act;
   C. Transitional Medicaid; or
   D. individuals eligible under IV-E or State Adoption assistance.

To determine countable assets for the assistance unit, add the countable assets for all people who will be covered or counted in the assistance unit.

SECTION 2 FAMILY - RELATED INCOME LIMITS

Categorically Needy countable income limits are as follows:

I. parents or caretaker relatives eligible under Section 1931 of the Social Security Act: equal to or less than 150% of the Federal Poverty Level (See Chart 6).

II. parents or caretaker relatives, as identified in Part 3,Section 4.5.3: greater than 150% and equal to or less than 200% of the Federal Poverty Level (See Chart 6).

III. individuals age 19 and 20: equal to or less than 150% of the Federal Poverty Level (See Chart 6).

IV. pregnant women: equal to or less than 200% of the Federal Poverty Level (See Chart 6).

V. children under age 1: equal to or less than 185% of the Federal Poverty Level (See Chart 6).

VI. children age 1 up to and including age 18 (under age 19): equal to or less than 150% of the Federal Poverty Level (See Chart 6).

The Medically Needy countable income limit is the Protected Income Limit (PIL) for the appropriate assistance unit size (See Chart 5). For Medically Needy eligibility criteria, see Part 10.

SECTION 3 BASIC BUDGETING PRINCIPLES

To determine eligibility for the assistance unit, the following steps must be taken. These steps are detailed in this section.

- Determine the assistance unit size.
- Determine whose income will be budgeted.
- Determine the gross monthly income of the assistance unit members and those individuals who are responsible for them.
- Deduct disregards.
- Compare the result to the appropriate Federal Poverty Level (see Chart 6) for Categorically Needy or the Protected Income Level (PIL) (see Chart 5) for Medically Needy, whichever is appropriate.

Section 3.1 Assistance Unit Size

For a description of assistance units see Part 2, Section 2.

I. Determine who is requesting coverage.

II. Determine who must be included in the assistance unit:
   A. Add the child's legal parent(s) in the home, even if they are not to be covered, unless they are receiving SSI. If the parent is included in a SSI or State Supplement budget, the portion of the money allocated to the individuals in the assistance unit by SSI or State Supplement budgeting is counted in determining eligibility for this assistance unit (See Part 3, Section 3 for financial responsibility of relatives).
   B. Only when a woman's eligibility is based on pregnancy are the needs of the unborn child or children used to determine her eligibility. The needs of the unborn child or children are not used to determine eligibility for other household members.

      Example:
      A nineteen year old pregnant woman is living alone and working. Her earnings place her over the Categorically Needy payment standard for an individual under age 21. At this point, the Eligibility Specialist must consider the needs of the unborn child in determining eligibility, using the standards for two.

III. Determine all others who may be added to the assistance unit. These households members are:

   - stepparents
   - caretaker relatives
   - any step or blood relative under age 21

Section 3.2 Use of Income

Count the income of anyone who is included in the assistance unit. In addition count income that is deemed to the assistance unit as identified in Section 3.6 of this Part.

Section 3.3 Determination of gross monthly income (See Part 17)

The source of income and the time frame in which it is received must be considered in determining the gross income for a particular month.

Section 3.4 Disregards

The following are deducted from gross non-excluded income.

Section 3.4.1 Disregards from all Income

I. Child support ordered by a court or Title IV-D (DSER) -
Income used to comply with the terms of court - ordered child support or Title IV-D (DSER) child support order for children outside the home will be disregarded. This also applies to income which is garnished for court ordered or Title IV-D child support.

II. Income allocated to dependents -

There are situations where an adult member of the assistance unit is legally responsible for the support of individuals living in the home who are not eligible for coverage under a Family - Related group. For example, a legal parent allocating to a stepparent or a mutual child.

In such situations, that portion of the adult's income necessary to meet the unmet need of these dependents will be disregarded in the computation of available income. The unmet need will be determined by applying the available income of the dependents to the appropriate Full Need Standard (Chart 2).

If the adult member of the assistance unit elects to exclude an otherwise eligible child from the assistance unit, no allocation of the adult's income will be made toward the needs of the child. The child will be considered self-sufficient. In addition, income will not be allocated to any dependent with cashable assets in excess of the limit for the Section 1931 coverage group.

When determining eligibility based on pregnancy no allocation can be made to an unborn child.

Section 3.4.2 Earned Income Disregards

I. Work-related expenses (WRE) -
Disregard the first $90.00 per month of the total income earned by each individual in the assistance unit. This $90.00 disregard applies whether the individual is working part-time or full-time.

II. Dependent Care -
Disregard the actual cost, not to exceed $200 per month, for the care of each child under the age of two who is living in the home and receiving Medicaid.

Disregard the actual cost, not to exceed $175 per month, for the care of each child age two and older or an incapacitated adult who lives in the home and receives Medicaid.

The above disregards apply whether the individual is working full or part-time.

Section 3.5 Income Limit

Compare the result to the appropriate Federal Poverty Level (Chart 6).

If eligibility does not exist as Categorically Needy due to excess income or assets, eligibility may be gained through Medically Needy. Medically Needy applies the same budgeting procedures as Categorically Needy to determine countable income, however the income limit is the Protected Income Level (PIL).

Section 3.6 Special Budgeting Procedures

Add the income deemed under any special budgeting procedure below. When determining eligibility for stepparent families, pregnant minors, minor parents, strikers, or when other family members receive SSI/State Supplement, special budgeting procedures must be followed.

Section 3.6.1 Stepparents

When determining coverage for a family with a stepparent, the following Medicaid rules must be applied.

I. A stepparent is financially responsible for his/her spouse, but not his/her stepchildren.

II. Children are not financially responsible for their parents or their siblings.

III. Legal parents are financially responsible for their children with whom they reside except for an independent child. An independent child is an 18 to 21 year old who is pregnant or a parent.

IV. An individual over age 21 needs to reside with and get coverage in the same assistance unit with their child under age 18 (or is in school and will not graduate before their 19th birthday) in order to have a Section 1931 coverage group.

Opting off and income allocation - “Opting off” means that an individual has a coverage group and could be included in an assistance unit but is not included in that particular assistance unit.

V. A child can opt off. If a child opts off:
   A. the child is not counted in the assistance unit size;
   B. the child’s income does not count in (is not deemed to) the assistance unit; and
   C. there is no income allocation to this child.

VI. A legal parent is financially responsible for his/her child. The legal parent must be part of the assistance unit with his/her legal child unless the legal parent needs are met by a stepparent who is excluded. In this situation the legal parent is not included in the assistance unit size with his/her legal child. The legal parent’s income is still counted for (deemed to) his/her legal child. The legal parent’s gross income is used in this situation. See Chart 2.

VII. A stepparent can opt on or off. If off, his/her assets do not count for the legal parent. If the stepparent is excluded from the assistance unit in order to cover the stepchild:

A. the stepparent is not counted as part of that assistance unit.
B. stepparent income does not count for the stepchild but is counted for the legal parent.
C. all children for whom the stepparent is legally responsible must be removed from the assistance unit (the mutual child and stepparent's legal child).
D. the legal parent can allocate to the stepparent and to the mutual child after stepparent income has been allocated to them.

If the stepparent is excluded from the assistance unit for any reason other than to get coverage for the stepchild or the stepparent's assets are more than $2,000, the legal parent cannot allocate income to the stepparent. The legal parent can still allocate to the mutual child (after any stepparent allocation). See Chart 2.

VIII. If the household consists of the stepparent, legal parent, stepchildren, and mutual children under age 21, first determine if the whole unit meets the financial criteria. If the entire unit is not eligible, there are several options:

A. Any child may be removed along with that child's income and assets. That child may be eligible as a member of another assistance unit as long as all financial eligibility rules are followed, specifically, financial responsibility.
B. A stepparent may choose to be excluded from the assistance unit. A stepparent must be excluded if his/her income causes ineligibility for the stepchild.

Note: If the stepparent is excluded from an assistance unit, all the children for whom the stepparent is financially responsible must be removed from this assistance unit. This includes the mutual children. An allocation must be made by the stepparent for those members who have been removed. These individuals may be eligible as members of another assistance unit as long as all financial eligibility rules are followed. When the stepparent is not included, the following exclusions will be applied to the stepparent's income:

1. The first $90.00 of the stepparent's gross earned income.
2. An additional amount equal to the appropriate Full Need Standard for the support of the stepparent and other individuals who are living in the same household but whose needs are not taken into account in making the Medicaid eligibility determination and for whom the stepparent is financially responsible or are claimed by the stepparent as dependents for IRS purposes.
3. Any actual payments of alimony or child support to persons not living in the home.
4. Any amount actually being paid by the stepparent to individuals not living in the home but who are claimed or could be claimed by the stepparent as dependents for IRS purposes and under IRS rules.

All of the remaining income is considered available to the remainder of the assistance unit as unearned income.

Note: When the stepparent is an SSI recipient, the stepparent's needs, as well as income and assets, will be excluded in the determination of eligibility for the remainder of the assistance unit.

C. The legal parent may be removed -

When the legal parent is removed, some or all of the legal parent's income may be used to determine the eligibility of the stepchildren. The amount of the legal parent's income available to the remaining assistance unit depends on how much of the legal parent's needs are met by the stepparent's income.

To determine the amount of the legal parent's income which is available to the stepchildren if the legal parent is removed:

1. Determine the countable monthly income of the stepparent as in VIII (B) above. If this amount is equal to or more than the appropriate Full Need Standard for one adult, the legal parent's needs are considered to be met. All of the legal parent's gross income is considered as unearned income, available to meet the needs of the stepchildren. Do not count any of the stepparent's income to meet the needs of the stepchildren.
2. Subtract any allocations from the legal parent's income (such as an allocation to a mutual child if the stepparent cannot meet the child's needs. The legal parent can also allocate to the stepparent as long as the stepparent is excluded in order to cover the stepchild.
3. Compare the result with the appropriate Full Need Standard for one adult.

If this amount is less than the appropriate Full Need Standard (see Chart 2) for one adult, the legal parent's needs are not considered to be met. Subtract from the legal parent's gross income enough to meet the unmet need. The remainder of the legal parent's income is considered available as unearned income to meet the needs of the legal parent's children.

Section 3.6.2 Pregnant Minors and Minor Parents

A minor parent or pregnant minor is a legal parent who is under 18 years of age. In Medicaid, the financial responsibility of relatives is limited to available income from the grandparents to the minor parent or pregnant minor only, not to the grandchild. Therefore, a case involving a minor parent or pregnant minor maybe treated the same as an excluded stepparent case substituting the term "grandparent" for the term "stepparent" and "minor parent" for "legal parent". See Stepparent section, above.

When eligibility is based solely on pregnancy, see Part 3, Section 4.3.

If the grandparent(s) wants coverage, or it is to the advantage of those wanting coverage, everyone can be included as one assistance unit.

Section 3.6.3 Strikers

Definitions:
A **"strike"** is "any concerted stoppage of work by employees (including a stoppage by reason of expiration of a collective bargaining agreement) and any concerted slowdown or other concerted interruption of operations by employees" (29 USC §142(2) - National Labor Relations Board).

"Participation in a strike" means an individual is involved in a strike, including persons who are absent from work without good cause during the strike period.

"Good cause for absence" means an individual may be absent from work provided the reason for absence is vacation, illness or emergency which began prior to the strike and continues into the strike period as long as the individual intends to return to work at the end of the vacation, illness or emergency regardless of whether or not the strike continues. An individual may also be absent for good cause if the individual can demonstrate that to return to work would jeopardize health and safety.

It is assumed that an individual who is participating in a strike on any day of the month will be on strike on the last day of the month. A striker who is on strike on the last day of the month is ineligible for assistance until the strike is ended. If the individual was assumed to be on strike on the last day of the month but the strike was settled prior to the last day of the month, coverage may be given for that month.

When a parent, stepparent or other specified relative included in the assistance unit is participating in a strike without good cause on the last day of the month, the income and assets of the individual are treated as if they were not on strike. See Section 3.6.1 of this Part, (for the stepparent) or Part 3, Section 3 (for the parent or specified relative) for the remaining assistance unit.

Section 3.6.4 Family Members who are SSI/State Supplement Recipients

In Family - Related coverage groups, when SSI or State Supplement payments are received by some family members, that member is not included in the assistance unit. The SSI/State Supplement payment is excluded income. Only income allocated by SSI budgeting to individuals in the assistance unit is counted in determining eligibility.

Examples:

1. The family consists of a husband, wife and two mutual children. The wife receives SSI, the husband is employed and neither of the children have income. SSI budgeting has an ineligible child allocation that is adjusted annually. SSI makes an allocation for each of the ineligible children (See Chart 3.2). The assistance unit size is three, consisting of the husband and two children. Countable income for the assistance unit is the sum of the ineligible child living allowance for each child (twice the amount in Chart 3.2).
2. The family consists of a husband, wife and two mutual children. One child receives SSI. The only household income is the father's earnings. SSI has a parent allocation and an ineligible child allocation that is adjusted annually (See Chart 3.2). SSI allocates a parent allocation and an ineligible child allocation. The assistance unit size is three, consisting of the parents and the child not on SSI. Countable income for the assistance unit is the sum of the allocation for two parents in the household and the ineligible child living allowance.

PART 5
CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) – CUB CARE

SECTION 1 SCOPE

The Children's Health Insurance Program (CHIP) is authorized under Title XXI of the Social Security Act. Cub Care is the name of the CHIP program in Maine. It is available to individuals who are under the age of 19 who are ineligible for Medicaid and who meet certain other requirements as identified in this section. Coverage became available as of 8/1/98.

The Department has the right to collect from other available insurance or from settlement(s) for accidents or injuries whenever the Medical ID was used.

SECTION 2 BASIC ELIGIBILITY REQUIREMENTS

To be eligible for Cub Care, individuals must meet the basic eligibility requirements for getting full Medicaid coverage as identified in Part 2, Sections 3, 4 and 5 regarding residency and citizenship and Social Security numbers. There is no requirement to refer the non-custodial parent without health insurance to the Division of Support Enforcement and Recovery (DSER).

I. Children Excluded from Coverage:

A. a child who is eligible for coverage under the Medicaid program. This includes coverage under Transitional Medicaid (TM) and Katie Beckett. If the individual chooses not to pay a premium due for TM or Katie Beckett the family is considered ineligible for Medicaid and the children under age 19 will be potentially eligible for Cub Care.

B. a child age 19 and over.

C. a child residing in a public institution or an inpatient psychiatric facility.

A public institution is one in which the facility is under the administrative control of the state or federal government. Examples are Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, the Maine State Prison, or Mountain View Youth Development Center

A child who is residing in an inpatient psychiatric facility is not eligible for Cub Care. An inpatient psychiatric facility includes Riverview Psychiatric Center, Dorothea Dix Psychiatric Center, Acadia and Spring Harbor. If a child is an inpatient in a psychiatric unit of a general medical hospital, the child is potentially eligible for Cub Care.

D. a child who is eligible for coverage under the State Employee Health Insurance program through a relative with whom they are residing. Individuals employed by Elementary and Secondary public school systems are not considered covered under this program. Individuals covered under the State Employee Health Insurance program are employees for:

1. the Executive, Judicial, and Legislative branches;
2. the Maine Turnpike Authority;
3. Maine Maritime Academy;
4. the Maine State Retirement System;
5. the Maine Blueberry Commission in Orono;

6. the Maine Potato Board in Presque Isle;
7. the Maine Dairy Council in Augusta;
8. the Maine Sardine Council in Winterport
9. employees of AFSME Council 93 in Augusta;
10. employees of MSEA, State Street, Augusta; and
11. employees, including teachers, of the Community Colleges.

The Community Colleges are as follows:

a. Northern Maine Community College in Presque Isle;
b. Washington County Community College in Calais;
c. Eastern Maine Community College in Bangor;
d. Kennebec Valley Community College in Fairfield;
e. Central Maine Community College in Auburn;
f. Southern Maine Community College in South Portland; and
g. York County Community College in Wells.

E. A child who is covered under a group health insurance plan through an employer or under health insurance as defined by the Health Insurance Portability and Administrative Act (HIPAA). This includes most insurance plans except for those covering one particular service or illness only, such as insurance for dental care or cancer.

This exclusion applies regardless of whether the coverage is provided through an adult who resides with the child or through an adult living in another household.

II. Children with a Three Month Waiting Period -

With certain exceptions noted below, there is a three month waiting period before a child can be covered by Cub Care if that child is dropped from health insurance provided through an employer.

For example, if the insurance ends January 10th, Cub Care cannot start until May.

There is no three month waiting period if any of the following exists:

A. The individual who dropped the coverage does not reside with the child.

B. The family (employee) pays 50% or more of the cost of the child's coverage.

For example, if the monthly cost of the child's coverage is $100 and the family pays $65.00, the family is considered to be paying 50% or more of the cost of the child's coverage.

C. The family pays over 10% of all family income for family coverage (including the child dropped from coverage).

Family income is defined as the total gross non-excluded income of: the child, the child's siblings and step-siblings under age 21 with whom they reside, the adult dropping the coverage and their spouse with whom whey reside.

Income includes both earned and unearned income.

D. The individual had good cause for terminating the insurance coverage.

Good cause exists when the individual can substantiate that the coverage was dropped for a reason other than to be covered by Cub Care. Some examples are: The adult lost coverage for the child because of a change in employment, termination of coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), or termination for a reason not in the control of the employee.

Reminder: There is no three month waiting period if a child is dropped from an individual health insurance plan (not provided through an employer).

SECTION 3 APPLICATION PROCESS

I. An application is the request for medical coverage made by signing and dating the Agency's application form. The individual or anyone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

The date of application is the date the signed application form is received in any regional office. Applications must be processed within forty-five days of their receipt by the Agency. If the applicant is not sent a notice of the eligibility decision within forty-five days, temporary coverage will be authorized as identified in Part 2, Section 12.3.1.

All signed applications will be acknowledged in writing. A written decision of eligibility will be sent to the applicant.

An application is valid for authorizing coverage as of the month the application is received or the following month.

II. When an individual applies for medical coverage, this is considered to be an application for Medicaid and Cub Care.

III. Verification of Eligibility Factors -

Verification of information needed to determine eligibility must be requested initially from the individual. If information is requested from other sources (with the exception of public records) the individual must be informed. If collateral contacts are necessary and the individual does not give consent, denial or termination must occur.

When a decision cannot be made due to inconclusive or conflicting information, the individual will be notified what questions remain and what needs to be resolved. If the Department cannot determine that eligibility exists after contacting the individual or collateral contacts, assistance will be denied or terminated.

SECTION 4 ASSETS

There is no asset criteria for eligibility under Cub Care.

SECTION 5 INCOME

Income must be greater than 150% and equal to or less than 200% of the Federal Poverty Level (See Chart 6) for the appropriate assistance unit size.

SECTION 6 BUDGETING

I. In determining the appropriate assistance unit size and whose income will be budgeted, the rules of Medicaid will be followed as identified in Part 2, Section 2 (Assistance Units), Part 3, Section 3 (Financial Responsibility of Relatives); Part 4, Section 3.6 (Step Parents, Pregnant minors, Family members on SSI, and Strikers).

II. Determination of countable income -
   A. Income excluded by Family - Related Medicaid will also be excluded under Cub Care.
   B. Disregard the first $90.00 per month of total income earned by each individual in the assistance unit. This $90.00 disregard applies whether the individual is working part-time or full-time.
   C. Countable income is gross non-excluded monthly income minus earned income disregard. Countable income will be used in the determination of the eligibility and in determining the amount of the premium.
   D. Income is projected over a twelve month eligibility period.
   E. Medicaid rules are used in anticipating income and in the treatment of irregular, fluctuating, contract, seasonal, and self-employment income, as well as income in-kind, vendor payments and outside contributions.

SECTION 7 CHANGES

I. The child remains eligible for Cub Care throughout the twelve month period without regard to changes in income. However, coverage can be ended if the child no longer meets any of the other eligibility requirements identified under “basic eligibility requirements.”

II. The child must be moved to Medicaid coverage if s/he withdraws from Cub Care and the child becomes Medicaid eligible due to a change in circumstances and the change is expected to last for a full calendar month. The change to Medicaid will be made effective the month the change occurred as long as this change is reported within ten days of its occurrence; otherwise, it is effective the month the change is reported.

   If the family withdraws from Cub Care, this will end the twelve month enrollment period. If coverage continues under Cub Care or Medicaid, this starts twelve months of continuous Medicaid coverage.

III. A child can be added to Cub Care when some members of the household are already covered by Cub Care.

   For example:
   - the child moves into a household;
   - the child becomes ineligible for Medicaid.

When a child is added, the premium will be based on the household income already established for the current enrollment period.

Household income will not be reestablished even if the child being added has income of their own.

The child can be added effective the month the change occurred as long as the change is reported within ten days of its occurrence; otherwise, the child is added effective the month the change is reported.

A premium is due for each month a child is open for Cub Care coverage unless exempted from payment.

IV. When a child is covered by Medicaid and becomes ineligible, coverage will be reviewed for Cub Care. A ten day notice will be given when a child moves from Medicaid to Cub Care coverage.

SECTION 8 ELIGIBILITY PERIODS

I. Coverage under Cub Care is determined for a twelve month enrollment period for all members of a household, beginning with the month of application or, if ineligible for that month, coverage starts in the following month. There is only one enrollment period for a household. A household is composed of people residing together among whom there is a financial responsibility.

II. Eligibility is determined for a twelve month period by projecting income over that twelve month period, including the month of application. The child remains eligible for the twelve month period without regard to changes in income.

In some instances, the individual is not eligible for coverage during the month of application but is eligible for the following month. In this situation, the twelve month eligibility period begins with the month following the month of application.

III. Premiums are set at the beginning of the twelve month enrollment period and do not change regardless of income. Any income changes must be reported when the child reapplies for coverage.

Changes affecting eligibility must be reported within ten days of their occurrence. Examples of such changes include: an eligible child no longer resides in the household, or s/he is covered by health insurance. “Occurrence” is the date the change takes place.

The individual may withdraw from Cub Care and end his/her twelve month enrollment period if s/he becomes Medicaid eligible (See Section 7 of this Part).

IV. Reapplications -

The individual must reapply and be found eligible in order for coverage to continue beyond a twelve month enrollment period.

The individual will be sent a reapplication before the twelve month enrollment period ends. In order for coverage to continue for the next twelve months, premiums that have been due must be paid, the child must be otherwise eligible, and there are no penalties in effect.

If, by the 15th of the 12th enrollment month, a completed reapplication and all needed documentation is received by OIAS, coverage can continue uninterrupted as long as there is financial eligibility and premiums that were due have been paid.

V. A child who has been covered by Cub Care and whose income exceeds 200% of the Federal Poverty Level (See Chart 6) at the end of the twelve month enrollment period will be provided notice for possible extended coverage through the Health Insurance Purchase Option (HIPO). Refer to Chapter 335 Health Insurance Purchase Option (HIPO) in this manual. (10-144 CMR Chapter 335)

SECTION 9 NOTICES

I. Eligibility or Ineligibility -

Individuals will be notified in writing as soon as eligibility is determined. If some of the individuals applying for medical coverage are eligible and some are not, the notice must specify who is or is not eligible and the reasons for each individual's ineligibility.

Individuals whose eligibility begins after the month of application must be sent a denial notice for the months of ineligibility.

When an individual is determined to be ineligible, the notification will contain:

A. a statement that the application has been denied;
B. the specific reason(s) for the denial;
C. the manual citations which support the decisions; and
D. an explanation of the individual's right to request a hearing;

II. Adverse Action -

In situations when the intended action is to discontinue eligibility or to reduce services, timely and adequate notice must be given to the recipient. However, coverage will not be continued beyond the enrollment period pending a hearing decision. Also, as long as a child is open for Cub Care coverage, a premium will be due and unpaid premiums will incur a penalty.

"Timely" means that the notice must be mailed twelve days before the intended change would be effective (ten days for notice plus two days for mail).

"Adequate" means a written notice which includes a statement of:

A. the action the Department intends to take;
B. the reasons for the intended action;
C. the regulations supporting such action; and
D. an explanation of the rights to request a hearing.

1. Denials: If a child is not eligible for Medicaid but eligible for coverage under Cub Care, s/he needs to be informed of his/her eligibility for Cub Care, and that Medicaid has been denied.

   If an application is denied for Family - Related Medicaid and Cub Care, notification will be given that other coverage may be available if the household has large medical bills or a child has a disabling condition.
2. Closings: If coverage under Cub Care is ended for a reason other than the enrollment period has ended, the individual will be given adequate and timely notice. When the child is granted coverage for the twelve month period, s/he will be informed that coverage will automatically end at the end of the twelve month period.

SECTION 10 ADMINISTRATIVE HEARINGS

Rules regarding hearings are identified in Part 1, Section 7; except as they differ for Cub Care as identified in this section. A hearing may be requested for an adverse action taken during the enrollment period, but benefits will not be continued beyond the enrollment period pending the hearing decision. For coverage to continue beyond the enrollment period, the individual must file a reapplication and be found eligible without a penalty. If for some reason a household's premium is increased during the enrollment period due to adding a child to Cub Care and the increase is appealed, the increased premium will be effective when the child is added to Cub Care coverage pending the hearing decision. The household's increased premium is due in accordance with the policies of this section and any unpaid premium is subject to a penalty of ineligibility.

If a household appeals a penalty period being imposed at the time of reapplication, the penalty will be imposed pending the hearing decision.

If the hearing decision reverses the Department action, any penalty imposed will be lifted and any increased premiums that have been paid will be returned to the household.

SECTION 11 PREMIUMS

Section 11.1 General

Except for Alaska Natives and Native American Indians who are members of a Federally recognized Tribe, individuals who are eligible for Cub Care must pay a premium. Chart 8 identifies the amount of the premium that is due based on income and the number of children covered under Cub Care.

The premium for the twelve month enrollment period does not change except to reflect the number of children being covered.

Any change in premium is effective the month the child's coverage begins or ends.

Section 11.2 Coverage for the Current Enrollment Period

I. Premiums are due on the first day of each month for coverage for that month. When a premium is not paid by the first of the month in which it is due, the Department will give notice of non-payment.

Note: Notice will also be given at the beginning of the 12th month of the twelve month enrollment period for any premiums that are still unpaid.

II. There is a grace period for non-payment of premiums. For the first through the eleventh months of the twelve month enrollment period, the grace period extends through the last day of the twelve month enrollment period.

The individual will also be notified that coverage will end at the end of the 12th month without further notice if a reapplication is not received.

For example, if the enrollment period is 11/08 through 10/09, the individual has until 10/31/09 to pay his/her premiums for month one through eleven.

The grace period for payment of the premium due in the 12th month is the 15th of month number thirteen.

For example, if the twelve month enrollment period is 11/'08 to 10/09, the individual has until 11/15/09 to pay his/her premium for month twelve.

If the 1st or the 15th fall on a weekend or holiday, the premium is then due on the next workday.

Section 11.3 Nonpayment of Premiums

I. Following a current enrollment period, there may be a period of ineligibility because premiums have not been paid or not paid when they are due. Pemiums are due on the first day of every month.

II. At the beginning of the 12th month of the enrollment period, notification will be given if any premiums for the enrollment period have not been paid when due. The individual will also be notified of the penalty incurred because of the nonpayment.

The penalty will be lifted if the payment is subsequently received by the Agency within the grace period.

III. Premiums can be paid monthly, for more than one month at a time, or they can be paid in advance for the twelve month enrollment period. Payments will be credited to the earliest months of coverage first, during the current enrollment period.

Example:
A monthly premium of $8.00 is due during a twelve month enrollment period from January to December and the first payment for $40.00 is received on June 1st. Months one through five will be credited with a premium paid. The June payment is overdue.

IV. There is a month of ineligibility for each month a premium was due, coverage was received, and a premium payment was not made when due.

The maximum period of ineligibility is three months.

The penalty periods start in the first month following the end of the enrollment period in which the premium was due.

Example:
If no premiums are paid for the twelve month enrollment period of 1/08 through 12/08, the child is ineligible for Cub Care for the months of 1/09, 2/09, and 3/09.

V. If the twelve month enrollment period is shortened due to a withdrawal from Cub Care, a penalty will be imposed for each month Cub Care coverage was received and a premium was due and was not paid by the end of the enrollment period.

Example:
An enrollment period of July through December ends on August 31st due to a withdrawal from the program. If the premiums due for July and August have not been paid by August 31st there will be a penalty period of two months, starting on September 1st when the individual is not eligible for Cub Care.

VI. Any penalty under Cub Care will run concurrently with Medicaid coverage. For example, if a child is denied coverage under Cub Care due to nonpayment of a premium for July and August, but the child is eligible for Medicaid during those months, Medicaid would be granted. The child is then potentially eligible for Cub Care in September.

If a child under penalty due to nonpayment of a premium reapplies and is found to be otherwise eligible for Cub Care, the penalty period will be imposed for up to the first three months following the end of the enrollment period in which the premium was due. Coverage will be granted for the remaining months.

Example:
During a January to June enrollment period, no premiums were paid. A reapplication is filed and the children are financially eligible. July, August, and September are penalty months and eligibility exists for October, November, and December.

VII. If a child moves from a household where a penalty has been imposed for nonpayment of a premium to a household where there is no penalty, the child is potentially eligible for Cub Care.

The penalty stays with the adults responsible for the premium payment.

VIII. Good cause for nonpayment exists and no penalty is imposed if premiums are not paid or not paid when due because of the following reasons:

A. mail delay;
B. illness of the child's responsible relative; or
C. unanticipated emergency beyond the control of the responsible relative.

Section 11.5 Refunds

A refund is due if:

I. a premium has been paid due to agency error,

II. a payment is received after the grace period. This payment, at the option of the family, will be:
   A. refunded to the family;
   B. credited to past due premiums; or
   C. credited to future premiums due.

PART 6
SUPPLEMENTAL SECURITY INCOME (SSI) - RELATED MEDICAID COVERAGE

SECTION 1 SSI AND MEDICAID

The Social Security Administration administers the SSI Program which was established to meet the needs of aged, blind or disabled individuals. The basic needs in the SSI Program are established for individuals and couples by the Federal government.

Individuals who receive SSI or State Supplement payments, or are eligible under Section 1619(b) of the Social Security Act do not need to file a separate application for Medicaid. They are automatically eligible for Medicaid unless they refuse to assign their rights to medical payments (see Part 2, Section 6) for medical care or are ineligible due to Medicaid Qualifying Trust rules (see Appendix H). Section 1619(b) individuals are those who are considered disabled but their earned income disqualifies them for an SSI payment. However, due to the use of a higher income guideline by SSI, they continue to be carried as an open SSI case and they are Medicaid eligible.

In general, the criteria in this section follows those used by the Social Security Administration when determining the eligibility for Supplemental Security Income (SSI) for individuals who are aged (at least age 65), blind or disabled. When the SSI office makes an eligibility decision based on disability or blindness the decisions may not be overturned by the Department unless new information is presented, or conditions change. In this case, an independent decision of the individual's or couple's eligibility Medicaid may be made.

SECTION 2 SSI APPEALS OF DISABILITY DECISIONS

If the Department of Health and Human Services has an open Medicaid case in any category, except for temporary coverage, this coverage will continue until a decision is reached on an SSI application or appeal regarding disability or until other Medicaid eligibility criteria are not met. The appeal must be filed in a timely manner according to SSI rules.

SECTION 3 RETROACTIVE MEDICAID BENEFITS FOR SSI RECIPIENTS

An individual who has been determined by the Disability Determination Services (DDS) to meet the disability criteria for receipt of SSI also meets the disability criteria for SSI - Related Medicaid benefits for the three months prior to application for SSI benefits. If there is an indication that the onset of the disability was between the first day of the third prior month and the application date eligibility begins with the first month of disability. Unless there is information to the contrary, the individual's statement of the onset may be accepted. If there is an indication that the individual was not disabled on the first day of the third month prior to the application for SSI, and if there is no information which would indicate the date of the onset of disability, then the procedures outlined in Section 4.3 of this Part must be followed. In determining retroactive Medicaid eligibility for all SSI recipients (aged, blind or disabled) all eligibility factors must be met. The best information available regarding income and assets should be used.

SECTION 4 BASIC ELIGIBILITY REQUIREMENTS

Individuals who are aged, blind or disabled and are not receiving SSI or a State Supplement payment may be eligible for Medicaid as SSI - Related if they meet the basic criteria of the SSI Program below.

Section 4.1 Aged

The individual must be 65 years of age in or before the month in which eligibility begins.

Section 4.2 Blind

The individual must have, in terms of ophthalmic measurement, central visual acuity of 20/200 (can see on the eye examination chart at 20 feet what a normal vision can see at 200 feet) or less in the better eye with best correcting glasses or must have a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends at an angular distance of no greater than 20 degrees or must have a visual field efficiency reduced to 20% or less; or if in the opinion of the consulting ophthalmologist the visual field limitation encroach on the central visual axis sufficient to interfere with useful vision. Such a person has what is known as economic blindness which prevents the performance of ordinary activities for which eyesight is essential. For determining the visual field efficiency, the amount of radial contraction in the eight principal meridians shall be determined, and the sum of these eight, divided by 420 (the sum of the eight principal radii of the industrial visual field) multiplied by 100 will give the visual field efficiency of one eye in percentage.

Section 4.3 Disabled

Current eligibility for Social Security, Railroad Retirement, Medicare or SSI benefits based on disability or blindness is proof of disability.

For individuals whose SSI Benefits are terminated, for reasons other than disability, a contact to the local Social Security Office should be made to determine the next disability review date. For Medicaid purposes this review date will be adopted.

If the individual is not currently receiving benefits from one of the sources above, then an independent disability decision must be made. To determine if a person meets the SSI standard of disability, a referral will be made to the Medical Review Team (MRT). This group consists of a physician and a caseworker who specialize in medical eligibility determinations. This group makes the decision as to whether or not the individual meets the SSI standard of disability and establishes any additional reviews of medical disability.

Section 4.3.1 Making the Decision

I. This decision is based on a medical report which must include a substantive diagnosis based either on existing medical evidence or upon current medical examination. To end coverage based on disability, the Medical Review Team must determine that medical improvement as set forth in 20 CFR 416.994 has occurred in relation to the most recent decision that was favorable to the individual.

   The medical evidence must be from an acceptable source. Acceptable sources are:

A. licensed physicians;
B. licensed osteopaths;
C. licensed or certified psychologists;
D. licensed optometrists for the measurement of visual acuity and visual fields. (A report from a physician may be required to determine other aspects of eye diseases);
E. a hospital, clinic, sanitarium, medical institution or health care facility; or
F. P.E.T. and other school medical records.

Reports from chiropractors are not acceptable.

II. The social history must contain sufficient information to make it possible to relate the medical findings to the activities of substantial gainful employment and to determine if the individual is disabled.

III. An impairment or combination of impairments is not severe if it does not significantly limit physical or mental ability to do basic work activities.

Basic work activities are the abilities and aptitudes necessary to do most jobs. Examples of these include:

A. physical functions such as walking, standing, sitting, lifting, pushing, pulling, reaching, carrying, or handling;
B. capacities for seeing, hearing and speaking;
C. understanding, carrying out, and remembering simple instruction;
D. use of judgment;
E. responding appropriately to supervision, co-workers and usual work situations; and
F. dealing with changes in a routine work setting.

IV. The following are criteria which the MRT uses to determine if an individual meets the definition of initial disability and any additional reviews for SSI - Related disability coverage:

An individual is determined to be disabled only if the physical or mental impairments have lasted or can be expected to last for a continuous period of not less than twelve months, expected to end in death, or are so severe that the individual is not only unable to do previous work, but cannot (considering age, education and work experience) engage in any kind of Substantial Gainful Activity (SGA) which exists in the community regardless of:

A. whether a specific job vacancy exists; or
B. whether the individual would be hired if application for work were made.

If the individual is not working, disability must be based on activities which still can be performed despite limitations (residual functional capacities). Activities, age, education and work experience will be used when the limitations would not permit the individual to return to prior work in order to determine if the individual can participate in any other type of work.

V. A child is considered disabled if there is any medically determinable physical or mental impairment of comparable severity.

VI. The physical or mental impairment must be one that results from anatomical, physiological, or psychological abnormalities which are demonstrable by medically acceptable clinical and laboratory diagnostic techniques. The individual must follow any prescribed treatment plan.

VII. Coverage may be granted or continued if the individual has good reason for not following a prescribed treatment plan. These reasons include:
   A. the specific medical treatment is contrary to the established teaching and tenets of the individual's religion.
   B. the prescribed treatment is cataract surgery for one eye but there is an impairment of the other eye resulting in a severe loss of vision which is not subject to improvement through treatment.
   C. surgery was previously performed with unsuccessful results and the same surgery is again being recommended for the same impairment.
   D. the treatment is very risky, unusual, or of a great magnitude such as open heart surgery or organ transplants.
   E. the treatment involves amputation of an extremity or a major part of an extremity.

VIII. A person who otherwise qualifies for medical benefits, by reason of disability, cannot be an eligible individual for any month if determined to be a drug addict or an alcoholic unless undergoing treatment that may be appropriate and available for that condition. If the individual is in an institution it must be approved for this purpose and treatment must be available.

IX. An applicant may receive Medicaid coverage if the Medical Review Team (MRT) determines that s/he is presumptively disabled or blind and meets all other financial and non-financial requirements for Medicaid. A final determination must be made within six months of the presumptive decision.
   A. Presumptive eligibility entitles the individual to full Medicaid benefits. If subsequently found not medically or otherwise eligible, adequate and timely notice must be given before coverage stops.
   B. The start date for presumptive decisions is the first day of the month in which the decision is made. If the final decision is that the individual is not eligible, the closing will take place even if a hearing is requested. A reconsideration cannot be done.
   C. If an individual’s prior application has been denied base on medical factors, a presumptive decision can be made only when there is sufficient evidence of an worsening of his/her physical or mental condition (or the existence of a new impairment) which could demonstrate a strong likelihood that the subsequent presumptive decision should be allowed.
   D. A presumptive decision can be made when the alleged impairment falls within the following categories:
      1. amputation of two limbs or a leg at the hip;
      2. total deafness or blindness;
      3. a stroke more than three months ago with continued marked difficulty in walking or using a hand or arm;
      4. cerebral palsy, muscular dystrophy or muscle atrophy;
      5. diabetes with amputation of a foot;
      6. Down Syndrome;
      7. mental retardation;
      8. HIV infection;

9. a child age 6 months or younger showing low weight at gestational age (age at birth based on date of conception);
10. a physician or knowledgeable source confirms an individual is receiving hospice services due to terminal cancer; or
11. spinal cord injury producing the inability to ambulate without the use of a walker or bilateral hand-held assistive device.

Section 4.3.2 Referral to Vocational Rehabilitation

Persons under age 65 who are blind or disabled, are to be referred to Vocational Rehabilitation for review of the individual's need to use their services.

Section 4.3.3 Reconsiderations (Appeals)

An individual may request a reconsideration (appeal) within thirty days of notification of the disability decision. A reconsideration is done when additional information regarding the original impairment is available. If requested within ten days of the date of the denial notice, the original application date is used and temporary coverage may be granted on the 46th day.

For individuals being closed because it has been determined that they are no longer disabled, coverage will continue if a reconsideration is requested within ten days of the closing notice.

Any request for reconsideration made more than thirty days from the date of the notice of the disability decision requires a new application.

Section 4.3.4 Determination of Continued Eligibility when the Disabled Individual Begins to Work

When earnings are reported the Medical Review Team (MRT) will be alerted when:

I. a medical review has not been done nor has one been scheduled in the past or coming six months. These are usually situations of longer term disability such as asthma. The MRT will reschedule a review within the next six to twelve months. This gives the individual an opportunity to try the job, on an ongoing basis, to see if work is possible on this basis.

II. the MRT has identified the situation as one in which recovery is expected even if a review has been done or is expected to be done in the past or coming six months. In this instance the MRT may do a complete review regardless of the scheduled review date and request current medical information if recovery is expected within six months. Usually these are situations with a short term disability such as recovery from an accident.

    If the individual is not scheduled for further medical review, the MRT does not need to be alerted when earnings are reported, but any earnings must be budgeted. These are usually situations of terminal illness or severe disability with no chance of recovery.

SECTION 5 COVERED INDIVIDUALS

Section 5.1 Definitions

When determining SSI - Related eligibility, individuals are considered to be eligible individuals, ineligible spouses, eligible couples or an eligible child.

An "eligible individual" is the person who is applying for or receiving Medicaid.

An "ineligible spouse" is the person to whom the individual is married, who is living with the individual, and who is not applying for or is not receiving Medicaid. The spouse can choose to be an ineligible spouse.

An "eligible couple" are married individuals, living together, who both have made application for or are recipients of SSI, the State Supplement or SSI - Related Medicaid. Both individuals must meet all eligibility criteria. It is not possible to treat each spouse as an eligible individual if they are living together. Each spouse is considered an eligible individual effective the month after they cease to live together. For married couples who are residing in the same nursing home room (see Part 14, Section 4.2) or who are applying for waiver services in the community (see Part 13, Sections 4 and 6), special criteria may need to be considered.

An individual whose marriage has been terminated through death, divorce or annulment is considered not married.

An "eligible child" is an individual who has a disability or visual impairment and who is neither married nor the head of a household and

- under age 18; or
- under age 22 (through age 21) and a student regularly attending school or college or training designed to prepare him/her for a paying job. The child/student can have the student earned income exclusion (See Part 17, Section 4.54) and an ineligible child allocation (See Part 7, Section 2.2.1).

Child status ends effective with the month after the month of attainment of age 18 (age 22 if a student) or the month after the month s/he last meets the definition of a child.

Section 5.2 Eligible Groups

All SSI - Related Medicaid eligible individuals and couples must meet financial guidelines and be a member of one of the following groups:

Section 5.2.1 Individuals or Couples Meeting SSI/State Supplement Criteria

Individuals or couples who meet the criteria for SSI or the State Supplement and who have not applied or who do not want to apply for either or both cash payments.

Section 5.2.2 Individuals or Couples Eligible Under the Pickle Amendment or Lynch VS. Rank

Commencing 4/1/77, those individuals or couples formerly entitled to concurrent benefits from SSI and Social Security who would be eligible for SSI if annual cost of living adjustments are not counted (See Appendix C for specifics).

Section 5.2.3 Individuals or Couples Residing in Adult Foster Homes (Private or State Assisted) or Flat Rate Boarding Homes

Individuals or couples who are residing in these homes have special income guidelines for State Supplement eligibility. If income exceeds these special guidelines the individual or couple may still be eligible for MaineCare (See Part 12).

Section 5.2.4 Individuals or Couples Residing in Cost Reimbursement Boarding Homes, and Residential Care Facilities

Individuals or couples who are residing in these homes have special income limits for MaineCare coverage (See Part 12).

Section 5.2.5 Individuals in Nursing Care Facilities

Individuals must be in a facility licensed by the Department of Human Services to provide nursing care services. There are four types of facilities:

I. General Hospitals (Awaiting Placement)

II. Skilled Nursing Care Facilities (SNF)

III. Intermediate Nursing Care Facilities (ICF)

IV. Nursing care sections of the following institutions for the care of the mentally disabled:
   A. Riverview Psychiatric Center (RPC)
   B. Dorothea Dix Psychiatric Center (DDPC)

   Individuals in these types of facilities must meet special eligibility criteria (See Part 14).

Section 5.2.6 Individuals Receiving Nursing Care in Community Settings

There are programs available for individuals who require nursing home care and are living in the community. These programs are called "Home and Community Based Waiver Programs" because they provide special services and follow special eligibility criteria (See Part 13).

The waiver programs are:

I. Elderly and Adults with Disabilities Waiver

II. Physically Disabled Waiver

III. Mental Retardation Services Special Benefits Services Waiver

IV. Support Services Waiver

Section 5.2.7 Newborns Born to Mothers on Medicaid

If the newborn's mother is receiving Medicaid (or is covered as part of the retroactive period) on the date the baby is born, the baby is eligible for coverage regardless of the newborn's income or assets. The mother must be fully covered by Medicaid on the day of the baby's birth. In other words, if mother meets the deductible amount on the day of the baby's birth and is partially responsible for any medical bills on that date, the newborn is not eligible in this group.

Coverage continues for one year. This means that the baby is eligible without regard to: changes in family income or composition, cooperation with DSER, cooperation with TPL, obtaining a Social Security number or declaring citizenship status.

Section 5.2.8 Children Eligible Under "Katie Beckett"

Individuals under this eligibility option are children with disabilities, age 18 and younger, who are living in the community and would be eligible for Medicaid if they were in need of institutional level of care. There are no special services provided to this group (See Part 7, Section 5).

Section 5.2.9 Certain Individuals Receiving Social Security Disabled Widow(er)'s Benefits who are not Receiving Medicare

These are individuals who are not eligible for Medicare and who lost their SSI or State Supplement benefits due to receipt of disabled widow(er)'s benefits from Social Security. If the individual meets all other SSI criteria and would be eligible for SSI or State Supplement benefits if the amount of Social Security benefits received as a disabled widow(er) were excluded income, the individual is eligible for categorically needy, SSI - Related Medicaid coverage. The exclusion of income from the Social Security disabled widow(er) continues until the individual is eligible for Medicare or would be ineligible for SSI or State Supplement benefits for a reason other than the income from Social Security disabled widow(er)'s benefits.

Section 5.2.10 Disabled Adult Children (DAC)

A Disabled Adult Child is an individual who lost his/her eligibility for SSI or State Supplement on or after 7/1/87 due to an increase in or initial receipt of Social Security Benefits based on their DAC status. These individuals who maintain their DAC status with Social Security may continue to receive Medicaid coverage. In determining eligibility for Medicaid, the increase in Social Security Benefits that resulted in SSI ineligibility will be disregarded. Other changes in income will be taken into account and will affect eligibility. Countable income must be under the current SSI or State Supplement income limit.

A person receives Social Security Benefits under DAC status if the following conditions are met:

I. s/he is the child (or eligible grandchild) of a retired, deceased or disabled worker;

II. the individual is at least 18 years of age; and

III. disability (including blindness) began before age 22.

Individuals may lose coverage under this group and later regain it. Continued eligibility is not necessary.

Section 5.2.11 Other Covered Groups

Within this section there are other groups which are included in Federal Law. These are listed in Appendix D for informational purposes.

Section 5.2.12 Individuals Under Age 18 Who are Closed From SSI Due to August, 1996 Change in Disability Criteria

Individuals under age 18 are Medicaid eligible if the individual:

I. was in current pay status with SSI in August, 1996;

II. is closed due to not meeting the child disability standards that became effective on 8/23/96;

III. continues to meet the SSI child disability criteria in effect prior to 8/23/96; and,

IV. continues to meet federal SSI income and resource standards.

If the individual is closed from SSI for a reason other than not meeting the changed disability criteria, such as being over income or assets, or failing to cooperate in establishing eligibility, this protected status does not apply and the individual must then meet current Medicaid eligibility criteria.

Once an individual has been receiving Medicaid under this protected status and they fail to meet any of the criteria in I – IV above, the protected status is lost and eligibility is determined using the current Medicaid criteria.

Section 5.2.13 Working Disabled

This coverage group includes individuals who meet the SSI standard for disability and who have earnings subject to federal tax withholding but are not eligible for Medicaid under any other coverage group. These individuals may buy into Medicaid by paying a monthly premium if the specific requirements of this coverage group are met. This is an SSI - Related coverage group using SSI - Related rules for treatment of income and assets, however, there are income and asset limits specific to this coverage group.

Section 5.2.14 Section 1619(b)

Section 1619(b) refers to the section in the Social Security Act which authorizes coverage for this group. These are individuals who are considered disabled by SSI but their earned income disqualifies them for an SSI payment. However, due to the use of a higher income guideline by SSI, they continue to be carried by SSI case as an open case and they are Medicaid eligible.

PART 7
SSI - Related Medicaid Budgeting

This Part describes the budgeting process for income and assets in SSI - Related Medicaid coverage.

SECTION 1 TREATMENT OF SSI - RELATED ASSETS

Assets must be under the following limits on any day of the month to be eligible for that month.

Section 1.1 Categorically Needy Asset Limit

$2000 for a single individual, a married individual not living with a spouse or a child.

$3000 for an individual living with an ineligible spouse or an eligible couple.

Section 1.2 Working Disabled Asset Limits

$8000 for a single individual, a married individual not living with a spouse or a child.

$12,000 for an individual living with an ineligible spouse or an eligible couple.

Section 1.3 Deeming of Assets

When an eligible individual is living in the same household with an ineligible spouse, or if the eligible individual is a child under age 18 residing in the same household with a parent, the assets of the spouse or parent must be included in determining eligibility.

The assets of an ineligible spouse, or parent living with the individual, are deemed to the individual and are combined with the applicant's own assets.

Section 1.3.1 Exclusions to Deeming Process

The assets listed below are excluded in determining the amount of the ineligible spouse's or ineligible parent's assets:

I. Assets excluded in Part 16 are also excluded here.

II. Assets owned by a stepparent.

III. Pension Funds (IRA's & Keogh's) which belong to the ineligible spouse or ineligible parent.

IV. Parent's assets are not considered in determining eligibility for the "Katie Beckett" coverage group.

V. If the asset is only in the child's name, then it does not affect the parent's eligibility since there is no deeming from child to parent.

VI. In determining eligibility for a child some assets may be deducted for legal parents and the balance applied to the child's asset limit. No assets are deducted for a stepparent.

The non-excluded assets of the parent in excess of $2000 (if the child is living with one legal parent) or $3000 (if the child is living with both parents)

are deemed to the child and combined with the child's own non-excluded assets. The combined amount of deemed and own assets must be under the $2000 limit.

Example:
The legal parents of Joe have non-excluded assets that total $4000. Joe has $200 of non-excluded assets of his own. We will deem $1000 of the parent's assets to Joe. Joe now has $1200 of countable assets which will be applied against his $2000 asset limit.

Section 1.3.2 Duration of Deeming

I. Deeming ends the month after the ineligible spouse and eligible individual cease to live together for any reason.

II. Deeming from parent to child stops the month after the child reaches age 18 or the month after the child no longer resides with the parents.

SECTION 2 SSI – RELATED INCOME BUDGETING PROCESS

This section describes the method used to budget income of household members when eligibility is being determined for SSI - Related Medicaid (see also Part 17 – Income).

Section 2.1 Disregards
The following are deducted from the individual's or couple's gross non-excluded income in this order:

Section 2.1.1Federal Disregard
Twenty dollars a month from earned or unearned income.

Note: The $20.00 disregard is not applied to income based on need. This means there is no $20.00 exclusion of a VA Pension or Veteran's Financial Assistance (which is based on need). The $20.00 disregard does apply to VA Compensation (which is not based on need).

Section 2.1.2 Impairment - Related Work Expenses (IRWE)
Impairment - Related Work Expenses (IRWE) are to be deducted from a SSI - Related disabled individual's gross earnings. IRWE allowable deductions and limits are outlined in Appendix B.

Section 2.1.3 Earned Income Disregard
$65.00 is deducted from earned income. One half of the remaining earnings is also disregarded. This does not pertain to Sheltered Workshop Income (See Section 2.1.5 of this Part).

Section 2.1.4 State Disregard
The State of Maine also allows an added deduction of $55.00 for an individual and $80.00 for a couple.

Note: There is no $55.00 state disregard of income when determining eligibility for State Supplement for individuals residing in residential care living arrangements defined in Part 12, Section 1.

Section 2.1.5 Special Group Disregards

I. Pickle Disregard –
Individuals or couples covered under the Pickle Amendment (see Appendix C) have all Cost of Living Adjustment's (COLA's) to Social Security benefits received since the closure of concurrent entitlement for SSI or State Supplement and Social Security disregarded. This disregard applies also to COLA increases of the spouse even if the spouse is not eligible as a Pickle.

II. Disabled Adult Children Disregard –
Individuals or couples receiving Social Security benefits as Disabled Adult Children have a portion of their Social Security benefits disregarded. The amount of the disregard equals the Social Security increase due to the initial DAC Award causing the loss of SSI or State Supplement.

The individual or couple loses this disregard when they marry, unless they marry another DAC.

III. Disabled Widow(er) (DWB) Benefit Disregard –
The amount of the disregard as a Disabled Widow(er) is the amount of the Social Security benefits that caused the loss of SSI or State Supplement benefits. Disabled Widow(er)s maintain this status when they marry as long as they are still disabled.

IV. Shelter Workshop Disregard -

Subtract	$20	Federal disregard, if not previously deducted
Subtract	$50	from remaining sheltered workshop income
Subtract	1/2	of remaining sheltered workshop income

Section 2.2 Deeming of Income

When an eligible individual is living in the same household with an ineligible spouse, or if the eligible individual is a child under age 18 residing in the same household with a parent, the income of the spouse or parent must be included in determining eligibility.

The income of an ineligible spouse, or parent living with the individual is deemed to the individual and are combined with the applicant's own income.

Section 2.2.1 Allocation

Before income is deemed an amount is deducted from income which is set aside for the support of certain individuals other than the eligible individual. Specifically:

I. Ineligible child allocation:
   A. when determining eligibility for an eligible child, allow an allocation from the parent’s income for each ineligible child living in the household. In a household where there is a stepparent to an eligible child, use the legal parent’s income to meet the allocation for mutual children.
   B. when determining eligibility for an individual or a couple, allow an allocation from the parent’s income for each ineligible child living in the household.

1. for SSI, the State Supplement and when using the Pickle, DWB, or DAC disregards, an allocation is allowed only from the income of an ineligible spouse
2. in other Medicaid determinations, an allocation is allowed from the income of the eligible individual or couple as well as the ineligible spouse.
3. stepparents can allocate to legal children only (including mutual), not to step-children.
4. allow an allocation for a child who is under age 22 (through age 21) and a student regularly attending school or college or training designed to prepare him/her for a paying job. The allocation can be used for a child who is away at school as long as they are considered to be temporarily absent. A child away at school is considered temporarily absent if s/he returns home on some weekends, holidays, or vacations and parent(s) have authority to make decisions on the child's behalf whether or not this authority is exercised.
5. allocations from a spouse's or parent's income for an ineligible child in the household (or temporarily absent from the household) end the month the child attains age 18, or if a student, age 22.
6. the amount of the allocation is equal to the difference between the ineligible child allocation amount in Chart 3 and the ineligible child's gross monthly income. Gross monthly income for this purpose is gross non-excluded income (Part 17) minus the specific exclusions in Section 2.2.2 of this Part.

II. Parent Allocation - when determining eligibility for an eligible child:
   A. deduct an amount from an ineligible parent's own income when deeming parental income to an eligible child. This is the parent allocation.
   B. the amount is equal to the parent'(s) allocation in Chart 3.2.
   C. step-parents are not included in the parent allocation.

Section 2.2.2 Exclusions to Deeming Process

I. The following is excluded income when determining the income to be deemed from the ineligible spouse to the eligible spouse:
   A. All income that is excluded for an eligible individual.
   B. Income from TANF, General Assistance or federal program benefits that are based on need (such as Veteran's Pension). In addition, exclude any income that was counted or excluded by any of these benefits.
   C. Income used to comply with the terms of court ordered support and Title IV-D support payments.
   D. When deeming from an ineligible spouse to an eligible spouse, exclude an amount equal to the "ineligible spouse standard" in Chart 3.5. This exclusion is taken first from unearned income and any remainder is taken from earned income.

II. The following is excluded income when determining the income to be deemed from an ineligible parent to an eligible child:

Note: Income is not deemed from a stepparent. When looking at the parent allocation, look at the amount for a one-parent household. The eligible child is treated as "living with others".

A. All income that is excluded for an eligible individual.
B. Income from TANF, General Assistance or federal program benefits that are based on need (such as Veteran's Pension). In addition, exclude any income that was counted or excluded by any of these benefits. No parent allocation is made.
C. Income used to comply with the terms of court ordered support and Title IV-D support payments.

III. The following is excluded income when determining the income of an ineligible child to whom an income allocation is made:

All income that is excluded for an eligible individual with one exception. There is no one-third exclusion of child support received for the ineligible child.

Note: An ineligible child allocation is not made to a child who is receiving TANF, SSI or State Supplement.

IV. When determining eligibility for a child:
If siblings receive SSI or State Supplement, treat them as eligible children in the budgeting process. Exclude the SSI or State Supplement payments the siblings receive.

Section 2.2.3 Duration of Deeming

I. Deeming ends the month after the ineligible spouse and eligible individual cease to live together for any reason.

II. Deeming from parent to child stops the month after:
A. the child reaches 18; or
B. the month after the child no longer resides with the parents for any reason.

SECTION 3 SSI - RELATED BUDGETS FOR AN INDIVIDUAL/CHILD

The following describes budgeting for:

- SSI or State Supplement for eligible individuals.
- Pickle, DAC, DWB for eligible individuals.
- Categorically Needy Medicaid for eligible individuals.
- SSI, State Supplement and Categorically Needy Medicaid for eligible children.

Note: If an individual is over income or assets under Categorically Needy, eligibility needs to be determined under Medically Needy criteria (See Part 10).

Section 3.1 Budget for SSI or State Supplement Payment

I. Combine all gross unearned income.

II. Subtract the $20.00 Federal Disregard where applicable. The remainder is the net unearned income.

III. Combine all gross earned income.

IV. Subtract any remainder of the $20.00 Federal Disregard not deducted from unearned income.

V. Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.

VI. Subtract the earned income disregard of $65.00.

VII. Divide the remaining earned income by two. The remainder is net earned income.

VIII. Combine net earned and unearned income. The remainder is total net income.

If total net income is below the appropriate SSI Income Standard for one, based on living arrangement, the individual meets the income criteria for an SSI payment.

If receiving SSI, the individual also gets a State Supplement. If over income for SSI, s/he may be eligible for a State Supplement only payment.

IX. Subtract the State Disregard for one ($55.00), except for those in living arrangements D, E, F, G, H (See Chart 3.6). The remainder is countable income.

If countable income is below the appropriate State Supplement Income Standard for one, based on living arrangement, the individual meets the income criteria for the State Supplement only payment (See Part 11 for more information on State Supplement eligibility).

Section 3.2 Budget for Medicaid Coverage Under Pickle Amendment or Disabled Adult Child (DAC) or Disabled Widow(er) Disregards

Follow the budgeting process in Section 3.1 for an individual, except that the Pickle, DAC, and/or DWB income disregard(s) are subtracted after step I. and before step II (Federal Disregard).

Follow the budgeting process for a disabled child in Section 3.4 of this Part. In determining the child's countable income deduct the Pickle disregard between steps I and II (Federal disregard).

If countable income is below the State Supplement Income Standard, the individual is Medicaid eligible.

Section 3.3 Budget for Categorically Needy Medicaid Coverage

Individuals who are not eligible under Section 3.1 or Section 3.2 or who choose not to apply for SSI/State Supplement, may get Medicaid coverage (if otherwise eligible) by using the following budget process.

I. Combine all gross unearned income.

II. Subtract the $20.00 Federal Disregard, where applicable. The remainder is the net unearned income.

III. Subtract any allocation to an ineligible child. An ineligible child is one who is not receiving TANF, SSI or State Supplement.

To determine the allocation, deduct each child's countable income from the maximum child allocation (see Chart 3.2). The remainder for each child is combined to determine the total allocation. The remainder is the individual's net unearned income.

IV. Combine all gross earned income.

V. Subtract any remainder of the $20.00 Federal Disregard not deducted from the unearned income.

VI. Subtract any remainder of the ineligible child allocation not deducted from the unearned income.

VII. Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.

VIII. Subtract the earned income disregard of $65.00.

IX. Divide the remaining earned income by two. The remainder is net earned income.

X. Combine the net earned and unearned income.

XI. Subtract the State Disregard for 1 ($55.00). The remainder is the countable income.

If countable income is equal to or below 100% of the Federal Poverty Level (See Chart 6) for one and eligibility is based on age or disability, the individual is Medicaid eligible.

Note: The State Supplement budgeting criteria must be used for an individual whose eligibility is based solely on blindness. However, if the individual also meets the SSI criteria for disability use the budgeting criteria in this section.

If countable income is greater than the Federal Poverty Level (See Chart 6) for one, go to the Medically Needy Part 10.

Section 3.4 SSI, State Supplement and Categorically Needy budget for a child

I. Subtract the allocation for ineligible children and/or aliens from the parental unearned income.

II. If the allocations are greater than the unearned income, or there is no unearned income, subtract the excess allocations from the parental earned income.

III. Subtract the $20.00 Federal Disregard from any remaining parental unearned income.

IV. If the remaining unearned income is less than $20.00, subtract the remainder of the $20.00 from the parents' combined earned income.

V. Subtract $65.00 from the remaining earned income.

VI. Subtract one-half the remaining earned income from the result of Step V.

VII. Add the result of Step III (countable unearned income) to the result of Step VI (countable earned income).

VIII. Subtract the parental living allowance (see Chart 3.2) from the result of Step VII (parental countable unearned and earned income).

IX. Divide the result of Step VIII by the number of eligible children in the household. This is unearned income to the eligible child(ren).

If there is more than one eligible child in the household, divide the deemed income equally among them. However, do not deem in excess of the amount which, when combined with the child's own income, would make the child ineligible. That excess is deemed in equal amounts among the other eligible children in the household in addition to their equal shares of the deemed income (See Example 2 below).

Determine the child's countable income:

I. Combine the deemed income with the child's own unearned income.

II. Subtract the $20.00 Federal Disregard. The remainder is the net unearned income.

III. Combine all gross earned income.

IV. Subtract any remainder of the $20.00 Federal Disregard not deducted from the unearned income.

V. Subtract any Impairment Work-Related Expenses (IRWE) outlined in Appendix B.

VI. Subtract the earned income disregard of $65.00.

VII. Divide the remainder by two. The remainder is the net earned income.

VIII. Combine the net earned and unearned income.

IX. Subtract the State Disregard for one (see Chart 3.1). The remainder is the countable income.

If the countable income is below the SSI/State Supplement Income Standard for one, see Chart 3.4, (living in the household of another) the child may be eligible for a SSI / State Supplement payment (See Part 11).

If countable income is equal to or below 100% of the Federal Poverty Level (See Chart 6) for one the child is Medicaid eligible.

If countable income is greater than the Federal Poverty Level (See Chart 6) for one, go to the Medically Needy Part 10.

Examples:

1. Mr. and Mrs. Fry have two children, Linda (age 10) and Mike (age 11). Mike has been found disabled through the Medical Review Team. Mr. Fry earns $600 weekly. There is no other income for the family.

$ 600	weekly gross income (Mr.)
X 4.3	
$2580	monthly gross income
- $ 319	ineligible child allocation to Linda
$2261	
- $ 20	federal disregard
$2241	
- $ 65	earned income disregard
$2176	
- $1088	earned income disregard (1/2 the remainder)
$1088	
- $ 956	living allowance for two parents (Chart 3.2)
$ 132	deemed to Mike
- $ 20	federal disregard
$ 112	
- $ 55	state disregard
$ 57	countable income for Mike

Mike's income is less than the SSI/State Supplement standard for one. He is eligible for Medicaid and may be eligible for SSI.

If the countable income was equal to or above the appropriate SSI/State Supplement Standard compare the countable income to 100% of the Federal Poverty Level (See Chart 6) for one.

2. Kevin and Beth Ham have two children, Barbara and Dick, both of which meet disability criteria. Dick receives an annuity of $600 monthly due to an accident.

$3765.00	Kevin's monthly earnings
$ 20.00	federal disregard
$3745.00	
- $ 65.00	earned income disregard
$3680.00	
- $1840.00	earned income disregard (1/2 the remainder)
$1840.00	
- $ 934.00	parent allocation
$ 906.00	income to be deemed to eligible children

The $906.00 would be deemed equally between the two eligible children. Doing so would make Dick over income. As a result, we will deem an amount to Dick up to the Categorical Income limit and the balance is

deemed to Barbara. This will result in both Barbara and Dick being eligible for Medicaid.

	$ 926.00	Categorical Income limit
	$ 600.00	Dick's annuity
	$ 326.00	amount deemed to Dick
	$ 906.00	income to be deem to eligible children
-	$ 326.00	amount deemed to Dick
	$ 580.00	amount deemed to Barbara

SECTION 4 BUDGET FOR A COUPLE OR FOR AN ELIGIBLE INDIVIDUAL WITH AN INELIGIBLE SPOUSE

The following describes budgeting for an eligible couple or eligible individual with an ineligible spouse:

- SSI or State Supplement
- Pickle, DAC, DWB
- Categorically Needy Medicaid
- SSI, State Supplement and Categorically Needy Medicaid

Note: If over income or assets under Categorically Needy, eligibility needs to be determined under Medically Needy criteria (See Part 10).

In SSI - Related coverage groups, when one spouse is receiving an SSI/State Supplement benefit, that spouse is included in the assistance unit. The SSI/State Supplement payment is excluded income. All other countable income of the SSI/State Supplement recipient is used to determine eligibility for the assistance unit.

Example:
Barb VanMarpel receives SSDI of $600 and SSI of $57.00. Her husband Antonio, age 83, has retirement income of $300, monthly. Barb is eligible for Medicaid because she receives SSI. Eligibility needs to be determined for Antonio. The budget for his eligibility will use Barb's SSDI of $600 and his retirement of $300. The budgeting process used is for an eligible couple.

Section 4.1 Budget for SSI or State Supplement Payment

I. Budget for an Eligible Couple -
Follow the budgeting steps for an individual with the following exceptions:
   A. the income of the couple is used
   B. the State Disregard for two is used in Step XI ($80.00).
   C. Net income is compared to the SSI Income Standard for two based on living arrangement.
   D. If ineligible for SSI, countable income is compared to the State Supplement Income Standard for two based on living arrangement.

II. Budget for an Eligible Individual with an Ineligible Spouse -
   A. Pretest: The individual must have countable income less than the SSI or State Supplement Income Standard for one.

      - Determine the eligible individual's countable income, using steps I – IX in Section 3.1.

- If this figure is equal to or greater than the SSI or State Supplement Income Standard for one the individual does not meet the pretest and is not eligible under this section.
- If this figure is less than the SSI or State Supplement Income Standard for one, based on the living arrangements (see Chart 3.4), the individual is potentially eligible for SSI or State Supplement.

The SSI or State Supplement budgeting process continues with deeming income from the ineligible spouse.

B. Deeming of income from the ineligible spouse -

Note: See Section 2.2.2 of this Part on Deeming of Income for special income exclusions allowed from the income of an ineligible spouse.

- Combine all of the ineligible spouse's unearned income.
- Subtract any allocation to an ineligible child. An ineligible child is one who is not receiving TANF, SSI or State Supplement. To determine the allocation, deduct each child's countable income from the maximum child allocation (see Chart 3.2).

The remainder for each child is combined to determine the total allocation.

Note: For SSI or State Supplement eligibility, only the ineligible spouse can allocate income to an ineligible child.

The remainder is the spouse's net unearned income.

- Combine all of the ineligible spouse's earned income.
- Subtract any remaining child allocation from the earned income.

The remainder is the spouse's net earned income.

C. Eligibility of the Eligible Spouse -

- Combine the individual's gross unearned income with the spouse's net unearned income (after the child allocation has been deducted).
- Subtract the $20.00 Federal Disregard, where applicable.
- Combine the individual's gross earned income with the spouse's net earned income (after any remaining child allocation is deducted).
- Subtract any remainder of the $20.00 Federal Disregard not deducted from the unearned income.
- Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.
- Subtract the earned income disregard of $65.00.
- Divide the remaining earned income by 2. The remainder is the net earned income.

- Combine the net earned and unearned income. This is the total net income.

  If total net income is below the SSI Income Standard for two, based on living arrangement, and the individual met the pretest, the eligible individual meets the income criteria for an SSI and State Supplement payment.

  If over income for SSI, s/he may be eligible for just a State Supplement payment.

- To determine if the eligible individual can receive just a State Supplement payment subtract the State Disregard for two ($80.00), except for those in living arrangement D, E, F, G (See Part 11). The remainder is the countable income.

If the countable income is below the State Supplement Income Standard for two, (See Chart 3.4) based on living arrangement, and the individual met the pretest, the eligible individual meets the income criteria for just a State Supplement payment

Part 11 has additional information on State Supplement.

If countable income is greater than the Federal Poverty Level (See Chart 6) for one, go to the Medically Needy Part 10.

Section 4.2 Budget for Medicaid for Coverage Under Pickle Amendment or Disabled Adult Child (DAC) or Disabled Widow(er) (DWB) Disregards

Follow the budgeting process in section 4.1, steps A, B and C, except that the Pickle DAC, and/or DWB income disregard(s) are subtracted before the Federal Disregard.

If countable income is below the State Supplement Income Standard for two, the individual is Medicaid eligible.

Section 4.3 Budget for Categorically Needy Medicaid Coverage

A couple or an eligible individual with an ineligible spouse who is not eligible under 4.1 or 4.2 or who chooses not to apply for SSI/State Supplement, may get Medicaid coverage (if otherwise eligible) by using the following budget process.

> **Note:** See Section 2.2.2 of this Part on Deeming of Income for special income exclusions allowed from the income of an ineligible spouse.

Combine all gross unearned income of the couple.

I. Subtract the $20.00 Federal Disregard where applicable.

II. Subtract any allocation to an ineligible child. An ineligible child is one not receiving TANF, SSI or State Supplement. To determine the allocation, deduct each child's countable income from the maximum child allocation (See Chart 3.2). The remainder for each child is combined to determine the total allocation. The remainder is the net unearned income.

III. Combine all gross earned income of the couple.

IV. Subtract any remainder of the $20.00 Federal Disregard not deducted from unearned income.

V. Subtract any remainder of the ineligible child allocation.

VI. Subtract any Impairment-Related Work Expenses (IRWE) outlined in Appendix B.

VII. Subtract the earned income disregard of $65.00.

VIII. Divide the remaining earned income by two. The remainder is net earned income.

IX. Combine the net earned and net unearned income.

X. Subtract the State Disregard for two ($80.00). The remainder is countable income.

If countable income is equal to or below 100% of the Federal Poverty Level for two (see Chart 6) and eligibility is based on age or disability, the individual or couple is Medicaid eligible.

Note: The State Supplement budgeting criteria must be used for an individual or couple whose eligibility is based solely on blindness. However, if the individual or couple also meets the SSI criteria for disability use the budgeting criteria in this section.

SECTION 5 KATIE BECKETT COVERAGE

Katie Beckett is a MaineCare coverage group for children who are ineligible under a Family - Related or any other SSI - Related coverage group and who:

I. are age 18 and under (up to age 19);

II. reside in the community (not in a medical institution);

III. meet the SSI/SSA criteria for disability; and

IV. need in-patient care provided by a hospital, nursing facility, psychiatric hospital, or an ICF-MR. The cost of providing care outside the facility must not exceed the annual cost of institutional care needed by the child as determined by the Office of MaineCare Services.

V. If a child covered under Katie Beckett no longer resides with the parent(s), parental deeming under SSI - Related rules ends (See Section 2.2.3 of this Part). The child may then be eligible as SSI - Related and may not need the Katie Beckett coverage group.

Section 5.1 Income and Assets

If the criteria in I – IV above are met, the income and assets of the child only are considered in determining financial eligibility. Parental income and assets are disregarded. There is no cost of care and there is no penalty for transfer of resources.

I. The child's gross income as defined in SSI - Related coverage must be less than or equal to the Categorical Nursing Care Limit (see Chart 4.1). If income exceeds this amount, the individual is not eligible.

II. The child's countable assets as defined in Part 16 must be less than $2,000.

Section 5.2 Premiums

I. Except for Alaska Natives and Native Americans who are members of Federally-recognized Tribes, the Department must receive monthly premiums as described below, in order for the child to receive Katie Beckett coverage.

A. Amount:

1. The amounts of the monthly premiums, based on family income as a percentage of the Federal Poverty Level, are identified in Chart 3.12.
2. The premium amounts in the chart apply to a family, regardless of the number of Katie Beckett children in the family.
3. For purposes of calculating family income as a percentage of Federal Poverty Level to determine monthly premiums, family size is the total of the child or children covered under the Katie Beckett group, his or her siblings and his or her parents who reside in the household. Family income is based on gross monthly non- excluded income of the family. Income excluded by SSI - Related coverage and stepparent income (unless the stepparent is to be counted in the family size) are both excluded.

a. There are no deductions or disregards from income.
b. Current income is projected over a twelve month period.
c. SSI - Related Medicaid rules are used in anticipating income and in the treatment of irregular, fluctuating, contract, seasonal and self-employment income.
d. Premium amounts due can be changed if there is a change in income or health insurance that is expected to last for more than a full calendar month. The change in premium amount is effective the month after the month the change in income or health insurance occurred, as long as the change in income or health insurance is reported within ten days of its occurrence; otherwise, the change in premium is effective the month after the month the change in income or health insurance is reported. Adverse action notice will be given when a premium is increased.
e. There are two premium schedules:

i. a standard premium for children without any other creditable private health insurance coverage. Creditable insurance coverage is defined in 42 U.S.C. §300gg(c)(1) and includes any health benefits plan, individuals or group, a medical care program of the Indian Health Service or another tribal organization, any government insurance

plan for Armed Forces, Peace Corps volunteers or government employees, provided by a carrier for the purposes of providing, paying for or reimbursing expenses for health services. Creditable insurance coverage does not include coverage which is limited in scope such as dental insurance or vision care insurance; and

ii. a discounted premium for children covered by a private health insurance plan.

Note: For families using the Private Health Insurance Program (PHIP) benefit, the standard premium schedule applies.

B. Payment:

1. Payment is due to be received by the Department on the first day of the month for which the child receives coverage.
2. Premiums can be paid monthly, for more than one month at a time, or in advance for the twelve month eligibility period. Payments will first be credited to the earliest months of coverage during the current twelve month eligibility period. If retroactive coverage is granted according to Part 2, Section 13.4, then payment will also be due for the retroactive months of coverage. These payments for retroactive coverage will be created first.

   For example: A monthly premium of $92.00 is due during the twelve month review period from January to December and the first payment of $92.00 is received on March 1st. Month one (January) will be credited with a premium paid. The February and March payments are overdue.

3. Payment must be paid up to date every three months. If not, advance notice of closing will be sent to end coverage the last day of the 3rd month.

   For example: The 1st month of coverage is January. As of March 1st, premiums for January, February, and March are paid. As of June 1st, payments are received by DHHS for April, but no payment is received for May or June. Action is taken to end Medicaid coverage effective June 30th.

4. There is a grace period for nonpayment of premiums. The grace period extends through the last day of every 3rd month.
5. If payment is received the month following the month coverage has ended, a new medical assessment is not needed to determine if the child is in the need of institutional level of care. Reapplications for any following months require a new medical assessment. A prior decision on meeting the SSA disability criteria can be used if the review date of this decision is in the future.
6. If MaineCare coverage under the Katie Beckett group is closed due to non-payment or non-timely payment of a premium,

coverage under Katie Beckett cannot be reinstated for twelve months starting with the month the closing is effective unless all past due premiums are paid in full.

7. Coverage under this group can be reinstated in fewer than 12 months if there is good cause for late or non-payment of premiums because of one of the following reasons:
   a. mail delay;
   b. illness of the parent; or
   c. unanticipated emergency beyond the control of the parent or the responsible individual.

C. Refunds -
A refund is due if an agency error occurs. Any adjustment will be limited to twelve months prior to knowledge that an agency error has occurred.

II. If a child under age 18 is getting Medicaid coverage through the SSI cash program and he/she becomes ineligible for an SSI cash payment due to the parents' income or assets, the child may continue to get full Medicaid coverage and a $40.00 payment through the SSI and State Supplement program if the child:
   A. is disabled;
   B. received SSI benefits while in a medical facility (hospital or nursing home) for at least one month; and
   C. meets the inpatient level of care standard for Katie Beckett.

The SSI office will ask the state Department of Health and Human Services to see if the child meets the medical need standard for the Katie Beckett option. The SSI office will let the parents know if the child meets the criteria and can get the $40.00 payment from SSI/State Supplement as well as continued Medicaid coverage. SSI may refer to this option as the "waiver of parental deeming".

SECTION 6 BUDGETING FOR WORKING DISABLED

There is a two step test of income that must be met.

I. Countable unearned income must be equal to or less than 100% of the Federal Poverty Level (See Chart 6).

II. Countable unearned and earned income subject to federal tax withholding must be less than 250% of the FPL (See Chart 6).

Section 6.1 Earnings

The individual must have earnings subject of federal tax withholding but there is no minimum work requirement and no SGA earnings test.

Section 6.2 Disability

The individual must meet the SSI criteria for disability. This criteria is met if there is currently in effect a decision by the Social Security Administration that this disability criteria is met.

Section 6.3 Changes

If the individual becomes eligible for Medicaid without a premium because of a change in income and that change is expected to last for a full calendar month, the individual will be moved to Medicaid coverage without a premium. This change is made effective the month the change occurred as long as this change is reported within ten days of its occurrence; otherwise, it is effective the month the change is reported. "Occurrence" is the date the change takes place.

The individual will be given a refund for any prepaid months in which s/he is subsequently moved to coverage without a premium.

Section 6.4 Premiums

I. Due Date/Amount of Premium -

A premium payment is due for each month the individual is open for Medicaid under this coverage group unless s/he is exempt from a premium as identified below.

If a couple is eligible under this coverage group, there is one premium for the couple based on the couple's countable income.

Premiums are due on the first day of each month of coverage.

The premium amount is based on countable monthly income projected for the twelve month eligibility period and does not change. A premium is effective the month an individual is added for coverage under this coverage group. Any decrease in premium is effective the month the individual's coverage under this group ends.

If countable monthly income is over 150% and equal to or less than 200% of the FPL (See Chart 6), the monthly premium is $10.00. If countable monthly income is over 200% and less than 250% of FPL the monthly premium is $20.00.

II. Exemptions from Premium Payment -

An individual is exempt from a premium:

A. if countable income is less than or equal to 150% of the Federal Poverty Level (See Chart 6);
B. if s/he is responsible for paying for their Medicare Part B premium; or
C. if there is good cause for premiums not paid or not paid when due because of one of the following reasons:
    1. mail delay;
    2. illness of the individual or their responsible relative; or
    3. an anticipated emergency beyond the control of the individual or their responsible relative.
D. For periods of retroactive coverage or temporary coverage.

III. Payment of Premiums -

A. Premiums can be paid monthly, for more than one month at a time, or they can be paid in advance for the twelve month eligibility period.

Payments will be credited to the earliest months of coverage first, during the current 12 month eligibility period.

Example:
A monthly premium of $10.00 is due during a twelve month eligibility period from January to December and the first payment of $50 is received on June 1st. Months one through five will be credited with a premium paid. The June payment is overdue.

B. When a premium is not paid by the first of the month in which it is due the Department will give notice of nonpayment.
C. There is a grace period for nonpayment of premiums. The grace period extends through the last day of the twelve month eligibility period.

Example:
If the eligibility period is January through December, the individual has until December 31st to pay his or her premiums for the period January to December. If the last day of the month falls on a weekend or holiday the premium is then due on the next workday.

D. When eligibility under this coverage group ends prior to the end of the twelve month eligibility period, the grace period for premium payment extends to the last day of the month in which coverage under the Working Disabled group ends.

Example:
An individual granted 10/07 has a review date of 9/08 but his coverage is changed to Medicaid without a premium for 12/07. The grace period for payment of premiums for October and November is November 30th.

E. When eligibility under this coverage group is continued pending a hearing and a premium is due, the grace period is the last day of the month for which coverage is provided.

Example:
The premium for the month of July is due July 1st. The grace period extends to July 31st.

IV. Non Payment of Premiums -
A. At the beginning of month twelve of the eligibility period, notification will be given if any premiums for the eligibility period have not been paid when due. The individual will be notified of the penalty to be imposed because of the nonpayment.
B. At the twelve month review a determination will be made as to whether there are any overdue premiums. If so, coverage under the Working Disabled group will end unless there is “good cause” for nonpayment. Coverage as Working Disabled cannot begin again until any unpaid premiums are paid.

V. Administrative Hearings -
A. Coverage as Working Disabled continues pending a hearing decision if a hearing is timely requested even if the individual is not paying

premiums that are due. If the individual was responsible for paying a premium prior to the proposed negative action, this premium will continue to be due.

B. If the individual is upheld at the hearing and they have overpaid any premiums s/he will be issued a refund.

PART 8
Medicare Buy-In (Medicare Savings Program [MSP])

The Department pays the premium for Medicare Part B coverage for recipients of SSI and other eligible individuals who are Medicare eligible. This payment is called the Buy-In. The Department also provides additional benefits for Qualified Medicare Beneficiaries (QMB) which are detailed below.

There is usually a delay between the time an individual is eligible for the Buy-In and the time the Buy-In begins. During this time, the individual continues to have premiums deducted from their Social Security benefits (See Appendix A)

Social Security enrolls SSI clients for the Buy-In of Medicare Part B premiums. If the individual needs assistance with payment of Medicare Part A premiums, DHHS enrolls the individual in QMB.

Other individuals may be eligible for the Buy-In if they meet the criteria of one of the groups below. If not open for or applying for Medicaid, these individuals need to file an application with the Department. Except for the income and asset criteria described below, individuals must meet the basic requirements for SSI - Related Medicaid. The exception is those individuals who have end stage renal disease. They do not need to meet the age or disability requirements.

SSI - Related Categorically Needy Medicaid budgeting rules are used for Buy-In.

Individuals eligible under the Pickle Amendment are eligible for payment of Medicare Part B premiums.

Buy-In is a separate benefit within Medicaid. As a result, one spouse of an eligible couple can choose to be an ineligible spouse in order to give Medicaid to the other, and at the same time be looked at as an eligible couple for Buy-In.

> **Example:**
> Mr. and Mrs. Mazure apply for MaineCare. Both have Medicare. Mr. Mazure has Social Security income of $920. Mrs. Mazure has Social Security of $600. Using SSI - Related Categorically Needy budgeting for an eligible couple both are eligible for Buy-In but over income for Medicaid.
>
> We can do a budget for Medicaid coverage that has Mrs. Mazure as an eligible individual and Mr. Mazure as an ineligible spouse. This allows us to use the exclusions to deeming found in Part 7, Section 2.2.2. This will result in Mrs. Mazure being eligible for Medicaid. The end result is both receiving Buy-In and Mrs. Mazure receiving Medicaid.

SECTION 1 INDIVIDUAL WHO OPTED OUT OF MEDICARE

If the individual opts out of Medicare Part A and/or B coverage when it is first offered and is now eligible for Buy-In, DHHS will start their coverage without waiting for open enrollment. The Medicare Part A and/or B start date will be the effective date of the Buy-in.

> **Note:** An individual who is not eligible for Buy-In would have to wait until open enrollment (January, February or March) of the following year to enroll in Medicare Part A or B.

SECTION 2 QUALIFIED MEDICARE BENEFICIARY (QMB)

A Qualified Medicare Beneficiary is an individual who:

I. is entitled to Medicare Part A or voluntarily enrolled in Medicare Part A;

II. has income equal to or less than 150% of FPL (See Chart 6); and

III. effective 1/1/06, there is no asset limit.

Under this group:

I. Medicaid pays the cost of Medicare Part A and/or B premiums, as well Medicare Part A and B deductibles and coinsurances (See Appendix A).

II. an individual may be eligible for QMB and Medicaid at the same time.

III. coverage begins the month after an eligibility decision is made. There is no three month retroactive period.

SECTION 3 SPECIFIED LOW INCOME MEDICARE BENEFICIARY (SLMB)

A Specified Low Income Medicare Beneficiary is an individual who:

I. is entitled to Medicare Part A or is voluntarily enrolled in Medicare Part A;

II. has income over 150% of the Federal Poverty Level (FPL) and equal to or less than 170% of FPL (See Chart 6); and

III. effective 1/1/06, there is no asset limit.

Under this group:

I. Medicaid pays the cost of Medicare Part B premium (see Appendix A);

II. an individual may be eligible for SLMB and Medicaid at the same time; and

III. coverage begins the month of application, retroactive to three months (but not prior to 1/1/93).

SECTION 4 QUALIFYING INDIVIDUAL (QI)

A Qualifying Individual is one who:

I. is entitled to Medicare Part A or is voluntarily enrolled in Medicare Part A;

II. has income more than 170% of the Federal Poverty Level (FPL) (see Chart 6) but less than 185% FPL; and

III. effective 1/1/06, there is no asset limit.

Under this group:

I. Medicaid pays the cost of the Medicare Part B premium;

II. the individual cannot receive Medicaid coverage and this benefit at the same time; and

III. coverage begins the month of application up to three months retroactive but no earlier than 1/1/98.

SECTION 5 QUALIFIED DISABLED AND WORKING INDIVIDUAL (QDWI)

A Qualified Disabled and Working Individual is one who:

I. is entitled to Medicare Part A;

II. is not eligible for Medicaid;

III. has lost entitlement to Social Security disability benefits due to excess income from wages;

IV. has countable income equal to or less than 200% of the FPL (See Chart 6); and

V. has countable assets less than or equal to $4000.

Under this group:

I. Medicaid pays the cost of the Medicare Part A Premium.

II. Coverage begins the month of application, up to three months retroactive.

PART 9
SPECIAL GROUPS – HIV/AIDS WAIVER, BREAST AND CERVICAL, NON-CATEGORICAL

SECTION 1 HIV/AIDS Waiver

Individuals can get limited benefits under Medicaid for people with HIV/AIDS if they meet medical and financial requirements identified in this section.

If an individual who is eligible for this benefit becomes eligible for any Categorically Needy or Medically Needy coverage group s/he will be moved to that coverage group. This includes someone who meets a deductible or spend down or, for example, an individual who has a reduction in income so that s/he qualifies for Family - Related coverage with income under 150% of the Federal Poverty Level (See Chart 6). This individual's coverage group is then changed from the HIV/AIDS Benefit to the Categorical coverage group.

If an individual who is enrolled in a Categorical coverage group becomes ineligible including someone who must meet a new deductible or spend down, but is eligible for HIV/AIDS Benefits, that individual will be changed to HIV/AIDS Benefit. This will happen even if there is a wait list for HIV/AIDS Benefits.

An individual cannot get coverage for the HIV Benefit and the Maine Rx Plus or Low Cost Drugs for the Elderly and Disabled (DEL) at the same time unless DEL is supplementing Medicare Part D.

Section 1.1 Basic Eligibility Requirements

Individuals must meet all the basic eligibility requirements for getting MaineCare coverage identified in Part 2. This includes the rules on residency, citizenship, social security numbers, assignment of rights to medical payments and support rights as well as applying for other benefits. There is no age requirement.

Section 1.1.1 Medical Eligibility

The individual must be diagnosed as HIV positive. This diagnosis is confirmed by the Maine Center for Disease Control (MCDC). The individual must also comply with the treatment regimen as identified in the MaineCare Benefit Manual.

Section 1.1.2 Financial Eligibility

If an individual is financially eligible for SSI - Related coverage, a disability decision will be done by the Medical Review Team if a disability decision has not been made by Social Security and the individual agrees to cooperate with this determination.

Section 1.2 Income

The SSI - Related rules on income exclusions in Part 17 are applicable to this coverage group.

Gross income must be equal to or less than 250% of the Federal Poverty Level (See Chart 6).

There is no deeming of income from the spouse. There is no cost of care.

When determining MaineCare coverage for a spouse not applying for or enrolled in the HIV Benefit, the income/assets of both spouses are considered under the rules

for the spouse's coverable group. For example, if the spouse is being considered for SSI - Related coverage, the income and assets of both spouses are considered when determining eligibility for the spouse.

Section 1.3 Assets

There are no asset criteria.

Section 1.4 Premiums

A premium payment is due for each month the individual is open for Medicaid under this coverage group unless s/he is exempt from a premium as identified below.

Premiums are due on the first day of each month of coverage.

The premium amount is based on gross monthly income projected for the twelve month enrollment period. A premium is effective the month an individual is added for coverage under this group and ends effective the month coverage under this coverage group ends. See Chart 3.10 for premium amounts due.

Section 1.4.1 Payment of Premiums

I. Premiums can be paid monthly, for multiple months, or they can be paid in advance for the twelve month enrollment period. Payments will be credited to the earliest months of coverage first, during the current twelve month enrollment period.

   For example: A monthly premium of $20.00 is due during a twelve month enrollment period from January through December and the first payment of $220 is received on December 1st. Months one through eleven will be credited with a premium paid. The December payment is overdue.

II. When a premium is not paid by the first of the month in which it is due the Department will give notice of nonpayment.

III. There is a grace period for nonpayment of premiums. The grace period extends through the last day of the twelve month enrollment period.

   For example: If the enrollment period is January through December, the individual has until December 31st to pay his or her premiums for the period January to December.

   If the last day of the month falls on a weekend or holiday the premium is then due on the next workday.

IV. If eligibility under this coverage group ends prior to the close of the twelve month enrollment period, the grace period for premium payment extends to the last day of the month in which coverage under this group ends.

   For example: an individual granted 10/07 has a review date of 9/08 but his coverage is changed to Medicaid without a premium for December. The grace period for payment of premiums for October and November is November 30th.

V. If eligibility under this coverage group is continued pending a hearing and a premium is due, the grace period is the last day of the month for which coverage is provided.

For example: the premium for the month of July is due July 1st. The grace period extends to July 31st.

Section 1.4.2 Exemptions from Premium Payment

An individual is exempt from a premium:

I. If gross income is less than or equal to 150% of the Federal Poverty Level (See Chart 6) .

II. If there is good cause for premiums not paid or not paid when due because of one of the following reasons:
   A. Mail delay;
   B. Illness of the individual or their responsible relative; or
   C. Unanticipated emergency beyond the control of the individual or their responsible relative.

III. During periods of retroactive coverage.

Section 1.4.3 Changes in Premium Amount

If the individual's income changes so that no premium is due or the amount of premium increases or decreases, this change will be made as follows:

I. the change in income must be expected to last a full calendar month;

II. the change will be effective for the month the income changed as long as the change is reported within 10 days of it's occurrence; otherwise, the change is effective the month the change is reported; and

III. the premium amount will be changed no more than once every 6 months.

Section 1.4.4 Non-Payment of Premiums

I. At the beginning of month twelve of the enrollment period, notification will be given if any premiums for the enrollment period have not been paid when due. The individual will be notified of the penalty to be imposed because of the non-payment.

II. At the twelve month review a determination will be made as to whether there are any overdue premiums. If so, coverage for this benefit will end unless there is "good cause" for non-payment. Coverage cannot begin again until any unpaid premiums are paid. When the unpaid premiums are paid and the individual is otherwise eligible, the individual is re-enrolled even if there is a wait list and regardless of the individuals place on the waiting list.

Section 1.5 Administrative Hearings

I. Coverage for this benefit continues pending a hearing decision if a hearing is requested, even if the individual is not paying premiums that are due. If the individual was responsible for paying a premium prior to the proposed negative action, this premium will continue to be due.

II. If the individual is upheld at the hearing and they have overpaid any premiums s/he will be issued a refund.

Section 1.6 Wait List

Enrollment for this benefit is capped based on expenditures. If enrollment is frozen, individuals who have been determined to be medically and financially eligible will be placed on a wait list that is maintained by the Maine Center for Disease Control and Prevention (MCDC). The rules for the waiting list are in the MaineCare Benefits Manual.

When the Office of Integrated Access and Support is informed by the MCDC that individual's coverage can start, financial eligibility will be updated before coverage for this benefit can start.

SECTION 2 BREAST AND CERVICAL CANCER

Medicaid is provided to women who are under age 65 and otherwise meet the eligibility guidelines set forth in DHHS Rules for the Maine Breast and Cervical Health Program (MBCHP), 10-144, Chapter 707 *et seq.*

Individuals are initially authorized coverage under this group based on data collected by the Maine Center for Disease Control and Prevention (MCDC) and transferred electronically to the Office of Integrated Access and Support (OIAS). Coverage is continuous for one year or as long as the individual is in need of treatment, whichever is longer. When eligibility under this group ends, the individual will be reviewed by OIAS for continued coverage under another MaineCare coverage group.

Basic Non-Financial eligibility requirements for getting Medicaid coverage identified in Part 2 apply to this group. This includes the rules on residency, citizenship, social security numbers, and assignment of rights to medical payments.

SECTION 3 NON-CATEGORICAL ELIGIBILITY

Section 3.1 Basic Eligibility Criteria

The individual must be between the ages of 21 up to and including age 64, not residing as a specified relative with a child under age 18 (or is age 18 and expects to graduate from high school prior to their 19th birthday) and be ineligible under any other coverage group.

If the individual claims to have a disability that would meet the MaineCare requirement, a disability determination will be done. The individual can get temporary coverage, if eligible, until a decision is made.

Basic Non-Financial eligibility requirements for getting MaineCare coverage identified in Part 2 apply to this group. This includes the rules on residency, citizenship, social security numbers, and assignment of rights to medical payments.

Section 3.2 Assets

The countable asset limit is $2,000 for an individual, $3,000 for a couple. The rules on the definition of assets and asset exclusions used in SSI - Related Medicaid coverage are used for this group.

Section 3.3 Income

Gross non-excluded monthly income must be equal to or under 100% of the Federal Poverty Level (See Chart 6). The rules on the definition of income and income exclusions used in SSI - Related Medicaid coverage are used for this group. There are no income disregards.

Section 3.4 Budgeting

The rules for Medicaid SSI - Related budgeting are used in determining the size of the assistance unit and whose income to count.

Individuals in this coverage group are not eligible under Medically Needy.

Section 3.5 Wait List - Procedures to Prevent Program Expenditures from Exceeding Budget

I. DHHS may institute a wait list for this program when DHHS determines that there are insufficient funds with which to add additional individuals.

II. Individuals on the wait list have no rights to coverage under this program.

III. Wait List Procedure -

A. The wait list will be maintained statewide by the date the Office of Integrated Access and Support receives the application.

B. The "application date" for purposes of placement on the wait list is:

1. The date an application form is received from someone who has not been enrolled in MaineCare coverage for one month.
2. If an individual who has been enrolled in Medicaid becomes financially eligible under the Non-Categorical coverage group at the time he or she becomes ineligible for another Medicaid coverage group, the date of application is the day following the date the individual's other Medicaid coverage group ends.
3. If an individual between the ages of 21 and 64 has been getting forty-five day Temporary Coverage (pending an eligibility decision for coverage under another Medicaid group) and the Temporary Coverage ends, the application date is the date of the original application for coverage under another Medicaid coverage group.

C. Individuals on the wait list will become eligible for coverage if and when the Department determines that program funding is available. When the Department determines that program funding is available, individuals will be enrolled on the basis of their application date. The earliest applications will be enrolled first. For example, those applying March 15th will be enrolled before those applying March 16th. No retroactive coverage is available for individuals enrolled off the wait list.

If an individual has been on the wait list for over 3 months, his or her financial eligibility will be updated before coverage is authorized. If the individual is then found to be ineligible, he or she will be dropped from the wait list. To get back on the wait list, he or she will need to reapply. If eligible, the new application date will be used to put them on the wait list.

An individual who fails to respond to the financial eligibility update process, but who establishes “good cause” (See Section 3.6 below) for not responding, will be given sixty days from the date he or she is dropped from the wait list to submit an application. If financial eligibility exists, the individual will be authorized coverage the first day of the month he or she returns the completed application.

Section 3.6 Reinstatement Process

When a non-categorical individual’s coverage is closed for failure to respond to a redetermination request, that individual will have sixty days from the date of closure to regain coverage if good cause exists. (Coverage will be retroactive back to the original date of closure, even if a wait list is in effect.) Good cause reasons must be demonstrated by the individual, and can include, but are not limited to;

I. circumstances beyond the individuals control such as illness, or

II. non-receipt of notice.

Section 3.7 Discontinuance of the Wait List

When the Commissioner determines that the program expenditures will not exceed the program cap for the current waiver year, then the Department shall enroll eligible individuals to the extent necessary to provide coverage to as many persons as possible within the program budget, in accordance with the above rule.

PART 10
MEDICALLY NEEDY ELIGIBILITY CRITERIA

If eligibility does not exist as Categorically Needy, an assistance unit may still gain eligibility through Medically Needy even if assets exceed the Categorically Needy asset limit, or countable income exceeds the appropriate Federal Poverty Level (FPL) (See Chart 6).

The asset and income limits for Medically Needy are used to determine eligibility.

Note: Budgeting for Categorically Needy and Medically Needy are the same.

SECTION 1 MEDICALLY NEEDY ASSET LIMITS

Assets can be under the following limits on any day of the month to be eligible for that month.

I. For Family - Related coverage groups:

The maximum amount of countable assets an individual or assistance unit may retain for Medically Needy eligibility is:

$2,000 for one person
$3,000 for two persons
$ 100 for each additional person

To determine the appropriate assistance unit size, whose assets will be counted, and the asset limit:

A. Count all people who will be covered.
B. Add in the child(ren)'s legal parent(s) in the home, even if they are not to be covered unless they receive TANF or SSI.

II. For SSI - Related coverage groups:

$2000 for an individual not married or not living with a spouse, Including an individual who is a child.

$3000 for an eligible couple or an individual living with an ineligible spouse

SECTION 2 MEDICALLY NEEDY INCOME LIMITS

For Family – Related coverage groups: the income limit is the Protected Income Level (PIL) based on the assistance unit size as determined in Part 4, Section 3.1.

For SSI - Related coverage groups:

I. Medically Needy Coverage for an Individual -
If an individual is not Medicaid eligible under Categorically Needy, the Protected Income Level (PIL) for one (see Chart 5) is deducted from the countable income. The result is used in determining the amount of the deductible to be met prior to beginning Medically Needy coverage.

II. Medically Needy Process in Deeming to an Eligible Child -

If the child is not eligible under Categorically Needy, then the Protected Income Level (PIL) for one (see Chart 5) is deducted from the countable income. The result is used in determining the amount of the deductible to be met prior to beginning Medically Needy coverage.

III. Medically Needy Coverage for a Couple -
If the couple or eligible individual with an ineligible spouse is not Medicaid eligible as Categorical Needy, the Protected Income Level (PIL) for two (see Chart 5) is deducted from the countable income. The result is used in determining the amount of the deductible to be met prior to beginning Medically Needy coverage.

SECTION 3 MEDICALLY NEEDY DEDUCTIBLE PROCESS

Individuals who are ineligible under Categorically Needy and whose income is above the appropriate Protected Income Level (PIL) are not eligible for Medicaid until they meet a deductible. This deductible is met by applying incurred costs for necessary medical services as outlined below.

The deductible is determined as follows:

I. Determine the countable income.

II. Subtract the PIL for the appropriate assistance unit size (See Chart 5).

III. Multiply by the number of months in the eligibility period (usually six months) (See Part 2, Section 13.2).

The result is the deductible amount for the eligibility period.

Before opening coverage at any time during the eligibility period, the worker must review and update the deductible amount. If there are any changes in income (use actual income received where possible), assistance unit composition or Protected Income Levels, a new deductible amount will be figured.

To be applied to the deductible, bills must be submitted within one year of the date of application.

If the deductible is met using medical costs that are not covered under Medically Needy, the individual will become eligible as of the first day of the eligibility period. Otherwise, coverage will begin when the deductible is met.

Once the deductible is met and eligibility begins, bills for a coverable service may be submitted that could have been used to meet the deductible. These bills will be covered if they are submitted within one year of the date of the eligibility decision.

SECTION 4 APPLICABLE MEDICAL COSTS

The cost of necessary medical services for individuals in the assistance unit and for individuals whose income or assets are or would be used in determining eligibility may be applied against the deductible.

For individuals who are included in more than one assistance unit, the cost of necessary medical services can be applied toward each deductible.

When an individual has sufficient costs to meet the deductible, but an accurate start date cannot be determined due to missing bills or pending insurance payments, begin eligibility for the first full month. Back date eligibility when all information is provided.

Example:

- Deductible time period June through November. Deductible amount $3600.
- $5000 in applicable medical costs are received that would result in individual meeting the deductible August 15th. However, an additional $2000 in medical costs incurred prior to August 15th are pending third party insurance payments.
- Open coverage effective September 1st.
- Once the additional $2000 in medical costs has been adjusted by the third party insurance payments, the start of coverage prior to September 1st will be determined.

Medical costs are applied in the following order:

I. Verified medical insurance premiums, including Medicare.

Note: Indemnity insurance premiums are not allowed. These are policies that pay for length of stay or a condition (such as cancer) but not for a specific service.

II. Verified actual costs incurred during the eligibility period for medical or remedial care costs not covered under Medicaid such as eyeglasses, dental services and hearing aides for individuals over age 21.

III. Medical costs incurred during the eligibility period by individuals who are part of the assistance unit but not eligible for coverage (such as an ineligible spouse or deeming parent in an SSI - Related unit or the parents of an individual whose eligibility is based on being under age 21).

IV. The unpaid balance on a loan taken out to pay for an old medical bill which was incurred prior to the eligibility period provided:

A. The proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the old medical bill may be deducted. Any portion used for another purpose may not be deducted.

B. Neither the medical bill nor the unpaid balance of the loan were previously applied against another deductible.

C. Only the principal part of the unpaid balance may be used in the deductible - not the interest.

This provision allows the individual to use the liability to the lender in place of the liability to the provider.

V. Medical costs incurred prior to the eligibility period and not applied toward another deductible, and which are unpaid on the first day of the eligibility period, which resulted in eligibility.

Example:

Individual has a medical bill of $5000. He has a deductible for January through June of $4500. He meets the deductible and in July incurs another $4500 deductible. The $500 remaining from the $5000 medical bill can be used towards the new deductible.

VI. Additional services or items necessary for medical treatment such as transportation, long distance telephone calls to medical providers, cost of lodging to receive treatment away from home and nonprescription items or drugs incurred during the eligibility period.

VII. Medicaid coverable costs, paid or unpaid, incurred during the eligibility period in order of service date, including the following medical costs:
   A. Medical costs incurred during the eligibility period as long as they have not been written off by the provider during the eligibility period.
   B. Medical costs paid with all state or local funds such as General Assistance, DEL and some payments by Vocational Rehabilitation (VR).

Once the deductible has been met, the eligible individuals in the assistance unit will be eligible for Medicaid for the remainder of the eligibility period or until information is provided which would change the eligibility.

SECTION 5 NON-APPLICABLE MEDICAL COSTS

The following types of medical bills cannot be considered toward a deductible:

I. Medical costs incurred and paid prior to the eligibility period.

II. Portions of medical costs applied toward a previous deductible, if the deductible is met.

III. Portions of medical costs paid by insurance, including Medicare adjustments.

IV. Medical costs paid by individuals or groups outside the assistance unit for which the individual has no obligation to repay. The exception is medical costs paid with all state or local funds such as General Assistance, DEL and some payments by Vocational Rehabilitation (VR).

V. Medical costs incurred by individuals who are not members of the assistance unit and whose income and assets are not used in determining eligibility.

VI. Payments on old medical bills incurred prior to the eligibility period.

VII. Medical costs incurred during a penalty period.

VIII. Unpaid costs of care to a medical institution or waiver agency during periods of eligibility.

Example:
This example shows how medical expenses are applied to a deductible and the order in which they must be applied.

An individual, age 22, determined disabled in April, submits the following bills to meet a deductible of $3820 for April through September.

Determine that there are no changes to the deductible amount and that all of the bills submitted can be used toward the current remaining deductible:

Total Deductible: $3820.00

1. Medical Insurance premium ($79.05 monthly X 6)
   - $ 474.30
   Remaining deductible $3345.70

2. Items not covered by Medicaid
   Eyeglasses (purchased 4/12) - $ 125.00
   Remaining deductible $3220.70

3. Old unpaid medical bills
   Doctor's statement shows an outstanding balance
   as of 3/31 of $650.00 - $ 650.00
   Remaining deductible $2570.70

4. Medicaid coverable costs paid or unpaid incurred
   During the eligibility period

   The hospital bill for 4/3 through 4/6 ($3500) was not itemized for insurance payments ($1200). To determine the daily portion of the hospital bill the client is responsible for - divide the total insurance payment by the total hospital bill to the 4th decimal place ($1200 ÷ $3500 = .3428).

   4/3 Charges
   Multiply 4/3 hospital bill by .3428 ($1500 x .3428 = $514.20)
   Subtract the result from the 4/3 hospital bill
   ($1500 – $514.20 = $985.80)

   4/3 hospital charge used against the deductible - $ 985.80
   Remaining deductible $1584.90

   4/4 Charges
   Multiply 4/4 hospital bill by .3428 ($1000 x .3428 = $342.80)
   Subtract the result from the 4/4 hospital bill
   ($1000 – $342.80 = $657.20) $ 657.20
   Physician's bill after insurance + $ 65.00
   Prescription + $ 46.25
   Total charges for 4/4 - $ 768.45
   Remaining deductible $ 816.45

   4/5 Charges
   Multiply 4/5 hospital bill by .3428 ($900 x .3428 = $308.52)
   Subtract the result from the 4/5 hospital bill
   ($1000 – 308.52 = $691.48) $ 691.48
   Physician's bill after insurance + $ 200.00
   Radiology services after insurance + $ 400.00

Total charges for 4/5 $1291.48

The charges for 4/5 are greater than the remaining deductible of $816.45.

The applicant met the deductible on 4/5. The first full day of coverage is 4/6.

The applicant is responsible for the remaining deductible of $816.45 and there are a number of bills on 4/5. There is a manual process to distribute the applicant's responsibility to each provider.

To determine the applicant share for each provider for bills incurred on 4/5:

1. Divide remaining deductible by total charges for 4/5 to the 4th decimal place. ($816.45 ÷ $1291.48 = .6322)

2. Multiply each provider's bill by .6322. This is the amount the applicant is responsible for.

Hospital	$691.48 x	.6322	=	$437.13
Physician	$200.00 x	.6322	=	$126.44
Radiology	$400.00 x	.6322	=	$252.88
Applicant responsibility for 4/5				$816.45

Notes:
When a hospital bill covers more than one day, a notice is sent to the applicant and the hospital. The notice includes the total bill from admit to discharge and of that amount the total the applicant is responsible for.

If medical bills are received for a period prior to the date the deductible was met, but between the first date of eligibility and the Medicaid eligibility date, a notice will be sent to the client and provider showing a zero responsibility for the client.

SECTION 6 VERIFICATION OF MEDICAL COSTS

All costs applied to the deductible must be verified. For each item, with the exception of transportation costs, the applicant must provide a dated bill or receipt showing the name of the provider, date of service, type of service, costs and any insurance payments. If the applicant does not provide an appropriate bill or receipt, the cost cannot be applied.

For transportation, the individual's record must show the reason the cost was incurred, the place visited and the date. A receipt is required if the applicant paid someone else for the transportation. If the applicant's car was used, the actual cost of gas and oil may be calculated or a mileage cost allowed (using current allowance authorized by State Employees Contract). The individual should be given the opportunity to choose whichever option they prefer.

PART 11
STATE SUPPLEMENT

In 1974 the Maine Legislature established the State Optional Supplement Program to provide an allowance for basic needs. To receive a State Supplement, the individual must be receiving SSI or would be eligible except for income or citizenship (22 M.R.S.A. §3271).

> **Note:** SSI counts income-in-kind. State Supplement does not. If an individual is ineligible for SSI when counting income-in-kind they may be eligible for State Supplement.

If the individual is financially eligible for SSI, the individual must apply for and receive SSI. The month of SSI entitlement is the first month that SSI eligibility exists. The first SSI payment is issued for the month following the month of entitlement.

The State Supplement is effective the same month as the SSI payment.

If the individual is not eligible for SSI but is eligible for a State Supplement payment, this benefit will be authorized without a referral to SSI. The payment will be effective the month following the month of eligibility.

SECTION 1 NON-FINANCIAL CRITERIA

When determining eligibility for the State Supplement only, the individual must comply with Medicaid rules for assignment of rights (See Part 2, Section 6) and residency (See Part 2, Section 4).

SECTION 2 INDIVIDUALS INELIGIBLE FOR SSI DUE TO THE 8/96 CITIZENSHIP RULES

When individuals have been denied SSI due to the 8/96 citizenship rules they may be eligible for a State Supplement payment. Upon application to the Department they must meet all other eligibility criteria in this section. This excludes individuals eligible for emergency services only.

State Supplement budgeting rules, found in Part 7, Section 2, are used to determine countable income. The payment is the difference between countable income and the maximum SSI payment plus the State Supplement amount for the living arrangement.

> **Example:**
> Barb Doyle is a 70 year old individual who is not eligible for SSI due to 8/96 citizenship rules. She is receiving a pension of $300 and lives in the community.
>
> Her countable income is:

$ 300	Pension
- $ 20	Federal Disregard
- $ 55	State Disregard
$ 225	Countable Income

> Her payment amount is:

$ 674	Max SSI payment level (eff. 1/09)
+ $ 10	State Supplement payment level

$ 684	
- $ 225	Countable Income
$ 459	Payment Amount

If we know the individual is not eligible for SSI due to citizenship rules described above, there is no need for a separate SSI eligibility determination.

SECTION 3 SUBSTANTIAL GAINFUL ACTIVITY (SGA)

"Substantial Gainful Activity" (SGA) is full or part time work that involves physical or mental activities which are usually done for pay or profit, although there may not be a profit.

Applicants who have average monthly earnings of more than $980 a month are considered to be engaging in SGA. (see Appendix B for calculation of this application pretest).

Applicants who are determined to be engaged in Substantial Gainful Activity are not eligible for State Supplement.

Applicants who have stopped work in the month of application do not have to meet the SGA test. Any income from the terminated employment is countable income.

Recipients who are working must continue to meet the definition of disability.

The following are examples of activities that would not be considered Substantial Gainful Activity:

I. A job is made for an individual out of sympathy or compassion, or which can be performed only because others provide more assistance or supervision than would be characteristic of a bona fide employment situation or a market for the goods or services is created more out of sympathy than intrinsic value received.

II. A job that is part of occupational therapy prescribed and supervised by a physician.

III. An activity which is in the nature of a hobby and does not provide a bona fide job opportunity from the standpoint of genuine economic demand and remuneration.

IV. Activity which is part of an active Vocational Rehabilitation program constituting training and supervised by a rehabilitation agency.

SECTION 4 MONTH OF FIRST PAYMENT

I. For those living alone/with others or residing in a Flat Rate Boarding Homes or Adult Foster Homes, the State Supplement benefit starts the month following the month of application or the month of eligibility, whichever is later.

   For example, if an individual applies for and is eligible for SSI in 3/08, the first month for which the SSI and State Supplement benefits are authorized will be 4/08.

II. For Cost Reimbursed Boarding Homes, Adult Family Care Homes and Residential Care Facilities, the State Supplement benefit will be effective the month following the month a decision is made.

For example, if the State Supplement is being authorized on June 2nd, July will be the first month a check is issued.

SECTION 5 TYPES OF LIVING ARRANGEMENTS

The amount of the State Supplement benefit depends on an individual's living arrangement.

If an individual is eligible for part of a month, they are eligible for a full month benefit.

Codes used by SSI and adopted for State Supplement use:

A Individuals in living arrangement A are living alone or with others. This includes an individual living with their ineligible spouse. It also includes minor children living with their parents. Individuals in this living arrangement receive a State Supplement benefit of $10.00. For a couple, the benefit is $7.50 per individual. This amount does not vary. If eligible for a State Supplement, the benefit amount is $10.00/$7.50.

If an individual in this living arrangement is eligible for a Spousal Living Allowance(SLA), see Part 12, Section 5, the Living Allowance is a State Supplement.

- Instead of $10.00, when the individual is getting SSI, the SLA benefit amount is found in Chart 3.11
- Instead of $10.00, when the individual gets a State Supplement only, the amount of the benefit is determined according to Part 12, Section 5.

C Individuals in this living arrangement are living in the household of another. They receive a benefit of $8.00. A couple receives $6.00 per person. This benefit amount does not vary. If eligible for a State Supplement, the benefit amount is $8.00/$6.00.

- If an individual in this living arrangement is eligible for a Spousal Living Allowance (see Part 12, Section 5), the Living Allowance is a State Supplement. Instead of $8.00, when the individual is getting SSI, the SLA benefit amount is found in Chart 3.11.
- Instead of $8.00, when the individual gets a State Supplement only, the amount of the benefit is determined according to Part 12, Section 5.

D Living in a State or Waiver State Adult Foster Home: The maximum benefit is $49.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for the SSI but under income for the State Supplement, the State Supplement will vary depending upon the individual’s countable income.

E Living in a Flat Rate Boarding Home: These facilities are licensed by the State to provide care for up to six individuals. The maximum benefit for an individual is $217.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for SSI, but under income for the State Supplement, the State Supplement will vary depending upon the individual's countable income.

F Living in an Adult Family Care Home: These facilities are licensed by the State to care for up to five people. The maximum State Supplement for individuals is $234.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for SSI but under income for the State Supplement, the State Supplement will vary depending upon the individual's countable income.

G Living in a Cost Reimbursed Boarding Home. These facilities are licensed by the State to care for seven or more individuals. The maximum State Supplement benefit for an individual in this living arrangement is $234.00. If the individual is eligible for SSI, the maximum is authorized. If the individual is over income for SSI but under income for the State Supplement, the State Supplement will vary depending upon the individual's countable income.

H Living in a medical institution: Residing in a medical institution means that the individual is living there for more than thirty consecutive days and is expected to remain. The State Supplement for individuals in this living arrangement is $10.00. For a couple, it is $20.00. This amount does not vary.

I Residential Care Facility: These facilities are licensed by the State to care for seven or more individuals. The State Supplement benefit is $10.00. For a couple the benefit is $7.50 per individual. The amount does not vary.

For those in living arrangements A/C/H, the benefit amount is fixed. Once the individual is eligible for the State Supplement, they get the appropriate State Supplement benefit.

For living arrangements D/E/F/G, the amount of the State Supplement will vary with countable income when the individual is not eligible for SSI. When is eligible for SSI, the individual receives the maximum State Supplement amount.

SECTION 6 CHANGES IN LIVING ARRANGEMENT

If an individual is receiving a State Supplement in one living arrangement and moves to a different arrangement, any increase in benefit will be made effective the month the individual is in the new living arrangement up to three months retroactive to the month the move is reported to the Department.

Any decrease in benefits will be given timely notice of adverse action.

For example, the individual moves from a Cost Reimbursed Boarding Home to his own home and reports this on 7/2. The August State Supplement payment will be reduced to $10.00. If this had been reported on 7/22, the September payment would be reduced to $10.00.

SECTION 7 SSI CLOSINGS

When the individual is receiving a State Supplement and SSI and the SSI is subsequently closed, the State Supplement payment will be ended unless the individual is eligible for a State Supplement only payment or the SSI closing is timely appealed with SSI and the individual meets all other eligibility rules.

SECTION 8 REPRESENTATIVE PAYEE

A Representative Payee for an SSI or SSA payment may be used for the State Supplement check.

If not receiving an SSI or SSA benefit, the State Supplement check may be received by other than the individual if that person is the individual's legal guardian, conservator or has power of attorney.

SECTION 9 LOST, STOLEN, DESTROYED, OR RETURNED CHECKS

When an individual reports a check has been lost, stolen or destroyed prior to cashing, the agency has the responsibility to replace it. In the instances when there is reason to believe there has either been a forgery or duplicate checks have been received and cashed by the recipient, the following procedures have been established.

I. Forgeries -
When the photocopy of the original check is sent to the OIAS office, staff must meet face-to-face with the individual or Representative Payee to determine whether or not the signature is theirs. If the individual or Representative Payee states it is not, then a Forgery Affidavit will be completed (SWIM-052) and the original sent to FIR with a copy to Division of Financial and Personnel Services and a copy for the record. This initiates an investigation to determine who cashed the check.

If the individual or Representative Payee agrees that the signature on the original check is theirs, OIAS staff may refer for fraud.

II. Replacing a Check -
When a household presents a damaged check, which a bank refuses to cash, the worker will take the following steps:

A. Complete a SWIM-050 (Stop Payment).
B. Complete a SWIM-051 (Application for a Duplicate Check).
C. Void the damaged check.
D. Forward the original forms and the damaged check to the Division of Financial and Personnel Services. A copy is retained for the record.

PART 12
RESIDENTIAL CARE

The rules in this Part are used for individuals who reside in any of the following living arrangements. Individuals residing in these living arrangements are not considered to be "institutionalized" as described in Part 14.

SECTION 1 LIVING ARRANGEMENTS

Adult Foster Home (AFH):
Each AFH usually serves one to three individuals who are usually being served by the Office of Adults with Cognitive and Physical Disabilities (OACPD). OACPD groups AFH into:

- Private AFH or "Foster Waiver Homes" where residents are also enrolled in the OACPD Home & Community Based Waiver Program, and

- State Assisted AFH where residents are enrolled in SSI/State Supplement and/or OACPD Home & Community Based Waiver Program. This distinction is used for OACPD purposes only. Medicaid eligibility is determined using the same rules for all AFH but the State Supplement amount is different for each group (See Part 11 for information regarding the State Supplement).

Flat Rate Boarding Home (FRBH)
Each FRBH usually serves up to five individuals who are usually being served by OACPD.

Cost Reimbursed Boarding Home (CRBH)
CRBH serve six or more individuals. These facilities are classified as Private Non-Medical Institutions (PNMI).

Residential Care Facility (RCF)
RCF serve six or more individuals. These facilities are classified as Private Non-Medical Institutions (PNMI).

Adult Family Care Home (AFCH)
AFCH serve up to five individuals. Residents of AFCH receive a greater level of care than is provided in a CRBH or RCF but less than that provided in a nursing facility. These facilities are classified as a Private Non-Medical Institutions (PNMI).

Eligibility for coverage requires that the individual:

- has a coverable group.

- meets asset criteria.

- meets income criteria

For individuals residing in a CRBH, RCF, or AFCH above it is necessary to determine the amount that the individual is expected to pay toward the cost of their care if they are found to be eligible for coverage.

SECTION 2 COVERABLE GROUPS

For all living arrangements individuals must have a Medicaid coverable group. This can be any coverable group including Non-Categorical. The individual need not be in an elderly or disability coverage group.

SECTION 3 RESIDENTIAL CARE ASSET CRITERIA

For all living arrangements, when determining eligibility for Medicaid "countable assets" are assets after exclusions (see Part 16).

For all facilities in this Part, countable assets must be under $2000 for an individual or $3000 for a couple.

Countable assets, exclusions and deductions are identified in Part 16. Apply these rules based on the coverable group the individual is in.

Transfer of asset rules found in Chapter 336 of this Manual apply to individuals residing in a CRBH, RCF, or AFCH.

SECTION 4 RESIDENTIAL CARE INCOME CRITERIA

For all living arrangements, when determining eligibility for Medicaid "countable income" is gross income minus exclusions (See Part 17) and disregards (See Part 7, Section 2.1).

Section 4.1 Adult Foster Homes (AFH)

Residents are considered to be individuals 'living with others". If a married couple resides in the facility, at the option of the couple, eligibility may be determined as a couple if either member of a couple is not eligible when treated as an individual. The countable income of each spouse is totaled. Each spouse is deemed to receive one-half of this total and each is compared to 100% FPL.

I. If countable income is under the income limit for SSI/State Supplement the individual needs to apply for SSI/State Supplement in order to get help with their costs for residing in the AFH. When eligible for SSI/State Supplement, Medicaid coverage is also provided.

   Note: Residents of "State Assisted" AFH are potentially eligible for a $49.00 State Supplement. Residents of "Private AFH" are potentially eligible for $10.00 State Supplement.

II. If countable income is equal to or over the State Supplement income limit for this living arrangement the individual is eligible for Medicaid if countable income is equal to or under 100% FPL (See Chart 6).

III. If countable income is over 100% FPL (See Chart 6) the Individual may be eligible for Medicaid under Medically Needy (See Part 10)

IV. If countable income is over 100% FPL (See Chart 6) and the individual is applying for a Home and Community Based Waiver Program (See Part 13), Medicaid eligibility is determined using the rules of that program.

Section 4.2 Flat Rate Boarding Homes (FRBH)

Residents of FRBH are considered to be individuals "living with others". If a married couple resides in the facility, at the option of the couple, eligibility may be determined as a couple if either member of a couple is not eligible when treated as an individual. The countable income of each spouse is totaled. Each spouse is deemed to receive one-half of this total and each is compared to 100% FPL (See Chart 6).

I. If countable income is under the income limit for SSI/State Supplement the individual needs to apply for SSI/State Supplement in order to get help with their costs for residing in the FRBH. When eligible for SSI/State Supplement, Medicaid coverage is also provided.

II. If countable income is equal to or over the State Supplement income limit for this living arrangement the individual is eligible for Medicaid if countable income is equal to or under 100% FPL.

III. If countable income is over 100% FPL the individual may be eligible for Medicaid under Medically Needy (See Part 10).

IV. If countable income is over 100% FPL and the individual is applying for a Home and Community Based Waiver Program, Medicaid eligibility is determined using the rules of that program (See Part 13).

Section 4.3 Cost Reimbursement Boarding Homes (CRBH), Residential Care Facilities (RCF) and Adult Family Care Homes (AFCH)

Residents of these facilities are considered to be individuals "living with others". If a married couple resides in the facility, at the option of the couple, eligibility may be determined as a couple if either member of a couple is not eligible when treated as an individual. The countable income of each spouse is totaled. Each spouse is deemed to receive one-half of this total and each is compared to the private rate for the CRBH and RCF or the income limit in Chart 3.9 for AFCH.

I. If countable income is under the income limit for SSI/State Supplement the individual needs to apply for SSI/State Supplement in order to get help with the cost of their care. When eligible for SSI/State Supplement, Medicaid coverage is also provided.

II. If countable income is equal to or over the State Supplement income limit for this living arrangement the individual is eligible for coverage if countable income is equal to or under the thirty-one day private rate for the CRBH and RCF or the income limit in Chart 3.9 for the AFCH in which they reside.

III. If countable income is over the private rate, the individual may become eligible if they meet a deductible (See Part 10 for the rules on Medically Needy).

Medical services provided by the facility are medical costs incurred by the individual. They are used before other medical expenses to determine if the individual meets the deductible. These medical services are projected over a six month period. They are identified by the Office of MaineCare Services and are assigned a daily rate (cost). The daily rate is multiplied by thirty-one days to determine the monthly amount.

IV. If countable income is over 100% FPL and the individual is applying for a Home and Community Based Waiver Program (See Part 13), Medicaid eligibility is determined using the rules of that program. The rules in this section are used to determine the cost of care. The cost of care is paid to the facility.

Section 4.3.1 Determining the Cost of Care for an Individual

I. A cost of care or assessment is determined for all individuals. The cost of care is the monthly amount the individual is expected to contribute toward the cost of his/her care in the facility.

II. The individual has a zero cost of care for the month they are admitted to the facility. There is a cost of care for the month of discharge.

III. Cost of Care for an Individual:

A. Determine gross monthly income. Total gross monthly income includes the State Supplement benefit:

1. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual's death, (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if both the election is irreversible and the reduction amount does not exceed $1,000 per month.

2. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction allowed is up to and including $1,000 per month per child.

B. From total gross monthly income, subtract:

1. Earned income disregard (See Part 7, Section 2.1),

2. Current federal, state or local income tax deductions,

An adjustment may be made if there are current federal, state or local income tax deductions from the individual's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

Examples:

- Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00 per month can be allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

- Last year $600 was the tax liability. $25.00 per month is being withheld for income tax. A deduction of $50.00 per month is allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

Note: If an individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

3. $70 (personal needs and federal disregard);

4. Medicare premium for the individual;

5. HUD Standard -The HUD Standard is a monthly subsidy given to a facility by the Department of Housing and Urban Development on behalf of residents of the facility; and

6. health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a CRBH, RCF, Nursing Facility or covered by a Home and Community Based Waiver,

Premiums must be incurred by the individual residing in the specified facility. If the health insurance is provided by the individual's spouse through his/her coverage, this is not considered to be a cost incurred by the individual who resides in a facility. It is a cost incurred by the individual's spouse.

Note: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

C. The result is the cost of care.

Note: If there is a partial month transfer of asset penalty, the individual may be responsible for an amount in addition to his or her cost of care (See Chapter 336 of this Manual).

Section 4.3.2 Determining the Cost of Care for a Couple

I. Determine gross monthly income of the couple. Total gross monthly income includes the State Supplement benefit.

A. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual's death, (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if both the election is irreversible and the reduction amount does not exceed $1,000 per month.

B. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction allowed is up to and including $1,000 per month per child.

II. From total gross monthly income, subtract:

A. Earned income disregard (Part 7, Section 2.1);

B. Current federal, state or local income tax deductions;

An adjustment may be made if there are current federal, state or local income tax deductions from the individual's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

Examples:

- Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00 per month can be allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

- Last year $600 was the tax liability. $25 per month is being withheld for income tax. A deduction of $50 per month is allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

Note: If an individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

C. $120 (personal needs and federal disregard);

D. Medicare premium for the individual;

E. HUD Standard; and

F. Health insurance premiums incurred by either or both spouses for either or both spouses.

Note: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

III. Divide the result by two. The result is the cost of care for each spouse.

Note: If there is a partial month transfer of asset penalty, the individual may be responsible for an amount in addition to his or her cost of care (See Chapter 336 of this Manual).

Section 4.3.3 Determining the Cost of Care for an Individual or Couple open on SSI.

For an individual or a couple open for an SSI benefit, the cost of care is the maximum SSI and State Supplement benefit for an individual/couple (see Chart 3.6) minus the following deductions:

I. personal needs of $50.00 for an individual/$100 for a couple;

II. Federal Disregard of $20.00 for those with income in addition to SSI/State Supplement as long as their income is not based on need (for example, VA pension does not get this disregard, but VA compensation does);

III. health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a CRBH, RCF, Nursing Facility or covered by a Home and Community Based Waiver; and

IV. the HUD Standard.

Section 4.3.4 Changes in the cost of care are made in the following situations

I. The individual paid a cost of care that was more than what was actually due. When this was due to Department error, the individual cost of care is adjusted retroactively up to one year from the date the error is discovered by the Department. When this was due to error by the individual, no adjustment is made.

II. The individual paid a cost of care that was less than what was actually due. Whether this is due to error by the Department or the individual, the individual's cost of care is adjusted retroactively up to three months from the

date the error is discovered by the Department without advance notice. This includes an adjustment for a lump sum payment.

SECTION 5 SPOUSAL LIVING ALLOWANCE (SLA)

I. A spousal living allowance can be given to the spouse of an individual who is residing in a Cost Reimbursed Boarding Home (CRBH)/Adult Family Care Home AFCH)/Residential Care Facility (RCF).

II. In this section, the term “individual” refers to the spouse residing in a CRBH, AFCH, or RCF. The term “at home spouse” refers to the spouse applying for or receiving the spousal living allowance. The “at home spouse” must be legally married under State of Maine law to the individual.

III. When an individual is getting help from Medicaid with their expenses in a CRBH, AFCH, or RCF, the at home spouse may be eligible for a spousal living allowance. This is a payment that is made directly to the at home spouse.

The living allowance starts the month of application by the at home spouse or the first full calendar month the individual is residing in a CRBH, AFCH, or RCF, whichever is later.

Example:
The at home spouse applies in 10/08 but 11/08 is the first full calendar month his/her spouse is residing in a Residential Care Facility. 11/08 is the first month of payment.

IV. An application is considered to be filed for the living allowance when:

A. the individual residing in the CRBH/AFCH/RCF files an application for help to pay for their residential care expenses or;

B. the at home spouse requests a spousal living allowance and s/he is receiving assistance through the Food Supplement Program, Medicaid, SSI or the State Supplement.

If none of the above applies, the at home spouse must file a separate application with OIAS.

Section 5. 1 Eligibility

I. Non-Financial Criteria –

A. The at home spouse must be living alone or with others (living arrangement A) or living in the household of another (living arrangement C). The spouse cannot be living in a residential care facility or medical institution. Living arrangements are further defined in Part 11, Section 5.

B. If the at home spouse is not otherwise covered by Medicaid s/he must meet the basic eligibility requirements identified in Part 2 regarding citizenship, residency and providing a Social Security Number.

C. The at home spouse does not need to meet the SSI - Related rule of being aged, blind or disabled.

II. Financial Criteria –

A. countable assets must be less than $2,000. The rules on treatment of assets are the same as the SSI - Related rules that are outlined in Part 7, Section 1 and Part 16;

B. countable income of the at home spouse must be less than 100% of the Federal Poverty Level (See Chart 6) for one; and

C. countable income is determined using the SSI - Related rules that are identified in Part 7, Section 2 and Part 17.

Section 5.2 Benefits

I. The at home spouse may be eligible for a payment of up to 100% of the Federal Poverty Level (See Chart 6) for one. There are no partial month benefits. If eligible for part of the month, then benefits will be authorized for the entire month.

A. If the at home spouse is receiving an SSI payment, the monthly living allowance for SSI recipients is the amount listed in Chart 3.11. This amount is authorized in place of the $10.00/$8.00 State Supplement and is considered a State Supplement.

B. If the at home spouse is receiving the State Supplement only (not SSI) the living allowance will be the difference between countable income and 100% of the Federal Poverty Level (See Chart 6) for one. This will be authorized in place of the $10.00/$8.00 State Supplement and is considered a State Supplement.

C. If the at home spouse is receiving Medicaid but not SSI or State Supplement, the living allowance will be the difference between the spouse's countable income and 100% of the Federal Poverty Level (See Chart 6) for one.

D. If the at home spouse is not receiving SSI, State Supplement or Medicaid, the living allowance will be the difference between the spouse's countable income and 100% of the Federal Poverty Level (See Chart 6) for one.

Example:
Mr. Komart enters a Residential Care Facility in 7/08. Mrs. Komart meets all non-financial and financial rules to receive a spousal living allowance effective 8/08. Her only income is Social Security

Retirement of $775 monthly. Her spousal living allowance is determined as follows:

Step 1		$ 775	(gross income)
	-	$ 20	(federal disregard)
	-	$ 55	(state disregard)
		$ 700	(countable income)
Step 2		$ 867	(100% FPL for one)
		-$ 700	(countable income)
		$ 167	(spousal living allowance)

II. The Spousal Living Allowance continues as long as the at home spouse is financially and otherwise eligible and as long as s/he has a spouse residing in a CRBH, AFCH, or RCF who is being helped with their expenses by Medicaid.

PART 13
HOME AND COMMUNITY-BASED WAIVER

SECTION 1 DEFINITIONS

Individuals can get Medicaid coverage and special services if they meet the medical and financial requirements of one of the following coverage groups:

I. **Home and Community Benefits for the Elderly and for Adults with Disabilities Waiver:** This is for individuals (age 18 or older) who meet nursing facility level-of-care requirements and choose to remain at home. Some of the services include: care coordination, personal support services, home health services, adult day health services, transportation, emergency response system, environmental modifications and respite services. The program rules are in Section 19 of the MaineCare Benefits Manual, (10-144 CMR Chapter 101)

II. **Community Support Benefits for Members with Mental Retardation or Autistic Disorders:** This benefit provides support services to members who most commonly live on their own or with families; there are occasionally individuals living in group homes who are also eligible. The major support services are community support and work support. This waiver does not provide any residential services. The program rules are in the MaineCare Benefits Manual, Section 29.

III. **Home and Community Benefits for the Physically Disabled Waiver**: This program is for individuals with physical disabilities who are age 18 or older. Individuals in this program choose to manage and direct their own personal care attendant. Some of the services provided are: supports brokerage functions, personal care attendant services, and the emergency response system. The program rules are in the MaineCare Benefits Manual, Section 22.

IV. **Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorder Waiver**: This waiver offers a comprehensive mix of services to members age 18 or older. The major services offered are: home support—including support to live alone or in settings with others (*i.e. group homes*), community support, and work support. The program rules are in the MaineCare Benefits Manual, Section 21.

These individuals are residing in the community, and have been classified as needing nursing facility level-of-care requirements or meeting the ICF-MR level of care.

V. **Home and Community Based Waiver Benefit for Children with Intellectual Disabilities and/or Pervasive Developmental Disorders (ID and/or PDD):** This waiver provides an alternative to institutional care to children aged five through twenty with ID and /or PDD who would otherwise require services in an ICF/MR or a psychiatric hospital. The services offered through this waiver and other program rules are specified in the MaineCare Benefits Manual, Section 32.

An individual eligible for waiver may live with family members eligible for community MaineCare. The waivered individual's income and assets are used in the eligibility determination for the remaining family members.

Example:
Mr. Clooney lives with his wife, Wendy. They meet SSI - Related criteria as a married couple. Mr. Clooney's eligibility for community MaineCare will be based on the combined income and resources of the couple, with an income limit for a household of two. Wendy's eligibility for waiver services is based on income and resources owned solely by her.

Eligibility for the Medicare buy-in is determined using community rules for a couple. Eligibility for waiver does not affect how the Medicare Buy-In is determined.

SECTION 2 COVERABLE GROUPS

Individuals applying for Waivers must have a coverable group.

SECTION 3 CLASSIFICATION

Individuals must be eligible for nursing facility, ICF-MR, or psychiatric hospital level of care, depending on the medical criteria of the specific waiver program. This determination is done by the Department of Health and Human Services or a designated agency.

SECTION 4 WAIVER ASSETS

The waivered individual's assets must not exceed the SSI - Related asset limit for an individual (See Part 7, Section 1).

Countable assets are defined in Part 16 with the following exceptions:

I. Assets of a non-waivered spouse are not deemed when determining eligibility for the spouse applying for the Waiver as of the first day of the month in which the individual is considered to be in nursing facility or ICF-MR level care status.

II. Assets that are owned jointly are considered wholly owned by the waivered individual.

III. If both eligible individuals are in a waiver status, the asset limit is $2000 for each.

IV. There is no computation of the community spouse's protected share of assets.

Section 4.1 Transfer of Assets

Transfers by the individual or their spouse may be subject to a penalty. Follow the procedures outlined in Part 15. Individuals who are Medicaid eligible under the following coverage groups are not subject to the transfer of asset penalty:

I. any Family - Related group;
II. an SSI - Related group with an income limit of 100% FPL; or
III. Non-Categorical Group.

SECTION 5 WAIVER INCOME

Income guidelines for individuals under the Waiver Programs follow the definitions in Part 17 with the following exceptions:

I. Gross income of an individual must be less than or equal to the Categorical Nursing Care limit (See Chart 4.1). If income exceeds this amount, determine eligibility using the Medically Needy process in Part 10.

II. There is no deeming of income from the non-waivered spouse.

III. If the income of the individual is being reduced due to previous overpayments by government agencies, the reduced payment amount is used.

IV. VA pensions that are Aid and Attendance or based on unusual medical expenses are not counted as income.

SECTION 6 WAIVER COST OF CARE

A cost of care is determined for any month in which eligibility exists.

Cost of care is determined by the budgeting process for that waiver and paid to the appropriate agency.

The cost of care is due for each month for which services are provided even if services are not provided for a full calendar month.

The cost of care may be adjusted without timely notice and may be adjusted retroactively (See Part 14, Section 6.2).

Individuals who are Medicaid eligible under the following coverage groups do not have a cost of care:

I. any Family - Related group;

II. an SSI - Related group with an income limit of 100% FPL; or

III. Non-Categorical Group.

Note: If there is a partial month transfer of asset penalty the individual may be responsible for an amount in addition to their cost of care (See Part 15, section 2.8).

Section 6.1 Budgeting

Note: VA pensions that are Aid and Attendance or based on unusual medical expenses are not used to determine the cost of care in the Home and Community Based Waivers.

I. Determine the individual's gross monthly income. If this figure is over the Categorical Nursing Care limit (see Chart 4.1), use the SSI-Related budget for an individual (Part 7) and the deductible process (Part 10) to determine eligibility.

Once the individual is Medicaid eligible, use the following steps to determine the individual's cost of care.

A. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual's death (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if the election is irreversible and the reduction amount does not exceed $1,000 per month.
B. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction allowed is up to and including $1,000 per month, per child.
C. An adjustment may be made if there are current federal, state or local income tax deductions from the individual's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

Examples:

1. Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00 per month can be allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

2. Last year $600 was the tax liability. $25.00 per month is being withheld for income tax. A deduction of $50.00 per month is allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

Note: If an individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

D. When a husband and wife are living together and are both covered by a Waiver, they each may have a cost of care. However, they may allocate income to each other to reduce or eliminate the cost of care.

Example:
Husband and wife are both eligible for Waiver. The husband has SSA of $1,400. The wife has SSA of $700. We allocate $350 to the wife so each will have $1,050 used in the calculation of their individual costs of care.

II. For Section 1 (I), (II), and (III) of this Part (Home and Community Benefits for the Elderly and for Adults with Disabilities Waiver, Community Support Benefits for Members with Mental Retardation, and Home and Community Benefits for the Physically Disabled Waiver), subtract 125% Federal Poverty Level for one. For Section 1 (IV) and (V) of this Part (Home and Community Benefits for Members with Intellectual Disabilities or Autistic Disorders Waiver and Home and Community Based Waiver Benefit for Children with Intellectual Disabilities and/or Pervasive Developmental Disorders [ID and/or PDD]), subtract 200% Federal Poverty Level for one. See Chart 6, Federal Poverty Levels, of this Manual. This is the Personal Needs Allowance for the individual. For the Waiver for Adults with Physical Disabilities, in addition, subtract the actual costs of the following disability-related expenses that are not payable by the waiver, the Medicaid program, or a third party payer:
   A. Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening.
   B. Communication devices: adaptations to computers for communication or environmental control, speaker telephone, teletext devices.
   C. Wheelchair (manual or power) accessories: accessories, lab tray, seats and back supports.
   D. Adaptations to transportation vehicles: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving.
   E. Hearing aids.
   F. Glasses and adapted visual aids.
   G. Environmental control units: devices that substitute for touch control such as a voice activated device to adjust lighting.
   H. Assistive animals (purchase only).
   I. Personal emergency response systems.

III. Subtract the cost of:
   A. Medicare payments for the individual.
   B. Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a CRBH, RCF, AFCH, Nursing Facility or covered by a Home and Community-Based Waiver.

Notes:
Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the non-waivered spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the non-waivered spouse.
Indemnity insurance premiums are not allowed. These are policies that pay for length of stay or a condition but not for a specific service. Third Party Liability should be contacted to assess cost effectiveness. If cost-effective, TPL will arrange for premium payment.

C. Certain Medical Expenses:
   1. Unpaid medical expenses incurred by the individual for necessary medical services. This includes payment on the unpaid balance of a loan taken out to pay for medical expenses incurred prior to Medicaid coverage provided the proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the medical bill may be deducted and only the principal (and not the interest) part of the unpaid balance may be used as a deduction.
   2. A medical expense will not be deducted from the cost of care if:
      a. the expense was covered by insurance (including Medicare).
      b. the expense was not covered due to a Medicaid penalty period of ineligibility.
      c. the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely and requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Office of Elder Services (OES).
      d. the expense is the cost of care to a medical institution or a waiver agency during periods of Medicaid coverage.
      e. the expense was for a Medicaid covered service and the individual was covered by Medicaid.
   3. Verified medical expenses are deducted from the cost of care in the month following the month in which the bills are received in the regional office.

IV. Subtract any spousal allocation. To determine this:
   A. Determine the spouse's gross monthly income, including SSI and TANF payments.
   B. Subtract the gross monthly income from the maximum spousal allowance (see Chart 4.2).
   C. The balance is the spousal allocation.

V. Subtract any dependent allocation. When an individual eligible under the Waivers has dependents living at home, an allocation may be allowed for their needs. For purposes of this section, a dependent is defined as a minor or dependent child, dependent parents, or dependent siblings of the waivered individual or non-waivered spouse. These dependents are individuals who may be claimed for tax purposes under Internal Revenue Code. To determine the allocation:
   A. determine the dependent(s) gross monthly income, including SSI and TANF payments.
   B. subtract the gross monthly income from the appropriate maximum dependent allowance (See Chart 2). The balance is the dependent allocation.

VI. The remainder is the individual's cost of care.

Example:
Don Renoir is 75 years old. He has applied for the Elderly Waiver. Assets in his name only are under $2,000. He receives Social Security and a pension totaling $1,500 per month.

His spouse, Claudette, has Social Security of $500 per month.

The 19-year old son, who is the couple's dependent, lives with them. He has zero monthly income.

$1,500.00	Mr. Renoir's gross monthly income
-1,064.00	personal needs allowance for Mr. Renoir (125% of FPL)
$ 436.00	
- 96.40	Medicare Part B premium
$ 339.60	
- 123.00	spousal allocation
$ 216.60	
- 154.00	dependent allowance
$ 62.60	Mr. Renoir's cost of care

Spousal allocation is determined as follows:

$623.00	maximum spousal allocation
-500.00	spouse's gross income
$123.00	spousal allocation

Dependent allocation is determined as follows:

$154.00	maximum dependent allowance
-0.00	income of Mr. Renoir's son
$154.00	dependent allocation

PART 14
INDIVIDUALS IN MEDICAL INSTITUTIONS

The rules in this Part are used for individuals who are institutionalized. An institutionalized individual is one who applies for or receives Medicaid and is expected to stay at least thirty days in a hospital or nursing facility.

A Community Spouse is a person who, according to Maine state law, is married to an institutionalized spouse.

A spouse living in a AFH, FRBH, CRBH, RCF, or AFCH (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (see Part 13) is considered a Community Spouse.

Eligibility for an institutionalized individual requires that the individual:

- Meets the definition of Institutionalization
- Has a coverable group
- Has a medical need classification
- Meets asset criteria
- Meets income criteria

If eligible, a cost of care will be determined based on the individuals income.

Individual who are changing from institutionalized status to community status must be given advanced notice if coverage is ending.

SECTION 1 INSTITUTIONALIZED

Institutionalization: A person is considered institutionalized when he/she resides in a hospital or nursing facility and is expected to remain for thirty consecutive days. A hospital is one that is primarily for the care and treatment of patients with disorders other than tuberculosis or mental disease.

Individuals who die prior to the end of the thirty day period are considered to be institutionalized.

Special income and asset rules are triggered for the person who is institutionalized. These special rules are effective on the first day of the month in which the thirty days of institutionalization starts.

> **Example:**
> The individual enters a hospital or nursing facility on March 20th and remains for at least thirty consecutive days. Special income and asset rules are effective March 1st.

Section 1.1 Special income and asset limits

The special income and asset limits for institutionalization are as follows:

I. Residing in a Hospital -
   A. Gross income of the individual must be equal to or less than the Categorically Needy Income Limit in Chart 4.1. If the individual's gross income exceeds the Categorically Needy Income Limit in Chart 4.1, eligibility is determined using Medically Needy rules. See Part 7.

B. Countable assets of the individual must be under $2,000. If there is a community spouse, the Community Spouse Share of Assets is determined as defined in Section 4.3 of this Part.
C. The cost of care for the individual starts in the first full calendar month residing in a hospital. If there is a community spouse, a Community Spouse Monthly Income Allowance and Income Allocation is determined, as defined in this Part.

II. Residing in a Nursing Facility or skilled section of a hospital -
A. Gross income of the individual must be less than the private rate for a semi-private room in the facility where the individual resides. If the income of the individual is over the Categorically Needy Income Limit in Chart 4.1 but under the private rate for the facility a deductible must be met (See Section 5 of this Part).
B. Countable assets of the individual must be under $2,000. If there is a community spouse, the Community Spouse Share of Assets is determined as defined in Section 4.3 of this Part.
C. The cost of care for the individual starts in the first full calendar month they reside in a nursing facility or skilled level of care. Cost of care is determined as defined in this Part.

If there is a community spouse, a Community Spouse Monthly Income Allowance and Income Allocation is determined, as defined in Section 6.1.1 of this Part.

D. If the gross income of the individual exceeds the private rate for a semi-private room in the facility where the individual resides:
1. the individual may be eligible under Medically Needy, but no nursing care costs are covered;
2. a Community Spouse Asset Allocation is given (See Section 4.3 of this Part); and
3. no cost of care is determined and as a result no Community Spouse Monthly Income Allowance is given.

SECTION 2 COVERABLE GROUPS

Individuals applying for nursing facility coverage must have a Medicaid coverable group. This can be any coverable group including Family - Related. The individual need not be in a elderly or disability coverage group.

If the individual only qualifies for a coverage group that does not pay for nursing care services the individual is not given a cost of care since nursing care services are not being paid. This includes Non-Categorical, HIV Waiver and Breast and Cervical Cancer groups (See Part 9).

SECTION 3 MEDICAL NEED CLASSIFICATION

In order for Medicaid to pay for nursing facility care the person must be in medical need of that level of care. This decision is made by the Department of Health and Human Services or its designee.

Section 3.1 Individuals ineligible due to a transfer of assets

If the individual meets the medical need criteria but is ineligible for help with long term care costs due to a transfer of assets, the Categorically Needy Income Limit in Chart 4.1 is used to determine Medicaid eligibility.

Section 3.2 Individuals who are not in need of nursing facility level of care

I. If an individual in a Nursing Facility does not meet the medical need criteria, that person may still be eligible for Medicaid coverage if the individual would be eligible if they were living in the community. Coverage is determined using the rules in Parts 6, 7 and 10 for an individual in the living arrangement, "living alone or with others". In this situation, Medicaid will not pay for nursing care costs nor can they be used toward meeting a deductible.

II. Awaiting Placement for Residential Care (DAP or APRC) . If an individual is in need of residential care but there are no beds available the individual may remain in the nursing facility as awaiting placement to a residential care facility. This coverage is for individuals converting from private pay including Medicare to Medicaid and found not in need of nursing facility level of care. MaineCare may help the individual with the cost of care if they meet eligibility criteria below.

   A. The Office of Elder Services (OES) must establish that the individual meets non-financial criteria as identified in the MaineCare Benefits Manual.
   B. The following financial criteria must be met:
      1. the asset and all non-financial criteria are the same as for an individual residing in a Residential Care Facility (RCF). See Part 13;
      2. countable income is determined using the same rules as for an individual residing in a RCF; and
      3. the individual's countable income must be less than the amount in Chart 3.8 A cost of care to be paid to the nursing facility is determined using the same rules as for an individual in a RCF. SSI and State Supplement benefits are counted when determining the cost of care.

         If countable income is equal to or over the amount in Chart 3.8, the daily rate in Chart 3.8 can be used as the cost incurred for medical expenses in determining a “spend-down” (deductible).

   C. If countable income is equal to or less than the Community Medicaid income limit for the individual’s coverable group, they can get Medicaid coverage in addition to help with the cost of room and board under APRC.
   D. If countable income is over this amount, but less then the amount in Chart 3.8, the individual is eligible for APRC only (not Medicaid).
   E. Coverage under APRC ends when:
      1. the Office of Elder Services (OES) determines the individual no longer meets the non financial criteria as identified in the MaineCare Benefits Manual; or
      2. the individual becomes financially ineligible.

SECTION 4 INSTITUTIONAL ASSET CRITERIA

Individuals must use their assets to meet their needs. Specific types and amounts may be retained by the individual and community spouse to meet current and future needs.

All available assets are to be used in determining eligibility. Countable assets are defined in Part 16. Asset limits are defined in Part 7, Section 1.

Unless exempt, a transfer of assets by the individual is subject to a penalty. Refer to Part 15 to assess if a transfer has occurred and if a penalty needs to be applied.

Countable assets of the individual must be under $2000 on any day of the month for which eligibility is determined.

Section 4.1 Long Term Care Partnership Program

Maine has established a Long Term Care Partnership Program at the direction of the 122nd Legislature. This program provides incentives to Maine's citizens to purchase long term care insurance by disregarding some assets of the person, if they must apply for financial assistance for help with their long term care needs. This program shall take effect upon notice of approval of the corresponding State Plan Amendment by the Federal Centers for Medicare and Medicaid Services (CMS).

I. Insurance Policy

A. To meet the requirements of this MaineCare program, the long term care insurance policy must be a qualified State long term care insurance partnership as certified by the Maine Bureau of Insurance. Certification requires several factors which include:

1. the policy must cover an insured who was a Maine resident when coverage became effective under the policy. If the individual has a long term care partnership policy from another state which also participates in this program and has agreed to provide reciprocal disregards for Medicaid applicants with qualified partnership plans, Maine will provide the same disregards. The individual must still otherwise qualify for MaineCare assistance as detailed in part II. and III. of this section.
2. the policy must meet the definition of a qualified long term care insurance policy in the IRS Code §7702B(b) and 26 U.S.C. §7702B(b), and must meet the Model regulations specified in 42 USC §1396p(b)5
3. the policy must have been issued or re-issued on or after the effective date of the approved State Plan Amendment,
4. the policy must meet consumer protection standards of inflation protection, and its issuers are subject to training requirements of the Bureau of Insurance (Maine Bureau of Insurance Regulations 02-031 CMR chapter 425).

B. Prior to making application for MaineCare the individual must have used the available coverage and benefits under the approved Long Term Care Policy.

II. Eligibility for MaineCare

A. All non-financial eligibility requirements as detailed in Section 1000 of this manual must be met.
B. Applicant must meet the medical qualifications for assistance.
C. Applicant's long term care insurance policy will be reviewed to determine if it meets the qualifications stated above, and to determine the extent of benefits paid so far by the terms of the policy.
D. In addition to exempting assets routinely exempted under MaineCare rules, the amount of benefits paid to or on behalf of the insured applicant will be disregarded in the eligibility determination.

III. Post-Eligibility Considerations

A. MaineCare benefits will only be paid for those expenses otherwise covered as outlined in the MaineCare Benefits Manual and for which the recipient's insurance policy has exhausted the benefits.
B. The amount of the individual's assets disregarded under the above provisions continues to be disregarded post-eligibility throughout the lifetime of the individual, even if the disregarded assets have been transferred post-eligibility.
C. If the policy benefits paid exceed the individual's assets at the time of application, additional assets up to the value of the benefits paid will be disregarded.

Section 4.2 Assets of Couples Residing in a Nursing Facility

If the total assets of a couple in the same room in a nursing facility exceed the standard for a couple, they can decide who will be the eligible spouse and assets can be transferred to the ineligible spouse. Each spouse is treated as an individual. Coverage can begin for the eligible spouse effective the month countable assets for the eligible spouse are below the standard for an individual.

If the couple reside in different rooms in the same facility or in different facilities, then each is treated as an individual when determining the asset limit. Coverage can begin for the eligible spouse effective the month countable assets for the eligible spouse are below the standard for an individual.

No spousal allowance of income or assets is determined since the ineligible spouse is not living in the community.

Section 4.3 Assets of the Institutionalized Individual with a community spouse

When an institutionalized individual has a community spouse, the couple's assets are looked at under special rules. These special rules determine how much of the couples assets are attributed to the community spouse and the institutionalized spouse. The amount attributed to the community spouse is called the Community Spouse Asset Allowance. The amount attributed to the institutionalized spouse is an available asset for the individual.

Determine the Community Spouse Asset Allowance -

I. Total all countable assets owned by the community spouse and the institutionalized spouse (his, hers, theirs) on the first day of the month of application.

II. The community spouse is allowed to keep all countable assets owned by the couple up to the amount in Chart 4.4. This is the Community Spouse Asset Allowance. Any share of the couple's assets over this amount is considered to be available to the institutionalized spouse.

    The Community Spouse Asset Allowance may be increased over the amount of Chart 4.4 if the gross monthly income of the community spouse and the Community Spouse Monthly Income Allocation is less than the Monthly Income Allowance (See Section 6.1.1 in this Part for definitions). This determination is made through the Administrative hearings process described in Section 4.4 of this Part.

III. The $8000 savings exclusion (See Part 16, Section 2.46) is applied to the amount available to the institutionalized spouse. This exclusion is not applied to the total countable assets or to the Community Spouse Asset Allowance.

IV. The result is compared to the asset limit for an individual.

The assets required to meet the Monthly Income Allowance shall be based on the Monthly Income Allowance set at the time of application.

Section 4.4 Hearing to Increase the Community Spouse Asset Allowance

Either the community spouse or institutionalized spouse may request a hearing if they have filed an application and they are dissatisfied with the determination of:

I. The Community Spouse Asset Allowance.

II. The amount of assets attributed to the institutionalized individual.

The hearing will be held within thirty days of the request.

The Department will make a determination of whether an amount greater than the Community Spouse Asset Allowance (Chart 4.4) is needed to raise the community spouse income to the Monthly Income Allowance.

If the individual agrees with the Department’s decision, a hearing is requested using the Consent Decree in Appendix F.

If the individual disagrees with the Department’s determination, s/he may request a face-to-face hearing.

A determination is made as follows on whether assets in addition to the Community Spouse Asset Allowance (Chart 4.4) are needed to meet the Monthly Income Allowance:

I. Monthly Income Allowance and the Community Spouse Income Allocation are determined according to Section 6.1.1 of this Part.

II. the community spouse’s gross monthly income and the Community Spouse Monthly Income Allocation (from the institutionalized spouse) are subtracted from the Monthly Income Allowance. This is the income deficit.

III. the Department will get two estimates of the price of a single premium lifetime annuity that will generate a payment equal to the deficit.

IV. the average of these two estimates shall be substituted for the amount of assets attributed to or protected for the community spouse when the Community Spouse Asset Allowance (Chart 4.4) is less than the averaged cost of an annuity.

    If the Community Spouse Asset Allowance in Chart 4.4 is greater than the averaged cost of the annuity, there shall be no substitution for the cost of an annuity.;

V. the spouse is not required to purchase this annuity.

Section 4.5 Transfer of Assets to the Community Spouse

Once the Community Spouse Asset Allowance has been established, the couple has twelve months to transfer the protected assets to the sole ownership of the Community Spouse.

Section 4.6 Non-Cooperation from the Community Spouse

If the community spouse does not make assets available to the institutionalized spouse, eligibility will not be denied if:

I. the institutionalized spouse has assigned to the State any rights to support from the community spouse. A referral will be made to the Third Party Liability Unit (TPL) on behalf of the institutionalized spouse who gains eligibility for nursing care assistance when deemed assets are not made available by the community spouse;

II. the institutionalized spouse is unable to execute an assignment of support due to physical or mental impairment. The State has the right to bring a support proceeding against a community spouse without an assignment under these conditions; or

III. the State determines that denial of eligibility would cause an undue hardship. The consequences of being denied Medicaid for nursing care by itself does not constitute undue hardship.

SECTION 5 INCOME CRITERIA

Individuals must use their income to meet their needs.

Gross non-excluded income is used in determining eligibility. Gross non-excluded income is defined in Part 17 with the following exception: If the income of the institutionalized spouse is being reduced due to previous overpayments by government agencies, the reduced payment amount is used.

Income exclusions used for SSI - Related categories are used to determine gross non-excluded income.

Unless exempt, a transfer of income by the individual is subject to a penalty. Refer to Part 15 to assess if a transfer has occurred and if a penalty needs to be applied.

Section 5.1 Income Ownership

The income ownership rules for purposes of this Part supersede any State laws relating to community property or the division of marital property. The rules of ownership of income are as follows:

I. Income payments made solely in the name of one spouse are available only to that respective spouse.

II. When an income payment is made in the names of both spouses, one half is considered to be available to each, unless there is documentation to the contrary.

III. If the payment of income is made in the names of the institutionalized spouse or the community spouse, or both, and to another person or persons, the income is available to each spouse in proportion to the spouse's interest. When both spouses' names are on the payment and no interest is specified, one half of the couples' interest is considered available to each spouse.

IV. Income from a trust is counted to the extent it is considered available (Part 16, Section 2.52).

Section 5.2 Income Limits

Gross non-excluded income of the individual must be less than the private rate for a semi-private room in the facility where the individual resides.

Section 5.2.1 Income below the Categorically Needy Income Limit

If an individual has income below the categorically needy income limit (see Chart 4.1). See Section 6 of this Part to determine the cost of care.

Section 5.2.2 Income equal to or over the Categorically Needy Income Limit

If an individual has income equal to or over the categorically needy income limit, but under the private rate for the facility a deductible must be met.

Depending on the gross income the deductible is always met by incurring the Medicaid rate or private rate for the facility. Specifics on which rate to use are explained below. Eligibility occurs on the first day of the month of eligibility for the six month period.

The deductible is met as follows:

A. Combine all gross unearned income.
B. Subtract the $20.00 Federal Disregard, where applicable. The remainder is the net unearned income.
C. Combine all gross earned income.
D. Subtract any remainder of the $20.00 Federal Disregard not deducted for the unearned income.
E. Subtract the earned income disregard of $65.00.
F. Divide the remaining earned income by two. The remainder is the net earned income.
G. Combine the net earned and unearned income.
H. Subtract the Protected Income Level (PIL) for one (See Chart 5).
I. Multiply this figure by six to determine the total for the deductible period. This is the individual's deductible.
J. Subtract the cost of:

1. Medicare payments of the individual.
2. Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in an AFH, FRBH, CRBH, RCF, or AFCH, (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (See Part 13).

   Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

   Note: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability should be contacted to assess cost effectiveness. If cost effective, TPL will arrange for premium payment.

3. Outstanding medical bills incurred by the individual for necessary medical services (See Part 10).

K. The balance is the remaining deductible. The deductible is met as follows:
   1. If the gross income is in excess of the Categorical Income limit (Chart 4.1) and less than the Medicaid rate, subtract the Medicaid Rate for the six month period.
   2. If the gross income is equal to or over the Medicaid rate for the facility but less than the private rate, subtract the private rate for the six month period.

SECTION 6 COST OF CARE

Institutionalized individuals are responsible for paying toward their cost of care for stays of a full calendar month. This includes those who may have paid privately for a portion of the month.

If an individual moves from one nursing facility to another the payment goes to the facility where the individual was residing on the first day of the month. If the individual moves from one facility to another on the first day of the month, the facility to which the individual moves is paid the cost of care.

If the individual was institutionalized on the first day of the month for which eligibility is being requested, the cost of care begins with that month.

If an individual was living in the community on the first day of the month for which eligibility is being requested then the first cost of care is owed for the following month.

If the individual was in acute status in a hospital for a full calendar month the individual may not owe anything for hospital costs due to payments from Medicare and/or other insurance. A cost of care is still determined. The hospital will be responsible to collect any portion that is actually owed.

When, after third party payments, the balance owed is less than the individual's cost of care, the lesser amount will be collected by the facility. This also applies when an individual is in a skilled nursing facility and covered by Medicare and QMB. A cost of care will be established. Since QMB covers the Medicare co-insurances and deductibles no cost of care will be collected until the Medicare days end.

There is no cost of care for SSI recipients in a medical institution if the Social Security Administration determines that the individual will be returning home within three months of entering the facility.

Individuals who receive SSI and whose total income is less than $60.00 (based on being in a nursing facility) have no cost of care.

The amount of an individual's cost of care may be adjusted without advance notice (See Section 6.2 of this Part).

Individuals who are no longer in a nursing facility are to be refunded their cost of care for that month by the facility. If the individual is entering a AFH, FRBH, CRBH, RCF, or AFCH (as defined in Part 12, Section1), or receiving Home and Community Based Waiver services (see Part 13). a cost of care may be owed to the new provider based on the eligibility requirements for this new program.

Section 6.1 Determining the Individual's Cost of Care

The individual's cost of care is what the individual is expected to pay towards the cost of their care at the institution. The cost of care is determined by considering the individual's income minus certain expenses and the Community Spouse Monthly Income Allocation.

For individuals who are categorically eligible, there is one determination process to follow. For those who are medically needy the determination process varies, depending on the individual's income.

For any month that an individual is considered to be institutionalized, a community spouse's income is never used in determining the cost of care, including a partial month, except in determining the Community Spouse Monthly Income Allocation.

Section 6.1.1 Determining the Community Spouse Monthly Income Allocation

At the time of application a determination is made of the Community Spouse Monthly Income Allocation.

The Community Spouse Monthly Income Allocation is the amount of income the institutionalized spouse is allowed to give to the community spouse before paying the cost of care.

Definitions:

Minimum Monthly Income Standard – This is an amount set by Federal law used in the formula to determine the Monthly Income Allowance (See Chart 4.4).

Monthly Income Allowance – This is the Minimum Income Standard plus excess shelter costs.

Monthly Excess Shelter Standard – This is an amount set by Federal law. If the community spouse has shelter costs that exceed this amount, the excess can

be used in determining the Community Spouse Monthly Income Allowance (See Chart 4.4).

Maximum Monthly Income Allocation – This is an amount set by Federal law that establishes the limit on income that can be allocated to the community spouse.

Community Spouse Monthly Income Allocation – This is the Monthly Income Allowance minus the community spouse's income.

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The Community Spouse Monthly Income Allocation is determined as follows:

I. Determine if the community spouse has excess shelter costs:

   Total the following shelter expenses for the community spouse's primary residence:
   A. rent or mortgage payment (principal and interest);
   B. taxes, homeowner's and renter's insurance payments;
   C. maintenance charges for condominiums or cooperatives; and
   D. the Standard Utility Allowance used by the State in the Food Supplement Program. The utility standard will be reduced to the extent it is included in cooperative or condominium maintenance fees (See Appendix J for the computation of the utility standard).
      1. If the countable monthly shelter expenses are less than or equal to the Monthly Excess Shelter Standard (Chart 4.4) no shelter costs are given in the allowance.
      2. If the countable monthly shelter expenses are greater than the Monthly Excess Shelter Standard, the difference is the Excess Shelter Cost.

II. Combine the excess shelter cost with the Minimum Monthly Income Standard. This figure may not exceed the Maximum Monthly Income Allocation. This is the Monthly Income Allowance.

III. Determine the gross monthly income of the community spouse including TANF/SSI payments. Include income actually generated from the Community Spouse Asset Allocation.

IV. Subtract gross monthly income from the Monthly Income Allowance amount in II. above. (If the gross monthly income of the community spouse is equal to or greater than the Monthly Income Allowance, no income allocation is made from the institutionalized spouse).

V. The balance is the Community Spouse Monthly Income Allocation. This income is allocated from the institutionalized spouse to the community spouse.

The Monthly Income Allowance must not exceed the Maximum Monthly Income Allocation (See Chart 4.4).

This allocation can only be increased by:

I. a court order specifying a higher amount, or

II. an administrative hearing that establishes that the community spouse needs income above the Minimum Monthly Income Allowance due to exceptional financial circumstances.

Examples:

1. Excess Shelter	$ 547
Minimum Monthly Income Standard	+ $1839
Monthly Income Allowance	$2386
Community Spouse Gross Income	- $ 500
Community Spouse Monthly Income Allocation	$1886

2. Excess shelter	$1098
Minimum Income Standard	+ $1839
Monthly Income Allowance	$2937

The Monthly Income Allowance exceeds the cap set by the Maximum Monthly Income Allocation. This limits the Allowance to the Maximum Monthly Income Allocation.

Maximum Monthly Income Allocation (Chart 4.4)	$2841
Minus Community Spouse gross income	- $ 700
Community Spouse Monthly Income Allocation	$2141

Section 6.1.2 Administrative Hearing Process for Income

The community spouse or institutionalized spouse may request an administrative hearing if they have filed an application and they are dissatisfied with the determination of:

I. the Monthly Income Allowance;

II. the Community Spouse Monthly Income Allocation; and/or

III. the excess shelter cost.

Either spouse may request a revision of the Monthly Income Allowance if they can establish a need, due to exceptional circumstances, which would create a financial hardship if more funds were not made available. This may occur either through the hearing process or a court order. The circumstances that caused the request are subject to departmental review yearly to determine if continued receipt of the increased allowance is warranted.

If either spouse establishes that the community spouse needs income above the level otherwise provided by the Monthly Income Allowance, due to exceptional circumstances resulting in significant financial duress, there shall be supplemented to the Monthly Income Allowance, an amount adequate to provide such additional income as is necessary. “Financial duress” is defined as the inability of the community spouse to meet current monthly household and/or medical expenses. “Such additional income as is necessary” is defined as the amount by which the community spouse’s actual and necessary household and/or medical expenses exceed the Monthly Income Allowance.

In order to establish exceptional circumstances resulting in significant financial duress, either spouse must establish that the community spouse has made use of resources and income to meet current monthly household and medical expenses, and that he or she has no other ability to meet those expenses. Exceptional circumstances will not be deemed to exist where application of the Monthly Income Allowance results in a change or inconvenience to the lifestyle of the community spouse if necessary monthly household and medical expenses can nevertheless be met.

Once an application has been filed, either spouse may request an administrative hearing to increase the Community Spouse Asset Allowance (see Section 4.2 of this Part) if the community spouse's monthly income does not meet the Monthly Income Allowance. The additional assets are requested so that they will generate income and raise the community spouse's total available income to meet the Monthly Income Allowance. The additional allocation of assets to the community spouse may be revised as of the month of application. The Community Spouse Asset Allowance may not be revised prior to that month.

Section 6.1.3 Dependent Allocation

When an institutionalized individual has dependents living at home, an allocation may be allowed for their needs. The method of determining the allocation amount depends on whether there is a community spouse.

For purposes of this section, a dependent is defined as a minor or dependent child, dependent parent(s), or dependent sibling(s) of the institutionalized individual or community spouse, who are residing with the community spouse. These dependents are individuals who may be claimed by the institutionalized or community spouse for tax purposes under Internal Revenue Code.

I. Dependent Allocation with a Community Spouse -

To determine the allocation:

A. Determine the gross monthly income of each dependent member including SSI, TANF, and adoption assistance payments. Assets are considered only to the extent of interest or dividend income being generated.
B. Compare the gross income of each individual to the Minimum Monthly Income Standard. (See Chart 4.4)

If the gross monthly income is equal to or greater than the Standard, no allocation is made.

If the gross monthly income is less than the Minimum Monthly Income Standard, subtract the income from the Standard. Divide the remainder by three. The resulting figure is the allocation for each dependent.

II. Dependent Allocation Without a Community Spouse –

To determine the allocation:

A. determine the gross monthly income of all dependents living together including SSI, TANF and Adoption Assistance payments. Assets are considered only to the extent of income being generated by the assets.

B. compare the gross income of all dependents living together to the Full Need Standard in Chart 2 for the appropriate unit size. For example, three dependents would use the unit size of three.

If gross monthly income is equal to or greater than the standard, no allocation is made.

If gross monthly income is less than the standard, subtract the income from the standard. The resulting figure is the allocation to the dependents.

Section 6.1.4 Calculating Cost of Care for Individuals below the Categorical Income Limit

I. Determine the individual's gross monthly income.
   A. If the individual has elected an option under his or her retirement plan that results in a reduced benefit to the individual in exchange for a continued benefit to the spouse upon the individual's death (e.g. a joint and survivor annuity option), then that reduced amount will be considered to be gross income. However, the reduced amount may be used only if the election is irreversible and the reduction amount does not exceed $1,000 per month.
   B. If income is garnished due to a court order for child support the reduced amount of the income is used. The maximum reduction is $1000/child/month.

II. An adjustment may be made if there are current federal, state or local income tax deductions from the individual's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed.

Examples:

1. Last year $600 was the tax liability. $80.00 per month is withheld for income tax. Only $50.00 per month can be allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

2. Last year $600 was the tax liability. $25.00 per month is being withheld for income tax. A deduction of $50.00 per month is allowed as a deduction as this is the current tax liability ($600 ÷ 12 = $50.00).

Note: If an institutionalized individual is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

III. Subtract the appropriate personal needs allowance. This is:
   A. $40.00 per month, or
   B. $130.00 for the following individuals:
      1. those receiving the reduced VA pension of $90.00 who are not in a VA facility, or
      2. those in VA nursing facilities who receive a VA pension and are single with no dependents or are the surviving spouse with no dependents

C. up to the maximum dependent allowance (Chart 4.2) for an individual who participates in a sheltered workshop. To determine the actual amount:
   1. Subtract $40.00 from any unearned income.
   2. Subtract any remainder of the $40.00 from earned income.
   3. Subtract $50.00 from any remaining earnings.
   4. Subtract one-half of any remaining earnings.

   The deductions of $40.00 and $50.00 and the one-half remainder figure are added together. This figure is the personal needs allowance. This figure may not exceed the maximum dependent allowance (Chart 4.2).

IV. Subtract the cost of:
   A. Medicare payments for the individual.
   B. Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a RCF, CRBH, Nursing Facility, or covered by a Home and Community Based Waiver.

      Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

      Note: Indemnity insurance premiums are not deducted. They are policies that pay for lengths of stay or for a condition and not for specific services. Third Party Liability (TPL) should be contacted to assess cost effectiveness. If cost effective, TPL will arrange for premium payment.

   C. Certain Medical expenses:
      1. Paid or unpaid medical expenses incurred by a Medicaid covered individual, while residing in the facility, for necessary medical services as long as:
         a. the service is not covered in the per diem rate of the facility as determined by the MaineCare Benefits Manual.
         b. the service is not one the facility is expected to provide. The facility is expected to provide services contained in a written order or plan of care established by the individual's physician.
      2. A medical expense will not be deducted from the cost of care if:
         a. the expense was covered by insurance (including Medicare).
         b. the expense was not covered due to a Medicaid penalty period of ineligibility.
         c. the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Office of Elder Services (OES).

d. the expense is the unpaid cost of care to a medical institution or a waiver agency during periods of Medicaid coverage.
e. the expense was for a Medicaid covered service and the individual was covered by Medicaid.

V. Subtract any spouse's and/or dependent's allocation. These figures are determined in Section 6.1.1 or 6.1.3 of this Part.

VI. The remainder is the individual's cost of care.

Note: If there is a partial month transfer of asset penalty the individual may be responsible for an amount in addition to their cost of care (See Part 15, Section1.8).

Example:
John enters the hospital on 2/17 from home. He moves to a nursing facility on 2/27. He is married and his wife Joan continues to live in their apartment. They have a $13,500 certificate of deposit from which they receive the interest monthly. They also have a checking account with a balance of $738.29. John receives Social Security benefits of $729.50 and Joan receives $529.80. The subsidized rent is $550.00 monthly, including heat and lights.

Income Allocation

Joan's income		John's income	
$529.80	Social Security	$729.50	Social Security
+ 65.26	interest income		
$595.06			

$550.00	Rent
+ 24.00	Telephone
$574.00	
-552.00	(30% of $1839 – Chart 4.4))
$ 22.00	Excess shelter

+1839.00	Minimum Monthly Income Standard (Chart 4.4)
$1861.00	($2841 maximum – Chart 4.4)
- 595.06	Joan's income
$1265.94	Income allocation to community spouse

Cost of Care

$729.50	John's income
- 40.00	personal needs
$689.50	
- 99.90	Medicare premium (Appendix C)
$589.60	
-1265.94	Income allocation to community spouse
0.00	Cost of care

Section 6.1.5 Calculating the Cost of Care for Individuals with Income Equal to or Over the Categorical Income Limit and less than the Private Rate

An individual is not expected to pay more than the Medicaid rate of the facility for a cost of care.

If the individual's gross income is over the Categorical Income limit but under the Private rate of the facility, multiply the daily Medicaid rate of the facility by thirty-one days. Compare the cost of care as calculated in Section 6.1.4 of this Part to the thirty-one day Medicaid rate. The individual is responsible to pay the lesser of the two amounts, either the cost of care or the Medicaid rate.

Example:
Dick Reel entered a nursing facility on 1/17/08, from home. Dick receives $2972 in Civil Services benefits, $798 in Social Security benefits and a pension of $1800 monthly. The private rate is $200 per day and the Medicaid rate is $100 per day.

Income

$2972.00	Civil Service
$ 798.00	Social Security
$ 1800.00	Pension
$5570.00	Total

Deductible (See Section 5.2 of this Part)

$ 5570.00	Dick's gross income
- 20.00	Federal disregard
$ 5550.00	
- 315.00	PIL (1)
$ 5235.00	
X 6	Deductible period
$ 31410.00	Deductible
- 578.40	Medicare premiums
$ 30831.60	
18600.00	Medicaid rate for 6 months
$ 12231.60	

Because there is a remaining deductible use the Private rate instead of the Medicaid rate for 6 months.

$ 30,831.60	
- $ 37,200.00	Private rate for 6 months
0.00	Remaining deductible

Cost of Care

$ 5570.00	Dick's gross income
- 40.00	Personal needs
$ 5530.00	
- 96.40	Medicare premium
$5433.60	Cost of Care

Dick’s cost of care will be $3100 monthly. This is the Medicaid rate for the facility and it is less than the cost of care calculated using the rules in section 6.1.4.

Section 6.2 Changes in the Cost of Care

I. The individual paid a cost of care that was more than what was actually due. When this was due to Department error, the individual cost of care is

adjusted retroactively up to one year from the date the error is discovered by the Department. When this was due to error by the individual, no adjustment is made.

II. The individual paid a cost of care that was less than what was actually due. Whether this is due to error by the Department or the individual, the individual's cost of care is adjusted retroactively up to three months from the date the error is discovered by the Department without advance notice. This includes an adjustment for a lump sum payment (see Section 6.4 of this Part).

Section 6.3 Non-Covered Medical Expenses

Verified medical expenses that can be deducted from the cost of care are deducted for the month following the month the bills are received in the office.

For individuals who die and had incurred non-covered medical expenses, the last cost of care can be adjusted for the month in which they die.

Individuals who only receive $40.00 per month SSI and have a $0 cost of care are not reimbursed for non-covered medical expenses.

Example:
Jack Snow purchases two bottles of Tylenol at $11.49 each and two hearing aide batteries at $10.00 each. Receipts are submitted on 3/5. Gross Social Security is $891.80.

Cost of Care

$891.50	Gross Social Security
- 40.00	Personal needs
- 96.40	Medicare premium
- 20.00	Uncovered medical expenses (see note below)
$735.10	Cost of care

Note: Cannot allow Tylenol - (generic brand for Tylenol is supplied by the facility. If Tylenol is prescribed by a physician and included in the plan of care, it is supplied by the facility and the cost is not allowed as an uncovered medical expense).

Section 6.4 Lump Sums

All lump sum payments, with the exception of SSI, are treated as income in the month received.

Any portion of a lump sum remaining the following month is an asset. Social Security and SSI retroactive payments are an excluded asset for nine months.

Section 6.5 Medicare Buy-In for Institutionalized Individuals

Medicare Buy-In is determined the same as for those who live in the community. See Part 8 for a description of the Buy-In programs.

If a couple is residing in the same room they are considered to be living together. If they are residing in separate rooms they are considered to be living apart.

Aid and Attendance is not used in this process.

PART 15
TRANSFER OF ASSETS

SECTION 1 TRANSFER OF ASSETS FOR INSTITUTIONALIZED INDIVIDUALS

When an individual disposes of assets for less than fair market value on or after the look back period they may have to serve a penalty period before coverage can begin for institutional level of care services. The services are:

- Nursing facility services
- Nursing facility services in a medical institution
- Home and Community Based Waiver Services

The individual may be eligible for all other Medicaid services.

Section 1.1 Definition of the look back period

For transfers taking place before 2/8/06 the look back period is thirty-six months prior to the month in which the individual is institutionalized and applies for Medicaid.

For transfers taking place on or after 2/8/06 the look back period is sixty months prior to the month in which the individual is institutionalized and applies for Medicaid.

If the individual has had multiple periods of institutionalization and/or applications, the look back period starts with the first date on which the individual was institutionalized and applied for Medicaid.

Section 1.2 Definition of "Individual"

In establishing whether a transfer of assets has taken place, the term "individual" includes the individual him/herself as well as:

I. the individual's spouse; or

II. a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse or with legal authority to act in place of or on behalf of the individual or the individual's spouse.

Section 1.3 Definition of Assets Subject to Transfer

For transfer purposes, an asset includes all income and resources of the individual and the individual's spouse. This includes any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action or lack of action by the individual as defined above, including but not limited to renouncing an inheritance or failing to exercise a spousal share in a challenge to a will.

To determine the effect that the transfer has on eligibility, several questions must be answered:

I. What was transferred?

II. Who was the transfer made to?

III. When was the transfer made?

IV. What did the individual or couple receive in exchange?

V. Why was the transfer made?

Section 1.4 Exempt Transfers

The following may be transferred without penalty:

I. The home, if it is transferred to:
   A. a child who is under age 21 or who does or would meet SSI criteria of total and permanent disability or blindness;
   B. a sibling who has an equity interest in the home and was residing in the home for at least one year prior to the individual going to the medical institution.

      Example:
      A brother and sister have joint ownership of a home in which they both lived for the last five years prior to the brother going into a nursing facility. The brother may transfer his interest in the home to his sister without penalty.

      A penalty would be established if:
      1. the sister was not a joint owner or had no equity interest in the home, or
      2. the sister had not lived in the home one year prior to the institutionalization of her brother.

   C. a child over age 21 who does not meet the SSI criteria of blindness or disability if the child was residing in the home for at least two years prior to the individual's entering the medical institution and was providing care which enabled the institutionalized individual to live at home rather than a medical institution for this time; or
   D. a spouse.

II. Any asset transferred to the individual's child who does or would meet SSI criteria of total and permanent disability or blindness. This exemption also applies to the transfer of assets by the individual or the individual's spouse to a trust established solely for the benefit of the individual's child who does or would meet the SSI criteria total and permanent disability or blindness.

III. Assets transferred to a trust established solely for the benefit of an individual under 65 years of age who does or would meet the SSI criteria of total and permanent disability.

IV. Assets which the owner intended to dispose of at fair market value or for other valuable consideration but, without being at fault, the owner did not obtain full fair market value.

V. Assets transferred exclusively for a purpose other than to qualify for Medicaid either at the time of the transfer or at some future date. "Exclusively" means, transferred for that reason only and solely. It is not enough to prove that there was a reason to transfer in addition to gaining Medicaid eligibility. The reason for transferring must be exclusive of gaining Medicaid eligibility.

VI. Assets transferred for less than fair market value once all the assets have been returned to the individual. There is no penalty as of the month in which all the assets are returned to the individual. When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. A penalty remains in effect for the past time period during which the asset had been transferred.

VII. Assets transferred to (or for the sole benefit of) the spouse.

VIII. Assets transferred thirty-six months (sixty months for assets transferred on or after 2/8/06) prior to the month in which the individual is institutionalized and applies for Medicaid. When a transfer involved assets of a trust, the look back period is thirty-six or sixty months (sixty months for all types of trusts after 2/8/06) depending on the type of trust involved (See Part 16, Section 2.52).

IX. Assets transferred for Fair Market value.

X. Irregular or infrequent gifts provided the cumulative amount of the gifts do not exceed $500 per calendar quarter. Each gift is analyzed separately. This provision does not mean that the first $500 per quarter is excluded when the cumulative amount of those gifts is more than $500.

A transfer is considered to be for the "sole benefit of" a spouse, blind or disabled child or disabled individual when no individual or entity except the spouse, blind or disabled child or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any other time in the future.

Section 1.5 Fair Market Value

A transfer for fair market value incurs no penalty. Fair market value may be received in cash by the individual.

Fair Market Value is an amount that can be expected to be received for selling a similar article on the open market in the geographic area involved.

The compensation received for the asset must be in a tangible form with intrinsic value that is equivalent to or greater than the value of the transferred asset. A transfer for love and consideration is not a transfer for fair market value.

Fair market value may be received by the individual in the form of payment of the individual's past medical expenses and debts if measurable and verified. Fair market value must be received by the individual and not delivered at a future date.

Fair market value may also be received in the form of past support for basic necessities if such support is measurable and verified. A reasonable value must be placed on the support provided and the specific time period must be substantiated for which it was given.

Past support for basic necessities does not include any items given as a gift or any services provided by relatives. Past support for basic necessities may include clothing, transportation or personal care provided by a relative only if this clothing, transportation or personal services were provided as part of a legally written enforceable agreement whereby the individual would transfer the asset in payment

for clothes, transportation or personal services once those services have been received.

An Individual may only transfer assets for services provided by a relative if the transfer takes place at the time the service is rendered and:

I. the services must be performed after a written agreement has been executed between the applicant and provider. Other provisions stated above continue to apply.

II. at the time of the receipt of the services, the applicant may not be residing in a nursing facility or a CRBH, AFCH, or RCF.

III. at the time of the receipt of the services, the services must have been recommended in writing and signed by the applicant's physician, as necessary to prevent the transfer of the applicant to residential care or nursing facility care. Such services may not include the mere providing of companionship.

IV. at the time of application, the Department will verify the agreement by reviewing the written contract between the applicant and the provider / relative which must show the type, frequency and duration of the services being provided to the applicant and the amount of consideration (money or property) being received by the provider / relative. If the amount paid for the services is above the fair market value of the services at the time the services were delivered, then the applicant will be considered to have transferred the assets for less than fair market value. If in question, fair market value of the services may be determined by consultation with an area business which provides such services.

Section 1.6 Disproving the Presumed Transfer

Any transfer taking place will be presumed to have been made for the purpose of becoming or remaining eligible for Medicaid, unless the individual furnishes clear and convincing evidence that the transaction was for some other purpose and that there was no intent at the time to apply for Medicaid within the foreseeable future. It is the Department's responsibility to demonstrate that a transfer took place and to establish the date of the transfer. It is the individual's responsibility to prove that the transfer took place for reasons other than to gain eligibility for Medicaid.

If the individual wants to disprove the presumption that the transfer was made to establish Medicaid eligibility, the burden of proof rests with the individual. The individual must demonstrate that the transfer was specifically and solely for some other purpose than to receive Medicaid. Statements and evidence to disprove the transfer must be contained in the individual's record.

The statement should cover, but not necessarily be limited to the individual's:

I. purpose for transferring the asset;

II. attempts to dispose of the asset for fair market value;

III. reasons for accepting less than the fair market value for the asset;

IV. plans for and ability to provide financial support after the transfer;

V. relationship, if any, to the persons to whom the asset was transferred; and

VI. belief that the fair market value was received.

In addition to the individual having to prove that the transfer was made specifically and solely for a purpose other than to be Medicaid eligible, other factors to be considered include:

I. a sudden onset of a disability or blindness after the asset was transferred;

II. the diagnosis of a previously undetected disabling condition after the transfer occurred;

III. unexpected loss of other assets following the transfer;

IV. unexpected loss of income after the transfer occurs; and

V. court ordered transfers.

Section 1.7 Establishing Date and Value of a Transfer

This will depend on the type of asset transferred.

I. For assets other than bank accounts a transfer of assets occurs when:
   A. title (ownership) or legal interest to property has passed from the individual to another individual. For example: Sole ownership of a home valued at $100,000 is transferred to another. The value of the transfer is $100,000.
   B. the individual establishes a joint ownership, tenancy in common, joint tenancy or other similar arrangement, such as adding a name to stocks, bonds, or real property. In addition to legally transferring part ownership, the individual has taken action which reduced or eliminated their ownership or control of the remainder of the asset. The date of the transfer is the date that the joint ownership was established. The amount of the transfer is the total uncompensated value of the asset. For example: In 10/05 the individual establishes joint ownership of their home valued at $100,000. The value of the transfer is $100,000. The date of the transfer is 10/05.
   C. the asset is converted from an accessible to an inaccessible asset. An example is when assets are placed in an irrevocable trust.
   D. the individual takes action to refuse the receipt of assets.
   E. unless otherwise exempt, when real property is sold and the individual holds a promissory note, a transfer of assets must be assessed as follows:
      1. if the individual sold property for less than fair market value (see Section 1.5 of this Part), a transfer of assets has occurred amounting to the difference between the sale price (the presumed value of the note) and the value of the property. To determine the sale price the presumed value of the note is used.

2. if the current value of the note is less than the presumed value, the difference between the two amounts is a transfer of assets.

The total amount of assets transferred due to (1) and (2) above incurs a penalty, and the date of the transfer is the date the real property is sold.

F. As of 2/8/06, funds used to purchase a promissory note, loan or mortgage can be considered a transfer of assets unless the note, loan or mortgage**:**
   1. has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Social Security Administration, found online at: http://www.ssa.gov/OACT/STATS/table4c6.html).
   2. provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
   3. prohibits the cancellation of the balance upon death of the lender.

   If the conditions in 1, 2, and 3 above are not met, the value of the transfer is the outstanding balance due on the note, loan or mortgage as of the date of the individual's application for Medicaid.

G. The individual transfers ownership in real property and retains a life estate. In order to determine the value of the transfer penalty refer to Appendix E – Life Estate and Remainder Interest Table. Using the age of the individual at the time of transfer, find the amount in the column of Chart, "Remainder", and multiply it by the fair market value of the property at the time of the transfer. This is the value of the transfer.

H. The individual transfers a life estate interest in real property. In order to determine the value of the transfer penalty refer to Appendix E – Life Estate and Remainder Interest Table. Using the age of the individual at the time of transfer, find the amount in the column, "Life Estate" and multiply it by the fair market value of the property at the time of the transfer. This is the value of the transfer.

I. Purchase of a life estate after 2/8/06. The money used to purchase a life estate interest in another individual's home is considered a transfer of assets, unless the applicant resides in the other individual's home for at least one full and consecutive year beginning on the date of purchase. The value of the life estate must still be calculated in order to determine if the applicant received fair market value for the purchase, regardless of how long the applicant lived in the home. If the applicant paid more than the life estate is worth, then the difference is a transfer for less than fair market value and is subject to a penalty.

II. With bank accounts, a transfer of funds in an account is determined to take place when:
   A. funds, owned by the individual (see Part 16, Section 2.5), are withdrawn by the other joint owner(s) from an account and used for other than the sole benefit of the individual; or

B. another person's name is added to the individual's account, the money in the account is owned by the individual, and the intent of the individual in giving access is to convey ownership of those funds. Intent to convey ownership must be documented with a clearly written statement of intent to transfer the funds in the account to the joint owner. This statement must be:
   1. duly executed in the presence of the notary public; and
   2. signed by the individual at the time the account was made joint or within a reasonable period of time, usually one week but maybe longer due to circumstances beyond the control of the client.

   Note: Evidence of an intent to transfer the funds in the account at the time that the name was added to the account will be rebutted by evidence that the individual continued to use the funds.

Section 1.8 Establishing a Penalty

Once it has been determined that a transfer of assets has occurred for less than fair market value, the penalty period must be determined.

When a penalty is imposed, it is only the long term care services that cannot be paid. The individual may be eligible for all other MaineCare services.

I. The penalty period is determined as follows:
   A. Determine the date that each transfer occurred.
   B. Determine the amount of the transfer.
   C. Divide the amount of the transfer by the average monthly private rate for a semiprivate room for a nursing facility at the time of application (see Chart 4.3). This determines the number of whole months of ineligibility based on the transfer.
   D. For transfers occurring prior to 2/8/06: Any remaining fraction is to be disregarded.
   E. For transfers occurring on or after 2/8/06: When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility in Chart 4.3, or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:
      1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.
      2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.
      3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period.

         Example:
         If the monthly private rate is $6,000 and the transfer amount is $56,400, this would result in a transfer penalty of 9.4 months. To determine the remainder amount, you would take $6,000 X 9 months = $54,000. $56,400 minus $54,000

= $2,400. You would add $2,400 to the cost of care for one month. If the penalty period begins March 1st, it would end November 30th $2,400 would be added to the cost of care for December.

In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

Example:
Individual enters nursing facility November 27th. There is a partial month transfer penalty of $3000. The first month a cost of care is due is December. The $3000 partial month transfer penalty will be added to the December cost of care.

II. If there has been more than one transfer in the same month, the penalty period is determined as follows:
   A. Determining the total, cumulative, value of all transfers in the same month.
   B. Divide the amount by the average monthly private rate for a semiprivate room for a nursing facility at the time of application (see Chart 4.3). This determines the number of whole months of ineligibility.
   C. For transfers occurring prior to 2/8/06: Any remaining fraction is to be disregarded.
   D. For transfers occurring on or after 2/8/06: When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility in Chart 4.3, or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:
      1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.
      2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.
      3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period. In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

III. If there have been multiple transfers occurring on or after 2/8/06 in more than one month during the look-back period, all transfers can be added together into one penalty period using the following method:
   A. Accumulate all transfers.
   B. Divide the amount by the average monthly private rate at the time of application for a semiprivate rate for a nursing facility (See Chart 4.3). This determines the number of whole months of ineligibility.
   C. The transfer is treated as one transfer and is treated as if it occurred on the earliest date of the multiple transfers.

D. When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility in Chart 4.3, or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:
   1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.
   2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.
   3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period. In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

IV. For transfers occurring prior to 2/8/06, the penalty period begins with the month in which the transfer for less than fair market value occurred. If a penalty is already in effect for that month, the penalty period will begin with the next non-penalty month.

The penalty period for transfers made on or after 2/8/06 begins with the later of:

A. the first day of a month in which the transfer for less than fair market value occurred; or
B. the first day of the month the individual is eligible for Medicaid and would otherwise be receiving help with the cost of long term care services based on an approved MaineCare application were it not for the Department imposing an asset transfer penalty period; and
C. the first day which does not occur during any other period of ineligibility.

V. At the time both spouses become institutionalized, have applied for and are otherwise eligible for MaineCare and there is a penalty period in effect for either spouse, the remaining penalty period can be divided between the spouses into any combination of full months. Whether there is a division of the penalty and, if so, how it will be divided, is a decision of the spouses.

When, for some reason, one spouse is no longer subject to a penalty (for example, no longer lives in a nursing facility or dies), the remaining period applicable to both spouses must be served by the remaining spouse.

Section 1.9 Hardship Waiver

The individual applying for help with the cost of nursing facility services or home and community based waiver services may be able to get the period of ineligibility waived if they can show that the transfer penalty places them in an undue hardship situation. It is the responsibility of the individual to prove the claim of undue hardship.

I. Determine if undue hardship exists. An undue hardship exists if this denial would:
   A. deprive the individual of medical care such that the individual's health or life would be threatened; or
   B. deprive the individual of food, clothing, shelter, or other needs of life.

II. Determine whether to waive the penalty when undue hardship exists. The penalty can be waived if:
   A. the individual was exploited as assessed by the Office of Elder Services; or
   B. the individual can prove all of the following:
      1. Neither the individual nor the spouse have the means to pay for the cost of nursing facility or home and community based waiver services, taking into consideration all exempt and non-exempt income and assets.
      2. The recipient of the transferred asset is unable or unwilling to make the value of the transfer or any part of it available to pay for the individual's cost of nursing facility or home and community based waiver services.
      3. The individual has made all reasonable efforts to recover the transferred asset or its equivalent value. The individual must cooperate with the Department in any recovery activity that is undertaken.
      4. The individual must agree in writing that if the transferred assets or equivalent value are recovered, the individual will reimburse Medicaid for funds expended as a result of the approved claim of undue hardship.

III. The result of being denied Medicaid for nursing facility services or home and community based waiver services, by itself, is not considered undue hardship.

IV. The Department will use the following process for undue hardship determinations:
   A. All denials/closures due to a transfer of assets will include a written notice that an "undue hardship" provision exists and can be considered according to the criteria indicated above if the applicant/recipient requests it.
   B. A claim of undue hardship must be made no later than thirty days from the date of the denial/closure notice. With the individual's written permission, an authorized representative or the facility in which the individual resides can claim undue hardship on the individual's behalf.
   C. A decision on a claim of undue hardship will be made and the applicant notified in writing within thirty days of the claim being made.
   D. An appeal from any adverse action including a denial of a claim of undue hardship must be made within thirty days of the notice of denial. Applicants/recipients will be given written notice of this right to a hearing.
   E. In II. B.1. above, the Department will not use income and assets provided to the community spouse to prevent impoverishment in determining whether the individual or the spouse have the means to pay the cost of long term care services in the facility.

(Part 15, Section 2, Parts 2.1 through 2.9 are deleted)

PART 16
ASSETS

Assets: Cash, other liquid resources or real or personal property.

Liquid assets: Cash or other resources that can be converted into cash on demand.

Non-liquid assets: Real or personal property that cannot be converted into cash on demand.

Equity Value: The fair market value of real or personal property minus any encumbrances. Examples of encumbrances are: mortgages, liens, and other debts on or attached to the property.

Fair market value: Amount that can be expected to be received for selling a similar article on the open market in the geographic area involved. The individual may refute the fair market value determined by the Department by providing statements from two credible sources.

Any asset which has no saleable value will not be used in determining eligibility because it has no equity value.

Examples:

- Homes that, due to structural damage, and their location on leased property, have no resale value.
- Vacant property not large enough to be sold due to changes in zoning laws.
- Vehicles, which cannot be sold due to mechanical or other problems.

Ownership: Power, authority or title to sell, exchange, convert or redeem any property. Property in the name of a child is available to both child and parent, as the parent can make it available.

Available asset: An asset that has a value which is legally obtainable by the individual. If there is a penalty for early or late withdrawal to get the asset, the available asset is the amount after the penalty is taken.

Unavailable asset: An asset that has a value which is legally unobtainable to the individual.

Real Estate and other Non-Liquid Assets:
In determining the value of this countable asset, the type of ownership must be established.

If the owners have "joint tenancy", each owner has an equal interest in the total value of the property.

If the owners are "tenants in common", each owner has a share in the property. Generally, each owner can sell that share without the consent of the other owners. If the terms of ownership prohibit sale of one owner's portion or the other owner(s) refuses to agree to sell, the real estate is excluded.

SECTION 1 USE OF ASSETS

Individuals must use their assets to meet their needs before MaineCare will be available. Specific types and amounts may be retained to meet current and future needs. See explanation of specific assets that follow.

If assets are potentially available, applicants, recipients or others acting on their behalf must take action to make them available.

All available assets are to be used in determining eligibility.

Unavailable assets are not to be used in determining eligibility.

SECTION 2 TREATMENT OF ASSETS

Unless specifically indicated as excluded or unavailable, all assets are counted toward the appropriate limit (See Part 4, Section 1 and Part 7, Section 1) whether listed here or not. The following is a list of assets that include the most common types.

For the purpose of this Part, Family - Related categories refer to Part 3 and SSI - Related categories refer to Parts 6, 9 and 11, 12, 13, and 14.

Section 2.1 Agent Orange - *excluded for all categories*
All Agent Orange settlements as provided for under PL 100- 687 and 101-201 are excluded.

Section 2.2 Alaskan Native Claims - *excluded for all categories*
The tax-exempt portions of payments made pursuant to PL 92-203, the Alaskan Native Claims Settlement Act are excluded.

Section 2.3 Annuities - *partially excluded for all categories*

I. <u>Policy applicable to all MaineCare including residential care and long term care</u>
An annuity is an investment on which an individual receives fixed payments for a lifetime or a specified period of time. The annuity may be purchased by the individual or a third party. If the annuity is purchased by other than the individual, the payments are counted as income. There is no countable resource nor is there a transfer of assets.

A. Definitions -
1. Deferred annuity -- this is an annuity under which the benefit payment will begin at some future date. The individual has not yet selected a payment option (life only, ten year period certain, etc.)
2. Annuitized -- this is an annuity under which the individual is receiving a benefit payment under a payment option (life only, ten year certain, etc.) which they have selected.

B. Annuities purchased before 2/8/06
1. The current cash value of the annuity available to the individual, including the principal and interest earned on the principal, minus any penalty fees for withdrawal, is a countable resource.

2. Payments from annuities are considered income to the individual for whom the payments are designated.

C. Annuities Purchased on or after 2/8/06
1. Payments from annuities are considered income to the individual for whom the payments are designated.
2. The current cash value of the annuity available to the individual including the principal and interest earned on the principal minus any penalty fees for withdrawal is a countable resource.

II. Policy applicable to long term care -
Applicants for and recipients of Medicaid long term care or residential care coverage must disclose a description of any interest the individual or community spouse has in an annuity regardless of whether the annuity is irrevocable or is treated as an asset. This must be disclosed at the time of initial application and at re-determination.

A. Annuities purchased before 2/8/06 -
If the individual has purchased other than a straight life annuity, a transfer of assets has occurred. This is because the individual has purchased not only a benefit for him/herself but also payments to a beneficiary. The value of the transfer is equal to the difference between the cost of the annuity purchased and the cost of a straight life annuity providing the same monthly benefit. The date of the transfer is the date the payment option is selected and the funds cannot be returned to the individual. To determine if the transfer is subject to a penalty, refer to Part 15.

B. Annuities Purchased on or after 2/8/06 -
1. An annuity purchased by or on behalf of an annuitant who has applied for Medicaid with respect to long term care services will be treated as a transfer of assets unless:
   a. the annuity is an Individual Retirement Annuity (26 U.S.C. §408(b,q); or
   b. the annuity is purchased with proceeds from
      i. an Individual Retirement Account or a simple retirement account (26 U.S.C. §408(a), (c), or (p) ;
      ii. a simplified employee pension (26 U.S.C. §408(k); or
      iii. a Roth IRA (26 U.S.C. §408); or
   c. the annuity is:
      i. irrevocable and non-assignable; and
      ii. actuarially sound (as determined in the Social Security Administration Life Expectancy Table. This table can be found on the internet at http://www.ssa.gov/OACT/STATS/table4c6.html); and
      iii. provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.
2. The purchase of an annuity by the individual or the community spouse shall be treated as the disposal of an asset for less than fair market value unless:
   a. the State of Maine is named as the remainder beneficiary in the first position for the total amount of Medicaid paid on behalf of the individual; or

b. the State of Maine is named as such a beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or representative of the child disposes of their remainder for less than fair market value.

Section 2.4 Assets being converted – *excluded for SSI - Related categories*

Assets which are in the process of being converted are exempt during the period they are unavailable.

Examples:

- insurance policies which have been sent to the insurance company,
- property which is being probated and
- stocks which have been submitted for redemption.

Section 2.5 Bank accounts (including savings, checking, money market and certificates of deposit) -

Included are individual and jointly owned bank accounts and other jointly owned liquid assets:

I. Individual Accounts - the funds in these accounts are to be totally available to the individual.

II. Joint Accounts -

A. <u>For all categories</u>

Funds in these accounts are considered to be owned by the individual unless there is proof that funds in the account were contributed by another joint owner of the account.

If the individual claims that s/he does not own the money in the account s/he must provide evidence that this money belongs to the other joint owner(s). Any money in that account which the individual can show was contributed by one of the other joint bank account owners is excluded.

Verification of ownership of the funds may be shown through bank statements, written statement from the source that provided the funds to the account, letters of award showing proof of ownership, or other clear and convincing evidence satisfying the Eligibility Specialist that the money in the account is not available to the applicant or recipient

Any money in the account which, even though contributed by the joint owner, is intended for use by the applicant/recipient (such as a gift) is countable to the individual. The Department will presume this portion is considered as any other available asset unless credible evidence is given showing this was not a gift.

B. <u>For SSI - Related categories only</u> -

When evidence is provided that funds in the account belong to another joint owner, the individual must remove her name from the account or establish a separate account with the funds she does own. This must be done within thirty days of successful presentation of ownership evidence.

a. If it is necessary to obtain guardianship, conservatorship or power of attorney for one of the joint owners, the thirty day count will not begin until the process of obtaining guardianship, etc., is completed. If the Department determines that there is no active pursuit of the appointment, the thirty day count will begin.

The account will be considered owned in equal portions when the two or more joint holders are eligible individuals or couples.

When a joint name is added to the account, funds are considered to be transferred to the joint name added if conditions in Part 15, Section 1.7 (II) are met.

Examples:

1. Mr. and Mrs. Jones have a 33 year old son, John. Because John has to travel a great deal to work he added his parents' names to his savings and checking accounts so they could pay his bills if needed. The Jones' were able to verify that John had deposited from his own money all of the funds in the account and that all of the transactions were for his benefit. They were given thirty days to remove their names from the accounts.

2. Martha Thompson has a joint checking account with her daughter, Jane. Jane has POA for her mother. Jane's paychecks ($1400 monthly) and Martha's Social Security check ($600) both go into this account. They live together and split expenses. Jane does not need to invoke her POA to access the money in the account. Since only 30% of the money going into the account is from Martha's income, only this percentage of the total balance is considered to be hers. Martha will have thirty days to remove Jane's name or to establish an account of her own, with her portion of the funds.

III. Other jointly owned liquid assets -
A distinction is made between jointly owned bank accounts and other jointly owned liquid assets, such as stocks and bonds.

For other types of jointly owned liquid assets, each joint owner owns an equal share of the asset. For example, if there were 3 joint owners each would own a one-third interest in the asset.

Example:
Two sisters are applying for assistance. They have stocks left to them by their brother. This is verified by a copy of his will. Instead of the entire value being counted by each, one half of the value counts for each sister.

If the individual or couple establish that other joint owners refuse to sell jointly owned property, the value of the asset is excluded. This exclusion does not apply if any joint owner has the ability to convert the jointly owned asset to cash without the permission of the other owners or if the joint owners are a couple. See the policy on transfers for a possible transfer penalty the individual has established joint ownership.

Section 2.6 Burial Contracts/Spaces/Funds

Excluded for all categories -

I. Prepaid burial contracts (mortuary trusts) set up before 3/1/06, regardless of value.

II. Prepaid burial contracts (mortuary trusts) set up on or after 3/1/06, are excluded so long as either the contract is less than or equal to the statewide average for burial and funeral costs of $12,000. If the contract is for more than $12,000 then the estate of the Medicaid recipient must be named the beneficiary of any funds remaining after payment of funeral and burial charges.

III. Burial spaces intended for the use of the individual, spouse or other member of the immediate family, are an excluded asset

For SSI - Related categories only -

I. Separate identifiable account for their burial expenses.
   A. For each individual exclude up to $1500 set aside in a separate identifiable account for their burial expenses as long as the individual does not have a total of $1500 in all of the following funds:
      - prepaid burial
      - excluded face value of whole life insurance
      - cash value of counted whole life insurance policies
      - prepaid burial contract
   B. In order to be excluded as "funds designated for burial", funds held as cash, (i.e., bank accounts or certificates of deposit), must be separately identifiable as a different account and cannot be co-mingled with non-burial related funds.
   C. The funds are excluded as burial funds effective the month in which they are separated.
   D. Once this money is considered a designated burial fund certain conditions must be met:
      1. there must be documentation in the case to show that no transactions are made to the asset except for the posting of interest and the addition of funds.
      2. any interest accrued is excluded as income or asset as long as the individual remains continuously eligible for MaineCare and no withdrawals are made from the fund. Interest on these funds is excluded even if the total amount of the original designated funds plus the accumulated interest exceed the $1500 limit.

Examples:

- The individual indicates that a savings account of $1450 has been set aside for burial. At the time of the next review, the savings account has increased due to accumulated interest to $1563. The entire savings account continues to be an excluded asset and the interest is not considered income.

- Several months later, the individual becomes ineligible for MaineCare. If the individual reapplies and continuous

coverage does not exist, up to $1500 of the designated burial funds and accumulated interest since the original designation can be excluded as an asset.

E. At time of review, if burial funds have been co-mingled with non-burial related funds, the individual must be given an opportunity to separate the funds before they are counted as a resource. The funds must be separated by the end of the month that is two months after the month of review in which the individual is advised of the need to separate the funds.

Example:
If the review is due 9/07 the individual should be advised that funds must be separated by 11/30/07. If they are not, the exclusion does not apply unless the reason for non-separation is beyond the control of the individual.

F. Determine whether the separate identifiable account can total $1500 as follows:

1. Term insurance is excluded as an asset and does not count against the $1500 limit.
2. For each individual deduct the amount of any prepaid burial contracts from the $1500 limit.
3. If the face value of whole life insurance has been excluded, deduct the amount of the face value from the $1500 limit (See Section 2.27 of this Part).
4. If an individual's whole life policies are not excluded then deduct the cash value from the $1500 limit. If there is a loan against the policy, deduct the net cash value from the $1500 (See Section 2.27 of this Part).

Examples:

- The individual has one insurance policy with a face value of $1600 and a cash value of $1300. There are no prepaid burials. The policy can be considered a $1300 designated burial fund.

- The individual has one insurance policy with a face value of $1600 and a cash value of $1800. There are no prepaid burials. The policy can be considered a $1500 designated burial fund. The remaining $300 cash value is added to the other countable assets.

- The individual has one insurance policy with a face value of $1600 and a cash value of $1700. There is a prepaid burial plan for $500 as well. Only $1000 of the cash value can be considered a designated burial fund as the allowable limit of $1500 is offset by the $500 prepaid burial. The remaining cash value of $700 is added to other countable assets.

$ 1700	Cash surrender value of whole life insurance policy
+ $ 500	Add: Prepaid burial contract

$ 2200	Total
- $ 1500	Maximum exclusion
$ 700	Countable asset

Section 2.7 Certificates of Deposit - *countable for all categories*

The amount of the countable asset is the proceeds available to the individual or couple if they were to cash in the certificate now, minus penalties for early withdrawal. Taxes are not treated as a penalty.

Section 2.8 Commercial Transportation Tickets - *excluded for SSI-Related categories*

The value of a domestic commercial transportation ticket received as a gift by an individual (or his or her spouse) and not converted to cash will be excluded in the determination of the individual's assets. Domestic travel is defined as travel among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Section 2.9 Continuing Care Retirement Communities (CCRC) / Life Care Community (LCC) – *partially excluded for SSI - Related categories*

Admission contracts offer a range of housing and health care services to serve older persons as they age and as their health care needs change over time. CCRC's generally offer independent living units, assisted living, and nursing facility care for persons who can afford to pay the entrance fees. These facilities are paid primarily with private funds, but a number also accept Medicaid payment for nursing facility services. In order to operate in the State of Maine, this type of facility must have permission from the Bureau of Insurance and be licensed by the Department of Health and Human Services.

As of 2/8/06, the CCRC and LCC facilities that accept Medicaid payment are allowed to require in their admissions contracts that residents spend their resources, declared for the purposes of admission, on their care before they apply for Medicaid. With this in mind, an applicant for Medicaid who has resided in such a community must provide a copy of their admission contract as part of their Medicaid application. If there is an additional contract related to their entrance fee, that must be provided also. If the contract provides for a lifetime care agreement, the applicant will be ineligible for Medicaid.

The individual's entrance fee in a CCRC or LCC shall be considered an available asset for the purposes of Medicaid eligibility to the extent that:

I. the individual has the ability to use the entrance fee, or the contract provides that the entrance fee may be used, to pay for care should other resources or income of the individual be insufficient to pay for such care.

II. the individual is eligible for a refund of any remaining entrance fee when the individual dies or terminates the contract and leaves the facility; and the entrance fee does not confer an ownership interest in the CCRC or LCC.

For applicants with community spouses, only that part of the entrance fee that is not protected for by the community spouse's resource allowance would be considered a countable asset.

Section 2.10 Disaster Relief Act - *excluded for SSI - Related categories only*

Assistance received under the Disaster Relief Act of 1974 (PL 93-288), or other assistance provided under a federal statute because of a catastrophe which is declared to be a major disaster by the President of the United States, is excluded in determining countable resources:

I. for a period of nine months from the date of receipt;

II. interest earned on the assistance is excluded from resources for a period of nine months beginning on the date the assistance is received; and

III. the initial nine month period will be extended for a reasonable period up to an additional nine months when it is found the individual has good cause for not having necessary repairs or replacement of damaged or destroyed property completed. Good cause exists when circumstances beyond an individual's control prevented the repair or replacement of such property within the nine month time period.

Section 2.11 Disaster Unemployment Assistance – *excluded for all categories*
Disaster Unemployment Assistance authorized in P.L. 100-707, U.S.C. Section 5155(d) (1988) is excluded. This is paid to an individual unemployed as a result of a major disaster.

Section 2.12 Earned Income Tax Credit (EITC) – *excluded for Family - Related categories*
Excluded for the month of receipt and the following month.

Section 2.13 Energy Assistance (Other than HEAP) - *excluded for all categories*
Any other benefits paid through federal laws to eligible households for the purpose of providing energy assistance is excluded.

Section 2.14 Escrow Accounts - *excluded for all categories*
Escrow accounts set up by the U.S. Department of Housing and Urban Development (HUD) for families who are participating in the Family Self Sufficiency Program are not considered a countable resource.

Any interest paid on these accounts is not countable income. As long as the individual is receiving any state, federal or other public assistance for housing they cannot access this amount.

This program is a five year program open to all Section 8 housing participants which aims to help the family to become self-sufficient at the end of the five year period.

When the account becomes available, it is counted as a resource and/or interest income.

Section 2.15 Experimental Housing Allowance Payments - *excluded for Family - Related categories*
Payments made under Annual Contributions Contracts entered into prior to 1/1/75, under Section 23 of the US Housing Act of 1937, as amended.

Section 2.16 Food Produced for Home Consumption – *exclude for all categories*
Food produced in home farming for consumption by the assistance unit is excluded.

Section 2.17 Governor Baxter School for the Deaf Compensation - *excluded for all categories*

One time cash payment from the Governor Baxter School for the Deaf Compensation Authority. Interest on this compensation is excluded as income and any accrued interest is excluded as an asset.

Section 2.18 Grants, Loans, and Scholarships

I. Administered by Commissioner of Education – PL 90-575 – Title V -
The grants and loans are:
- Basic Education Opportunity Grant Program (Pell Grants)
- National Direct Student Loan program (Perkins Loans)
- Supplemental Education Opportunity Grant Program (SEOG)
- Guaranteed Student Loan Program
- State Student Loan Program

A. Family - Related categories – *exclude all*
B. SSI - Related categories – *exclude for all undergraduates and exclude only tuition and fees for graduate students*

II. All other grants/loans/scholarships -
A. Family - Related categories – *exclude tuition and fees*
B. SSI - Related categories – *exclude tuition and fees for undergraduates and count for all other students*

Section 2.19 Home Energy Assistance Program (HEAP) – *excluded for all categories*

Benefits paid to eligible households under the Home Energy Assistance Act of 1980, Title III of PL 96-223 (LIHEAP) is excluded.

Section 2.20 Household Goods – *excluded for all categories*

Items used in day-to-day living such as clothing, household furnishings, utensils, home and property maintenance tools and equipment, heirlooms, wedding and engagement rings, basic jewelry.

Section 2.21 Housing Act Assistance – *excluded for SSI - Related categories*

Effective 10/1/76 the value of any assistance paid with respect to a dwelling unit under the United States Housing Act of 1937, the National Housing Act, section 101 of the Housing and Urban Development Act of 1965, or Title V of the Housing Act of 1949 as provided by section 2(h) of PL 94-375.

Section 2.22 HUD Community Development Block Grant - *excluded for Family - Related categories*

HUD community development block grant funds received to finance the rehabilitation of privately owned residences. Individuals receiving a grant are precluded by HUD regulations from using grant monies for purposes other than major property repairs or capital improvements. Payment is by check made payable either directly to the contractor or jointly to the contractor and property owner.

Section 2.23 Individual Development Accounts (IDA) - *excluded for all categories*

An IDA is a special bank account that is set up by or for the individual to allow the individual to accumulate funds for specific purposes.

There are two types of IDA's in Maine: a Family Development Account (FDA) for TANF recipients and a Demonstration Project IDA which is available to anyone. The Demonstration Project IDA is also known as Assets for Independence Act (AFIA) IDA. Individual contributions to either IDA are matched by state and/or federal funds.

I. Family Development Account (FDA for TANF recipients) -
   A. Any income used by the individual to fund this account is excluded as income.
   B. Any asset used by the individual to fund this account is excluded as an asset including up to $10,000 of lump sum income remaining in the month following receipt.
   C. Any individual contributions that are matched are excluded as income or asset.
   D. Accrued interest on FDA funds is excluded as income or asset.
   E. Withdrawals from these accounts at any time must be used for the following purposes in order for the fund to remain an exempt asset. When withdrawals are used for any other purpose this will result in the fund being considered a countable asset effective the month of the withdrawal. The TANF Program determines if this condition is met.
      1. expenses for education or job training to attend an accredited or approved post secondary education or training institution;
      2. the purchase or repair of a home that is the primary residence;
      3. the purchase or repair of a vehicle used for transportation to work or to attend an education or training program;
      4. capital to start a small business for any member of the assistance unit 18 years of age or older;
      5. health care costs of a member of the assistance unit that are medically necessary and that are not covered by public or private insurance;
      6. to address an emergency that may cause the loss of shelter, employment or other basic necessities; or
      7. to address other essential family needs approved by the Department.

I. Demonstration Project Account (AFIA) -
   A. any income used by the individual to fund an AFIA is excluded as income.
   B. any individual contributions that are matched are excluded as income or assets.
   C. accrued interest on AFIA funds is excluded as income or assets.
   D. withdrawal from these accounts is allowable only for certain reasons as determined by the agency authorizing this IDA. These reasons include post- secondary educational expenses, acquiring a residence, or expenditures for operating a business.

Section 2.24 Insurance Settlements – *partially excluded for all categories*

Portions of insurance settlements earmarked and used, or intended to be used for specific purposes, are exempt for 6 months from date of receipt. Examples are back medical bills and attorney and legal fees associated with the settlement.

Verification of use, or intent to use, may be shown through verbal or written statements from those providers to whom the individual owes money associated with the settlement. For example, unpaid medical bills or attorney fees.

Portions of insurance settlements not specifically earmarked and used or intended to be used for specific purposes are income in the month received and any remaining portion is an asset in the following month.

For specific information regarding accident and injury settlements when the individual was on MaineCare see Part 2, Section 6.

For settlements associated with the replacement of an excluded asset, see Section 2.42 of this Part.

Section 2.25 JTPA and Job Corps – *excluded for Family - Related categories*

All JTPA or Job Corps payments except on-the-job training income of an individual, at least 19 years old, who is not a dependent child.

Section 2.26 Life Estate - *countable for all categories*

A "life estate" is ownership of real property. Ownership is limited to the term of life, usually that of the owner of the life estate, and may have other conditions attached such as occupancy.

Life estates can be acquired by inheritance or by purchase, or can be retained when property is sold, such as when the individual sells the right to ownership after death and retains the right to ownership during their lifetime.

The monetary value of a "life estate" and the "remainder" must be established so that the applicant's assets or transfer of assets can be properly valued.

To establish the value of the property rights, refer to Appendix E.

Using the individuals' age, find the amount in the first column, "Life Estate", and multiply it by the current fair market value of the property. The result is the current value of the life estate owned by the individual. This is a countable asset but can be exempted with an intent to return if the real property is the primary residence.

Section 2.27 Life Insurance

Term life insurance is an excluded asset since it has no cash value.

I. <u>Policy applicable to Family - Related categories</u> -

The cash surrender value of life insurance is excluded.

II. <u>Policy applicable to SSI - Related categories</u> -

Life insurance is excluded as long as the combined face value of all whole life policies owned by the individual on the same insured does not exceed $1500. If the total face value of all whole life policies owned by the individual on the same insured exceeds $1500, then the cash values, minus any outstanding loans, is counted against the asset limit. A portion of the cash value may be excluded for burial purposes (See Section 2.6 of this Part).

Examples:

1. An individual has a face value life insurance policy of $1000 and one for $500. Even if the cash value exceeds $1500, these are

excluded.

2. An individual has a $2000 face value whole life policy. The cash value is $1790. This results in assets of up to $1790 counted against the asset level. Also see Section 2.6 of this Part for potential exclusions for burial purposes.

3. An individual has a $2000 face value whole life policy. The cash value is $1790 but there is a $500 outstanding loan against the policy. This could result in an asset of up to $1290 ($1790 minus the $500 loan) counted against the asset limit (See Section 2.6 of this Part regarding exclusions for burial purposes).

4. An individual owns a policy on himself that has a $1000 face value and owns a policy on his wife with the same face value. Even though both policies are owned by the individual they are exempt because the total face value on each insured is under $1500.

Section 2.28 Life Lease (Tenancy) - *excluded for all categories*

This is a contract arrangement to live in a certain place, usually for the term of life. It is not ownership and therefore is not a countable asset.

Section 2.29 Loans – *excluded for all categories*

Money borrowed by an individual is not counted as either an asset or income for the month received. Any remainder is considered an asset in the following month.

Written statements from both the individual and the party lending the money must be obtained indicating that the funds are a loan, the amount and the plan for repayment. Without verification of the loan the funds will be considered a gift and treated as a lump sum (See Section 2.30 of this Part).

Section 2.30 Lump Sum Payments – *partially excluded for all categories*

Income that has accumulated and is received in one payment by the individual is considered a lump sum. This includes Worker's Compensation, Retroactive Social Security payments, Unemployment Benefits received retroactively due to the result of a hearing, and Veteran's Benefits. Gifts, inheritances, lottery winnings and insurance settlements are also considered to be a lump sum payment.

Lump sum payments are counted as income in the month received, and any remaining the next month are counted as an asset. SSI lump sum payments are excluded income.

<u>Policy applicable to SSI - Related categories</u>

SSI or Social Security retroactive payments are excluded as an asset for nine months. After that, any portion remaining becomes a countable asset.

Section 2.31 Native American payments

<u>Excluded for all categories</u> -

I. Any payments distributed per capita to or held in trust for members of any Indian tribes under PL 92-524, 93-134, 94-540, 97-458 or 98-64.

II. Receipts distributed to members of certain Indian tribes referred to in Section 5 of PL 94-114, effective 10/17/75, and PL 98-123 and 98-124, effective 10/13/83.

III. Any income or assets accruing to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians pursuant to PL 96-420 (the Maine Indian Claims Settlement Act of 1980).

IV. The tax exempt portions of payments made pursuant to PL 93-203, the Alaskan Claims Settlement Act.

Excluded for SSI - Related categories -

I. Native American payments as detailed in Title 20 CFR, Part 416 Appendix to Subpart K (IV)(b) and (c).
II. Per capita distribution payments, receipts from trust lands and dividend payments to members of various native American and Indian tribes such as Blackfeet, Gros Ventre, Grand River Band, Alaskan Native Claims Settlement Act under the provisions of Distribution and Judgement Funds (PL 92-254 Sections 4, 6, and 7), Receipts from Lands Held in Trust for Indian Tribes (PL 94114, Section 6).

Any assets accruing to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians pursuant to PL 96-420, the Maine Indian Claims Settlement Act of 1980.

Section 2.32 Nazi Persecution Payments - *excluded for Family - Related categories*
Payments made to victims of Nazi persecution under Public Law 103-286 (Nazi Persecution Victims Eligibility Benefits).

Section 2.33 Nutrition and Food Assistance – *excluded for all categories*
The value of food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended (PL 92-433 and PL 93-150). Any benefits received under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended.

The value of benefits received under the Food Supplement Program (formerly Food Stamps) or Donated Commodities is excluded.

Section 2.34 Pension Plans (**Individual and Employee)** - *excluded for SSI - Related categories*
Earnings can be set aside in individual or employee pension plans, such as Simplified Employee Pension Plan (SEP), Individual Retirement Account (IRA), Keogh Plan or Deferred Compensation Plan. Each particular plan sets forth regulations governing accumulation and availability of funds. Often monies can be obtained upon demand although penalties for early withdrawal may decrease the asset value. Withdrawals may be taken as a lump sum, annuity or periodic income, or as with Deferred Compensation Plans the funds cannot be obtained until retirement or termination of employment. There is often a waiting period after retirement or termination during which funds are not available.

Funds are a countable asset at the point they are made available.

Section 2.35 Promissory Notes and Mortgages – *countable for all categories*

I. Policy applicable to all MaineCare including residential care and long term care -

A mortgage is a pledge of property to a creditor as security for the obligation or repaying a debt (note).

A note is a written promise to pay or repay a specific amount of money at a stated time. The note specifies conditions such as the amount to be paid, frequency of payments and interest rate.

The note, to be enforceable, and therefore to be of any value, needs to be signed by the debtor and needs to identify, in a complete and precise manner, the obligations to repay.

The presumed value of the note is the principal to be repaid minus any repayments on principal that have been made.

The presumed value can be refuted by obtaining a statement from two sources in the business of buying notes, such as a mortgage company. The statement should identify the amount the source would presently pay for the note and describe the basis for that amount.

The current value of the note then becomes the current sale value. If different sale values are obtained, the higher amount will be used.

II. Policy applicable to long term care -

A transfer of assets occurs when the current sale value of the note is established at less than the presumed value. The amount of the transfer is the amount by which the presumed value exceeds the current sale value. The date of the transfer is the date the note was signed by the debtor. (See Part 15 for treatment of asset transfers.)

As of 2/8/06, funds used to purchase a promissory note, loan or mortgage can be considered a transfer of assets (see Part 15) unless the note, loan or mortgage:

A. has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Social Security Administration, found online at: http://www.ssa.gov/OACT/STATS/table4c6.html)
B. provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
C. prohibits the cancellation of the balance upon death of the lender.

In the case of a promissory note, loan or mortgage that does not meet the conditions in A, B, and C. above, the value of the note, loan or mortgage to be considered in determining the amount of the asset transfer shall be the outstanding balance due as of the date of the individual's application for Medicaid.

Section 2.36 Property used for home consumption - *excluded for all categories*

All property and equipment used to produce goods or services for home consumption. This includes garden plots, wood lots and livestock.

Section 2.37 Property used to produce income - *excluded for all categories*

Property and equipment used in the production of income includes real property, boats, trucks, machinery and livestock. This also includes garden plots, wood lots and rental property that are income producing and liquid assets used as part of a business or trade.

I. With eligibility decisions effective before 3/1/06, all property and equipment which is used to produce income is exempt. This property/equipment will continue to be excluded when it is precluded from use because of a temporary disability or any other reason beyond the control of the individual as long as resumption of income production is likely.

II. With eligibility decisions effective 3/1/06, income producing property and equipment can be excluded as a countable asset as long as, after three years of operation, the property produces countable income that equals or exceeds 4.04%, which is the average interest rate for a twelve month Certificate of Deposit (CD) at banks in Maine.

   A. Countable income is income that is produced by the property and/or equipment as determined by the MaineCare rules for treating income (See Part 17, Section 3.8).

   B. To determine if the countable income equals or exceeds 4.04%:

      1. Multiply 4.04% by the fair market value of the property and/or equipment minus encumbrances.

      2. Countable income must at least equal the result in (1.) in order for the property and/or equipment to be excluded as an asset.

   C. If the countable income has changed considerably in any year, countable income is averaged for the last three years.

   D. The test for income producing property to be an excluded asset is applied only after the property and/or equipment has three years of operation.

III. Income producing property is excluded as a countable asset regardless of the annual rate of return if:

   A. The property cannot be used due to circumstances beyond the control of the individual and resumption of income production is likely.

   B. The property cannot be used due to the inability of the individual to use the property for up to twenty-four months.

   C. The individual is temporarily disabled and resumption of income production is likely.

   D. The property has not been in operation or production for three years or more.

   E. The owner is making good faith efforts to sell the property at a reasonable price.

Section 2.38 Radiation Exposure Compensation Act – *excluded for all Family - Related categories*

Money received under the Radiation Exposure Compensation Act for injuries or death resulting from radiation due to nuclear testing and uranium mining.

Section 2.39 Real Property

With the exception of the exclusions below real property is a countable asset.

I. All real property may be excluded if:
   A. it is up for sale at fair market value with a Realtor or actively being advertised by the owner in the geographic area of the property. If reasonable offers are turned down, no exclusion will be given. A reasonable offer is one, which reflects the price on the open market given the condition and location of the property.
   B. two different knowledgeable sources in the geographic area agree that the property cannot be sold due to a specific condition.
   C. it is held in Joint Tenancy or Tenants in Common with others who refuse to sell the property. A statement from the joint owner is required or documented evidence that such a statement was asked for but not provided.
   D. it meets the criteria of Income Producing Property defined in Section 2.37 above.

II. Primary Residence -
   A. Policy applicable to all MaineCare categories, including residential care and long term care -

      The home which the individual considers their primary residence and the land and all buildings on that land are exempt. This exemption also applies to any adjoining land as long as it is not separated by real property owned by others. Presence of any easement, road, waterway or other natural boundary does not change the exemption.

      The home is exempt during periods of temporary absences of the individual, spouse or dependent as long as they indicate their intent to return. (i.e. nursing home care, boarding home, hospitalization, visiting, etc.) Except for visiting, a written statement of intent to return must be submitted. If the client is unable to make this statement, someone acting on the individual's behalf, such as the individual's guardian, conservator or holder of Power of Attorney may do so.

      Once a declaration of intent is made it is valid until an intent not to return home is declared. At that time the home would become a countable asset on the first day of the month after the month in which the declaration is made.

      Note: Except for migrant workers (Part 2, Section 4), when a primary residence is located out of state, it cannot be exempted as a countable asset on the basis of an intent to return home. This intent to return to an out of state residence is inconsistent with the residence requirement which is that the individual be living in Maine and intend to remain here.

   B. Policy applicable to SSI - Related categories -

      The home is exempt if occupied by the spouse or dependent of the individual. A dependent is someone who is financially or medically dependent on the individual. This person is or could be claimed as a dependent for IRS purposes.

C. Policy applicable to Long Term Care -

Effective with applications for Medicaid for long term care services submitted on or after 1/1/06; the individual shall not be eligible for long term care assistance if the individual's equity interest in their primary residence exceeds $750,000. This rule is also effective for re-determinations of eligibility made for those applicants whose initial application was on or after 1/1/06.

To determine the equity interest an individual has in their primary residence, consider the following:

1. The Department needs to see a statement of fair market value such as a recent appraisal from an individual or company licensed to do so.
2. The amount of an individual's equity interest in their home is equal to the current market value of the home minus any encumbrances, such as a mortgage or other loan that is secured by the home. (Not including a home equity line of credit that has not been utilized.)
3. A reverse mortgage or a home equity loan outstanding on the property would decrease the equity, but The Department must examine the mortgage or home equity note to see if there has been a transfer of assets.
4. The Department must see loan documentation to verify that it is a valid transaction with a company in the business of providing home loans or a private individual.
5. This rule does not affect an individual's eligibility for community MaineCare services if otherwise eligible.

The rule does not apply if the spouse of the individual, or dependent, or disabled child of the individual is lawfully residing in the home.

III. For real property not exempted above the equity value of that property is counted. The value of real property is established by statements from two real estate appraisers or town tax valuation adjusted to 100% valuation rate. If jointly owned the countable asset is the proportion of ownership interest in the real property.

Example:
A piece of land is left to an individual and his two sisters. Although there are three owners, the will indicated that one half of the property is owned by the individual. Therefore, one half of the equity becomes a countable asset unless otherwise excluded.

Section 2.40 Relocation assistance

I. *Excluded for all categories* -
Payments made under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970.

II. *Excluded for Family - Related categories* -

Relocation assistance allowances under the Federal Aid Highway Act of 1968

Section 2.41 Reparation Payments – *exclude for SSI - Related categories*
Japanese Restitution Payments and German Reparation Payments are excluded.

Section 2.42 Replacement of an excluded asset – *excluded for SSI - Related categories*
Cash received or in-kind replacement received to replace or repair an excluded asset that is lost, stolen or damaged is excluded for a period of nine months. An additional nine months can be given when circumstances beyond the individual's control prevented the replacement or repair of the asset.

Example:
The individual has a motor vehicle that was excluded as his primary vehicle under Section 2.53 of this Part. The vehicle was involved in an accident. The insurance company gives the individual a check to replace the vehicle. The individual has nine months in which to purchase another vehicle or repair the damaged one. If at the end of the nine month period the individual still has the money, it will be counted against the asset limit.

Section 2.43 Reverse Mortgage – *excluded for all categories*
Proceeds from a reverse mortgage are treated as proceeds of a loan and are not income. Any proceeds available in the month following the month of receipt are a countable resource. This arrangement allows the homeowner to borrow, via a mortgage contract, a percentage of the appraised value of his/her home equity.

The homeowner receives a periodic payment (or a line of credit) which does not have to be repaid as long as the borrower lives in the home. In most reverse mortgages the original loan does not have to be repaid until the homeowner dies, sells the home, or moves.

Section 2.44 Ricky Ray Hemophilia Relief Fund Act – *excluded for all categories*
Payments received under the Ricky Ray Hemophilia Relief Fund Act of 1998. Interest income generated on these payments is countable income and any accrued interest is excluded as an asset. These payments are not subject to special rules on trusts or transfer of resource penalty. Payments are not counted in determining cost of care.

Section 2.45 Savings Bonds – *countable for all categories*
These are countable to the extent of their current cash value. New bonds have no cash value for six months from the date of issue.

If they are jointly owned, the amount to be counted is based on the proportion of ownership interest. If the joint owners (indicated by "and" on the bonds) refuse to sell, then the bonds are unavailable as an asset to the assistance unit.

Section 2.46 Savings Exclusion - *excluded for all categories, except State Supplement*
Up to $8,000 of savings for an individual, $12,000 for an assistance unit of two or more. Any amount over the excluded amount is counted toward the asset limit. Savings is defined as an account which earns interest or dividends except that a checking account does not need to earn interest/dividends. "Savings" includes:

- savings or checking account including those in a credit union;
- IRA;
- Keogh;
- available cash value of an annuity;
- stocks;
- bonds;
- mutual funds; and
- cash surrender value of life insurance.

The $8,000/$12,000 exclusion applies to all accounts subject to the exclusion. The exclusion is not applied to each account.

Section 2.47 Self-Support Plans for Blind or Disabled Individuals - *excluded for SSI - Related categories*

Any asset necessary to carry out an approved plan for achieving self-support for a blind or disabled individual is excluded. The plan must be approved by the Bureau of Rehabilitation Services or the Social Security Administration.

Section 2.48 Stepparent Assets

Family - Related categories -

Assets owned solely by the stepparent are excluded unless the stepparent is a member of the assistance unit. This does not include any amount given to the unit (such as a gift). This portion is considered as any other available asset. Assets owned solely by the stepparent are excluded even if the legal parent is a member of the unit.

SSI - Related categories -

Assets owned solely by the stepparent are excluded.

Section 2.49 Stocks, Bonds and Mutual Fund Shares - *counted in all categories*

The value of these assets is determined by multiplying the number of shares by the current value per share. Since the amount indicated on the certificates may be less than actually owned (due to stock splits and reinvestment of dividends) it is important to establish, with the company or broker, the actual number of shares.

If the shares are owned jointly with others (other than the spouse) then the amount of the countable asset is based on the proportion of ownership interest the individual or couple has.

If signatures are required by the other joint owners, in order for the shares to be sold and the joint owners refuse to sell, then the value of these shares is unavailable as an asset to the assistance unit.

If a decision is made to sell the shares, the value is excluded from the time a formal request is made until the proceeds of the sale are dispersed to the individual or couple by the company or broker.

Section 2.50 Supplemental assistance – *excluded for Family - Related categories*

Assistance such as General Assistance, provided by public or private agencies to help recipients and applicants meet emergency situations.

Section 2.51 Susan Walker Settlement – *excluded for all categories*

Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et al, and payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement.

When payments are made in lieu of a class settlement, the agreement must be signed by all parties on or before 12/31/97 or 270 days after the date on which a release is first sent to the persons to whom the payment is to be made.

Section 2.52 Trusts – *partially excluded for all cate*gories

A "trust" includes any legal instrument or device that is similar to a trust.

There are special provisions for the treatment of assets placed in a trust. The term "asset" includes income as well as resources. Application of the trust provisions govern the treatment of assets in the trust.

A payment from a trust is any disbursal from the corpus of the trust or from income generated by the trust. A payment may include cash as well as non-cash or property disbursements, such as, the right to use and occupy real property.

For trusts established on or before 8/10/93 for services provided on or before 4/30/94 refer to Appendix H.

The following rules are effective for trusts established on or after 8/11/93 for Medicaid provided on or after 5/1/94.

I. Trusts established by the individual -
   A. Special rules apply to the treatment of trusts established by the individual. These rules apply without regard to:
      1. the purposes for which the trust is established;
      2. whether the trustees have or exercise any discretion under the trust;
      3. any restriction on when or whether distributions may be made from the trust; or
      4. any restrictions on the use of distributions from the trust.
   B. A trust is considered to be established by an individual if the assets of the individual were used to form all or part of the corpus of the trust and if any of the following entities and/or individuals established the trust other than by will:
      1. the individual;
      2. the individual's spouse;
      3. a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse or with legal authority to act in place of or on behalf of the individual or the individual's spouse.

      When a trust corpus includes assets of someone other than the individual, these rules apply only to the individual's portion of the trust assets. The individual's countable income and resources must be prorated based on the proportion of the individual's assets in the trust to those other persons.

C. When a trust is set up as of 3/1/06 as part of a negotiated settlement of the individual or his/her spouse, the trust is considered to be set up by the individual and is not a third party trust. A 'negotiated settlement' is one in which the individual as defined above and others confer, bargain, or discuss with the view of reaching an agreement. Examples of a negotiated settlement are: a divorce or an insurance settlement. Any funds transferred to a trust as a result of a negotiated settlement, are considered to be funds that are owned by and transferred by the individual.

D. Revocable Trusts - are trusts which can, under state law, be revoked by the individual or an entity in (B) above or a court. It includes a trust which ends if some action is taken by the individual.

In the case of a revocable trust:

1. the entire corpus and the income produced by the corpus of the trust is considered a resource available to the individual;
2. payments from the trust to or for the benefit of the individual are considered income to the individual; and
3. any other payments from the trust are considered to be assets that are transferred. The look back period for transfers is sixty months (See Part 15, Section 1.1).

When real property is transferred to a revocable trust, it is considered to be available to the individual because it is accessible.

Effective with transfers on or after 9/1/02, a primary residence, while an available asset, cannot be exempted on the basis of an "intent to return" or as the residence of the community spouse because the property is not owned by the individual.

Similarly, property used to produce income is an available asset but is not exempted as income producing property because it is not owned by the individual.

E. Irrevocable Trusts - are trusts which cannot in any way be revoked by the individual or entity in (B) above.

In the case of irrevocable trusts:

1. if there are any circumstances under which payment from the trust could be made to or for the benefit of the individual including a payment at a future date, the following rules apply:
    a. the portion of the corpus that could be paid to or for the benefit of the individual is a countable resource to the individual. The income produced by this portion of the corpus is also a countable resource to the individual.
    b. payments actually made from the corpus (or from income produced by the corpus) to or for the benefit of the individual are income to the individual.
    c. payments actually made from the corpus (or from income produced by the corpus), but not to or for the benefit of the individual, are a transfer of assets. The look back period is thirty-six months (See Part 15) for all of these payments made from the corpus before 2/8/06.

All payments made on or after 2/8/06 are subject to a sixty month look back period (See Part 15).

2. if no payment could be made under any circumstances to or for the benefit of the individual the following rules apply:
   a. the portion of the corpus from which no payment could be made to or for the benefit of the individual is considered to be an asset that has been transferred.

      Income on this portion of the corpus from which no payment could be made to or for the individual is also considered to be an asset that has been transferred.

      The look back period is sixty months (See Part 15).

   b. the date of the transfer is the date of the establishment of the trust or, if later, the date on which payment is unavailable to the individual.
   c. the value of the transfer includes any payments made after the trust is established or payment to the individual is unavailable.

F. Exemptions:
The following trusts are exempt from the provisions of (E) above. No transfer is considered to take place as a result of establishing the trust, except as indicated in 2. (below) relating to pooled trusts. The income and resources considered available to the individual are those made available by the trust.

1. a trust containing the assets of an individual under age 65 who does or would meet the SSI criteria for disability if:
   a. the trust is established for the sole benefit of the individual by the individual's parent, grandparent, legal guardian or a court; and
   b. the state will receive all amounts remaining in the trust upon the death of the individual up to an amount equal to the total Medicaid paid on behalf of the individual after due payment of any legal obligations of trust.

This trust is considered to be established for the "sole benefit of" the individual if no other individual or entity can benefit from the assets transferred in any way whether at the time the trust is established or at any time in the future. A trust may provide for reasonable compensation to trustees to manage the trust and for beneficiaries after Medicaid has been reimbursed.

The trust may contain assets of individuals other than the disabled individual.

This exemption remains once the individual turns age 65 as long as there are no changes in the terms of the trust once the individual attains age 65. Any assets added as of age 65 are not subject to exemptions under (E) above.

2. a trust containing the assets of an individual who does or would meet the SSI criteria for disability if:
   a. the trust is established and managed by a non-profit association;
   b. a separate account is maintained for each beneficiary of the trust but for purposes of investment and management of funds, the trust pools these accounts;
   c. the accounts in the trust are established solely for the benefit of the disabled individual by the individual or the individual's parent, grandparent, legal guardian or by a court; and
   d. to the extent that amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, the trust pays to the state an amount equal to the total amount of Medicaid paid on behalf of the beneficiary after due payment of any legal obligations of the trust.

   However, any assets added to the trust as of age 65 may be subject to a transfer penalty (see Part 15).

   A trust is considered to be established for the "sole benefit of" the individual if no other individual or entity can benefit from the assets transferred in any way whether at the time the trust is established or at any time in the future. A trust may provide for reasonable compensation to trustees to manage the trust and for beneficiaries after Medicaid has been reimbursed.

   An individual age 65 or older is not automatically considered to meet the SSI criteria for disability. This must be determined as in Part 6, Section 4.3.

3. trusts that are set up with retroactive SSI benefits awarded under the Sullivan v. Zebley, 493 U.S. 521 (1990) decision.

II. <u>Trusts Established for the Individual by Someone Else</u> -
With trusts that are set up for the individual by someone else including those that are set up by will, trust funds are available assets unless the terms of the trust make them unavailable.

If the trust is irrevocable, that is, no member of the assistance unit or any responsible relative residing in the home has the power to revoke the trust arrangement or change the name of the beneficiary, what is available to the client is what is made available according to the terms of the trust.

A. The terms of the trust may specify the amount/frequency and/or purposes for which the funds may be used or this may be left to the discretion of the trustee(s). The terms of the trust may use a combination of both trustee discretion and specific fund usage.
B. Of the funds left to trustee discretion, what is available to the client is whatever the trustee makes available.

C. Funds made available are considered as income or assets in accordance with applicable Medicaid eligibility rules for the situation.
D. If the terms of the trust restrict withdrawal by written approval of a judge of the courts, regular withdrawals will be treated as any other income. Irregular withdrawals, in order to be disregarded, must be used to supplement the needs of the person for whom the trust is drawn up.

Examples:

1. An individual has a trust fund that was established upon the death of his parents based on their will. From this he is to receive $500 from the interest each month and $10,000 every three years to buy a new vehicle. The monthly payments are income. The $10,000 is used to purchase an excluded asset (the old vehicle is traded in to purchase the new one).

   This trust is irrevocable in accordance with the provisions above. The terms of the trust specify the amount, frequency and for part of the payments (the $10,000) the purpose. Medicaid policy treats interest payments as income and excludes the vehicle as an asset.

2. A trust was set up for the individual by his father who is deceased. The individual is to receive $200 per month for as long as the fund lasts. The fund currently has $140,000. The individual can get all the funds in the trust if there is an emergency.

   The $200 per month is considered income as long as this represents interest income. The remainder of the fund is considered an asset (currently $140,000) since it can be accessed by the individual.

3. A trust is set up for the individual by her grandmother. It is irrevocable and the trustee has full discretion in disbursement of the funds (totaling $75,000) based on the needs of the individual.

   Since the trust is irrevocable, what is considered available to the individual is whatever the trustee, in her discretion, makes available.

Section 2.53 Vehicles

I. <u>For all categories:</u>
The following exclusions are applied in the manner most advantageous to the individual:

A. Exclude one vehicle which is used to provide transportation for the household, such as passenger cars, trucks, boats and special vehicles such as motorcycles, snowmobiles, animal drawn vehicles and even animals. This includes vehicles that are unregistered, inoperable or in need of repair.
B. A second vehicle is totally excluded regardless of value if it is:
   1. needed for employment or to seek employment;
   2. needed to secure medical treatment;

      Note: This exclusion does not apply to individuals residing in a nursing or residential care facility. These facilities are required

to provide Medicaid eligible individual with any transportation needed to secure medical treatment.

3. modified for operation by a person with a disability or is modified for the transportation of a person with a disability; or
4. necessary because of climate, terrain, distance, or other similar factors, or to provide transportation to perform essential daily activities.

In order for an individual to have a second vehicle for reasons 1-4 above, they must show a need for two separate vehicles.

Examples:

- An individual lives on an island, leaves one car on the island and one car on the mainland to avoid having to transport a car on the ferry.
- An elderly applicant has two cars. An adult (or minor) child who lives with her uses one of the vehicles for work. The applicant needs the other vehicle to secure medical treatment.

II. <u>For Family - Related categories:</u>
The equity value of all the other vehicles will be used toward the asset limit. To determine the equity value:

A. Determine the fair market value. This is the average trade-in value from “The National Automobile Dealers Association's (NADA) Used Car Guide Book”, making appropriate deductions as listed in the guide but do not add for options. A household’s estimate can be used for vehicles not listed in the car guide unless it appears unreasonable. Allowance can be made for a vehicle in less than average condition if true value is verified by a reliable source.
B. Subtract from the fair market value the total amount owed on the vehicle in mortgages, liens and other debts.

III. For SSI - Related categories;

A. If no vehicle is totally excluded, the fair market value in excess of $4500 is counted as an asset. The fair market value is established by using the "trade-in value" listed in the "National Automobile Dealers Association's (NADA) Used Car Guide". The individual may prove that the vehicle is worth less than the value listed by NADA by providing verification from two reliable sources.

Note: This exclusion involves the fair market value and not the equity in the vehicle. For this reason the individual may wish to exclude the vehicle with the highest value and not the one with the most equity.

B. Unless excluded, the equity value of any other vehicle is counted. For business vehicles see Section 2.37 of this Part.

Examples:

1. Sally and Jim have two vehicles that are not excluded. They have a Buick worth $7000 (FMV) on which they owe $6000. They also have a Ford worth $5000 (FMV) that they own free and clear.

If the Buick is partially excluded they would be over assets.

$7000 (FMV/$1000 equity) - $4500 exclusion = $2500
$5000 (FMV and equity) Ford = $5000 countable

This results in countable assets of $7500 from these two vehicles.

If the Ford is partially excluded only $1500 would be counted against the asset limit.

$5000 (FMV and equity) Ford - $4500 exclusion = $500
$7000 (FMV/$1000 equity) Buick = $1000 countable

2. Mrs. Johnson has a five year old car that is not totally or partially excluded. The fair market value (FMV) is $6000. She still owes $5000 on this.

   $6000 (FMV) - $4500 exclusion = $1500 countable asset

   Even though the equity is only $1000, $1500 is counted as an asset, because of the fair market value.

Section 2.54 Veterans Payments for Vietnam Veterans' natural children - *excluded for all categories*

VA monthly payments made to or on behalf of Vietnam veterans' natural children regardless of their age or marital status for any disability resulting from spina bifida suffered by such children are excluded from income and resources. Interest earned on unspent payments is not excluded.

Section 2.55 Volunteer Service Programs – *excluded for all categories*

Any payment whether cash or in-kind made under the Domestic Volunteer Service Act Public Laws (93-113)

I. Title I - Corporation for National and Community Service (CNCS)(formerly ACTION)
   - AmeriCorps State and National, AmeriCorps NCCC, and AmeriCorps* VISTA
   - University Year for Action (UYA)
   - Special and Demonstration Volunteer Programs

II. Title II - National Older American Volunteer Programs which now include
   - Foster Grandparent Program
   - Senior Companion Program
   - Retired Senior Volunteer Program (RSVP)

III. Title III - **(**repealed and now contained within the Small Business Act)
   - Service Corps of Retired Executives (SCORE)
   - Active Corps of Executives (ACE)

PART 17
Income

Income is the receipt of money, or the value of goods and services, which can be used to provide for food, shelter or clothing.

Income is counted in the month it is received, whether it is for a previous, current or future period. Any portion remaining is counted with all other assets in the following month. (See Part 16, Section 2.30). This provision pertains to all types of income including lump sums from wages, inheritances and lottery winnings.

The exception to the month received rule is direct deposits and other electronic transfers of funds. These are counted for the month they were intended to be received even if they are posted early or late.

SECTION 1 DETERMINATION OF MONTHLY GROSS INCOME

The gross amount of income (before payroll or other deductions) is used. The source of income and the time frame in which it is received must be considered in determining the gross income for a particular month. Income received less frequently than monthly must be counted in the month received unless it is contract income.

For prospective coverage, income anticipated to be received over the eligibility period must be used.

For retroactive coverage, the actual income for the period to be covered must be used.

SECTION 2 GARNISHMENT OF INCOME

Garnishment is when income is withheld by administrative or court order to pay a creditor or overpayment by a government agency.

For Family - Related categories: income prior to garnishment is used with the exception of garnishment of unearned income to recover an overpayment. This includes, but not limited to, unemployment benefits (UIB), Social Security and Worker's Compensation.

For SSI - Related categories: income is counted even if it is garnished unless the individual was receiving Medicaid at the time a government overpayment occurred. In this case the reduced amount of payment is used in determining the amount of income.

SECTION 3 TYPES OF INCOME

Section 3.1 Attributed income

The amount of tips reported to IRS by large restaurants. It is based on a formula and may not reflect the amount actually received by the employee. The attributed tips are shown on the W-2. It is the responsibility of the employer to keep a daily log of tips actually received. The log of tips will be used to determine the amount of tips countable as income. If there is reason to believe that tips are being underreported, the individual and, with the individual's permission, the employer or collateral sources should be contacted.

Section 3.2 Contract Income

Income received by employees for a set period of time. It may be a full year or for a shorter term, such as school teachers.

Divide the most recent contract income by the length of the term of the contract to determine the monthly average.

Section 3.3 Earned Income

Income received in payment for the labor or services of an individual. It includes cash payments, wages, salaries, commissions, sheltered workshop wages, and profits from self-employment (See Section 3.8 of this Part), severance, contractual payments and deferred compensation.

Section 3.4 Fluctuating Income

Income received by an employee in different amounts each pay period or at irregular intervals. The differences may be due to the number of hours worked, hourly wage rate, output (such as piecework and some types of commissions) or the number of employers (such as baby sitting).

In these cases, the individual's income must be examined over the broadest period of time possible. If the "year to date" (YTD) figure is an accurate reflection of the current situation, divide the amount by the number of weeks the YTD covers and budget this average as regular weekly income.

If the YTD is not accurate, the average weekly income should be based on a review of income representative of the current situation. If there are unusually high or low weeks, then an exploration of how likely they are to continue must be made and their inclusion or exclusion documented.

Section 3.5 Lump Sum Income

Lump sum income is a non-recurring payment received as a result of an accumulation of income or windfall income. Some examples are: retroactive portions of Social Security, Workers' Compensation, Unemployment, Disability, VA or other benefits, pay raises, inheritances, and lottery winnings.

Lump sum income is treated as income in the month of receipt and as an asset in the following month. See Section 4.40 of this Part for exclusions to income and Part 16, Section 2.30 for exclusions as an asset.

Section 3.6 Regular Income

Income received by an employee at regular intervals and in the same amount each pay period. This includes income of salaried employees and hourly wage earners who work the same number of hours at the same hourly pay each week.

The amount of income to be used is based on the frequency it is received.

When income is received once a month, that is the monthly gross income.

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When income is received twice a month (usually the first and fifteenth of each month), multiply the gross wages by two.

When income is received biweekly, multiply the gross wages by 2.15.

When income is received weekly, multiply the gross wages by 4.3.

Section 3.7 Seasonal Income

Income that is not received year round. During the off-season, no income is received from the seasonal occupation.

Seasonal income is budgeted for the period that the individual is actually working. To determine an anticipated amount, use the income received for the most recent season of employment, taking into consideration any expected increases or decreases in income.

Section 3.8 Self-Employment Income

For all categories -

Income received by a self-employed individual who is engaged in a business enterprise. This includes independent contractors, franchise holders, owners / operators, farmers, people who produce and sell a product, and service-type businesses.

If the most recent tax return is available showing the profit or loss, and there have been no major changes, then the monthly gross income is determined by dividing the net profit or loss amount by twelve. The net profit or loss can be found on the appropriate IRS schedule such as the Schedule C.

If a tax return is unavailable, the profits have changed considerably, or the business was started after the beginning of the tax year, the most detailed records showing the net profit should be used. The records may include ledger sheets, receipt books, self-employment work sheets, or any reasonable form of documentation. All deductions allowed by the Internal Revenue Service, including depreciation, may be used.

Some sources of income, though exempt from taxation, are counted in MaineCare. An example is Difficulty of Care payments. The amount that is counted will be the gross receipt minus expenses associated with the production of this income.

The net loss from one source of self-employment is deducted against other earnings including other sources of self-employment income of the individual, his/her spouse or other members of the assistance unit. This applies whether a couple filed a joint income tax return or separate returns, and regardless of which member of the assistance unit incurred the loss. This includes, in SSI - Related categories, the ineligible spouse and parents of disabled children.

Do not allow a deduction for losses from a prior year.

For Family - Related Categories -

For Family - Related categories net income from rental property, roomer and boarders is treated as earned income.

For SSI - Related categories -

For SSI - Related categories net income from rental property is treated as earned income when Income Tax is filed on a Schedule C. It is treated as unearned income if filed in a Schedule E. Net income from roomers and boarders is treated as unearned income.

Section 3.8.1 Corporations

I. A business incorporated as an LLC, a Sub-S or S corporation:
   A. The income of the corporation is owned by the individual.
   B. The assets of the corporation are owned by the individual.

II. A business incorporated as a C corporation:
   A. The income of the corporation is owned by the corporation and is not countable to the individual unless it is distributed to the individual as income.
   B. The assets of the corporation are owned by the corporation and are not countable to the individual except for (C) below.
   C. If the individual owns a share of any corporation but is not employed at least twenty hours per week in the corporation, the individual's share of the corporation is a countable asset. The individual's share is their percentage of ownership in the corporation's book value or market value; whichever is greater. Book value is the corporation's assets minus liabilities.

Section 3.8.2 Sole Proprietorship

This is a business owned by the individual. The business is not incorporated under IRS rules. The individual owns all the assets and income of the business.

Section 3.8.3 Partnership

This is an agreement between two or more individuals who share profit and loss in a business. The specific terms of a partnership determine whether income and assets are owned by the individual unless the provisions of Section 3.8.1 of this Part apply.

Section 3.9 Unearned Income

Income received for something other than payment for the labor or services of an individual.

It includes Social Security, Veteran's Benefits, pensions, dependent's allotments, maintenance agreements, contributions, support payments, annuities, dividends, interest, or unemployment compensation.

Service charges are not deductible in determining dividend or interest income.

For SSI - Related categories roomer and boarder and rental income reported or filed on Schedule E of the Income Tax Form (See Section 3.8 of this Part) are unearned income.

SECTION 4 TREATMENT OF INCOME

Section 4.1 Adoption Assistance – *excluded for Family - Related categories*

Adoption Assistance Payments.

Section 4.2 Agent Orange Settlements – *excluded for all categories*

Agent Orange Settlements as provided for under PL 100-687 and 101-201.

Section 4.3 ASPIRE Payments – *excluded for Family - Related categories*
Exclude all payments made by the ASPIRE-TANF Program.

Section 4.4 Burial Funds – *excluded for SSI - Related categories*
Interest on funds designated for burial or interest earned on the value of agreements representing the purchase of burial spaces (provided the burial spaces are excluded from assets and provided the interest is left to accrue) as long as there is no break in the receipt of assistance. (See Part 16, Section 2.6).

Section 4.5 Cafeteria Plans – *partially excluded for all categories*
Portions of IRS Section 125 payments retained by the employer as payment for benefit items chosen by the employee from the Section 125 menu or "cafeteria plan" are excluded.

Section 4.6 Child Support
For all categories -
Child support payments are income to the child(ren) for whom the payments are intended. This rule applies even if the child does not reside with the parent receiving the payment or if the payments include arrearages (past due amounts) or if the "child" for whom the payments are intended is now over age 18.

For Family - Related Categories -
The first $50.00 per month of current child support payments received by the assistance unit whether received through DSER or direct *is excluded*.

Child support paid by the Department that is in excess of the monthly obligation is excluded. This applies only to TANF recipients

Section 4.7 Children eligible for SSI - Related coverage
The following exclusions from the child's income apply:

I. The first $1640 per month of earned income, not to exceed $6600 per calendar year, for a student attending school regularly as defined by the learning institution.

II. One-third of child support, including a military allotment. The payment may be voluntary or court ordered.

Section 4.8 Children not included in the assistance unit – *excluded for Family - Related categories*
Income of children not included in the assistance unit is not used to determine eligibility of those in the assistance unit. However, their income may be used to determine the amount of income allocated from the assistance unit (See Part 4 for budgeting).

Section 4.9 Combat Pay - *excluded for SSI Related categories*
Hostile fire allotment paid by the Uniformed Services.

Section 4.10 Commercial Transportation Tickets - *excluded for SSI - Related categories*
The value of a domestic commercial transportation ticket received as a gift by an individual (or his or her spouse) and not converted to cash will be excluded in the

determination of the individual's income. Domestic travel is defined as travel among the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands.

Section 4.11 Compensated Work Therapy Program – *excluded for all categories*

Earnings received under the Compensated Work Therapy Program established by Title 38 U.S.C. Section 1718 and administered by the Department of Veteran Affairs. Monies received under this program are considered a social service benefit and not to be considered countable income.

Section 4.12 Cost of Living Adjustment (COLA)

There are two types of income exclusions associated with annual Cost of Living Adjustments. One exclusion is used for any COLA taking effect in January, February and March (See Section 4.11.1 below), while the other only applies to Social Security and Railroad Retirement benefits (See Section 4.11.2 below).

Section 4.12.1 Cost of Living Adjustments taking effect January, February and March – *excluded for all categories*

All annual Cost of Living Adjustments (COLA) that take effect in January, February or March, will be excluded for any individual in a Medicaid coverable group whose income limit is based on the FPL. This exclusion will remain in effect until the month following the month that the new annual Federal Poverty Levels (FPL) are published in the Federal Register. This exclusion also applies to individuals covered by DEL, Maine Rx, Cub Care, and Medicare Buy-In.

Examples:

1. An individual is an ongoing MaineCare recipient. He received a Social Security COLA in January. The Federal Poverty Levels are published in February. The COLA is excluded until March. The cost of living increase is counted in the budget as of April.

   This exclusion also applies in determining retroactive coverage.

2. An individual applies in April. The poverty levels were published in February. The Social Security COLA received in January will be excluded for the retroactive months of January, February and March.

   This exclusion does not apply to individuals covered under Home and Community Bases Waivers and Medically Needy since the Federal Poverty Levels are not used in determining their eligibility.

Section 4.12.2 Social Security and Rail Road Retirement Cost of Living Adjust. (COLA) - *excluded for SSI - Related categories (not excluded for State Supplement)*

If the COLA results in ineligibility for individuals covered under SSI - Related categories, the amount of SSA / RR received prior to the most recent COLA is used to determine eligibility.

This applies to individuals:

I. covered under SSI – Related categories using the Federal Poverty Level as an income limit.

II. covered under Medicare Buy-In.

This applies to individuals in the following living arrangements when comparing their income to the Medicaid rate for the facility:

- Awaiting Placement for Residential Care,
- residing in Cost Reimbursed Boarding Homes,
- in Residential Care Facilities, and
- in Adult Family Care Homes whose income goes over the Medicaid rate.

This exclusion is not used to determine the cost of care for these facilities.

Example:
A disabled individual is eligible and receiving Medicaid. In January he receives his SSDI COLA of $35.00. This increase puts him over the FPL in effect for that month.

The increase will not be counted until the month following the month the new FPL's are published.

In February the new FPL's are published. The individual's countable income is still greater than the new FPL level because of the COLA received in January. The COLA of $35.00 received in January will be excluded to determine the individual's countable income.

This exclusion ends if:

I. the individual loses Medicaid coverage for any reason for three consecutive months.

To determine if an individual has lost Medicaid coverage for three consecutive months the retroactive period of a reapplication must be taken into account. If including the retroactive months the indiviudal was not closed for three consecutive months, the disregard will continue.

Example:

An individual with a COLA disregard closes in June. He reapplies in November. By applying the COLA disragard in the retroactive month of August, September and October the indiviudal is eligibile. The indiviudal will keep the COLA disregard for retroactive and prospective months.

II. the indiviudal's countable income, including the disregarded SSA/RR COLA, is below the FPL.

The individual may again be eligible for the disregard in later years if they again become ineligible due to COLA changes in SSA / RR and FPL.

If the individual receives added or increased income from a source other than SSA / RR at the time of the COLA adjustments, this disregard can be used only if ineligibility is caused by the change in SSA/RR income.

When budgeting for a couple this disregard applies to the SSA / RR of both individuals even though disregarding the COLA increase of only one member of the couple would result in keeping Medicaid coverage for the couple.

Section 4.13 Disability Insurance Payments – *excluded for SSI - Related categories*
All payments made on behalf of an individual under a credit life or credit disability insurance policy (i.e. payment of car payments or mortgage when you become disabled).

Section 4.14 Disabled Widowers Benefits – *excluded for SSI - Related categories*
Social Security benefits received by some disabled widow(er)s who are not receiving Medicare (See Part 6, Section 5.2.9).

Section 4.15 Disaster Relief - *excluded for SSI - Related categories*
In-kind or cash assistance received as the result of a disaster declared by the President of the United States.

Section 4.16 Disaster Unemployment Assistance – *excluded for all categories*
Disaster Unemployment Assistance authorized in P.L. 100-707,42 U.S.C. Section 5155(d) (1988). This is paid to an individual unemployed as a result of a major disaster.

Section 4.17 Earned Income Exclusions for Blind or Disabled – *excluded for SSI - Related categories*
Earned income which is used to meet expenses of producing income by a person who is blind or disabled is excluded. This includes earnings excluded by SSI as part of a PASS plan. These expenses include transportation to and from work (in accordance with IRS guidelines or actual cost if not using own car), cost of caring for a guide dog, child-care, licenses, lunches, Braille instruction, professional association dues, income taxes, tools, union dues and computer training.

Section 4.18 Earned Income Tax Credit (EITC) – *excluded for Family - Related categories*
EITC received as advance payment in weekly wages or received in one sum.

Section 4.19 Emergency Assistance – *excluded for all categories*

Section 4.20 Emergency Conservation Services Program – *excluded for SSI - Related categories*
Any assistance provided in cash or in-kind under the Emergency Conservation Services (ECS) Program (PL 93-644, Sections 222 and 95-568) including cash to prevent fuel cut-offs.

Section 4.21 Experimental Housing Allowance Program – *excluded for all categories*
Payments made under Annual Contribution Contracts entered into prior to 1/1/75, under Section 23 of the U. S. Housing Act of 1937, as amended.

Section 4.22 FmHA Utility Reimbursement – *excluded for all categories*

Section 4.23 Food produced for personal consumption by members of the household – *excluded for all categories*

Section 4.24 Food Supplement Program (FSP) – *excluded for all categories*
The value of benefits under the Food Supplement Program or food distributed by the Department of Agriculture are excluded.

Section 4.25 Foster Care Payments

Excluded for Family - Related categories -
IV-E Foster Care Maintenance Payments

Payments received from the Department or other agencies for foster children in licensed or approved homes who are not part of the assistance unit.

Excluded for SSI - Related categories -
Foster care payments to a provider of foster care for a child or adult who is not an eligible individual but who is living with an eligible individual and who was placed there by a public or private agency.

Section 4.26 General Assistance – *excluded for all categories*

Section 4.27 Goods and services – *excluded for Family - Related categories*
Goods and services not included in the list of basic requirements (See Chart 1.)

Section 4.28 Governor Baxter School Compensation – *excluded for all categories*
One time cash payment from the Governor Baxter School for the Deaf Compensation Authority. Interest on this compensation is excluded as income and any accrued interest is excluded as an asset.

Section 4.29 Grants, Loans Scholarships

I. Administered by Commissioner of Education – PL 90-575 – Title V

A. The grants and loans are:
1. Basic Education Opportunity Grant Program (Pell Grants)
2. National Direct Student Loan program (Perkins Loans)
3. Supplemental Education Opportunity Grant Program (SEOG)
4. Guaranteed Student Loan Program
5. State Student Loan Program

Family - Related – *exclude all*

SSI - Related – *exclude for all undergraduates and exclude only tuition and fees for graduate students*

B. All other grants/loans/scholarships:

Family - Related – *exclude tuition, fees, other necessary educational expenses, and child care in accord with Part 4, Section 3.*

SSI - Related – *exclude tuition and fees and other necessary educational expenses for undergraduates and count for all other students*

Educational expenses include lab fees, student activity fees, transportation, stationary supplies, books, technology fees, and impairment related expenses necessary to attend school or perform school work.

II. Federal College Work Study Program - *excluded for all categories*.

III. For Family - Related categories only –
Certain grants, loans and scholarships to the extent that they do not include funds for items such as food, shelter, clothing or personal needs:

A. Educational programs for veterans -

The Veterans Administration (VA) sponsors several different educational assistance programs. One does not have to be a veteran to qualify for assistance under some of the programs.

Each individual who qualifies for and receives educational assistance receives an award letter from the VA which indicates the amount to be received and the period of time during which it will be received.

That part of the payment received from the VA for an individual's dependents who are in the assistance unit must be counted as available income to those individuals.

B. Any funds granted for educational purposes that are based on need and consider the TANF payment as income in determining educational assistance, the grant, loan, or scholarship is excluded. This applies whether or not payment is made direct to the institution or to the student for educational purposes.

Verification of these conditions must be obtained through the student, the institution or the source prior to disregarding any portion of the funds.

Section 4.30 Home Based Care Funds – *excluded for all categories*

Section 4.31 Home Energy Assistance Program (HEAP) – *excluded for all categories*
Assistance with fuel bills or weatherization assistance received through the Home Energy Assistance Program (HEAP).

Section 4.32 Housing

Excluded for all categories -

I. Value of relocation assistance under the Uniform Relocation and Real Property Acquisition Policies Act of 1970 (PL 91-646 Title II). This does not include payment for the fair market value of the property.

II. Any interest paid on HUD escrow accounts is not countable income as long as a family is receiving any state, federal or other public assistance for housing and they cannot access this amount. The "Family Self-Sufficiency Program" is a five year program open to all section 8 housing participants which aims to help the family become self-sufficient at the end of the five years. When the account becomes available, it is countable as a resource and/or interest income.

III. Value of assistance for housing under the Housing Authorization Act of 1976 (PL 94-375) or Housing Act of 1937 as amended by PL 92-213.

For Family - Related categories only –

HUD community development block grant funds received to finance the rehabilitation of a privately owned residence. HUD monies must be used for major property repairs or capital improvements. HUD payments are made by check payable directly to the contractor or jointly to the contractor and property owner.

Section 4.33 HUD Utility Reimbursement - *excluded for all categories*

Section 4.34 Individual Development Accounts – *excluded for all categories*

Contributions to an Individual Development Account (IDA). See the asset rule for a definition of an IDA.

I. Family Development Account (FDA for TANF recipients) -

A. any income used by the individual to fund this account excluded as income.
B. any asset used by the individual to fund this account is excluded as an asset including up to $10,000 of lump sum income remaining in the month following receipt.
C. any individual contributions that are matched are excluded as income.
D. accrued interest on FDA funds is excluded as income or asset.
E. Withdrawals from these accounts at any time must be used for the following purposes in order for the fund to remain an exempt asset:
   1. expenses for education or job training to attend an accredited or approved post secondary education or training institution;
   2. the purchase or repair of a home that is the primary residence;
   3. the purchase or repair of a vehicle used for transportation to work or to attend an education or training program;
   4. capital to start a small business for any member of the assistance unit 18 years of age or older;
   5. health care costs of a member of the assistance unit that are medically necessary and that are not covered by public or private insurance;
   6. to address an emergency that may cause the loss of shelter, employment or other basic necessities; or
   7. to address other essential family needs approved by the Department.

When withdrawals are used for any other purpose this will result in the fund being considered a countable asset effective the month of the withdrawal. The TANF Program determines if this condition is met.

II. Demonstration Project Account (AFIA) -

A. any income of the individual deposited in an AFIA are excluded as income.
B. any individual contributions that are matched by another party are excluded as income or assets.
C. accrued interest on AFIA funds are excluded as income or assets.
D. withdrawal from these accounts is allowable only for certain reasons as determined by the agency authorizing this IDA. These reasons include post- secondary educational expenses, acquiring a residence, or expenditures for operating a business.

Section 4.35 Income of those who could be in the household except they are in a medical facility – *excluded for Family - Related categories*

Income of persons who could be members of the assistance unit except that they are in a hospital, intermediate care facility (ICF) or skilled nursing facility (SNF). In most situations, the income of the individual in the hospital or nursing home is used to determine nursing home eligibility. This also takes place when the individual is in an acute care facility for a period of more than sixty days or immediately upon entering a hospital for a kidney transplant.

Section 4.36 Income tax refunds – *excluded for all categories*

Note: These are countable assets on the first day of the month following the month received.

Section 4.37 Irregular or Infrequent Income – *excluded for all categories*

Earned or unearned income, from a single source, which is received irregularly (receipt cannot reasonably be expected) or infrequently (no more than once during a calendar quarter). This amount is not to exceed $60.00 per calendar quarter for unearned income and $30.00 per calendar quarter for earned income. This includes small gifts of income such as those received at Christmas, graduation, birthdays or anniversaries.

Section 4.38 Job Related Expenses – *excluded for Family - Related categories*

Reimbursement for job related expenses such as travel or uniforms to the extent that they do not represent a gain or exceed actual expenses.

Section 4.39 JTPA/Job Corp Payments

Family - Related categories -

All JTPA income or Job Corps payments are excluded except on-the-job training income of an individual at least 19 years old who is not a dependent child.

SSI - Related categories -

Payment by JTPA for supportive services such as child-care, transportation, medical care, meals and other reasonable expenses are excluded.

Note: All other payments from JTPA are considered income.

Section 4.40 Loans – *excluded for all categories*

Money borrowed by an individual providing there is clear evidence of an agreement to repay. The proceeds of the loan are not income in the month borrowed, however, they are considered countable assets in the following month.

Written statements from both the individual and the party lending the money must be obtained indicating that the funds are a loan, the amount and the plan for repayment. Without verification of the loan the funds will be considered a gift and treated as a lump sum (See Section 4.40 below).

Section 4.41 Lump Sum Income

Income that has accumulated and is received in one payment by the individual is considered a lump sum. This includes Worker's Compensation, retroactive Social Security payments, Unemployment Benefits received retroactively due to the result of a hearing, and Veteran's Benefits. Gifts, inheritances, lottery winnings and insurance settlements are also considered to be a lump sum payment.

Lump sum income is counted as income in the month received, and any remaining the next month are counted as an asset. SSI lump sum payments are excluded income.

For Family - Related categories –
Deduct the following to determine the amount of countable lump sum income:

I. attorney's fees; and

II. any portion earmarked and verified as having been used for the purpose for which it was paid (i.e., monies for back medical bills resulting from accident or injury, funeral and burial costs, replacement or repair of a lost resource, etc.).

III. In addition, exclude as income any amount used within thirty days of receipt for any of these purposes:
   A. expenses for education or job training to attend an accredited or approved post secondary education or training institution;
   B. The purchase or repair of a home that is the family's primary residence;
   C. the purchase or repair of a vehicle used for transportation to work or to attend an education or training program; and
   D. capital to start a small business for any member of the assistance unit who is 18 years of age or older.

IV. In addition, exclude as income up to $10,000 used within thirty days of receipt for any of the following purposes:
   A. health care costs of a member of the assistance unit that are medically necessary and that are not covered by public or private insurance;
   B. to address an emergency that may cause the loss of shelter, employment or other basic necessities;
   C. to address other essential family needs approved by the Department;
   D. transferred to a Family Development Account authorized by state law or to a separate identifiable account; withdrawals from these accounts at any time must be used for the items in (III) and (IV). Withdrawals used for purposes other than in (III) and (IV) terminate the exemption of the fund as an asset. This determination is made by TANF.

Any amount remaining in the month following receipt is a countable asset.

SSI - Related categories –
SSI or Social Security retroactive payments are excluded as an asset for nine months. After that, any portion remaining becomes a countable asset.

The exception to the month received rule is direct deposits and other electronic transfers of funds. These are counted for the month they were intended to be received even if they are posted early or late.

Section 4.42 Native American payments

Excluded for all categories –

I. Any payments distributed per capita to or held in trust for members of any Indian tribes under PL 92-524, 93-134, 94-540, 97-458 or 98-64.

II. Receipts distributed to members of certain Indian tribes referred to in Section 5 of PL 94-114, effective 10/17/75, and PL 98-123 and 98-124, effective 10/13/83.

III. Any income or assets accruing to members of the Passamaquoddy Tribe, the Penobscot Nation and the Houlton Band of Maliseet Indians pursuant to PL 96-420 (the Maine Indian Claims Settlement Act of 1980).

IV. The tax exempt portions of payments made pursuant to PL 93-203, the Alaskan Claims Settlement Act.

Excluded for SSI - Related categories –

I. Native American payments as detailed in Title 20 CFR, Part 416 Appendix to Subpart K (IV).
II. Per capita distribution payments, receipts from trust lands and dividend payments to members of various native American and Indian tribes such as Blackfeet, Gros Ventre, Grand River Band, Alaskan Native Claims Settlement Act under the provisions of Distribution and Judgment Funds (PL 92-254 Sections 4, 6, and 7), Receipts from Lands Held in Trust for Indian Tribes (PL 94114, Section 6).

Section 4.43 Nazi persecution payments – *excluded for Family - Related categories*
Payments made to victims of Nazi persecution under Public Law 103-286 (Nazi Persecution Victims Eligibility Benefits).

Section 4.44 Nutrition and Food Assistance – *excluded for all categories*

I. The value of supplemental food assistance under the Child Nutrition Act of 1966 (WIC), as amended and the special food services program for children under the National School Lunch Act, as amended (PL 92-422, PL 90-302 and PL 93-150).

II. Any benefit received under Title VII Nutrition Program for the Elderly, of the older Americans Act of 1965, as amended by PL 95-478.

Section 4.45 Payments to replace income – *excluded for SSI - Related categories*
All payments made to replace income that has been lost, destroyed or stolen.

Section 4.46 Radiation Exposure Compensation – *excluded for all categories*
Money received under the Radiation Exposure Compensation Act for injuries or death resulting from radiation due to nuclear testing and uranium mining.

Section 4.47 Rent rebates – *excluded for SSI - Related categories*
Rebates by any public agency of taxes or rent rebate on real property.

Section 4.48 Repayment of a loan – *excluded for all categories*
Money received as the repayment of the principal of a loan (including a promissory note) is not income in the month received. Any amount retained in the following month is considered a countable asset. Money received as interest payments is considered income in the month received.

Example:
A couple sells their home and holds a mortgage at 10%. They receive $315 per month as a mortgage payment. Of that amount, $200 is interest and must be counted as income in the month received. The remaining $115 is repayment of the principal and is excluded income for the month. Any portion of the principal remaining in the following month is a countable asset for that month.

Section 4.49 Ricky Ray Hemophilia Fund – *excluded for all categories*
Payments received under the Ricky Ray Hemophilia Relief Fund Act of 1998. Interest income generated on these payments is countable income and any accrued interest is excluded as an asset. These payments are not subject to special rules on trusts or a transfer of resource penalty. Payments are not counted in determining a cost of care.

Section 4.50 Savings bonds – *excluded* for SSI - Related categories
Interest on Series E, EEE and H Savings Bonds is not counted as income at any time. When these bonds are redeemed, the interest is a countable asset.

Interest on Series HH Savings Bonds is paid by direct deposit, semi-annually. The interest would be considered unearned income in the month received.

Section 4.51 Self Support Plans – *excluded for SSI - Related categories*
That portion of earned or unearned income needed to fulfill a plan for self-support approved by Vocational Rehabilitation or the Social Security Administration (including PASS plans) for an individual who is disabled or blind.

Section 4.52 Selling, replacing or exchanging an asset – *excluded for all categories*
Money received as a result of selling, replacing or exchanging an asset is excluded as income. They are assets that have changed their form.

Section 4.53 Senior Community Service Employment Program (SCSEP) – *excluded for SSI - Related categories*
A wage or salary from the Senior Community Service Employment program is earned income. Anything else is excluded. Community Service Employment is a Program for older Americans authorized under Chapter 35, Title 42 of U.S. Code.

Section 4.54 SSI Payments – *excluded for SSI - Related categories*
SSI benefits received by a spouse, parent or other family member when determining non-nursing care assistance.

Section 4.55 Student Income – *excluded for Family - Related categories*
Wages of dependent children under the age of 21 as long as they are full-time students or part-time students not employed full time.

Students are considered students throughout the calendar year, including summer months as long as they intend to return to school in the fall.

A student is one who is attending a school, college or university or a course of vocational training designed to prepare the student for gainful employment. This includes a participant in the Job Corps Program.

An individual under the age of 21 may be considered a student regularly attending a school or a training course if:

I. enrolled in and physically attending full time (as certified by the school or institution) a program of study or training leading to a certificate, diploma or degree;

II. enrolled in and physically attending at least half-time (as certified by the school or institution attended) a program of study or training leading to a certificate, diploma or degree and is regularly employed in or available for and actively seeking part-time employment; or

III. enrolled in a program of study or training leading to a certificate, diploma or degree but unable to attend half-time or seek part-time employment because of a verified physical handicap.

Section 4.56 Susan Walker Settlement – *excluded for all categories*

Payments made from any fund established pursuant to a class settlement in the case of Susan Walker v. Bayer Corp., et al, and payments made pursuant to a release of all claims in a case that is entered into in lieu of the class settlement.

When payments are made in lieu of a class settlement, the agreement must be signed by all parties on or before 12/31/97 or 270 days after the date on which a release is first sent to the persons to whom the payment is to be made.

Section 4.57 TANF – *excluded for SSI - Related categories*

TANF benefits received by a spouse, parent or other family member are excluded. These people are also not counted as members of the assistance unit during the budgeting process.

Section 4.58 VA Benefits for Vietnam veterans' children with spina bifida – *excluded for all categories*

VA monthly payments made to or on behalf of Vietnam veterans' natural children regardless of their age or marital status for any disability resulting from spina bifida suffered by such children are excluded from income and resources. Interest earned on unspent payments is not excluded.

Section 4.59 VA Benefits that have special treatment – *partially excluded for SSI - Related categories*

I. Excluded as income is that portion of a VA benefit (Pension or Compensation) which is paid to disabled veterans, their spouses, widows or parents as an Aid and Attendance, Housebound Allowance or payments resulting from Unusual Medical Expenses.

There are two exceptions to this rule:

A. Benefits in excess of $90.00 per month are counted in determining the cost of care for a resident of a State Veteran's Nursing Home if the resident is a veteran with no dependents or surviving spouse with no dependents.
B. There is no exclusion of benefits when determining the cost of care in a RCF, CRBH, or AFC.

II. VA benefits for dependents. VA may increase the amount of a benefit if the veteran or surviving spouse has a dependent.
   A. When the increase is included in the payment to the veteran or surviving spouse and the dependent resides with the veteran or surviving spouse. This is called an “augmented benefit." The share attributed to a dependent is income to the dependent only. If the dependent does not live with the veteran or surviving spouse, the dependent’s share is not income to anyone.
   B. When the dependent of a veteran or surviving spouse does not live with the veteran or surviving spouse VA may pay the increase directly to the dependent. This is called an “apportionment” or “apportioned benefit”. This payment is unearned income to the dependent.

Section 4.60 Vendor Payments – *excluded for SSI - Related categories*

Vendor payments (payments for goods or services provided to an eligible individual or couple which are made directly to a vendor by a third party).

Section 4.61 Volunteer Service Programs – *excluded for all categories*

Any payment whether cash or in-kind made under the Domestic Volunteer Service Act Public Laws (93-113)

I. Title I - Corporation for National and Community Service (CNCS)(formerly ACTION):
   A. AmeriCorps State and National, AmeriCorps NCCC, and AmeriCorps* VISTA,
   B. University Year for Action (UYA), and
   C. Special and Demonstration Volunteer Programs.

II. Title II - National Older American Volunteer Programs which now include:
   A. Foster Grandparent Program
   B. Senior Companion Program
   C. Retired Senior Volunteer Program (RSVP)

III. Title III - **(**repealed and now contained within the Small Business Act):
   A. Service Corps of Retired Executives (SCORE)
   B. Active Corps of Executives (ACE)

Appendix A
Medicare and the Buy-In Process

Medicare (Title 18 of the Social Security Act) is a health program administered by the Centers for Medicare and Medicaid Services (CMS). Coverage is available to nearly everyone over age 65 and those who have been receiving Social Security Benefits as disabled for twenty-four consecutive months.

Medicare Part "A" provides hospital, hospice and skilled nursing facility benefits. It is available without charge to individuals who have worked a certain number of quarters where FICA deductions are mandated. People who are not eligible automatically may enroll by paying a monthly premium.

Medicare Part "B" is optional medical insurance for which everyone enrolling must pay a monthly premium. Most individuals pay the same amount but when enrollment in Part B is postponed, individuals pay a different rate. There is an increase in the premium for each year of delay in enrolling in Medicare Part B. Part "B" assists in payments for doctors, outpatient hospital care, therapy, ambulance and laboratory services.

Both parts of Medicare have deductibles and coinsurance charges which are the responsibility of the individual, although private insurance plans (Medigap) may be purchased which cover these payment gaps.

The following groups of individuals and couples are provided with additional benefits by Medicaid when enrolled in Medicare:

	Payment of Part A	Payment of Part B	Payment of Medicare Deductible & Co-Ins.
SSI and State Supplement Recipients		X	X
Pickle Amendment		X	X
Qualified Medicare Beneficiaries (QMB)	X	X	X
Qualified Disabled and Working Individual (QDWI)	X		
Specified Low Income Medicare Beneficiaries (SLMB)		X	
Qualifying Individuals (QI) Part 1		X	

Aside from Medicare Parts A and B there is Medicare Part D which is a prescription drug benefit through private insurance companies. People who are enrolled in Medicare Buy-In have reduced costs for their medications under Medicare Part D.

The state payment for Medicare premiums is done with a monthly data exchange between the State and Federal governments. There is usually a delay between the time an individual is eligible for the buy-in and the time the buy-in begins. During this time, the individual continues to have the premium deducted from their Social Security or Railroad retirement check. Once the buy-in begins, the individual receives the gross Social Security Benefit. They are reimbursed by Social Security or Railroad retirement for the premium collected during any delay period.

Appendix B
Calculation for Substantial Gainful Activities (SGA) and Impairment Related Work Expenses (IRWE)

To compute SGA earnings and costs of certain items and services needed to work and related to medical impairment will be deducted from the monthly average gross earnings. These costs are allowable even though the items and services are also used for daily living needs in addition to work, unless otherwise stated below. The costs for each item must be the responsibility of the disabled individual. Actual or potential reimbursements from another source will reduce the allowable deduction.

Example:

Individual purchases crutches for	$80.00
Reimbursement from another source	- $64.00
Allowable cost	$16.00

I. Allowable Expenses for Consideration

A. Attendant Care Services - Only that portion of cost associated with assistance:
   1. traveling to and from work:
   2. with personal functions while at work (such as eating and toileting):
   3. with work related functions (such as reading, communicating): and
   4. with personal functions at home for work (such as dressing, administering medications).

Note: Attendant care services may be paid to a family member only if that person suffered an economic loss by ending this job or other employment in order to perform these services. The family member can be related by blood, marriage, or adoption, and need not live with the disabled person.

B. Medical Devices - This item includes durable equipment (such as canes, wheelchairs, crutches).

C. Prosthetic Devices (such as artificial limbs).

D. Work Related Equipment specifically designed to accommodate an impairment (such as typewriters and telecommunication devices for deafness).

E. Residential Modifications:
   1. Outside - For individuals employed away from home, changes may be made to the outside of the home to permit transportation to work (such as the installation of an exterior ramp for a wheelchair confined person or special railing or pathways for a person requiring crutches).
   2. Inside - If an individual is employed at home, costs of modifying the inside of the home is allowed to create a work space to accommodate the individual's impairment. Only those expenses associated directly with the work area will be allowed, (such as the enlargement of the doorway leading to the work area).

Note: If the cost can be deducted as a business expense for the IRS, then it cannot be deducted in this calculation.

F. Non-medical Appliances and Equipment - Appliances and equipment specifically prescribed by a physician as essential for control of the impairment. Essential means the item must be one that if not available would cause immediate adverse impact on the individual's ability to function in work activity. (such as the need for an electric air cleaner for an individual who has severe respiratory disease and must work in a purified air environment).

G. Drugs and Medical Services - including diagnostic procedures to control medical impairments. These items must be prescribed or utilized to reduce or eliminate symptoms of the impairment or to slowdown its progression. The diagnostic procedures must be performed to ascertain how the impairment is progressing or to determine what type of treatment is needed (such as anticonvulsant drugs for epilepsy, antidepressant drugs for mental disorders, radiation treatments or chemotherapy for cancer patients). Items or services not directly related to the impairment are not allowable deductions (such as routine annual physical exams, optician services when the impairment is not visual and dental checkups).

H. Medical Supplies - Medical items utilized for work and directly related to the impairment. (such as catheters, bandages, irrigating kits and face masks).

I. Transportation - Payments for transportation are limited to the following:

1. Own Vehicle:
   a. If the individual's impairment necessitates a modified vehicle needed for travel to work, modifications must be critical to the individual's operation or use of the vehicle and directly related to the impairment. The cost of the modifications is deductible but not the cost of the vehicle.
   b. If the impairment prevents use of public transportation to and from work, a physician must verify that the need to drive is caused by the impairment and not the lack of public transportation.
   c. The standard IRS mileage rate will be given for the trip to and from work and also, if needed, the cost to hire a driver.
2. Hired Transportation - Actual payments made to hire a driver will be allowed but not a mileage allowance.

   Exception:
   Except for mileage and modifications, costs for the operation of any vehicle are not allowable.

J. Installation, Maintenance and Repairs - Costs directly associated with these services for all appliances or devices, which qualify as a deduction in this appendix.

II. Limits on Deductions

Payments for allowable expenses must be made during a month when the individual was working. An individual is considered working even if absent from work temporarily to receive medical treatment.

In addition, a portion of payments for certain items made in any of the eleven (11) months preceding a month of work can be used.

> **Note:** Allowable deductions in anticipation of work are limited to durable items such as medical devices, prosthesis, work related equipment, residential modifications, non-medical appliances and vehicle modifications, as defined in Section A above. Payments for services and expendable items such as drugs, oxygen, diagnostic procedures, medical supplies, and vehicle operating costs are not deductible for purposes of determining payments in anticipation of work.

For recurring expenses, payments made on a regular periodic basis, on credit and paid in installments, or rental, may be used.

For non-recurring expenses the one time payment may be deducted in one month or over a twelve consecutive month period beginning with the month of payment.

For down payments a separate deduction process is possible which may be prorated for up to a year. The proration may be for a shorter time period if the regular monthly payments are extended over a period of less than twelve months. When this happens, the proration time period for the down payment and duration of the regular monthly payments will be the same.

> **Example:**
> Individual begins to work on 3/1/07 and at the same time purchases special equipment which costs $4800, giving $1200 down. The balance of $3600, plus interest of $540.00, is to be repaid in thirty-six installments of $115 per month beginning 4/1/07

$ 1200.00	Down payment 3/07
+ $ 1265.00	Monthly payments
$ 2465.00	
÷ 12	Months
= $ 205.42	Monthly deduction

> A monthly deduction of $205.42 would be allowed. Beginning 3/08, the deduction changes to the regular monthly payment of $115.00 per month.

Before any payments are used as deductions against SGA, the amounts must be determined reasonable.

Amounts up to the prevailing charges for durable medical equipment, prosthetic devices, medical services, and similar medically-related items and services as set by Medicare will be allowed. If the individual pays more than the prevailing charge allowed under Medicare it will be allowed if he or she can establish that the average is consistent with normal charges within their community.

> **Example:**

Mr. Adams applies for Medicaid based on his disability. His assets are below $2000. His income consists of Social Security benefits of $132.90 gross and part time earnings of $530.00 gross a month.

After determining that the job was not created out of sympathy, a hobby, or part of therapy or Vocational Rehabilitation training, the presence and value of impairment related work expenses must be considered.

Mr. Adams is currently paying for a special shoe made from a mold and which costs $682.00. He has been making $50.00 payments monthly after an initial $100.00 down payment in 3/08 when he also found employment.

Using the policy under down payments, the calculation for the pretest is:

$ 100.00	Down payment
+ $ 582.00	
$ 682.00	
÷ 12	Months
$56.83	Monthly payments over one year

As an allowable Impairment Related-Work Expense:

$ 530.00	Gross wages
- $ 56.83	IRWE
$ 473.17	Compare to earnings allowable standard. (see example to calculate eligibility).

Appendix C
Pickle Amendment

In order to be considered under this amendment all of the following criteria must be met:

I. There must have been concurrent entitlement to both SSI or State Supplement and Social Security benefits no earlier than 4/1/77. Concurrent entitlement can occur without concurrent receipt. Usually entitlement to Social Security benefits occurs the month prior to receipt of the first Social Security check.

II. The individual or couple must be current recipients of Social Security benefits.

III. The reason for closure of SSI benefits can be for any reason.

IV. If there is a spouse, with Social Security benefits used in the deeming process, the COLA of the spouse may also be disregarded even if the spouse does not qualify for PICKLE status. This disregard applies only when using the SSI income standard as the criteria.

When these conditions are present, all COLA's since the last loss of SSI or the State Supplement (but not prior to 7/77) will be disregarded from monthly countable income as the last step in that process.

Individuals or couples, who are categorically eligible, without using this disregard, are not eligible under the Pickle Amendment.

As an additional benefit, the State of Maine will pay the Medicare Part B premium of Pickle individuals or couples. (see Appendix A)

Once an individual or couple is covered under this group, each additional COLA is disregarded along with the initial increase to determine continued eligibility.

Individuals or couples remain in this group until ineligible due to other SSI criteria, such as no longer living in Maine, increase in assets, increase in income from another source, or change in living arrangements.

Individuals and couples may lose coverage under this group and later regain it. Continuous eligibility is not necessary.

Example:
Mr. Tom Keys' SSI was closed when he became entitled to Social Security benefits in 6/97. A review was completed to determine Medicaid coverage.

$ 600.00	Gross income
- $ 20.00	Federal disregard
$ 580.00	
- $ 55.00	State disregard
$ 525.00	> State Supplement standard ($494.00 eff. (1/97)

This determination placed Tom in a deductible for 6/97 – 11/97. In 2/05, Mr. Keys reapplies.

$ 718.20	
- $ 20.00	Federal disregard
$ 698.20	
- $ 55.00	State disregard
$ 643.20	> State Supplement standard ($589.00)
- $ 118.20	Pickle disregard of COLAs 1/98 - 2005
$ 525.00	< Categorical standard ($589.00)

This results in eligibility effective 2/2005.

One of the problems that may arise during calculation of this disregard results when all the prior Social Security benefits needed are not available through old records of SVES. However, using the following formula and chart, the COLA's can be determined when only one benefit amount is confirmed.

$$\frac{\text{Current Gross Benefit}}{\div\ 1 + \text{COLA increase \%}}$$

previous gross benefit

Cost of Living Adjustment to Social Security Benefits

Check Received Month/Year	Percent of Increase	New Medicare Premium
July 1977	5.9%	$7.60
July 1978	6.5%	$8.20
July 1979	9.9%	$8.70
July 1980	14.3%	$9.60
July 1981	11.2%	$11.00
July 1982	7.4%	$12.20
July 1983	Delayed	Delayed
January 1984	3.5%	$14.60
January 1985	3.5%	$15.50
January 1986	3.1%	$15.50
January 1987	1.3%	$17.90
January 1988	4.2%	$24.80
January 1989	4.0%	$31.90
January 1990	4.7%	$28.60
January 1991	($33.90 Jan – Apr) $29.80 reimbursement	$29.90
January 1991	5.4%	$29.90
January 1992	3.7%	$31.00
January 1993	3.0%	$36.60
January 1994	2.6%	$41.10
January 1995	2.8%	$46.10
January 1996	2.6%	$42.50
January 1997	2.9%	$43.80
January 1998	2.1%	$ 43.80
January 1999	1.3%	$45.50
January 2000	2.5%	$45.50
January 2001	3.6%	$50.00
January 2002	2.6%	$54.00
January 2003	1.4%	$58.70
January 2004	2.1%	$66.60
January 2005	2.7%	$78.20
January 2006	4.1%	$88.50
January 2007	3.3%	$93.50
January 2008	2.3%	$96.40
January 2009	5.8%	$96.40
January 2010	--	$110.50
January 2011	--	$115.40
January 2012	3.6%	$99.90

Example:
Check received 10/82 shows a benefit amount of $182. The gross would be $12.20 more to account for Medicare.

$194.20
÷ 1.074
$208.571 or $209 In 1981 Medicare was an even $11.00.

This method is not fault free because the Social Security Administration has changed the rounding off rule several times in recent years. The method will be off if the individual receives benefits based on a spouse or parent's earnings record. Also, if a change in benefit type took place, such as the individual is receiving benefits from a living spouse who dies, changing the claim type to widow benefits.
If correction of prior eligibility for Medicaid is needed, to determine how far back to start a Medicare buy-in, refer to the standards below:

	Individual				**Couple**			
Date	Setting	Fed Dis.	State Dis.	Standard	Setting	Fed Dis.	State Dis.	Standard
Apr 1977	alone	$20	$42.30	$177.80	alone	$20	$64.40	$266.70
	with others	$20	$44.30	$175.80	with others	$20	$67.40	$266.70
	HH of another	$20	$44.30	$119.87	HH of another	$20	$67.40	$177.80
Jul 1977	alone	$20	$42.30	$187.80	alone	$20	$64.40	$281.70
	with others	$20	$44.30	$185.80	with others	$20	$67.40	$278.70
	HH of another	$20	$44.30	$126.54	HH of another	$20	$67.40	$189.80
Jul 1978	alone	$20	$42.30	$199.40	alone	$20	$64.40	$299.10
	with others	$20	$44.30	$197.40	with others	$20	$67.40	$296.10
	HH of another	$20	$44.30	$134.27	HH of another	$20	$67.40	$201.40
Jul 1979	alone	$20	$42.30	$218.20	alone	$20	$64.40	$327.30
	with others	$20	$44.30	$216.20	with others	$20	$67.40	$324.30
	HH of another	$20	$44.30	$146.80	HH of another	$20	$67.40	$220.20
Jul 1980	alone	$20	$42.30	$248.00	alone	$20	$64.40	$372.00
	with others	$20	$44.30	$246.00	with others	$20	$67.40	$369.00
	HH of another	$20	$44.30	$166.67	HH of another	$20	$67.40	$250.00
Jul 1981	alone	$20	$42.30	$274.70	alone	$20	$64.40	$412.00
	with others	$20	$44.30	$277.70	with others	$20	$67.40	$409.00
	HH of another	$20	$44.30	$184.47	HH of another	$20	$67.40	$276.67
Jul 1982	alone	$20	$42.30	$294.30	alone	$20	$64.40	$441.40
	with others	$20	$44.30	$292.30	with others	$20	$67.40	$438.40
	HH of another	$20	$44.30	$292.30	HH of another	$20	$67.40	$438.40
Jul 1983	alone	$20	$42.30	$314.30	alone	$20	$64.40	$471.40
	with others	$20	$44.30	$312.30	with others	$20	$67.40	$468.40
	HH of another	$20	$44.30	$312.30	HH of another	$20	$67.40	$468.40
Jan 1984	alone	$20	$42.30	$324.00	alone	$20	$64.40	$487.00
	with others	$20	$44.30	$322.00	with others	$20	$67.40	$484.00
	HH of another	$20	$44.30	$322.00	HH of another	$20	$67.40	$484.00
Jan 1985	alone	$20	$42.30	$335.00	alone	$20	$64.40	$503.00
	with others	$20	$44.30	$333.00	with others	$20	$67.40	$500.00
	HH of another	$20	$44.30	$333.00	HH of another	$20	$67.40	$500.00
Jan 1986	alone	$20	$42.30	$346.00	alone	$20	$64.40	$519.00
	with others	$20	$44.30	$344.00	with others	$20	$67.40	$516.00
	HH of another	$20	$44.30	$344.00	HH of another	$20	$67.40	$516.00
Jan 1987	alone	$20	$42.30	$350.00	alone	$20	$64.40	$525.00
	with others	$20	$44.30	$348.00	with others	$20	$67.40	$522.00
	HH of another	$20	$44.30	$348.00	HH of another	$20	$67.40	$522.00

	Individual					Couple				
Date	Federal Dis.	State Dis.	Living Alone	Living with Others	Living in HH of Another	Federal Dis.	State Dis.	Living Alone	Living with Others	Living in HH of Another
Jul 1987	$20	$55	$350	$350	$348	$20	$80	$525	$525	$522
Jan 1988	$20	$55	$364	$364	$362	$20	$80	$547	$547	$544
Jan 1989	$20	$55	$378	$378	$376	$20	$80	$568	$568	$565
Jan 1990	$20	$55	$396	$396	$394	$20	$80	$594	$594	$591
Jan 1991	$20	$55	$417	$417	$415	$20	$80	$625	$625	$622
Jan 1995	$20	$55	$468	$468	$466	$20	$80	$702	$702	$699
Jan 1996	$20	$55	$480	$480	$478	$20	$80	$720	$720	$717
Jan 1997	$20	$55	$494	$494	$492	$20	$80	$741	$741	$738
Jan 1998	$20	$55	$504	$504	$502	$20	$80	$756	$756	$753
Jan 1999	$20	$55	$510	$510	$508	$20	$80	$766	$766	$763
Jan 2000	$20	$55	$523	$523	$521	$20	$80	$784	$784	$781
Jan 2001	$20	$55	$541	$541	$539	$20	$80	$811	$811	$808
Jan 2002	$20	$55	$555	$555	$553	$20	$80	$832	$832	$829
Jan 2003	$20	$55	$562	$562	$560	$20	$80	$844	$844	$841
Jan 2004	$20	$55	$574	$574	$572	$20	$80	$861	$861	$858
Jan 2005	$20	$55	$589	$589	$587	$20	$80	$884	$884	$881
Jan 2006	$20	$55	$613	$613	$611	$20	$80	$919	$919	$916
Jan 2007	$20	$55	$633	$633	$631	$20	$80	$949	$949	$946
Jan 2008	$20	$55	$647	$647	$645	$20	$80	$971	$971	$968
Jan 2009	$20	$55	$674	$674	$672	$20	$80	$1011	$1011	$1008
Jan 2011	$20	$55	$698	$698	$696	$20	$80	$1048	$1048	$1045

Appendix D
Other Coverage Groups Still in Federal Law

INDIVIDUALS OR COUPLES WHO WOULD HAVE LOST AID TO THE AGED, BLIND OR DISABLED (AABD) COVERAGE SOLELY DUE TO AN INCREASE IN SOCIAL SECURITY BENEFITS IN AUGUST, 1972

Individuals or couples must have been receiving or eligible to receive AABD in 8/72, and must have received an increase in Social Security Benefits in 8/72. Individuals or couples who would have been eligible for AABD except that they were residing in an institution are also included in this section. If the individual or couple would be eligible for SSI after disregarding the increase in Social Security, the individual or couple is eligible for coverage as Categorically Needy.

INDIVIDUALS WHO WERE ELIGIBLE AS "ESSENTIAL SPOUSES" IN DECEMBER 1973

The individual must have been living with a recipient of the Aid to the Aged, Blind or Disabled (AABD) program in 12/73 and receiving Medicaid at that time. "Essential Spouse's needs must have been used to determine the amount of the AABD grant." In order to continue Medicaid for the "essential spouse", the former AABD recipient must continue to be eligible for an SSI payment and the needs of the "essential spouse" must continue to be included in determining the payment to the SSI recipient.

INSTITUTIONALIZED INDIVIDUALS WHO WERE ELIGIBLE IN DECEMBER 1973

The individuals must have been eligible for Medicaid in 12/73 as inpatients of medical institutions or intermediate care facilities that were participating in the Medicaid program. The individual must continue to meet Medicaid eligibility requirements in effect in 12/73, continue to reside in the institution and be classified as needing institutionalized care.

BLIND AND DISABLED INDIVIDUALS WHO WERE ELIGIBLE IN DECEMBER 1973

The individuals must meet all current Medicaid eligibility criteria except those for blindness or disability and must have continued to meet all criteria for Medicaid, including blindness and disability, in effect in 12/73.

Appendix E
Life Estate and Remainder Interest Tables

Age	Life Estate	Remainder	Age	Life Estate	Remainder
0	0.97188	0.02812	53	0.82028	0.17972
1	0.98988	0.01012	54	0.81054	0.18946
2	0.99017	0.00983	55	0.80046	0.19954
3	0.99008	0.00992	56	0.79006	0.20994
4	0.98981	0.01019	57	0.77931	0.22069
5	0.98938	0.01062	58	0.76822	0.23178
6	0.98884	0.01116	59	0.75675	0.24325
7	0.98882	0.01118	60	0.74491	0.25509
8	0.98748	0.01252	61	0.73267	0.26733
9	0.98663	0.01337	62	0.72002	0.27998
10	0.98565	0.01435	63	0.70696	0.29304
11	0.98453	0.01547	64	0.69352	0.30648
12	0.98329	0.01671	65	0.67970	0.32030
13	0.98198	0.01802	66	0.66551	0.33449
14	0.98066	0.01934	67	0.65098	0.34902
15	0.97937	0.02063	68	0.63610	0.36390
16	0.97815	0.02185	69	0.62086	0.37914
17	0.97700	0.02300	70	0.60522	0.39478
18	0.97590	0.02410	71	0.58914	0.41086
19	0.97480	0.02520	72	0.57261	0.42739
20	0.97365	0.02635	73	0.55571	0.44429
21	0.97245	0.02755	74	0.53862	0.46138
22	0.97120	0.02880	75	0.52149	0.47851
23	0.96986	0.03014	76	0.50441	0.49559
24	0.96841	0.03159	77	0.48742	0.51258
25	0.96678	0.03322	78	0.47049	0.52951
26	0.96495	0.03505	79	0.45357	0.54643
27	0.96290	0.03710	80	0.43659	0.56341
28	0.96062	0.03938	81	0.41967	0.58033
29	0.95813	0.04187	82	0.40295	0.59705
30	0.95543	0.04457	83	0.38642	0.61358
31	0.95254	0.04746	84	0.36998	0.63002
32	0.94942	0.05058	85	0.35359	0.64641
33	0.94608	0.05392	86	0.33764	0.66236
34	0.94250	0.05750	87	0.32262	0.67738
35	0.93868	0.06132	88	0.30859	0.69141
36	0.93460	0.06540	89	0.29526	0.70474
37	0.93026	0.06974	90	0.28221	0.71779
38	0.92567	0.07433	91	0.26955	0.73045
39	0.92083	0.07917	92	0.25771	0.74229
40	0.91571	0.08429	93	0.24692	0.75308
41	0.91030	0.08970	94	0.23728	0.76272
42	0.90457	0.09543	95	0.22887	0.77113
43	0.89855	0.10145	96	0.22181	0.77819
44	0.89221	0.10779	97	0.21550	0.78450
45	0.88558	0.11442	98	0.21000	0.79000
46	0.87863	0.12137	99	0.20486	0.79514
47	0.87137	0.12863	100	0.19975	0.80025
48	0.86374	0.13626	101	0.19532	0.80468
49	0.85578	0.14422	102	0.19054	0.80946
50	0.84743	0.15257	103	0.18437	0.81563
51	0.83674	0.16326	104	0.17856	0.82144
52	0.82969	0.17031	105	0.16962	0.83038

STATE OF MAINE
DEPARTMENT OF HEALTH AND HUMAN SERVICES

To: _____ Case No: _____
_____
_____

CONSENT DECISION

On or about_____a hearing was requested on behalf of (applicant)_____
to appeal the allocation of spousal assets.

Both (applicant & spouse)_____and the Department agree to the following:

(applicant)_____resides in a nursing facility and applied for Medicaid on_____.
(applicant's spouse) _____is the community spouse.

As indicated below, (applicant's spouse) _____can keep $_____ of the couple's countable assets effective _____.

INCOME ALLOWANCE

$ _____ Monthly mortgage/rent
+ _____ Real estate taxes
+ _____ Condo fees
+ _____ Home owners insurance
+ _____ Utility standard
$ _____ Total shelter expenses
- 552.00 (30% of $1,839.00 – Chart 4.4)
$ _____ Excess Shelter Expense
+ 1,839.00 Minimum Monthly Income Standard (Chart 4.4)
$ _____ Monthly Income Allowance (may not exceed $2,841.00 – Chart 4.4)
- _____ Community spouse's gross income
- _____ Community spouse monthly income allocation
= _____ Deficit in meeting Monthly Income Allowance

Average cost of an annuity to generate $_____ per month income is $_____.

Dated _____ Signed_____(Supervisor)_____
for the Department of Health and Human Services

Dated _____ Signed _____
Institutionalized spouse or representative

Based upon the agreement between the parties, this CONSENT DECISION to the hearing requested in this matter is the final agency action on the appeal.

Dated_____Signed _____
Hearing Officer

Appendix G
Supplies Provided to Recipients in a Nursing Facility

Below is a list of Supplies and Equipment provided to recipients by a Nursing Facility as part of regular rate of reimbursement:

The following items may not be billed by either the facility or supplier. Facilities which service a special group of the disabled are expected to furnish that equipment which is normally used in their care (e.g. children's wheelchairs) as a part of their reasonable cost.

Routine supplies and personal care items which are provided by the Nursing Facility under 67.05-11(A), may not be purchased by a resident and then deducted from their cost of care. The Nursing Facility must provide any brand name item to the resident as part of the Nursing Facility regular rate of reimbursement if the resident has a therapeutic need as documented by the physician.

1. Alcohol, swabs and rubbing
2. Analgesics: (non-prescription): 1) Acetaminophen: tablets, 325 mg, 500 mg; liquid; suppositories, 325 mg, 650 mg. 2) Aspirin: tablets, 325 mg, plain, buffered, coated; suppositories, 325 mg, 650 mg.
3. Antacids: aluminum hydroxide, magnesium hydroxide: gel and tablets (ex. Maalox). 2) Aluminum/magnesium hydroxide with simethicone (ex. Mylanta, Maalox Plus). 3) Calcium carbonate tablets (ex. Tums). 4) Calcium carbonate/magnesium hydroxide tablets (ex. Rolaids).
4. Alternating pressure pads, air mattresses, "Egg crate" mattresses, gel mattresses
5. Applicators
6. Bandages
7. Band-Aids
8. Basins
9. Beds (standard hospital type, not therapy beds)
10. Bed pans
11. Bed rails
12. Blood pressure equipment
13. Bottles (water)
14. Canes
15. Calcium supplements: 1) Calcium carbonate (ex. Tums). 2) Calcium carbonate with vitamin D (ex. Oscal).
16. Catheters
17. Catheter trays (disposable)
18. Chairs (standard, geriatric)
19. Combs
20. Commodes
21. Corner chair
22. Cotton
23. Cough syrup & expectorants: (non-prescription) 1) Guiafensin (ex. Robitussin). 2) Guiafensin - DM (ex. Robitussin DM) 3) Ammonium chloride/diphenhydramine (ex. Benylin).
24. Crutches
25. Cushions (e.g., comfort rings)
26. Dietary supplements
27. Disinfectants
28. Douche trays (disposable)
29. Dressings
30. Enema equipment
31. Enteral feedings, supplies and equipment
32. Facility deodorants
33. Gauze bandages (sterile & unsterile)
34. Glucometers
35. General services such as administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas
36. Gloves (sterile)
37. Gloves (unsterile)

38. Gowns
39. Hemorrhoidal preparations
40. Ice bags
41. Incontinent supplies full brief - all sizes; bed pans; undergarment liners, disposable or reusable; under pads.
42. Iron supplements (oral: ferrous sulfate; ferrous gluconate; liquid and/or tablet
43. Irrigation trays
44. Laundry services, personal (including supplies and equipment)
45. Laxatives: Stool softeners: docusate sodium liquid or capsule. Bulk: psyllium. Stimulants: Bisacodyl tablets and suppositories; docustae casanthranol, liquid and/or capsule. Enemas: saline; phosphate types (ex. Fleets); oil retention. Misc.: Milk of Magnesia; glycerin suppositories; lactulose and analogs (when used as a laxative); mineral oil.
46. Lotions (emollient) and Lubricants (skin, bath oil)
47. Mouth wash
48. Ointments and creams (over the counter), including petroleum jelly and hydrocortisone 0.5%
49. Ophthalmic lubricants: tears, ointments
50. Oxygen, for emergency and prn use only
51. Parenteral solutions, supplies and equipment
52. Pillows
53. Pitchers (water)
54. Powders (medicated and baby)
55. Prone boards
56. Rectal medicated wipes
57. Restraints (posey, thoracic chest supports, tilt in space chairs, wedge pillows, etc.)
58. Shampoo: three types: 1) regular; 2) medicated; and 3) no tears - baby shampoo
59. Sheepskin
60. Shower chairs/ Tub seats
61. Soap: include one hypoallergenic type
62. Special dietary supplements
63. Specimen containers
64. Sterile I.V. or irrigation solution
65. Stethoscope
66. Sunscreen - level 30
67. Supplies (non-prescription) necessary for the treatment of decubiti
68. Suture sets
69. Swabs, medicated or unmedicated
70. Syringes and needles
71. Tapes
72. Testing materials to be used by staff or facility
73. Thermometers
74. Tissues
75. Toothbrush
76. Toothpaste - two types accepted by AFA; and a denture cleaner
77. Towels, washcloths
78. Tongue depressors
79. Traction equipment
80. Trapezes
81. Tubes (gavage, lavage, etc.)
82. Urinals
83. Urinary drainage equipment and supplies (disposable)
84. Vitamins: two brands acceptable to pharmacy and dietary
85. Walkers
86. Wheelchairs - standard, including those with removable arms and leg rests, pediatric, "hemi" chairs, reclining wheelchairs
87. Routine personal hygiene and grooming to include, but not limited to: shave, shampoo, bathing, nail clipping (unless specified as a covered service by a podiatrist in the MaineCare Benefits Manual), unless the services of a barber or hairdresser are requested by and paid for by the resident
88. Routine transportation of residents or laboratory specimens to hospital or doctors offices

Appendix H
Transfers Prior to January 1, 1994 and Trusts Prior to August 11, 1993

These rules apply to trusts that are set up prior to 8/11/93.

TRUSTS
Trust funds are available assets unless the terms of the trust make them unavailable.

If the trust is irrevocable, that is, no member of the assistance unit or any responsible relative residing in the home has the power to revoke the trust arrangement or change the name of the beneficiary, what is available to the client is what is made available according to the terms of the trust.

I. The terms of the trust may specify the amount/frequency and/or purposes for which the funds may be used or this may be left to the discretion of the trustee(s). The terms of the trust may use a combination of both trustee discretion and specific fund usage.

II. Of the funds left to trustee discretion, what is available to the client is whatever the trustee makes available.

III. Funds made available are considered as income or assets in accordance with applicable Medicaid eligibility rules for the situation.

IV. If the terms of the trust restrict withdrawal by written approval of a judge of the courts, regular withdrawals will be treated as any other income. Irregular withdrawals, in order to be disregarded, must be used to supplement the needs of the person for whom the trust is drawn up.

Examples:
1. An individual has a trust fund that was established upon the death of his parents based on their will. From this he is to receive $500 from the interest each month and $10,000 every three years to buy a new vehicle. The monthly payments are income. The $10,000 is used to purchase an excluded asset (the old vehicle is traded in to purchase the new one). This trust is irrevocable in accordance with the provisions above. The terms of the trust specify the amount, frequency and for part of the payments (the $10,000) the purpose. Medicaid policy treats interest payments as income and excludes the vehicle as an asset.
2. A trust was set up for the individual by his father who is deceased. The individual is to receive $200 per month for as long as the fund lasts. The fund currently has $140,000. The individual can get all the funds in the trust if there is an emergency. The $200 per month is considered income as long as this represents interest income. The remainder of the fund is considered an asset (currently $140,000) since it can be accessed by the individual.
3. A trust is set up for the individual by her grandmother. It is irrevocable and the trustee has full discretion in disbursement of the funds (totaling $75,000) based on the needs of the individual. Since the trust is irrevocable, what is considered available to the individual is whatever the trustee, in her discretion, makes available.

Medicaid Qualifying Trusts
Even if a trust is irrevocable, it may be considered as an available asset if it meets certain conditions listed below. These are called Medicaid Qualifying Trusts. This is a type of trust or other legal device which:

I. is established by the individual or individual's spouse (other than by will). It may be irrevocable or established for purposes other than to enable the grantor to qualify for Medicaid;

II. the individual is the beneficiary of all or part of the payments from the trust;

III. the distribution of such payments is determined by one or more trustees who are permitted to exercise discretion with respect to the distribution to the applicant; or

IV. when established by the individual's or spouse's legal guardian or power of attorney, the trust is considered to have been established by the individual or spouse whom they represent.

The amount of this trust that is counted as an asset is the total undistributed amount that is permitted under the terms of the trust that the trustee could disburse if he, as trustee, exercised his full discretion.

Because Medicaid is the payer of last resort, it is expected that individuals (and their spouses) access available trust income and assets before turning to Medicaid. The assets and income from trusts that contain provisions that purport to limit the trustee's discretion to disburse funds in situations related to the individual's application for Medicaid are to be considered without regard to such provisions. For example, the assets and income of a trust are to be considered without regard to any provisions that purport to limit the trustee's discretion to disburse funds when the individual applies for Medicaid or enters a nursing home.

Example:
Mary establishes a trust under which she is a beneficiary. The trustee has discretion to distribute all of the assets of the trust to Mary except if she applies for Medicaid or enters a nursing home. In those circumstances, the trust states that the trustee does not have discretion to disburse the funds to Mary. At the time Mary applies for Medicaid, the trust is valued at $200,000. All of the $200,000 is considered available to Mary.

Amounts actually distributed are counted as income and/or assets using applicable eligibility rules for the situation.

When determining eligibility for Nursing care assistance, the value of an irrevocable trust may constitute an uncompensated transfer of assets. See Part 15.

If the Department determines that denial of eligibility would constitute undue hardship, these provisions may be waived. The consequence of being denied Medicaid coverage by itself does not constitute undue hardship.

Exceptions:

1. When the beneficiary of a trust is a mentally retarded individual who resides in an Intermediate Care Facility MR the trust is not considered a Medicaid qualifying trust provided the trust or initial decree was established prior to 4/7/86 and is solely for the benefit of the mentally retarded individual.

2. Trusts that are set up with retroactive SSI benefits awarded under the Zebley vs. Sullivan decision are exempted from the provisions of the Medicaid Qualifying Trust and transfer of assets rules.

Examples:

1. The individual's wife set up a trust fund for him before she died. The trust is irrevocable. The individual receives monthly payments of $100.00 from interest accrued on the principal and the trustee may disburse the remaining funds (currently $150,000) to meet living expenses. This is a Medicaid Qualifying Trust because it was set up by the individual's wife (not by will). Therefore, the total amount of the trust ($150,000) is a countable asset. This is the total undistributed amount of the trust that the trustee could disburse if she exercised her full discretion.

2. Same as Example 1 except: Added to the monthly interest income of $100.00, the remaining funds are disbursed in $3,000 semi-annual payments for the life of the individual. Any funds remaining at his death are passed to the individual's daughter. The trustee has no discretion in the disbursement of funds. Here, both the $100.00 per month and the $3,000 semi-annual payment are income. Since the trustee has no discretion in disbursement of funds, nothing else is countable.

3. The individual sets up a trust fund for himself that is irrevocable. He receives $500.00 per month from interest. The principal will be donated to the Save the Whale Foundation at his death. The trustee has no discretion in disbursement of funds. This is not a Medicaid Qualifying Trust even though it was set up by the individual other than by will for his benefit because the trustee has no discretion in distribution of the trust funds. The disbursement of $500.00 per month are counted as income under the general rules applying to trusts.

Couples Residing in a Nursing Facility

If the total assets of a couple in the same room in a nursing facility exceed the standard for a couple, one of the individuals may reapply for assistance. This results in one being an ineligible spouse. Beginning the first of the month after being denied, only the assets remaining in the name of the eligible spouse are considered when determining eligibility.

If the couple resides in different rooms in the same facility or in different facilities, then each is treated as an individual when determining the asset limit. Since there is no penalty for transfer of assets between spouses, they can decide who will retain the assets.

No spousal allowance of income or assets is determined since the ineligible spouse is not living in the community.

Transfer of Assets

"Assets" are defined as cash or other liquid assets or real or personal property.

When determining eligibility for BME, BMR and ALPHA Waivers and nursing care services, the following applies to transfers to individuals by the applicant or the applicant's spouse. Transfers between spouses do not incur a penalty. Although an individual or couple may be eligible in the community, once a request is made for waiver or nursing care services all assets must be checked back thirty months from date of application to determine if a transfer has occurred.

Transfers only affect_nursing and waiver services, all other Medicaid services may still be covered.

To determine the effect that the transfer has on eligibility several questions must be answered:

I. What was transferred?

II. Who was the transfer made to?

III. When was the transfer made?

IV. What did the individual or couple receive in exchange?

V. Why was the transfer made?

Exempt Transfers

The following may be transferred without penalty:

I. The home if it is transferred to
   A. a child who is under age 21 or who does or would meet SSI criteria of total and permanent disability or blindness.
   B. a sibling who has an equity interest in the home and was residing in the home for at least one year prior to the individual going to the medical institution.

      Example:
      A brother and sister have joint ownership of a home in which they both lived for the last five years prior to the brother going into a nursing facility. The brother may transfer his interest in the home to his sister without penalty.

      A penalty would be established if:
      1. the sister was not a joint owner or had no equity interest in the home, or
      2. the sister had not lived in the home one year prior to the institutionalization of her brother.

   C. a child over age 21 who does not meet the SSI criteria of blindness or disability if the child was residing in the home for at least two years prior to the individual's entering the medical institution and was providing care which enabled the institutionalized individual to live at home rather than a medical institution for this time.
   D. a spouse.

II. Any asset transferred to the individual's child who does or would meet SSI criteria of total and permanent disability or blindness.

III. Assets which the owner intended to dispose of at fair market value or for other valuable consideration but, without being at fault, the owner did not obtain full fair market value.

IV. Assets, exempt or non-exempt, transferred to (or for the sole benefit of) the community spouse.

V. Assets transferred thirty months prior to the date of application.

VI. Assets transferred for Fair Market value:

Fair Market Value

A transfer for fair market value incurs no penalty. Fair market value may be received in cash. It may also be in the form of past support for basic necessities or past medical expenses and debts, if measurable and verifiable. A reasonable value must be placed on the support provided or medical costs and the specific time period for which it is given substantiated. Past support for basic necessities does not include such items as gifts, clothing, transportation or personal care provided by relatives unless these were provided as part of a legally enforceable agreement whereby the individual would transfer the asset or otherwise pay for such items.

Examples of transfer for fair market value:

1. An individual transfers ownership of a life insurance policy to a funeral home.

2. An individual's sister pays all household expenses while he waits for an insurance settlement of $5000. He verifies that his rent, utilities and food came to $4500. He may transfer the $4500 to his sister without penalty because these are basic necessities which are measurable and verifiable.

Examples of transfers for less than fair market value:

1. A couple sells their home to their son for $40,000. The assessed value is $70,000. A $30,000 transfer has occurred.

2. An individual has help from her daughter with shopping, cleaning and preparing meals. The daughter spends four to eight hours a week providing these services. When the individual enters a nursing facility she transfers $25,000 to her daughter to compensate for these services. Since these were not provided as part of a legally enforceable agreement to pay for these services, the transfer does result in a penalty.

3. A neighbor comes in for an hour a day to help a couple prepare meals and do laundry. Two years later the couple give the neighbor $50,000. Two months later they enter a nursing facility. Based on the average cost for homemaker services in the area a value of $10.00 per hour is placed on these services and $7280 of the transfer is allowed. The remaining $42,720 would be a transfer for less than fair market value.

Disproving the Presumed Transfer

Any transfer taking place will be presumed to have been made for the purpose of becoming or remaining eligible for Medicaid, unless the individual furnishes clear and convincing evidence that the transaction was for some other purpose and that there was no intent at the time to apply for Medicaid within the foreseeable future. It is the Department's responsibility to demonstrate that a transfer took place and to establish the date of the transfer. It is the individual's responsibility to prove that the transfer took place for reasons other than to gain eligibility for Medicaid.

If the individual wants to disprove the presumption that the transfer was made to establish Medicaid eligibility, the burden of proof rests with the individual. The individual must demonstrate that the transfer was specifically and solely for some other purpose than to receive Medicaid. Statements and evidence to disprove the transfer must be contained in the individual's record.

The statement should cover, but not necessarily be limited to the individual's:

I. purpose for transferring the asset;

II. attempts to dispose of the asset for fair market value;

III. reasons for accepting less than the fair market value for the asset;

IV. plans for and ability to provide financial support after the transfer;

V. relationship, if any, to the persons to whom the asset was transferred; and

VI. belief that the fair market value was received.

In addition to the individual having to prove that the transfer was made specifically and solely for a purpose other than to be Medicaid eligible, other factors to be considered include:

I. a sudden onset of a disability or blindness after the asset was transferred;

II. the diagnosis of a previously undetected disabling condition after the transfer occurred;

III. unexpected loss of other assets following the transfer;

IV. unexpected loss of income after the transfer occurs; and

V. court ordered transfers.

Establishing Date and Value of a Transfer

I. Assets other than bank accounts. A transfer of assets occurs on the date when:
   A. title (ownership) or legal interest to property has passed from the individual or spouse to another individual;
   B. title to property has been given by establishing joint ownership, such as adding a name to stocks, bonds, real property;

The value of the transfer is the value of the asset or the part of the asset that is transferred. For example:

1. Sole ownership of a home valued at $100,000 is transferred to another. The value of the transfer is $100,000.
2. Sole ownership of a home valued at $100,000 becomes jointly owned with another person. The value of the transfer is $50,000.

C. a document has been signed and delivered by the individual or spouse to another individual to transfer title at some future date. This concept does not include a will but does include a signed but unregistered deed;

D. the asset is converted from an accessible to an inaccessible asset. An example is when assets are placed in an irrevocable trust or a name is removed from a jointly owned asset; or

E. the individual or spouse refuses to accept items which would be countable assets.

II. With bank accounts, a transfer of funds in an account is determined to take place when:

A. funds, owned by the individual, are withdrawn by the other joint owner(s) from an account and used for other that the sole benefit of the individual; or

B. another person's name is added to the individual's account, the money in the account is owned by the individual, and the intent of the individual in giving access is to convey ownership of those funds.

1. If the individual maintains that there was an intent to transfer funds in the bank account at the time a joint name was added, this intent must be documented.
2. Documentation consists of a clearly written statement of intent to transfer the funds in the account to the joint owner. This statement must be:
   a. a notarized statement; or
   b. signed by the individual at the time the account was made joint or within a reasonable period of time, usually one week but maybe longer due to circumstances beyond the control of the client.

Note: Evidence of an intent to transfer the funds in the account at the time that the name was added to the account will be rebutted by evidence that the individual continued to use the funds.

Examples:

- George adds his son Larry's name to a $50,000 bank account in 8/91. In 6/92 Larry withdraws $50,000 which he used to make renovations on his (Larry's) home. George is applying for nursing care services 9/92.
  - Whose money is the $50,000? The money in the account is made up of deposits by George. This is George's money and there is a potential transfer.
  - What was George's intent of adding son's name? If the intent was to convey ownership of the funds

in the account, this must be documented with a notarized statement by George. In this situation, there is no statement from George. No transfer occurred when Larry's name was added as a joint owner.
  - The 6/92 withdrawal is then examined as a transfer. Since Larry used the $50,000 that was withdrawn for other than the sole benefit of George, a transfer has occurred. Unless the transfer is exempted (4120.01), the penalty is assessed for $50,000 as of 6/92.

- Sally adds her son's name (Sam) to her bank account in 12/88. At that time there was $70,000 in her account. At the time of adding her son's name to the account she signs a statement that she intends to transfer the funds in the account. Subsequently, Sally cashes a check for $10,000 from the account. Also during the transfer penalty period, Sam cashes a check for $20,000 from the joint account. At the time Sally applies for nursing care services in 9/92, there is $40,000 in the account.

  - The $20,000 spent by Sam was a transfer subject to penalty. This is because Sally's continued use of the funds in the account rebuts her written statement saying she intended to transfer the funds to her son at the earlier time. Since the funds were Sally's when Sam cashed the check for $20,000, this is a transfer subject to penalty.
  - The $40,000 remaining in the account is considered an available asset for Sally.

- Butch adds his nephew's name (Charles), to his (Butch's) solely owned bank account in 1/89. The $70,000 in the account was owned by Butch. There is documentation that Butch intended to transfer the funds in the account at that time. In 5/92, Butch sells a piece of his solely owned property for $20,000 and deposits this money in the joint account. Charles cashes a $20,000 check from the account in 6/92. The account totals $70,000 at the time Butch applies for nursing care services in 9/92.

  - The $20,000 withdrawn by Charles in 6/92 is considered to be part of the $70,000 that Butch intended to give his nephew in 1/89. Therefore, this $20,000 may not be subject to transfer penalty.
  - Of the remaining $70,000 in the account:
    - $20,000 is a countable asset for Butch since this $20,000 was deposited by him from his funds.

- $50,000 is owned by Charles due to the 1/89 transfer of funds.

Establishing a Penalty

A period of ineligibility is imposed on the individual in a nursing care status if the individual or spouse disposes of an asset for less than Fair Market Value.

When a penalty is imposed, it is only the nursing care services that cannot be paid. The individual may be eligible for all other Medicaid services.

Once it has been determined that a transfer of assets has occurred for less than fair market value, the penalty period must be determined.

A special determination must be made for each transfer.

I. Determine the date that each transfer occurred.

II. Determine the amount of the transfer.

III. Divide the amount of the initial transfer by the current average monthly private rate at the time of application for a semiprivate room rate for a nursing facility (see Chart 4.3).

This determines the number of months of ineligibility based on the initial transfer. Any remaining fraction is to be disregarded. The penalty period may not exceed thirty months. The penalty period begins with the month in which the uncompensated transfer occurred. If there had been more than one transfer and a penalty is already in effect for that month, the penalty period will begin with the next non-penalty month.

Examples:

1. An individual adds her daughter's name to her savings account on 4/14. A transfer for the entire balance has taken place. Based on the amount of funds in the account at the time of transfer she is ineligible for 7.3 months. Eligibility potentially begins 11/1.

2. An individual has a solely owned savings account with $60,000 in it. In 10/92 he transfers $60,000 to his daughter. He also owns stocks worth $40,000 which he transfers to his son in 12/92.

   10/92 $60,000 ÷ $3619 = 16.5 months, potentially eligible 2/94
   12/92 $40,000 ÷ $3619 = 11 months, potentially eligible 1/95

   The penalty on the 12/92 transfer does not start until 2/94. This is the first non-penalty month after the 12/92 transfer.

   In this case the individual is potentially eligible as of 1/95.

Appendix I
Preparation for and Participation in the Administrative Hearing Process

The purpose of a hearing is to review whether the Agency acted in accord with defined policy and procedural requirements in carrying out its actions. The review is usually requested in relation to proposed closings, denials, decreases in the level of coverage, and changes in deductible amounts. The hearing may also include questions of medical eligibility, classification for nursing care status and eligibility for retroactive coverage.

Hearings are not formal in the sense that there are oaths given, set formal procedures of addressing individuals concerned, or required procedures for entering objections or questioning at a particular time. Hearings are not casual conversations or arguments, however.

In addition to reviewing the decision itself, the Hearing Officer has the responsibility, at the hearing, to review whether appropriate procedures were followed in carrying out the action.

The Hearing Report

The agency representative has the responsibility to be prepared to give a report and to answer questions that may be asked by the Hearing Officer of other participants in the hearing. The Eligibility Specialist must make sure that proper written notice, with an advance notice period, if applicable, was forwarded to the applicant or recipient. The notice must cite the manual section on which the decision to deny or reduce benefits is based. It is not sufficient to state: "You have excess assets," or "You have excess income." The amount of assets or income should be given. In addition, the agency limit on assets or income should be cited. It might be necessary to cite more than one manual reference. If so, this should be done.

If the action results in a request for a hearing the Eligibility Specialist should submit a copy of the notice which was sent to the applicant or recipient to the Hearing Officer. The copy of the notice and other pertinent documents will become a permanent part of the Hearing Record.

When notified of a request for a hearing, the Eligibility Specialist must prepare a detailed report outlining what was done and why it was done. The report should indicate how the decision was made. If income is an issue, the Eligibility Specialist must elaborate on how net income was determined. If assets are an issue, the Eligibility Specialist must show what was considered as an asset. If medical eligibility is an issue, specifics should be given as to what went into the decision that the individual no longer is considered incapacitated or disabled in accord with agency policy. If the decision involved the Medical Review Team, contact must be made with that unit. The MRT will provide medical information if necessary.

If negative action is taken because information is incomplete, inconclusive or conflicting, the Eligibility Specialist must show what is inconclusive and why more information is needed. The Eligibility Specialist also has responsibility to show that specific information was requested and that the individual was given the opportunity to resolve questions before action was taken.

A copy of the report is sent to the individual requesting the hearing by the Division of Administrative Hearings prior to the hearing. If the agency is informed that the individual has a representative for the hearing, a copy of the report is also sent to the representative.

To the extent that the report is complete and concise, it will assist the Hearing Officer in conducting the hearing and will assist the applicant or recipient in understanding or questioning information.

The Hearing

The Hearing Officer will begin the hearing by giving an opening statement. In the opening statement, the Hearing Officer will:

I. cite the case name and basis purpose of the hearing;

II. request the names of all present;

III. remind all persons that the hearing is being recorded and that individuals should follow procedures by:
   A. identifying themselves and referring to each other by name during the hearing;
   B. make an effort to speak loud enough to be heard by all participants and face the recording equipment while talking.

Note that exhibits will be presented during the hearing.

After an opening statement by the Hearing Officer, the Eligibility Specialist will be asked to present a copy of the notice which was sent to the applicant or recipient.

The Hearing Officer will request a verbal report outlining the actions taken and the basis of the action. The report submitted by the Eligibility Specialist may be read or used as the basis for the verbal report. The Hearing Officer may ask additional questions if there areas which are unclear. In addition, copies of documents such as medical statements, budgets, lists of assets or medical bills may be requested by the Hearing Officer. When requested, copies of these items should be given to the Hearing Officer and the individual requesting the hearing.

The individual or the representative may question the decision of the Eligibility Specialist. Questions should be made through the Hearing Officer and not between the persons involved.

The individual requesting the hearing will be given the opportunity to:

I. question any information;

II. refute any information;

III. present any additional information or make any comments.

In situations where additional information is presented, the Hearing Officer will decide whether the information had a bearing on the decision in question at the time of the decision or whether the information relates to a period of time

subsequent to the decision. If the latter is the situation, the information should only be considered in a re-application or in carrying out a subsequent review.

After both parties have presented information and entered any questions and the Hearing Officer is satisfied that pertinent data has been presented, the Officer will summarize the issue as much as possible.

A continuance of the hearing may be determined by the Hearing Officer if additional date is needed, obtainable, and not available at the hearing. If the applicant or recipient requests a continuance, the Hearing Officer will determine if it would be appropriate.

The agency representative should always have manual material at the hearing and be prepared to cite necessary data from the manual.

Appeal

When the above procedures are followed and there is further appeal through the courts, those persons responsible for representing the agency have issues that are clearly defined. In addition, procedures such as adequate and specific notice may be raised in court even if not mentioned at a hearing. Thus, it is necessary that procedures taken, as well as the decision made, be reviewed at the hearing.

Appendix J
Computation of Utility Standard

Utility Standard Allowances are approved through the Food and Nutrition Service of the United States Department of Agriculture and are included in the rules for Maine's Food Supplement Program at 10-144 CMR Chapter 301.

Utility Expenses:

The community spouse has the option of using the full standard utility allowance (FSUA or actual utility expenses as deductions. As of 9/1/08 the FSUA is $700 per month. They must incur expenses for heating or air conditioning bills which are separate and apart from rent/mortgage or receive assistance from HEAP or ECIP in order to qualify for the FSUA. At the time of redetermination, and one additional time during each twelve month period, the community spouse may change the option between actual expenses and the FSUA.

Standard Utility Allowance:

When expenses are incurred on an irregular basis, use the FSUA between billing periods. The FSUA cannot be used for a community spouse who lives in a public or private rental unit, which has central utility meters and charges the residents only for excess heating or air conditioning costs. If someone outside of the household is paying the entire cost of heating/cooling, and the payment is excluded as a vendor payment, the utility allowance is not allowed.

> **Note:** Assistance from HEAP or ECIP automatically entitles the community spouse to the FSUA.

The FSUA is not allowed when utility expenses are included in the rent unless the community spouse receives assistance from HEAP or ECIP, the residence is metered separately, or the community spouse can otherwise provide verification that there are separate charges for heat and/or air conditioning.

Actual Utility Costs:

If the community spouse resides in public housing, which has central utility meters and is charged only for excess utility costs, the excess amount incurred is allowed.

Whenever the FSUA is not permitted, the community spouse may claim the actual expenses or elect to use the following individual standard if the expense is incurred:

- cooking fuel and/or electricity (other than heat)
  water and/or sewer, trash collection — $ 203.00 (effective 2/1/2010)
  $ 214.00 (effective 10/1/2010)
- telephone — $ 31.00 (effective 2/1/2010)
  $ 42.00 (effective 10/1/2010)

Shared Residence:

To determine the utility allowance when the residence is shared by the community spouse and other persons, divide the appropriate utility allowance equally among the parties who pay for the cost. This prorated share is the utility allowance.

I. Home Temporarily Vacated:
   Shelter expenses can be allowed if the principle residence is temporarily vacated due to employment or training, illness, natural disaster or casualty loss only if:

   A. the community spouse intends to return
   B. the home is not leased or rented while the community spouse is absent.

Note: Verification of actual utility cost for an unoccupied home is required if a deduction will be used. The SUA is not allowed for unoccupied homes.

II. Handling of Expenses Other Than Mortgage, Residence Insurance:

A. Except when an expense is averaged, a deduction is allowed only in the month the expense is billed or otherwise becomes due, regardless when the community spouse expects to pay the expense. Amounts from past billing periods are not deductible.

B. For an expense to be deductible, it must be payable to someone outside the household.

C. Fluctuating expenses may be averaged. Expenses, which are billed less often then monthly, may be averaged forward over the interval between scheduled billings or if there is no schedule, over the period the expense is intended to cover. Interest, carrying charges, insurance, or penalties are not allowance expenses. Interest portions on mortgage payments are allowable.

D. That portion of the household shelter expenses associated with a business or trade is not considered as a deductible shelter expense.

E. That portion of the shelter expenses paid by an excluded vendor payment shall not be allowed as a deduction. Shelter expenses paid via a countable vendor payment shall be allowed.

F. Shelter expenses shall be computed based upon expected expenses to be billed. Anticipation of the expense shall be based upon the most recent month's bills unless it is reasonably certain that a change will occur.

G. Expenses billed weekly are converted by multiplying by 4.333 and those billed biweekly by 2.167 to obtain monthly figures.

III. Verification:

Utility expenses must be verified if the amounts claimed are in excess of the SUA and a deduction would result.

A move to a new residence requires reassessment of all shelter expenses.

CHART 1
ITEMS INCLUDED IN THE BASIC COST CHART

Housing: includes either a payment for rent or home ownership costs (which include taxes, mortgage payments, insurance and property maintenance), heating fuel, water, electricity, gas, refuse disposal, household textiles such as sheets and towels, furniture and appliance replacement, house wares, laundry and cleaning supplies, paper products, services and telephone at the basic rate.

Food: includes all food eaten at home, meals eaten at work or school and snacks.

Clothing: includes basic inner and outer clothing, undergarments, footwear, dress and work clothing, cleaning and pressing services and shoe repair.

Personal Care: includes haircuts, hair dressing, and such items as toothpaste, shaving cream, and shampoo.

Other Family Consumption: includes newspapers, magazines, entertainment expenses and allowances for participation in sports, hobbies and other recreation.

CHART 2
DEPENDENT ALLOCATIONS USING AFDC RELATED LIMITS

The amounts below are used for income allocations for dependents in Home and Community Based Waivers and dependents of nursing home residents when there is no community spouse. They are based on the Full Need Standard in the AFDC Program as of 8/96.

	ADULTS INCLUDED	ADULTS NOT INCLUDED
Unit Size	**Full Need**	**Full Need**
1	262	154
2	412	295
3	553	437
4	695	579
5	837	721
6	979	863
7	1120	1005
8	1262	1146

Add $142 to Full Need for each additional person.

Chart 3
SSI - RELATED INCOME STANDARDS, ALLOCATIONS AND DISREGARDS

Chart 3.1 - Disregards (eff. 7/1/87)

$20.00 Federal disregard
$55.00 State disregard for Individual
$80.00 State disregard for Couple

Chart 3.2 - Maximum Allocations (eff.1/1/2012)

$350.00 Ineligible child living allowance.
$698.00 One parent - living in the household.
$1048.00 Two parents living in the household.

Chart 3.3 - Maximum Income-in-Kind (eff.1/1/2012)

Individual: $253.47 (Living alone or with others)
$232.75 (Living in the household of another)
Couple: $370.00 (Living alone or with others)
$349.00 (Living in the household of another)

Chart 3.4 - Maximum Countable Income (eff. 1/1/2012)

Individual: $708.00 (Living alone or with others)
$706.00 (Living in the household of another)
Couple: $1063.00 (Living alone or with others)
$1060.00 (Living in the household of another)

Chart 3.5 - Ineligible Spouse Standard (eff. 1/1/2012)

$350.00 Ineligible spouse in the deeming process

Chart 3.6 - SSI and State Supplement Maximum Income and Payment Amounts (eff.1/1/2012)

INDIVIDUAL			COUPLE			
Living Arrangement	SSI Countable Income Limit & Maximum Benefit	State Supplement Benefit	State Supplement Countable Income Limit	SSI Countable Income Limit & Maximum Benefit	State Supplement Benefit	State Supplement Countable Income Limit
A	$698.00	$10.00	$708.00	$1048.00	$15.00	$1063.00
C	$698.00	$8.00	$706.00	$1048.00	$12.00	$1060.00
D	$698.00	$49.00	$747.00	$1048.00	$273.00	$1321.00
E	$698.00	$217.00	$915.00	$1048.00	$590.00	$1638.00
F	$698.00	$234.00	$932.00	$1048.00	$636.00	$1684.00
G	$698.00	$234.00	$932.00	$1048.00	$636.00	$1684.00
H	$30.00	$10.00	$40.00	$60.00	$20.00	$80.00
I	$698.00	$10.00	$708.00	$1048.00	$15.00	$1063.00

If countable income is less than the SSI limit plus $20.00 for a particular “Living Arrangement”, the individual should apply for SSI in order to get the SSI benefit and State Supplement. If more, but less than the “State Supplement Income Limit” (plus $75 for living arrangements A and C), the individual can apply at Department of Health and Human Services for the State Supplement only.

Chart 3.7 - Annual QI 2 Benefit - removed

Chart 3.8 - Awaiting Placement for Residential Care (APRC)/ Days Awaiting Placement (DAP)

Note: The rates below are set by the Office of MaineCare Services and reproduced here for reference.

	Maximum Allowable Monthly Income	**Medical Expenses Used In Meeting Spendown (Deductible): Daily Rate**
7/1/99	$1,617	$35.62
7/1/00	$1,727	$38.44
7/1/01	$1,811	$40.58
7/1/02	$2,012	$48.90
7/1/03	$2,214	$69.26
7/1/04	$2,258	$70.43
7/1/05	$2,512	$79.50
7/1/06	$2,594	$81.99
7/1/07	$2,663	$83.98
7/1/08		

Chart 3.9 - Income Limit for Adult Family Care Homes

Note: The rates below are set by the Office of MaineCare Services and are reproduced here for reference.

	Adult Family Care Homes
01/01/99	$1,661
01/01/00	$1,673
01/01/01	$1,691
01/01/02	$1,706
01/01/03	$1,728
01/01/04	$1,740
07/01/04	$2,580.44
01/01/05	$3,565
01/01/06	$3,712
01/01/07	$3,834
01/01/08	$3,922
01/01/09	$4,149
01/01/12	$4,298

Chart 3.10 – Premiums for HIV Benefit [Maine Section 1115 Health Care Reform Demonstration For Individuals with HIV/AIDS] – 6/1/2012

INCOME LEVEL	MONTHLY PREMIUM
Equal to or less than 150% of Federal Poverty Level (See Chart 6)	0
150.1% - 200% of Federal Poverty Level (See Chart 6)	$31.04
200.01% - 250% of Federal Poverty Level (See Chart 6)	$62.07

Chart 3.11 – Spousal Living Allowance for SSI Recipients

Note: For non-SSI recipients the amount of the Living Allowance is the difference between countable income and 100% federal poverty level (See Chart 6).

2/2002	$249
2/2003	$252
2/2004	$267
2/2005	$274
1/2006	$269
1/2007	$283
1/2008	$285
1/2009	$284
1/2011	$289
1/2012	$288

Chart 3.12 – Premiums for MaineCare Katie Beckett Coverage Group

Family Income as a % of FPL Federal Poverty Level	Monthly Premium with Private Insurance	Monthly Premium without Private insurance
150 – 200%	$11	$30
201 – 250%	$14	$40
251 - 300%	$18	$50
301 - 350%	$21	$60
351 - 400%	$25	$70
401 - 450%	$30	$85
451 - 500%	$35	$100
501 - 550%	$40	$115
551 - 600%	$46	$130
601 - 700%	$51	$145
701 - 800%	$61	$175
801 - 900%	$72	$205
901 – 1000%	$84	$240
1001-1200%	$96	$275
1201-1400%	$117	$335
1401-1600%	$138	$395
1601-1800%	$159	$455
1801-2000%	$182	$520
2001-2500%	$207	$590
2501%+	$263	$750

Chart 4
NURSING CARE LIMITS

Chart 4.1 Categorically Needy Nursing Care Status Income Limits

$1869.00 eff. 1/1/07
$1911.00 eff. 1/1/08
$2022.00 eff. 1/1/09
$2094.00 eff. 1/1/12

This is used as the income limit for:

- Categorically Needy Nursing Care Status
- Home and Community Based Waivers
- Katie Beckett coverage
- SSI - Related or Family - Related coverage group in a hospital for thirty consecutive days

Chart 4.2 Maximum Waiver Allowances

The amounts below are used as the maximum spousal allowance for Home and Community Based Waivers:

$623.00 eff. 1/1/07
$637.00 eff. 1/1/08
$674.00 eff. 1/1/09
$698.00 eff. 1/1/12

Chart 4.3: Nursing Care Private Rate

$3917.00 eff. 8/1/1994
$6255.00 eff. 1/1/2006
$6778.00 eff. 1/1/2008
$7258.00 eff. 1/1/2009
$7667.00 eff. 9/1/2011

Chart 4.4 Spousal Impoverishment

- Community Spouse Asset Allowance

	Maximum
1/1/07	$101,640
1/1/08	$104,400
1/1/09	$109,560
1/1/12	$113,640

- Minimum Monthly Income Standard

$1,712.00 eff. 7/1/07
$1,750.00 eff. 7/1/08
$1,822.00 eff. 7/1/09
$1,839.00 eff. 7/1/11

- Monthly Excess Shelter Standard (this amount is 30% of the Minimum Monthly Income Standard [above] for the corresponding effective date)

$513.00 eff. 7/1/07
$525.00 eff. 7/1/08

$547.00 eff. 7/1/09
$552.00 eff. 7/1/11

- Maximum Monthly Income Allocation
  $2,541 eff. 1/1/07
  $2,610 eff. 1/1/08
  $2,739 eff. 1/1/09
  $2,841 eff. 1/1/12

Chart 5
PROTECTED INCOME LEVEL

The following levels are effective 11/91:

Unit Size	Protected Income Level
1	315
2	341
3	458
4	575
5	691
6	808
7	925
8	1033
9	1150
10	1266

Add $116 for each additional person.

Chart 6
FEDERAL POVERTY LEVELS

FEDERAL POVERTY LEVELS - EFFECTIVE JANUARY 2012

The following dollar amounts are based on the federal poverty level published in the Federal Register. The amounts will be changed whenever the Federal Poverty Level is adjusted

Family Size	100%	120%	125%	133%	135%	150%	160%	170%	185% (+25%)	200%	250%	350%
1	$ 931	$ 1,117	$ 1,164	$ 1,239	$ 1,257	$ 1,397	$ 1,490	$ 1,583	$ 1,723 ($2,154)	$ 1,862	$ 2,328	$ 3,258
2	$ 1,261	$ 1,513	$ 1,577	$ 1,677	$ 1,703	$ 1,892	$ 2,018	$ 2,144	$ 2,333 ($2,917)	$ 2,522	$ 3,153	$ 4,413
3	$ 1,591		$ 1,989	$ 2,116		$ 2,387	$ 2,546	$ 2,705	$ 2,944 ($3,680)	$ 3,182		$ 5,568
4	$ 1,921		$ 2,402	$ 2,555		$ 2,882	$ 3,074	$ 3,266	$ 3,554 ($4,443)	$ 3,842		$ 6,723
5	$ 2,251		$ 2,814	$ 2,994		$ 3,377	$ 3,602	$ 3,827	$ 4,165 ($5,207)	$ 4,502		$ 7,878
6	$ 2,581		$ 3,227	$ 3,433		$ 3,872	$ 4,130	$ 4,388	$ 4,775 ($5,969)	$ 5,162		$ 9,033
7	$ 2,911		$ 3,639	$ 3,872		$ 4,367	$ 4,658	$ 4,949	$ 5,386 ($6,733)	$ 5,822		$ 10,188
8	$ 3,241		$ 4,052	$ 4,311		$ 4,862	$ 5,186	$ 5,510	$ 5,996 ($7,495)	$ 6,482		$ 11,343
Each added person	$ 330		$ 413	$ 439		$ 495	$ 528	$ 561	$ 611 ($764)	$ 660		$ 1,155

Chart 7
FEE SCHEDULE FOR QDWI

If Monthly Countable Income is	Monthly Payment Required Is This % of the Current Medicare Part A Premium
150% FPL - 160% FPL	10%
160.01% - 170%	20%
170.01% - 180%	30%
180.01% - 190%	40%
190.01% - 200%	50%
Over 200%	Not Eligible

Countable income is determined using SSI - Related rules.

Chart 8
CUB CARE

Family Income as % of Federal Poverty Level	Monthly Premium for 1 Child	Monthly Premium for 2 or More Children
150.1% to 160%	$ 8	$16
160.1% to 170%	$16	$32
170.1% to 185%	$24	$48
185.1% to 200%	$32	$64

10-144 CODE OF MAINE REGULATIONS CHAPTER 333
LOW COST DRUGS FOR THE ELDERLY AND DISABLED (DEL)

The Maine Drugs for the Elderly Benefit, also referred to as the Maine Low Cost Drugs for the Elderly or Disabled (DEL) Program, is authorized by, and these regulations are issued under, the authority of 22 M.S.R.A., Sec. § 254-D. The responsibility for implementing this legislation is with the Department of Health and Human Services. Although utilized as part of the MaineCare Eligibility Manual (10-144 CMR Chapter 332), , this benefit is a separate chapter in the DHHS section of the Code of Maine Regulations (10-144 CMR Chapter 333). Part references below are to earlier Parts and Sections of the MaineCare Eligibility Manual.

SECTION 1 COVERED INDIVIDUALS

I. Age -
Individuals must be age 62 or older *or* age 19 through age 61 and meet the disability criteria for SSI (Supplemental Security Income under Title XVI of the Social Security Act). See Part 6, Section 5.1.

II. Residence -
Individuals must meet Medicaid criteria for residence (See Part 2, Section 4).

III. Citizenship -
Individuals must meet Medicaid criteria for citizenship except they do not need to provide documentation of citizenship or identity (See Part 2, Section 3).

Certain individuals who do not meet the Medicaid citizenship requirements may be eligible for DEL. They are:

A. Undocumented alien – aliens who do not have documentation of their citizenship status from BCIS.
B. Ineligible alien – aliens legally admitted on a temporary basis. The following are examples of individuals who are ineligible aliens:
   1. Foreign government representatives on official business and their families and employees;
   2. Visitors for business or pleasure, including exchange visitors;
   3. Aliens in travel status while traveling directly through the Unites States;
   4. Crewmen on shore leave;
   5. Treaty traders and investors and their families;
   6. Foreign students;
   7. International organization personnel and their families and servants;
   8. Temporary workers, including agricultural contract workers;
   9. Members of foreign press, radio, film or other information media and their families; or
   10. Parolee in the U. S. under Section 212 (d)(5) for less than one year unless they are granted “temporary parolee status”.

The following individuals are not eligible for DEL. They are considered to be residents of a public institution.

I. Inmates of the state prison, juvenile corrections facilties, local or county jails.

II. Individuals admitted to reside in a public (or private) medical institution classified as an IMD (Institution for Mental Disease) for over thirty days: Spring Harbor, Acadia, Riverview Psychiatric Center, Dorothea Dix Psychiatric Center.

Section 1.1 DEL and Medicare Part D

An individual who meets all criteria in this Part will have their benefit affected by the following conditions:

I. Individuals who are enrolled in Medicaid or HIV Limited Benefit are not eligible for DEL unless they are also eligible for Medicare Part D.

II. Individuals who apply for DEL and who are eligible for Medicare Part D must take action to enroll in Medicare Part D and a Prescription Drug Plan at the next available opportunity to do so.

III. Individuals who are enrolled in DEL and subsequently become eligible for Medicare Part D must enroll in Medicare Part D and a Prescription Drug Plan at the first available opportunity to do so.

IV. If the individual does not comply with II. or III. above they are ineligible for DEL until they comply.

There is good cause for not enrolling in Medicare Part D and a Prescription Drug Plan if:

I. The individual is denied enrollment by Medicare or by a Medicare Prescription Drug Plan due to circumstances beyond his/her control.

II. The individual has prescription drug coverage which is determined by the insurer to be creditable coverage. Creditable coverage means that the coverage on average is at least as good as the standard Medicare Prescription drug plan.

SECTION 2 APPLICATION PROCESS

An application is the request for DEL coverage made by signing the Agency's application form for DEL or MaineCare. The individual or anyone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

The date of application is the date the signed and dated application form is received in any regional office of the Department of Health and Human Services.

All signed applications will be acknowledged in writing. A written decision of eligibility will be sent to the applicant.

Coverage starts the first day of the month of application or the first day of the month an individual meets program requirements, whichever is later.

A reapplication is any signed application form received after the Adverse Action Notice Period. This includes review forms returned after that period.

All applicants or reapplicants will be given information in writing, or verbally if appropriate, about the following:

I. services covered under DEL;

II. the individual's rights, including hearings; and

III. responsibilities of recipients, including reporting changes.

Individuals who are enrolled in Medicaid and/or Medicare Buy-In (MSP), who are eligible for Medicare Part D, are deemed to be eligible for and enrolled in DEL. They do not need to file a separate application for DEL.

Section 2.1 Assets

There is no asset criteria.

Section 2.2 Income

Gross non-excluded income of the applicant and spouse is used to determine eligibility. SSI - Related eligiblity criteria is used to determine what is considered as income and income exclusions. Income exclusions include the exclusions in the SSI - Related deeming process.

Gross monthly income must be equal to or less than 185% of the Federal Poverty Level (See Chart 6).

If the assistance unit spends at least 40% of its gross monthly income on prescription drugs, the monthly income limit is increased by 25%.

SECTION 3 CONTINUED ELIGIBLIITY

Individuals enrolled in DEL have their eligiblity reviewed every twenty-four months. Once determined to be eligible and enrolled in the program, individuals are continuously eligible for twenty-four months starting with the month of enrollment or the month of the most recent review without regard to changes in income.

Individuals must continue to meet the requirements of age, disability, residency, citizenship as defined in this rule. Once an individual does not comply with any of the requirements set forth in this rule, that individual is ineligible for the DEL program.

Individuals must notify the Department within ten days when they know, or should know, of a change to their circumstance that would disqualify them from the program.

SECTION 4 NOTICE OF ELIGIBILITY

Individuals will be given written notice of eligibility (See Part 2, Section 15).

SECTION 5 ADMINISTRATIVE HEARINGS

Individuals have the right to request a hearing if they disagree with action taken in regard to their eligibility (See Part 1, Section 7).

SECTION 6 GRANDFATHERED GROUP

Certain individuals do not meet the current eligibility rules for the DEL benefit but they were enrolled in the DEL benefit at one time from 8/1/98 to 7/31/99. These individuals are eligible for DEL as long as another household member is currently enrolled in this benefit.

10-144 CODE OF MAINE REGULATIONS CHAPTER 334
MAINE Rx PLUS

This is a state program enacted in 22 M.R.S.A. § 2681. The responsibility for implementing this legislation is with the Department of Health and Human Services (hereinafter "Department"). Although utilized as part of the MaineCare Eligibility Manual (10-144 CMR Chapter 332), this benefit is a separate chapter in the DHHS section of the Code of Maine Regulations (10-144 CMR Chapter 334). Part references below are to Parts and Sections of the MaineCare Eligibility Manual.

SECTION 1 COVERED INDIVIDUALS

An individual is covered if that person satisfies the requirements of this section.

Individuals who are enrolled in Medicaid or for the HIV Limited Benefit are not eligible for Maine Rx Plus.

I. Residence -
Individuals must meet Medicaid criteria for residence (Part 2, Section 4).

II. Citizenship -
Individuals must meet Medicaid criteria for citizenship except they do not need to provide documetation of citizenship or identity (see Part 2, Section 3).

Certain individuals who do not meet the Medicaid citizenship requirements may be eligible for Maine Rx. They are:

A. Undocumented alien – aliens who do not have documentation of their citizenship status from BCIS.
B. Ineligible alien – aliens legally admitted on a temporary basis. The following are examples of individuals who are ineligible aliens:
   1. Foreign government representatives on official business and their families and employees;
   2. Visitors for business or pleasure, including exchange visitors;
   3. Aliens in travel status while traveling directly through the United States;
   4. Crewmen on shore leave;
   5. Treaty traders and investors and their families;
   6. Foreign students;
   7. International organization personnel and their families and servants;
   8. Temporary workers, including agricultural contract workers;
   9. Members of foreign press, radio, film or other information media and their families; or
   10. Parolee in the U. S. under Section 212 (d)(5) for less than one year unless they are granted "temporary parolee status."

III. Age - There is no age criteria.

SECTION 2 APPLICATION PROCESS

An application is the request for Maine Rx Plus coverage made by signing the Agency's application form for Maine Rx Plus or MaineCare. The individual or anyone acting on the individual's behalf may sign the application form. The applicant may choose anyone to help in completing the form.

The date of application is the date the signed and dated application form is received in any regional office of the Department.

All signed applications will be acknowledged in writing. A written decision of eligibility will be sent to the applicant.

Coverage starts the first day of the month of application or the first day of the month an individual meets program requirements, whichever is later.

A reapplication is any signed application form received after the Adverse Action Notice Period. This includes review forms returned after that period.

All applicants or re-applicants will be given information in writing, or verbally if appropriate, about the following:

I. services covered under Maine Rx Plus;

II. the individual's rights, including hearings; and

III. responsibilities of recipients, including reporting changes.

Section 2.1 Assets

There are no asset criteria.

Section 2.2 Income

Non-excluded gross monthly income is countable for Maine Rx.

If the individual meets the rule for a Family - Related assistance unit, the Family - Related rules are used to determine what is countable income and whose income to count. See Part 3 and 17.

If the individual meets the rules for the Non - Categorical or SSI - Related assistance unit the SSI - Related rules are used to determine what is countable income and whose income to count. See Parts 6 and 17.

If the individual meets the rules of more than one assistance unit, the rules that are most advantageous to the individual are used.

Non-excluded gross monthly income must be equal to or less than 350% of the Federal Poverty Level (See Chart 6) for the assistance unit.

If income exceeds this amount coverage may be available if the assistance unit meets a spend down requirement as determined by the Office of MaineCare Services. The criteria are set forth in 10-144 CMR 104 §3.

Income exclusions used in Family - Related and SSI - Related Medicaid are used for Maine Rx Plus. When income is fully or partially excluded by one of the groups and not the other, the rule that is most beneficial to the individual is used.

SECTION 3 CONTINUED ELIGIBILITY

Individuals enrolled in Maine Rx have their eligiblity reviewed every twenty-four months. Once determined to be eligible and enrolled in the program, individuals are continuously eligible for twenty-four months starting with the month of enrollment or the month of the most recent review without regard to changes in income.

Individuals must continue to meet the requirements of residency and citizenship as defined in this rule. Once an individual does not comply with any of the requirements set forth in this rule, that individual is ineligible for the Maine Rx program.

Individuals must notify the Department within ten days when they know, or should know, of a change to their circumstance that would disqualify them from the program.

SECTION 4 NOTICE OF ELIGIBILITY

Individuals will be given written notice of eligibility (See Part 2, Section 15).

SECTION 5 ADMINISTRATIVE HEARINGS

Individuals have the right to request a hearing if they disagree with action taken in regard to their eligibility (See Part 1, Section 7).

10-144 CODE OF MAINE REGULATIONS CHAPTER 335
HEALTH INSURANCE PURCHASE OPTION

Health Insurance Purchase Option (HIPO) established through P.L. 1997, Chapter 777 and 22 M.R.S.A. § 3173 and § 3174, and 22 M.R.S.A. §3174-T(2)(E), provides 18 months of extended health coverage to children under the age of 19 who are no longer eligible due to changes in income.

SECTION 1 ELIGIBILITY CRITERIA

- A child enrolled in Cub Care whose family income at the end of the child's enrollment period exceeded the maximum Cub Care income limit in effect at the time of reapplication; or
- A child enrolled in MaineCare whose family income exceeded the maximum MaineCare income limits and the maximum Cub Care limits at the time of reapplication.

SECTION 2 ELIGIBILITY PERIOD

Health coverage through the Health Insurance Purchase Option may be purchased for a period of up to eighteen (18) continuous months.

The eligibility period begins the first month following the last month of MaineCare or Cub Care coverage. Coverage may be purchased under this option beginning with any month of the eligibility period. If application for HIPO is made after the first month of eligibility, coverage may be purchased retroactive to the first month of eligibility.

Example: MaineCare coverage for DiDi Smith, 7 years old, ended April 30, 2010 because her family income exceeded the maximum income limit at the time of the MaineCare review. DiDi is eligible for HIPO effective May 1, 2010 through October 31, 2011. An application for HIPO coverage was received on January 3, 2011 and retro coverage was not requested. Didi is eligible for HIPO effective January 1, 2011 through October 31, 2011 (10 months) as long as premiums are paid timely as outlined in Section 5 below.

The eligibility period ends if an individual withdraws voluntarily or is terminated for non-payment of premium. Individuals who withdraw participation in HIPO or are terminated cannot re-enroll for the remainder of the eligibility period.

SECTION 3 NOTICE OF HIPO

Individuals will be informed of the availability of extended health coverage through HIPO at the time they are given notice of ineligibility at reapplication for Cub Care or termination of MaineCare due to excess income. A second notice will be sent thirty (30) calendar days after the initial notice to individuals who have not responded.

SECTION 4 APPLICATION FOR PARTICIPATION

Individuals who request to participate in this option will be sent information about the program and an agreement form to complete.

The child's responsible party is required to sign the agreement which specifies terms & conditions of participation, and for whom coverage will be purchased. Terms & Conditions include the monthly premium amount, due dates, and termination of coverage if a payment is not received timely.

The Department will verify the child's eligibility period and provide return payment vouchers for each month of coverage requested to purchase.

SECTION 5 PREMIUM PAYMENT

The monthly premium amount is determined annually by the Office of MaineCare Services as outlined in the Maine State Services Manual, 10-144 CMR Chapter 104, Section 5.

The premium for the first month of coverage is due before the end of the month. Subsequent premiums are due on the first (1st) day of each month of coverage.

Premiums may be paid monthly or for multiple months at a time.

A premium must be paid for an entire month; partial payments will not be accepted.

Premiums that are not received by the due date are considered overdue, and coverage will end effective the next month, unless there is good cause. Good cause exists if premiums are not paid by the due date because of the following reasons:

- Mail delay; or
- Illness of the covered child's responsible adult; or
- Unanticipated emergency beyond the control of the responsible adult.

SECTION 6 NOTICE OF TERMINATION AND RIGHT TO A HEARING

Individuals who are terminated from participation in HIPO will be notified in accordance with Part 5, Section 9 of the MaineCare Eligibility Manual, 10-144 CMR Chapter 332 and the Right to a Hearing is as outlined in the Maine State Services Manual, 10-144 CMR Chapter 104, Section 1, Administrative Policies and Procedures.

8/5/2012
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10-144 CODE OF MAINE REGULATIONS CHAPTER 336
Transfer of Asset Penalty for State-Funded Assistance in Residential Care

As directed in P.L. 2011, Ch. 380, Part MM, the Department of Health and Human Services will impose a penalty (waiting period) for State-Funded Assistance in certain residential care settings for those who transfer their assets for less than Fair Market Value within the "look back period." The residential care settings are Residential Care Facility, Cost Reimbursed Boarding Home, and Adult Family Care Home as defined in Chapter 332, Part 12.

State-Funded Assistance is assistance provided pursuant to 22 M.R.S. § 3174-A. This provides assistance with the cost of room & board and medical costs incurred while meeting the medically-needy deductible as described in Chapter 332, Part 10 of the MaineCare Eligibility Manual.

A transfer subject to Chapter 336 will not impact eligibility for Medicaid generally, but may impact eligibility for specific Medicaid services as found in Chapter 332, Part 15 of the MaineCare Eligibility Manual. This transfer penalty is separate and distinct from any transfer penalty imposed on institutionalized individuals in Chapter 332, Part 15 of the MaineCare Eligibility Manual.

SECTION 1 DEFINITION OF THE LOOK BACK PERIOD

The period of time that the Department uses to determine whether a penalty for improper transfer of assets will be imposed is called the "look back period."

The look back period is on or after sixty months prior to the first day of the month in which the individual resides in a Residential Care Facility, Cost Reimbursed Boarding Home, or Adult Family Care Home and applies for State-Funded Assistance.

If the individual has had multiple periods of residing in one of the above facilities and/or applications for State-Funded Assistance, the look back period starts sixty months prior to the first day of the month in which the individual first resides in one of the facilities above and applies for State-Funded Assistance.

SECTION 2 DEFINITION OF INDIVIDUAL

In establishing whether a transfer of assets has taken place, the term "individual" includes the individual him/herself as well as:

I. the individual's spouse; or

II. a person, including a court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse or with legal authority to act in place of or on behalf of the individual or the individual's spouse.

SECTION 3 DEFINITION OF ASSETS SUBJECT TO TRANSFER

For transfer purposes, an asset includes all income and resources of the individual and the individual's spouse. This includes any income or resources which the individual or the individual's spouse is entitled to but does not receive because of action or lack of action by the individual as defined above, including but not limited to renouncing an inheritance or failing to exercise a spousal share in a challenge to a will.

To determine the effect that the transfer has on eligibility, several questions must be answered:

I. What was transferred?

II. Who was the transfer made to?

III. When was the transfer made?

IV. What did the individual or individual's spouse receive in exchange?

V. Why was the transfer made?

SECTION 4 EXEMPT TRANSFERS

The following may be transferred without penalty.

I. The individual's home, if it is transferred to:
   A. the individual's child, if the child is under the age of 21 or does or would meet SSI criteria of total and permanent disability or blindness.
   B. a sibling of the individual, if the sibling has an equity interest in the home and was residing in the home for at least one year immediately before the date of the individual's admission to a Residential Care Facility, Cost Reimbursed Boarding Home or Adult Family Care Home.

      Example:
      A brother and sister have joint ownership of a home in which they both lived for the last five years prior to the brother's admission to a Residential Care Facility, Cost Reimbursed Boarding Home or Adult Family Care Home.
      The brother may transfer his interest in the home to his sister without penalty.

      A penalty would be established if:
      1. the sister was not a joint owner or had no equity interest in the home, or
      2. the sister had not lived in the home for at least one year immediately before the brother moved to one of the above facilities.

   C. a child of the individual, if the child is over the age of 21 and does not meet the SSI criteria of total and permanent disability or blindness, and the child was residing in the home for at least two years immediately before the individual's admission to one of the above facilities and was providing care which enabled the individual to live at home rather than in one of the above facilities for this time.

D. the individual's spouse.

II. Any asset transferred to the individual's child who does or would meet SSI criteria of total and permanent disability or blindness. This exemption also applies to the transfer of assets by the individual or the individual's spouse to a trust established solely for the benefit of the individual's child who does or would meet the SSI criteria of total and permanent disability or blindness.

III. Assets transferred to a trust established for the sole benefit of the individual, where the individual is under 65 years of age at the time of transfer and does or would meet the SSI criteria of total and permanent disability.

IV. Assets which the owner intended to dispose of at Fair Market Value or for other valuable consideration but for which, without being at fault, the owner did not obtain full Fair Market Value.

V. Assets transferred exclusively for a purpose other than to qualify for State-Funded Assistance either at the time of the transfer or at some future date. "Exclusively" means, transferred for that reason only and solely. It is not enough to prove that there was a reason to transfer in addition to gaining State-Funded Assistance. The reason for transferring must be exclusive of gaining State-Funded Assistance.

VI. Assets transferred for less than Fair Market Value that are subsequently returned to the individual. There is no penalty as of the month in which all the assets are returned to the individual. When only part of an asset or its equivalent value is returned, a penalty period can be modified but not eliminated. A penalty remains in effect for the past time period during which the asset had been transferred.

VII. Assets transferred to (or for the sole benefit of) the individual's spouse.

VIII. Assets transferred more than sixty months prior to the month in which the individual resides in a Residential Care Facility, Cost Reimbursed Boarding Home, or Adult Family Care Home and applies for State-Funded Assistance.

IX. Assets transferred for Fair Market Value.

X. Irregular or infrequent gifts provided the cumulative amount of the gifts do not exceed $500 per calendar quarter. Each gift is analyzed separately. This provision does not mean that the first $500 per quarter is excluded when the cumulative amount of those gifts is more than $500.

A transfer is considered to be for the "sole benefit of" a spouse, blind or disabled child or disabled individual when no individual or entity except the spouse, blind or disabled child or disabled individual can benefit from the assets transferred in any way, whether at the time of the transfer or at any other time in the future.

SECTION 5 FAIR MARKET VALUE

Fair Market Value is an amount that can be expected to be received for selling a similar article on the open market in the geographic area involved.

A transfer for Fair Market Value incurs no penalty. Fair Market Value may be received in cash by the individual.

The compensation received for the asset must be in a tangible form with intrinsic value that is equivalent to or greater than the value of the transferred asset. A transfer for love and consideration is not a transfer for Fair Market Value.

Fair Market Value may be received by the individual in the form of payment of the individual's past medical expenses and debts if measurable and verified. Fair Market Value must be received by the individual at or before the time of transfer and not delivered at a future date.

Fair Market Value may also be received in the form of past support for basic necessities if such support is measurable and verified. A reasonable value must be placed on the support provided and the specific time period must be substantiated for which it was given.

Past support for basic necessities does not include any items given as a gift. Additionally, past support for basic necessities does not include goods or services provided by relatives, with the exception of clothing, transportation or personal care provided by a relative pursuant to a legally written enforceable agreement whereby the individual agreed to transfer the asset in payment for clothes, transportation or personal care once those services have been received.

Fair Market Value may be received by the individual in the form of services (other than those qualifying as a basic necessity) provided by a relative, but only if:

I. the transfer takes place at the time the service is rendered;

II. the services are performed subject to a written agreement that has been executed prior to the delivery of services, specifying the type, frequency and duration of the services being provided to the individual and the amount of consideration (money or property) being received by the relative;

III. at the time of the receipt of the services, the applicant is not residing in a Residential Care Facility, Cost Reimbursed Boarding Home, Adult Family Care Home, or nursing facility;

IV. at the time of the receipt of the services, the applicant's physician has determined that the services are necessary to prevent the transfer of the applicant to residential care or nursing facility care, and has so stated in a written, signed document; and

V. the services do not include the mere providing of companionship.

Whenever an individual has transferred assets within the look back period in exchange for services provided by a relative, the Department will review the written contract between the individual and the provider / relative at the time of individual's application. If the amount paid for the services is above the Fair Market Value of the services at the time the services were delivered, then the individual will be

considered to have transferred the assets for less than Fair Market Value. If in question, Fair Market Value of the services may be determined by consultation with an area business which provides such services.

SECTION 6 DISPROVING THE PRESUMED TRANSFER

Any transfer of assets by the individual within the look back period will be presumed to have been made for the purpose of becoming or remaining eligible for State-Funded Assistance, unless the individual furnishes clear and convincing evidence that the transaction was for some other purpose and that there was no intent at the time to apply for State-Funded Assistance within the foreseeable future. It is the Department's responsibility to demonstrate that a transfer took place and to establish the date of the transfer. It is the individual's responsibility to prove that the transfer took place for reasons other than to gain eligibility for State-Funded Assistance.

If the individual wants to disprove the presumption that the transfer was made to get help with State-Funded Assistance, the burden of proof rests with the individual. The individual must demonstrate that the transfer was specifically and solely for some other purpose than to receive State-Funded Assistance. Statements and evidence to disprove the transfer must be contained in the individual's record.

The statement should cover, but not necessarily be limited to the individual's:

I. purpose for transferring the asset;

II. attempts to dispose of the asset for Fair Market Value;

III. reasons for accepting less than the Fair Market Value for the asset;

IV. plans for and ability to provide financial support after the transfer;

V. relationship, if any, to the persons to whom the asset was transferred; and

VI. belief that the Fair Market Value was received.

In addition to the individual having to prove that the transfer was made specifically and solely for a purpose other than to get State-Funded Assistance, other factors to be considered include:

I. a sudden onset of a disability or blindness after the asset was transferred;

II. the diagnosis of a previously undetected disabling condition after the transfer occurred;

III. unexpected loss of other assets following the transfer;

IV. unexpected loss of income after the transfer occurs; or

V. court ordered transfers.

SECTION 7 ESTABLISHING DATE AND VALUE OF TRANSFER

The means of establishing the date and value of a transfer will depend on the type of asset transferred, as detailed below.

I. Assets other than bank accounts. A transfer of assets occurs when:
   A. title (ownership) or legal interest to property has passed from the individual to a third party. For example: Sole ownership of a home valued at $100,000 is transferred to another. The value of the transfer is $100,000.
   B. the individual establishes a joint ownership, tenancy in common, joint tenancy or other similar arrangement, such as adding a name to stocks, bonds, real property. In addition to legally transferring part ownership, the individual has taken action which reduced or eliminated their ownership or control of the remainder of the asset. The date of the transfer is the date that the joint ownership was established. The amount of the transfer is the total uncompensated value of the asset. For example: In 10/95 the individual establishes joint ownership of his or her home valued at $100,000. The value of the transfer is $100,000. The date of the transfer is 10/95.
   C. the asset is converted from an accessible to an inaccessible asset. An example is when assets are placed in an irrevocable trust.
   D. the individual takes action to refuse the receipt of assets.
   E. unless otherwise exempt, when the individual sells real property in exchange for a promissory note, a transfer of assets must be assessed as follows:
      3. if the individual sold property for less than Fair Market Value (see Section 5), a transfer of assets has occurred amounting to the difference between the sale price (the presumed value of the note) and the value of the property. To determine the sale price the presumed value of the note is used.
      4. if the current value of the note is less than the presumed value, the difference between the two amounts is a transfer of assets.

      The total amount of assets transferred due to (1) and (2) above incurs a penalty, and the date of the transfer is the date the real property is sold.
   F. The purchase of a promissory note, loan or mortgage will be considered a transfer of assets (*see* Chapter 332, Part 15) unless the note, loan or mortgage**:**
      1. has a repayment term that is actuarially sound (as determined in accordance with actuarial publications of the Social Security Administration, found online at: http://www.ssa.gov/OACT/STATS/table4c6.html).
      2. provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and
      3. prohibits the cancellation of the balance upon death of the lender.

      If the conditions in 1, 2, and 3 above are not met, the value of the transfer is the outstanding balance due on the note, loan or mortgage as of the date of the individual's application for State-Funded Assistance.

II. With bank accounts, a transfer of funds in an account is determined to take place when:
   A. funds deposited in a joint account and owned by the individual (*see* Chapter 332, Part 16, Section 2.5), are withdrawn by the other joint owner(s) from the account and used for other than the sole benefit of the individual; or

B. another person's name is added to the individual's account, the money in the account is owned by the individual, and the intent of the individual in giving access is to convey ownership of those funds. Intent to convey ownership must be documented with a clearly written statement of intent to transfer the funds in the account to the joint owner. This statement must be:
   1. duly executed in the presence of the notary public; and
   2. signed by the individual at the time the account was made joint or within a reasonable period of time, usually one week but maybe longer due to circumstances beyond the control of the individual.

   Note: Evidence of an intent to transfer the funds in the account at the time that the name was added to the account will be rebutted by evidence that the individual continued to use the funds.

SECTION 8 ESTABLISHING A PENALTY

Once it has been established that a transfer of assets for less than Fair Market Value occurred within the look back period, the penalty period must be determined.

Any penalty imposed under this Chapter will apply only to State-Funded Assistance. No penalty under this Chapter will be applied to other state services or Medicaid services for which the individual qualifies.

There are three different methods of calculating the penalty period as follows.

I. If there has been only one transfer during the look back period:
   A. Determine the date that each transfer occurred.
   B. Determine the amount of the transfer.
   C. Divide the amount of the transfer by the average monthly private rate for a semi-private room for a nursing facility at the time of application (*see* Chapter 332, Charts, Chart 4.3). This determines the number of whole months of ineligibility based on the transfer.
   D. When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility in (*see* Chapter 332, Charts, Chart 4.3), or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:
      1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.
      2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.
      3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period.

      Example:
      If the monthly private rate is $6,000 and the transfer amount is $56,400, this would result in a transfer penalty of 9.4 months. To determine the remainder amount, you would take $6,000 X 9 months = $54,000. $56,400 - $54,000 = $2,400. You would add

$2,400 to the cost of care for one month. If the penalty period begins March 1st, it would end November 30th. $2,400 would be added to the cost of care for December.

In an instance where the penalty period is less than a full month, the partial month penalty will be added to the cost of care in the first month a cost of care is due.

Example:
The individual enters a Residential Care Facility on November 27th. There is a partial month transfer penalty of $3000. A cost of care will be due beginning with the month of December. The $3000 partial month transfer penalty will be added to the December cost of care.

II. If there has been more than one transfer in the same month, the penalty period is determined as follows:
   A. Determine the total, cumulative, value of all transfers in the same month.
   B. Divide the amount by the average monthly private rate for a semiprivate room for a nursing facility at the time of application (*see* Chapter 332, Charts, Chart 4.3). This determines the number of whole months of ineligibility.
   C. When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility (*see* Chapter 332, Charts, Chart 4.3), or the penalty calculation includes a partial month, the partial month shall be counted and implemented as a period of ineligibility using the following method:
      1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.
      2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.
      3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period. In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

III. If there have been multiple transfers in more than one month during the look-back period, all transfers can be added together into one penalty period using the following method:
   A. Add all transfer amounts together.
   B. Divide the amount by the average monthly private rate at the time of application for a semiprivate rate for a nursing facility (*see* Chapter 332, Charts, Chart 4.3). This determines the number of whole months of ineligibility.
   C. The transfer is treated as one transfer and is treated as if it occurred on the earliest date of the multiple transfers.
   D. When the value of the transfer is less than the average monthly private rate for a semi-private room for a nursing facility (*see* Chapter 332, Charts, Chart 4.3), or the penalty calculation includes a partial

month, the partial month shall be counted and implemented as a period of ineligibility using the following method:

1. After determining the amount of transfer and dividing that amount by the average monthly private rate for a semiprivate room for a nursing facility, impose a period of ineligibility for the whole months.
2. Convert the remaining partial month into a dollar amount by multiplying the number of whole months by the monthly private rate used in the calculation above, and subtracting that figure from the total amount of the transfer.
3. This remainder is added to the cost of care for the first month of eligibility after imposing the penalty period. In an instance where the penalty period is less than a full month the partial month penalty will be added to the cost of care in the first month a cost of care is due.

IV. The penalty period for transfers begins with the later of:

A. the first day of a month in which the transfer for less than Fair Market Value occurred;

B. the first day of the month the individual is eligible for Medicaid and would otherwise be receiving State-Funded Assistance based on an approved MaineCare application were it not for the Department imposing an asset transfer penalty period; or

C. the first day which does not occur during any other period of ineligibility.

V. In the case of a married couple which is assessed a penalty at the time both spouses reside in a Residential Care Facility, Cost Reimbursed Boarding Home, or Adult Family Care Home and have applied for and are otherwise eligible for State-Funded Assistance, and there is a penalty period in effect for either spouse, the remaining penalty period can be divided between the spouses into any combination of full months. Whether there is a division of the penalty and, if so, how it will be divided, is a decision of the spouses.

When, for some reason, one spouse is no longer subject to a penalty (for example, no longer lives in a Residential Care Facility or dies), the remaining period applicable to both spouses must be served by the remaining spouse.

SECTION 9 HARDSHIP WAIVERS

The Department may waive a transfer penalty under this Chapter where the transfer penalty would impose an undue hardship on the penalized individual. It is the responsibility of the individual to prove the claim of undue hardship.

I. Determine if undue hardship exists. An undue hardship exists if this denial would:

A. deprive the individual of medical care such that the individual's health or life would be threatened; or

B. deprive the individual of food, clothing, shelter, or other needs of life.

II. Determine whether to waive the penalty when undue hardship exists. The penalty can be waived if:

A. the individual was exploited as assessed by the Department of Health and Human Services Adult Protective Services; or

B. the individual---

1. Can prove all of the following:
    a. Neither the individual nor the spouse have the means to pay for room & board and medical costs incurred while meeting the medically needy deductible without State-Funded Assistance, taking into consideration all exempt and non-exempt income and assets.
    b. The recipient of the transferred asset is unable or unwilling to make the value of the transfer or any part of it available to pay for the individual's cost of room & board and medical costs incurred while meeting the medically needy deductible.
    c. The individual has made all reasonable efforts to recover the transferred asset or its equivalent value. The individual must cooperate with the Department in any recovery activity that is undertaken.

AND

2. The individual must agree in writing that if the transferred assets or equivalent value are recovered, the individual will reimburse the Department for funds expended as a result of the approved claim of undue hardship.

III. The result of being denied State-Funded Assistance, by itself, is not considered undue hardship.

IV. The Department will use the following process for undue hardship determinations:
    A. All denials/closures due to a transfer of assets will include a written notice that an "undue hardship" provision exists and can be considered according to the criteria indicated above if the applicant/recipient requests it.
    B. A claim of undue hardship must be made no later than thirty days from the date of the denial/closure notice. With the individual's written permission, an authorized representative or the facility in which the individual resides can claim undue hardship on the individual's behalf.
    C. A decision on a claim of undue hardship will be made and the applicant notified in writing within thirty days of the claim being made.
    D. An appeal from any adverse action including a denial of a claim of undue hardship must be made within thirty days of the notice of denial. Applicants/recipients will be given written notice of this right to a hearing.
    E. In sub-section II.B.1.a. above, the Department will not use income and assets provided to the community spouse to prevent impoverishment in determining whether the individual or the spouse have the means to pay the cost of room & board and medical costs incurred while meeting the medically needy deductible.