

TITLE 469
ASSISTANCE TO THE AGED, BLIND, OR DISABLED PAYMENT (AABD/PMT)
NEBRASKA MEDICAL ASSISTANCE PROGRAM (NMAP); AND
STATE DISABILITY PAYMENT AND MEDICAL PROGRAM (SDP)

CHAPTER 1-000 GENERAL BACKGROUND

1-001 Legal Basis: Assistance to the Aged, Blind, or Disabled (AABD) was established by the Nebraska Legislature in 1965 by Neb. Rev. Stat. Section 68-1001. It replaces former programs of Old Age Assistance, Blind Assistance, and Aid to the Disabled.

Medicaid was established by Title XIX of the Social Security Act. The Nebraska Legislature established the program for Nebraska Medicaid Program in Neb. Rev. Stat. Sec. 68-903. The Nebraska State Disability Program (SDP) was established by the Nebraska Legislature in 1976 by Neb. Rev. Stat. § 68-1005.

1-002 Purpose and Scope: The AABD Program was established to provide financial aid and medical assistance to persons in need who are age 65 and older, or who are age 64 and younger and blind or disabled according to the Retirement, Survivors, and Disabled Insurance (RSDI)/Supplemental Security Income (SSI) Program definition of blindness or disability (see 469 NAC 2-007.02).

The State Disability Program was established to provide financial aid and medical assistance to persons who are blind or disabled and who meet the program definition of blindness or disability (see 469 NAC 2-007.02) but do not meet the durational requirements.

~~NMAP, also known as Medicaid, provides medical services to aged, blind, or disabled persons, who are otherwise eligible and who do not have sufficient income and resources to meet their medical needs.~~

~~The maintenance portion of the AABD and SD Programs is funded entirely by state money. The medical assistance portion of the AABD Program is funded by federal and state money. For SDP, the medical assistance portion is funded by state dollars.~~

1-003 Administration: The Assistance to the Aged, Blind, or Disabled Program (AABD), Nebraska Medicaid Program (NMAP/Medicaid), and State Disability Program (SDP) are administered by the Nebraska Department of Health and Human Services in accordance with state laws and with the rules, regulations, and procedures established by the Chief Executive Officer of the Nebraska Department of Health and Human Services.

1-004 Definition of Terms: For use within AABD, NMAP, and SDP, the following definitions of terms will apply unless the context in which the term is used denotes otherwise.

AABD/MA: A previous categorical program consisting of financial assistance and medical assistance, ~~or medical assistance only. Two types of cases are included in the medical assistance only category:~~ The medical portion of the Assistance to the Aged, Blind, or Disabled, not including the State Disability Program medical assistance, is handled under the 477 NAC Medicaid. The financial assistance portion is now known as AABD Payment or SDP Payment.

- ~~1. Medical Assistance With No Share of Cost (MA only): A case in which there is income sufficient to meet daily maintenance needs but insufficient to meet medical needs. The case is opened for medical assistance only with no grant payment; and~~
- ~~2. AABD/Medical Assistance Share of Cost Case (MA with Share of Cost): A case in which there is sufficient income to meet daily maintenance needs and a portion but not all of the unit's medical needs. The case is opened for medical assistance with no payment for medical services made until the Share of Cost is obligated toward medical services.~~

AABD PAYMENT: The financial assistance/payment portion of the AABD Program. Also, known as AABD/PMT.

Adequate Notice: Notice of case action which includes a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s), (see also 469 NAC 1-008.03C).

Aged: A client who is age 65 or older.

Applicant: An individual who applies for assistance.

Application: The action by which the individual indicates the desire to receive assistance by submitting an application.

Application Date: For new and reopened cases, the date a properly signed application is received or the received date by the agency on an electronic application (e-app). When adding a program to a properly signed application, this is the date that the new program is requested.

Application Signature: Applications may be signed in writing or by electronic signature.

Application Submission: Applications may be submitted in person, by mail, by fax, or by electronic transmission.

Approval/Rejection Date: The date that the new or reopened case is determined eligible or rejected by the Nebraska Department of Health and Human Services.

Assignment: The legal transfer of an individual's right to benefits to the Nebraska Department of Health and Human Services.

Blind: A Category of eligibility for clients who are age 64 and younger and who are blind in accordance with program standards.

Categorical Assistance: Assistance administered by the Nebraska Department of Health and Human Services. For the purposes of this definition, it includes Aid to Dependent Children (ADC)/MA, Child Welfare Payment and Medical Services Program/MA, Assistance to the Aged, Blind, or Disabled (AABD)/MA, State Disability Program (SDP)/MA, Refugee Resettlement Program/MA; and ~~Children's Medical Assistance Programs--Medicaid.~~

Client: An individual either applying for or receiving assistance. This term is used when the same policies apply to an applicant and a recipient.

Deeming: The process of determining the amount of income and resources of a parent or sponsor which must be considered available to meet the client's needs.

Disabled: A category of eligibility for clients who are age 64 and younger and who are disabled in accordance with program standards.

Equity: The fair market value of property minus the total amount owed on it.

Essential Person (EP): A needy individual:

1. Who lives in the home of the client;
2. Who is not eligible for assistance in his/her own right;
3. Who is necessary to the well-being of the client; and
4. Whose needs are included in the client's budget.

This determination is made by SSI or by the client.

For EP's included in determining a payment budget, see 469 NAC 3-006.02-ff. For EP's included in determining eligibility for NMAPSDP, see 469 NAC 4-007.

Fair Market Value: The price an item of a particular make, model, size, material, or condition will sell for on the open market in the geographic area involved.

Grant Case: A case receiving a state supplement payment, ~~or eligible to receive a grant payment which is nullified by an SSI payment.~~ Either term, grant or payment, may be used to make reference to the state supplement.

Inquiry: Any question received by phone, letter, electronic transmission, or personal contact without any indication that the individual wishes to apply. This may or may not be followed by a request or application for assistance.

Need: A condition of eligibility referring to economic need.

Needy Individual: One whose income and resources for maintenance are found under assistance standards to be insufficient for meeting the basic requirements (see also 469 NAC 2-009-ff. and 2-010-ff.).

Payment: A case receiving a state supplement grant. Either term, payment or grant, may be used to make reference to the state supplement.

Payment Effective Date: The month and year that the grant payment is to be effective.

Pending Case: A case in which the application has been taken and eligibility is yet undetermined. All pending cases must be entered on N-FOCUS within two working days.

Power of Attorney: A written statement allowing one person to act for another person. A power of attorney may be authorized generally for the management of a specified business or enterprise or more often specifically for the accomplishment of a particular transaction. There is no court involvement or supervision in the appointment. The statement does not have to be notarized.

A standard or non-durable power of attorney automatically becomes null and void when the appointing individual becomes incompetent. A durable power of attorney continues in effect even when the appointing individual becomes incompetent. The power of attorney document should clearly specify if it is a durable power of attorney.

~~Prospective Eligibility for Medical Assistance: The date of eligibility beginning the first day of the month of the date of request if the client was eligible for MA in that same month.~~

Prudent Person Principle: The practice of assessing all circumstances regarding case eligibility and using good judgment in requiring further verification or information before determining initial or continuing eligibility (see also 469 NAC 1-010).

Recipient: An individual who is receiving assistance.

Rejected Case: A case in which an application was completed and signed but the applicant did not meet the categorical, procedural, or financial requirements of the program.

Request: An action by which an individual's desire to receive assistance is made known to the local office. A request may be made by telephone, letter, electric transmission, or an interview.

Request Date: The date the client requests assistance. For reopened cases, this is the date of the new request. For program changes, this is the request date for the new program.

Retroactive Eligibility for SDP Medical Assistance: The date of eligibility beginning no earlier than the first day of the third month before the month of request if the following conditions were met:

1. Eligibility was determined and a budget computed separately for each of the three months;
2. A medical need existed; and
3. Eligibility requirements were met at some time during each month.

Retroactive Payment: Any payment made during the current month but for a prior month.

Share of Cost: A client's financial out-of-pocket obligation for medical services when countable income exceeds the medical maintenance income level. The Share of Cost amount is the difference between the unit's countable income and the appropriate medical maintenance income level. This amount must be obligated or paid to medical providers before Medicaid will pay on the remaining medical bills.

SDP/MA: A categorical program consisting of financial assistance and medical assistance or medical assistance only. ~~Two types of cases are included in the medical assistance only category.~~ The term SDP is used when the manual reference(s) apply to both the grant and medical portions of the program.

SDP Medical: The medical assistance portion of the State Disability Program. Also known as SDP/MA. Two types of SDP cases are included in the medical assistance only category:

1. Medical Assistance With No Share of Cost (SOC) (MA only): A case in which there is income sufficient to meet daily maintenance needs but insufficient to meet medical needs. ~~The case is opened for medical assistance only with no grant payment; and~~
2. SDP/Medical Assistance SOC Case: A case in which there is sufficient income to meet daily maintenance needs and a portion but not all of the unit's medical needs. The case is opened for medical assistance with no payment for medical services made until the SOC is obligated toward medical services.

SDP Payment: The financial assistance/payment portion of the State Disability Program. Also known as SDP/PMT.

SSI Federal Benefit Rate: The maximum SSI benefit payable based on the individual's living arrangement, e.g., own home, nursing home, living in another's home.

Supplemental Payment: Any payment made for and during the current month after major payroll has run.

Third Party Medical Payment: A payment from any health insurance plan, individual, or group for medical expenses.

Timely Notice: A notice of case action dated and mailed at least ten calendar days before the date the action becomes effective (see 469 NAC 1-008.03A2).

Unit: Eligible/needy individuals considered in determining the grant/payment amount and/or medical assistance.

Withdrawal: A voluntary written retraction of an application.

1-005 Worker Responsibilities: The worker has the following responsibilities.

1-005.01 Duties at Initial Application or Redetermination: At the time of initial application and redetermination, the worker shall -

1. Allow anyone who requests assistance to complete an application;
2. Give an explanation of the program requirements;
3. Collect and review the information entered on the application form;
4. Explain the eligibility and payment factors and how changes will affect eligibility and payment;
5. Explain the eligibility and payment factors that require verification;
6. Obtain the client's written consent for the needed verifications;
7. Explore income that may be currently or potentially available such as RSDI, SSI, Veteran's Assistance benefits (VA), etc.;
8. Give information about the social and other financial services available through the agency, ~~such as social services and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);~~
9. Inform the client about his/her rights and responsibilities (see 469 NAC 1-006 and 1-007);
10. Inform ~~the~~ an SDP medical client that s/he must show his/her medical card to all providers and must inform the worker of any health insurance plan, any individual, or any group that may be liable for the client's medical expenses;
11. Explain the assignment of third party medical payments and the requirement to cooperate in obtaining third party medical payments and refund any payments received directly;
- ~~12. Inform the client of the requirement to participate in the Nebraska Health Connection, if applicable (see 469 NAC 4-009 ff.)~~
- ~~13-12.~~ Complete necessary reports and information forms;
- ~~14-13.~~ Act with reasonable promptness on the client's application for assistance;
- ~~15-14.~~ Provide adequate notice to the client of -
 - a. Approval for a grant and the amount;
 - b. Approval for SDP medical assistance;
 - c. Rejection of the application and the reason; or
 - d. Confirmation of the client's voluntary withdrawal; and
- ~~16-15.~~ Explain the appeal process (see 465 NAC 2-001.02-ff.).
{Effective 7/25/95}

1-005.02 Continuing Responsibilities: The worker has the continuing responsibility to:

1. Provide adequate notice of any action affecting the client's assistance case (see 469 NAC 1-008.03-ff. to determine if timely notice is necessary);
2. Treat the client's information confidentially; and
3. Uphold the client's civil rights.

1-005.03 Nursing Facility Admissions: The worker must refer any AABD grant or SDP client requesting nursing facility services to the admitting nursing facility for the identification screen and Pre-Admission Screening Process (PASP) as required by 471 NAC 12-000-ff.

1-006 Client Responsibilities: The client is required to:

1. Provide complete and accurate information. State and federal law provides penalties of a fine, imprisonment, or both for persons found guilty of obtaining assistance or services for which they are not eligible by making false statements or failing to report promptly any changes in their circumstances;
2. Report a change in circumstances no later than ten days following the change. This includes information regarding:
 - a. Monthly expenses;
 - b. Resources or other financial matters;
 - c. Employment status;
 - d. The composition of the household;
 - e. Living arrangements;
 - f. Address;
 - g. Disability status;
 - h. A temporary absence from the home of any unit member; and
 - i. Changes in the amount of monthly income, including:
 - (1) All changes in unearned income; and
 - (2) Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes for AABD, 30 hours per week is considered full-time. The client must report new employment within ten days of receipt of the first paycheck, and a change in wage rate or hours within ten days of the change.
3. Present his/her medical card to providers;
4. Inform the medical provider and worker of any health insurance plan, any individual, or any group that may be liable for his/her medical expenses;
5. Cooperate in obtaining any third party medical payments;
6. Enroll in a health plan and maintain enrollment if:
 - a. One is available to the client;
 - b. The client is able to enroll on his/her own behalf; and
 - c. The Department has determined that enrollment in the plan is cost effective.
7. Reimburse to the Nebraska Department of Health and Human Services or pay to the provider any third party medical payments received directly for services which are payable by SDP Medical or the Nebraska Medical Assistance Medicaid Program;
8. Pay any unauthorized medical expenses;
9. Pay any required medical copayment (see 469 NAC 4-008 ff.);
- ~~10. Meet the requirements of the Nebraska Health Connection, if applicable (see 469 NAC 4-009);~~
- ~~11. Cooperate with state and federal quality control; and~~
- ~~12. Contact the agency for an interview within 30 days of the date of application if notified that an interview is required as instructed by the agency in writing.~~

{Effective 6/28/11}

1-006.01 Sanction for Non-Cooperation With Quality Control: A client must cooperate with state and federal quality control as a condition of eligibility. If a client fails to cooperate, s/he is ineligible for one month only. The worker closes the case the first month possible, considering adequate and timely notice. The following month, the worker reopens the case if the client is otherwise eligible. If at anytime QC notifies the worker that the client has cooperated, assistance is restored for the month the case was closed.

1-007 Client Rights: The client has the right to:

1. Apply. Anyone who wishes to request and/or apply for assistance must be given the opportunity to do so. No one may be denied the right to apply for public assistance;
2. Reasonably prompt action on his/her application for assistance (see 469 NAC 1-008.02B);
3. Adequate notice of any action affecting his/her application or assistance case (see 469 NAC 1-008.03-ff. to determine if timely notice is necessary);
4. Appeal to the Director for a hearing on any action or inaction with regard to an application, the amount of the assistance payment, or failure to act with reasonable promptness. The appeal must be filed in writing within 90 days of the action or inaction;
5. Have his/her information treated confidentially;
6. Have his/her civil rights upheld. No person may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, or political belief;
7. Have the program requirements and benefits fully explained;
8. Be assisted in the application process by the person of his/her choice; and
- ~~9. Receive medical assistance without a separate application if s/he is eligible for categorical assistance; and~~
- ~~10.9.~~ Referral to other agencies.

1-008 Application Processing

1-008.01 Request: A request for AABD grant assistance or SDP may be made in person, by letter, or by telephone, fax, or electronic submission and may be made by the applicant, his/her guardian or conservator, an individual acting under a duly executed power of attorney (see 469 NAC 1-004), or another person authorized to act for the applicant. The worker must record the request date on the application. If an interview cannot be scheduled within 14 days from the date of request, an application must be mailed promptly or the client must be informed of the electronic application.

A request is terminated:

1. When a properly signed application is received;
2. When the applicant or his/her representative notifies the worker of withdrawal; or
3. After 30 days if the worker has heard nothing further from the applicant or his/her representative. However, the worker may continue to hold a request pending if there is reason to believe the applicant intends to complete his/her application.

1-008.02 Application: A request becomes an application when a properly signed application is received. A properly signed application contains:

1. Name;
2. Address; and
3. Proper signature, as defined by the appropriate program.

An application may be signed by an individual for himself/herself or by the applicant's guardian, conservator, an individual acting under a duly executed power of attorney, or another person authorized to act for the applicant. The worker must use prudent person principle in deciding who may sign the application.

~~An application for medical benefits only may be taken on behalf of a deceased person. If there is no one to represent the deceased person, the administrator of the estate may sign the application. The eligibility requirements must have been met at the time medical services were rendered.~~

1-008.02A Alterations: The application, when completed and signed by the client or his/her representative, constitutes his/her own statement in regard to his/her eligibility. If the worker adds information received from a client to a properly signed application, the worker must date the information and:

1. Note the information received from the client; or
2. If the information is not received from the client, identify the source of the information.

The worker may add information to an application up to the date of approval or completed redetermination.

1-008.02B Prompt Action on Applications: The worker must act with reasonable promptness on all applications for assistance. The worker must make a determination of eligibility of an application within 45 days from the date of the request for a client applying under the blind or aged category and within 60 days from the date of request for a client applying under the disabled category. If circumstances beyond the control of the worker prevent action within the required time, the worker must record the reason for the delay in the case record. The worker must send a Notice of Action informing the applicant of the reason for the delay. The 45 or 60-day time period must not be used as a routine waiting period before approving assistance. Until a determination of eligibility is made, the worker must send a Notice of Action every 45 days from the date of request for a pending application for the blind or aged category and every 60 days for the disabled category.

1-008.02C SDP MA Application with Share of Cost: An application for SDP medical assistance for an individual with a Share of Cost who has a medical need may be approved with no medical payments authorized until the applicant has met his/her obligation.

1-008.02D AABD Payment and SDP Application with Excess Resources: An application for assistance for an individual who has excess resources may be held pending until the resources are reduced. For resource spenddown procedures, see 469 NAC 2-009.11.

For eligibility for a grant, see 469 NAC 2-009.08. For SDP medical eligibility, see 469 NAC 4-005.

~~1-008.02E Application with a Designated Provider: Any individual may apply for medical assistance with a designated provider who has contracted with the Department to accept Medicaid applications at their location.~~

~~{Effective 6/28/11}~~

1-008.02DE Withdrawals: The applicant may voluntarily withdraw an application. If the applicant verbally withdraws the application, the worker must request a written statement of withdrawal. The worker must make note of the withdrawal in the case record and give written confirmation of withdrawal to the applicant on a Notice of Action (see 469 NAC 1-008.03C).

If the applicant does not provide written confirmation of the withdrawal within 30 days from the application date, the worker must reject the application. The worker must send a Notice of Action to the applicant notifying him/her of the rejection.

1-008.02GF Authorization for Investigation: For some sources the worker asks the client to sign a Release of Information when it appears that information given is incorrect, when the client is unable to furnish the necessary information, or for sample quality control verification. A copy of the authorization for release of information from the Application for Assistance may be used if the source will accept it.

1-008.02HG. New Application: A new application is required after one calendar month of ineligibility.

1-008.03 Notice of Finding: The worker must send adequate notice using a Notice of Action to notify the client of any action affecting his/her assistance case. The Notice of Action must be sent to the last-reported address. If the form is inadvertently sent to the wrong address, the worker must send a new form, allowing the client ten days from the date the corrected form is sent (if adequate and timely notice is required). If the client resides in a skilled nursing care, intermediate care, or long term care facility, a copy of the Notice of Action must be sent to the facility.

{Effective 10/1/97}

1-008.03A Types of Notices

1-008.03A1 Adequate Notice: An adequate notice must include a statement of what action(s) the worker intends to take, the reason(s) for the intended action(s), and the specific manual reference(s) that supports the action or the change in federal or state law that requires the action(s). The worker must send an adequate notice no later than the date of action.

1-008.03A2 Timely Notice: A timely notice must be dated and mailed at least ten calendar days before the date that action would become effective, which is always the first day of the month.

1-008.03B Adequate and Timely Notice: In cases of intended adverse action (action to discontinue, terminate, suspend, or reduce assistance or to change the manner or form of payment or service to a more restrictive method, i.e., protective payee, ~~medical lock-in~~), the worker must give the client adequate and timely notice.

1-008.03C Situations Requiring Adequate Notice: In the following situations, the worker may dispense with timely notice but shall send adequate notice no later than the effective date of action.

1. The agency has factual information confirming the death of a client;
2. The agency receives a written and signed statement from the client -
 - a. Stating that assistance is no longer required; or
 - b. Giving information which requires termination or reduction of assistance, and indicating, in writing, that the client understands the consequence of supplying the information;
3. The client has been admitted or committed to an institution, and no longer qualifies for assistance;
4. The client has been placed in skilled nursing care, intermediate care, long-term hospitalization, or Assisted Living Waiver;
5. The client's whereabouts are unknown and agency mail directed to the client has been returned by the post office indicating no known forwarding address. The agency shall make the client's checkgrant available to the client if his/her whereabouts become known during the payment period covered by a returned checkcorrespondence;
- ~~6.5.~~ The client has been accepted for assistance in another state and that fact has been established;
- ~~7.6.~~ A change in level of medical care; or
- ~~8.7.~~ A special allowance granted for a specific period is terminated and the client has been informed in writing at the time of initiation that the allowance automatically terminates at the end of the specified period.

{Effective 5/11/99}

1-008.03D Waiver of Notice: If a client agrees to waive his/her right to a timely notice in situations requiring timely notice, the worker shall obtain a statement signed by the client to be filed in the case record.

1-008.03E In Fraud Cases: At least five days' advance written notice must be given if -

1. The agency has facts indicating that action should be taken to discontinue, suspend, terminate, or reduce assistance because of probable fraud by the client; and
2. The facts have been verified where possible through collateral sources.

1-008.03F Continuation of Benefits: In cases of adverse action where the worker is required to send timely and adequate notice, if the client requests an appeal hearing within ten days following the date Form IM-8 is mailed, the worker shall not carry out the adverse action until a fair hearing decision is made. This regulation does not apply to those situations outlined in 469 NAC 1-008.03C where the worker is required to send adequate notice only.

This regulation does not restrict the worker from continuing normal case activities and implementing changes to the assistance case that are not directly related to the appeal issue.

The worker shall not carry out an adverse action pending an appeal hearing if -

1. The case action being appealed required adequate and timely notice (see 469 NAC 1-008.03B and 1-008.03C);
2. The client requests an appeal hearing within ten days following the date the notice of finding is mailed; and
3. The client does not refuse continued assistance on Form DA-6.

If the worker's action is sustained by the hearing decision, the worker may institute recovery procedures against the client to recoup the disputed amount of assistance furnished the client during the appeal period (see 469 NAC 3-007.03B). Any amount of overpayment must be shown on the system so that it may be recouped if the client becomes eligible at a later date (see 469 NAC 3-007.03B).

1-008.03F1 Refusal of Continued Benefits: A client may refuse continuation of benefits pending an appeal hearing by checking the statement to that effect on Form DA-6 or handwriting a refusal.

1-008.03F2 Continuation of AABD/MA Payment Benefits Pending an RSDI/SSI Appeal: If the worker receives information that the client has been determined no longer disabled by RSDI/SSI, the worker shall determine the last month that RSDI/SSI benefits are payable. Then the worker shall close the case the first month possible taking into account the advance notice requirement, unless -

1. The client files an appeal of RSDI/SSI's determination and will continue to receive benefits pending the appeal; and
2. The client loses the appeal because the administrative law judge determines that the client is not disabled. In that case the worker shall close the case as soon as the appeal decision is reached, taking into consideration the ten-day notice requirement.

1-009 Redetermination of AABD Payment or SDP Eligibility: The worker shall redetermine eligibility according to the following material. Whenever there is reported or suspected ineligibility of a client, the worker shall take immediate action.

1-009.01 Complete AABD Payment and SDP Redetermination: The worker must do a complete redetermination of eligibility every 12 months. The worker may use either a new or a previously completed application. Eligibility may be redetermined in less than 12 months to coordinate review dates for more than one program.

If the client is eligible for SDP medical assistance only or SDP medical assistance with Share of Cost but no further medical needs are apparent or indicated, or the case is ineligible, the worker must close the case and send a ten-day notice. The worker must determine if the client has a medical need by discussing the situation with the client, using the client's medical profile, etc. The worker closes the case if there is no medical need.

SDP Note: The worker must explain on the notice of action that the client may reapply if there is a medical need at a later date.

In addition to the complete redetermination, the worker must complete income, resource, and disability reviews as described in following material.

1-009.01A Redetermination for SSI Recipients: The worker is not required to complete an application at the time of redetermination for clients who are receiving SSI.

If SSI is discontinued and the last application was completed more than 12 months from the last month of eligibility for SSI, the worker must conduct a complete redetermination of eligibility within the next 30 days, including completion of an application. If it has been less than 12 months since completion of the last application, the worker must review all eligibility requirements that are necessary for continued assistance.

Exception: A redetermination is not required for periodic non-pay for income due to an extra pay period.

Note: Clients who are determined eligible for Medicaid by SSI under the provisions of 1619(b) are not required to complete an application at redetermination. The worker does not need to verify resources (see 469 NAC 2-009.01). The worker must verify income and budget it for grant (see 469 NAC 2-010.01C and 3-006.01).

1-009.02 Income Review: The worker must review income eligibility every 12 months for AABD/MA Payment and SDP/MA.

An income review is not required for SSI recipients. Income must be reviewed for clients who are placed in 1619(b) status by SSI.

{Effective 6/28/11}

1-009.03 Disability Review: Workers must complete procedures for review of disability for SDP/MA or AABD/MA Payment cases when DHHS (see 469-000-329) as required by the State Review Team on Form DM-5R, "Disability Report," which is every six months for SDP/MA and may be every 12 months for AABD/MA, has made the disability determination. DHHS shall determine the duration for the disability, not to exceed 12 months, and the redetermination shall comply with the disability duration set by DHHS.

1-010 Prudent Person Principle: When the statements of the client are incomplete, unclear, or inconsistent, or when other circumstances in the particular case indicate to a prudent person that further inquiry must be made, the worker must obtain additional verification before eligibility is determined. The client has primary responsibility for providing verification of information relating to eligibility.

Verification may be supplied in person, through electronic submission, the mail, or from another source (as an employer). If it would be extremely difficult or impossible for the client to furnish verification in a timely manner, the worker must offer assistance.

1-011 (Reserved)

1-012 Summary of Forms: Instructions for the forms used in this program are contained in the Public Assistance Forms Manual.

CHAPTER 2-000 ELIGIBILITY REQUIREMENTS: To be eligible for AABD/MMA Payment (AABD/PMT), SDP State Disability Program (SDP – applies to both Payment and Medical portions), SDP Payment (SDP/PMT) or SDP Medical or SDP Medical (SDP/MA), the individual must meet the following eligibility requirements:

1. Application (see 469 NAC 2-001);
2. U.S. citizenship or alien status (see 469 NAC 2-002);
3. Nebraska residence (see 469 NAC 2-003);
4. Social Security number (see 469 NAC 2-004)
5. Age (see 469 NAC 2-005);
6. Relative responsibility (see 469 NAC 2-006);
7. Blindness or disability (see 469 NAC 2-007);
8. Institutionalization (see 469 NAC 2-008);
9. Resources (see 469 NAC 2-009);
10. Income (see 469 NAC 2-010);
11. Cooperation in obtaining third party medical payments (see 469 NAC 2-011); and
12. Non Receipt of other assistance (see 469 NAC 2-012).

{Effective 6/28/11}

All medical assistance criteria in this manual refers to the State Disability Program only. See Title 477 for AABD and other Medicaid programs.

2-001 Application: An individual wishing to apply for AABD Payment and SDP assistance must complete and submit an application(s) as required by the Department of Health and Human Services. A relative or other person acting for the client may complete the application.

The agency will conduct a face-to-face interview if requested by the client, or determined necessary by the agency using the prudent person principle (see 469 NAC 1-010). The agency will conduct a face-to-face interview if requested by the client. If a client, for good reason, is unable to conduct a face-to-face interview in the DHHS office, then the worker and the client must identify a mutually acceptable time and place, such as a hospital, senior or community center, or the client's home.

{Effective 07/17/2013}

2-002 Citizenship and Alien Status: In order to be eligible for AABD/MA Payment or SDP/MA, an individual's status must be documented as one of the following using acceptable documents, as defined by federal regulations, and See appendix listed in 469-000-301, and ~~469-000-309.~~

1. A citizen of the United States;
Note: A child born in the United States is a U.S. citizen. A newborn who was determined to be eligible for Medicaid in the month of birth meets citizenship and identity requirements without further verification; this includes newborns whose birth expenses were paid through Emergency Medicaid Assistance for Aliens.
2. Qualified Aliens as defined in Section 431 of the Immigration and Nationality Act (INA):
 - a. An alien who was admitted as a lawful permanent resident (LPR) and has resided in the United States for at least five calendar years from the date of entry or who has worked or can be credited with 40 qualifying quarters of work. Medicaid eligible pregnant women and children are exempt from the five year bar;
 - b. A refugee admitted to the U.S. under Section 207 (INA);
 - c. An asylee under Section 208 of INA;
 - d. Victims of severe form of trafficking (Victims of Trafficking and Violence Protection Act of 2000);
 - e. An alien whose deportation is withheld under Section 243(h) of INA;
 - f. An alien from Cuba or Haiti who was admitted under Section 501(a) of the Refugee Education Assistance Act of 1980;
 - g. A refugee who entered the U.S. before April 1, 1980, and was granted conditional entry;
 - h. An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or parent or by a member of the spouse or parent's family who is residing in the same household as the alien, but only after having resided in the United States for at least five calendar years from the date of entry or who has worked or can be credited with 40 qualifying quarters of work. The child or children of a battered alien meeting these requirements are also eligible. Medicaid eligible pregnant women and children are exempt from the five year bar;
3. Iraqi and Afghan aliens granted special immigration status;
4. An Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing and Related Programs Appropriations act, 1988, as amended;
5. An alien with past or current military involvement defined as an alien veteran who is on active duty (other than active duty for training) with any of the U.S. Armed Forces units or who has been honorably discharged (not on account of alienage) and who has fulfilled minimum active-duty service requirements. Minimum active-duty is defined as 24 months or the period for which the person was called to active duty. The spouse or unmarried dependent child of an alien veteran as described in this paragraph;
6. An alien who is paroled into the U.S. under Section 212(d)(5) of INA, but only having resided in the United States for at least five calendar years from the date of entry or who has worked or can be credited with 40 qualifying quarters of work; or
7. For SDP M~~medical assistance~~ only, certain American Indian tribe members born in Canada or outside the United States or who are a member of an Indian tribe;

~~Note: Aliens who do not meet the requirements above may be eligible for emergency medical services only (see 469 NAC 4-002.02A). A pregnant alien women or alien child who does not meet the above may be eligible as lawfully present and will need Central Office approval.~~

Any individual born in the United States is considered a U.S. citizen. This includes children whose parents are not U.S. citizens, such as undocumented alien parents or parents with student visas.

Receipt of SSI, SSDI, or Medicare is sufficient proof of citizenship or lawfully admitted alien status.

Individuals who declare to be U.S. citizens and meet all other eligibility requirements must be given a reasonable opportunity to present satisfactory documentation of citizenship or nationality. Medical/AABD payments benefits or SDP benefits must not be denied, delayed, reduced, or terminated pending receipt of the requested citizenship verification. The Department may authorize one additional ten-day extension for verification if the necessary information has been requested by the client. If the Department has requested verification, such as an out-of-state birth certificate, benefits will not be denied or terminated while awaiting receipt. Once an individual has declared s/he is a U.S. citizen or national and has provided all other information to determine eligibility, benefits must be provided.

If the client is not cooperating in providing documentation, the client must be closed.

{Effective 07/17/2013}

2-002.01 Verification of Alien Status: When a client states that one or more of the unit members for whom assistance is being requested is an alien, the worker must require the client to present verification for each alien member. If the client has documentation containing an alien registration number, the worker must verify the alien status using the Systematic Alien Verification for Entitlements (SAVE) system. For further verification procedures, see 469-000-300 and 469-000-~~313~~-309.

2-002.02 Repatriation Program: The Repatriation Program provides temporary assistance, care, and treatment for up to 90 days for U.S. citizens or dependents of U.S. citizens who have returned from foreign countries. To qualify for repatriation assistance the individual must be returned from a foreign country because s/he is destitute or ill (including mentally ill) or because of war, threat of war, or a similar crisis. A request must be made by the State Department to the U.S. Department of Health and Human Services to receive the individual in the United States and to provide the necessary care, treatment, and assistance.

Assistance may be provided for up to 90 days from the date the individual arrives in the United States. This assistance may include reception service, food, shelter, clothing, and transportation. It may also include payment for special services such as medical and psychiatric care. Any assistance that is provided through General Assistance or Emergency Assistance may be reimbursed through federal funds. The individual is required to sign an agreement to repay the U.S. government for the cost of the assistance provided.

Assistance provided through the Repatriation Program is not counted as income in determining initial eligibility for categorical assistance.

The Central Office will contact the appropriate local office with specific instructions if an individual is eligible for assistance through the Repatriation Program.

2-003 Residence: To be eligible for assistance, a client must be a Nebraska resident. A resident is defined as an individual living in the state voluntarily with the intent of making Nebraska his/her home. Migrants and itinerant workers are considered residents of Nebraska if they are living in Nebraska and entered the state to seek employment or to fulfill a job commitment.

The agency must not deny assistance because an individual has not resided in the state for a specified period.

2-003.01 Incapable of Indicating Intent: For purposes of this section, an individual is considered incapable of indicating intent if:

1. His/her I.Q. is 49 or less or s/he has a mental age of 7 or less, based on tests acceptable to the ~~mental retardation~~ State developmental disabilities agency; ~~in the state;~~
2. S/he is judged legally incompetent; or
3. Medical documentation obtained from a physician, psychologist, or other person licensed by the state in the field of ~~mental retardation~~ developmentally disabled, or other documentation acceptable to the state, supports a finding that s/he is incapable of indicating intent.

2-003.02 Residence of Individuals Entering the State: The intent of an individual to establish Nebraska residence must be investigated in accordance with this regulation if the individual comes into the state and immediately enters a facility licensed by the Nebraska Department of Health and Human Services. ~~Regulation and Licensure.~~

To determine the individual's intent to establish residence in Nebraska the worker must consider the individual's purpose for entering the state. The individual is considered a Nebraska resident if his/her purpose for entering the state was because s/he:

1. Desired to be near to close friends or relatives in the state;
2. Previously resided in the state; or
3. Has other contacts in the state.

If none of the previously mentioned conditions exist, the worker must evaluate the client's intent to establish residence. If the client states that s/he plans to establish residence but the situation seems to indicate otherwise, the worker must review factors such as when the client entered the state, whether the client maintains a residence or owns property (including real and/or personal property) in another state, place of residence of the client's spouse and other immediate family members; and length of time in the Nebraska facility on private pay. The worker must also consider if the client was eligible for medical assistance in the state in which s/he previously resided, how the client was referred to the facility in Nebraska (e.g., family member, hospital staff, social service worker in the other state, etc.), where the client would reside if s/he moved out of the facility in Nebraska, and any other related factors. Before denying assistance, the worker must describe the circumstances on ~~Form ASD-17~~ and submit it to the the question to Central Office as required by Central Office, including any information relating to the listed factors. At the Central Office a review and a decision will be made based upon the information relating to the listed factors.

{Effective 4/11/95}

2-003.03 Placement in an Out-of-State Institution: 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.

2-003.04 Individuals Receiving a State Supplementary Payment (SSP): For any individual who is receiving an SSP, the state paying the SSP is the state of residence.

2-003.05 Institutionalized Individuals: The state where the institution is located is the individual's state of residence unless the worker determines that the individual is a resident of another state, according to the following regulations.

For any institutionalized individual who is age 20 or younger or who is age 21 or older and became incapable of indicating intent before reaching age 21, the state of residence is:

1. That of his/her parent(s), or his/her legal guardian at the time of placement; or
2. That of the parent(s) or legal guardian if the individual is institutionalized in that state.

For any institutionalized individual who became incapable of indicating intent at or after reaching age 21, the state of residence is the state in which the individual is physically present except where another state makes a placement.

2-003.06 Non-Institutionalized Individuals

2-003.06A Age 20 and Younger: For any non-institutionalized individual age 20 or younger whose eligibility is based on blindness or disability, the state of residence is the state in which s/he is living. Any other non-institutionalized individual age 20 or younger is a resident of the state in which s/he is living other than on a temporary basis.

2-003.06B Age 21 and Older: For any non-institutionalized individual age 21 or older, the state of residence is the state where s/he is:

1. Living with the intention to remain permanently or for an indefinite period (or if incapable of stating intent, where s/he is living); or
2. Living and which s/he entered with a job commitment or seeking employment (whether or not currently employed).

2-003.07 Absence ~~From~~ from the State: The agency may not deny assistance because an individual has not resided in the state for a specified period.

2003.07A Temporary Absence: The agency may not terminate a resident's eligibility because of that person's temporary absence from the state if the person intends to return when the purpose of the absence has been accomplished, unless another state has determined that the person is a resident there for assistance purposes.

2-003.07B Loss of State Residence: Eligibility for AABD/MA payment or SDP/MA ends if the family unit leaves Nebraska with the intent of establishing its home in another state. The family may receive an AABD/MA payment or SDP/MA assistance from Nebraska (if otherwise eligible) for a period not to exceed two months to enable the other state to process the application.

A family unit may not receive an AABD/MA payment or SDP/MA assistance from Nebraska beyond the date on month in which it has been found eligible for categorical assistance from another state.

Exception: Individuals who leave the state for longer than two months may continue to receive an AABD/MA payment or SDP/MA assistance in Nebraska if they are absent for a temporary purpose and intend to return.

2-003.07C Out-of-State Medical: If an out-of-state provider does not sign an agreement with NMAP SDP medical or Medicaid and accept the reimbursement rate, the SDP client is liable for any medical bills. Payment may be approved for services provided outside Nebraska in the following situations:

1. When an emergency arises from accident or sudden illness while a client is visiting in another state and the client's health would be endangered if care is postponed until s/he returns to Nebraska or if s/he travels to Nebraska;
2. When a client customarily obtains service in another state because the service is more accessible;
3. When the client requires a medically necessary service that is not available in Nebraska but is available in another state; and
4. When long term care services are provided in another state.

Payment for items 3 and 4 must be prior authorized by the Division of Medical Medicaid and Long-Term Care Services before the services are provided. The provider shall request prior authorization of payment from the appropriate staff of the Division of Medical Services. Prior authorization of Item 3 may include economical transportation as a provider payment if needed.

2-003.08 Disqualification for Misrepresenting Residence: Any person convicted in federal or state court of having fraudulently misrepresented his/her residence in order to obtain AABD/MA Payment or SDP assistance in two or more states is ineligible for AABD/MA Payment or SDP assistance for ten years from the date of conviction. Only the individual convicted of the misrepresentation is ineligible; other members of the family or household may receive benefits.

{Effective 12/27/97}

2-004 Requirement of Social Security Number (SSN): All eligible members of the AABD/MA Payment or SDP/MA unit shall furnish Social Security numbers (SSN). The SSN, in conjunction with other information, provides evidence of identity of the individual.

2-004.01 Application for an SSN: If the client has not applied within 30 days of the date s/he is given the Referral for Social Security Application, the worker must not include the client in determining the size of the assistance unit. Before taking adverse action, the worker must take into consideration the client's ability to follow through on the referral (such as lack of transportation, no visit by SSA to the contact station, lack of required verification documents, etc.) and use prudent person principle.

2-004.01A SSN Application for a Newborn: If Enumeration at Birth was not done as verified by a Vital Statistics Alert, the worker must refer the parent or payee to the Social Security office via a Referral for Social Security Number Application by the first day of the second month following the mother's discharge from the hospital after the birth. If the child is not born in a hospital, a Referral for Social Security Number Application must be completed by the first day of the second month following the birth regardless of where the child is born. If the parent or payee fails or refuses to apply for a Social Security number, the provisions in 469 NAC 2-004.01 are followed for eligibility for a grant.

The parent is required to provide the SSN by the next redetermination or within six months after the parent receives the SSN, whichever is earlier.

~~Note: Application for an SSN for a newborn is not an eligibility requirement during the 12 months of continuous eligibility for MA (see 477 NAC 1-012.02C).~~

{Effective 5/8/05}

2-004.02 Assistance Pending Verification of SSN: After the client has been referred to SSA, if s/he is otherwise eligible, assistance is not delayed, denied, or discontinued pending the verification or assignment of an SSN.

{Effective 2/3/93}

2-005 Age

2-005.01 Age Limits: To be eligible for AABD/MA Payment or SDP/MA, an individual must meet the following age limits:

1. To qualify as aged, an individual must be age 65 or older. A payment is made for the month the individual becomes age 65 if otherwise eligible.
2. To qualify as blind, an individual must be age 64 or younger.
3. To qualify as disabled, an individual must be age 64 or younger.

The month that an already eligible blind or disabled AABD payment or SDP payment person becomes 65, s/he becomes eligible for assistance to the aged (see Application Date and Request Date, 469 NAC 1-004). A new application is not required; however, the worker must update the necessary information on N-FOCUS.

2-005.02 Birthdate Used if Birth Information Is Incomplete: When birth information is incomplete, a birthdate is designated as follows:

1. If the year but not the month is known, July is used.
2. If the day of the month is not known, the 15th is used.

2-006 Relative Responsibility

2-006.01 Spouse for Spouse: A divorce dissolves the marriage of a couple and there is no longer spouse-for-spouse responsibility. A legal separation does not dissolve the marriage. The worker shall use the following guidelines in determining financial responsibility for a married couple.

1. Living Together - No Medicaid Waiver Services.

Consider income and resources of both spouses living together in the same household as available to each other. Use the resource standard for two for grant or SDP medical. Budget together for ~~grant or medical~~, AABD payment or SDP whether one or both are eligible.

Exception: If only one spouse receives SSI and the other spouse receives VA benefits based on need which SSI is disregarding, budget the SSI spouse separately for grant. If the spouse receiving VA is eligible for AABD/MA payment, budget him/her separately for ~~grant~~ AABD payment or SDP medical. This only applies if they would be ineligible for SSI as a couple. If they would both be eligible for SSI, the non-SSI spouse must apply (see 469 NAC 2-010.01B6c(1)).

2. Living Together - Medicaid Waiver Services

If both spouses are eligible and one or both receive waiver services, consider income and resources together for grant eligibility. Use the grant resource standard for two and budget together for grant unless the exception under number 1 applies. For SDP medical eligibility, consider income and resources separately. Use the medical resource standard of one for each and budget separately for SDP medical.

If only one spouse is eligible, consider income and resources together for AABD grant eligibility. Use the grant resource standard for two and budget together for grant. The exception in number 1 applies. For SDP medical eligibility, use the spousal impoverishment treatment of resources and income. Refer to 469 NAC 2-009.02C-ff. for resources and 469 NAC 4-007.01 for income budgeting on Form DA-4M. An assessment and designation of resources must be completed.

3. Living Apart - Neither in a Specified Living Arrangement

Consider income and resources separately beginning in the first full month the ~~couple ceases~~ couple ceases to live together. Allow the client(s) a resource standard for one for grant or SDP medical and budget the client(s) separately. Total countable resources for the couple must not exceed \$8,000 for SDP medical eligibility. Total countable resources for the couple must not exceed \$4,000.00 for grant eligibility. Follow this guideline whether one or both are eligible.

Exception: If either spouse is current pay SSI, follow SSI budgeting rules.

4. Living Apart - Both in a Specified Living Arrangement

If both spouses are in a specified living arrangement, consider income and resources separately. Allow the client(s) a resource standard for one for grant or SDP medical. Budget the client(s) separately for AABD grant, SDP grant, and/or SDP medical. Follow this guideline whether one or both are eligible.

5. Living Apart - One in a Specified Living Arrangement

If only one spouse is eligible, spousal impoverishment rules apply for treatment of income and resources. See 469 NAC 2-009.02C-ff. for resources. An assessment and designation of resources must be completed. Budget the client separately for grant and apply the grant resource standard for one. For SDP medical, allow the client the resource standard for one and budget ~~on Form DA-4M~~ (see 469 NAC 4-007.01).

If both spouses are eligible and one enters a specified living arrangement, consider income and resources separately beginning in the first full month the ~~couple ceases~~ couple ceases to live together. Allow each a resource standard for one for ~~grant or medical~~ AABD payment or SDP. Budget separately for AABD grant or ~~medical~~ SDP.

Note: If one spouse is temporarily absent from the home, continue to consider the couple's income and resources together. An absence of less than 90 days may be considered temporary. If the spouse will be absent longer than 90 days, determine if the client plans or is able to return home.

2-006.02 Parent for Child: The worker shall deem income and resources of a parent(s) to a child age 17 or younger if living in the same household. See 469 NAC 2-009.04 and 2-010.01F1 for deeming procedures and exceptions to this deeming requirement.

2-007 Blindness or Disability

2-007.01 Eligibility Requirements Applicable Only to Blind or Disabled: All applicants for ~~Aid to the Blind or Aid to the Disabled~~ AABD payment or SDP after January 1, 1974, must meet the medical definitions of blindness or disability of the RSDI/SSI Programs as administered by the Social Security Administration (SSA). The determination by SSA that an individual is disabled or blind must be accepted for eligibility for AABD/MA. In some cases, ~~the State Review Team (SRT)~~ DHHS may make the determination of blindness or disability (see 469 NAC 2-007.03B03A1).

If the client has a pending SSI/RSDI decision, the client must sign a DHHS designated form (e.g. IM-17) to allow DHHS to be reimbursed from SSA for interim assistance in order to be considered for AABD payment or SDP eligibility.

2-007.01A Grandfathered Cases: All individuals who ~~received~~ were determined to be AABD/MA Payment eligible before July 1, 1973, and received a payment for December, 1973, must be considered blind or disabled by the standards in effect in July, 1973. If SSI determines in a subsequent review that blindness or disability has ceased, the case must be referred to the ~~SRT~~ DHHS designated medical consultant reviewer (MCR) for review of blindness or disability using standards in effect in July, 1973. ~~The SRT~~ An MCR determines whether disability continues and if the AABD/MA payment case remains open.

2-007.01A1 Standards in Effect in July, 1973: The following standards for blindness and disability were in effect in July, 1973.

2-007.01A1a Blindness: Economic blindness is defined as visual acuity of 20/200 or less in the better eye with best corrective glasses. An individual with central visual acuity of more than 20/200 in the better eye with proper correction must be considered blind if the widest diameter of the visual field does not extend beyond an angular distance of twenty degrees.

2-007.01A1b Disability: An individual must have been permanently and totally disabled.

2-007.01A1b(1) Definitions

Permanent and total disability: Physical, functional, and/or mental impairment, from which recovery cannot reasonably be expected. The individual must not be able to engage in a useful occupation, including holding a job or homemaking.

Permanence does not rule out the possibility of rehabilitation, restoration, or even recovery from the impairment.

Totally involves considerations in addition to those verified through the medical findings, such as age, training, skills, work experience, and the probable functioning of the individual in a particular situation in light of the individual's impairment.

Physical impairment refers to loss or defect of arms or legs, malfunctioning of the organs of the body, or physiological disturbances with structural damage.

Mental impairment refers to conditions characterized by a marked and consistent failure to adjust to the emotional, social, or intellectual demands of living. The individual requires the assistance of another person in the essential activities of daily living.

The following conditions are considered mental impairments:

1. Psycho-neuroses;
2. Psycho-physiological reactions;
3. Personality disorders;
4. Mental deficiency; and
5. Psychoses applied to individuals who have been released from a state mental hospital.

The mental impairment must prevent the individual from functioning independently with respect to the essential activities of daily living.

Useful occupations: Productive activities which add to economic wealth, or produce goods or services which have a monetary value.

The following are not included in "useful occupations":

1. An activity such as a hobby;
2. An activity which does not provide a bona fide job opportunity, i.e., if the individual quit, no replacement would be hired; and
3. That part of a rehabilitation program which is officially designated as "training," and which is carried on under supervision.

Homemaking: The ability to assume home management and decision-making responsibilities and provide essential services for at least one other person.

The following activities are included in homemaking:

1. Shopping for food and supplies;
2. Planning and preparing meals;
3. Washing dishes;
4. Cleaning house;
5. Making beds;
6. Washing and ironing clothes; and
7. Caring for young children, including:
 - a. Lifting and carrying infants and, in emergency, pre-school children;
 - b. Bathing and dressing the children;
 - c. Training and supervising them; and
 - d. Accompanying the children to community activities, for medical care, etc.

If a person is determined unable to perform homemaking activities, s/he must be unable to perform a significant combination of the previously listed activities, because of impairment, unable to perform for the required number of hours daily, or unable to perform predictably enough to meet the responsibilities involved.

2-007.02 Definitions of Disability and Blindness: The following definitions are used by SSA and SRT the DHHS designated Medical Consultant Review (MCR) process in making a determination for AABD/MA Payment and SDP/MA.

Disability for AABD/MA Payment: An individual is considered disabled if s/he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months. A child through age 17 is considered disabled if s/he suffers from any medically determinable physical or mental impairment of comparable severity.

Blindness for AABD/MA Payment: An individual is considered blind if s/he has central visual acuity of 20/200 or less in the better eye with correcting lens or a field defect in which the peripheral field has contracted to such an extent that the widest diameter of visual field subtends an angular distance of no greater than 20 degrees.

Disability for SDP/MA: An individual is considered disabled for SDP/MA if s/he is unable to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 6 months from onset and not more than 12 months. ~~SRT~~The DHHS designated medical consultant reviewer always makes the determination for SDP/MA. The individual must be ineligible for other Medicaid programs.

2-007.03 Determination of Eligibility for the Blind or Disabled

2-007.03A Referral ~~to the Social Security Administration (SSA)~~for a Medical Consultant Review (MCR): In the determination of AABD payment eligibility for aid to the blind or disabled or SDP assistance, all eligibility requirements except that of the disability determination are the responsibility of the local office.

2-007.03A1 SDP is only an option for applicants whose Social Security disability (e.g. SSI, RSDI, SSDI) application has been denied due to 'lack of duration'. SDP Procedures may be found at 469-000-329.

Note – Other situations where DHHS may make the disability determination prior to or without an Social Security determination, such as income or resources in excess of SSI limits, lack of severity, a need for immediate long term hospitalization, an individual in an institution, a deceased individual or a non-U.S. citizen will be addressed through NAC 477 and handled by the DHHS Division of Medicaid and Long-Term Care (MLTC) or such Division responsible for Title XIX (Medicaid).

~~Duties of the IM Worker: The IM worker shall–~~

- ~~1. Have the applicant complete an application for assistance;~~
- ~~2. If the individual has monthly income less than the referral amount (see 469-000-211), s/he may be eligible to receive SSI benefits. Refer the applicant via Form SSA-1610 to SSA for a determination of disability. SSA will determine eligibility for RSDI and/or SSI disability benefits;~~
- ~~3. Complete Form IM-17E or IM-17P and attach two copies to Form SSA-1610. Annotate at the top of this form that this is a new claim. This will act as a lead for SSI and protect a filing date for the reimbursement of state and/or county funds furnished for meeting basic needs during the period of eligibility determination by SSI;~~
- ~~4. Complete Form ASD-46 for authorizing the release of medical information by SSA if needed for a referral to the SRT; and~~
- ~~5. Take the following action when a determination is returned from SSA:

 - ~~a. If the applicant is determined disabled and eligible for RSDI and/or SSI, determine eligibility for AABD/MA. If the applicant is determined presumptively disabled by SSI, s/he may be eligible for AABD/MA for any month s/he receives presumptive payments. For retroactive or prospective months not covered by an RSDI/SSI determination, make a referral to the SRT for a disability determination;~~~~

- ~~b. If the applicant is not reviewed by SSI because the applicant has income and/or resources in excess of SSI program standards, refer the case to the SRT for a determination of disability or blindness. If determined blind or disabled by the SRT, determine eligibility for AABD/MA or SDP/MA (see 469 NAC 2-000). If at a later date income or resources fall below SSI standards, a referral to SSI must be made. Send all pertinent medical information to SSI;~~
- ~~— {Effective 4/11/95}~~
- ~~c. If the applicant is not eligible for SSI because the applicant's disability is not anticipated to last for a continuous period of 12 months (lack of duration), refer the case to the SRT for a determination of disability. If determined disabled by the SRT, determine eligibility for SDP/MA. Advise the client that s/he has the right to appeal SSI's denial and assist the client in completing the appeal papers, if necessary;~~
- ~~d. If the applicant is not eligible for SSI because the applicant is not considered disabled due to lack of severity or the ability to engage in substantial gainful activity, reject the application. Do not make a referral to the SRT; or~~
- ~~e. Use the original date of request in determining eligibility for a grant and medical assistance if the applicant:~~
- ~~(1) Is rejected by SSI because the applicant is not considered disabled due to lack of severity or the ability to engage in substantial gainful activity;~~
- ~~(2) Appeals SSI's decision; and~~
- ~~(3) Wins his/her appeal with SSI.~~
- ~~See 469 NAC 2-010.01B4a for retroactive SSI benefits.~~

2-007.03B For AABD payment, if the individual is not eligible for SSI or RSDI and was not denied by SSA for lack of duration, the individual will need to apply first for Medicaid through MLTC. An application for AABD payment, if no determination of blind or disabled by MLTC is received, it is to be denied as the disability requirement has not been met. If MLTC, through their DHHS designated medical review process, makes a determination that the individual is disabled for Medicaid, the MLTC disability determination will be accepted for determining AABD payment eligibility. The individual will need to provide a DHHS required application for AABD payment. The start date of eligibility for AABD payment, if all other eligibility criteria are met, will be the date of the individual's application for Medicaid.

2-007.03B Direct Referral to the State Review Team (SRT): In the following situations, the IM worker may submit a referral directly to the SRT for a determination of disability and its probable duration without waiting for an SSI determination if the individual is not eligible for another assistance program, and during the initial interview it is apparent that:

- ~~1. The individual has income and/or resources in excess of the limit for the SSI Program. The worker must continue to monitor the client's potential eligibility for SSI. If income and/or resources fall below the SSI limit, the worker must make a referral immediately. The client is allowed 60 days to apply for this potential benefit (see 469 NAC 2-010.01B6a);~~
- ~~2. The individual requires immediate long term hospitalization and/or treatment for a severe impairment before SSI can make a determination, or would be required to extend his/her hospital stay solely because of a delay in processing the SSI application, i.e., due to SSI's required waiting periods before a decision on certain types of disability can be made such as cancer or stroke (this does not include diagnostic examinations or tests, routine medications, or drug/alcohol treatment). The worker must make an immediate referral to SSI;~~
- ~~3. The individual is institutionalized (e.g., nursing home or public institution) and SSI will be unable to make a determination. An individual is eligible for SSI benefits while institutionalized only if Medicaid will pay 50 percent of his/her care. Therefore, SSI may, in some cases, wait for a determination of eligibility for NMAP. The worker must make an immediate referral to SSI;~~
- ~~4. The individual is deceased and SSI will not make a disability determination; or~~
- ~~5. The individual is a non-U.S. citizen who SSI will not review.~~

~~See 469-000-329 for forms and procedures for making a referral to the State Review Team.~~

~~{Effective 8/18/03}~~

2-007.03C Payment for Examination and Transportation: The cost of medical examinations to determine initial or continuing SDP eligibility may not exceed the established Medicaid allowable fee. The cost of a medical examination to determine eligibility is an allowable Title XIX expenditure if the individual is eligible for medical benefits on the date of the examination. If the initial application is rejected, the cost of the examination must be paid from administrative funds.

The cost of transportation necessary to secure the examination, and subsistence expense when it is necessary for the individual to secure the required services away from home are paid from administrative funds if the application is rejected. If the application is approved, the cost of transportation and subsistence expense is allowed in the budget as a special need (see 469 NAC 3-004.03A1 and 3-004.03A5).

2-007.03D Subsequent Referrals to the Social Security Administration (SSA): The local office shall continue to monitor the client's potential eligibility for RSDI and SSI benefits even though the SRTDHHS designated MCR has made the determination of disability.

2-008 Institutionalization: An individual may qualify for AABD/MA or SDP/MA while living in an institution only if the institution is subject to the licensing requirements of the Nebraska Department of Health.

2-008.01 Definitions: The following definitions are used in the administration of assistance to individuals who are institutionalized.

Inmate of a Public Institution: A person who is living in a public institution and receiving treatment and/or services which are appropriate to the person's requirements. A person is not considered an inmate when s/he is in a public educational or vocational training institution for purposes of securing educational or vocational training, or s/he is in a public institution for a temporary period pending other arrangements appropriate to his/her needs.

Inpatient: A patient who has been admitted to a medical institution on the recommendation of a physician or dentist and is receiving room, board, and professional services in the institution on a continuous 24 hour-a-day basis.

Institution: An establishment which furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor and, in addition, provides some treatment or services which meet some need beyond the basic provision of food and shelter.

Institution for Mental Diseases: An institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services.

Institution for the ~~Mentally Retarded~~ Developmentally Disabled or Persons with Related Conditions: An institution (or distinct part of an institution) that is primarily for the diagnosis, treatment, or rehabilitation of persons with developmental disabilities, i.e., epilepsy, ~~mental retardation~~ developmentally disabled, cerebral palsy, and other related conditions. The institution provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health and rehabilitative services to help each individual function at his/her greatest ability.

Medical Institution: An institution which is organized to provide medical care, including nursing and convalescent care, and has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards. The institution must be authorized under state law to provide medical care.

Public Institution: An institution that is the responsibility of a governmental unit, or over which a governmental unit exercises administrative control.

Publicly Operated Community Residence: A publicly operated residence designed to serve no more than 16 residents and providing some services beyond food and shelter such as social services, help with personal living activities or training in socialization and life skills. Occasional or incidental medical or remedial care may also be provided. Excluded from the definition are the following facilities even if their accommodations are for 16 residents or fewer; residential facilities adjacent to any large institution or multi-purpose complex; educational or vocational training institutions; correctional or holding facilities for individuals whose personal freedom is restricted because of a court sentence, holding or pending disposition; medical treatment facilities such as hospitals and skilled nursing facilities.

2-008.02 Licensed Institutions: Nebraska currently has the following public institutions licensed for the treatment of mental diseases and/or ~~mentally retarded individuals~~ developmental disabilities.

1. Hastings Regional Center (HRC);
2. Norfolk Regional Center (NRC);
3. Lincoln Regional Center (LRC); and
4. Beatrice State Developmental Center (BSDC).

2-008.02A Levels of Care: The previously listed facilities may be licensed by the Nebraska Department of Health and Human Services, ~~Regulation and Licensure~~ Public Health and certified under ~~NMAP~~ Medicaid as one or more of the following types of facilities:

1. Acute hospital;
2. Psychiatric; and
3. Intermediate care facility for the ~~mentally retarded~~ persons with developmental disabilities (ICF/MRDD).

Coverage may be provided to persons of all ages in the previously listed facilities for acute hospital and ICF/MR levels of care if the individuals are otherwise determined eligible.

Psychiatric care is ~~provided only~~ available to SDP medical eligible individuals, ~~who are age 21 or younger and 65 or older. If an individual is receiving treatment in a facility on his/her 21st birthday, s/he is eligible until the sooner of:~~

- ~~1. Release; or~~
- ~~2. The month of his/her 22nd birthday.~~

Exception: An individual is not eligible to receive an AABD/MA Payment or SDP/MA if in a prison, (unless the individual is hospitalized while in prison), jail or veteran's hospital (see 469 NAC 2-008.07).

{Effective 5/8/05}

2-008.0403 Patients in a Medical Institution: Assistance may be provided for a client who is a patient in a medical institution, i.e., hospital, nursing home, etc., if all other eligibility factors are met. Psychiatric wards of medical hospitals are considered part of the medical institution and are not subject to the restriction on psychiatric care identified in 469 NAC 2-008.02A.

2-008.0504 Convalescent Leave: Eligibility of individuals "on convalescent leave or visit" from public medical institutions is determined in accordance with the usual program standards. Eligibility is based on their living situation and needs while on leave.

2-008.0605 Responsibility for Determining Nature of Institution: The Central Office is responsible for determining the public or private nature of an institution, and whether a public institution is one in which otherwise eligible individuals may receive assistance.

2-008.0706 Criteria for Determining the Public Nature of Institutions: Prisons, jails, etc., are designated in the law as public institutions whose inmates are ineligible to receive assistance. Governmental participation in financial support of an institution, in policy formulation, or in the application of policy to specific situations, is evidence of the public control which makes it a public institution. Payment from public funds to, or in support of, individuals in a private institution is not considered governmental participation in support of the institution.

{Effective 4/11/95}

2-008.0907 Factors Relating to Eligibility of Clients in Institutions

2-008.09A07A Beatrice State Developmental Center (BSDC) and Regional Centers: Superintendents of BSDC and of the regional centers are the guardians for the patients.

If the client does not have a court-appointed guardian or conservator, payment may be made to the superintendent on behalf of the patient. It is not necessary for the superintendent to file letters of guardianship or conservatorship, and the application for assistance may be signed by the patient.

2-008.09B07B Private Institution and Home: The private institution in which the client chooses to reside may be a fraternal, benevolent, or charitable institution, or the client may make plans for living in a home which is privately owned and operated and which furnishes shelter, board, and care according to the client's needs. In determining the eligibility of a person living in a private institution or home, it is necessary to determine if s/he has entered into any agreement with the institution that s/he is to receive shelter and care in return for a transfer of property, insurance, or other assets.

In determining eligibility of an individual in a private institution, it is necessary to determine what the institution is able to furnish its guests from its own resources. The individual may be eligible to receive assistance if residing in one of the facilities previously described if the terms of his/her stay do not in any way restrict the use of his/her personal assets or income and if the individual has a need.

{Effective 4/11/95}

2-009 Resources: The total equity value of available non-excluded resources of the client or client and responsible relative (see 469 NAC 2-006) or client and essential person (see 469 NAC 3-006.02) is determined and compared with the established maximum for available resources which the client may own and still be considered eligible. If the total equity value of available non-excluded resources exceeds the established maximum, the client is ineligible.

Note: According to 469 NAC 2-006-ff., assets of each spouse are considered available to the other unless there is a divorce or spousal impoverishment provisions apply.

The following are examples of resources:

1. Cash on hand;
2. Cash in savings or checking accounts;
3. Certificates of deposit;
4. Stocks;
5. Bonds;
6. Investments;
7. Collectable unpaid notes or loans;
8. Promissory notes;
9. Mortgages;

10. Land contracts;
11. Land leases;
12. Revocable burial funds;
13. Trust or guardianship funds;
14. Cash value of insurance policies;
15. A home;
16. Additional pieces of property;
17. Trailer houses;
18. Burial spaces;
19. Motor vehicles;
20. Life estates;
21. Farm and business equipment;
22. Livestock;
23. Poultry and crops;
24. Household goods and other personal effects;
25. Contents of a safe deposit box;
26. Tax refunds;
27. Elective share of a spouse's augmented estate; and
28. Revocable, assignable, or saleable annuity.

{Effective 2/14/09}

2-009.01 Verification of Resources: Before determining eligibility of an AABD/MA or SDP/MA client who does not receive SSI, the worker must verify and document in the case record all resources. The worker is not required to verify resources of an SSI recipient including a client who is determined eligible for 1619(b) status by SSI. For any retroactive or prospective month that an AABD/MA client is not in current pay status for SSI, the worker must verify resources. Verification of resources consists of but is not limited to the following information:

1. A description of the type of resource to include account or policy number(s), legal descriptions (for property), etc.
2. The location of the resource (i.e., name and address of the bank, insurance company, etc.);
3. Current value of the resource, encumbrances against the resource, and the resulting equity value (see 469 NAC 2-009.06);
4. Description of current ownership (see 469 NAC 2-009.03 ff.); and
5. Source of verification and the date the verification is obtained.

If the client or spouse of the client has a guardian, the worker may use the guardian's report to the court for verification. The guardian's report applies only to the period covered by the report. The worker must follow regular verification procedures if there is no guardian's report or the report does not coincide with the date of redetermination.

The worker must also note any additional information that may affect resource eligibility.

If the Central Office notifies the worker that there may have been a deprivation of resources by an SSI recipient, see 469 NAC 2-009.10.

2-009.02 Definition of Available Resources: For the determination of eligibility, available resources include cash or other liquid assets or any type of real or personal property or interest in property that the client owns and may convert into cash to be used for support and maintenance.

2-009.02A Unavailability of Resource: Regardless of the terms of ownership, if it can be documented in the case record that the resource is unavailable to the client, the value of that resource is not used in determining eligibility. The worker must consider the feasibility of the client's taking legal action to make the resource available. If the worker determines that legal action can be taken, the worker must allow the client 60 days to initiate legal action. After 60 days, if the client has not filed legal action, the case is closed for failure to comply. The resource is not considered available until the legal action is completed.

In evaluating the availability of benefit funds, such as funds raised by a benefit dance or auction, the worker must determine the purpose of the funds and if the client has access to them. If the client cannot access the funds to pay normal maintenance needs, the funds are not considered available.

An applicant or recipient must file in county court for the maximum elective share of a deceased spouse's augmented estate as specified in Neb. Rev. Stat. sections 30-2313 and 30-2314.

The worker must monitor the status of the resource.

{Effective 5/8/05}

2-009.02B Excluded Resources: Disregarded income is also disregarded as a resource unless there is regulation stating otherwise. See 469 NAC 2-010.01H for the listing of income treatment. In addition, the following resources are excluded in making a determination of eligibility:

1. Real property which the individual owns and occupies as a home;
2. Household goods and personal effects of a moderate value used in the home;
3. Cash surrender value of life insurance policies with combined face values of \$1,500 or less per individual (see 469 NAC 2-009.07A4);
4. A specified maximum in proceeds from an insurance policy irrevocably assigned for the purpose of burial of the client (see 469 NAC 2-009.07A3b);
5. Irrevocable burial trusts up to the specified amount per individual and the interest if irrevocable (see 469 NAC 2-009.07A3);
6. Burial space items or a contract for the purchase of burial space items owned by a client or designated family member (see 469 NAC 2-009.07A3(d)(1));

7. Burial spaces (see 469 NAC 2-009.07A3d);
8. Up to \$1,500 set aside for burial arrangements (see 469 NAC 2-009.07A3c);
9. One motor vehicle if it is used for employment, medical transportation, or as the client's home. If the client has more than one motor vehicle, s/he may designate the vehicle to be excluded (see 469 NAC 2-009.07B7).
10. Certain trusts (including guardianships). The person(s) in whose behalf the trust is established may be ineligible but this may not affect eligibility of the other person(s) in the unit (see 469 NAC 2-009.07A6).
11. Certain life estates in real property (see 469 NAC 2-009.07B8);
12. Income received annually, semi-annually, or quarterly which is prorated on a monthly basis and included in the budget. This income is excluded as a resource over the period of time it is being considered as income;
13. The unspent portion of any RSDI or SSI retroactive payments (excluded for six months following the month of receipt);
14. U.S. savings bonds (excluded for the initial six-month mandatory retention period);
15. A resource used in the client's trade or business (see 469 NAC 2-009.07B11);
16. A maximum of \$6,000 equity value of nonbusiness property (real or personal) that is used to produce goods or services essential to daily activities (see 469 NAC 2-009.07B11a);
17. The unspent portion of an AABD or SDP retroactive payment (excluded for six months following the month of receipt);
18. Victims compensation payments, i.e., payments received from a state or local government to aid victims of crime (excluded for nine months beginning with the first month after receipt);
19. Payments received from a state or local government to assist in relocation (excluded for nine months beginning with the first month after receipt);
20. An unavailable job-related retirement account that is held by the employer;
21. An Individual Development Account (an account set up for postsecondary education or purchase of a client's first home); and
22. Medicare Set-aside accounts that may be used only for payment of medical bills of Medicare beneficiaries.

The worth of resources, both available and excluded, is determined on the basis of their equity.

For any of these funds to be excluded as a resource, they must be segregated in a separate account so that they can be identified. If the funds are not in a separate account, the worker shall allow the client 30 days from notification of the requirement to set up a new account. After 30 days, the resource is included in the resource limit if the client fails to segregate the funds. If this makes the client ineligible for a grant and the client subsequently segregates the funds, the worker shall determine eligibility for a grant for the month of segregation.

Several excludable resources may be combined in a single account.

{Effective 8/2/2000}

2-009.02C Spouse for Spouse Responsibility and Designation of Resources for SDP Medical

2-009.02C1 Definitions

Alternate Care Spouse: A spouse who is living in a specified living arrangement.

Assessment of Resources: A listing of all countable resources owned jointly or separately by a couple when one is residing in a specified living arrangement and the other is residing in the home. Following an assessment, the spouse in the specified living arrangement may or may not apply for assistance.

Community Spouse: A spouse who is:

1. Not applying for or receiving assistance;
2. Not residing with the alternate care spouse unless the alternate care spouse is eligible for Home and Community-Based Waiver Services; and
3. Not in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for ~~the mentally retarded persons with developmental disabilities~~.

Continuous Residence: A period of at least 30 consecutive days.

Designation of Resources: A listing of the amount of resources retained by each spouse that is completed at the time of application for assistance when one spouse is residing in a specified living arrangement and the other spouse is residing in the home.

Specified Living Arrangement: A specified living arrangement includes residence in -

1. An adult family home;
2. A long term care facility including Assisted Living Waiver;
3. An assisted living facility;
4. A center for the developmentally disabled;
5. The home with eligibility for Home and Community Based Waiver Services; or
6. A medical institution.

{Effective 5/8/05}

2-009.02C2 Resources Reserved for the Community Spouse: Resources may be reserved for the community spouse when the alternate care spouse is residing continuously in a specified living arrangement and ~~applies for medical assistance~~. completes an application for AABD payment or SDP.

The amount of resources that a community spouse may reserve is based on the Consumer Price Index. This figure is adjusted annually. See 469-000-205 for the amount of resources a community spouse may reserve.

The reserved amount of resources is calculated from the total resources owned by the couple and verified.

2-009.02C3 Assessment of Resources: Either spouse may request an assessment of their resources no earlier than the beginning of a period of continuous residence in a specified living arrangement. An assessment of resources may not be finalized and signed until a client has been in a specified living arrangement for 30 consecutive days or would have been except for death. A couple is allowed only one assessment. The worker must complete an Assessment of Resources listing all countable resources owned jointly or individually by the couple the month the spouse entered the specified living arrangement. If a transfer or sale of resources occurred during the month the spouse entered the specified living arrangement, then the assessment of resources must list all countable resources owned jointly or individually by the couple on the day the spouse entered the specified living arrangement. The couple is allowed resource exclusions listed in 469 NAC 2-009.02B.

Ownership of the home, one automobile, and all essential property (business property and \$6,000 equity in non-business property used to produce goods for home consumption) may be transferred to the community spouse. Other resources transferred to the community spouse are limited to that spouse's protected resource amount. The alternate care spouse is not eligible for Medicaid SDP Medical if resources in excess of the protected amount have been transferred.

If the community spouse transfers away any resource for less than fair market value, it is a deprivation of resources.

See 469 NAC 2-009.10-ff.

The worker must verify and document all resources declared by the couple. The couple or their representative has the primary responsibility for providing verification and documentation. The assessment must be completed within 90 days from the request.

{Effective}

2-009.02C3a Appeal of Assessment: The Assessment of Resources notifies the couple that they may appeal the assessment of resources. The couple may appeal:

1. The value assigned to the resource(s); and
2. The amount reserved for the community spouse. If the ~~couple~~ showcouple shows that the community spouse requires more than the limit, s/he may be allowed to reserve more.

In order to appeal, the alternate care spouse must SDP apply for medical assistance, even if s/he has excess resources.

Note: Income from the institutionalized spouse must first be used before additional reserved resources for the community spouse may be considered.

2-009.02C3b Jointly Owned Resources: If the resources are held jointly with persons other than the spouse, the worker determines ownership according to 469 NAC 2-009.03 ff.

2-009.02C3c Unavailable Resources: If the worker determines that the resource is not available after applying 469 NAC 2-009.02A, the value of the resource is excluded from the total.

2-009.02C3d Treatment of Resources Not Included on Assessment: Since the resource assessment is completed only once, the total value of countable resources which are owned by either or both spouse and which are acquired, discovered, or lose their exclusion after completion of the assessment and before the designation are considered available resources and cannot be used to increase the community spouse's resource allowance calculated at the time of the assessment.

Examples of resources which may lose their exclusion are the home when the community spouse no longer resides in it or business property in which the community spouse is no longer actively engaged in operating.

2-009.02C3e Continued Validity of Assessment: The Assessment of Resources remains valid as long as the alternate care spouse does not return to the home without waiver services (even if s/he moves from one specified living arrangement to another). If the alternate care spouse returns home without waiver services, the Assessment of Resources becomes invalid. If the alternate care spouse returns to a specified living arrangement, the original Assessment of Resources is again valid.

2-009.02C4 Designation of Resources: When the spouse in the specified living arrangement is eligible for medical assistance, the worker must complete a Designation of Resources. The Designation of Resources lists the amount of resources retained by each spouse.

The worker must re-verify and document all resources.

{Effective 5/8/05}

2-009.02C4a Transfer of Ownership: A resource must appear on record in the name of the spouse to which the resource is designated on the Designation of Resources.

The couple is allowed 90 days from the date of notice of approval to complete a required transfer of ownership to the appropriate spouse. Once the worker determines that the alternate care spouse is otherwise eligible, the worker approves the case without waiting for completion of the transfer. On a Notice of Action, the worker must advise the couple of the 90-day period. If the couple fails to complete the transfer within 90 days, the worker closes the case.

Transfers of countable resources from the alternate care spouse to the community spouse are not considered a deprivation of resources as long as the amount transferred to the community spouse, when added to his/her own resources, does not exceed the amount the community spouse is allowed to reserve as calculated at the time of assessment.

The alternate care spouse may be eligible in the retroactive months if the couple's resources did not exceed the allowable limit plus the amount reserved for the community spouse, even if the couple has not completed a Designation of Resources or necessary transfers of ownership. (See 469-000-316, #2).

Excluded resources (e.g., the home, one automobile, and essential property) transferred solely to the community spouse are not a deprivation of resources. If the community spouse disposes of a resource for less than fair market value, it is considered deprivation of a resource.

{Effective 5/8/05}

2-009.02C4b Treatment of Resources Not Included on Designation:
Resources that are acquired or which lose their exclusion after a Designation of Resources is signed are counted as follows:

1. A resource in the name of the alternate care spouse is considered his/hers;
2. A resource in the name of the community spouse is considered his/hers; or
3. A resource that is jointly owned is divided between the spouses.

Examples of resources which may lose their exclusion are the home when the community spouse no longer resides in it or business property in which the community spouse is no longer actively engaged in operating.

The alternate care spouse may transfer a resource that is in his/her name or his/her share of a jointly owned resource to the community spouse if the amount of resources combined with the community spouse's other resources does not exceed the spousal allowance calculated at the time of assessment. This may occur if the community spouse has had to use some of the assets reserved at the time of the assessment. It allows the alternate care spouse to transfer resources back to the community spouse so that the community spouse may maintain the reserved amount on the Assessment of Resources. The alternate care spouse must provide a written statement of his/her intent to transfer the resource. The alternate care spouse is allowed 90 days from the date of report of the resource to complete the transfer. The worker must notify the couple in writing of the 90-day limit.

{Effective 5/8/05}

2-009.02C4c Assigning Support Rights: If the couple have resources that exceed the allowable amount and refuse to spend down which prevents Medicaid eligibility for the alternate care spouse, the Department has the legal right to bring support proceedings against the community spouse.

{Effective 5/8/05}

2-009.02C4d Continued Validity of the Designation: The designation of resources remains valid even if either spouse enters a different specified living arrangement. If the couple does live together in the home without eligibility for waiver services, the designation becomes invalid. Spouse for spouse responsibility again applies.

If the alternate care spouse later moves out of the home or becomes eligible for waiver services, the original designation again becomes valid and the alternate care spouse is allowed a resource level for one.

If the community spouse applies, s/he must reduce his/her designated resources to the maximum allowable for:

1. One if the couple is not in the home together or in the home with eligibility for waiver services; or
2. Two if the couple is in the home and ineligible for waiver services.

{Effective 5/8/05}

2-009.03 Determination of Ownership of Resources: A resource which appears on record in the name of a client or responsible relative (see 469 NAC 2-006) must be considered belonging to the client. The worker must verify ownership of real estate through records in the offices of the register of deeds or county clerk.

If the worker substantiates that the client is not the true owner of a resource, it is permissible to allow the client to remove his/her name from the title of ownership in order to reflect true ownership. The client is allowed 60 days to make this change without affecting eligibility. After the client removes his/her name from the resource, eligibility may be determined retroactively and/or prospectively. If the client does not remove his/her name in 60 days, the resource is counted.

2-009.03A Jointly Owned Resources: When a client has a jointly owned resource that is considered available, the worker must use the guidelines in the following regulations.

2-009.03A1 Resources Owned With Other Clients: If a client owns a resource with another client who is on categorical assistance, the worker must divide the value of the resource by the number of owners, regardless of the terms of ownership. The appropriate value is counted for each unit.

This reference also applies to resources owned with a spouse or child.

2-009.03A2 Resources Owned With Non-Clients: If a client owns a resource with an individual who is not receiving categorical assistance, the worker must determine the appropriate value to be assigned to the client.

2-009.03A2a Real Estate: The worker must verify ownership of real estate through records in the offices of the register of deeds or county clerk. The worker must verify the terms on which property is held in cases of joint ownership. Records of the county court have information in regard to estates which have not been settled or which are in probate. The worker must consult the records of the county court if the property has come to the holder as a part of an estate; if by joint purchase, the facts will appear in the record of the deed.

2-009.03A2b Motor Vehicles: The worker must verify ownership of a motor vehicle. The title, not the registration, of a motor vehicle legally determines ownership.

2-009.03A2c Bank Accounts: The worker must verify the terms of the account with the financial institution. If any individual on the account is able to withdraw the total amount, the full amount of the account is considered the client's. If all signatures are required to withdraw the money, the proportionate share must be counted toward the client.

If the client verifies that none of the money belongs to him/her, the client must be allowed 60 days to remove his/her name from the account. The client must provide proof of the change. After the client removes his/her name from the account, eligibility may be determined retrospectively and/or prospectively. If the client does not remove his/her name in 60 days, the money is counted as a resource.

If a portion is the client's, the worker must notify the client of the requirement to put the money in a separate account.

2-009.04 Consideration of Relative Responsibility: When the client (i.e., a spouse or parent) has relative responsibility for a client in another assistance unit and the responsible relative owns the resource(s), the worker must divide the value by the number of units to determine the amount to be counted to each. An AABD/MA or SDP/MA couple is considered one unit.

Exception: If the responsible relative receives SSI, none of the value of the resource(s) is considered to the other unit.

{Effective 5/8/05}

2-009.05 Inheritance: When a client receives an inheritance, verified payment of debts or obligations of the deceased are subtracted from the settlement.

2-009.06 Value and Equity: Equity is the actual value of property (the price at which it could be sold) less the total of encumbrances against it (mortgages, mechanic's liens, other liens and taxes, and estimated selling expenses).

If the encumbrances against the property equal or exceed the price for which the property could be sold, the client has no equity and the property is not an available resource.

2-009.06A Secured Debts: The total value of unpaid personal taxes and other personal debts secured by mortgages, liens, promissory notes, and judgments (other than those on which the statute of limitations applies) is subtracted from the gross value of the encumbered property, to find the equity. The worker shall document in the case record the type of debt and plan under which payment was made. The client's statement of debts may usually be accepted unless information to the contrary is available.

2-009.06B Determination of Value: The worker may use public tax records to determine the sale value of a resource. If there is a question as to the accuracy of the sale value determined by tax records, verification may be obtained from a real estate agent, car dealer, or other appropriate individual.

2-009.07 Types of Resources: Resources can be divided into two categories: liquid and non-liquid.

2-009.07A Liquid Resources: Liquid resources are assets that are in cash or financial instruments which are convertible to cash. See 469-000-325 for examples of liquid resources.

2-009.07A1 Cash, Savings, Investments, Money Due: Cash on hand, cash in checking and savings accounts, salable stocks or bonds, certificates of deposit, promissory notes and other collectable unpaid notes or loans and other investments are available resources.

2-009.07A2 Land Contracts: A land contract, or real estate contract of sale, is considered a resource to the seller of the property if the contract can be sold. In determining the value of the contract, the worker and/or the client determines the salability of the contract and the resulting value (see 469 NAC 2-009.06). The contract is not considered salable unless there is a known buyer. If the contract is determined to be salable, the net value of the contract becomes the value at which it could be sold minus encumbrances, etc., against the property.

If it is determined and documented that the contract is not salable, the contract is not considered an available resource to the client. The worker must review the salability at all redeterminations or as the worker feels necessary.

Any income received from the land contract is considered unearned income to the client (see 469 NAC 2-010.01H, item 2322).

2-009.07A3 Funds Set Aside for Burial: A specified maximum may be disregarded if it is set aside for the purpose of paying burial expenses. The individual may choose to put the money in:

1. A pre-need burial trust. If the client has an irrevocable burial trust for more than the specified maximum, the excess is considered an available resource;
2. A policy of burial insurance. If the client has irrevocably assigned more than the specified maximum in burial insurance, the excess is not an available resource but may be a deprivation of resources (see 469 NAC 2-009.10); or
3. A maximum of \$1,500 designated for burial (see 469 NAC 2-009.07A3c). These funds may be in an account or in an insurance policy.

If the client has a combination of an irrevocable burial trust, and/or burial insurance that exceed the specified maximum, see 469-000-310 to determine how to treat the excess. An individual may transfer funds from an irrevocable burial trust fund into an insurance policy if there is no lapse of time between the withdrawal and the transfer.

See 469 NAC 2-009.07A3d for the treatment of burial spaces and burial space items.

2-009.07A3a Irrevocable Burial Trusts: If the money was put in an irrevocable burial trust on July 16, 1982, or later, it is not considered an available resource. According to Nebraska law, an individual is allowed to deposit funds up to the specified maximum in an irrevocable trust fund created for the purpose of a prearranged funeral plan.

Therefore, the value up to the specified maximum of an irrevocable burial trust and any accrued interest or dividends on that amount, if irrevocable, are considered unavailable and are disregarded. The mortuary may retain an additional amount not to exceed 15 percent, but this amount must not be included in the burial trust.

An irrevocable burial trust fund must be deposited with a financial institution. For burial trusts contracted on December 31, 1986, or earlier, a written copy of the contract for a prearranged funeral plan must be on file with the financial institution. For burial trusts contracted on January 1, 1987, or later, a written copy of the contract may be retained by the client or the funeral home.

In determining whether the value of a burial fund contracted in Nebraska is considered available, the worker must verify the terms of the contract with the financial institution. The worker must determine also if the contract stipulates that the interest or dividends are irrevocable. If a burial fund is drawn up in another state, the worker must verify the contract terms and determine whether that state allows irrevocable burial funds or whether the value of the fund is available to the client regardless of the contract terms.

Questions regarding burial funds contracted out of state ~~should~~must be sent ~~on Form ASD-17 to Central Office Economic Assistance~~ along with a copy of the contract, ~~to the Central Office, Attention: Public Assistance.~~

2-009.07A3a(1) Interest on Burial Trusts: For irrevocable burial trusts contracted on December 31, 1986, or earlier, the individual was allowed to stipulate whether the interest or dividends accruing to the trust fund were irrevocable. If the interest or dividends are irrevocable, they are disregarded. The worker shall determine if the contract stipulates that the interest or dividends are irrevocable.

For irrevocable burial trusts contracted on January 1, 1987, or later, all accrued interest or dividends are also irrevocable.

2-009.07A3b Burial Insurance: Burial insurance is defined as insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured, or a life insurance policy that is irrevocably assigned for the specific purpose of burial. When the proceeds of a life insurance policy are irrevocably assigned for the purpose of burial, the cash value is not available and is disregarded as a resource.

2-009.07A3c Money Designated for Burial: Up to \$1,500 may be disregarded for each individual if it is set aside for the purpose of paying burial arrangements for the individual or the individual's spouse. This exclusion is in addition to the burial space exclusion. This exclusion is not in addition to a burial trust or burial insurance that has been irrevocably assigned.

The \$1,500 must be reduced by subtracting:

1. The face value of whole life insurance policies owned by an individual if the cash surrender value of the policies have been excluded from resources; and/or
2. The amount(s) set aside in an irrevocable trust or other irrevocable agreement available to meet funeral expenses.

Exception: Any amount designated solely for burial space items either in an insurance policy or a trust (revocable or irrevocable) is not subtracted from the \$1,500.

The funds set aside for burial arrangements must be kept separate from other funds. If the funds are not segregated from other resources, the exclusion does not apply to any of the resources. Burial funds that are combined with other resources are treated as non-excluded resources.

Interest earned on these excluded burial funds and appreciation on the value of the funds are excluded from resources if left to accumulate and become part of the separate, identified burial account.

These funds are no longer considered as funds designated for burial if any of the principal or interest is withdrawn. If the worker verifies that withdrawals have been made, the remainder is considered a resource.

Exception: If the client has an account that is funded by insurance that is specified for burial space items, any remainder continues to be disregarded if the client withdraws funds from the account.

2-009.07A3d Burial Spaces: The value of burial spaces held for the purpose of providing a place for the burial of the client, his/her spouse, and members of the client's immediate family ~~are~~ not counted as an available resource. The immediate family includes minor and adult children, including adopted children and stepchildren, brothers, sisters, parents, adoptive parents, and the spouses of these individuals. A burial space includes a crypt, mausoleum, urn, casket, marker, vault, or other repository for the remains of a deceased person. This exemption also applies to markers, vaults, etc., and the charges for opening and closing the grave, but does not include services, burial fees, etc. These items are exempt only if they are actually purchased. If the client has a life insurance policy for the purchase of burial items, the cash value is included in the specified maximum if the policy is irrevocably assigned (see 469 NAC 2-009.07A3b).

2-009.07A3d(1) Burial Space Items Held in a Contract: Burial space items may be disregarded when they are held for an individual by way of a contract. To meet the requirement that the item is actually purchased, the contract must state that the individual has purchased a particular item for a specified price. Revocability is not an issue for burial space contracts as long as the agreement itself represents the individual's ownership.

The contract may be funded by money set aside in a bank account or in a burial insurance policy. Any interest accrued and left to accumulate is not counted as income.

If it is burial insurance which has been irrevocably assigned, it is treated according to 469 NAC 2-009.07A3b and the specified maximum applies. If a total of more than the specified maximum in burial insurance is irrevocably assigned for services and/or burial space items, the amount above the specified maximum may be considered a deprivation of a resource under 469 NAC 2-009.10.

If the client transfers ownership of a life insurance policy to someone else, e.g., a mortuary or a relative, and there is a contract with a mortuary for purchase of burial space items which the insurance policy will be used to fund, the cash value of the policy is not considered a resource since the client does not own it and this is not considered deprivation of a resource.

2-009.07A4 Life Insurance

2-009.07A4a Definitions

Cash surrender value: Amount which the insurer will pay (usually to the owner) upon cancellation of the policy before death of the insured or before maturity of the policy.

Face value: Basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions. (In determining the face value of a policy, the original face value of the policy is used.)

Insured: The person whose life is insured.

Insurer: The company that insures others.

Owner: The person who has the right to change the policy.

{Effective 5/8/05}

2-009.07A4b Cash Surrender Value: Using the following criteria, the cash surrender value of life insurance owned by the client is considered a resource. If the combined original face value of all the life insurance policies owned by the client exceeds \$1,500, the cash surrender value of all the policies is considered a countable resource. Each person in the unit is allowed the \$1,500 exemption for the face value of his/her life insurance.

The worker must disregard the following in determining the combined original face value of all life insurance policies:

1. Burial insurance; and
2. Life insurance policies where the proceeds are irrevocably assigned for the purpose of burial.

See 469 NAC 2-009.07A3b for the treatment of burial insurance.

If the cash surrender value is to be counted towards the total resource of a client, consideration is given to any outstanding loans against the policy in determining net cash surrender value (see 469 NAC 2-009.06).

{Effective 5/8/05}

2-009.07A4c Adjustment: The client can usually adjust a large insurance policy to a smaller amount providing limited protection and allowing the client to benefit from accumulated savings.

2-009.07A4d Interest and Dividends: Interest and dividends actually paid to the client from all life insurance policies are treated according to 469 NAC 2-010.01H, item 6.

2-009.07A5 Long-Term Care (LTC) Partnership Program: Resources equal to the amount of benefits paid out by a qualified Long-Term Care Partnership policy are disregarded for an individual applying for Medicaid if the policy was issued on July 1, 2006, or later, and the individual is otherwise Medicaid-eligible. The benefits may be paid as direct reimbursement of long term care expenses, or paid on a per diem or other periodic basis, for periods during which the individual received long term care services. The disregard is applied to the amount of benefits paid to or for the individual as of the month of application, even if additional benefits remain available under the terms of the policy.

The amount of the resource disregard is also excluded from estate recovery.

{Effective 1/19/08}

2-009.07A5a Definition of a Qualified Long-Term Care Partnership Policy: A Qualified LTC Partnership policy is a long-term care insurance policy that has been approved by the Nebraska Department of Insurance. The Department accepts the Department of Insurance's certification of the policy. If an individual has a long term care insurance policy that does not meet the requirements for a Qualified LTC Partnership policy because it was issued before July 1, 2006, the individual may exchange the policy for another.

{Effective 1/19/08}

2-009.07A5b Exchange of Non-Partnership Policy for Qualified LTC Partnership Policy: An individual may exchange a policy that does not meet the requirements of a qualified LTC Partnership Policy for one that does meet the requirements. The date of exchange is considered the issue date for the qualified LTC Partnership Policy.

{Effective 1/19/08}

2-009.07A5c Reciprocity with Other States: The Department will accept qualified LTC Partnership Policies issued in other states with Long-Term Care Partnership Programs.

{Effective 1/19/08}

2-009.07A6 Trust, Guardianship/Conservatorship, and Annuity Funds: When a guardianship, conservatorship, annuity, or trust has been established on behalf of a client and the client(s) who has applied has resources exceeding the total resource limit for an AABD grant or SDP grant and/or medical (see 469 NAC 2-009.08), the worker must verify if the trust, guardianship/conservatorship, or annuity is available to the client.

2-009.07A6a Definitions: For the purposes of these regulations, the following definitions apply.

Annuity: A right to receive periodic payments, either for life or a term of years.

Beneficiary: Any individual, or individuals, designated in the trust to receive any disbursement from the corpus of the trust, or from income generated by the trust, which benefits the party receiving it. A payment from a trust may

include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.

Grantor: Any individual who creates a trust. It includes the following:

1. The client;
2. The client's spouse;
3. A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the individual or the individual's spouse (guardian/conservator); or
4. A person, including a court or administrative body, acting at the direction or upon the request of the client or the client's spouse.

Irrevocable Trust: A trust which cannot, in any way, be revoked by the grantor.

Medicaid-Qualifying Trust: A trust or similar legal device that was established before August 11, 1993, by a client (or his or her spouse) under which:

1. The client is the beneficiary of all or part of the payments from the trust; and
2. The amount of the distribution is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed to the individual and the distributable amount from a Medicaid-qualifying trust has no use limitation.

Pooled Trust: A trust containing the assets of a disabled individual(s) that is established and managed by a nonprofit association in a separate account solely for the benefit of a disabled individual.

Revocable Trust: A trust which can be revoked by the grantor. A trust which provides that the trust can only be modified or terminated by a court is considered to be a revocable trust, since the grantor (or representative) can petition the court to terminate the trust. A trust called irrevocable but which will terminate if some action is taken by the grantor is a revocable trust for purposes of these regulations.

Special Needs Trust: A trust containing the assets of a client age 64 or younger who is disabled and which is established for the sole benefit of the client by a parent, grandparent, legal guardian, or a court.

Testamentary Trust: A trust established through a will.

Trust: For purposes of these regulations, a trust is any arrangement in which an individual (grantor) transfers property to another person(s) (trustee[s]) with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated beneficiaries. The trust must be valid under state law and manifested by a valid trust instrument of agreement. A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefit of the beneficiaries.

The term trust also includes any legal instrument or device that is similar to a trust for purposes of these regulations. It involves a grantor who transfers property to an individual or entity with the intention that it be held, managed, or administered by the individual or entity for the benefit of the grantor or others. This can include (but is not limited to) escrow accounts, investment accounts, pension funds, irrevocable burial trusts, annuities, and other similar entities managed by an individual or entity with fiduciary obligations.

2-009.07A6b Testamentary Trusts: Testamentary trusts may be excluded as resources, depending on the availability of the funds to the individual or his/her spouse as specified in the terms of the trust.

2-009.07A6c Annuities

2-009.07A6c(1) Purchased or Annuitized Before February 8, 2006: Where the client cannot assign or change the ownership or payee, the annuity is unavailable. A determination must then be made if a deprivation has occurred. If the expected return on the annuity is commensurate with the life expectancy of the client, the annuity can be deemed actuarially sound and no deprivation has occurred.

If the average number of years of expected life remaining for the client does not coincide with the life of the annuity (i.e., the client is not reasonably expected to live longer than the guarantee period of the annuity), a deprivation has occurred. The look back period is the same for trusts, i.e., 60 months. See 469-000-212 Period Life Tables.

2-009.07A6c(2) Annuity Transaction On or After February 8, 2006:

Revocable and assignable annuities are a countable resource. A saleable annuity which has not been sold is a countable resource for the amount annuitized, less the payment(s) amount already received. A saleable annuity which has been sold for a value consistent with the secondary market is a countable resource in the amount of the proceeds. If a saleable annuity is sold for less than a value consistent with the secondary market, it will be valued at the current secondary market amount and the difference will be subject to deprivation of resources regulation.

2-009.07A6c(2)(a) Annuities Excluded from Resources: An annuity which has been annuitized will be excluded from countable resources if it meets the following conditions:

1. The annuity is considered either an individual retirement annuity according to Internal Revenue Code (IRC) or a deemed Individual Retirement Account under a qualified employer plan by IRC; or
2. The annuity is purchased with the proceeds from a simplified employee pension; and
3. The annuity is irrevocable and non-assignable, the individual who owned the retirement account or plan is receiving equal monthly payments with no deferral or balloon payments, and the scheduled payout period is actuarially sound based on the individual's life expectancy.

The applicant or recipient must verify that the annuity meets these requirements.

2-009.07A6c(2)(b) Deprivation of Resources for Annuity Transactions: For long term care services (see 469 NAC 2-009.10B), an annuity transaction after February 8, 2006, is treated as a disposal of an asset for less than fair market value unless the State of Nebraska is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid, or is named as the remainder beneficiary in the second position after the community spouse and/or minor or disabled child. An annuity is also treated as a disposal of assets for less than fair market value unless it is irrevocable and non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments. This provision also applies to a community spouse.

The issuer of an annuity must notify the Department when there is a change in the amount of income or principal withdrawn from the annuity.

2-009.07A6d Revocable Trusts: In the case of a revocable trust:

1. The entire corpus of the trust is counted as an available resource to the client;
2. Any payments from the trust made to or for the benefit of the client are counted as income;
3. Any payments from the trust which are not made to, or on behalf of, the client are considered assets disposed of for less than fair market value (see 469 NAC 2-009.10); and
4. If the client must go to court to access the funds, the client or his/her guardian or conservator is allowed 60 days to initiate court action.
 - a. An applicant is allowed 60 days from the approval date; and
 - b. A recipient is allowed 60 days from the date of notification of the requirement to file for access.

2-009.07A6e Guardianships/Conservatorships: When a fund is established in the process of the appointment of a guardianship or conservatorship, the worker must determine if the funds are available without court approval. The client is ineligible for categorical assistance until the guardian gives the local office written notice of refusal to spend guardianship/conservatorship monies for the care and maintenance of the client. In order to be considered current notice, it must be given within one year of its use in determining eligibility for categorical assistance. After current notice has been given, the client, if otherwise eligible, may receive benefits if all judicial remedies are pursued to determine the availability of the funds. This may include an appeal to the proper district court and, if necessary, to the Court of Appeals and the Nebraska Supreme Court. However, certain guardianships/conservatorships are not reasonably available and judicial review may be waived; these include some guardianships/conservatorships where the guardian or conservator's discretion is limited and certain guardianships/conservatorships established from the proceeds of a personal injury case on behalf of a child.

The child or his/her guardian/conservator must file a request for access to the funds in a court of competent jurisdiction within:

1. For an applicant, 60 days from the approval date;
2. For a recipient, 60 days from the date of notification of the requirement to file for access.

If the petition or application has not been filed after 60 days, the client is no longer eligible for AABD/MA or SDP/MA.

2-009.07A6f Irrevocable Trusts:

2-009.07A6f(1) Trusts Established Before August 11, 1993: For a Medicaid-qualifying trust established before August 11, 1993, the maximum amount that could have been distributed from either the income or principal is considered an available resource.

A Medicaid-qualifying trust is a trust or similar legal device that was established by a client (or his or her spouse) under which:

1. The client is the beneficiary of all or part of the payments from the trust; and
2. The amount of the distribution is determined by one or more trustees who are permitted to exercise any discretion with respect to the amount to be distributed to the individual and the distributable amount from a Medicaid-qualifying trust has no use limitation.

A trust that was established by a client's guardian or legal representative, acting on the client's behalf, falls under the definition of a Medicaid-qualifying trust. If a client is not legally competent, for example, a trust established by his/her legal guardian (including a parent) using the client's assets can be treated as having been established by the client, since the client could not establish the trust for himself/herself.

2-009.07A6f(2) Trusts Established On or After August 11, 1993: In accordance with Sections 1917 (c) and (d) of the Social Security Act, the following regulations apply to all trusts created on or after August 11, 1993.

These regulations apply to any client who establishes a trust, who is a beneficiary of a trust, and who is an applicant or recipient of Medicaid. A client is considered to have established a trust if his or her assets or assets of his or her spouse were used to form a part or ~~all of the~~ entire corpus of the trust other than by will.

These include trusts established by:

1. The individual;
2. The individual's spouse;
3. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or
4. Person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

Where a trust includes the assets of another person or persons as well as the assets of the client and/or his/her spouse, the rules in this section apply only to the portion of the trust attributable to the assets of the client and/or the client's spouse.

2-009.07A6f(2)(a) Payment Can Be Made From Trust: The following applies when payment may be made to the individual and/or the individual's spouse under the terms of the trust:

1. Payments from income, or from the corpus, made to or for the benefit of the client and/or the client's spouse are treated as income to the client.
2. If there are any circumstances under which payment from the trust corpus could be made to or for the benefit of the client and/or the client's spouse, the portion of the corpus from which payment to or for the benefit of the client or the client's spouse could be made must be considered a resource available to the client.
3. Any portion of the corpus that could be paid to or for the benefit of the client and/or the client's spouse is treated as an available resource.
4. Payments from income or from the corpus that are not made to or for the benefit of the client and/or the client's spouse are treated as transfers of assets for less than fair market value.

2-009.07A6f(2)(a)[1] Exceptions: A trust is not considered available if it is established for a disabled client age 64 or younger (receiving or eligible to receive SSI, RSDI, or AABD) and is a:

1. Special needs trust: A trust containing the assets of the client and established solely for the benefit of the client by the client's parent, grandparent, legal guardian, or a court if the State will receive all amounts remaining in the trust upon the death of the client or upon termination of the trust up to the amount of total medical assistance paid on behalf of the client; or
2. Pooled trust: A trust containing the assets of the client and:
 - a. 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 assets, the trust pools these accounts;
 - c. Accounts in the trust are established solely for the benefit of individuals who are blind or disabled (receiving or eligible to receive SSI, RSDI, or AABD); and
 - d. The trust contains the provision that the State of Nebraska will receive all amounts remaining in the trust for the beneficiary upon the death of the client up to the amount of total medical assistance paid on behalf of the client.

2-009.07A6f(2)(b) Payment Cannot Be Made from Trust: When payments from some portion or all of the trust cannot under any circumstances be made to or for the benefit of the client, or where there is some portion of the trust from which no payments can be made to or for the benefit of the client, all of the corpus, or income on the corpus, which cannot be paid to the client is considered a transfer of assets for less than fair market value.

2-009.07A6g Hardship Procedures: A trust will not be considered available if denial of assistance would cause undue hardship.

2-009.07B Non-Liquid Resources: Non-liquid resources are tangible properties which need to be sold if they are to be used for the maintenance of the client. They include all properties not classified as liquid resources, such as:

1. A home;
2. Additional pieces of property;
3. Trailer houses;
4. Burial lots;
5. Motor vehicles;
6. Life estates;
7. Farm and business equipment;
8. Livestock;
9. Poultry and crops; and
10. Household goods and other personal effects.

2-009.07B1 Exemption of Home: The AABD/MA Payment or SDP/MA client's home is exempt from consideration as an available resource, with the following limitations.

2-009.07B1a Definition of Home: A home is defined as any shelter which the individual owns and uses as his/her principal place of residence. The home includes any land on which the house is located and any related outbuildings necessary to the operation of the home.

2-009.07B1b Adjacent Lots: Lots adjacent to the home are considered available if they can be sold separately from the home. If the worker determines and documents in the case record that the lots adjacent to the home cannot be sold or are not saleable due to the location or condition of the property, the adjacent lots are also exempt.

2-009.07B1c Home Equity Value: For applications on or after January 1, 2006, or later, the individual is not eligible for any long term care services specified at 469 NAC 2-009.10B if the equity value interest in the home exceeds the specified amount.

2-009.07B2 Removal from Home: If the individual moves away from the home and does not plan or is unable to return to it, the worker must determine when the home becomes an available resource in accordance with the following provisions.

The home continues to be exempt as a resource while it is actually occupied by the client's spouse or dependent relative. A dependent relative includes the client's:

1. Child, stepchild, or grandchild age 17 or younger;
2. Child, stepchild, or grandchild age 18 or older if aged, blind, or disabled and receiving or eligible to receive SSI; AABD/MA; SDP/MA; and other categorical assistance; or
3. Brother, sister, stepbrother, stepsister, half brother, half sister, parent, stepparent, grandparent, aunt, uncle, niece, nephew, or the spouse of any persons previously named even after the marriage has been terminated by death or divorce (who is receiving or who would be eligible for categorical assistance except for income and resources and who lived in the home at any time one year before the client moved away from the home).

When the client moves to a nursing home or to an assisted living facility and is receiving AD waiver services, and it is not possible to determine immediately if the client will be able to return home, a maximum of six months may be allowed to make that determination.

Unless the client or the client's representative signs a statement that the individual will not return to the home, or the home is already listed for sale, it is not possible to determine immediately if s/he will return home.

After a maximum of six months, the home may no longer be considered the individual's principal place of residence and must be considered an available resource. However, the client is allowed time as described in 469 NAC 2-009.07B4b to liquidate the property before it affects eligibility.

Note: The six months begin with the first full month following the month of admission.

After the client is admitted, if the home is exempt because it is occupied by one or more of the relatives identified previously, the six months begin with the first full month following the month that the home is no longer allowed the exemption for occupation.

{Effective 5/8/05}

2-009.07B2a Liquidation of Home: As soon as the determination is made that the client will not be able to return home, the worker must allow the client time to liquidate the property (see 469 NAC 2-009.07B4).

The client is also allowed time for liquidation if s/he leaves the home for a reason other than entering a medical institution.

2-009.07B3 Sale of Home: If the AABD/MA or SDP/MA client sells his/her home, the net proceeds become an available resource unless reinvested immediately in another home. In order to be allowed time to reinvest the proceeds, the client must be residing in the home at the time of the sale and move directly to his/her new home.

Net proceeds are the remainder after payment of the mortgage, realtor's fees, legal fees, etc. The worker must verify any deductions.

2-009.07B4 Liquidation of Real Property: When a client has excess resources because of real property, s/he may be eligible to receive an AABD/MA grant or SDP/MA pending liquidation of the resource, according to the following regulations. This reference does not apply if the community spouse under spousal impoverishment regulations will retain any of the proceeds from the sale. The community spouse is not a client.

Note: If the client has excess resources because of real property other than the home, s/he is ineligible until the month the Agreement to Sell Real Property and Repay Assistance is signed.

{Effective 5/8/05}

2-009.07B4a Definition of Real Property: Real property is defined as land, houses, or buildings.

2-009.07B4b Time Limits for Liquidation: The worker must exclude real property which the client is making a good faith effort to sell.

First the worker must determine if the individual has the legal authority to liquidate the property. If not, the client is allowed 60 days to initiate legal action to obtain authority to liquidate (see 469 NAC 2-009.02A). If the client owns the property with other persons, see 469 NAC 2-009.07B4b(2).

Once the client has the legal authority to liquidate the property, the worker must obtain the client's signature on the Agreement to Sell Real Property and Repay Assistance. The client is allowed six calendar months to liquidate the real property. If the client refuses to sign the Agreement to Sell Real Property and Repay Assistance, s/he is immediately ineligible because of excess resources.

The six-month period begins with the month following the month in which the Agreement to Sell Real Property and Repay Assistance is signed. Once the Agreement to Sell Real Property and Repay Assistance is signed, the six calendar months are counted, whether or not the client is receiving assistance. If after the Agreement to Sell Real Property and Repay Assistance is signed the client goes into current pay status for SSI, the Agreement to Sell Real Property and Repay Assistance is void. If the client later goes into non-pay status for SSI, a new Agreement to Sell Real Property and Repay Assistance is signed and a new six-month liquidation period is established.

If the client moves back to the home and subsequently moves out again during the six-month period, s/he is only allowed the months remaining in the original six-calendar month period.

One liquidation period is allowed for each piece of real property that is determined to cause excess resources, even if the case is closed and subsequently reopened.

{Effective 5/8/05}

2-009.07B4b(1) Extension of Time Limit: If the client is unable to liquidate the property in six calendar months, the supervisor may authorize an additional three calendar months. In determining whether to allow a three-calendar-month extension, the supervisor must consider:

1. If the property has been placed on the market with a real estate licensee or;
2. If the client is asking a fair price for the property;
3. If the asking price has been reduced;
4. If the client understands the requirement for liquidation of the property;
5. If the client has not refused a reasonable offer to purchase; and
Note: If there is not a better offer, a reasonable offer is defined as at least 2/3 of either the estimated current market value or the proven actual value.
6. The economic conditions in the area and if real estate is selling.

The three calendar months are counted whether or not the client is receiving assistance. If the client moves back to the home during the three-month period and subsequently moves out again, s/he is allowed the months remaining in the three months.

Before the three-month extension ends, if the client has exhausted all possibilities for selling the property but it is not sold, the worker must submit all information regarding the property and its salability on ~~Form ASD-17 to Public Assistance~~, Central Office, Economic Assistance to determine if the resource is available, in accordance with the guidelines previously listed.

{Effective 2/28/07}

2-009.07B4b(2) Joint Ownership: Real property that is jointly owned is excluded if sale of the property would cause the other owner (whether the other owner is on assistance or not) undue hardship. However, if undue hardship ceases to exist, the property is included in countable resources and handled according to the following regulations.

If the client owns the property with other persons who are not on assistance and the real property is not the principal place of residence of the other owner(s), the worker contacts the other owners to determine if they are willing to liquidate their interest in the property. If all parties are willing to liquidate, the worker proceeds with the liquidation process. If one or more of the parties do not wish to liquidate, the worker applies 469 NAC 2-009.02A and requires the client to take legal action to force a sale of the property. The worker may obtain a written statement from the other parties and file it in the case record. After a legal determination is made regarding the availability of the client's interest in the property, the worker takes the appropriate action.

{Effective 5/11/99}

2-009.07B5 Additional Pieces of Real Property: The worker shall determine and use in computing the amount of the unit's total available resources the potential sales value of all real property, other than the allowed exemption for the home.

2-009.07B6 Burial Spaces: See 469 NAC 2-009.07A3d.

2-009.07B7 Motor Vehicles: The worker must disregard one motor vehicle regardless of its value as long as it is necessary for the client or a member of his/her household for employment, medical treatment, or use as the home. If the client has more than one motor vehicle, the worker excludes the vehicle with the greatest equity.

Exception: The client designates the disregarded vehicle for the Assessment of Resources.

Any other motor vehicles are treated as nonliquid resources and the equity is counted in the resource limit. The client's verbal statement that the motor vehicle is used for employment or medical treatment is sufficient.

Exception: A client in a nursing home or receiving services through an Assisted Living Waiver is not allowed the disregard of any motor vehicles because medical transportation is included in the payment to the facility.

{Effective 5/8/05}

2-009.07B7a Determination of Fair Market Value: For motor vehicles that are counted in the resource total, the worker uses the fair market value. Cars, trucks, SUVs, vans, motorcycles, recreational vehicles, motorboats and watercraft, and planes are included in the category of motor vehicles. To determine the fair market value of vehicles, the worker must use the trade-in value as shown in either the Kelly Blue Book or the National Auto Dealers Association (NADA) Used Car Guide. If the vehicle is not listed in the Kelly Blue Book or the NADA Used Car Guide, or if the client or the worker feels the value listed in the Guide is inappropriate or not a true valuation of the vehicle, the worker may:

1. Contact the county assessor's office for the assessed value;
2. Use the client's most recent vehicle tax statement; or
3. Have the client obtain the vehicle's value from used car dealers.

2-009.07B7b (Reserved)

2-009.07B8 Life Estates: The owner of a life estate in real property is generally unable to sell the property. Therefore, the worker must include the net income from the life estate in the budget rather than considering the life estate as an available resource. If the owner of a life estate transfers it to another individual, the worker must determine if it is deprivation of a resource (see 469 NAC 2-009.10). If the life estate is sold, the proceeds ~~is~~are counted as a resource. See 469-000-208 for the Life Estate Interest Table.

It is a disposal of assets to purchase a life estate interest in another individual's home unless the purchaser resides in the home for at least 12 months after the date of purchase.

2-009.07B9 Household Goods and Personal Effects: Household goods and personal effects of moderate value used in the home are exempt. Household goods are defined as including household furniture, furnishings and equipment used in the operation, maintenance, and occupancy of the home or in the functions and activities of the home and family life, as well as those items which are for comfort and accommodation. Personal effects include clothing, jewelry, items of personal care, etc.

2-009.07B10 Loans: A bona fide loan to a client or financially responsible relative is disregarded as a resource. A bona fide loan is defined as one that must be repaid. The agreement for repayment may be verbal or written and the loan may be owed to an individual or to an organization or agency. Using prudent person principle the client's statement is adequate verification that the loan must be repaid.

For income treatment, see 469 NAC 2-010.01H.

2-009.07B11 Essential Property: If the client owns a resource that is used in his/her trade or business, the resource is disregarded, regardless of the value. This includes real property such as land, houses, or buildings as well as personal property such as farm machinery, business equipment, livestock, poultry, crops, tools, safety equipment, or business bank accounts as long as the funds are separated from other liquid resources. The client or a responsible relative (spouse or parent) must be actively involved in the day to day operation of the trade or business as a primary means of earning a livelihood. See 469-000-318 for examples. If the client or responsible relative is not actively involved in the trade or business, it must be due to circumstances that are beyond the individual's control, e.g., illness, and there must be a reasonable expectation that the use will resume.

{Effective 4/11/95}

2-009.07B11a Nonbusiness Property: A maximum of \$6,000 equity value of nonbusiness property (real or personal) that is used to produce goods or services essential to daily activities is excluded from resources. For instance, an individual may maintain livestock for consumption in his/her own household.

The property must be in current use or there is the reasonable expectation that use will resume.

A vehicle such as a garden tractor may qualify for this exemption; an automobile does not qualify.

Any equity in excess of \$6,000 is counted as a resource. If the excess resource is real property, see 469 NAC 2-009.07B4 for regulations on liquidating real property.

2-009.07B12 Trailer Houses and Other Portable Housing Units: If a client occupies a trailer house or other portable housing unit as his/her home, the property is allowed the resource exemption for a home (see 469 NAC 2-009.07B1). If the client enters a nursing home, s/he is allowed the exemption of a home for up to six months (see 469 NAC 2-009.07B2).

If the trailer house or other portable housing unit is used for the client's trade or business, see 469 NAC 2-009.07B11. If it is used to produce goods for the client's own consumption or use, see 469 NAC 2-009.07B11a.

2-009.07B13 Farm Equipment: If the farm equipment is used for the client's trade or business, see 469 NAC 2-009.07B11. If it is used to produce goods for the client's own consumption or use, see 469 NAC 2-009.07B11a.

If it is necessary to determine the equity in farm equipment, the worker may use tax assessor's records or consult a farm equipment dealer to arrive at a market value. The worker must verify any loans, liens, etc., to determine equity.

2-009.07B14 Business Equipment, Fixtures, Machinery: If business equipment, etc., is used for the client's trade or business, see 469 NAC 2-009.07B11. If it is used to produce goods for the client's own consumption or use, see 469 NAC 2-009.07B11a.

If it is necessary to determine the value of these resources, the worker may use the owner's estimate of the current market price for the equipment, fixtures, or machinery. If the client is unable to provide an estimate or if the worker feels the estimate is inaccurate, other sources may be used, such as an auctioneer, county assessor, etc.

2-009.07B15 Livestock, Poultry, Crops (Growing and on Hand): If the livestock, poultry, and crops are grown for the client's trade or business, see 469 NAC 2-009.07B11. If they are grown for the client's own consumption, see 469 NAC 2-009.07B11a.

If it is necessary to determine the value of these resources, the worker may use the owner's estimate of the current market price for livestock, poultry, and crops (growing and harvested). If the client is unable to provide an estimate or if the worker feels the estimate is inaccurate, the worker may consult other sources such as an auctioneer, county assessor, etc.

2-009.08 Maximum Available Resource Levels for Grant Eligibility: The established maximum for available resources which the client, or the client and responsible relative or essential person (see 469 NAC 3-006.02), may own and still be considered eligible for a grant, according to unit size, are as follows:

1. One member unit - client only \$2000
If a couple has a valid designation of resources and:
 - a. There is an eligible spouse and an ineligible spouse, the resource level for the eligible spouse is \$2,000; or
 - b. The ineligible spouse later becomes eligible; each spouse is allowed \$2,000.

2. Two member unit - \$3000
 - a. Client and eligible spouse;
 - b. Client and ineligible spouse; or
 - c. Client and ineligible spouse who have designated resources but the client returns home or no longer is eligible for waiver services;
 - d. Client and other essential person; (This may be a disabled minor child and one parent if that parent is considered an EP); and

3. Three or more member unit - \$3000 plus
 - a. Client and spouse; or \$25 for each
 - b. Client and other essential additional EP
person; and
 - c. Additional essential persons.

If the client has resources in excess of the allowable limit for a grant, the client is ineligible and the AABD Payment or SDP Payment case must be closed or denied. Worker must consider eligibility for MASDP Medical using the resource levels in 469 NAC 4-005.01. For procedures on designating resources, see 469 NAC 2-009.02C-ff.

If two or more related AABD/MA Payment or SDP/MA Payment clients (other than a married couple), i.e., an eligible AABD/MA grant parent and his/her eligible AABD/MA grant minor child or two or more unrelated eligible AABD/MA grant clients, reside in the same household, each client is entitled to a resource maximum of \$2000.

The treatment of resources of a spouse, a parent, or an essential person is the same as for a client (see 469 NAC 2-006).

If the total equity value of available non-excluded resources exceeds the maximums specified above, the client(s) is ineligible. Resources must be below these maximum resource levels for one day in the month in order for the client to be eligible for a grant in that month.

2-009.08A Resources of a Spouse, Parent, or Other Essential Person (EP): All resources of a client and spouse or other EP who is included in the budget and who share the same home are considered available for the support of both unless one spouse is eligible for or receiving waiver services. ~~(see 469 NAC 2-009.02C ff.)~~. Relative responsibility includes eligible spouse for spouse (eligible or ineligible) and parents for children who are age 17 or younger and still considered part of their household. (See 469 NAC 2-006 for relative responsibility and 469 NAC 2-009.02C-ff. for the designation of resources.)

If the client and spouse are legally separated or divorced, consideration must still be given to jointly owned resources and their availability in determining the individual's eligibility.

In the case of an eligible client whose payment standard has been increased because of the inclusion of EP's (see 469 NAC 3-006.02), the resources of the essential person(s) are considered available to the client. Resources of an essential person are treated the same as the resources of the eligible client. However, if the resources of the essential person make the client ineligible (unless the essential person is the ineligible spouse or parent of a minor child), the essential person may be removed from the budget. Once the EP is removed from the budget, his/her resources are no longer considered.

2-009.09 Deeming of Resources of A Parent: In considering the resources of a parent(s) who is not considered an EP towards an eligible child age 17 or younger and living in the parent's household, the following resources are considered to the child whether or not they are actually made available:

1. All resources exceeding \$2,000 in the case of one parent; or
2. All resources exceeding \$3,000 in the case of -
 - a. Two parents;
 - b. One parent and spouse of the parent; or
 - c. One parent and one minor sibling.
3. \$25 each additional minor sibling in the parent(s)' household.

Resource exclusions listed in 469 NAC 2-009.02B apply to the parent's resources. The resources of the eligible child's brothers and sisters are not considered towards the child.

Note: If income of a parent is not deemed according to 469 NAC 2-010.01F1, resources are also not deemed.

2-009.10 Deprivation of Resources: Any action taken by the individual, or any other person or entity, that reduces or eliminates the individual's or spouse's recorded ownership or control of the asset for less than fair market value (full value) is a deprivation of resources. The worker must verify the fair market value of the resource at the time the resource was disposed of and determine the equity value of the resource by taking into consideration any encumbrances against the resource. This includes:

1. Recorded transfer of ownership of real property;
2. Not receiving the spousal share of an augmented estate;
3. Purchase of a life estate in another individual's home without meeting the 12-month requirement to reside there;
4. Promissory notes, loans, mortgages, and contract sales for less than fair market value and not enforced;
5. Purchase of an irrevocable, nonassignable annuity if Medicaid is not the preferred beneficiary and the annuity is issued on February 8, 2006, or later;
6. Any transfer above the protected spousal reserved amount to a community spouse; and
7. Purchase of any contract or financial instrument, including an endowment or insurance, where- the criteria for fair market value are not met.

The criteria for fair market value are not met when:

1. The term of the instrument exceeds the life expectancy of the applicable client(s);
2. The instrument does not provide for equal monthly or annual payments commencing immediately during the term of the contract;
3. The instrument does not provide for the recovery of assets in the event of default; or
4. The instrument contains exculpatory or cancellation terms of balance due.

A service given for free at the time cannot later be claimed as an amount owed.

When an asset is placed in an annuity on February 8, 2006 or later, see annuity regulations at 469 NAC 2-009.07A6c(2).

Trust regulations at 469 NAC 2-009.07A6 ff. take precedence over deprivation when an asset is placed in a trust.

When real property in which the individual has a life estate is sold, the individual or spouse must receive as a lump sum his/her life estate interest from the net proceeds, or the entire net proceeds invested and the individual(s) who has the life estate receives all the income.

{Effective 2/14/2009}

2-009.10A Deprivation of Resources for a Grant: The worker needs to investigate for deprivation of a resource if an individual or an individual's spouse applies for or becomes eligible for a grant. For deprivation of resources for SDP medical assistance, see 469 NAC 2-009.10B.

{Effective 6/18/2001}

2-009.10A1 Look Back Period: To determine if a client or his/her spouse deprived himself/herself of a resource in order to qualify for an AABD grant, payment, the worker must look back 36 months from when the individual applies for AABD grant assistance or, if later, the date on which the individual or spouse disposes of resources for less than fair market value.

The look back period for grant is always 36 months.

{Effective 6/18/2001}

2-009.10A2 Period of Ineligibility for a Grant: If the worker determines that an individual disposed of a resource, the applicant or recipient is ineligible for a grant for the number of months calculated by dividing the uncompensated value of the resources disposed of by the maximum AABD payment to the individual. The number of months the individual is ineligible for a grant must not exceed 36. If the applicant or recipient is eligible for SSI but for a period of ineligibility due to a disposal, the AABD grant period of ineligibility is the same as the SSI period of ineligibility. Ineligibility for a grant begins with the month of transfer. Receipt of any grant during the period of ineligibility results in an overpayment and recoupment procedures apply (see 469 NAC 3-007.03B2).

2-009.10B Deprivation of Resources for SDP Medical Assistance: The worker needs to investigate for deprivation of a resource only if an individual or an individual's spouse resides in a specified living arrangement which is defined as:

1. Residing in a nursing home;
2. Receiving the skilled level of care in a hospital, i.e., swing bed services;
3. Requesting or Receiving Home and Community Based Services including an Assisted Living waiver, home health care or personal care services; or
4. Residing in an Intermediate Care Facility for Persons with **Mental Retardation/Developmental Disabilities**.

If a couple chooses to do an assessment of resources, see 469 NAC 2-009.02C3.

2-009.10B1 Exceptions to Deprivation Rule: For all disposals of assets, regardless of date, an exception may be made if:

1. A satisfactory showing is made to the State that the individual intended to dispose of the assets either at fair market value or for other valuable consideration;
2. The assets were transferred exclusively for a purpose other than to qualify for SDP medical assistance; or
3. All assets transferred for less than fair market value have been returned to the individual.

Also see 469 NAC 2-009.10C.

~~2-009.10B2 Disposal of Resources Before February 8, 2006:~~

~~2-009.10B2a Look Back Period: To determine if a client or his/her spouse deprived himself/herself of a resource to qualify for medical assistance, the worker must look back 36 months before the month of application. The worker must look back 60 months in cases of a trust or annuity.~~

~~For medical assistance, the look back is triggered when the individual first applies for Medicaid and is in a specified living arrangement or is on Medicaid and enters a specified living arrangement. When an individual applies for Medicaid more than once, the look back period is based on the first date the individual meets both requirements.~~

~~To determine the countable value disposed of, the worker:~~

- ~~1. Takes the equity the client has in the resource (equity equals fair market value minus encumbrances);~~
- ~~2. Subtracts any compensation received by the client; and~~
- ~~3. Subtracts the allowable resource level shown at 469 NAC 4-005.01 from the result of step 2 if this is the first disposal.~~

~~2-009.10B2b Period of Ineligibility: If the worker determines that an individual disposed of a resource, the applicant or recipient is ineligible for medical assistance for the number of months determined by dividing the countable value of the resource by the actual monthly cost of care in the specified living arrangement at the current private pay rate. The period of ineligibility begins with the month of disposal, even if the client was not in a specified living arrangement during the time.~~

~~If the division results in a fraction, the worker rounds down to the nearest whole number.~~

~~In determining the period of ineligibility, the worker uses the fair market value of the transferred resource only. The value of other resources and income are not included in the calculation.~~

~~For periodic disposals within the look back period, the worker determines each separately; the periods of ineligibility run consecutively.~~

~~The remaining time of ineligibility is divided by two and shared by the couple if the community spouse enters one of the living arrangements listed in 469 NAC 2-009.10B during the period of ineligibility of the institutionalized spouse.~~

2-009.10B32 Disposal/Transfer of Resources on February 8, 2006, or Later:

~~2-009.10B3a2a Look Back Period: To determine if a client or his/her spouse deprived himself/herself of a resource to qualify for medical assistance, the worker must look back 60 months before the month of application.~~

For medical assistance, the look back is triggered when the individual first applies for Medicaid and is in a specified living arrangement or is on Medicaid and enters a specified living arrangement. When an individual applies for Medicaid more than once, the look back period is based on the first date the individual meets both requirements.

To determine the countable value disposed of, the worker:

1. Takes the equity the client has in the resource (equity equals fair market value minus encumbrances);
2. Subtracts any compensation received by the client; and
3. Subtracts the allowable resource level shown at 469 NAC 4-005.01 from the result of step 2 if this is the first disposal.

2-009.10B3b2b **Period of Ineligibility for SDP Medical:** If the worker determines that an individual disposed of a resource, the applicant or recipient is ineligible for medical assistance for the number of months determined by dividing the countable value of the resource by the actual monthly cost of care in the specified living arrangement at the current private pay rate. If the period of ineligibility is longer than 12 months, the SDP case is to be closed or denied and the client will need to apply for Medicaid. If the period of ineligibility is less than 12 months, the period of ineligibility begins:

1. If the individual is on MedicaidSDP Medical, with the month of entry into a specified living arrangement; or
2. If the individual is not on MedicaidSDP Medical, the month of application if in a specified living arrangement.

The individual must be ~~Medicaid~~ eligible for SDP medical assistance except for the deprivation of resources in the month of application. It does not apply to an application month in which the individual is ineligible because of excess resources or other eligibility criteria.

If the division results in a fraction, the worker converts the fraction to a dollar amount and includes that amount as unearned income for the applicable month.

In determining the period of ineligibility, the worker uses the fair market value of the transferred resource only. The value of other resources and income are not included in the calculation.

For periodic disposals within the look back period, the worker determines each separately; the periods of ineligibility run consecutively. Multiple fractional month transfers are cumulative and treated as one transfer.

The remaining time of ineligibility is divided by two and shared by the couple if the community spouse enters one of the specified living arrangements listed in 469 NAC 2-009.10B during the period of ineligibility of the institutionalized spouse.

2-009.10B3e2c **Availability of Hardship Waiver Process:** The individual may request in writing to the Local Office or Call Center a hardship waiver exception when imposing a period of ineligibility for transfer of assets would deprive the individual of medical care so that his/her health or his/her life would be endangered. A notice of discharge from the facility is not necessary to demonstrate that health or life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life.

The facility in which the institutionalized individual resides may file the undue hardship waiver request on behalf of the individual with the written consent of the individual or his/her legal representative.

The documentation will be scanned and the request will be submitted to Central Office, Economic Assistance for determination, ~~along with~~ along with information including, but not limited to, spouse's resources, any written demand for return of assets, any legal action taken to recover the asset, documentation of the individual that signed for or requested the transfer of assets, and living arrangement of the individual(s) at time of transfer. The Central Office will make a determination within 30 days ~~from receipt of~~ of receiving the hardship waiver request by the Central Office. If circumstances beyond the control of the agency prevent action within the required time, the Central Office will send a notice to the individual who filed the hardship waiver request.

The guardian, conservator, or anyone acting on behalf of the client must attempt to recover transferred assets. Up to 30 days of nursing home services may be provided if the individual is cooperating to the fullest extent in attempting to recover transferred assets.

If cooperation ceases, undue hardship no longer exists.

A hardship waiver will be denied if the individual or his/her spouse participated in the transfer.

A denial of hardship waiver request may be appealed.

2-009.10C Transfers Not Considered Deprivation for Grant or Medical: It is not considered a deprivation if:

1. An applicant or recipient transferred a resource to his/her spouse or to an individual with power of attorney or a guardian or conservator for the sole benefit of the applicant or recipient's spouse;
2. An applicant or a recipient's spouse transferred a resource to an individual with power of attorney or a guardian or conservator for the sole benefit of the applicant or recipient's spouse;
3. A resource was transferred to a trust established solely for the benefit of the individual's son or daughter who is blind or disabled (receiving or eligible to receive SSI, RSDI, AABD payment, or MA Medicaid);
4. A resource was transferred to the individual's son or daughter who is blind or disabled (receiving or eligible to receive SSI, RSDI, AABD, or MA); or
5. A resource was transferred to a trust established solely for the benefit of an individual age 64 or younger who is disabled (receiving or eligible to receive SSI, RSDI, AABD payment, or MA Medicaid).

For transfer of a home, see 469 NAC 2-009.10C1.

2-009.10C1 Transfer of a Home: It is not considered a deprivation of a resource if an applicant or recipient transfers title to his/her home to his/her:

1. Spouse;
2. Son or daughter who:
 - a. Is age 20 or younger;
 - b. Is blind or disabled (receiving or eligible to receive SSI, RSDI, AABD Payment or ~~MA~~Medicaid based on blindness or disability); or
 - c. Was residing in the home for at least two years before his/her parent requested assistance or entered the living arrangement listed at 469 NAC 2-009.10B and provided care to his/her parent which permitted the parent to reside at home rather than be institutionalized or receive Home and Community Based Waiver Services; or
3. Sibling who has an equity interest in the home and who was residing in the home for at least one year immediately before his/her sibling requested assistance or entered the previously listed living arrangement (469 NAC 2-009.10B).

{Effective 6/~~18/2001~~18/2001}

2-009.11 Reduction of Resources: The client may reduce available resources to the allowable limit if the case record contains documentation that the resources have been reduced and the unit is within the allowable resource limits. An application for an individual who has excess resources other than real property may be held pending until the resources are reduced. For treatment of real property which causes the client to have excess resources see 469 NAC 2-009.07B4 ff.

The client may reduce his/her resources by paying any secured or unsecured debts, purchasing personal property, establishing burial funds, or expending the resources in any manner that the client deems appropriate. If the client is in a medical institution or receiving waiver services, s/he cannot give away resources in order to establish SDP medical assistance eligibility per 469 NAC 2-009.10. If the client is not in a medical institution or receiving waiver services, giving away the excess resources is not considered a deprivation of a resource. If the client reduces resources in any way except paying on outstanding medical bills, eligibility is effective the first day of the month in which the resources are actually expended if all other eligibility factors are met. The client's statement of expenditures is acceptable.

The client may do a resource spenddown to establish an earlier SDP medical effective date if s/he has outstanding medical bills. However, medical eligibility may not begin earlier than the third month before the request for assistance (see 469 NAC 4-003). In order for a client with excess resources to establish an earlier medical effective date, s/he must pay all of the excess resources on medical bills incurred no earlier than the third month before the month of request. The medical expense does not have to be a Medicaid covered service. The client should pay on the oldest medical bills incurred within the retroactive period and continue paying bills until the amount of the excess resources has been expended. Medical eligibility may begin with the first day of the month in which the last medical bill was paid which reduced the resources to the allowable limit. The worker must verify expenditures for medical bills.

If the client has excess resources in the month of application it is not necessary to verify resources in any of the retroactive months. The resource spenddown of the excess resources from the month of application is all that is necessary. If the client does not have excess resources in the month of application, the worker must verify resources in the oldest retroactive month in which the client has outstanding medical bills. If there are excess resources during this retroactive month, the worker must use only this amount of excess resources to complete the resource spenddown.

See 469-000-319 for procedures related to documenting a resource spenddown.

2-010 Income: Need is determined by considering the amount of total net income of the AABD/MA or SDP/MA client (and spouse or other EP's whose needs are included in the budget) in relation to individual requirements.

In the case of an eligible client whose payment standard has been increased because of the inclusion of EP's (see 469 NAC 3-006.02), income of the essential person(s) is considered available to the client. Income of an essential person is treated the same as income of the eligible client. However, if the income of the essential person makes the client ineligible (unless the essential person is the ineligible spouse or parent of a minor child), the essential person may be removed from the budget. Once the EP is removed from the budget, his/her income is no longer considered.

When there is a client living in a specified living arrangement (see 469 NAC 2-009.02C1) and a spouse in the community, income is budgeted according to 469 NAC 4-007.01ff).

2-010.01 Definition of Income: Income is defined as gain or recurrent benefit received in money or in-kind (see 469 NAC 2-010.01B1b) from employment, business, property, investments, gifts, benefits, or annuities, at regular or irregular intervals of time.

2-010.01A Availability: All income, whether earned, or unearned must be considered if received and currently available for the use of the individual.

2-010.01B Types of Income

2-010.01B1 Earned Income: Earned income is money received from wages, tips, salary, commissions, profits from activities in which an individual is engaged as a self-employed person or as an employee, or items of need received at no cost in lieu of wages.

Note: Reimbursement for employment-related expenses such as mileage, lodging, or meals is not considered earned income.

2-010.01B1a Contractual Income: The worker shall prorate income paid on a contractual basis. The worker shall prorate the income over the number of months covered under the contract, even if the client is paid in fewer months than the contract covers. For example, if a teacher's contract is for 12 months, but s/he is paid over 9 months, the income is prorated over the 12-month period.

Income received intermittently such as farm income is prorated over the period it is intended to cover.

2-010.01B1b In-Kind Income: In-kind income is the value of food, clothing, shelter, or other items received in lieu of wages.

2-010.01B1c Disregards for Self-Employment: Operating expenses related to producing the goods or services and without which the goods or services could not be produced are deducted from gross income. Operating expenses may include -

1. Cost of goods sold;
2. Advertising;
3. Bad debts from sales or services;
4. Bank service charges;
5. Car and truck expenses;
6. Commission;
7. Employee benefit programs;
8. Freight/shipping costs;
9. Insurance;
10. Interest on business indebtedness;
11. Laundry and cleaning;
12. Legal and professional services;
13. Office supplies and postage;
14. Rent on business property;
15. Repairs and maintenance;
16. Supplies;
17. Utilities and telephone;
18. Wages; and
19. Transportation other than to and from work and child care (see 469-000-324339 for the allowance for transportation).

2-010.01B1c(1) Operating Expenses - Farm Income: The following expenses related to farm income are considered operating expenses:

1. Cost of goods sold;
2. Cost of labor;
3. Repairs and maintenance;
4. Interest;
5. Rent of farm, pasture;
6. Feed purchased;
7. Seeds, plants purchased;
8. Fertilizers, lime, and chemicals;
9. Cost of machines leased;
10. Supplies purchased;
11. Breeding fees;
12. Veterinary fees, medicine;
13. Gasoline, fuel, or oil;
14. Storage, warehousing;
15. Insurance;
16. Utilities;
17. Freight, trucking;
18. Conservation expenses;
19. Land clearing expenses; and
20. Employee benefit programs.

2-010.01B1c(2) Operating Expenses Not Allowed: The following expenses are not allowed as operating expenses:

1. Depreciation;
2. Personal business expenses such as subscriptions, dues to professional organizations and unions, training courses, etc.;
3. Personal transportation;
4. Purchase of capital equipment;
5. Payments on the principal of loans; and
6. Business-related entertainment expenses.

If the 1040 document is used to verify income, the worker does not allow depreciation as a cost of operation and does not count capital gains and other gains from lines 13, 14, and 15 of Form 1040 as income.

2-010.01B1c(3) Offset of Earnings: If a client has a combination of farm or self-employment income and regular earned income, the regular earnings may be offset with a loss from the self-employment or farm operation. See PAF 13-1 for completion of the Self-Employment and Farm Income Worksheet.

2-010.01B2 Unearned Income: Unearned income includes but is not limited to -

1. Retirement, Survivors, and Disability benefits;
2. Railroad Retirement;
3. Child support;
4. Military service benefits;
5. Civil service benefits;
6. Unemployment compensation;
7. Gifts;
8. Disability insurance benefits;
9. Disability benefits paid by an employer (this does not include sick leave); and
10. Returns from securities or investments (i.e., stocks, bonds, annuities, or savings) in which the individual is not actively engaged.

If payments are received annually, semi-annually, or quarterly, the amount is prorated on a monthly basis.

2-010.01B2a RSDI Benefits: For budgeting, the gross amount of RSDI is used; the gross amount is the RSDI benefit with no Medicare premium deducted and rounded down to the nearest whole dollar.
{Effective 7/10/2000}

~~Exceptions: Certain specified groups of individuals retain Medicaid eligibility without regard to required receipt of Social Security benefits because they are considered to be receiving SSI.~~

- ~~1. Disabled Early Widow(er)s/COBRA Widow(er)s who meet all the following requirements:
 - a. Lose SSI due to mandatory receipt of Title II widows benefits;
 - b. Are not yet eligible for Medicare Part A;
 - c. Are at least age 50, but not yet age 65; and
 - d. Would continue to be eligible for SSI benefits if they were not receiving the Title II benefits;~~
- ~~2. Disabled Adult Children (DAC)/Childhood Disability Beneficiaries (CDB) who meet all the following requirements:
 - a. Lose SSI or 1619(b) after 11/10/1986 (Public Law 99-643) due to mandatory receipt/increase of Title II benefits on a parent's record due to retirement, death, or disability of a parent;
 - b. Are over the age of 18;
 - c. Whose blindness or disability began before the age of 22; and
 - d. Would continue to be eligible for SSI (including the SSI resource standard) if they were not receiving the Title II disabled adult child's benefits;~~

- ~~3. Section 503/Pickle Amendment Group who meet all the following requirements:
 - ~~a. Currently receiving Title II;~~
 - ~~b. Lost SSI/SSP but would still be eligible for those benefits if the total amount of the Title II cost-of-living increases received since losing SSI/SSP benefits while also entitled to Title II benefits was deducted from income. Cost-of-living increases include the increases by the individual, spouse or financially responsible family member; and~~
 - ~~c. Was eligible for and receiving SSI or a State supplement concurrently with Title II for at least one month after April 1, 1977.~~~~

- ~~4. Disabled Widow(er)s/Additional Reduction Factor (ARF) Widow(er)s who meet all the following requirements:
 - ~~a. Have a disability;~~
 - ~~b. Were receiving SSI/SSP benefits in December, 1983 and lost SSI/SSP benefits in January 1984 due to a statutory elimination of an additional benefit reduction factor for widow(er)s before attainment of age 60 who have been continuously entitled to widow(er)s insurance based on disability since January 1984;~~
 - ~~c. Applied for benefits under this group no later than July 1, 1988; or the later date for 209(b) States established under the court order in *Darling v. Bowen*, 685 F. Supp. 1125; and~~
 - ~~d. Would continue to be eligible for SSI/SSP benefits if he or she had not received the increase in Title II benefits.~~~~

2-010.01B2a(1) Delay in Counting RSDI Increase: After the annual RSDI cost of living increase, if a client would go from grant or MA only status to MA excess because his/her income exceeds the Federal Poverty Level, the worker shall continue using the current RSDI amount. The month after the month that the new FPL figures are published, the worker shall determine the client's eligibility by comparing the increased RSDI benefit to the new FPL guidelines.

The delayed COLA provision applies only if the RSDI increase would cause the client to have excess income. If there is an increase in other unearned income or the client starts receiving other unearned income in the same month as the COLA in RSDI benefits, the delayed COLA provisions do not apply.

2-010.01B2b SSI Benefits: SSI benefits are not used in computing Form ~~IM-25 and DA-3M~~ the budgets but the Federal Benefit Rate (FBR) is are used by the system to calculate the amount of the state supplemental payment.

2-010.01B2c Contributions: Contributions are verified payments which are paid to or for the unit. Contributions received regularly to aid in the support of the client, either in the form of money payments or items of need, are considered unearned income.

Payments by relatives directly to an alternate living arrangement that is not a medical facility are not counted as a contribution.

The standard of need is not reduced due to the presence in the household of a self-supporting household member. However, if the self-supporting member is contributing to the support of the household, only the amount in excess of the proportionate share is counted as unearned income. (The proportionate share is figured by dividing the standard of need plus actual shelter cost by the number of persons in the household.) For treatment of loans, see 469 NAC 2-009.07B10.

{Effective 4/11/95}

2-010.01B2c(1) Temporary Crisis Assistance: In determining initial eligibility only, a contribution is not counted when the applicant states that -

1. S/he has no income and has been forced to share a living arrangement with a self-supporting individual; or
2. An individual not in the household is paying the applicant's shelter costs; and
3. The applicant plans to make other arrangements (move, pay all or a share of the expenses) as soon as s/he has income.

2-010.01B2c(2) Nursing Facility, Assisted Living Waiver, or Hospital Care: Contributions to or for a client who is receiving nursing facility, Assisted Living Waiver, or hospital care are considered unearned income in the client's budget if Medicaid is or will be paying any part of the nursing facility, Assisted Living Waiver, or hospital care.

Exception: If a client resides in a nursing facility, a payment to the facility for the client to enable him/her to have a single room is not considered income in the client's budget if Medicaid is or will be paying any part of the nursing home care.

Contributions to assist a client in paying for private care are not considered income in the client's budget. The client may be determined eligible for payment of other medical services, e.g., medication, coinsurance and deductibles, doctor bills, etc.

{Effective 11/1/05}

2-010.01B2c(3) Life Insurance Premiums: Payment of premiums on small protective life insurance policies is not considered a contribution.

2-010.01B2c(4) Health Insurance Premiums: Payment of a health insurance premium by another individual is not considered a contribution as long as the premium is paid to the insurance company, not to the client.

The amount of the premium is not allowed as a deduction on the Medicaid budget if the client does not pay the premium.

2-010.01B2d Third Party Medical Payments: Income received from a third party that pays the client directly is -

1. Disregarded if it is refunded to the provider or the Department as reimbursement for a specific service; or
2. Counted as unearned income if the client fails or refuses to refund these payments.

If the client receives a third party medical payment directly and the medical expense for which the third party medical payment is intended is payable by NMAP/Medicaid, the worker shall send a demand letter advising the client that s/he must reimburse the Department or the provider up to the amount of payment which has been or will be made for the specific service. The client is allowed ten days from the date of notification to reimburse the Department or pay the provider.

If an applicant receives a third party medical payment for services which are payable by NMAP Medicaid, the worker must not delay determination of eligibility for assistance and authorization for payment pending the applicant's reimbursement. At the time the application is approved, the worker must notify the client of the number of days left in which to reimburse the payment.

If the client refunds within ten days, the worker must take no further action. If the client fails or refuses to refund within ten days, the worker must consider the entire third party payment as unearned income in the first month possible. Taking into account adequate and timely notice. Any balance remaining is considered a resource in the following month.

2-010.01B2d(1) Income-Producing Policies: Income received from an insurance policy that supplements the client's income is treated as unearned income. These policies provide income regardless of the type of service being provided or the condition of the client. If it is verified that the income was applied to medical bills, the income is not counted in the client's budget.

{Effective 4/11/95}

2-010.01B2e Inheritance and Gifts: If the client receives a gift or inheritance, it is considered unearned income in the month of receipt or report and should be counted in the budget the first month possible, considering timely notice; any unspent remainder is considered a resource in the following month.

2-010.01B2f Life Estate Or Land Contract Income: If an applicant receives periodic life estate or land contract income, e.g., annual, semi-annual or quarterly, and the last periodic payment has been spent before the application, the life estate/land contract income may be considered unavailable and not counted in the budget. When the application is approved the worker must notify the client that s/he must report receipt of the next payment within ten days and that the life estate/land contract income must then be counted in the budget.

{Effective 5/11/99}

After report of the first payment following approval of the case the worker may:

1. Prorate each payment and count it in the budget over the period it is intended to cover; or
2. If the client files a tax return, the most recent Form 1040 may be used to estimate total life estate income to be received over a year. The countable amount may be prorated monthly and counted in the budget until the next Form 1040 is provided.

For examples of deprivation of resources, see 469-000-315.

2-010.01B3 Irregular Income: Irregular income is income, earned or unearned, which varies in amount from month to month or which is received at irregular intervals. This may be due to irregular employment, but even when an individual works regularly, the income may be irregular because of factors such as seasonal increases or decreases in employment and earnings, e.g., day labor, sales work on a commission basis, child care, etc.

The worker uses an average of three consecutive months, if available, to project future income unless there has been a significant change (see 469 NAC 2-010.01C1 ff.).

Small, irregular earnings which are not computable or predictable are not considered.

2-010.01B4 Accumulated Benefit Payments: Accumulated payments of Retirement, Survivors, and Disability Insurance (RSDI); Railroad Retirement; veteran's pensions; worker's compensation; or other benefit payments which are received in a single sum are not considered income. Any unspent remainder is considered a resource in the month following the month of receipt or report, taking into account the timely notice provision.

Exception: The unspent portion of an RSDI, SSI, or state supplement retroactive payment is excluded for six months following the month of receipt (see 469 NAC 2-009.02B).

{Effective 12/17/95}

2-010.01B4a Accumulated SSI Payments: When an applicant has been approved for retroactive SSI benefits, if the following are in place, the worker does **not** consider the SSI benefits when computing a retroactive state supplement payment:

1. There must be an AABD application date that corresponds with the time frame approved by SSI;
2. Verified disability begin date;
3. Form IM-17 completed and SDX shows state reimbursement;
4. The SSI check has been or will be received by Central Office;
5. The Central Office has not returned any of the retroactive SSI money to the client; and
6. There are no RSDI amounts included in the retroactive SSI payments.

If there are **no** RSDI benefits and SSA sends the SSI retroactive check directly to the applicant or Central Office has received the SSI check and has returned all or a portion to the client, the worker must use the SSI Federal Benefit Rate (FBR) in any grant budget month there is an SSI payment due.

If RSDI benefits were used in determining the amount of the SSI check, the portion that is RSDI must be used when computing state supplement payments. (RSDI benefits by law must not be assigned to reimburse the state for state supplement expenditures.)

Note: If the client is otherwise eligible at the time of approval and the worker is unable to verify the amount of SSI retroactive benefits, the worker must wait until the SSI amount is known to determine any retroactive state supplement benefits.

See 469 NAC 2-010.01B4 for exclusion as a resource.
{Effective 2/28/07}

2-010.01B4b Accumulated RSDI Payments: When calculating ~~Form IM-25~~ the budget to determine retroactive AABD payments, the worker must include as income the monthly amount of RSDI that would have been received during that month. If there is no budgetary need, the RSDI monthly amount is not included, ~~on Form DA-3M.~~

Note: If the client is otherwise eligible at the time of approval and the worker is unable to verify the amount of RSDI retroactive benefits, the worker must determine prospective eligibility but wait until the RSDI amount is known to determine any retroactive state supplement benefits.

2-010.01B5 Combined Case with a Lump Sum: When an individual in an ADC/MA - AABD/MA case receives a lump sum, the way the money is treated depends upon which individual the lump sum is intended for. RSDI and SSI lump sums are excluded as a resource for up to six months (see 469 NAC 2-009.02B).

2-010.01B5a AABD/MA Parent and ADC/MA Child: If the lump sum is intended for an AABD/MA parent, the money is considered for the parent in accordance with provisions in 469 NAC 2-010.01B4. The following month the money becomes a resource and must be divided proportionately between the cases.

2-010.01B5b AABD/MA Child and ADC/MA Parent: If the lump sum is intended for an AABD/MA child, the money is considered for the child according to 469 NAC 2-010.01B4. As the child does not have relative responsibility for other members of the family, the money is considered only for the AABD/MA case.

2-010.01B6 Potential Income: Potential income is defined as income based on entitlement or need which is usually determined by an administering agency as a result of an application for benefits by the individual. Potential income includes, but is not limited to, RSDI, categorical assistance, Railroad Retirement, ~~veteran's~~ veterans or military service ~~benefits,~~ benefits; unemployment compensation, disability insurance benefits, and worker's compensation (see also 469 NAC 2-010.01B6c). Medicare is not considered a potential benefit.

The worker must consider potential income for each client and for EP's in the household whenever the EP's requirements are considered in determining the need and amount of the client's payment. The client and any EP's are required to apply for any benefits for which s/he appears to be entitled within 60 days of the date the worker notifies the client of the requirement. The worker must not delay determination of eligibility for assistance and/or authorization of payment pending determination of entitlement for benefits.

After the worker has determined an applicant's eligibility for categorical assistance, s/he must notify the client in writing of the requirement to apply for a benefit for which the applicant appears eligible and inform the client of the number of days left in which to apply.

Benefit payments subsequently received are considered in the same manner as other income in determining need.

2-010.01B6a Need to Apply and Comply with Requirements: A client is expected to make grant application for and accept benefits promptly after the worker has discussed the client's apparent entitlement to the benefits. The client is notified on a Notice of Action of the number of days left in which to apply. The worker must document in the case record when the client was informed of the possibility of benefits. The worker must set up a special review to see if the client is grant eligible for or already receiving benefits. If the individual fails or refuses to make application within 60 days after notification by the worker or refuses to accept benefits for which s/he has been determined eligible, eligibility cannot be determined.

If a client's benefit is terminated for noncompliance, s/he should be given ten days to make contact to reestablish the benefit. If no contact is made within ten days, eligibility cannot be determined.

If an EP (including the ineligible spouse and the parent of a minor child) whose requirements are considered in determining the need of a client fails or refuses to apply for or comply with requirements for benefits for which s/he is apparently eligible, the EP's requirements are not considered in determining the client's need, and the income of the client is not applied toward meeting the EP's requirement. However, income and resources of responsible relatives are still considered in determining the eligibility of the client (see 469 NAC 2-006).

2-010.01B6b Veteran's Benefits: Clients who are veterans, their spouses, and the widows of veterans may be eligible for Aid and Attendant services. This service may be available and should be explored if the individual resides in a nursing home, in his/her own home, or in an Adult Foster Home or other alternate arrangement when the individual requires aid with daily living activities.

2-010.01B6c Supplemental Security Income Program (SSI): If a client has not applied for SSI, an application must be filed immediately (see 469 NAC 2-007.03A1).

2-010.01B6c(1) SSI Referral: A client must be referred to SSI if:

1. The client lives alone and has monthly unearned income less than the referral amount for an individual (see 469-000-211);
2. An eligible couple are living together and have monthly unearned income less than the referral amount for a couple (see 469-000-211); or
Note: Both must apply for SSI.
3. An individual is in a nursing home and has unearned income of less than \$50 per month.

Exception: If income is less than these amounts but resources are more than 469 NAC 2-009.08 and less than 469 NAC 4-005.01, the worker does not make an SSI referral but must consider eligibility for medical assistance.

All individuals otherwise eligible must be approved for a state supplement without waiting for SSI's determination.

{Effective 4/11/95}

2-010.01B7 School District Payments: School districts are required by law to provide proper education for school-age children who are handicapped. The district can provide this in the school setting or by contracting with other facilities.

If a school-aged child is receiving nursing home care, including ICF, ICF/MRDD, SNF, or chronic care, and the school district is contracting with the facility in providing the child's educational needs, the worker must disregard the school district payment as income if the payment is designated for educational services only. If any or all of the school district payment is for residential services, that portion must be shown as POS on N-FOCUS. In either situation, the worker must budget the correct SON based on the child's living arrangement.

If the school-aged child resides in a board and room or other alternative care facility, the worker must determine if the school provides payment for the child's board and room. If payment is being made to the facility, the payment is disregarded as income. The SON for personal needs only is used instead of using the full consolidated alternate care standard. The worker shall document the payment in the case record.

2-010.01C Verification of Income: The worker must verify income every 12 months (see 469 NAC 2-010.01B3). Regular income must be verified using one month's income as a minimum. Irregular income must be verified using the three most consecutive months, if available. This review may be eliminated for cases where the only source of income is RSDI, SSI, or another similar stable source of income, and there is no reason to believe the amount will change.

Initially, the worker verifies RSDI benefits by viewing the direct deposit records or N-FOCUS interface. Documentation of the verification must be contained in the case record (see 469 NAC 2-010.01B2a).

Generally RSDI (Social Security) is verified by the Bendex for current recipients of AABD/MA. Changes in benefits for current recipients are reported on N-FOCUS via the BDE interface and are used to determine the following month's budget, taking into consideration the ten-day notice requirement.

When there is a discrepancy in the verified amount of the check and the Bendex for the month of the check, the worker must initiate a SVES Request. This procedure does not apply to discrepancies with the buy-in.

The worker is not required to verify any income when a client receives SSI (for the exception, see 469 NAC 3-006.01A). If the client has been determined eligible for 1619(b) status by SSI, the worker must verify income. The worker must use the State Data Exchange (SDX) to verify receipt of SSI benefits and determine the correct federal benefit rate. Changes in SSI benefits for current recipients are reported on N-FOCUS via the SDX interface.

The worker may use the SDX to verify the amount of periodic extra earned income or periodic unearned income to be used in a client's AABD/MA grant budget if s/he is in non-pay status for SSI for one month due to the receipt of this periodic income. This may be Net Countable Unearned Income, Deemed Income, or Net Countable Earned Income of the client. The amount of income from any of these fields may be used from the SDX and counted in the client's budget, if it has been updated by SSI. No income disregards are allowed as they have already been allowed by SSI. If the client has periodic extra earned income, the worker counts the income for grant, but not for medical if the client has gone into 1619(b) status. If the client receives periodic unearned income, e.g., life estate income received annually or semi-annually, or deemed income from a spouse/parent, the worker counts it for both grant and medical budgeting.

Approval of ~~ana~~ grant application must not be delayed if all eligibility factors are met but the worker is unable to obtain verification of the amount of any RSDI and/or SSI benefits due to SSA's delay in determining the amount(s). The worker must compute ~~grant and medical~~ budgets without the RSDI income. At the time of approval, the worker must notify the client on a Notice of Action that s/he must report receipt of any RSDI and/or SSI benefits. The worker must include the RSDI in the budget in the first month possible considering the ten-day notice requirement. If retroactive benefits are received, see 469 NAC 2-010.01B4-ff.

{Effective 6/28/11}

2-010.01C1 Prospective Budgeting: The worker must average the most recent three months' actual income to arrive at the gross income amount for the income period. Income conversion charts are used for weekly and bi-weekly income. This figure is used to project medical eligibility for the next 12 months unless:

1. There was a significant change in the income of the previous three months; or
2. The worker anticipates a significant change during the projected 12-month period.

When income fluctuates, the worker must use an average of income for the three most recent consecutive months. When income is stable, the worker must use one month's income.

{Effective 6/28/11}

2-010.01C1a (Reserved)

2-010.01C1b Change: The client must report the following changes:

1. New employment;
2. Termination of employment;
3. Change in the amount of monthly income, including -
 - a. All changes in unearned income (including beginning and termination of unearned income); and
 - b. Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes for AABD, 30 hours per week is considered full-time. The client must report new employment within ten days of receipt of the first paycheck, and a change in wage rate or hours within ten days of the change.
4. Change in household composition, such as the addition or loss of a unit member; or
5. Change or receipt of a resource including cash on hand, stocks, bonds, money in a checking or savings account, or a motor vehicle.

{Effective 5/8/05}

2-010.01C1b(1) General Rules: The following procedures are used in handling changes in income:

1. Initiate action within three working days to verify the change;
2. Determine new income amount;
3. Estimate income on information available. When projecting income, use the conversion tables and convert weekly or bi-weekly income to a monthly amount (see 469-000-201). If the client receives semi-monthly or monthly income, do not convert the income.
4. For an adverse action, send a timely notice. Make the change the first month possible. If the change is not an adverse action, re-do the budget for the month that the change was reported;
5. If the income figure in step 3 is verified, use that figure in the next three months' payment budgets if no other changes are reported;
6. If the income used in step 3 is based on the client's statement, compute the budget for the month following receipt of verification. Use the conversion tables to compute income received weekly or bi-weekly (see 469-000-201); and
7. If no other changes have been reported, determine after three months' receipt of income if income fluctuates or is stable and apply the appropriate rules.

The worker shall record in the case record the date of reported change, method of estimating income, and the date verification was made. Only one budget may be based on the client's declaration of income. If the worker has not received verification for the second budget, the case must be suspended.

2-010.01C1b(2) Procedures for Changes: The worker shall first determine if the change(s) affects SDP MA eligibility. If it does, the worker shall -

1. Compare resources to the resource limit; (see 469 NAC 2-009.08 or 4-005.01);
2. Determine eligibility based on the household composition;
3. Recompute the budget; and
4. Send an adequate and timely notice of change (see 469 NAC 1-008.03B).

2-010.01C2 Retroactive Medical Eligibility: To determine retroactive SDP medical eligibility, the worker shall use the month's actual income (see 469 NAC ~~4-003, item 2)~~ 4-003.01B).

2-010.01D Income as It Applies to Resources: Income received by a client during any one month for maintenance costs may not be considered a resource for that month. Any income not spent for maintenance is considered a resource in the subsequent month.

2-010.01E Computation of Income

2-010.01E1 Income Disregards

2-010.01E1a General \$20 Disregard: Every unit receives a \$20 income disregard. A married couple who ~~is~~ are living together and budgeted together ~~are~~ is considered a unit and get one \$20 disregard. The income disregard is applied to unearned income first; any remainder is subtracted from earned income. For clients who are receiving SSI, see 469 NAC 3-006.01A.

Clients who are receiving Assisted Living AD Waiver services receive the \$20 disregard.

Exception: Clients who are living in a nursing home, public institution, hospital or other medical institution, do not receive a \$20 disregard.

{Effective 5/11/99}

2-010.01E1b Earned Income Disregards: The amount deducted from adjusted gross earned income (the amount after deduction of the cost of operation if self-employment income and the remainder of the general disregard from wages or self-employment) for each unit is in the following material.

2-010.01E1b(1) Aged or Disabled Clients: See 469-000-202 for:

1. Aged or disabled clients; or
2. The aged, blind, or disabled client's:
 - a. Ineligible spouse;
 - b. EP; or
 - c. Sponsors of aliens for deeming purposes.
{Effective 4/11/95}

2-010.01E1b(2) Blind or Blind Aged Clients: The worker determines net income for blind or blind aged clients by disregarding the first \$85 plus 1/2 of the balance.

2-010.01F Deeming Income of Responsible Persons: Income of the following individuals is considered in determining a client's eligibility when s/he does not receive SSI:

1. Parent for child age 17 or younger and still considered part of the household; and
2. Sponsor for an alien.

When there is a self-supporting parent(s) for children in two different units, the procedures for deeming found at 469 NAC 2-010.01F1-ff. are followed and the resulting deemed income is divided between the units with the children on AABD/MA payment or SDP/MA.

A portion of the income of these individuals is deemed (determined available) to the client using the following procedures.

2-010.01F1 Parent: If the client does not receive SSI, the worker must use the following guidelines to determine if the parent(s)' income is deemed:

1. If the minor is living in the same household with parent(s), the parent(s)' income must be deemed.

Exceptions: Home and Community Based Waivers: If a child, living in the parent(s)' home is receiving Medicaid services through a Home and Community Based Service waiver, the parent(s)' income and resources are not deemed when determining eligibility for SDP medical only. This does not require Central Office review. The parent(s)' income and resources must be deemed for grant eligibility.

~~Katie Beckett: If the child is not receiving waiver services, the income and resources of a parent are not deemed for medical assistance only if the minor is severely disabled and would require the level of care provided in a medical institution (Katie Beckett child) and requires certain medical services for special needs (see 471 NAC 12-014). This exception applies only if the cost of care in the home is less expensive than the cost of care in a medical institution. To determine if deeming may be waived, the worker must explain the situation on Form ASD-17, attach a current medical report, and forward it to the Central Office. The parent(s)' income and resources must be deemed for grant eligibility.~~

Autism Waiver: If a child, living in the parent(s)' home is receiving Medicaid services through Nebraska's a Home and Community Based Waiver for Children with Autism Spectrum Disorder, both the parent(s)' income and Autism waiver child's income must be verified solely to determine a premium due amount when the gross income exceeds 185% FPL.

2. If the minor is temporarily absent from the home but is still considered part of the household, the parent(s)' income must be deemed. Temporary absence includes, but is not limited to, school attendance where the minor returns to the home on a regular basis (weekends, vacations, or summers).
3. If the minor is permanently out of the home and no longer considered part of the household, the parent(s)' income must not be deemed. This includes facilities for the mentally-retarded persons with developmental disabilities or mentally illness.

When the parent(s) of an SSI child applies for categorical assistance, the worker should advise SSI of the potential eligibility of the parent(s). If the parent(s) is subsequently approved for assistance, the worker must advise SSI of the approval.

2-010.01F1a Exceptions to the Deeming Regulations: If a child age 17 or younger leaves a nursing facility or hospital where s/he was receiving an institutional personal needs amount SSI payment and goes home under a waiver, the worker must notify SSI of waiver eligibility. Even though income and resources of the parent(s) may make the child ineligible for SSI, if the child is waiver-eligible, SSI continues the institutional personal needs amount payment without deeming income and resources of the parent(s).
Note: If the parent(s) is receiving SSI, the worker must not deem any of the parent(s)' income.

See 469-000-326 for deeming calculation.

2-010.01F2 Deeming of Income of Sponsors of Aliens: The worker must consider 100 percent of the income and resources of a sponsor (and sponsor's spouse, if they are living together) when determining the eligibility of an eligible alien who applies for AABD payment or SDP if the sponsor has signed an affidavit of support under Section 213A of the Immigration and Nationality Act. The sponsor's income and resources will be considered available to the alien until the alien:

1. Becomes a U.S. citizen;
2. Has worked 40 qualifying quarters of coverage as defined under Title II of the Social Security Act or can be credited with the qualifying quarters as provided under Section 435 and the alien did not receive any federal means tested public benefit during that time period.

{Effective 5/8/05}

2-010.01F2a Definition of a Sponsor: A sponsor is an individual who:

1. Is a citizen or national of the United States or an alien who is lawfully admitted to the United States for permanent residence;
2. Is 18 years of age or older;
3. Lives in any of the 50 states or the District of Columbia; and
4. Is the person petitioning for the admission of the alien under Section 204 of the Immigration and Nationality Act.

An organization is not considered a sponsor.

{Effective 12/27/97}

2-010.01F2b Alien Duties: As an eligibility requirement, the alien is responsible for:

1. Providing income and resource information from the sponsor; and
2. Obtaining the necessary cooperation from the sponsor.

If the alien does not provide the necessary information, s/he is not eligible for assistance.

2-010.01F2c Sponsor of More Than One Alien: When an individual is a sponsor for two or more aliens who are living in the same home, the amount of deemed income and resources of the sponsor (and the sponsor's spouse, if living with the sponsor) is divided equally among the aliens.

When an individual sponsors several aliens but not all apply for assistance, the sponsor's total deemable income and resources are applied to the needs of the aliens who apply for assistance.

2-010.01F2d Deeming Exception: If a sponsored immigrant demonstrates that s/he or his/her child(ren) have been battered or subjected to extreme cruelty by a spouse or a parent or by a member of the spouse's or parent's family who is residing in the same household as the alien, deeming may be waived if a judge, an administrative law judge, or INS recognize the battery or cruelty.

2-010.01G Computation of Net Income

2-010.01G1 Income Disregarded: Income disregarded for the AABD/MA Payment or SDP/MA client is not considered in determining the eligibility of or the amount of assistance for the client or any other individual. Savings from disregarded income are considered the same as assets accumulated from any other source.

2-010.01G2 Income Taxes Paid: Income taxes that must be paid on unearned income are not deducted from the income for budgeting purposes.

2-010.01G3 Garnishments and Overpayments: If income, earned or unearned, is being garnished, the garnishment is not deducted from income in the budgeting process. If unearned income is being reduced because of a previous overpayment, the amount of the benefit before the deduction of the overpayment is considered as income.

Exception: The amount after deduction of the overpayment is used if the client received ~~both AABD/MA grant or SDP as well as another~~ and the other benefit at any time during which the overpayment occurred and the overpaid amount was included in the AABD/MA grant or SDP budget.

2-010.01G4 Offset of Earnings: If a client has a combination of farm, self-employment, and regular earned income, a loss from one source of income may be used to offset a gain from another source.

2-010.01H Treatment of Other Income in Determining Eligibility and Payment:

- | | |
|--|-------------------------------|
| 1. Sale of home produce | 1. Consider as earned income. |
| ----- | |
| 2. Home produce from garden, livestock, and poultry, used by the client(s) for his/her own consumption | 2. Disregard. |
| ----- | |

3. Self-employment income

3. Consider as earned income:
- a. Deduct total monthly cost of operation from the monthly gross business income (If 1040 document is used to verify income, do not allow depreciation as a cost of operation and do not count as income capital gains and other gains from lines 13, 14, and 15 of Form 1040);
 - b. From adjusted gross income, deduct the appropriate standard disregard for earned income (see 469 NAC 2-010.01E1 ff.).

4. Income from boarders, rented rooms, and apartments

4. Consider as unearned income:
- a. Deduct total monthly cost of operation from the monthly gross income (If 1040 document is used to verify income, the allowance for depreciation is added back in to arrive at the adjusted gross income figure);
 - b. From adjusted gross income, deduct the \$20 standard disregard.
Exception: Income received from one client/unit for board and room and all foster care payments are disregarded.

5. Rental income from real property

5. a. Consider as earned income if operated as a small business (see 469 NAC 2-010.01H, item 3).
- b. Treat like 469 NAC 2-010.01H, number 4 if not operated as a business.
Note: For both a and b, do not deduct payments on the principal of a loan.
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| 6. Declared cash winnings; interest, dividends (may be prorated on a monthly basis), etc; small and insignificant children's cash allowances; interest on Series H savings bonds | 6. Disregard if \$10 or less per month per individual for each income type. If more than \$10 per individual, count the amount that exceeds \$10 as unearned income in the budget. |
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| 7. Picket pay or strike pay | 7. a. Consider as earned income if the client is required to perform specific duties or participate for a specific number of hours. Allow the earned income disregards.
b. If the client is not required to perform specific duties or participate for a specific number of hours, consider as unearned income. |
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| 8. Interest on Series E savings bonds or other bonds which accrue interest | 8. Consider as unearned income when redeemed. |
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| 9. Income from life estate in real property | 9. Consider as unearned income; deduct from gross income any expenses specified as a condition of the life estate. |
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| 10. Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 | 10. Disregard. |
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| 11. Payments provided by a state or local government to assist in relocation | 11. Disregard. |
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| 12. Any student financial assistance to an undergraduate student provided under programs in Title IV of the Higher Education Act or under Bureau of Indian Affairs student assistance programs. This would include: | 12. Disregard. |

- a. Pell Grants (formerly called BEOG's);
- b. Supplemental Educational Opportunity Grants (SEOG);
- c. College work study;
- d. Perkins Loans (formerly National Direct Student Loans);
- e. Guaranteed student loans; (including PLUS loans and Supplemental Loans for Students);
- f. State Student Incentive Grants (SSIG); and
- g. Student assistance from the Bureau of Indian Affairs.

13. Any portion of grants, scholarships, or graduate assistantships not listed in item 12 and actually used for items such as tuition, books, fees, equipment, special clothing needs, transportation to and from school, child care services necessary for school attendance, etc. Transportation costs are allowed if the client uses private transportation or the actual cost of public transportation. The client must provide verification of the expenses.

Money received from the GI Bill, Veterans Administration under the Veterans Education and Employment Assistance Act for education expenses of a veteran, or BIA, is treated the same way. (This reference applies to undergraduate students, graduate students, and students working for a second undergraduate degree.)

13. Disregard.

14. Any portion of a grant, scholarship, or funds paid out from a Veterans Education and Employment Assistance account not used for the items listed in number 13.

14. Consider as unearned income and prorate over the period for which it is intended to cover.

15. Financial assistance for a graduate student or a student working for a second undergraduate degree if the student is required to work in order to receive the assistance. This includes work study, stipends, fellowships, and graduate assistantships.

15. Consider as earned income.

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| 16. Payments to a client participating in training or school attendance subsidized by the Division of Vocational Rehabilitation | 16. Disregard. |
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| 17. Payments from Title I Workforce Investment Act (WIA) for classroom training | 17. Disregard. |
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| 18. Earnings received from the employer or compensation in lieu of wages under a Title I WIA program | 18. a. For clients age 18 and younger who are full-time students, disregard for six months per calendar year; then consider as earned income.
b. For clients age 19 and older, consider as earned income. |
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| 19. Title I WIA program allowance paid to the client or vendor payments made to the provider for supportive services, such as transportation, meals, special tools, and clothing. This includes temporary Welfare to Work payments made through Workforce Development. | 19. Disregard for all ages. |
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| 20. Indian judgment funds distributed as per capita payments to members of Indian tribes or held in trust by the Secretary of the Interior, interest and investment income accrued on Indian judgment funds while held in trust, and purchases made with the funds | 20. Disregard. |
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| 21. Indian Land Lease | 21. Disregard. |
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| 22. Income from land contracts | 22. Consider as unearned income. |
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| 23. Payments from the Nutrition Program for the Elderly | 23. Disregard. |
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| 24. Payments for services or reimbursement of expenses to volunteers serving as foster grandparents, senior health aides, or senior companions; Service Corps of Retired Executives (SCORE); Active Corps of Executives (ACE); and any other programs under Title II and III (P.L. 93-113) | 24. Disregard. |
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25. Fuel assistance payments and allowances	25. Disregard.
26. Payments to AmeriCorps volunteers	26. Disregard.
27. Federal and state income tax refunds	27. Disregard.
28. EIC and AEIC	28. Disregard.
29. The value of assistance under a National School Lunch or Child Nutrition Program	29. Disregard.
30. HUD rental and/or utility subsidies under Section 8 of the Housing Act (lump sum or monthly payments)	30. Disregard.
31. The value of assistance paid under the U.S. Housing Act of 1937, National Housing Act, Section 101 of Housing and Urban Development Act of 1965, Title V of Housing Act of 1949	31. Disregard.
32. Food stamps	32. Disregard.
33. The value of federally donated foods	33. Disregard.
34.a. Assistance received under the Disaster Relief Act of 1974 or under a federal statute because of catastrophe declared to be a major disaster by the President and any interest earned on the assistance	34.a. Disregard.

b. Insurance payments for damage to personal property	b. Disregard
35. Any assigned child/spousal support	35. Disregard.
36. Unassigned child support paid on behalf of an AABD child	36. Disregard 1/3 of the amount.
37. Subsidized adoption or subsidized guardianship payments from Title IV-E or child welfare funds	37. Disregard.
38. Income from the sale of blood or plasma	38. Consider as unearned income.
39. Agent Orange settlement payments	39. Disregard.
40. Loans	40. Disregard bona fide loans that must be repaid.
41. Veterans Assistance benefits received by the spouse of an SSI recipient if the spouse is applying for or receiving AABD/MA	41.a. Disregard the amount of VA benefits, if any, that are budgeted by SSI to the SSI spouse. b. Consider as unearned income the remainder on the AABD/MA budget of the non-SSI spouse.
42. Veterans pension benefits reduced to \$90 for individuals receiving Medicaid	42. Disregard.
43. Income from Experience Works, Inc. Senior Community Service Employment, and any other income received under Title V of the Older Americans Act	43. Consider as earned income.

44. Victims compensation payments, i.e., payments received from a state or local government to aid victims of crime

44. Disregard.

45. Any payment received from the Radiation Exposure Compensation Trust Fund

45. Disregard. Any interest earned on unspent RECTF payments is counted as unearned interest income.

46. Jury duty pay

46. Disregard.

47. Benefits under Public Law 104-204 for a child born with spina bifida and whose parent(s) is a Vietnam veteran

47. Disregard.

48. Payments made from any fund established as a result of the case of Susan Walker v. Bayer Corporation, et al. to hemophilia patients who are infected with human immunodeficiency virus

48. Disregard.

49. Payments to individuals due to their status as victims of Nazi persecution

49. Disregard.

{Effective 5/8/05}

2-011 Cooperation in Obtaining Third Party Medical Payments: The application for AABD grant and/or medical or SDP assistance constitutes an automatic assignment of the client's rights to third party payments made on behalf of the client for medical care or services which are payable under NMAPSDP medical or Medicaid. As a requirement for assistance, the client must also cooperate (unless s/he has good cause for noncooperation) in securing any third party medical payments.

This assignment gives the Department the right to pursue and receive payments from any third party liable to pay for the cost of medical care and services of the client and any other unit member and which otherwise would be covered by NMAPSDP medical or Medicaid.

The assignment becomes effective with the date of eligibility for AABD grant and/or medical SDP assistance. For MASDP medical cases with a Share of Cost, the assignment becomes effective the first day of the cycle when the case status changes to 450, "obligation met."

{Effective 7/29/96}

2-011.01 (Reserved)

2-011.02 Third Party Payments Not Assigned: The following third party payments are not subject to the automatic assignment provision:

1. Medicare benefits; and
2. Payments from income-producing policies which subsidize the client's income while s/he is hospitalized or receiving medical care, regardless of the type of medical service being provided (see 469 NAC 2-010.01B2d(1)).

2-011.03 Cooperation Requirements: The client must cooperate in obtaining third party payments unless s/he has good cause for noncooperation (see 469 NAC 2-011.03B3).

Cooperation includes any or all of the following:

1. Providing complete information to the Department about third party medical coverage which s/he has or may have or on children in their care. This includes third party medical coverage provided by any other person or agency;
2. Providing any additional information or signing claim forms which may be necessary for identification and collection of potential third party payments;
3. Appearing as a witness in a court or another proceeding, if necessary;
4. Notifying the Department of any action s/he is initiating to recover money from a liable third party for medical care or services. This includes the identity of the third party and the entire amount of any settlement, court award, or judgment; and
5. Reimbursing the Department or paying the provider from any payments received directly from a third party for any services payable by ~~NMAP~~SDP medical or Medicaid; and
6. Taking any other reasonable steps to secure medical support payments.

2-011.03A Refusal to Cooperate: The worker is responsible for determining non-cooperation by the client. This determination is based on the client's failure or refusal to fulfill the requirements listed in 469 NAC 2-011.03.

2-011.03B Opportunity to Claim Good Cause

2-011.03B1 Notification of Rights: The worker must notify the client of the right to claim good cause for non-cooperation at the intake interview, redetermination, and whenever cooperation becomes an issue.

The worker must give the client a verbal explanation of good cause and the opportunity to ask questions.

{Effective 6/28/11}

2-011.03B2 Worker's Responsibilities if Good Cause Claimed: If the client claims good cause, the worker must:

1. Explain that the client has the burden of establishing the existence of a good cause circumstance; and
2. Obtain a signed statement from the client listing the reason(s) for claiming good cause. The client is allowed 20 days to present evidence of the claim.

2-011.03B3 Acceptable Circumstances for Good Cause: Good cause claims must be substantiated by signed statements. When documentary evidence is not available, the client must furnish sufficient information as to the location of the information.

To establish good cause, it must be documented that cooperation would not be in the best interest of the client because:

1. The client is physically or mentally incapable of cooperation; or
2. It is anticipated that cooperation could result in physical or emotional harm to the client.

2-011.03B3a Documentary Evidence: Documentary evidence which indicates these circumstances includes:

1. Medical records which document physical or emotional health history and present physical or mental health of the client;
2. Written statements from a physician or mental health professional indicating the diagnosis or prognosis concerning the client's physical or emotional condition;
3. Court, medical, criminal, protective services, social services, psychological, or law enforcement records which indicate that the third party might inflict serious physical or emotional harm on the client; or
4. Signed statements from individuals other than the client with knowledge of the circumstances which provide the basis for the claim.

2-011.03B4 Evidence Not Submitted by Client: When corroborative evidence is not submitted in support of a claim, the worker must:

1. Investigate the good cause claim when s/he believes that the claim is credible without corroborative evidence and the evidence is not available; and
2. Find good cause if the client's statement and the investigation indicate that the client has good cause for refusing to cooperate.

2-011.03B5 Worker Considerations: If the determination of good cause is not substantiated by documentary evidence, the worker must consider and document the following evidence:

1. The present physical or mental state of the client;
2. The physical or mental health history of the client;
3. Intensity and probable duration of the physical or mental upset; and
4. The degree of cooperation required by the client.

2-011.03B6 Decision on Good Cause: The worker must determine good cause and notify the client of the decision on a Notice of Action. If the worker determines that good cause does not exist, s/he allows the client ten days to respond from the date that the Notice of Action was mailed. If the client does not cooperate, withdraw the application, or request the case closed, a sanction is imposed.

2-011.03B7 Delay of Assistance Pending Determination: The agency must not deny, delay, or discontinue assistance pending a determination of good cause if the client has complied with the requirements of providing acceptable evidence or other necessary information. In most instances, a good cause determination must be made within 30 days following the receipt of a good cause claim.

2-011.03B8 Review of Good Cause: At the time of each redetermination, the worker must review a good cause claim based on a circumstance that is subject to change.

If circumstances remain the same, no action is required. A new determination is necessary if circumstances have changed. If good cause no longer exists, the requirement to cooperate must be enforced.

2-011.03C Sanction for Refusal to Cooperate: If the client fails or refuses to cooperate and there is no good cause claim or determination, the appropriate sanction is applied.

If the reason for non-cooperation is the client's failure or refusal to provide information about or obtain third party medical payments (see 469 NAC 2-011.03), the client is ineligible for grant and medical. Ineligibility continues until the client cooperates or cooperation is no longer an issue.

2-011.04 Third Party Medical Payments Received Directly: If the client receives a third party medical payment directly and the medical expense for which the third party medical payment is intended is payable by NMAPSDP medical or Medicaid, the worker must take the following actions:

Recoupment of Third Party Medical Payments:

1. Send a demand letter advising the client that s/he must reimburse the Department or the provider. The client is allowed ten days from the date of notification to reimburse the medical payment. For an applicant, the worker must not delay determination of eligibility for assistance and authorization for payment pending the applicant's reimbursement. At the time the application is approved, the worker must notify the client of the number of days left in which to reimburse the payment;
2. If the client refunds within the ten days, take no further action; or
3. If the client fails or refuses to refund within the ten days, consider the entire third party payment as unearned income in the first month possible, taking into account adequate and timely notice. Any balance remaining is considered a resource in the following month (see 469 NAC 2-010.01B2d).

If the insurance payment exceeds NMAPMedicaid rates, the excess is considered unearned income unless paid out on other medical services or supplies.

Regardless of the existence of a good cause claim, any third party medical payment that is received directly by the client must be reimbursed.

2-011.05 Willfully Withheld Information: When the evidence clearly establishes that a client willfully withheld information regarding a third party medical payment which resulted in an overpayment of ~~NMAP~~State Disability expenditures, the worker must refer the case to the Special Investigation Unit, Central Office, or in the Omaha Office to the Omaha Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker must take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker must complete normal case actions which include applying the appropriate sanction in this section.

2-011.06 Termination of Assignment: When a client's case is rejected, or closed, the automatic assignment terminates. The client's rights to any future third party medical payments are restored. However, the assignment remains in effect for the time period during which the client was on assistance.

2-012 Child Support Enforcement Services: Child Support Enforcement services are provided to an AABD/MA child age 18 or younger who has a noncustodial parent(s). If an adult does not have good cause (465 NAC 2-011.03B) and refuses to cooperate with Child Support for a child in his/her care, the AABD adult's grant and medical are closed. The child continues to be eligible.

2-013 Receipt of Other Assistance: An individual who receives a payment or whose needs are included in a payment of AABD/MA or SDP/MA may not at the same time receive a payment of another type of categorical assistance administered by the Department. This does not preclude the client of another type of assistance from being the payee for an Aid to Dependent Children grant made on behalf of a child in the individual's care.

If a client whose needs have been included in another categorical payment becomes eligible for AABD/MA or SDP/MA, the worker computes any retroactive payments on ~~Form IM-50~~ by considering the amount included in the other categorical grant for the individual.

Assistance from a source other than the Department may be used to supplement but not duplicate an assistance payment made for a particular need.

2-014 Ineligibility of Fleeing Felon: An individual is ineligible for AABD/MA grant and SDP assistance during any period in which the individual is:

1. Fleeing to avoid prosecution or custody or confinement after conviction for a crime or attempt to commit a crime that is a felony under the law of the place from which the individual is fleeing; or
2. Violating a condition of federal or state probation or parole.

CHAPTER 3-000 DETERMINATION OF BENEFITS

3-001 Description of Benefits: AABD/MA Payment or SDP/MA Payment assistance consists of money payments to the client, and/or SDP Medical payments are made directly to the provider for medical care and services. Neither service needs nor medical needs are shown on the budget form.

SDP Assistance payments to the client must not exceed the budgetary need of the unit. There is no minimum payment.

Provider payments for medical requirements are determined according to the standards in Title 471.

See Title 477 NAC for AABD Medical assistance.

3-002 (Reserved)

3-003 Planning the Assistance Budget: The worker shall plan the assistance budget with the client by discussing and explaining the following:

1. Budgeting process;
2. Individual requirements;
3. Persons whose needs may be included in the budget;
4. Use of items supplied or obtained in-kind;
5. Use of any income;
6. Determination of the amount of the assistance payment;
7. Provision of medical services; and
8. Why it is necessary for a client to keep the local office informed of changes in his/her circumstances which may affect his/her needs.

3-004 Individual Requirements Included in Assistance Budgets: The individual requirements are -

1. Standard of need;
2. Shelter up to the maximum; and
3. Special requirements.

3-004.01 Standard of Need: The standard of need is a consolidation of items necessary for basic subsistence with amounts based on unit size. Included in this standard are food, clothing, sundries, home supplies, utilities, laundry, telephone, garbage collection, and recreation. Also included in this standard amount are meals prepared away from home, therapeutic diet, special clothing allowance, meals furnished to a household employee, transportation for shopping, and special taxes or use charge.

The standard of need is based on the tables in 469-000-211.

3-004.01A Alternate Living Arrangements: The standard of need for alternate living arrangements is a consolidated allowance for items necessary for basic subsistence. Included in this standard are -

1. Board;
2. Room;
3. Clothing;
4. Personal needs;
5. Laundry;
6. Transportation; and
7. ~~Medical and remedial services (The consolidated standard of need for board and room [see 469 NAC 3-004.01A2] and licensed boarding homes [see 469 NAC 3-004.01A3] includes items 1 through 6 but does not include remedial services.)~~

Any items or needs required by licensing requirement, covered by Medicaid or other insurance or sources, or available from the alternate care facility as a courtesy to residents are not part of the standard of need. If a need arises which is not provided to the individual by the alternate care facility or by another means, consideration may be given to including an additional allowance according to 469 NAC 3-004.03, Special Requirements. (this excludes needs or item required by licensing requirements, covered by Medicaid or other insurance or sources, or available from the alternate care facility as a courtesy to residents).

If a client enters an alternate care facility and it appears that s/he may be able to return home, the cost of rent or home ownership and/or utilities may be allowed in accordance with the guidelines in 469 NAC 3-006.02B502A.

3-004.01A1 Licensing of Facilities: In determining the appropriate standard to be allowed, the worker shall verify the current licensure/certification of the facility. If the facility is covered under more than one licensure/ certification, the worker shall verify in which section the client is residing and which licensure/certification applies.

Nebraska law directs NHHSS and other public and private agencies whothat arrange and supervise living arrangements to report any facility which is not currently licensed and serves more than three individuals. The worker shall contact the Division in Central Office, Aged and Disabled Services responsible for licensing, if an unlicensed facility is identified.

3-004.01A2 Board and Room: Board and room does not include care or supervision and may be with a relative.

In addition to the actual amount of board and room paid, the client is allowed a personal needs allowance. The total allowance must not exceed the standard for Board and Room (see 469-000-211).

{Effective 1/9/2000}

3-004.01A3 Licensed Boarding Home: Boarding homes provide the following to four or more individuals who are essentially capable of managing their own affairs:

1. Sleeping and other living accommodations;
2. A dining room, cafe, or common kitchen; and
3. Domestic services requested by the individuals which will assist them in daily living activities.

If board and room is provided by the boarding home, the allowance is treated as board and room (see 469 NAC 3-004.01A2). If food is not provided by the boarding home, the appropriate standard of need plus the shelter allowance shown in 469 NAC 3-004.02A are allowed.

A non-licensed boarding home serving three or fewer is budgeted in the same manner.

3-004.01A4 Licensed Assisted Living Facility: An Assisted Living facility provides accommodation and board and care (e.g., personal assistance in feeding, dressing, and other essential daily living activities) for four or more individuals not related to the owner, occupant, manager, or administrator. These individuals are unable to sufficiently or properly care for themselves or manage their own affairs because of illness, disease, injury, deformity, disability, or physical or mental infirmity.

Individuals residing in Assisted Living facilities do not require the daily services of licensed, registered, or practical nurses. However, staff in an assisted living facility may assist the individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication.

The monthly standard for an Assisted Living Facility includes an allowance for personal needs of the client. (See 469-000-211 for the payment standard.)

{Effective 1/9/2000}

3-004.01A5 Certified Adult Family Home: An Adult Family Home is a residential living unit which provides full-time residence with minimal supervision and guidance to not more than three individuals age 19 or older. Service includes board and room with meals, standard furnishings, equipment, household supplies, and facilities to ensure client comfort. These individuals are essentially capable of managing their own affairs but are in need of supervision. This may include supervision of nutrition by the facility on a regular, continuing basis, but not necessarily on a consecutive 24-hour basis.

The monthly standard for an Adult Family Home includes an allowance for personal needs of the client. (See 469-000-211 for the payment standard.)

{Effective 1/9/2000}

3-004.01A6 Licensed Group Home for Children and/or Child Caring Agency (Formerly Group Homes for the Mentally Retarded): This group care facility provides 24-hour accommodation for minors including care and supervision. The home provides services to two or more individuals who are developmentally disabled.

The monthly standard for a Licensed Group Home for Children or a Child Caring Agency includes an allowance for personal needs of the client. (See 469-000-211 for the payment standard.)

{Effective 1/9/2000}

3-004.01A7 Licensed Center for the Developmentally Disabled: A center for the developmentally disabled is any facility, place, or building not licensed as a hospital which provides accommodation, board, training, and other services when appropriate, primarily or exclusively, for four or more persons who are developmentally disabled.

Staff in a center for the developmentally disabled may assist individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication.

The term "center" includes:

1. Group Residence - Any group of rooms located within a dwelling and forming a single habitable unit with living, sleeping, cooking, and eating facilities for 4 through 15 developmentally disabled persons.
2. Institution for the Developmentally Disabled - Any facility other than a skilled nursing facility or an intermediate care facility I or II where 16 or more developmentally disabled persons reside.

The monthly standard for a Licensed Center for the Developmentally Disabled includes an allowance for personal needs of the client. (See 469-000-211 for the payment standard.)

{Effective 1/9/2000}

3-004.01A8 Long Term Care Facility: The payment to a long term care facility includes an allowance for personal needs of the client which is determined by the licensure or certification of the facility where the client resides (see 469 NAC 3-004.01A ff.).

This facility may be considered for all alternate care standards. The maximum amount allowed is the Assisted Living standard (see 469-000-211 for the Assisted Living standard).

For a client living in a care facility, see 469 NAC 3-006.02B5.

{Effective 5/8/05}

3-004.01A9 Assisted Living Waiver: See 469-000-203 for the standard for an individual receiving Assisted Living Waiver services. The monthly standard includes an allowance for personal needs of the client.

{Effective 1/9/2000}

3-004.01A10 Licensed Mental Health Center: Mental health center means a facility where shelter, food, counseling, diagnosis, treatment, care, or related services are provided for a period of more than 24 consecutive hours to persons residing at the facility who have a mental disease, disorder, or disability.

3-004.01B AABD or SDP Standard of Need: The worker continues to use the standard of need for independent living and shelter costs or the consolidated standard for alternate living when SSI notifies the agency that the client will continue to receive full SSI payment for up to three months because the individual is likely to return to his/her previous living arrangement. The worker follows procedures in 469 NAC 3-006.02B5 for allowing shelter and/or utilities when:

1. SSI reduces or terminates the payment at the end of the three-month extension;
2. SSI determines that the client does not qualify for the full benefit for the three-month period; or
3. The client was not receiving SSI before admission to the medical facility.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the worker must use the standard of need which most accurately reflects the client's living arrangement (see 469 NAC 2-008.0302A).

{Effective 4/11/95}

3-004.02 Shelter: The item shelter includes rent and the expenses of home ownership.

If the client has gratuitously transferred the title for the home in which s/he is living, no allowance for shelter expense may be included. If the client retains a life estate in the home, see 469 NAC 3-004.02A2.

When an AABD/MA or SDP/MA client shares a household with other individuals who are not receiving categorical assistance, the AABD/MA or SDP/MA client is allowed the prorated share of the actual cost of shelter, up to the single shelter amount. If the client can provide verification that s/he is responsible for paying more than his/her prorated share, the actual cost up to the maximum may be allowed.

When AABD/MA or SDP/MA eligible clients live together in the same household in the combinations listed in 469 NAC 3-004.02A, item 2, their shelter allowance must not exceed the maximum multiple shelter amount (see 469-000-211).

{Effective 4/11/95}

3-004.02A Maximum Shelter Allowance: The worker uses:

1. The single shelter amount for one; or
2. The multiple shelter amount for:
 - a. A married couple who are living together;
 - b. An AABD/MA or SDP/MA parent living with a minor child; or
 - c. An AABD/MA or SDP/MA client living with other EP's whose needs are included in the budget.

~~(Clients who have Central Office approved shelter costs above the maximum before August 1, 1977, will be maintained at that level until the client moves.)~~

{Effective 4/11/95}

3-004.02A1 Rent: The allowance for rent should be sufficient to provide the family with decent quarters comparable to the standard for persons of modest circumstances in the same community (see 469-000-211).

{Effective 4/11/95}

3-004.02A1a Clients in Public Housing: When a client enters federally subsidized low-rent public housing from private housing, the budget must reflect the lowered rent amount. If the client is in public housing when s/he applies for assistance, the worker shall use the amount the client is responsible for paying at the time of application.

If the client remains in public housing and the shelter amount fluctuates, the budget must reflect increases in the shelter amount, but not decreases.

3-004.02A2 Home Ownership

3-004.02A2a Expenses of: Expenses of home ownership may be allowed if the client or spouse owns the home in which the client lives, provided the allowance does not exceed the maximum shelter limit allowed.

If the client or spouse has only a life interest in the home, the terms of the conveyance must be examined in determining whether the client or the titleholder is responsible for the expenses of home ownership. The case record must contain an explanation if an allowance is included in the budget.

3-004.02A2b Standards for Determining Costs: The cost of interest or payments on mortgages or contract purchases, current taxes, and insurance may be allowed in the assistance budget as follows:

1. Mortgage or Purchase Contract: Interest and payments on the mortgage or purchase contract on the home may be included in the budget.

2. Taxes: Current taxes on the home occupied by the client may be allowed on a monthly prorated basis unless the payment of taxes is included in the monthly payment on the mortgage or contract purchase.

Taxes may be allowed only for the lot(s) on which the house stands. No allowance may be made for taxes on other lots owned by the applicant unless the taxes cannot be determined separately from the taxes for the lot(s) on which the home is located.

If taxes have been allowed in an earlier budget but not paid, they may not be included in the budget again.

3. Insurance: The amount of the homeowner's insurance is included in the budget on a prorated or lump sum basis, unless insurance is a part of the payment on the mortgage or purchase contract.
4. Total Cost: The total cost of home ownership must not exceed the maximum shelter allowance.

3-004.03 Special Requirements: Special requirements are those that are essential because of the particular circumstances of an individual's situation. The inclusion of special requirements in the budget must be explained in the case record. In considering the need for a special requirement, the worker shall determine if the need is essential to the client's health and decency, and if the need could be met from another source. If the need is a one-time only expenditure, the worker shall consider whether the client has liquid assets available to totally or partially pay for the need. A trust that has been established for a disabled individual which has been excluded as a resource must be considered a resource for special needs. For procedures, see appendix 469-000-328.

{Effective 2/27/94}

3-004.03A Items That May Be Allowed as Special Requirements: The following may be allowed as special requirements in accordance with the provisions found at 469 NAC 3-004.03A-ff.:

1. Transportation;
2. Household furniture and appliances;
3. Expenses of moving;
4. Back taxes;
5. Subsistence to obtain medical care;
6. Maintenance for a service animal;
7. Guardian/conservator fee of \$10 per month;
8. Medical expenses of an EP;
9. Cost of home repair;
10. Automobile liability insurance; and
11. Lifelines.

{Effective 8/2/2000}

The local office may allow a special requirement differing in kind or in amount from those previously listed or allowed for in the standard of need or in the shelter allowance. The special requirement may be a one-time only need or an ongoing need. The client must provide documentation for the case record to verify the need for the expense in the budget. The worker must request prior Central Office approval on Form ASD-17 before allowing the expense in the budget.

3-004.03A1 Transportation: The cost of transportation may be allowed as a special requirement for obtaining medical services.

Transportation needs other than by the client's own car are referred to the social services unit on a Client Referral. If the social services unit returns the request stating it is unable to pay, the transportation cost must be allowed as a special requirement.

If public transportation is used, the cost for one attendant may be allowed if one is needed to accompany the client.

3-004.03A2 Furniture and Appliances: The cost of furniture and/or appliances is allowed if:

1. The unit lacks essential items; or
2. The items the unit has are no longer usable.

3-004.03A2a Payment Limits: Items may be either purchased or repaired if the cost is:

1. \$749.99 or less and the local office has given prior authorization;
or
2. \$750 or more and the Central Office has given prior authorization.

3-004.03A2b Installment Payments: If at the time of application, the client is making payments on an installment plan for new or used furniture or appliances, the worker must include an allowance to complete the payments, provided the cost is reasonable and the item(s) is needed.

3-004.03A3 Expense of Moving: The cost of moving personal belongings is included in the budget as a special requirement if the client is forced to move for reasons beyond the client's control, or if the move is made to obtain shelter at lower cost.

3-004.03A4 Back Taxes: Back taxes are allowed as a special requirement only if all of the following circumstances apply:

1. The individual would unquestionably lose the home if taxes are not paid;
2. The plan to remain in the home is preferred by the client and recommended by the worker; and
3. The taxes were not previously allowed as a shelter expense.

Back taxes, when allowed, may be paid in a lump sum or prorated.

3-004.03A5 Subsistence to Obtain Medical Care: The cost of meals and lodging is included in the budget when the expense is necessary to obtain approved health services and only if the client is away from home for 12 hours or more. The allowance for cost of meals is \$12 per day. Additionally, the cost of lodging will be allowed if reasonable and if receipts are provided by the client.

The \$12 allowance for cost of meals, plus the additional allowance for cost of lodging may also be provided for an attendant if one is needed to accompany the client.

Exception: Special requirements should not be used for meals and lodging if the facility is enrolled as an Ambulatory Room and Board provider.

3-004.03A6 Maintenance of a Service Animal: An allowance for medical or maintenance expenses for a service animal is included when there is a physician's statement that the client requires a service animal. A service animal is defined as a guide dog, signal dog, or another animal that is individually trained to provide assistance to an individual with a disability. For the amount of the allowance, see 469-000-211.

{Effective 8/2/2000}

3-004.03A7 Guardian/Conservator Fee: An allowance is included when a client has a court-appointed conservator or guardian. The actual fee or an amount not to exceed \$10 a month is allowed. The allowance may be removed if it is documented in the case record that the guardian or conservator does not wish to receive the \$10 allowance.

If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the actual amount approved by the court for these expenses may be allowed. The amount allowed by the court for the guardian/conservator's own expenses (in excess of \$120) may also be allowed as a special requirement. See 465 NAC 2-008.06 for attorney's fees.

3-004.03A8 Medical Expenses of an EP: If the client provides verification of payment of a medical bill or health insurance premium (except for income-producing policies) for an EP included in the budget, an amount up to the total monthly countable net earned and unearned income, including SSI, may be allowed. The EP must have incurred the medical bill since the client became eligible for assistance.

3-004.03A9 Home Repair: An allowance may be made for the cost of home repair if the client owns and occupies his/her home and the repair is considered essential to the occupancy of the home. If the cost of the repair exceeds \$1000, the worker shall submit a request (e.g. Form ASD-17) to the Central Office with the necessary documentation describing the repair and cost.

3-004.03A10 Automobile Liability Insurance: An allowance may be made for the cost of automobile liability uninsured and underinsured insurance required by state law. If the cost is \$274.99 or less for a six-month premium, the local office may approve the special requirement. If the cost is \$275 or more, the worker shall submit Form ASD-17 to the Central Office with the necessary documentation.

{Effective 12/17/95}

3-004.03A11 Lifelines: An allowance may be made for the installation and ongoing monthly fees for lifeline telephone service.

3-004.03B Items That Are Not Allowed as Special Requirements: The following items are not allowed as special requirements:

1. Personal computers because they are considered a vocational rehabilitation and educational item;
2. Smoking cessation programs because there are no national standards or official oversight of these programs. Guaranteed one time, long term smoking cessation success is not demonstrated by current programs;
3. Health club memberships and exercise or fitness equipment because these are related to weight loss and rehabilitation and essential components to assess the success of the individual program and to monitor the client's progress are unavailable;
4. Weight loss programs because there are no national recommendations and standards for these programs. Safety and efficacy issues are unresolved on the national level with no Federal Department of Agriculture or official oversight of this industry. Essential components for individualization for each person's special circumstances are not available;
5. Lawn care service, snow removal, and the equipment and supplies for them; and
6. Medical services and goods which are not covered by ~~the Nebraska Medical Assistance Program~~ Medicaid because of limits on amount, scope, or duration established by the Director of NDHHS Department.

3-006 Budget Computation

3-006.01 Budgeting Process for Clients Not Receiving SSI (Including Clients Determined Eligible for 1619(b) Status by SSI): The budget process for determining eligibility for and amount of assistance payment is completed on ~~Form IM-25~~, through the DHHS designated electronic system. The worker determines the budgetary need by comparing the monthly requirements of the unit to its net monthly income. To determine need, the worker shall -

1. Compute available net income;
2. Compute total requirements for the unit size; and
3. Measure all net income against total requirements. If the income is not sufficient to meet the total requirements, the difference is the budgetary need. If the income is sufficient to meet the client's total requirements, the client does not have a budgetary need. Close the payment case and if SDP Medicaid is applied for, then pend a Medicaid case. For SDP medical assistance, determine if there is a need for medical assistance using Form DA-3M or DA-4M and the criteria in Chapter 4-000. If the client has been determined eligible for 1619(b) status by SSI, it is not necessary to complete Form DA-3M (see 469 NAC 4-001.04)-the Medicaid eligibility is handled by MLTC.

Payment may begin no earlier than the month of application and no later than the month following the month of application if all eligibility requirements are met.

If at any time factors change that affect the budget, the worker shall recompute the budget.

3-006.01A AABD Payment Budgeting Process for Clients Receiving SSI: The budget for clients who are receiving SSI is completed on ~~Form IM-25~~, through the DHHS designated electronic system. To determine need, the worker shall -

1. Compute only the following available net income. This income is not allowed the \$20 general income disregard:
 - a. Income of non-spouse Essential Persons;
 - b. Veteran's Aid and Attendant benefits; and
 - c. Income allocated from another assistance unit (see 469-000-305);
 - d. Income of an ineligible spouse not used by SSI in the calculation of the client's SSI payment. SSI disregards the deemed income if it is less than the difference between the federal benefit rate for an individual and a couple. SSI calculates the SSI payment based on the federal benefit rate for an individual.
Exception: Do not include VA benefits of the ineligible spouse which are disregarded by SSI, see 469 NAC 2-006.01.
2. Determine total requirements based on the unit size; and
3. Measure net income (identified in number 1) against total requirements. If there is no budgetary need and the -

- a. Income and resources of a non-spouse essential person were included, remove income and needs of the EP from the budget and recalculate; or
- b. ~~If Veteran's Aid and Attendant benefits or income allocated from another assistance unit were included, determine eligibility for medical assistance (see Form DA-3M instructions, PAF 4-1).~~

3-006.01A1 Calculation of State Supplemental Payment: If it is determined that the client has a budgetary need and the client is receiving SSI, the computer automatically subtracts the SSI Federal Benefit Rate from the budgetary need to determine the amount of state supplemental payment. If the SSI Federal Benefit Rate is greater than the budgetary need, ~~the client is considered a grant case but does not receive a state supplemental payment~~ deny and close the case. (see 469 NAC 2-010.01B2b).

For a blind client receiving SSI who has earned income in the earned income field, N-FOCUS automatically adds \$20 to the warrant amount (see 469 NAC 2-010.01E1b(2)).

3-006.01A2 Budgeting Individuals in Long Term Care for Three Continuous Months: The worker shall use non-SSI budgeting procedures for individuals in long term care when SSI does not make a change in living arrangement at the end of three full continuous months and income exceeds the FBR for a single individual in an institution (see 469-000-207).

{Effective 4/11/95}

3-006.01B Deductions for Medical Insurance: Standards in 469 NAC 3-000 do not allow for deductions for medical insurance premiums, i.e., private policies, Medicare, etc., ~~on Form IM-25.~~ In in the AABD budget. Therefore, if an insurance premium is being deducted from the client's unearned income, the worker shall add the premium amount back in to arrive at the correct amount to show ~~on Form IM-25~~ in the AABD budget (see 469 NAC 2-010.01B2a). ~~Form DA-3M,~~ The SDP medical budget, which is computed based on standards in 469 NAC 4-000, can reflect medical insurance deductions (see 469 NAC 4-006.01).

~~3-006.01C Buy In of Part B: A client is eligible for state payment of Medicare Part B premium (buy in) if his/her income is equal to or less than 135% of the federal poverty level.~~

~~For Medicare beneficiaries (SLMB or Q1-1) who only receive Part B, see 469 NAC 7-000.~~

3-006.02 Persons Included in the Budget: The assistance budget is computed to determine the need of a client for assistance. Consideration must be given to the fact that presence in the home of other persons may be essential to the well being of the client and affect his/her need (see 469 NAC 1-004). The individual requirements of these EP's may be included in the budget of the client. EP's in the home may include the spouse, minor or adult children, grandchildren, parents, sisters, or brothers. The decision of whether an individual is essential to the client rests with the client. An ~~individual~~individual, who is considered a spouse by SSI, even though s/he is not married to the client, is considered an EP in the AABD budget. The EP is not eligible for assistance in his/her own right. If the couple has completed a designation of resources and protected resources above the resource limit for two persons, the income and needs of the community spouse are not included in the payment budget.

The needs of an ineligible spouse are not included as an EP in the client's budget if the ineligible spouse is receiving Veterans benefits based on need that SSI is disregarding in determining the client's SSI.

The needs of an EP may be included in the budget to determine eligibility for payment. When an EP has been included in the client's budget, their combined income and resources must not exceed standards (see 469 NAC 2-009.08 and 3-004.01B).

If an EP included in the budget has no other means of meeting medical needs and is not eligible for ~~MA~~Medicaid in his/her own right, see 469 NAC 3-004.03A8.

If there is no budgetary need, close the case and the worker must determine SDP medical eligibility for ~~MA~~ or ~~MA~~ with Share of Cost using the appropriate income level in 469 NAC 4-007. The appropriate maintenance level for ~~MA~~SDP ~~is~~medical is determined by considering the client(s) and the EP only if the EP is the spouse or minor child.

If the ineligible parent(s) of a minor AABD/~~MA~~ or SDP/~~MA~~ client does not have income which has been considered for deeming purposes, his/her needs may be included in the minor's budget if it has been determined that the parent's continued presence in the home is necessary for the child's well-being. If the parent has income which is being considered for deeming, his/her needs have already been recognized in this process (see 469 NAC 2-010.01F). If a parent's needs have been removed from an ADC/~~MA~~ unit for noncooperation (i.e., Employment First/employability or child support), his/her needs may not be included in the AABD/~~MA~~ or SDP/~~MA~~ child's budget.

{Effective 8/18/03}

3-006.02A Potential Assistance for Essential Persons (EP's): The worker must explore the possible eligibility for assistance of other EP's and require them to apply for any assistance for which they appear to be eligible (see 469 NAC 2-010.01B6 and 2-010.01B6a).

3-006.02B Determining Total Requirements: In determining the amount of the individual requirements in the following subparts, living independently includes rent, allowances for the cost of home ownership, and the cost of a room when the client is living in a boarding home and paying room only. Alternate living arrangements include board and room, licensed boarding homes, assisted living, certified adult family homes, licensed group homes for children and/or child caring agencies, and centers for the developmentally disabled.

Care facilities include nursing homes and public institutions for the treatment of mental diseases and/or mental retardation/developmental disabilities.

The following regulations discuss budgeting procedures for these living situations:

1. 469 NAC 3-006.02B1 Living Alone;
2. 469 NAC 3-006.02B2 Living With EP's;
3. 469 NAC 3-006.02B3 Living With Clients With Relative Responsibility;
4. 469 NAC 3-006.02B4 Living With Persons With No Relative Responsibility;
and
5. 469 NAC 3-006.02B5 Allowance While Living in a Care Facility.

3-006.02B1 Living Alone

3-006.02B1a Living Independently: The budget of an AABD/MA or SDP/MA client who is living alone in an independent living situation shows:

1. The standard of need for one (see 469-000-211);
2. The actual shelter expense up to the single shelter amount (see 469-000-211); and
3. Special requirements, if applicable (see 469 NAC 3-004.03).
{Effective 4/11/95}

3-006.02B1b Living in an Alternate Living Arrangement: The budget of a AABD/MA or SDP/MA client who is living alone in an alternate living arrangement shows:

1. The standard of need for the alternate living situation (see 469-000-211); and
2. Special requirements, if applicable (see 469 NAC 3-004.03).
{Effective 4/11/95}

3-006.02B2 Living With EP's

3-006.02B2a Living Independently: The budget of an AABD/MA or SDP/MA client who is living with EP's in an independent living situation shows:

1. The standard of need for the client plus EP's (see 469-000-211);
2. Actual shelter expense paid up to the multiple shelter amount (see 469-000-211); and
3. Special requirements, if applicable for the client and EP's (see 469 NAC 3-004.03).

{Effective 4/11/95}

3-006.02B2b Living in a Board and Room Arrangement: The budget of an AABD/MA or SDP/MA client who is living with EP's in a board and room arrangement shows:

1. Board and room as paid plus an allowance for personal needs up to the maximum for the client and EP (see 469-000-211); and
2. Special requirements, if applicable, for the client and EP's (see 469 NAC 3-004.03).

{Effective 4/11/95}

3-006.02B3 Living With Clients With Relative Responsibility: When the AABD/MA or SDP/MA client is living with an eligible individual for whom there is relative responsibility (see 469 NAC 2-006), payment is computed according to the guidelines in the following subparts.

3-006.02B3a Client and an Eligible Spouse

3-006.02B3a(1) Spouse on AABD/MA or SDP/MA: The needs of the eligible AABD couple who are living together (independently or in an unlicensed board and room) are shown on the same budget form and the payment is divided equally.

3-006.02B3a(1)(a) Living Independently: When the couple is in an independent living situation, the budget must show:

1. The standard of need for two (see 469-000-211);
2. Actual shelter expense paid up to the multiple shelter amount (see 469-000-211); and
3. Special requirements for each, if applicable (see 469 NAC 3-004.03).

{Effective 4/11/95}

3-006.02B3a(1)(b) Living in Board and Room Arrangement: When the couple is in an unlicensed board and room arrangement, the budget must show:

1. The actual amount of the board and room up to the maximum for the AABD/MA or SDP/MA client and the AABD/MA or SDP/MA spouse (see 469-000-211); and
2. Special requirements for an AABD/MA or SDP/MA client and/or an AABD/MA or SDP/MA spouse (see 469 NAC 3-004.03).

{Effective 4/11/95}

3-006.02B3a(2) Spouse on ADC/MA or CMAP or Refugee Resettlement Program (RRP): If an AABD/MA or SDP/MA client lives with a spouse who is receiving ADC/MA or RRP/MA, the budgets must be computed separately. Neither the needs nor the income of the ADC/MA or RRP/MA client may be considered in the AABD/MA or SDP budget.

{Effective ———}

3-006.02B3a(2)(a) Living Independently: When the couple is in an independent living situation, the budget for the AABD/MA or SDP/MA client will show:

1. The prorated share of the standard of need based on the total number in the case-(see 469-000-211);
2. The prorated share of the shelter allowance up to the multiple shelter amount based on the total number in the case (see 469-000-211); and
3. Special requirements, if applicable (see 469 NAC 3-004.03).

{Effective 5/11/99}

3-006.02B3a(2)(b) Living in an Alternate Living Arrangement: When the AABD/MA or SDP/MA client is in an alternate living arrangement, the budget for the AABD/MA or SDP/MA client will show:

1. The standard of need for the appropriate alternate living arrangement (see 469-000-211); and
2. Special requirements, if applicable (see 469 NAC 3-004.03).

{Effective 4/11/95}

3-006.02B3b Living With an Eligible Minor Child or Parent: If a client lives with an eligible minor child or parent (i.e., an AABD/MA or SDP/MA parent and an ADC/MA, AABD/MA, or SDP/MA, or CMAP child) the budgets are computed separately. ~~If the AABD/MA or SDP/MA client lives with an eligible minor child who is receiving CMAP, see 469 NAC 3-006.02.~~

If the AABD/MA or SDP/MA client lives with his/her minor child who is self-supporting, see 469 NAC 3-006.02B4a.

~~Note: The same budget treatment is used when an AABD child is living with a parent who is receiving SDP/MA, AABD/MA, or ADC/MA.~~

3-006.02B3b(1) Living Independently: When the client and the eligible child are in an independent living situation, the budget for each must show:

1. The prorated share of the standard of need based on the total number in the case (see 469-000-211);
2. The prorated share of the actual shelter paid up to the multiple shelter amount based on the total number in the case (see 469-000-211); and
3. Special requirements, if applicable (see 469 NAC 3-004.03).

~~Note: Parents are held financially responsible for their children through age 17 for AABD Payment and SDP, and through age 18 for CMAP.~~

{Effective 5/8/05}

3-006.02B3b(2) Living in an Alternate Living Arrangement: When the AABD/MA or SDP/MA client(s) is in an alternate living arrangement, the budget for each AABD/MA or SDP/MA client must show:

1. The standard of need for the appropriate alternate living arrangement (see 469-000-211); and
2. Special requirements, if applicable (see 469 NAC 3-004.03).

{Effective 4/11/95}

3-006.02B4 Living With Persons With No Relative Responsibility: Only the needs of the client are considered in the budget when the client is living with other individuals for whom there is no relative responsibility (see 469 NAC 2-006).

3-006.02B4a Living with Self-Supporting Individuals with No Relative Responsibility: If a client is sharing a household with a self-supporting individual for whom the client has no relative responsibility (see 469 NAC 2-006), the budget is computed:

1. On a board and room basis, if the client is required to pay board and room (see 469-000-211);
2. On an expense-sharing plan when in an independent living arrangement using:
 - a. The standard of need for one (see 469-000-211);
 - b. Shelter costs (not to exceed the maximum) determined by:
 - (1) The prorated share of total shelter costs based on the number of persons in the case (see 469-000-211) not to exceed the maximum single shelter amount; or
 - (2) The actual amount of shelter paid up to the single shelter amount if the client can verify that s/he pays an amount other than the prorated share; and
 - c. Special requirements, if applicable (see 469 NAC 3-004.03).
{Effective 5/11/99}

3-006.02B4b Living with Other Clients with No Relative Responsibility: The budget of an AABD/MA or SDP/MA client living in the same household with other clients for whom the AABD/MA or SDP/MA client has no relative responsibility (see 469 NAC 2-006) is computed according to instructions in 469 NAC 3-006.02B4b(1) and 3-006.02B4b(2).

If an AABD/MA or SPD/MA client lives in the same household with an ADC/MA client, the AABD/MA or SDP/MA client's budget must be computed separately. Neither the needs nor the income of any ADC/MA-client in the household may be considered in the AABD/MA or SDP/MA budget.

3-006.02B4b(1) Independent Living Arrangement: When the AABD/MA or SDP/MA client is in an independent living arrangement, the budget will show:

1. The standard of need for one (see 469-000-211);

2. The prorated share of total shelter costs based on the number of persons in the case not to exceed the single shelter amount (see 469-000-211); and
3. Special requirements if applicable (see 469 NAC 3-004.03).

{Effective 5/11/99}

3-006.02B4b(2) Living in a Board and Room Arrangement: When the AABD/MA or SDP/MA client is in a board and room or boarding home arrangement, the budget will show:

1. Board and room as paid plus personal requirements up to the maximum (see 469-000-211); and
 2. Special requirements, if applicable (see 469 NAC 3-004.03).
- {Effective 4/11/95}

3-006.02B5 Client Living in a Care Facility: The budget of a client living in a care facility shows:

1. The standard of need for ~~Form IM-25~~ the correct living arrangement (see 469-000-211); and
2. An amount up to \$10 when the client has a guardian or conservator who requests a fee (see 469 NAC 3-004.03A7).

The expense of home ownership and/or utilities may be allowed only until it is apparent that the client cannot live there again (not to exceed six months). The budget may also allow for the expense of rent and/or utilities for up to six months. The total time for either allowance must not exceed six months. The allowances must not exceed the maximum shelter amount for one (see 469-000-211) if the client does not have a spouse.

Exception: See 469 NAC 3-004.01B for budgeting a client who continues to receive full SSI benefits for up to three months.

Note: If a client in an alternate care facility goes to a care facility, the worker must continue to budget the alternate care standard until it is apparent that the client will not return to the alternate care facility (not to exceed two months). If the client remains in the care facility beyond two months, Central Office approval is required via a Question Referral in order to continue using the alternate care standard.

{Effective 4/11/95}

3-006.02B6 AABD/MA or SDP Child Living with Self-Supporting Parents: If an AABD/MA minor child lives with a self-supporting parent(s), the child's budget will show -

1. The prorated share of the standard of need based on the total number in the case (see 469-000-211).
2. The prorated share of the actual shelter paid up to the multiple shelter amount (see 469-000-211); and
3. Special requirements, if applicable (see 469 NAC 3-004.03).
{Effective 4/11/95}

3-007 Payments for Assistance

3-007.01 Non-Restricted Payments: AABD or SDP assistance payments are ~~money~~grant payments to the client, conservator, guardian, or individual acting under a duly executed power of attorney without restrictions as to the use of the funds.

3-007.02 Protective Payments: Protective payments may be made on behalf of a client who has a physical or mental impairment which causes an inability to manage AABD or SDP payments.

3-007.02A To a Guardian, Conservator, or Duly Executed Power of Attorney: If an AABD/MA or SDP client has a guardian, conservator, or individual acting under a duly executed power of attorney, AABD or SDP payments may be made to the appointed person on behalf of the client. Certified copies of the letter of guardianship, conservatorship, or power of attorney are filed with the local office.

3-007.02B To a Protective Payee: Protective payments may be made on behalf of a client who has a physical or mental impairment which causes an inability to manage AABD or SDP payments.

3-007.02B1 Supportive Evidence: The determination of the need for protective payments must be substantiated by a ~~physican's~~physician's statement or medical report of condition.

The case record must contain documentation of the reason protective payments were selected in lieu of guardianship or conservatorship.

3-007.02B2 Selection of Payee: The client and worker shall jointly select the payee when possible. The payee must be an individual who can visit the client on a regular basis to discuss financial matters.

Protective payees may include relatives, friends, clergy who have a concern for the well-being of the client, or adult foster home sponsors (when recommended by the social services worker).

The payee must not be -

1. A local office administrator;
2. An HHS employee who determines financial eligibility for the client in question;
3. Landlords, grocers, or other vendors of goods and services dealing directly with the client; or
4. The operator of an alternate care facility.

3-007.02B2a Service Provider: The worker must obtain Central Office approval before a service provider who contracts with the Department may act as protective payee for a client s/he serves.

3-007.02B3 Responsibilities: The protective payee is responsible for:

1. Paying maintenance needs from the grant (i.e., rent, utilities, food, clothing, etc.);
2. Explaining to the client how the grant will be spent;
3. Keeping records of payments received and disbursements made of funds; and
4. Treating confidentially all personal information concerning the family.

3-007.02B4 Fair Hearing: The client must be given the opportunity to appeal the initial decision or continuance of protective payments and the choice of the protective payee.

3-007.03 Erroneous State Supplement Payments

3-007.03A Underpayments: If a state supplement payment is made for an amount less than the amount the client was entitled to receive, a correction must be made. Retroactive corrective payments may be made for the 12 months preceding the month in which the underpayment is discovered. State supplement payments made to correct an underpayment are not considered income or a resource in the month paid or the month following the month paid.

3-007.03B Overpayments

3-007.03B1 Identification of an Overpayment: There are two types of overpayments:

1. Administrative errors: Worker errors caused by inaccurate computation or the worker's failure to take action; and
2. Client errors: Errors caused because the client supplies inaccurate or incomplete information or fails to provide information resulting in an overpayment.

All overpayments, regardless of cause, must be recouped.
{Effective 2/14/09}

3-007.03B2 Recoupment of Overpayments: If a state supplement payment is made for an amount greater than the amount the client was entitled to receive the overpayment is recouped by reducing current state supplement payments by at least ten percent.

The worker must first send a demand letter, giving the client the choice of reimbursing all or part of the overpayment or having future assistance reduced. If the client reimburses part of the overpayment, the remainder must be recouped by grant reduction. The worker must allow the client ten days to respond to the demand letter. If the client requests recoupment within the ten days, the worker must take necessary action at that time. If the client does not respond within ten days, the worker must begin recoupment procedures in the first month possible, taking into account adequate and timely notice.

Recoupment is limited to the amount of overpayment which occurred in the 12 months preceding the month in which the overpayment was discovered. If the overpayment occurred before the 12-month time limit, no action may be taken.

In cases of suspected fraud, the social service worker must refer the case to the Special Investigation Unit, Central Office, or in the Omaha Office, to the Omaha Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker must take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker should complete normal case actions. Normal case actions include closing a case that is found to be ineligible and recovering overpayments.

3-007.04 Case Records: The case records of the AABD/MMA or SDP/MMA client must be complete and contain facts to substantiate each action with respect to assistance payments. Case records must be retained for four years from the closing of the case.

3-007.05 Fraud: See 465 NAC 2-007-ff.

CHAPTER 4-000 NEBRASKA MEDICAL ASSISTANCE PROGRAM (NMAP): NMAP STATE DISABILITY PROGRAM – MEDICAL (SDP Medical): SDP medical provides medical care and services to those who do not have sufficient income to meet their medical needs and who qualify according to the program definitions as aged, blind, or disabled; but only if they have also had their SSA disability application denied due to lack of duration; but, determined blind or disabled by the DHHS designated medical consultant reviewer.

All references to medical in this Chapter refer to the State Disability Program cases only. All other medical eligibility guidelines are found in Title 477 NAC.

4-001 Eligibility Categories

4-001.01 SDP Medical Individuals Eligible for Assistance Grant and Medical Assistance (MA): The following individuals are eligible for MA without a separate eligibility determination:

1. Individuals who receive a payment from AABD/MA or SDP/MA; and
2. ~~Individuals who would receive a payment from AABD/MA if the SSI payment did not exceed the budgetary need~~ have been denied disability by SSA due to lack of duration but found disabled by the medical consultant review and meet all other SDP eligibility criteria except eligibility for a grant; or
2. Individuals who receive a payment for SDP are eligible for Medicaid without a separate determination.

{Effective 4/11/95}

4-001.02 Individuals Ineligible for SDP Assistance Grant Payment But Eligible for SDP MA Medical Only: Individuals who have income or resources in excess of the budgetary standards for AABD or SDP grants (see 469 NAC 3-000 ff.) are ineligible for an assistance grant; but must be reviewed for SDP Medical. The eligibility criteria for SDP Medical are the same as for AABD and SDP payments, with the exception of income and resource standards to be used if over the income or resource standards for a grant.

{Effective 4/11/95}

4-001.02A Emergency Medical Services for Aliens: Aliens who are not lawfully admitted for permanent residence in the United States, or are not granted temporary resident status under P.L. 99-603 are eligible for medical assistance for payment of emergency medical services if the following conditions are met:

1. ~~The alien has the sudden onset of a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) where the absence of immediate medical attention could reasonably be expected to result in-~~
 - a. ~~Serious jeopardy to the patient's health;~~
 - b. ~~Serious impairment to bodily functions; or~~
 - c. ~~Serious dysfunction of any bodily organ or part; and~~

~~2. The alien meets all eligibility requirements in 469 NAC 2-000 ff. except:~~

- ~~a. Citizenship and alien status (see 469 NAC 2-002);~~
- ~~b. Referral to SSA for determination of blindness or disability (see 469 NAC 2-007.03A). The SRT completes the review of blindness or disability (see 469 NAC 2-007.03B); or~~
- ~~c. Referral to SSI for potential income (see 469 NAC 2-010.01B6c(1)).~~

~~The determination that the client has an emergency medical condition in accordance with the guideline in number 1 and the review of blindness or disability is the responsibility of the State Review Team (SRT). The worker must submit current medical information (Form DM-5 and/or a narrative report) and Form DM-12D to the SRT. The SRT uses Form DM-5R to report to the worker the determination of medical emergency and the date by which this must be reviewed.~~

~~4-001.02B Eligibility of Family Members: The Medicaid eligibility of each family member must be determined based on the family's total countable income. The family's income is compared to the appropriate income standard for a family of that size. The worker must determine the eligibility of:~~

- ~~1. Uninsured children at an income level no greater than 185% of the Federal Poverty Level;~~
- ~~2. Insured children at an income no greater than the appropriate Federal Poverty Level determined by the child's age;~~
- ~~3. Adults using income standards no greater than the applicable medical categorical eligibility standards established by federal or state law.~~

~~For further explanation and examples, see 469-000-305.~~

4-001.03 (Reserved)

~~4-001.04 Blind or Disabled Recipients Eligible for MA: A blind or disabled recipient who has earned income is eligible for MA without regard to share of cost if s/he meets the guidelines in 469 NAC 4-001.04A or 4-001.04B. If a blind or disabled person reaches the age of 65, SSA may continue 1619(b) eligibility.~~

~~4-001.04A Current and Former SSI Recipients: A blind or disabled recipient who has earned income is eligible for MA without share of cost if s/he:~~

- ~~1. Received MA in the month before the month in which this reference applies and continues to receive SSI (regular SSI payments or special SSI payments under section 1619(a) of the Social Security Act); or~~
- ~~2. Received MA and SSI in the month before the month in which this reference applies and whose SSI payment stopped due to the level of earnings and who is determined by SSA to have special Medicaid status under section 1619(b) of the Social Security Act. The 1619(b) status can be verified from the State Data Exchange (SDX6, Special Medicaid Status field).~~

~~It is not necessary to compute Form DA-3M.~~

~~If SSA reviews the client's disability and determines that s/he is no longer disabled, the case must be closed in the first month possible considering the ten-day notice requirement.~~

~~4-001.04B Former AABD State Supplemental Payment (SSP) Recipients: A blind or disabled recipient who has earned income is eligible for MA without excess income if s/he:~~

- ~~1. Received an AABD state supplemental payment and MA (but not SSI) in the month before the month in which this reference applies;~~
- ~~2. Except for earnings continues to meet all of the eligibility requirements for AABD and has unearned income less than the AABD standard of need;~~
- ~~3. Continues to be blind or have a disabling impairment as determined by the State Review Team (SRT);~~
- ~~4. Would be seriously inhibited from working without medical assistance; and~~
- ~~5. Has earned income in an amount insufficient to provide the same level of benefits available from SSP, MA, and Title XX attendant care. The income threshold used by SSA for purposes of determining eligibility for 1619(b) status will be used for this determination.~~

~~It is not necessary to compute Form DA-3M.~~

~~The continuing blindness/disability review in number 3 must be completed before the end of the 12th month after this section applies, and annually thereafter. See 469 NAC 2-007.03B1, "Forms Necessary," to make the referral to the SRT for this review. The worker should note on Form DM-12D the client's status under this section.~~

4-002 Cooperation in Obtaining Health Insurance: As a condition of eligibility for MASDP, a client is required to enroll in an available health plan if the Department has determined that it is cost effective and the client is able to enroll on his/her own behalf. The Department then pays the premiums, deductibles, coinsurance, and other cost sharing obligations.

4-003 Effective Date of SDP Medical Eligibility: If an individual is eligible for medical assistance one day of the month, s/he is eligible the entire month. The effective date of eligibility for MASDP Medical is determined as follows:

1. Prospective eligibility is effective the first day of the month of request if the client was eligible for MASDP Medical in that same month and had a medical need.

~~Exception: For AABD/MA or SDP/MA blindness/disability cases, the date of prospective eligibility begins-~~

- ~~a. With the first month of entitlement for SSI or the month of onset of a disability which is established for RSDI (when this date is after the month of request); or~~
- ~~b. The first day of the month in which the State Review Team determines disability to exist, when this date is after the month of request.~~

~~Prospective periods of eligibility for AABD/MA disabled cases not covered by an SSI/RSDI disability decision may be submitted to the State Review Team for a disability decision (see 469 NAC 2-007.03B ff.). The person must have a medical need and meet other eligibility criteria. The SDP Medical eligibility cannot begin prior to the start date of the disability as determined by the medical consultant review.~~

2. Retroactive SDP Medical eligibility is no earlier than the first day of the third month before the month of request date or application date if there is no request date, if the following conditions are met:
 - a. Eligibility is determined and a budget computed separately for each of the three months;
 - b. A medical need exists; and
 - c. Elements of eligibility are met for each month.

An applicant may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period.

~~Retroactive periods of eligibility for AABD/MA blind/disabled cases not covered by an SSI/RSDI disability decision may be submitted to the State Review Team for a disability decision. The individual must have had a medical need and have met other eligibility criteria during those months.~~

If the client was not eligible for one or more months of the retroactive period, the case must contain documentation of the ineligibility.

~~4-003.01 Six Months' Continuous Eligibility: Children from birth through age 18 are eligible for six months of continuous Medicaid from the date of initial eligibility unless:~~

- ~~1. The child turns 19 within the 6 months;~~
- ~~2. The child moves out of state;~~
- ~~3. The worker determines that the original eligibility was based on erroneous or incomplete information;~~
- ~~4. The child dies; or~~
- ~~5. The child enters an ineligible living arrangement (see 477 NAC 2-008.01).~~

~~No income or resource review is required.~~

~~For budgeting after the six months' continuous Medicaid, see 477 NAC 1-010.01.~~

Note: Newborn children for whom Medicaid paid for the birth are eligible to age one year.

{Effective 6/28/11}

4-004 Use of Medical Budget Form DA-3M for SDP medical: The worker uses Form DA-3M or N-FOCUS to determine eligibility for medical assistance only and medical assistance share of cost cases. If at any time factors change that affect the budget, the worker must recompute Form DA-3M or N-FOCUS, the budget. See 469-000-335 for medical budget periods and 469-000-305 for examples of medical budgeting procedures.

If the parent(s)' income has been deemed to the child, the medical expenses (including insurance premiums) of the parent(s) and any siblings for whom the parent(s) is responsible for paying medical expenses may be applied to the child's share of cost.

~~4-004.01 Use of Budget Form DA-4M: The worker uses Form DA-4M or N-FOCUS for an eligible spouse in a specified living arrangement and an ineligible spouse in the community (see 469 NAC 4-007.01 ff.).~~

~~Side 2 of Form DA-4M is used to calculate the amount of income (if any) to be allocated from the eligible spouse to the ineligible spouse and/or family members.~~

~~Side 1 of Form DA-4M is used to calculate eligibility for medical assistance only or medical assistance with share of cost for the eligible spouse.~~

4-005 Treatment of Resources for SDP Medical: For the treatment of resources, the criteria outlined in 469 NAC 2-009 are used. The application for an individual who has excess resources other than real property may be held pending until the resources are reduced. For the liquidation of real property, see 469 NAC 2-009.07B4. Excess resources may be reduced by paying obligations for medical costs. SDP Medical eligibility begins with the first day of the month of the incurred obligation which was used to reduce the resources to the allowable maximum (see 469 NAC 2-009.11). Medical eligibility may not be established earlier than the three-month retroactive period.

4-005.01 Maximum Available Resource Levels: The established maximum for available resources which the client, or the client and responsible relative, may own and still be considered eligible for MASDP Medical, according to unit size, are as follows:

1. One member unit - client only \$4000
If a couple has a valid designation of resources and -
 - a. There is an eligible spouse and an ineligible spouse, the resource level for the eligible spouse is \$4,000; or
 - b. The ineligible spouse later becomes eligible, each spouse is allowed \$4,000.

2. Two member unit - \$6000
 - a. Client and eligible spouse;
 - b. Client and ineligible spouse; or
 - c. Client and ineligible spouse who have designated resources but the client returns home or no longer is eligible for waiver services.

For procedures on designating resources, see 469 NAC 2-009.02C-ff. For determination of ownership of resources, see 469 NAC 2-009.03. For resource levels for grant, see 469 NAC 2-009.08.

If two or more related AABD/MA or SDP/MA clients (other than a married couple), i.e., an eligible AABD/MA parent and his/her eligible AABD/MA minor child or two or more unrelated eligible AABD/MA clients, reside in the same household, each client is entitled to a resource maximum of \$4000.

The treatment of resources of a spouse or a parent is the same as for a client (see 469 NAC 4-005-2-009).

If the total equity value of available non-excluded resources exceeds the maximums specified above, the client(s) is ineligible. Resources must be below the maximum resource level for one day in the month in order for the client to be eligible for that month.

4-005.01A Deeming Resources of a Parent: In considering the resources of a parent(s) who is not considered an EP towards an eligible child age 17 or younger and living in the parent's household, the following resources are considered to the child whether or not they are actually made available:

1. All resources exceeding \$4,000 in the case of one parent; or
2. All resources exceeding \$6,000 in the case of -
 - a. Two parents;
 - b. One parent and spouse of the parent; or
 - c. One parent and one minor sibling.
3. \$25 each additional minor sibling in the parent(s)' household.

Resource exclusions listed in 469 NAC 2-009.02B apply to the parent's resources. The resources of the eligible child's brothers and sisters are not considered towards the child.

Note: If income of a parent is not deemed according to 469 NAC 2-010.01F1, resources are also not deemed.

4-005.02 Resource Review: The amount of total resources determines how often verification is required. Verification is completed on the following schedule:

<u>Resource Total</u>	<u>One Person</u>	<u>Verification Frequency</u>
\$3,925 to \$4,000		Monthly
\$3,850 to \$3,924.99		Quarterly
\$3,500 to \$3,849.99		Semi-Annually
\$0.00 to \$3,499.99		Annually

<u>Resource Total</u>	<u>Two Persons</u>	<u>Verification Frequency</u>
\$5,850 to \$6,000		Monthly
\$5,700 to \$5,849.99		Quarterly
\$5,550 to \$5,699.99		Semi-Annually
\$0.00 to \$5,549.99		Annually

If a worker has reason to believe that at any time there has been an increase in resources which may affect eligibility all resources must be verified immediately.

A resource review is not required for SSI recipients.

{Effective 6/18/2001}

4-006 Treatment of Income: For treatment of income, use criteria outlined in 469 NAC 2-010-ff.

4-006.01 Disregards for Medical Budgets

4-006.01A Medical Insurance Disregards: In addition to disregards outlined in 469 NAC 2-010.01E1, the cost of medical insurance premiums is deducted (including Medicare if the individual is responsible for paying it) (see 469 NAC 3-006.01C).

The cost of premiums for policies that are not considered health insurance are not allowed as a deduction for medical budgeting (see 469 NAC 2-010.01B2d).

4-006.01B Guardian or Conservator Fee: The expense of a guardian or conservator fee is allowed as paid, up to a maximum of \$10 per month. ~~(see 469 NAC 3-004.03A7).~~ If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of \$120) may also be disregarded.

~~{Effective 6/18/2001}~~

~~4-006.02 For Client(s) in a Long Term Care Facility or Receiving Assisted Living Aged and Disabled Waiver Services: In addition to the maintenance allowance for long term care or the standard for Assisted Living, the following expenses are deducted:~~

- ~~1. Cost of homeownership up to six months (see 469 NAC 3-006.02B5);~~
- ~~2. Cost of rent expense up to six months (see 469 NAC 3-006.02B5); and~~
- ~~3. Guardian or conservator fee as paid, up to a maximum of \$10 per month (see 469 NAC 3-004.03A7). If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of \$120) may also be allowed as a special requirement.~~

~~{Effective 5/11/99}~~

4-006.032 Repayment of SDP Medicaid Benefits Provided in Error: When an error has occurred in the amount of SDP Medicaid benefits received by the client because of erroneously reported income or changes in income and/or private health insurance premiums (not Medicare), the worker shall send Form IM-64 requesting voluntary repayment in the following situations:

1. The client failed to report a change timely and the amount of benefits in error is \$76 or more;
2. The client reported a change timely but the worker failed to take action in the first month possible and the amount of benefits in error is \$251 or more; or
3. The client failed to report a change timely, the worker failed to take action in the first month possible, and the amount of benefits in error is \$251 or more.

In determining if there was an error in SDP Medicaid benefits and the period for which repayment should be requested, the worker shall keep in mind that the client is allowed ten days to report a change and must be given a ten-day notice of an adverse action. When repayment is requested, the worker should attempt voluntary restitution from the client effective with the first month that the worker should have correctly adjusted the budget.

Note: In cases of suspected fraud, the social service worker shall refer the case via Form ASD-63 to the Special Investigation Unit, Central Office, or in the Omaha Office, to the Omaha Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, the worker shall take no action with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, the worker should complete normal case actions, including closing a case that is found to be ineligible and recovering benefits received in error.

4-006.03A2A Amount of Benefits in Error: The amount of benefits in error for a client who was AABD grant or grantSDP grant/MA or SDP MA only but should have been MASDP MA with a Share of Cost, or who was SDP MA with a Share of Cost but who should have had a larger Share of Cost, is the smaller of -

1. The amount of Medicaid services received for that month; or
2. The amount of Share of Cost in error.

4-007 Standard Levels: Computing an SDP Medical Budget: if the client is eligible for SDP/MA only or SDP/MA with excess: ~~The standard used to determine eligibility for medical assistance is determined by the unit or family size. When computing Form DA-3M, the following individuals are considered in determining the unit or family size:~~

1. ~~Client; and~~
2. ~~Spouse.~~

~~When computing side 1 of Form DA-4M, only the client is considered in determining the medically needy or Federal Poverty income level.~~

~~If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the worker shall use the standard of need which most accurately reflects the client's living arrangement.~~

When computing an SDP medical budget, ~~or side 1 of Form DA-4M,~~ the worker uses the following steps to determine if the client is eligible for SDP/MA only or SDP/MA with excess:

1. Compare the client's net income to the percent of the Federal Poverty Level (FPL) (see 469-000-207). If the client's income is equal to or less than the FPL, the client is eligible for MA only. If the client's income is more than the FPL, go to step 2 to determine the amount of Share of Cost. For clients in long term care, go directly to step 2.
2. Subtract the medically needy income level from the client's net income to determine the amount of Share of Cost (see 469-000-203).

When a client enters long term care, the standard is not reduced to the long term care level or Assisted Living Waiver level until the first full month that the client resides in long term care-or at a later month if criteria in 3-004.01A are met.

4-007.01 Income When the Eligible Spouse Is in a Specified Living Arrangement and the Ineligible Spouse and/or Family Member(s) Is in the Community

4-007.01A Definitions

Community Spouse: A spouse who is -

1. Not applying for or receiving assistance;
2. Not residing with the alternate care spouse unless the alternate care spouse is in the home and eligible for Home and Community-Based Waiver Services; and
3. Not in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for the mentally retarded persons with developmental disabilities.

Family Members: Minor children residing with a community spouse, or dependent parents or siblings of the community spouse or alternate care spouse who reside with the community spouse and could be claimed as dependents for tax purposes.

Maintenance Allowance: The amount deducted from an alternate care spouse's income to meet the maintenance needs of the community spouse and family members.

Maintenance Need Standard: The income standard to which the community spouse's and other family members' income is compared for the purpose of determining the amount of allowance which may be made from the alternate care spouse's income.

4-007.01B Allocation of Income: When computing the SDP medical assistance budget for an alternate care spouse in a specified living arrangement, only his/her income (calculated on side 1 of Form DA-4M) is considered. Income of a community spouse is not considered available to the alternate care spouse. Some of the income of the alternate care spouse may be allocated to the community spouse and/or family members to bring their income up to a minimum monthly amount. The amount which may be allocated is computed on side 2 of Form DA-4M. If the community spouse does not provide verification of his/her income, Form DA-4M budget is not used. Form DA-3M budget would be used for the client and no allocation of the client's income would be made to the community spouse.

When allocated allowances are not made available to the community spouse, the worker shall not deduct these allowances from the client's income on side one of Form DA-4M. The worker shall deduct allowances for other family members even if the institutionalized spouse does not make these allowances available to the family members.

The alternate care spouse must be residing in one of the following living arrangements for these special budgeting procedures to apply:

1. A long term care facility;
2. An Adult Family Home;
3. A Licensed Assisted Living Facility;
4. A Center for the Developmentally Disabled; or
5. Receiving services in a Home and Community Based Service Waiver.

If the spouse no longer meets the definition of a community spouse, i.e., s/he enters a specified living arrangement, spousal impoverishment budgeting stops the first month possible considering adequate and timely notice.

These budgeting procedures apply beginning with the month an eligible spouse enters a specified living arrangement (even if it is a partial month) and cease with the first full month the alternate care spouse is no longer in a specified living arrangement. An assessment and designation of resources must be completed.

The community spouse or other family member(s) must not be on assistance if s/he is included in this budgeting procedure. They may be eligible for assistance in their own right, but may choose not to apply if this is to their benefit.

{Effective 5/8/05}

4-007.01C Determining Ownership of Income: The worker shall verify all income to determine the amount of the income and the individual in whose name the income is received. If payment is made in the name of both spouses, half is considered available to each spouse. The worker shall divide income by the number of payees if payment is made in the name of one or both spouses and a third party. Only the spouse's proportionate share is considered available to him/her. If income is paid to one spouse and a third party but the verification reveals that the income is intended for both spouses, the worker shall include both spouses in the division to determine the proportionate share.

If income does not specify either spouse, one-half of the amount is considered available to each spouse.

The client may appeal the assumption of ownership of income.

4-007.01D Determining the Family Member's Maintenance Need Standard: To determine each family member's need standard, the worker -

1. Takes the percent of the Federal Poverty Level (see 469-000-203);
2. Subtracts the family member's gross income; and
Note: SSI is included as income.
3. Divides the result by 3.

The worker does a separate calculation for each family member. This is calculated on side 2 of Form DA-4M.

4-007.01E Determining the Spousal Maintenance Need Standard: To determine the community spouse's need standard, the worker -

1. Takes the percent of the Federal Poverty Level (see 469-000-203); and
2. Adds excess shelter costs, if any.

Excess shelter cost is the amount by which the rent or cost of home ownership (e.g. mortgage, taxes, insurance, cooperative/condominium maintenance fees) plus a utility standard exceed the prescribed shelter limit. The worker shall allow a utility standard even if utilities are included in the rent. The worker shall not prorate shelter costs even if someone lives with the community spouse. If the community spouse is paying board and room, the worker subtracts the food stamp allotment for one from the actual board and room paid to determine shelter. See 469-000-203 for the utility standard and the shelter limit. This is calculated on side 2 of Form DA-4M.

4-007.01F Determining the SDP Maintenance Allowance: To determine the amount of income from the alternate care spouse that may be allocated to the community spouse and other family members, the worker -

1. Takes the family maintenance need standard;
2. Adds the spousal maintenance need standard; and
3. Subtracts the gross income of the community spouse. SSI is included. If the community spouse has self-employment income, the worker uses adjusted gross income (after deducting the cost of operation).

This is calculated on side 2 of Form DA-4M.

The spousal maintenance allowance must not exceed the maximum in 469-000-203. However, if a court has ordered the client to make support payments to the spouse in excess of the maximum, the court order takes precedence over the maximum.

The worker shall notify the couple on Form IM-8 of the actual amount of the maintenance allowance, if any, which is being deducted from the alternate care spouse's income.

The couple may appeal the maintenance allowance. To support an increase in the maintenance allowance, either spouse must establish that the community spouse needs income above the maintenance allowance because of exceptional circumstances resulting in significant financial duress. If the couple wins their appeal, the community spouse may reserve more than the maximum maintenance allowance.

4-007.01F1 Income Provisions: The worker includes all income in the calculation, including SSI and income of minors. If the primary income - RSDI, SSI, earnings, etc., - is equal to or exceeds the maintenance need standard, the worker does not need to verify other income. The worker does not need to verify income for anyone if it is \$10 or less.

4-007.01G Budgeting the Alternate Care Spouse: The worker deducts the following amounts from the alternate care spouse's net earned and unearned income in computing the alternate care spouse's budget:

1. MNIL or FPL level (see 469 NAC 4-007, step 1 or step 2);
2. Guardian/Conservator fee;
3. Amount allocated to the community spouse and/or family member(s);
4. Medicare premium and/or health insurance premium. If the couple has a combined health insurance premium, the worker allows one-half of the amount on the client's budget.

This is calculated on side 1 of Form DA-4M.

For budget instructions see ~~PAF 4-3. Appendix 469-000-XXX.340.~~

~~4-007.02 Medical Budget Periods:~~ The medical budget is normally computed for one month but may be computed for a period up to six months. See 469-000-301 for procedures.

~~4-008 Required Copayments:~~ Effective April 1, 1994, AABD adults are required to pay a copayment for the medical services listed at 469-000-210. Copayment amounts are also listed at 469-000-210. Individuals who receive SDP assistance are exempt from paying copayments.

~~4-008.01 Covered Persons:~~ With the exceptions listed at 469 NAC 4-008.02, AABD adults are subject to the copayment requirement.

The client's Medicaid card will indicate whether the client is subject to the copayment requirement. The provider may also verify the client's copayment status by contacting the Nebraska Medicaid Eligibility System (NMES).

~~4-008.02 Exempted Persons:~~ The following individuals are exempted from the copayment requirement:

- ~~1. Individuals age 18 or younger;~~
- ~~2. Pregnant women through the immediate postpartum period (the immediate postpartum period begins on the last day of pregnancy and extends through the end of the month in which the 60-day period following termination of pregnancy ends);~~
- ~~3. Any individual who is an inpatient in a hospital, long term care facility (NF or ICF/MR), or other medical institution if the individual is required, as a condition of receiving services in the institution, to spend all but a minimal amount of his/her income required for personal needs for medical care costs;~~
- ~~4. Individuals residing in alternate care, which is defined as Assisted Living facilities, centers for the developmentally disabled, adult family homes and Licensed Mental Health Centers;~~
- ~~5. Individuals who are receiving waiver services, provided under a 1915(c) waiver, such as the Community-Based Waiver for Adults with Mental Retardation or Related Conditions; the Home and Community-Based Model Waiver for Children with Mental Retardation and Their Families; or the Home and Community-Based Waiver for Aged Persons or Adults or Children with Disabilities;~~
- ~~6. Individuals with a Share of Cost (over the course of the a Share of Cost cycle, both before and after the obligation is met);~~
- ~~7. Individuals who receive assistance under SDP (program 07); and~~
- ~~8. Individuals who are subject to a monthly TMA or MIWD premium.~~

{Effective 2/14/09}

~~4-008.03 Covered Services: For covered and excluded services, see 469-000-210.~~

~~4-008.04 (Reserved)~~

~~4-008.05 Client Rights: If a client believes that a provider has charged the client incorrectly, the client must continue to pay the copayments charged by that provider until the Department determines whether the copayment amounts are correct.~~

~~If the client is unable to pay the required copayment, s/he may inform the provider of the inability to pay. While the provider shall not refuse to provide services to the client in this situation, the client is still liable for the copayment and the provider may attempt to collect it from the client.~~

~~The client has the right to appeal under 465 NAC 2-001.02.~~

~~4-008.06 Collection of Copayment: For provider procedures, see 471 NAC 3-008.04.~~

~~4-009 Nebraska Health Connection (NHC): Managed care is required for all active Medicaid-eligible individuals except those excluded groups listed at 469-000-308. For more information, see Title 482.~~

Chapter 5-000 HEALTH CHECKS and Treatment Services for Conditions Disclosed During HEALTH CHECKS (EPSDT)

5-001 Introduction

5-001.01 Legal Basis: HEALTH CHECKS are covered under the Early and Periodic Screening, Diagnosis, and Treatment Program which was established by Title XIX of the Social Security Act. Section 1905(r) of the Social Security Act was added by the Omnibus Budget Reconciliation Act of 1989 (P.L. 101-239).

5-001.02 Purpose and Scope: HEALTH CHECK, the Nebraska Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program is a service available to all individuals age 20 and younger eligible for medical assistance. The goal is to provide each eligible individual the opportunity for achieving and maintaining optimal health status. This can be facilitated by the early detection of illness or defects through regular and periodic screening examinations, by providing follow-up care of the conditions detected, through regular and periodic screening examinations by providing continuity of care, and by promoting healthy lifestyles. It is intended to encourage and ensure that treatment is available and received by those eligible and in need of treatment by the application of medical knowledge and technology to cure, correct, or alleviate health problems. Preventive health care provides the following benefits:

1. Early detection and treatment of health problems to prevent serious impairment and to increase the chance of successful treatment;
2. Protection from certain preventable diseases by immunization for children at an early age;
3. Maintenance of good health and assurance of normal development through periodic check-ups and the establishment of a "medical home." In most cases, this will be a continuing relationship with a primary care physician; and
4. Savings of future medical costs.

The EPSDT program's objectives are ensuring the availability and accessibility of required health care resources and helping Medicaid children and their parents or caretakers effectively use them. This may be accomplished through care coordination. Care coordination includes:

1. ~~Provision of effective outreach/education activities which inform parents of the benefits of having their children receive HEALTH CHECK screening, diagnosis, and treatment services;~~
2. ~~Provision of consumer education to parents which assists in making responsible decisions about participation in preventive health care and appropriate utilization of health care resources;~~
3. ~~Assurance of continuing and comprehensive health care beginning with the screening through diagnosis and treatment for conditions identified during screening;~~
4. ~~Provision of assistance to families in making medical and dental appointments and in obtaining needed transportation; and~~
5. ~~Establishment of case management of screening services to monitor and document that all HEALTH CHECK (EPSDT) services are delivered within established time frames.~~

~~This may be accomplished through interagency agreement, managed care contract, or fee for service with qualified Medicaid-enrolled providers as determined by the NMAP. Examples of EPSDT participants in particular need of care coordination may be pregnant adolescents, children with special health care needs, medically fragile children, foster care children, and children with significantly environmental risk.~~

~~{Effective 5/8/05}~~

5-001.03 Definition of Terms: The following terms are defined in relation to HEALTH CHECK and treatment services under the EPSDT program:

Early: As soon as an individual's or a family's eligibility for assistance has been established; or, in the case of a family already receiving assistance, as early as possible in the individual's life. This includes informing Medicaid women so that prevention begins prenatally.

Periodic: Intervals established for examination or screening to ensure continued health and to detect conditions requiring treatment. Dental screening examinations are recommended for children three and older according to the American Dental Association. If a dental problem is suspected before age three, a dental screening should occur at that time. Medical, visual, and hearing exams are to begin with a neonatal exam and follow, at a minimum, the periodicity schedule based on the American Academy of Pediatrics schedule for health supervision visits (see 471 NAC 33-002.03). The physician may establish an alternate periodicity schedule based on medical necessity. The initial examination of a newborn is considered an initial HEALTH CHECK (EPSDT) examination and the child is considered participating in the program. Well-baby and well-child examinations are to be reported as HEALTH CHECK examinations through the HEALTH CHECK EPSDT program.

Screening Services: Periodic child health assessments which are regularly scheduled to examine and evaluate the general physical and mental health, growth, development and nutritional status of eligible children. The screenings are performed to identify those individuals who may require diagnosis, further examination, and/or treatment. Prior authorization approval of health, dental, vision, and hearing screening examinations for EPSDT participants is prohibited. The following screening services are included in the EPSDT benefit:

1. Health Screening Services:
 - a. Comprehensive health and developmental history (including assessment of both physical and mental health development);
 - b. Comprehensive unclothed physical examination;
 - c. Appropriate immunizations for age and for health history;
 - d. Appropriate laboratory procedures for age and populations groups; and
 - e. Health education (including anticipatory guidance);
2. Dental Screening Services: For children age three and older, dental screening services are furnished by direct referral to a dentist. Children age two and younger are screened by the screening physician as part of the health screening exam. If a dental problem is suspected before age three, a referral to a dentist for a dental screening should occur. Medically necessary and reasonable diagnosis and treatment including, at a minimum, relief of pain and infections, restoration of teeth, and maintenance of health are covered;
3. Vision Screening Services: An age-appropriate visual assessment. Medically necessary and reasonable diagnosis and treatment for defects in vision are covered; and
4. Hearing Screening Services: An age-appropriate hearing assessment. Medically necessary and reasonable diagnosis and treatment for defects in hearing are covered.

Diagnosis: The determination of the nature or cause of a physical or mental disease or abnormality. A diagnosis enables a physician to make a plan for treatment specific to the EPSDT participant's problems. Under certain circumstances, diagnosis may be provided at the same time as screening. In other circumstances, diagnosis may be provided during a second appointment. The diagnosis may or may not require further follow-up. It may result in referral for treatment.

Treatment Services: ~~HEALTH CHECK (EPSDT) follow-up services necessary to diagnose or to treat a condition identified during a HEALTH CHECK (EPSDT) health, visual, hearing, or dental screening examination are covered under the following conditions:~~

1. ~~The service is required to treat the condition (i.e., to correct or ameliorate defects and physical or mental illnesses or conditions) identified during a periodic or interperiodic HEALTH CHECK (EPSDT) screening examination and documented on the screening claim form (Form MC-5, Form HCFA-1500; dental claim form);~~
2. ~~The provider of services is a Medicaid-enrolled provider;~~
3. ~~The service is consistent with applicable federal and state laws that govern the provision of health care;~~
4. ~~The service must be medically necessary, safe and effective, not considered experimental/investigational (see 471 NAC 10-004.05), and must be generally employed by the medical profession~~
5. ~~Supplies, items, or equipment that is determined to be not medical in nature will not be covered~~
6. ~~Where alternative and medically appropriate modes of treatment exist and are available the NMAP may choose among the alternatives which services are available based on cost-effectiveness;~~
7. ~~Services currently covered under the Nebraska Medical Assistance Program will be governed by the guidelines of NMAP;~~
8. ~~Services not covered under the Nebraska Medical Assistance Program but defined in Section 1905(a) of the Social Security Act must meet the conditions of items 1 through 4 (above). Criteria and requirements for certain services are outlined in 471 NAC 33-000. Unless otherwise outlined, all services not covered under NMAP must be prior authorized by the Medical Services Division, Department of Social Services. Requests for prior authorization must be sent to: Nebraska Department of Social Services, Medical Services Division, EPSDT Coordinator. The screening practitioner shall submit the request which must include:
 - a. ~~A copy of the screening exam form or the name of the screening practitioner and the date of the screening exam which identified the condition; and~~
 - b. ~~A plan of care which includes:
 1. ~~History of the condition;~~
 2. ~~Physical findings and other signs and symptoms, including appropriate laboratory data;~~
 3. ~~Recommended service/procedure, including (if unknown) the potential provider of service (e.g., equipment, supplies) or where the services will be obtained;~~
 4. ~~Estimated cost, if available; and~~
 5. ~~Expected outcome(s).~~~~~~

The plan of care may be submitted on Form EPSDT-5, "Plan of Care," or as a statement by the screening practitioner. The Medical Director or designee shall make a decision on each request in an expeditious manner. Appropriate health care professionals may be consulted during the decision-making process. A copy of the decision will be sent to the screening practitioner and the client's worker in the local Social Services office. For wards of the Department, a copy of the decision is sent to the client's case manager in the local office. If the initial request is denied, additional information may be sent for reconsideration.

{Effective 5/8/05}

5-002 Worker Responsibilities

5-002.01 Informing Client: The worker must inform the client of HEALTH CHECK (EPSDT) at the time of application and redetermination. The worker must accomplish this by giving the client:

1. A verbal explanation of HEALTH CHECK (EPSDT), including a review of the HEALTH CHECK (EPSDT) pamphlet;
2. A pamphlet explaining HEALTH CHECK (EPSDT); and
3. The opportunity to ask questions.

Special emphasis is to be placed on informing for first time eligibles, mothers and families with infants or adolescents, or those not participating for over two years, or other eligible children considered 'at risk' for health care. A Medicaid-eligible woman's positive response to an offer of HEALTH CHECK (EPSDT) services during her pregnancy constitutes a request for services for the child at birth. For a child eligible at birth, the request for HEALTH CHECK (EPSDT) services is effective with the birth of the child.

These informing procedures are to be adapted to meet the needs of persons who are illiterate, blind, deaf, or who cannot understand the English language.

In addition, notifications are sent to clients informing them of when they are due for health and dental exams according to the periodicity schedule. All Claims Inquiry (CIGS4 1, Selection 17) is a resource for the eligibility worker to determine when the last screening examination was covered by Medicaid.

For those families requesting HEALTH CHECK (EPSDT) and also requesting support services, the worker must provide assistance or refer to the appropriate unit for assistance in arranging transportation, locating a doctor, dentist or other screening practitioner, or setting appointments. If the client has entered into a continuing care formal agreement, the continuing care provider may be responsible for some or all of the support services and follow-up (see 474 NAC 33-002.07A). For wards, see 471 NAC 41-004.

5-002.02 Assisting with Appointments: The designated worker must:

1. Offer and provide, if requested and necessary, assistance or referral in scheduling appointments and providing transportation for the screening exam and treatment services. A request for support services applies to screening, diagnosis, and treatment services unless otherwise indicated on the application or narrative. To ensure timely delivery of services, the worker must have available, upon request, the names and locations of Medicaid providers (physicians, clinics, dentists, including Title V providers);

2. Upon request for HEALTH CHECK (EPSDT) dental and/or health screening (including vision and hearing screens), provide the client or send to the screening physician, the Form MC-5 (many physician offices have a supply), and/or send the dental claim form to the screening dentist. The screening exams are to be performed within 120 days of the initial and periodic request. If the screening is overdue, one follow-up contact, documented and dated, is considered a good faith effort to provide timely delivery of services. This may be accomplished by the worker or by an automated client notice. A personal contact is the most effective method;
3. As follow up, inform the client of the need for further diagnosis or treatment services and provide assistance in transportation and appointment scheduling, if requested and necessary to enable the client to receive necessary diagnosis and treatment within 120 days after the date of the initial request for screening. This is accomplished by the worker or by an automated client notice. A personal contact is the most effective method. One follow-up contact, documented and dated, is considered a good faith effort to ensure initiation of treatment.

5-002.03 Documenting Contact and Assistance: Written documentation in the client file is necessary to show:

1. That the client has been informed and offered HEALTH CHECK (EPSDT) by written and oral explanation at the eligibility determination or redetermination.
2. That the supportive services of appointment scheduling and transportation assistance have been offered to the client and are provided at the client's request if necessary.
3. The steps taken by the designated worker to:
 - a. Assist the client to receive a screening examination(s);
 - b. Ensure that treatment has begun within 120 days of the screening request for those who needed further diagnosis and treatment. The local office copy of Form MC-5 is the record of the completed health screening, and the local office copy of the dental claim form is the record of a completed dental screening for children or verification of health and/or dental screening or need for further diagnosis and treatment may be accomplished by utilizing All Claims Inquiry, GICS1, Selection 17; and
 - c. Assist clients to receive periodic services according to the periodicity schedules in 471 NAC 33-002.03.

~~5-003 Coordination with Other Requirements for Physical Examinations: Efforts must be made to coordinate screening with programs such as required physicals in the public schools, Head Start, and other programs which require examinations. Form MC-5 is to be used by physicians to avoid duplication.~~

~~5-004 Referral for Services Not Covered by Medical Assistance: Referral assistance must be provided for treatment not covered by NMAP (i.e., those services not covered under 1905(a) of the Social Security Act) but found to be needed as a result of conditions disclosed during the screening exam.~~

~~This includes giving the family or client the names, addresses, and the telephone numbers of providers who have expressed a willingness to furnish uncovered services at little or no expense to the family. Workers may contact the EPSDT coordinator in the Medical Services Division for referral resources. Workers may utilize the Nebraska Resource Referral System to attempt to provide referral assistance.~~

~~5-005 Relations with Special Supplemental Food Programs for Women, Infants, and Children (WIC): Coordination with the WIC program is required. WIC provides specific nutritious supplemental food and nutrition education at no cost to Medicaid-eligible pregnant, postpartum, and breast-feeding women, infants, and children up to their fifth birthday. Referrals, when appropriate for the family, are required to local WIC agencies to access nutritional services and education.~~

~~5-006 Payment Procedure: For payment procedure, see 471 NAC 33-002.08.~~

~~CHAPTER 6-000 WORKING DISABLED PART A MEDICARE BENEFICIARIES: Individuals who were receiving RSDI disability benefits and return to work but remain disabled may continue to be entitled to Part A Medicare at no cost for 48 months.~~

~~The Omnibus Budget Reconciliation Act of 1989 allowed these individuals, at the end of 48 months, to enroll in Part A Medicare and pay a premium. It also required state Medicaid programs to purchase Medicare Part A premiums for these individuals.~~

~~6-001 Eligibility Requirements: In order to receive payment of the Medicare premium, the individual must meet the following eligibility requirements:~~

- ~~1. Application (see 469 NAC 2-001);~~
- ~~2. U.S. citizenship or alien status (see 469 NAC 2-002 ff.);~~
- ~~3. Nebraska residence (see 469 NAC 2-003 ff.);~~
- ~~4. Social Security number (see 469 NAC 2-004 ff.)~~
- ~~5. Age (see 469 NAC 6-001.01);~~
- ~~6. Relative responsibility (see 469 NAC 2-006);~~
- ~~7. Disability (see 469 NAC 6-001.02);~~
- ~~8. Institutionalization (see 469 NAC 2-008 ff.);~~
- ~~9. Resources (see 469 NAC 6-001.03);~~
- ~~10. Income (see 469 NAC 6-001.04); and~~
- ~~11. Receipt of other assistance (see 469 NAC 6-001.05).~~
~~{Effective 6/28/11}~~

~~6-001.01 Age: To be eligible for the payment of the Medicare premium, an individual must be age 64 or younger.~~

~~6-001.02 Disability: To be eligible for the payment of the Medicare premium, an individual must continue to have a disabling impairment as determined by SSA. SSA has the responsibility to periodically verify that the disability continues. If SSA determines through a continuing disability review that the client is no longer disabled, SSA notifies the Department and eligibility for AABD ceases. If the client voluntarily withdraws from Medicare Part A premium, eligibility for AABD ceases.~~

~~6-001.03 Resources: Resources are treated according to regulations in 469 NAC 2-009 through 2-009.07B16. For maximum resource limits, see 469-000-204.~~

~~6-001.04 Income: Income is treated according to regulations in 469 NAC 2-010.01 through 2-010.01H. For income limits see 469-000-204.~~

~~The worker budgets the client on Form DA-3M. If total net earned and unearned income is equal to or less than 200 percent of the OMB poverty guideline, the client is eligible for payment of the Medicare premium. If the income is more than the income limit, the client is ineligible for the Part A Medicare premium payment. If the client continues to pay the premium, s/he could choose to receive AABD/MA with excess income and attempt to spenddown if there is a medical need. If the client does not pay the Part A premium, s/he would be ineligible for AABD/MA (see 469 NAC 6-001.02).~~

~~6-001.05 Receipt of Other Assistance: Through the AABD program an individual may choose to receive either payment of the Medicare Part A premium or full medical assistance benefits but not both at the same time. While receiving either form of assistance, the client may request the other; however, the client is not eligible for full medical assistance benefits for any month for which the Department has paid the Medicare Part A premium.~~

~~If a client who is on AABD/MA with excess and is paying his/her own Part A Medicare premium fails to meet his/her excess obligation, the Department retroactively pays the Medicare Part A premium for the excess cycle. At the end of this excess cycle, the client must decide whether to continue with the state paying the Part A premium or to begin a new excess cycle and assume payment of the Part A premium him/herself.~~

~~CHAPTER 7-000 SPECIFIED LOW-INCOME BENEFICIARIES (SLMB) AND QUALIFIED INDIVIDUALS (QI-1): Current Medicare beneficiaries who meet the required income guidelines and all other eligibility requirements of the AABD program are eligible for payment of their Part B Medicare premiums. These individuals are eligible only for payment of the Medicare premium; they are not eligible for any additional medical services or public assistance. SLMB's and QI-1's are determined by income guidelines based on the Federal Poverty Limits.~~

~~Public Law 110-275, Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Section 112, required increased resource limits for this group. The resource limits are adjusted annually. An annual review is required to verify income and resources.~~

~~{Effective May 1, 2010}~~

~~7-001 Eligibility Requirements: In order to receive payment of the Medicare premium, the individual must meet the following eligibility requirements:~~

- ~~1. Face to face interview (see 469 NAC 2-001);~~
- ~~2. U.S. citizenship or alien status (see 469 NAC 2-002 ff.);~~
- ~~3. Nebraska residence (see 469 NAC 2-003 ff.);~~
- ~~4. Social Security number (see 469 NAC 2-004 ff.);~~
- ~~5. Age (see 469 NAC 2-005 ff.);~~
- ~~6. Relative responsibility (see 469 NAC 2-006);~~
- ~~7. Blindness or disability (see 469 NAC 2-007 ff.);~~
- ~~8. Resources (for treatment of resources, see 469 NAC 2-009 ff.; for resource limits, see 469 NAC 7-001.02);~~
- ~~9. Income (see 469 NAC 7-001.01);~~
- ~~10. Cooperation in obtaining third party medical payments (see 469 NAC 2-011); and~~
- ~~11. Receipt of other assistance (see 469 NAC 2-013).~~

~~7-001.01 Income: Income is treated according to regulations in 469 NAC 2-010.01 through 2-010.01H. The income limits are based on the Federal Poverty Level.~~

~~If total net earned and unearned income is equal to or less than the required income limit, the client is eligible for payment of the Medicare premium. If the income is more than the income limit, the client is ineligible for payment of the Medicare premium.~~

~~{Effective 1/19/08}~~

~~7-001.01A AABD with Share of Cost: The client may choose to receive AABD/MA with a share of cost and attempt to spend down if there is a medical need.~~

~~If a client who is on AABD/MA with a share of cost fails to meet any of his/her share of cost by the next case review and a medical need cannot be anticipated, a SLMB or QI-1 budget should be authorized.~~

~~If a client has been SLMB or QI-1 and later wants Medicaid share of cost for the same month(s) and up to six months before, a share of cost budget should be authorized.~~

~~7-001.02 Resources: Resource limits are adjusted annually.~~

~~CHAPTER 8-000 MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES: Working individuals who meet the necessary disability criteria, have income within income guidelines, and are working, are eligible for Medicaid. After application of income disregards, individuals with income less than 200 percent of the Federal Poverty Level (FPL) are eligible for Medicaid with no premium; individuals with income of 200 through 249 percent of the FPL are eligible for Medicaid with a monthly premium payment.~~

~~The Balanced Budget Act of 1997 allowed Medicaid for workers with disabilities. Neb.Rev.Stat. section 68-1020, allows a qualified individual with income from 200 through 249 percent of the Federal Poverty Level to pay a premium to obtain Medicaid eligibility.~~

~~8-001 Eligibility Requirements: In order to receive Medicaid, the individual(s) must:~~

- ~~1. Qualify for Medicaid except for income;~~
- ~~2. Not be eligible for AABD grant and/or medical, but may be a share of cost;~~
- ~~3. Meet Social Security or State Review Team definition of disability;~~
- ~~4. Be working;~~
- ~~5. Using a two-part income test have income within income guidelines (see 469-000-204);~~
- ~~6. Meet Medicaid resource limits (for treatment of resources, see 469 NAC 2-009 ff.; for resource limits, see 469 NAC 4-005.01); and~~
- ~~7. Pay a premium, if required.~~

~~8-001.01 Disability Determination: Individuals who are not receiving a Social Security Disability payment must be determined disabled by the State Review Team. Receipt of an SSDI payment meets the disability requirement.~~

~~8-001.02 Income Determination: The income calculation is a two-step process. For calculation procedures, see 469-000-330. The worker must consider income of the disabled individual and his/her spouse.~~

~~8-001.03 Premium Payment: If the individual is determined eligible for Medicaid with a premium, s/he must pay the full premium to the worker no later than the 21st day of the month following the month for which the payment is designated. See 469-000-330.~~

~~{Effective 5/8/05}~~

~~CHAPTER 9-000 WOMEN'S CANCER PROGRAM: Women who meet the eligibility requirements listed in 469 NAC 9-001 are eligible for Medicaid coverage.~~

~~The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows Medicaid for women who need treatment for breast or cervical cancer. Section 68-1020, Neb. Rev. Stat. authorizes this coverage in Nebraska.~~

~~9-001 Eligibility Requirements: In order to receive Medicaid, the woman must:~~

- ~~1. Be screened for breast and cervical cancer by Every Woman Matters;~~
- ~~2. Be found to need treatment for breast and/or cervical cancer, including a pre-cancerous condition or early stage cancer;~~
- ~~3. Be age 64 or younger;~~
- ~~4. Not be otherwise eligible for Medicaid;~~
- ~~5. Not be covered by creditable health insurance (see 469 NAC 9-001.01);~~
- ~~6. Be a Nebraska resident (see 469 NAC 2-003); and~~
- ~~7. Be a U.S. citizen or a qualified alien (see 469 NAC 2-002).~~

~~9-001.01 Creditable Health Insurance: For purposes of this program, creditable health insurance includes any health insurance coverage except a plan that:~~

- ~~1. Is limited scope coverage such as those which only cover dental, vision, or long term care;~~
- ~~2. Is coverage for only a specified disease or illness;~~
- ~~3. Does not include treatment for breast or cervical cancer (such as a period of exclusion); or~~
- ~~4. Has exhausted the woman's lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer.~~

~~9-001.02 Eligibility Period: Eligibility begins with the first of the month that the client signs the application for the Women's Cancer Program on the prescribed application which is incorporated into the appendix of these rules.~~

~~Eligibility continues as long as the client requires treatment for breast or cervical cancer, as determined by her physician, unless she becomes ineligible for some other reason. Eligibility automatically ends the last day of the month of the client's 65th birthday.~~

~~For pre-cancerous cervical conditions, eligibility automatically ends the last day of the month following the month treatment begins unless the physician provides the agency with a monthly statement that continued treatment is required. Continued treatment does not include continued surveillance, testing, or screening.~~

~~For breast and cervical cancer, a physician's statement verifying the need for treatment must be provided to the agency every six months for the woman to remain eligible for Medicaid coverage.~~

~~9-001.03 Presumptive Eligibility: The client may be determined presumptively eligible by a qualified Medicaid provider. Presumptive eligibility begins on the date that the qualified provider determines that the client appears to meet eligibility criteria.~~

Breast and Cervical Cancer Medicaid Supplement Form



Name _____

Social Security Number _____ Date _____

I certify that the above named individual has been screened for breast or cervical cancer and found to need treatment for breast or cervical cancer or pre-cancerous lesions.

▶
Every Woman Matter's Representative's Signature

▶
Every Woman Matter's Representative (Please Print)

MEDICAID INFORMATION

Are you a United States Citizen?

Yes No If NO, what is your immigration status? (Please attach a copy of your INS papers, if available)

Information on Health Insurance or Indian Health Insurance you already have?

Tell us the name of your insurance company, the policy number and the insured person's name on the policy.

Insurance Company or Employer	Phone Number of Company	Policy Number or Group Plan number	Insured Name on Policy

(We are required to ask the following questions to determine your possible eligibility for other categories of Medicaid.)

Area you Pregnant?

Yes No (Circle one)

Do you have children under the age of 19 living with you?

Yes No (Circle one)

Have you been determined disabled by the Social Security Administration or Health and Human Service's State Review Team?

Yes No (Circle one)

PRESUMPTIVE ELIGIBILITY

I certify that the above woman is eligible for Presumptive Eligibility.

▶
Provider Representative

Date of Presumptive Determination

▶
Name of Provider

Provider Address

NOTICE TO PROVIDERS: Please accept this form as proof of temporary Medical coverage for Women with Breast or Cervical Cancer. To check Medicaid Presumptive eligibility use the woman's Social Security Number with a two digit suffix when calling the Nebraska Medicaid eligibility (NMES) line at 1-800-642-6092.

NOTICE TO APPLICANT: Show this form to providers of services as proof of medical coverage. **Notice & Appeal Rights!**
PLEASE SIGN THIS STATEMENT: I certify that the information I have provided above is true to the best of my knowledge and I give permission for the State of Nebraska to make any necessary contacts to check my statements. I have read the list of my rights and responsibilities that is printed below. I know that I could be penalized if I knowingly give false information.

▶
Signature or Mark of Applicant

Date

▶
Witness if mark



Rights and Responsibilities

I understand that this application is an application for one kind of Medicaid and is not a full Medicaid application. I understand that if I am not eligible under this category of Medicaid, I may be eligible for Medicaid benefits on some other basis and have a right to complete a full Medicaid application. If you need assistance with food, utilities, day care or other needs contact your Local Department of Health and Human Service Office.

1. I know that the information I have given is confidential. I agree that medical information about me can be released only if needed to administer this program.
2. I know that any information I have given may be reviewed and verified by the State of Nebraska. I understand that I must cooperate fully with state and federal workers if my case is reviewed. No additional permissions are needed to get verification or other information.
3. I know that this application will be considered without regard to race, color, sex, age, disability, religion, national origin or political belief.
4. I know that I may ask for a hearing if I am not satisfied with any action taken by the State of Nebraska in connection with the program. I may also ask for a hearing if I feel that I have been discriminated against.
5. I know that the State of Nebraska will request and use information from a computer system called the State Income and Eligibility Verification System (IEVS). This computer system compares information about me with information from other agencies. Other agencies include the Internal Revenue Service, Social Security Administration, Veteran's Administration, Vital Statistics Agency and the Nebraska Department of Labor.
6. I know that Medicaid does not pay medical expenses that a third party, such as a private health insurance company, is suppose to pay. I give my rights to any third party payments to the Department of Health and Human Services. These payments may include payments from hospital and health insurance policies. I know that if I refuse to give my rights to third party payments to the Department of Health and Human Services I will not be eligible for Medicaid.

~~CHAPTER 10-000 MEDICARE PRESCRIPTION DRUG BENEFIT PROGRAM: Section 101 of Title I of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173) established Part D, the Voluntary Prescription Drug Benefit Program which added a prescription drug benefit to Medicare. To be eligible to enroll in Part D, the individual must be entitled to Medicare benefits under Part A (Hospital) or enrolled in Part B (Physician). The prescription drug coverage is provided under private prescription drug plans (PDP) or Medicare Advantage prescription drug plans (MA-PD). This coverage is effective beginning January 1, 2006.~~

~~Clients who are eligible for or enrolled in Part D Medicare prescription drug benefits are only eligible for limited Medicaid prescription drug coverage, see 471 NAC 16-003 or 471 NAC 16-004.01.~~

~~10-001 Low Income Subsidy (LIS) Assistance: Medicare Part D beneficiaries who submit an application and meet certain income and asset requirements may qualify for low income subsidy assistance with cost sharing and premiums. The two Medicare low income subsidy groups are:~~

- ~~1. Medicare individuals with income below 135% FPL and resources below the designated resource level for an individual or a couple. The eligible individuals pay:
 - ~~a. No premium if their premium is equal to the low income benchmark premium for Nebraska;~~
 - ~~b. No deductibles;~~
 - ~~c. Copayments; and~~
 - ~~d. No copayments after the individual spends the required amount in cost sharing; and~~~~
- ~~2. Medicare individuals with income below 150% FPL and resources below the designated resource level for an individual or a couple. The eligible individuals pay a:
 - ~~a. Sliding scale premium;~~
 - ~~b. Deductible;~~
 - ~~c. 15% coinsurance up to the established limit in total spending; and~~
 - ~~d. Copayments.~~~~

~~10-001.01 Income and Resource Requirements: The methodology used to determine income and resource eligibility of the two LIS groups is the same as the Supplemental Security Income and Aid to the Aged, Blind, or Disabled Programs (see Title 469, Chapters 1 through 4), with the following exceptions:~~

- ~~1. Household definition: For the LIS groups, a household (unit) includes an applicant and his/her spouse living in the same household, and individuals related to the applicant living in the household who are dependent on the applicant for 50 percent of their support. (This definition differs from the SSI/AABD definition which would include only a spouse and dependent children [see 469 NAC 2-006.01 and 2-006.02]).~~
- ~~2. Resources: For the LIS groups, the resource test is based on liquid assets (convertible to cash within 20 days). (All available resources are used to determine eligibility in SSI/AABD [see 469 NAC 2-009.02]).~~
- ~~3. Automobiles: For the LIS groups, all automobiles are excluded. (For SSI/AABD eligibility, one motor vehicle per unit is excluded per 469 NAC 2-009.07B7.)~~
- ~~4. Health Insurance Deduction: For the LIS groups, health insurance premiums are not deducted from income. (Health insurance premiums are deducted from income in determining AABD/MA only eligibility per 469 NAC 4-006.01A).~~

- ~~5. Guardian or Conservator Fee: For the LIS groups, a guardian or conservator fee is not allowed. (Guardian or conservator expenses as paid up to a maximum of \$10 a month are deducted from income for AABD/MA cases [see 469 NAC 4-006.01B]).~~

CHAPTER 11-000 MEDICARE SAVINGS PROGRAM/ QUALIFIED MEDICARE BENEFICIARIES (MSP/QMB): MSP/QMB is a new Medicaid group for individuals with income equal to or less than 100% FPL but who have resources in excess of the \$4,000 and \$6,000 limits. MSP/ QMB individuals who are within specific resource guidelines at 469 NAC 11-001.02 are eligible for payment of deductibles and co-pay costs associated with Medicare claims. They are not eligible for additional medical services or State supplement payments. An annual review is required to verify income and resources.

Public Law 110-275, Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), Section 112, required increased resources for this group. The resource limit amounts are adjusted annually.

11-001 Eligibility Requirements: In order to receive payment of the Medicare premium, deductibles, and co-pay costs associated with Medicare, the individual must meet the following eligibility requirements:

1. Application (see 469 NAC 2-001);
2. U.S. citizenship or alien status (see 469 NAC 2-002 ff.);
3. Nebraska residence (see 469 NAC 2-003 ff.);
4. Social Security number (see 469 NAC 2-004 ff.);
5. Age (see 469 NAC 2-005 ff.);
6. Relative responsibility (see 469 NAC 2-006 ff.);
7. Blindness or disability (see 469 NAC 2-007 ff.);
8. Resources (for treatment of resources, see 469 NAC 2-009ff.; for resource limits, see 469 NAC 11-001.02);
9. Income (see 469 NAC 11-001.01);
10. Cooperation in obtaining third party medical payments (see 469 NAC 2-011; and
11. Receipt of other assistance (see 469 NAC 2-013).

11-001.01 Income: Income is treated according to regulations in 469 NAC 2-010.01 through 2-010.01H. The income limits are based on 100% FPL.

The worker budgets the client on a medical budget. If total net earned and unearned income is equal to or less than 100% FPL and resources are less than the amount specified at 11-001.02, the client is eligible for MSP/QMB.

11-001.02 Resources: Resource limits are adjusted annually.