

**MD
MENTAL HYGIENE
ADMINISTRATION
SERVICES
1000 PRESTON STREET
BALTIMORE, MD 21201**

**STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
BENEFICIARY SERVICES ADMINISTRATION
DIVISION OF ELIGIBILITY
201 WEST PRESTON STREET
BALTIMORE, MARYLAND 21201**

DATE: Upon Receipt

MANUAL: Medical Assistance **EFFECTIVE**

ELIGIBILITY: citizenship, residency, life insurance for burial, trusts, personal needs allowance, waiver, Administrative Error Letter, spousal impoverishment, etc.

RELEASE NO: MR-110
ISSUED: May 2003

APPLICABLE: home property, life insurance, DDMH-257, personal needs allowance, Administrative Error Letter, aliens, HealthChoice

<u>Pages</u>	<u>Insert Pages</u>	<u>Item</u>	<u>Remove Pages</u>
500-8 500-10	500-1 – 500-8p DES 401	<u>Chapter 5 – Non-Financial Eligibility</u> (citizenship, residency, age, blindness)	500-1 – 500-10 Policy Alert 05-3 - 05-5
800-24	800-15- 800-22 (there will be no 800-23 and 800-24)	<u>Chapter 8 – Resources</u> (home property)	800-15 – 800-22
800-38	800-37 – 800-38	(life insurance for burial)	800-37 – 800-38
800-66, 800-86b	800-65 - 800-66, 800-86a - 800-86b	(trusts)	800-65 - 800-66 800-86a - 800-86b
1000-2	1000-1 – 1000-2	<u>Chapter 10 –Institutionalized Persons</u> (DHMH-257)	1000-1 – 1000-2
1000-24	1000-21 – 1000-22 (there will be no 1000-23 and 1000-24)	(personal needs allowance)	1000-21 – 1000-22
	Policy Alert 10-11 (after Policy Alert 10-10)	Policy Alert 10-11 “Process for Waiver Applicants Who Reside in a LTCF”	
	1100-7 , DHR/IMA 81	<u>Chapter 11 – Certification Periods</u> (Administrative Error Letter, DHR/IMA 81)	

<u>Item</u>	<u>Remove Pages</u>	<u>Insert Pages</u>
<u>COMAR 10.09.24</u> (Regulation .05 - 5-year bar for qualified aliens)	31 – 32-2	31 – 32-2
(Regulation .11 - 6-month guaranteed MA eligibility for HealthChoice enrollees)	111 and 112	111 and 112
<u>Schedules</u>		
Schedule MA-8 Spousal Impoverishment Standards	Schedule MA-8	Schedule MA-8

COMMENTS

- MA-8 Schedule is updated with new Spousal Impoverishment Standards, effective July 1, 2003. The community spouse’s Basic Maintenance and Shelter Allowance and the Excess Shelter Standard are increased each year, effective July 1.
- Chapter 10 is updated, effective July 1, 2003, with an increase in the personal needs allowance for Medical Assistance recipients in long-term care. In accordance with House Bill 422 passed in 2002, the allowance is increased to \$50 per month for individuals and \$100 per month for couples. Chapter 10 is also revised to stress that if the eligibility worker does not receive the DHMH-257 (Medical Review form) from the long-term care (LTC) facility by the due date for the applicant’s LTC eligibility determination, the application should be denied, after giving timely notice, for lack of this verification.
- Text in Chapter 5 with non-financial eligibility requirements related to citizenship and residency is updated. Included is a copy of the DES 401, “Emergency Medical Services to Ineligible Aliens”. These revised sections consolidate requirements previously issued in Policy Alerts, Policy Clarifications, and various DHR issuances. Amended text in COMAR 10.09.24.05 is also included. This stipulates that the 5-year bar on Medical Assistance eligibility for qualified aliens who entered the United States on or after August 22, 1996 begins when the individual entered the U.S. as a qualified alien or gained qualified alien status.
- Text in Chapter 8 is revised to clarify under what circumstances home property is counted or excluded as a resource. It also clarifies under what circumstances a lien may be placed on home property that was excluded as a resource for an institutionalized person. Text is also revised related to the use of life insurance to fund funeral or burial services. The section on trusts is revised to emphasize that a trust (special needs or otherwise) may only be counted as a resource of the beneficiary if some or all of it was established with the beneficiary’s or spouse’s money.
- Policy Alert 10-11, “Process for Waiver Applicants Who Reside in a LTCF”, clarifies the procedures to follow when a person who resides in a long-term care facility applies for a home and community-based services waiver.
- The change to Chapter 11, Certification Periods, clarifies when it is necessary for the eligibility worker to submit an Administrative Error Letter (DHR/IMA 81) to the DHMH Division of Claims Processing. Included is a copy of the form, which is printed by DHR.
- COMAR text for Regulation .11 is corrected to insert language about the guaranteed 6-month initial certification period of Medical Assistance eligibility for HealthChoice enrollees.

.05 Non-Financial Eligibility Requirements.

A. Citizenship.

1. Federal Medical Assistance Coverage.

(Note: Refer to the following Internet site for current federal requirements: www.cms.gov/immigrants)

In order to be eligible for federal coverage of full Medical Assistance benefits, a person shall be one of the following:

- (1) A citizen of the United States including:
 - (a) A person who was born in one of the 50 states, the District of Columbia, Puerto Rico, Guam, or the Virgin Islands,
 - (b) A child born abroad if both parents are United States citizens, or one parent is a United States citizen and that parent was a resident of the United States for at least 10 years, 5 of which were after the parent's 14th birthday,
 - (c) A person who has been naturalized in the United States, and
 - (d) A person who was born in American Samoa or Swain's Island and is considered a United States national;
- (2) A person who resided in the United States before August 22, 1996, and who is:
 - (a) A qualified alien as defined in this section,
 - (b) An honorably discharged veteran of the armed forces of the United States,
 - (c) An alien on active duty in the armed forces of the United States, or
 - (d) The spouse or unmarried dependent child of an honorably discharged veteran or alien on active duty in the armed forces of the United States;
- (3) A person who entered the United States on or

after August 22, 1996, and who is:

- (a) An alien who has been granted asylum under §208 of the Immigration and Nationality Act,
 - (b) A refugee admitted into the United States under §207 of the Immigration and Nationality Act,
 - (c) Alien whose deportation is being withheld under §243(h) of the Immigration and Nationality Act,
 - (d) An honorably discharged veteran of the armed forces of the United States,
 - (e) An alien on active duty in the armed forces of the United States, or
 - (f) The spouse or unmarried dependent child of an honorably discharged veteran or alien on active duty in the armed forces of the United States;
- (4) A person who entered the United States on or after August 22, 1996, and who:
- (a) Is a qualified alien as defined in this section, and
 - (b) Has resided in the United States Revised 11/02 for a period of at least 5 years with the status of a qualified alien; or
- (5) A non-qualified alien who is:
- (a) Eligible for and receiving Supplemental Security Income (SSI),
 - (b) A member of a federally-recognized Indian tribe, or
 - (c) An American Indian born in Canada.

An "alien" is an individual who is not considered a citizen of the United States. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996, federal welfare reform legislation signed into law on August 22, 1996, significantly changed aliens' eligibility for Medical Assistance (MA) and other public assistance. The Act contained provisions restricting the eligibility of certain legal aliens for the federal MA Program. Illegal aliens have never been eligible for full MA benefits in a federal category.

Maryland Medical Assistance Program eligibility for aliens is based on whether the alien is a "qualified" or "non-qualified" alien and whether the alien entered the United States before or after August 22, 1996, the effective date of the above-mentioned Act. The previous categories of lawful permanent resident and alien permanently residing in the United States under color of law (PRUCOL) have been superseded by the new category of "qualified alien".

Qualified Aliens

A qualified alien is an alien who is:

- A lawful permanent resident of the U. S.;
- A refugee;
- An asylee;
- An alien who has had deportation withheld under the Immigration and Nationality Act (INA);
- An alien approved by the Immigration and Naturalization Service (INS) as a Cuban or Haitian entrant, battered alien, or victim of a severe form of trafficking;
- An alien granted parole for at least 1 year by the

INS; or

- An alien granted conditional entry under immigration law in effect before April 1, 1980.

This definition eliminates most of the PRUCOL categories as well as eliminates PRUCOL as an eligibility classification.

Eligibility of Qualified Aliens Living in the United States Before August 22, 1996

Qualified aliens who were living in the United States prior to August 22, 1996 meet the citizenship requirements for the Maryland Medical Assistance Program whether or not they were receiving MA on that date.

The following persons also meet the citizenship requirements for the Maryland Medical Assistance Program if living in the United States prior to August 22, 1996, whether or not they meet the definition of a "qualified alien":

- An honorably discharged veteran;
- An alien on active duty in the armed forces of the United States;
- The spouse or unmarried dependent child of one of the persons.

Qualified Aliens Entering the United States On or After August 22, 1996

Qualified aliens who entered the United States on or after August 22, 1996 are not eligible for the Maryland Medical Assistance Program for a period of five years after either:

- the date of entry into the United States as a qualified alien or

- **the effective date of qualified alien status** if Revised 11/02 the person was not a qualified alien at entry to the US.

The five-year bar applies to the following qualified aliens:

- Lawful permanent residents;
- Aliens granted parole for at least one year; and
- Battered aliens.

The five-year rule does not apply to the following:

- Refugees;
- Asylees;
- Cuban and Haitian entrants;
- Victims of a severe form of trafficking;
- Aliens admitted to the country as an Amerasian immigrant;
- Legal permanent residents (LPRs) who first entered the country under another exempt category (e.g., as a refugee, asylee, Cuban or Haitian entrant, trafficking victim, or alien whose deportation was being withheld) and who later converted to LPR status;
- Aliens whose deportation is being withheld;
- Qualified aliens who also are an honorably discharged veteran, on active duty in the United States armed forces, or the spouse or unmarried dependent child of a an honorably discharged veteran or active duty serviceman;
- Members of a federally-recognized Indian tribe; and
- Certain American Indians born in Canada.

The above exceptions meet the citizenship requirements for the Maryland Medical Assistance Program with proper documentation of their alien status.

If qualified alien status is not verified through the SAVE system, the following documentation may be used:

Documentation that Applicant is a Qualified Alien

Acceptable documentation of qualified alien status consists of the following:

◦ Lawful Permanent Resident - INS Form I-551, or for recent arrivals, a temporary I-551 stamp in a foreign passport or on form I-94.

NOTE: The INS has replaced Forms I-151, AR-3 and AR-3a. If a lawful permanent resident presents one of these old INS forms as evidence of status, contact INS to verify status by filing a G-845 and attaching a copy of the old form. Also refer the applicant/beneficiary to INS to apply for a replacement card.

○ Refugees - INS Form I-94 endorsed to show entry as refugee under section 207 of the INA and date of entry to the United States; INS Form I-688B or I-766 annotated "274a 12(a)(3)" or Form 1571.

○ Asylees - INS form I-94 annotated with stamp showing grant of asylum under section 208 of the INA; a grant letter from the Asylum Office of the INS; Form I-688B or I-766 annotated "274a 12(a)(5); or an order of an Immigration Judge granting asylum. If the applicant/beneficiary presents a court order, contact INS to verify that the order was not overturned on appeal by filing a G-845 with the local INS district office,

attaching a copy of the document.

○ Alien who has had deportation withheld under §243(h) of the INA-Order of an Immigration Judge showing deportation withheld under §243(h) and date of the grant; or Forms I-688 or I-766 annotated "274a. 12(a)(10)." If applicant/beneficiary presents a court order, contact INS to verify that the order was not overturned on appeal by filing a G-845 with the local INS district office, attaching a copy of the document.

○ Alien granted parole for at least 1 year by the INS- INS Form I-94 endorsed to show grant of parole under §212(d)(5) of the INA and a date showing granting of parole for at least 1 year.

○ Alien granted conditional entry under the immigration law in effect before April 1, 1980-INS Form I-94 with stamp showing admission under §203(a)(7), refugee-conditional entry; or Forms I-688B or I-766 annotated "274a 12(a)(3)."

Evidence of Honorable Discharge or Active Duty Status

Acceptable documentation of honorable discharge or active duty status include the following documents:

○ Discharge: - An original of the veteran's discharge papers issued by the branch of service in which the applicant was a member.

○ Active Duty Military: - An original of the applicant's current orders posting the applicant to a military, air or naval base.

○ A self-declaration under penalty may be accepted pending receipt of acceptable documentation.

Non-Qualified Aliens

Any legal alien who fails to meet the definition of a qualified alien (including aliens formerly considered PRUCOL) and qualified aliens arriving after August 22, 1996, except those eligible for full MA benefits, are considered "non-qualified" aliens. Non-qualified aliens also include illegal aliens. These individuals are not eligible for full MA benefits in a federal category. An illegal or otherwise ineligible alien may be eligible for coverage of only emergency medical services in the X02 category if he/she receives treatment for an emergency medical condition and meets all other MA technical and financial eligibility requirements in COMAR 10.09.24.

Ineligible Aliens

An ineligible alien is an alien who is lawfully admitted to the U.S. for a temporary or specified time period and not for permanent residence (e.g., an alien admitted with a student visa). Ineligible aliens include the following:

- Foreign government representatives on official business and their families and servants;
- Visitors for business or pleasure including exchange visitors;
- Aliens in travel status while traveling directly through the U.S.;
- Crewmen on shore leave;
- Treaty traders and investors and their families;
- Foreign students;
- International organization representatives and personnel and their families and servants;
- Temporary workers including agricultural contract workers; and

- Members of foreign press, radio, film or other information media and their families.

Illegal Aliens

An illegal alien is any person not lawfully admitted for permanent residence in the U.S. These aliens either were never legally admitted to the United States for any period of time, or were admitted for a limited period of time and did not leave the United States when the period of time expired. This group includes persons residing in the U.S. illegally regardless of the means by which the alien arrived (e.g., border crossing by boat, train, car, bus, airplane or by foot).

2. X-Track - Coverage of Certain Aliens for State-Only Medical Assistance or for Only Emergency Medical Services

Certain “non-qualified” aliens who are not eligible for full Medical Assistance benefits in a federal category may be covered for full benefits in the State-only medical care coverage group of X01 or for only emergency medical services in the federal category of X02.

Children and Pregnant Women – Aliens (X01)

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 contained certain provisions restricting the eligibility of certain legal aliens for the federal MA Program. Covered for full MA benefits as State-only are children and pregnant women who arrived in the United States on or after August 22, 1996, meet the definition of “qualified alien”, but fail the citizenship requirements for federal coverage. They are eligible for State-only MA if the

alien is:

- (1) Younger than 18 years old;
- (2) A full-time student and reasonably expected to complete a program of secondary education or the equivalent level of vocational or technical training before the end of the calendar year in which the child turns 19 years old; or
- (3) Pregnant.

Emergency Medical Services for Illegal or Ineligible Aliens (X02)

A “non-qualified” alien, who fails to meet the citizenship requirements for full benefits under federal MA and who is not a child or pregnant woman eligible for X01, may be eligible for federal coverage of treatment of an emergency medical condition only. The illegal or otherwise non-qualified alien must meet all the financial and non-financial requirements of MA eligibility as defined in COMAR 10.09.24 and Chapters .05 and .09 of this Manual, except the technical requirements related to citizenship and a Social Security number (SSN).

Explanation of Emergency Medical Services

A “non-qualified” alien may be covered under X02 if the alien has an emergency medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

- Placing the patient’s health in serious jeopardy;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

Emergency medical services are not covered if they are related

to an organ transplant procedure.

Every labor and delivery is considered an emergency under this coverage provision.

General Eligibility Requirements

1. Except for citizenship/alien status requirements and enumeration (Social Security number), all MA technical and financial eligibility requirements for either the Families and Children (FAC) or the Aged, Blind or Disabled (ABD) coverage groups must be met for X02 coverage.
 - These requirements include assistance unit requirements and the consideration of income and resources of assistance unit members. Also considered are the income and resources of the spouse of a member or the parents of an unmarried minor child (under 21 years old).
 - A person between the ages of 21 and 64 who is not the parent or caretaker relative of an unmarried minor child in the household (i.e., is not technically eligible under rules for the Families and Children coverage category) must be determined blind or disabled by the Social Security Administration or DHR's State Review Team in order to meet the technical eligibility rules for the Aged, Blind Disabled coverage category.
 - The documentation of a person's immigration status is not required for coverage of emergency medical services. Also, aliens being considered for X02 coverage are not required to provide or apply for an SSN.
2. Only the person with incurred expenses for emergency medical

services may be certified in the X02 coverage group.

Medical Eligibility Requirements

1. Documentation of Emergency Services Other than Labor and Delivery Services. For an alien to be eligible in X02, the service received must be consistent with the Explanation of Emergency Medical Services above. The determination of whether the service meets the coverage requirements is determined by DHMH's review of the medical report about treatment received by the person. The medical report must be in sufficient detail to determine both the diagnosis and whether or not the treatment was of an emergency nature.

The medical documentation must include:

1. Diagnosis (or diagnoses) and
2. Description of treatment and
3. Dates of treatment.

The following is a list of acceptable medical documentation:

- When the patient has been discharged:
 1. Discharge summary

or

 2. Complete diagnoses, complete description of treatment and dates of treatment.

- When the patient has not been discharged:
 1. Admission/Emergency Room Sheet and
 2. Admission history and physical and
 3. Complete description of treatment to date.

- When the patient requires on-going treatment:

1. Detailed plan of care and
2. Time frames for plan of care.

The following materials are unacceptable for medical documentation:

1. Bills
2. Nurses' notes
3. State Review Team (SRT) materials, including DHR 402B
4. Case record materials, including immigration documents.

2. Documentation of Disability

Since coverage is available only to persons eligible in a federal category, a disability determination may be necessary in some cases. If the disability is not related to the emergency medical treatment but is necessary for a determination of eligibility in a federal category, the DHMH 4203 may be used for these purposes. However, if the condition which required the emergency treatment is the same as that which is believed to satisfy a disability requirement, the record of the emergency treatment should satisfy both the requirements in item 1., above, as well as those of this section.

In order to expedite the process if a disability determination is required, it is suggested that local departments not delay the SRT referral pending a determination of whether the services received meet the requirements of emergency medical services. However, regardless of the SRT decision, the applicant is not eligible if the emergency treatment criterion is not met. Conversely, the applicant is not eligible if the treatment was of an emergency nature but the applicant is not eligible in a federal MA category.

Documentation of Labor and Delivery Services

The applicant/representative must provide the LDSS with a copy of her Discharge Summary that is signed by her physician and also includes her name, admission and discharge date, and the course of her hospital stay.

Medical Eligibility Review Process

The medical report for determining medical emergency must be referred to: ←

**DHMH, Beneficiary Services Administration
201 West Preston Street, Room L-9
Baltimore, Maryland 21201**

Revised
2/02

Please mark envelopes: "Alien Emergency Services".

The DES 401 should accompany each report. The medical report will be evaluated by a Program physician to determine if the services received were for the treatment of an emergency medical condition. The local department will be notified of whether the services received meet that requirement.

NOTE: The medical eligibility review process does not apply to labor and delivery services. The LDSS will determine whether the woman meets the medical eligibility requirements based on the documentation of the labor and delivery services discussed above.

Certification of Eligibility for X02

If all eligibility requirements are met, certify on an OTO (one-time-only) basis the alien who has the incurred expense for the approved emergency service (including labor and delivery). Certify only for the month(s) in which the approved emergency service was received.

Denial of Eligibility for X02

Process the denial of an application for emergency medical services in the usual way on CARES. Additional denial reasons relevant for X02 include:

- "The service provided was not emergency in nature"
- "Technically ineligible (non-federal)"

EMERGENCY SERVICES TO INELIGIBLE ALIENS

Date: _____

TO: DHMH, Beneficiary Services Administration
201 West Preston Street, L-9
Baltimore, Maryland 21201

FROM: Local Department _____
Medical Assistance Unit

Unit Address: _____

Caseworker: _____

Telephone #: _____

RE: Determination of Emergency Services - Aliens

Case Name: _____

Case Number: _____

Date of MA Application: _____

The above-named applicant has submitted a Medical Assistance application for coverage of emergency services received from

_____ to _____ at _____
(date) (date)

Attached please find a copy of the medical report on the emergency services received by the applicant. Please provide a determination of whether or not the services meet the criteria for emergency services.

CARES Certification Procedures for X-Track for Aliens

CARES does not calculate financial eligibility for the State-only X01 (Medical Assistance for children and pregnant women - aliens) or the federal category of X02 (emergency medical services for illegal and ineligible aliens).

Therefore, if the applicant meets MA technical eligibility requirements other than citizenship and SSN, determine financial eligibility through the Trial Budget process in CARES. The following procedures have been implemented for processing applications for these coverage groups.

1) To determine if the applicant is financially eligible to receive Medical Assistance benefits, screen the applicant in the X01 or X02 coverage group, as appropriate. Initiate the trial budget process by pressing "PF18" on the "CIRC" screen. In Trial Budget use the "P" track for X01. Use the "P", "F" or "S" track for X02, depending upon the assistance unit composition.

2) a. If the applicant meets financial eligibility, print the "ELIG" and "MAFI" screens and include in the narrative that the MA eligibility determination is based upon a "Trial Eligibility" determination. Interview, Process and Finalize the case in the X01 or X02 category. Suppress the CARES notice and send the manual Notice of Eligibility.

b. If the applicant fails financial eligibility, print the "ELIG" and "MAFI" screens and include the reason for denial in the case narrative. Go through Interview, and deny the assistance unit on the "STAT" screen using the 572 reason code - "Worker Voided Application". Process and Finalize the AU, suppressing the notice on the "MAFI" screen. Send out the manual Notice of Ineligibility.

B. Residency.

(1) *In order to be eligible for the Maryland Medical*

Assistance Program, a person shall be a resident of Maryland.

The applicant's statement of his residential address on the signed application will be accepted as verification of State residency. No other verification of residency is necessary, unless the local department has reason to question the truth of the statement. Reason to question the stated address exists when the applicant furnishes inconsistent address information or when the applicant's address information varies from community knowledge or other information in the possession of the local department. In these instances, proof of the residential address must be provided by the applicant to meet the technical eligibility requirement of Maryland residency.

Note that a person who enters Maryland for other than a temporary purpose becomes a resident of Maryland on the day of entry.

No minimum duration of in-state residence can be required. Residency established on any date in the month of application for the Maryland Medical Assistance Program constitutes residency for the full month. A person who was a Maryland resident for only part of the period under consideration is ineligible on the basis of residency for any month in which he was not a resident.

- (2) *A person entering the State for a temporary purpose is not a resident of Maryland, except as otherwise specified in this section.*

A person is not a resident of Maryland if he came into Maryland for a specific, time-limited purpose and does not intend to remain here. (Note the exceptions for persons seeking employment and migrant workers and their families). A person who comes to Maryland voluntarily only seeking non-institutional medical care is not a resident of Maryland. A visitor to the State is not a resident.

A student from another state may or may not be a resident of Maryland. Among the factors to consider with regard to a student are: registration status with the school (in-state or out-of-state student), voter registration, address of record for student aid, and state of issuance of driver's license.

A person may not be eligible for Medical Assistance in two states at the same time. This does not mean that a case may not be open in two states at the same time. When a person moves from one state to another, the person is no longer eligible in the former state of residence. However, it may be administratively impossible for the former state to close the case immediately. The eligibility technician (ET) may not wait for the former state to process a case closure before granting MA eligibility to an otherwise eligible person. The fact that a case is still open in another state is not sufficient reason to deny or delay an otherwise eligible case. When granting eligibility in such a case, the ET should still make every effort to verify that the former state is aware of the change of residency. The case should be flagged for a reasonable interval to insure the closing is eventually verified.

- (3) *Residency is retained until abandoned. Temporary absence from the State, with the intention to return to the State, does not interrupt continuity of residency.*

The situation of a person who routinely lives part of each year in another state must be evaluated to determine which state is the permanent residence. A person is a Maryland resident if throughout his annual absence from Maryland he declares his intention to remain a resident of Maryland, he has an established residential address to return to in Maryland, and he has not been certified for Medical Assistance in another state. The anticipated dates of absence from Maryland should be ascertained and the case flagged for the anticipated date of return, if it falls within the certification period.

Routine absence from the State does not include periods of absence for medical treatment preauthorized under the Maryland Medical Assistance Program or for unanticipated medical care. Such absences would not adversely affect Maryland residency.

- (4) *Notwithstanding any other provisions of this section, the state of residence for a recipient of a state supplementary SSI payment is the state making the supplementary payment.*

A person receiving state-supplemented SSI from another state may move to Maryland with the intention of making his permanent home here. This person is not automatically eligible for Medical Assistance in Maryland until his change of state residence has been verified and appropriate changes in his payment amount have been made by the Social Security Administration. SDX provides the appropriate verification. Note: A person may become ineligible for SSI if he has income exceeding the basic SSI limitation and was eligible in his former state of residence only because of the higher

state supplement limitation.

(5) *Residency Criteria for Non-Institutionalized Persons.*

(a) A Non-Institutionalized Person Younger than 21 Years Old.

(i) Residence shall be established for the parent or parents or other caretaker relative with whom a non-institutionalized person younger than 21 years old lives. A child assumes the residence of the parent or other caretaker relative with whom the child lives.

(ii) Residence shall be established for the non-institutionalized person younger than 21 years old when it is determined that the child is not living with a parent or other caretaker relative and these persons are no longer responsible for the day-to-day care and supervision of the child.

(b) A non-institutionalized person 21 years old or older is a resident of the state in which he:

(i) Is living voluntarily with the intention of making his home; or

(ii) Is living at the time of application, if he is not receiving assistance from another state, and entered with a job commitment or seeking employment (whether or not currently employed).

The person who declares that he entered Maryland seeking employment meets the residency requirement. Proof of employment search is not necessary. However, the

eligibility technician should advise the applicant who has been unsuccessful in finding employment of the services available through the local Employment Security office and any other public employment agency operating in the area.

- (c) The temporary purpose restriction shall be waived for members of an assistance unit with a migrant worker, if the migrant worker otherwise qualifies.
- (d) Notwithstanding any other provisions of this regulation, the state of residence for a person placed in another state is the state making the placement.

(6) *Residency Criteria for Institutionalized Persons.*

- (a) For the purpose of this section, a person is considered incapable of indicating intent if:
 - (i) His IQ is 49 or less, or he has a mental age of 7 or less, based on tests acceptable to the DHMH Developmental Disabilities Administration;
 - (ii) He is judged legally incompetent; or
 - (iii) Medical documentation, or other documentation acceptable to the State, supports a finding that he is incapable of indicating intent.

Most persons residing in Maryland institutions are considered Maryland residents on that basis. However, some of these people should not be considered Maryland residents (such as, a person

placed by another state in a Maryland facility or a person under 21 years of age whose parents do not live in Maryland). For all other institutionalized persons, the ability to indicate an intent with regard to state residency governs the determination of the state of residence.

A person who had been judged legally incompetent or has been determined to be incompetent according to the procedures set out above may not make a binding statement of intent on his own behalf. The date on which the person is considered to have become incapable of indicating intent will be the date established by the court as the first day of incompetency, the date of the adjudication if no prior day of onset is specified by the court, or the date established by the certifying physician. The incompetency status will continue until rescinded by the court or revised by the certifying physician.

The person for whom current (within 6 months of the date of application) IQ or mental age determination exists will be determined incapable of indicating intent if those findings indicate an IQ of 49 or less or mental age of 7 or less. The IQ or mental age determination must have been made by a testing agency approved to administer IQ or mental age tests by the state of Maryland. Approved agencies include federal, state, and local governments; local boards of education; and licensed psychiatrists, psychologists, and associations of same. The effective date of the inability to indicate intent will be the date established by the testing agency as the earliest date to which the findings are applicable, or the date of the testing if no prior date of applicability is specified by the testing agency. The IQ or mental age determination will remain applicable

until modified by a more recent IQ or mental age determination made by an approved testing agency. An applicant is not required to prove IQ or mental age.

Any other institutionalized person will be assessed on the basis of his own statement of his ability to indicate intent, if he is representing himself in the application process.

- (b) A person is a resident of Maryland if he resides in an institution in Maryland, except as provided elsewhere in this section.
- (c) Notwithstanding any other provisions of this section, the state of residence for a person placed in an institution located in another state is the state making the placement.

A resident of a Maryland long-term care facility can intend to remain in that facility for an indefinite period and be considered a Maryland resident, while still having an intention to return to his home out-of-state at the end of his institutional stay. The out-of-state home may be excludable as home property.

- (d) A person younger than 21 years old is a resident of the state in which:
 - (i) His parents (or his legal guardian if one has been appointed) reside; or
 - (ii) The parent applying for Medical Assistance on his behalf resides (if the parents reside in separate states and there is no appointed legal guardian).
- (e) An institutionalized person who is 21 years old or older and became incapable of indicating intent when he was younger than 21 years old, is a resident of the state in which:

- (i) His parents or his legal guardian (if one has been appointed) reside; or
 - (ii) The parent applying for Medical Assistance on his behalf resides (if the parents reside in separate states and there is no appointed legal guardian).
- (f) Any other person who is 21 years old or older is a resident of the state in which he is living with the intention to remain permanently or for an indefinite period.

C. Age.

1. In order to be eligible as an aged person, a person shall be at least 65 years old.
2. For determining a person's age, July 1 shall be used as an arbitrary birthdate if the year, but not the month, of birth is known.
3. An age is reached the day before the anniversary of birth.
4. A person is considered aged beginning with the day before the anniversary of birth. When the month of birth is not known and the arbitrary birth date of July 1 has been established, the person is considered aged in July. The regulations applying to aged, blind, or disabled persons may not be applied to a non-blind or non-disabled person for any month prior to the first month that the person may be considered aged as determined by this standard.

5. The local department of social services shall accept the Social Security Administration's determination of age 65 for a person receiving a Social Security benefit based on age 65.

D. Blindness.

1. In order to be eligible as a blind person, a person shall meet the definition of blindness of Regulation .02B of COMAR 10.09.24.
2. Procedure for Determination of Blindness.
 - (a) The person shall be examined by an ophthalmologist or a licensed optometrist unless both of the person's eyes are missing.
 - (b) The ophthalmologist or licensed optometrist shall submit a report of the examination to the local department of social services.

Phase III - Reimbursement Requirement Not Met

If the LDSS does not receive a notice of reimbursement, no action is required on the cancelled case until the person reappplies. Upon reapplication, follow standard procedures to determine eligibility based on the new application date. The person is ineligible throughout each month following the month of cancellation in which excess resources existed.

If the recipient decides to reimburse the Program, he simply writes a check and mails it to the address indicated on the notice. The Division of Recoveries will send both the representative and the local department a receipt for the payment.

REAL PROPERTY

Home Property

The principal place of residence, or home, of an applicant/recipient (A/R) is generally excluded as a resource. "Home" is defined as any property in which a member of the assistance unit or any person whose income and resources are considered has an ownership interest and which serves as the individual's "principal place of residence". It is the shelter that the person considers his fixed or permanent residence and to which, whenever absent, the person intends to return.

Only one residence may be considered home property for an assistance unit. Real property may be excluded as home property even if the A/R is temporarily absent from it, providing the A/R intends to return and maintains it as the principal place of residence. It does not matter how soon the person intends to return. The individual's "principal place of residence" is verified based on the address used on official documents, such as bank statements, driver's license, tax forms.

There is no limit on the acreage of home property, which includes any land which appertains to the home and any other buildings located on such land. To appertain to the home, the real property must adjoin the plot on which the home is located and not be separated from it by intervening real property owned by others.

Where real property adjoins the plot on which the home is located and has contact with that plot, it does not matter if there is more than one document of ownership (e.g., separate deeds). It also does not matter that the home was obtained at a different time from the rest of the real property or that the holdings may be assessed and taxed separately. In considering whether real property appertains to the home plot, do not consider easements or public rights of way (e.g., streets, roads, utility lines) which run through or by the land and separate the land from the home plot or from the rest of the land. Watercourses, such as streams and rivers, do not separate land, but are included in the term "land". Land parcels which are adjoined side-by-side, corner-to-corner, or in any other fashion are considered to appertain to each other.

If the individual (and spouse if any) moves out of his or her "home" without the intent to return, the "home" becomes a countable resource because it is no longer the individual's "principal place of residence." If the individual moves into an assisted living facility, the facility becomes the "principal place of residence", unless it is documented that the individual is there for a short-term stay such as for respite care. The individual's equity in a former "home" becomes a countable resource effective the first day of the month following the month it is no longer his or her "principal place of residence."

When a recipient sells an excluded home property or has another type of cash settlement on it (e.g., insurance claims), the recipient has 90 days from the date of settlement to commit the money for an excluded home property, in order for the settlement to be excluded as a resource.

Home Property of an Institutionalized Person

For a person who is absent from the home due to institutionalization, the person's "home" is still the property in which the person (and spouse, if any) has an ownership interest and considers his fixed or permanent residence. The home property may be excluded as a resource if the person intends to return and the property is not held in a life estate with full powers. The excluded home property may be in Maryland or out-of-state. A resident of a Maryland long-term care facility (LTCF) can intend to remain in the LTCF for an indefinite period while still intending to return to his home, in-state or out-of-state, at the end of the institutional stay. Irrespective of the person's intent to return, the home may still be excluded as home property if a spouse or dependent relative (as defined below) of the institutionalized person continues to live in the home.

First, determine if the property can be excluded. If the property is excluded as a countable resource, then determine if a lien should be placed on the property. Never place a lien in order to exclude otherwise countable real property.

The DHMH Form 4255 (Statement of Intent to Return) must be completed for all LTC applicants, whether or not there is a spouse living in the home. This is because, in addition to the home's excludability and the applicability of lien procedures, the applicant's answer to the Statement of Intent to Return will determine whether the applicant's resources

are to be evaluated under COMAR 10.09.24.08G (does intend to return) or 10.09.24.08H (does not intend to return). The statement of intent may be made and signed by either the institutionalized person or the representative.

The property of an institutionalized person is excluded as the home if the institutionalized person intends to resume living in the home property, documented by signature on DHMH Form 4255. Whether or not the expressed intent is reasonable is irrelevant so far as excludability of the home property is concerned.

The home property is excluded as a resource, regardless of the institutionalized person's intent to return, if it is occupied by the A/R's:

- Spouse; or
- Any one of the following relatives if determined to be medically or financially dependent:
 - Adult or minor child, stepchild, grandchild
 - Adult or minor sibling, including step or half
 - Parents, including step and in-laws, and grandparents
 - Aunt/uncle and niece/nephew

If the institutionalized person expresses the intent not to return to home property, and a spouse or "dependent relative" does not reside in the property (or dies), it is a non-excluded, countable resource which must be evaluated in accordance with the appropriate provisions of this section, unless other provisions of this section cause it to be excluded.

If the decision is that the property is a countable resource, its equity value should be added with other countable resources to determine resource eligibility. The individual's equity in a former "home" becomes a countable resource effective the first day of the month following the month it is no longer his or her "principal place of residence" or "home property". The individual's "principal place of residence" is verified based on the address used on official documents, such as bank statements, driver's license, and tax forms.

Factors to Consider in Determining Occupancy and Dependency of Relatives

Dependency in this provision applies to the relative's own financial and/or medical condition which results in the relative's need to live in the home of the institutionalized person. It does not mean that the relative is or was actually a dependent of the institutionalized person.

The LDSS will make a decision on the relative's occupancy and dependency based on the following considerations:

- The AVR's unmarried son or daughter younger than 21 years old will be considered financially dependent without documentation other than age.
- The AVR's aged (65 years or older) son or daughter will be considered medically dependent upon documentation of age alone.
- A son, daughter, or other relative (as specified above) who was previously determined blind or disabled by the Social Security Administration (or by DHR's State Review Team as part of a MA eligibility determination) will be considered medically dependent without further documentation.
- If the relative's medical, mental, emotional condition, or age are such that requiring the relative to make other living arrangements would create hardship and the relative occupies the home, the conditions of dependency and occupancy are met as follow:
 - If the relative's financial circumstances are such that requiring the relative to move would create financial hardship and the relative occupies the home property, the relative is considered to be financially dependent; or
 - If the property is and has been the relative's residence for at least 2 years prior to the institutionalized person's admission to a LTCF, and the relative does not own or maintain another residence, the relative is considered to be financially dependent.

Local departments may require reasonable verification of occupancy circumstances or conditions of dependency, as follows:

- Begin with having the relative submit a written statement of occupancy and

condition of dependency. Verification of income and resources of a relative may be required to determine if a relative is financially dependent to the extent that the shelter arrangements in the immediate geographic area are greater.

- A severely handicapped or incapacitated person, though not blind or disabled, may suffer emotional or physical trauma if required to make other living arrangements. The relative may be required to verify any of these conditions with a statement from a physician.
- A relative who claims to have lived in the home for at least 2 years prior to the institutionalized person's admission to a LTCF may be required to provide evidence of this.

Lien on Home Property

If the decision is to exclude the home property, determine if the lien provision applies. However, never place a lien in order to exclude otherwise countable real property. The lien process can only occur after an institutionalized person is determined to be MA eligible in a long-term care category.

- While the AVR's spouse lives in the home, the home is excluded as a resource and a lien is not applicable, regardless of the AVR's response on the "Statement of Intent to Return".
- If the AVR's response on the "Statement of Intent to Return" is "no" and the home is not occupied by the spouse or a "dependent relative" (as defined above and also in COMAR 10.09.24.08), the home is counted as a resource. If a "dependent relative" occupies the home, it is excluded as a resource, and the eligibility worker must then determine if a lien is applicable. A lien is not applicable if the "dependent relative", as specified on the "Lien Worksheet, Part II" (and also in COMAR 10.09.24.15), is the applicant's:
 - spouse,
 - child under 21 years old,
 - son or daughter who was previously determined blind or disabled by SSA or SRT,
or

- sibling who has an equity interest in the home and was residing in the home for at least 1 year immediately before the date of the applicant's admission to a LTCF.
- If a lien may be applicable, proceed with the Medical Review process to determine if there is a likelihood that the applicant will return home. If yes, a lien should not be applied. If no, proceed with imposition of the lien on the home and any other real property.
- If the answer to the "Statement of Intent to Return" is "yes", there is no spouse or dependent relative in the home, and the home is deeded as a Life Estate with full powers, the home is a countable resource and no lien applies.
- If the home is subject to a lien, so is any other real property owned by the applicant. If the home is not subject to a lien, neither is other real property.
- Deny eligibility if the applicant or representative objects to a lien.
- The lien will be lifted if the recipient is discharged from the LTCF and resumes permanent residence in the home. Residence at any other location (e.g., assisted living facility, child's home) will not cause the lien to be lifted.
- If the spouse or dependent relative dies or vacates an excluded home, use the "Statement of Intent to Return" to reevaluate the home for excludability and applicability of a lien.

Sale of Home Property Before Completion of Lien Process

Local departments are expected to follow the lien procedures, when appropriate, for the home or other real property. If, for any reason, the home or other real property of a recipient is sold before completion of the lien process, the following procedures apply to the treatment of the proceeds from the sale:

1. Determine the amount of MA payments on the recipient's behalf. This information may be obtained by calling the DHMH Division of Recoveries and Financial Services at (410) 767-1781.
2. Instruct the recipient/representative to reimburse the Program by check in the amount of MA payments on the recipient's behalf. The check should be made payable to:
 - "Department of Health and Mental Hygiene"
 - "DHMH" or
 - "MA Recoveries"

The check should be mailed to:

**Department of Health and Mental Hygiene
Division of Recoveries
201 W. Preston Street
Baltimore, Maryland 21201**

or

**Department of Health and Mental Hygiene
Division of Recoveries
P.O. Box 13045
Baltimore, Maryland 21203**

3. Consider any remaining amount as a countable resource.

Ownership of Life Insurance

Life insurance policies are considered to belong to the insured unless the policy states that someone other than the insured owns the policy. For questionable ownership (e.g., in cases of minors), clarification can be made with the insurance company. Regardless of who pays the premiums, therefore, the insured is the owner unless otherwise established.

If the A/R assigns his or her life insurance benefits to a mortician or funeral director, that assignment is always revocable (Health-Occ. § 7-405(f)). Ownership of the life insurance policy remains with the A/R, and the A/R retains the right to redeem the policy for cash. In such a case, the policy is subject to the resource limitations and exclusions applicable to any life insurance policy.

**Irrevocable Assignment of Life Insurance Policy
to Fund Funeral or Burial Services**

A life insurance policy with a face value exceeding \$10,000.00 is a countable resource regardless of whether it is assigned to a representative for the purpose of funding funeral or burial expenses.

In order for a life insurance policy to be an acceptable means of funding funeral or burial services and, therefore, excluded as a resource, an assignment of the policy must accompany the life insurance policy and contain the following provisions:

1. The life insurance policy (policy number) is irrevocably assigned to the applicant's representative (representative's name) on the condition that the representative must use the proceeds from the policy solely for the funeral or burial of the insured. (Dated signatures of the insured and the representative are required.)
2. This assignment is permanent and cannot be revoked, amended or terminated. A copy of this assignment was mailed to (name of life insurance company) at (address of life insurance company) on (date).

(Note: Required provisions # 3 and #4 follow on page 800-38-1.)

is filed with a court periodically to give an accounting of the trustee's handling of the trust. It will include the beginning value of assets, any income accrued, any disbursements made, and the current value. This report should be obtained in order to verify income countable to the A/R and current assets in the trust.

If the trustee is not required to file such a report, other documentation must be obtained to verify income, disbursements, and the current status of the trust. Records compiled by the trustee must be accompanied by supporting documents, such as bankbooks, cancelled checks, receipts, etc.

Evaluation of Trusts

A trust may represent a countable asset, a source of income, or a disposal subject to penalty. In order to properly evaluate a trust, many factors must be taken into consideration. The first factor to consider is whose money went into the trust. **A trust may only be considered as a resource for an applicant/recipient (A/R) if some or all of the funds going into the trust were from the resources or income of the A/R or the A/R's spouse.** The second factor to consider is the date the trust was established. The rules for treatment of trusts established on or before August 10, 1993 differ from rules for trusts established after that date. The following policies and procedures are based on the date the trust was established.

RULES FOR TREATMENT OF TRUSTS

Pre-OBRA '93

This section is applicable to trusts established on or before August 10, 1993. It does not apply to trusts established after that date. A trust established on or before August 10, 1993, but which is funded, added to, or otherwise augmented after that date is treated under the pre-OBRA rules. However, the funds placed in the trust after that date may be considered disposals. In all cases, the A/R must document when assets were placed in the trust. A trust is only treated in accordance with this policy if the assets of the applicant/recipient (A/R) and/or the A/R's spouse formed all or a portion of the trust corpus.

Medicaid Qualifying Trusts

The policies discussed below are based upon the Consolidated Omnibus Budget Reconciliation Act of 1985, HCFA Medicaid Letter 92-54, and Section 3215 of the State Medicaid Manual.

The Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272) amended section 1902 of the Social Security Act to provide that assets in certain trusts would be countable for the purpose of determining eligibility for Medical Assistance. These trusts are called "Medicaid Qualifying Trusts."

A payment from an exempted trust may be considered a disposal for less than fair market value if the goods or services received are not commensurate with the expenditure.

C. Special Needs Trusts (New requirements based on COMAR amendments effective 4/29/02)

As with any other trust, a special needs trust may only be considered as a resource for the applicant/recipient (A/R) if some or all of the funds going into the trust were from the resources or income of the A/R or the A/R's spouse. To be not countable as a resource, a Special Needs Trust established after August 10, 1993 must meet all of the following criteria below in 1. - 11. (as specified in COMAR 10.09.24.08-2C):

1. The trust is irrevocable. Any trust that may be revoked or altered does not meet this criterion and so is counted as a resource.
2. The trust states that the beneficiary is disabled under COMAR 10.09.24.05E. The beneficiary's disability must be confirmed by the Social Security Administration or by the State Review Team. If the beneficiary has not been determined disabled by SSA or SRT, the trust is counted as a resource.
3. The beneficiary of the trust is younger than 65 years old at the time the trust is established. If the beneficiary was 65 or older when the trust was established, it is counted as a resource.
4. The trust was established by the beneficiary's parent, grandparent, legal guardian or a court. If the trust was established by any other person, it is counted as a resource.
5. The trust does not contain provisions that conflict with the policies set forth in COMAR 10.09.24.08-2. This means the trust must limit distributions to those that are for the sole benefit of the beneficiary. Also, no provision of the trust may thwart the Department's recovery, upon the death of the beneficiary, of Medical Assistance benefits paid on behalf of the beneficiary. If the trust conflicts with these policies, it is counted as a resource.
6. The trust provides that the Department shall receive all amounts remaining in the trust upon the death of beneficiary, or upon termination of the trust for any other reason, up to an amount equal to the total Medical Assistance benefits paid on behalf of the beneficiary. If the trust does not provide for State recoveries, it is counted as a resource.
7. The trust does not permit distribution of trust assets upon termination of the trust that would hinder or delay reimbursement to the Department. Aside from distribution of administrative costs for termination of the trust, the Department must have first claim to the trust assets, up to the amount of Medical Assistance payments. If the trust permits distribution of its assets when it is terminated, it is counted as a resource.
8. The trust does not place time limits, or any other limits, on the Department's claim for reimbursement under COMAR 10.09.24.08-2C(8). If the trust places a limit on State recoveries, it is counted as a resource.

- (9) The trust must contain all of the following provisions:
- (a) Additions, including resources and income, may not be made to the trust after the beneficiary is 65 years old.
 - (b) Expenditures from the trust must be used for the sole benefit of the beneficiary and must be directly related to the beneficiary's health care, education, comfort, or support.
 - (c) The beneficiary may not serve as trustee or in any other capacity that would allow the beneficiary to influence or exercise authority or control over trust distributions.
 - (d) The trustee must administer the trust in accordance with all of the following provisions of Estates and Trust Article § 15-502, Annotated Code of Maryland:
 - (i) The trustee may not have an interest in the trust's assets.
 - (ii) The trustee may not have discretion to use trust assets for the trustee's own benefit.
 - (iii) The trustee may not self-deal by selling trust assets to the trustees or buying trust assets from the trustee.
 - (iv) The trustee may not loan trust assets to the trustee.
 - (e) The trustee must not take more compensation than is allowed in the provisions of Estates and Trusts Article, §14-103, Annotated Code of Maryland.
 - (f) Any leases or mortgages that the trust holds must contain a provision that they either terminate or become due and payable when the beneficiary dies or the trust is terminated.
 - (g) If the trust owns titled property that is valued at more than \$500.00, the property must be titled to the trust, except for securities which may be held in the name of a nominee.
 - (h) If the trust owns an asset jointly with another, the ownership must be as tenants in common (see page 800-4), and the ownership agreement must provide that, when the trust is terminated, the property must be sold for fair market value or the other owners must purchase the trust's interest in the property for fair market value.
 - (i) Trust assets may not be held as an on-going business or enterprise, or as investments in new or untried enterprises.
 - (j) Trust distributions may not be used to supplement Medical Assistance payments to any health care provider serving the beneficiary. The provider is required to accept Medical Assistance reimbursement as payment in full for the services billed.
 - (k) Trust assets may not be used to compensate family members of the beneficiary for serving the beneficiary in any way, including:
 - (i) Caring for the beneficiary;
 - (ii) Accompanying the beneficiary on travel;
 - (iii) Providing companionship to the beneficiary ; or
 - (iv) Serving as trustees or on a trust advisory committee.

INTRODUCTION

Before determining a person's financial eligibility for a long-term care coverage category, it must first be determined that the person is considered institutionalized and that all non-financial requirements under COMAR 10.09.24.05 have been met (see Chapter 5). Institutionalized persons must meet the same MA non-financial requirements under COMAR 10.09.24.05 as non-institutionalized persons.

Also, the application process specified under COMAR 10.09.24.04 must be followed by the Eligibility Worker and by the applicant or representative. The applicant is entitled to an eligibility determination within 30 days of the application date (or 60 days if a disability determination is required), unless the Eligibility Worker grants an extension of time limits (see Chapter 4).

There are specific provisions for evaluation of resources for institutionalized persons, especially married couples (including separated couples). The special treatment of resources for married couples is called the "Spousal Impoverishment" provision and is addressed in this chapter. The lien provision is also briefly addressed in this chapter; however, for a thorough explanation of this provision, the Eligibility Worker must refer to COMAR 10.09.24.15 (see Chapter 15).

This chapter also deals with income eligibility for institutionalized persons, which is based on a comparison of a person's available income to the cost of the person's care in a Long-Term-Care Facility. This comparison determines if the person is eligible for MA, as well as whether the Program will assist with payments towards the cost of care. If the Program assists with payments towards cost of care, the person is also required to contribute his available income towards this expense.

This chapter also addresses continuing eligibility for institutionalized persons.

The Meaning of "Institutionalized"

Persons Aged 21 or Older

A person aged 21 or older is considered "institutionalized" when he/she:

- Resides in a licensed and certified Long-Term-Care facility (LTCF);
- Has resided in an LTCF for a continuous period of 30 consecutive days or, if less than 30 consecutive days, is likely to remain there for 30 consecutive days; and
- Has a medical need for Long-Term-Care (LTC) as certified by the Utilization Control Agent on the DHMH 257.

(**Note:** If the Eligibility Worker does not receive the DHMH 257 from the LTCF by the due date for the MA LTC eligibility determination, the application should be denied due to lack of this verification, in accordance with the provisions of COMAR 10.09.24.04J(3)--Information Required. However, before the application is denied, the applicant should be given timely notice of the need for receipt of the DHMH 257 and any other outstanding verifications, and be given a due date for return of the verifications.)

A person who is admitted to a LTCF and dies is considered institutionalized.

New August 2002

For a person who has resided in the LTCF less than 30 days, the Eligibility Worker must determine if the person is likely to remain for 30 consecutive days. This information may be obtained from the person's physician, a social worker who is familiar with the person's current medical condition and living arrangement, or the Utilization Control Agent. Documentation that has been collected to determine other eligibility factors, e.g.,

Income that is received on a regular basis in a constant amount is considered based on documentation from the source of income. This includes benefits such as Social Security, pensions, V.A. benefits, etc.

Income that is variable in amount or is received less frequently than once a month is projected throughout the period under consideration based on the amounts received in the twelve months prior to the period under consideration, or on projections documented by the source of such income. This projection for the period under consideration is then converted to average monthly amounts. This type of income includes interest, dividends, one time only income, lump sum benefits, etc.

For current eligibility, the monthly amount of regular income plus the average monthly amount of variable income equals the total monthly income.

For a retroactive month, total monthly income is the amount actually received in the month.

Determining Monthly Available Income

To determine monthly available income, begin with the total monthly income as determined above and deduct the following, in the following order:

- (1) A **Personal Needs Allowance** of **\$50.00** per month for an individual or **\$100.00** for an institutionalized couple (if both spouses are institutionalized and are aged, blind, or disabled, and their income is considered available to each other in determining eligibility); Effective
7/1/03
- (2) A **Residential Maintenance Allowance**;
- (3) A **Spousal Allowance**;
- (4) Either a **Family Allowance** for minor or dependent children, dependent parents, or dependent siblings of the institutionalized or community spouse who are residing with the community spouse; or a **Dependent Allowance**, as appropriate;
- (5) **Incurred expenses for medical care or remedial services** for the institutionalized spouse that are not subject to payment by a third party, including:
 - (a) Medicare and other health insurance premiums, deductibles or co-insurance charges; and
 - (b) Necessary medical care or remedial services recognized under State law but not covered under the Medical Assistance State Plan.

The personal needs allowance is always deducted first to insure that the institutionalized person has this money available to

him/her even if the remaining income is insufficient to cover the other deductions.

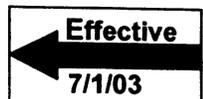
An SSI recipient is categorically needy and, as such, does not require a determination of income eligibility; however, available income must be calculated. SSI supplements a recipient's monthly income to allow the person's income to meet the SSI standard, which is \$30 for an institutionalized individual. In the first month of institutionalization, the SSI recipient is given the Personal Needs Allowance and Residential Maintenance Allowance (refer to pp. 1000-24 & 25). Since these two deductions are substantially greater than the SSI standard, there is no remaining income in the month of admission. Consequently, the SSI recipient has no income to contribute towards his/her COC. Beginning the second month of institutionalization, if an SSI recipient has no monthly income other than the SSI benefits, the SSI benefits are reduced to the SSI standard, which is less than the MA Personal Needs Allowance. Thus, the person will continue to have nothing to contribute to his/her COC. If an individual receives other non-excluded monthly income in addition to SSI benefits, the person's other monthly income is considered. The LDSS should require an application form to collect the information necessary to make an available income calculation.

To determine which deductions are applicable and the appropriate amount of each deduction, use the following guidelines:

1. Personal Needs Allowance

This is an allowance to enable the person to meet daily living expenses in the LTCF that are not covered by the Program.

- For each institutionalized person, the allowance is **\$50.00** per month. For an institutionalized couple, the allowance is **\$100.00** per month.
- For a person who resides in an intermediate care facility for the mentally retarded or mental institution and receives pay for therapeutic work activities, the personal needs allowance is \$100.00. If documented work expenses exceed this amount, additional allowance may be made for these up to the MNIL.



2. Residential Maintenance Allowance

This is a deduction to enable a lone person to maintain a community residence. A lone person is one who does not have a spouse or dependent children at home. This allowance is given if the person must pay expenses such as rent, mortgage, taxes or utilities in order to maintain his community residence.

POLICY ALERT 10-11

**MARYLAND HOME AND COMMUNITY-BASED SERVICES WAIVERS
Applicants Who Reside In a Long-Term Care Facility
EFFECTIVE: UPON RECEIPT**

Medical Assistance (MA) recipients in a long-term care facility (LTCF) who have applied for a home and community based services waiver and meet all other medical, technical, and financial waiver requirements may not be enrolled in the waiver until they are discharged from the LTCF to a community-based setting. The DHMH Division of Eligibility Waiver Services (DEWS) is responsible for processing the MA waiver application and pending it in CARES. The following procedures will be used for institutionalized MA recipients who apply for a waiver.

If the applicant has already received a “Notice of Ineligibility” for MA waiver eligibility from DEWS, the applicant must re-apply if the applicant wants waiver eligibility to be reconsidered.

For pending waiver applicants, if the waiver administering agency (the State agency or other designated entity responsible for administration of the waiver) determines that the applicant meets all the non-financial waiver eligibility requirements except that the applicant still resides in a LTCF, the waiver administering agency will send an “advisory” Authorization to Participate (ATP) to DEWS. This ATP will specify that it is an advisory ATP because the applicant still resides in a LTCF. Upon receipt of the advisory ATP, DEWS will determine MA waiver eligibility.

If the applicant is not MA waiver eligible, DEWS will send the applicant a waiver denial notice, specifying the reason(s) for MA waiver ineligibility.

If DEWS determines that the applicant appears to be MA waiver eligible based on the information provided so far, DEWS will send the applicant a waiver eligibility advisory opinion. The notice will inform the applicant that he/she may qualify for the waiver without reapplying, if he/she moves from the LTCF to the community within 6 months of the waiver application date (i.e., the date that the MA waiver application was received).

The local waiver case manager and the DEWS eligibility technician (ET) will follow up with the LTCF to establish the discharge date. The local waiver case manager will assist the applicant with the necessary arrangements for community living. When the applicant is ready to leave the LTCF, the waiver administering agency will send an “authorization” ATP to DEWS, confirming approval of waiver enrollment and proposing a waiver enrollment date (usually the discharge date from the LTCF).

If the applicant moves out of the LTCF to a community home within 6 months of the application date, a new MA application is not necessary. DEWS should inform the LTCF that it should send the discharge DHMH 257 to DEWS, rather than to the local department of social services (LDSS) which has the MA long-term care case. If the applicant is MA eligible for the waiver, DEWS will close the MA LTC case and open the MA waiver case. DEWS will send the waiver approval notice to the

applicant/representative, specifying the effective date for waiver enrollment, with a copy to the local waiver case manager and the waiver administering agency.

If the applicant does not move out of the LTCF within 6 months of the application date, the DEWS ET will send a denial notice to the applicant, giving as the reason that the MA application expired after 6 months. The applicant's representative, local waiver case manager, waiver administering agency and other appropriate parties should be copied. If the applicant is still interested in the waiver, the applicant will need to re-apply. A new application date and consideration period will be established by DEWS upon receipt of the new application.

Questions regarding this issuance should be directed to the DHMH Division of Eligibility Services at 410 767-1463 or 1-800-492-5231.

MARYLAND DEPARTMENT OF HUMAN RESOURCES
INCOME MAINTENANCE ADMINISTRATION

Department of Social Services

Date: _____

Recipient Name: _____

Recipient Address: _____

M. A. Number: _____

TO: Chief, Division of Invoice Processing
Medical Assistance Operations Administration
201 W. Preston Street, Room SS-18
Baltimore, Maryland 21201

Dear Sir:

Due to an administrative error, Medical Assistance was not previously authorized for the above named recipient. However, we have checked our records and found that he/she was eligible and has now been properly certified for the period from

Month _____ Day _____ Year _____ to _____ Month _____ Day _____ Year _____

Please accept medical providers' claims for this time period at this time and override the statute of limitations if necessary.

We regret any inconvenience that has been caused. If you have any further questions, please do not hesitate to contact me

at _____
(Telephone Number)

Sincerely,

Signature of Approving Authority

cc: _____
Provider Name

Provider Name

Provider Name

NOTE TO PROVIDER: Please submit a copy of this letter and the appropriate invoice for all claims for this period within 6 months of the date of this letter.

NOTE TO CLIENT: A copy of this letter has been sent to the above listed medical service providers. If you have other medical bills that you owe or have paid for this period, send that doctor, hospital or other provider a copy of this letter.

COMAR 10.09.24.04

APPLICATION

- (3) An Aged, Blind, or Disabled assistance unit member younger than 70 years old unless that member:
 - (a) Resides in a long term care facility, or
 - (b) Is chronically ill and non-ambulatory.

- W. An applicant shall sign consent forms as needed authorizing the Department or its designee to verify from sources such as an employer, banks, and public or private agencies, information needed to establish eligibility.

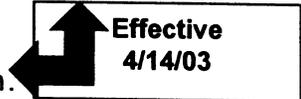
NON-FINANCIAL ELIGIBILITY REQUIREMENTS

.05 Non-financial Eligibility Requirements.

- A. Citizenship. In order to be eligible for Medical Assistance benefits for which federal financial participation is available, a person shall be one of the following:
- (1) A citizen of the United States;
 - (2) A person who resided in the United States before August 22, 1996, and who is:
 - (a) A qualified alien as defined under Regulation .02B of this chapter,
 - (b) An honorably discharged veteran of the armed forces of the United States,
 - (c) An alien on active duty in the armed forces of the United States,
 - (d) The spouse or unmarried dependent child of an honorably discharged veteran or alien on active duty in the armed forces of the United States;
 - (3) A person who entered the United States on or after August 22, 1996, and who is:
 - (a) An alien who has been granted asylum under §208 of the Immigration and Nationality Act,
 - (b) A refugee admitted into the United States under §207 of the Immigration and Nationality Act,
 - (c) An alien whose deportation is being withheld under §243(h) of the Immigration and Nationality Act,
 - (d) An honorably discharged veteran of the armed forces of the United States,

NON-FINANCIAL ELIGIBILITY REQUIREMENTS

- (e) An alien on active duty in the armed forces of the United States, or
 - (f) The spouse or unmarried dependent child of an honorably discharged veteran or alien on active duty in the armed forces of the United States; or
 - (4) A person who entered the United States on or after August 22, 1996, and who:
 - (a) Is a qualified alien as defined under Regulation .02B of this chapter, and
 - (b) Has resided in the United States for a period of at least 5 years after either:
 - (i) Entering the United States as a qualified alien, or
 - (ii) Gaining the status of a qualified alien.
- A-1. An alien, who fails to meet the citizenship requirements for which federal financial participation is available under §A of this regulation, shall be eligible for State-funded Medical Assistance if the alien is :
- (1) Younger than 18 years old;
 - (2) A full-time student and reasonably expected to complete a program of secondary education or the equivalent level of vocational or technical training before the end of the calendar year in which the child turns 19 years old; or
 - (3) Pregnant.
- A-2. An alien, who fails to meet the citizenship requirements for Medical Assistance under §A of this regulation, shall be eligible for emergency services as defined under Regulation .02B(20-1) of this chapter if the alien meets the financial and non-financial requirements of eligibility as defined under Regulations .05 and .09 of this chapter.

 Effective
4/14/03

NON-FINANCIAL ELIGIBILITY REQUIREMENTS

B. Residency.

- (1) In order to be eligible, a person shall be a resident of Maryland.
- (2) A person entering the State for a temporary purpose is not a resident of Maryland, except as specified in §B(5)(b)(ii) and (5)(c) of this regulation.
- (3) Residency is retained until abandoned. Temporary absence from the State, with the intention to return to the State, does not interrupt continuity of residency.
- (4) Notwithstanding any other provisions of this regulation, the state of residence for a recipient of a state supplementary payment is the state making the supplementary payment.
- (5) Residency Criteria for Non-institutionalized Persons.
 - (a) A Non-Institutionalized Person Younger than 21 Years Old.
 - (i) Residence shall be established for the parent or parents or other caretaker relative with whom a non-institutionalized person younger than 21 years old lives. A child assumes the residence of the parent or other caretaker relative with whom he lives.

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CERTIFICATION PERIODS**

- (b) Certification ends on the last day of the period under consideration.
 - (4) Individuals Eligible for the Maryland Medicaid Managed Care Program.
 - (a) Initial certification shall be a period of 6 months.
 - (b) Section C(4)(a) of this regulation applies only if the individual:
 - (i) Has not been eligible for Medical Assistance any time during the calendar month immediately before the month of application; and
 - (ii) Has no private health insurance.
 - (c) An individual certified under §C(4)(a) of this regulation is not subject to the unscheduled redetermination requirements of Regulation .12C(2) of this chapter.
 - (d) Subsequent certification periods shall be consistent with the provisions of this subsection.
 - (5) All Other Persons.
 - (a) Certification begins on the first day of the month of application.
 - (b) Certification ends on the last day of the period under consideration.
 - (6) Notwithstanding the provisions of §D(1)-(4) of this regulation, certification of a deceased person may not continue beyond the date of death.
 - (7) Notwithstanding the provisions of §D(1)-(4) of this regulation, certification of an eligible new member of the assistance unit pursuant to Regulation.06D of this chapter may not precede the date he becomes a member of the household.
- D. Date for Certification to Begin and End for Eligible Institutionalized Persons.
- (1) Persons Eligible for Retroactive Coverage Under Regulation .10C(5) of this Chapter.
 - (a) Certification begins on the first day of the period under consideration.

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- (b) Certification ends on the last day of the period under consideration.
- (2) Persons Eligible for Retroactive Coverage Under Regulation .10C(7) of this Chapter.
 - (a) Certification begins on the day the incurred medical expenses less health insurance and other third party coverage equal or exceed the excess available income.
 - (b) Certification ends on the last day of the period under consideration.
- (3) Persons Eligible for Current Coverage Under Regulation .10D(3) of this Chapter.
 - (a) Certification begins on the first day of the period under consideration or, at the option of the person or the person's representative, on the first day of the following month if coverage is not needed in the month of application.
 - (b) Certification continues until the person is determined ineligible and scheduled redetermination of eligibility shall be made at least once every 12 months.
- (4) Persons Eligible for Current Coverage Under Regulation .10D(5) of this Chapter.
 - (a) Certification begins on the day the incurred medical expenses less health insurance and other third party coverage equal or exceed the excess available income.
 - (b) Eligibility ends on the last day of the period under consideration or, if it is known that eligibility should terminate before the end of the period under consideration, on the appropriate earlier date, and scheduled redetermination of eligibility may not be made.
- (5) Notwithstanding the provisions of §D(1)-(4) of this regulation, certification of a deceased person may not continue beyond the date of death.

Schedule MA-8
Spousal Impoverishment Standards

	Resources	Effective
Maximum Spousal Share	\$90,660	1/1/03
Minimum Spousal Share	\$18,132	1/1/03

	Income	Effective
Basic Maintenance and Shelter Allowance	\$1,515	7/1/03
Excess Shelter Standard	\$ 455	7/1/03
Maximum Maintenance and Shelter Allowance (Sum of Basic Maintenance and Shelter Allowance and Excess Shelter Allowance)	\$2,267	1/1/03
Utility Standards:		
Heat included in rent	\$ 135	1/1/01
Heat paid separately from housing	\$ 224	1/1/01