October 10, 2025

GENERAL LETTER NO. 8-C-106

ISSUED BY: Bureau of Medicaid Eligibility Policy
Division of Community Access and Eligibility

SUBJECT: Employees' Manual, Title 8, Chapter C, **Medicaid Nonfinancial Eligibility**, Contents 1-3, 1-110, revised; 111 and 112, removed.

Summary

This chapter is revised to

- Correct the spelling of non-MAGI throughout the chapter
- Removed reference to ABC system where needed
- New Disability Determination Steps added steps added for Individuals who do not apply for SSDI or Disability Income Benefits
- Removed requirement to apply for Other Income Benefits

Effective Date

October 15, 2025.

Material Superseded

Remove the following pages from Employees' Manual, Title 8, Chapter C, and destroy them:

Page	Date
Contents 1-3	March 7, 2025
1-112	March 7, 2025

Additional Information

Refer questions about this general letter to your area eligibility determinations manager.

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Overview

All Medicaid clients must meet certain nonfinancial eligibility requirements. This chapter describes those requirements that apply to all Medicaid coverage groups in alphabetical order. These sections are followed by sections on nonfinancial requirements specific only to MAGI-related clients and to non-MAGI-related clients.

Assignment of Medical Support

Legal reference: 42 CFR 433.145, 441 IAC 75.14(4), 75 (Rule in Process)

As a condition of eligibility, Medicaid applicants and members must assign to the Department their rights to payments for medical support unless good cause exists. The support can be from any person for whom the client can legally make assignment. This includes the client's own rights to support, as well as those of other family members for whom application is made.

By signing the application form, the client or responsible person assigns payments from the client's health insurance to the Department. If other medical benefits are available to the client (possibly as a result of an injury or other trauma), the applicant assigns to the Department the rights to payment from the responsible party. This assignment begins upon the effective date of Medicaid eligibility.

Medical support payments made by an absent parent are assigned by entries on the Iowa Collections and Reporting (ICAR) system. Assignment is effective the same date that you enter information to approve the applicant's Medicaid eligibility. A Medicaid assignment does not apply to cash support payments that are not intended for medical support.

Assignment remains effective for the entire period for which assistance is granted. See Cooperation with Child Support Services for medical support determined through the child support services unit.

Medical Benefits from Other Sources

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid applicants and members must apply for and accept any medical resources that are reasonably available to them **without charge** when such resources are reasonably available to them. A medical resource is considered "reasonably available" when it may be obtained by filing a claim or an application.

Such medical resources include:

- Health and accident insurance.
- Eligibility for care through Veteran's Administration.
- Specialized health care services.
- Medicare, when the state will pay the premiums through the buy-in process.

EXCEPTION: Requirement to Apply for Medicare When Not Eligible for Free Medicare Part A.

- Medicaid applicants and members who are over 65 that do not qualify for free Medicare Part A are required to apply for **Conditional Medicare Part A** and **Medicare Part B** if they:
  - Are not already enrolled in a major medical plan,
  - Have income at or below 100% of the poverty level and assets within the Medicare Savings Plan limit, and
  - Do not receive Medicare Part B
- Medicaid applicants and members who are over 65 that do not qualify for free Medicare Part A are required to apply for **Medicare Part B only** if they:
  - Are not already enrolled in a major medical plan,
  - Have income above 100% of the poverty level and/or have assets within the Medicare Savings plan limit, and
  - Do not receive Medicare Part B.
- Medicaid applicants and members who already receive Medicare Part B are **not** required to apply for Conditional Medicare Part A as buy-in will automatically occur for Part A if QMB eligible.
- Elderly Legal Permanent Residents (LPR) are not eligible for Conditional Medicare Part A until they have lived in the USA for 60 continuous months. If the 60-months are interrupted by a trip outside of the USA that lasts at least one month, then the 60-month period starts anew with the date they return to the USA.
  - If date of entry is less than 60 months ago, set a reminder in WISE for the last month of the 60 month period and send them a request to apply for Conditional Medicare Part A and Part B as necessary in that month.

NOTE: Members may not apply for Conditional Medicare by using the online Medicare application. They must either enroll in person at their local Social Security office or they may call Social Security and schedule a telephone interview for assistance with the Conditional Medicare application.

Deny or cancel Medicaid benefits of the individual by entering a noncompliance reason in ELIAS when a Medicaid applicant or member fails to file a claim or application or to cooperate in the processing of that claim or application without proving good cause. See Cooperation in Obtaining Medical Resources and Cooperation With Investigations and Quality Control for additional information.

Citizenship

Legal reference: 42 CFR 435.406(a)(1), 441 IAC 75.11(2)“a”, P. L. 104-193

To be eligible for Medicaid, a person must be one of the following:

- A citizen of the United States,
- A U.S. national, or
- A qualified alien. See 8-L, Aliens for more information on eligibility criteria.

A “U.S. citizen” is defined as a person born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the U.S. Virgin Islands, or the Northern Mariana Islands.

People born abroad to U.S. citizen parents are generally, but not always, considered U.S. citizens.

A “U.S. national” is a person born in American Samoa, including Swain Island. However, the Independent State of Samoa (also known as Western Samoa) is not part of American Samoa, so individuals from this country are not U.S. nationals.

People who are not citizens or nationals by birth can become citizens through a process called “naturalization.” In addition, certain children born abroad who were not U.S. citizens at the time of birth may establish citizenship automatically under the Child Citizenship Act.

Declaring Citizenship or Alien Status

Legal reference: 42 CFR 435.407, 441 IAC 75.11(2)“b”, P. L. 99-603, Sec. 121, P. L. 104-193

Medicaid applicants must:

- Declare their citizenship or alien status as part of the application process.
- Have their status verified. (See Verifying Citizenship and Identity for citizenship verification requirements. For information about acceptable forms of verification for aliens, see 8-L.)

As a condition of eligibility, an attestation of citizenship or alien status shall be made for all applicants and members:

- On a state-approved Medicaid application or review form, or
- On form 470-2549, Statement of Citizenship Status.

Applicants and members must attest to their citizenship or alien status. The attestation may be signed by:

- The applicant or member, or
- Someone acting responsibly on the applicant’s or member’s behalf if the applicant or member is incompetent or deceased, or
- By any adult member of a family or household for whom Medicaid is being requested or received.

If this attestation is not made, the person for whom the attestation is required is not eligible for Medicaid (except emergency medical assistance).

Persons Exempt from Verification

Legal reference: 42 CFR 435.406, 435.407; 441 IAC 75 (Rules in Process), Sections 211(a) and 211(b)(3) of Public Law 111-3

Policy: Unless specifically exempted, all Medicaid applicants or members who claim to be United States citizens are required to have their citizenship and identity verified as a condition of eligibility.

The requirement to verify citizenship and identity **does not** apply to the following people who claim to be United States citizens:

- Current recipients of Supplemental Security Income (SSI), including 1619b individuals.

- Current recipients of Social Security disability income (SSDI) (benefits based on the person's disability).
- Current Medicare beneficiaries.
- People who were initially eligible for Medicaid due to deemed "newborn" status. This exemption continues even when "newborn" status ends, because people born in the U.S. to Medicaid-eligible mothers are permanently exempt from proving citizenship and identity.
- People born in another state who were initially eligible due to having deemed newborn status in that state. This includes people born to CHIP-eligible mothers if the other state's CHIP program covers pregnant women.

  NOTE: Children born to Medicaid–eligible or CHIP–eligible mothers in another state do not qualify for deemed newborn status in Iowa because the mother was not receiving Iowa Medicaid at the time of the child's birth.
- Children who are or were exempted while in out-of-home placement (e.g., foster care or relative placement) under the placement and care responsibility of the Department through a court order or voluntary placement agreement, regardless of the placement's licensing or payment status.
- Children who are or were exempted while in IV-E-funded subsidized adoption or subsidized guardianship.
- Applicants for presumptive Medicaid eligibility (but they are no longer exempt when they apply for ongoing Medicaid).
- Individuals who have previously presented satisfactory documentary evidence of citizenship.

NOTE: A person claiming to be an alien rather than a U.S. citizen **must** have their alien status verified as described in 8-L, Aliens. These exceptions **do not** apply to aliens.

All other Medicaid applicants or members claiming to be United States citizens **are** required to have their citizenship and identity verified as a condition of eligibility. See Loss of Exemption for procedures when a member becomes subject to verification after approval.

Procedure: Maintain any documentation needed to support the exempt status in the permanent section of the person's case file. Examples of documents showing an exempt status include:

- State Data Exchange (SDXD) printout showing current receipt of SSI.
- Benefit award letter from Social Security Administration.
- Income and Eligibility Verification System (IEVS) printout or copy of Medicare card showing current receipt of Medicare.
- Mother's SSNI screen print showing Medicaid eligibility in the month of the birth or other proof that the person had deemed "newborn" status.
- Other documents showing the person meets one of the exempt statuses.

Verifying Citizenship and Identity

Legal reference: 42 CFR 435.406, 435.407, and 435.949; 441 IAC 75.11(2)"c"; Sections 211(a) and 211(b)(3) of Public Law 111-3

Policy: Unless specifically exempted, all Medicaid applicants or members claiming to be United States citizens are required to have their citizenship and identity verified as a condition of eligibility. In most cases, Medicaid is available while the client is verifying citizenship and identity. See Reasonable Opportunity Period.

Documentation that citizenship and identity has been verified for each person subject to this requirement must be maintained in the Department's records. A hard copy of the document does not need to be retained. For this purpose, the Department's records include:

- The Inquiry Citizenship (ICIT) screen when proof was obtained electronically through the IEVS match with the Social Security Administration.
- The Vital Statistics List page in ELIAS.
- Copies of paper documents maintained in the Medicaid or Hawki case file.
- Notation in the Medicaid or Hawki electronic case file of the type of citizenship and identity verification received in either electronic or paper format.

Procedure: Electronic data matching is the primary method of verifying attested U.S. citizenship status. When possible, proof of citizenship and identity will be obtained via an automated match either through electronic data sources (EDS) in ELIAS or through Income and Eligibility Verification System (IEVS). When using the Vital Statistics Detail page in ELIAS, the verification will be displayed on the Vital Statistics List page.

When citizenship and identity is verified through the automated IEVS match, a record of the proof will be maintained electronically and displayed on the ICIT (Inquiry Citizenship) screen.

When acceptable proof is instead provided by the applicant or member, enter coding in the US and ID fields on each person's TD03 screen in the Automated Benefit Calculation (ABC) system to document that both citizenship and identity have been verified. Acceptable codes are listed in 14-B-Appendix and in "Easy Help." For cases in ELIAS, use the Vital Statistics Detail page.

See Reasonable Opportunity Period and Documentation Process for instructions on how to proceed when acceptable proof is not obtained via electronic data matching and was not provided by the applicant or member.

When a paper document is used as verification, a hard copy does not need to be retained if the verification is noted in the electronic case file.

If a member has more than one case record and citizenship and identity verification is in only one case file, note in the other case records where the documentation can be found.

Comment: Members are required to provide proof of citizenship and identity only once. Once provided, proof cannot be required again as a condition of Medicaid eligibility, unless there is reason to question the proof that was previously provided.

A person cannot receive Medicaid if that person is ineligible for a nonfinancial reason. Failure to provide proof of citizenship or identity within the reasonable opportunity period will result in Medicaid being denied or canceled. See 14-B-Appendix, Notice Codes for valid notice reasons.

Reasonable Opportunity Period (ROP)

Legal reference: 435.956(b), 435.911(c), 441 IAC 75(11)(2)(c)

Policy: Individuals whose attested U.S. citizenship status cannot be verified through an electronic data match shall be allowed a reasonable opportunity period (ROP) to provide proof of U.S. citizenship and identity. The ROP begins with the date a written request to provide the information is issued to the person or the date the **Notice of Action** is received and continues for 90 days. The date of receipt is considered to be 5 days after the date of the **Notice of Action**.

Medicaid shall be provided during the 90-day ROP if the person is otherwise eligible. If proof is not received by the end of the 90-day ROP, benefits end subject to timely notice requirements.

Procedure: Whenever possible, proof of citizenship and identity will be obtained through electronic data matching. The system will update eligibility coding if the match is consistent.

When the match is inconsistent or unavailable, the system will generate form **470-4858** or **470-4858(S), Request for Verification of Citizenship and Identity**, or form **470-4909** or **470-4909(S), Request for Proof of Citizenship and Identity**, as applicable to the case situation. The system tracks the ROP. (See Inconsistent Match or No Match for specific procedures.)

NOTE: These forms are not available for worker issuance because this would interfere with system tracking of the 90-day ROP. You may print a copy of the form from the electronic case file if necessary (e.g., if the client loses the original).

Approve Medicaid for new applicants and continue Medicaid for members during a 90-day ROP. See Retroactive Eligibility if an applicant has requested coverage in retroactive months.

For ABC cases, if acceptable proof is provided, record the receipt in the US and ID fields on the person's TD03 screen. To keep the system from incorrectly blocking subsequent Medicaid approvals, record receipt of the proof on TD03 even if the person is not currently in an active Medicaid status.

For ELIAS cases, if acceptable proof is provided, select the document type from the U.S. Citizenship Verification and Identity Verification fields. Then change the Verified field to a "verified" status.

If acceptable documentation has not been provided within 90 days, the systems will cancel the individual with timely notice.

Comment: Once a 90-day ROP begins, it does not change even if Medicaid is canceled for a different reason before the end of the 90-day period. The ROP lasts 90 days even if the person does not receive Medicaid during the entire 90-day period.

If a person who has been denied or canceled for another reason reapplies, begin a new 90-day ROP. This will be done automatically for cases in ELIAS.

No extensions are allowed for the 90-day ROP for providing proof of citizenship and identity. However, reinstatement and grace period policies do apply when proof is provided before the effective date of cancellation or within 14 days of cancellation or denial.

Continuous eligibility does not apply to children whose citizenship and identity is not verified within the 90-day ROP or the subsequent reinstatement and grace period.

ELIAS generates notification to the household about the ROP and explains what qualifies as acceptable proof, tracks the 90-day period, and cancels with timely notice if information is not received.

In ELIAS, the worker cannot see if an ROP has been granted. The worker can review past **Notice of Actions** to determine if an ROP has been granted.

For information specific to the ROP for immigrants, see 8-L, Aliens.

Loss of Exemption

Policy: When a member who was previously exempt from the citizenship and identity verification requirements loses the exempt status, Medicaid eligibility continues during the 90-day ROP.

Children losing an exempt status who are already continuously eligible are not required to verify citizenship and identity until the next annual review.

Procedure: The system will need to be updated to reflect that the member is no longer exempt from verifying citizenship and identity. EXCEPTION: For a child who is continuously eligible but loses an exempt status, do not make updates until the annual review.

Form **470-4909** or **470-4909(S), Request for Proof of Citizenship and Identity**, will be system-generated to request proof of citizenship and identity from the person, and the 90-day ROP will begin. Continue Medicaid during the 90-day ROP.

If acceptable proof is provided, record the documentation in the system.

Do not cancel the person's Medicaid due to lack of proof of citizenship and identity during the 90-day ROP. When proof is provided but is questionable or not acceptable:

- Contact the person by phone or by mail.
- Explain why the proof submitted is not acceptable, how acceptable proof can be obtained, and, if appropriate, offer to assist in obtaining the proof.
- Document phone contacts in the case file.

Retroactive Eligibility

Policy: Retroactive months are outside the ROP. Retroactive Medicaid eligibility shall **not** be approved until proof of citizenship and identity is received, and provided that retroactive coverage is needed and all retroactive eligibility requirements have been met as detailed at 8-B, Determining Eligibility for the Retroactive Period, and 8-A, Definitions: Retroactive Period.

Procedure: Process the Medicaid application as soon as it is received to begin the electronic data match process for verifying citizenship and identity. This will reduce processing delays on the retroactive portion of the Medicaid application.

Comment: Proof of citizenship and identity may be obtained directly from the applicant to allow the retroactive portion of the Medicaid application to be acted on without delay.

If proof is requested for the purpose of approving retroactive Medicaid, inform the person that submission of proof is optional unless electronic data matching does not verify the person's citizenship (including identity), but retroactive Medicaid cannot be approved until proof of citizenship and identity is received.

If the applicant provides proof of citizenship and identity, record the documentation in the system. If optional proof is not provided, take no negative action.

Documentation Process

Legal reference: Section 211(a) of Public Law 111-3; 441 IAC 75 (Rules in Process)

Policy: A person who attests to U.S. citizenship and provides name, social security number, and date of birth meets the citizenship and identity documentation requirements if the electronic data match verifies the person's citizenship (and identity).

A written request for verification shall be issued if:

- The electronic data match returns a response that does not verify the person's citizenship (and identity), or
- An electronic data match cannot be requested because the person does not have a social security number.

Procedure: The system will automatically attempt an electronic data match when a person:

- Is pended or approved on the system, and
- The system indicates documentation has not been provided.

Proof of citizenship and identity may be obtained directly from the applicant so that documentation is already on file in case the electronic data match is unable to verify the person's citizenship and identity.

> Mr. B files an application for Medicaid in person at the local office on June 28. An electronic data match will occur when his information is entered into the system.
>
> Since Mr. B is already in the local office, the IM worker records Mr. B's verification of identity since Mr. B provided his driver's license as proof of identity.

When a verification request will not be generated for a person who is required to verify citizenship and identity and has not done so, follow the procedures under No Match. A request for proof of citizenship and identity will **not** be sent when the worker indicates verification is not needed (e.g., person is exempt, verification is already on file, person is an alien).

Consistent Match (Verified)

Policy: When the electronic data match response to a request for proof of citizenship and identity is a consistent match, the person's citizenship (and identity) are verified. The person has met the citizenship and identity documentation requirements.

Procedure: No further action is needed for that person's ongoing Medicaid.

Comment: A response about an individual's citizenship (and identity) can be used **only** for the purposes of determining Medicaid or Hawki eligibility. These citizenship data matches **cannot** be used to determine eligibility for other programs (Food Assistance, FIP, CCA, etc.).

Inconsistent Match (Not Verified)

Policy: When the electronic data match response to a request for proof of citizenship and identity is an inconsistent match, the person's citizenship (and identity) are not verified. The system will generate a written request for verification of citizenship and identity to notify the person that:

- The person has 90 days to provide verification by either:
  - Correcting any errors in the name, social security number, or date of birth given to the Department so that SSA can verify the person's citizenship and identity;
  - Correcting any errors in the SSA's records and providing proof of citizenship and identity from SSA when this is done; or
  - Providing proof of citizenship and identity from the list of documents described under Acceptable Documentation.
- If proof of citizenship and identity is not provided within 90 days:
  - Medicaid eligibility will end and
  - Retroactive Medicaid, if requested, will be denied.

If the corrections produce a response that verifies the person's citizenship and identity, the system will update the coding. If retroactive eligibility has been entered in the system, a WISE alert will be sent to tell you that retroactive Medicaid coverage was requested and a decision may still be needed on retroactive eligibility.

If the person provides acceptable proof during the 90-day ROP, record the documentation in the system.

If proof is provided but is questionable or not acceptable:

- Contact the person by phone or by mail.
- Explain why the proof submitted is not acceptable, how acceptable proof can be obtained, and offer to assist in obtaining the proof if appropriate.
- Document phone contacts in the case file.

Do not cancel the person's Medicaid due to lack of proof of citizenship and identity during the 90-day ROP. If the person has not provided acceptable documentation within 90 days, the system will:

- Cancel the individual with timely notice.
- Send a WISE alert if the system shows retroactive coverage was requested, to tell you to deny retroactive eligibility.

See Retroactive Eligibility for additional information about retroactive Medicaid coverage and citizenship and identity requirements.

No Match (Not Verified)

Policy: An electronic data match request for proof of citizenship and identity will **not** be sent when:

- The person does not have a social security number or
- A request was already sent and the person's name, date of birth, social security number, or sex has not been changed on the system.

A written request for verification shall be issued. Medicaid shall be approved during the 90-day ROP.

Procedure: When proof of citizenship and identity is required for a person but cannot be requested via electronic data sources, a written request for proof will be system-generated. The request notifies the person that if proof of citizenship and identity is not provided within 90 days:

- Medicaid eligibility will end and
- Retroactive Medicaid, if requested, will be denied.

Form **470-4909** or **470-4909(S), Request for Proof of Citizenship and Identity** and **Comm. 258, Verifying Citizenship and Identity** will be system-generated and sent to a person who:

- Is approved on the system,
- Has all 9s or all 0s in the social security number field, and
- The system indicates documentation has not been provided.

NOTE: If a person with all 9s or all 0s later provides a social security number, entry of the social security number will cause a request for proof of citizenship and identity to be sent via electronic data sources.

If acceptable proof is provided during the 90-day ROP, record the documentation on the system. See Retroactive Eligibility for additional information.

If proof is provided but is questionable or not acceptable:

- Contact the person by phone or by mail.
- Explain why the proof submitted is not acceptable, how acceptable proof can be obtained, and, if appropriate, offer to assist in obtaining the proof.
- Document phone contacts in the case file.

Do not cancel the person's Medicaid due to lack of proof of citizenship and identity during the 90-day ROP. If the person has not provided acceptable documentation within 90 days, the system will:

- Cancel the individual with timely notice.
- Send a WISE alert to tell you to deny retroactive eligibility, if applicable.

See Retroactive Eligibility for additional information about retroactive Medicaid coverage and citizenship and identity requirements.

Acceptable Documentation

Legal reference: 42 CFR 435.407, 441 IAC 75 (Rules in Process), P. L. 111-3

Policy: Documents that are acceptable verification of U.S. citizenship and identity are categorized as either primary or secondary. Primary documents are acceptable proof of both citizenship and identity. When secondary documents are used to verify citizenship, separate proof of identity is also required.

See the ROP Reference Guide for a list of documents that are acceptable as verification of citizenship and identity.

An individual may use affidavits to verify both citizenship and identity. However, accept affidavits only as a last resort when no other form of verification is available. Affidavits must be signed under penalty of perjury but need not be notarized.

Original documents or copies certified by the issuing agency are **not** required. A photocopy, fax, scanned, or other copy must be accepted to the same extent as an original document, unless information on the copy submitted is inconsistent with other available information or the validity of the documentation is questionable.

Procedure: When a client submits original documents to prove citizenship or identity, **do not** date-stamp the originals. Instead, if retaining the documents, photocopy the originals and return them to the client. Date stamp the copy and place it in the case file. Make a notation in the electronic case file, of the type of citizenship and identity verification received.

Each state must conduct its own verification of citizenship and identity. However, Iowa can accept another state's copy of a document or another state's data match with that state's vital records.

Documents submitted by a person whose last name has changed (e.g., due to marriage or divorce) may be accepted if the documents match in every way except the last name. If there is reason to question whether the documents belong to the same person, request an official document verifying the change (e.g., marriage license, divorce decree).

Persons who have changed both their first and last names **must** produce documentation of the official change from a court or governing agency.

Health Insurance Premium Payment (HIPP) Program

Legal reference: 441 IAC 75.21(14)

The Health Insurance Premium Payment (HIPP) program is operated by the HIPP Unit at the Iowa Medicaid Enterprise (IME). The purpose of the HIPP program is to pay the cost of health insurance for Medicaid members when it is determined that doing so would result in cost savings to the Medicaid program.

Refer all households with a member who has health insurance available to the HIPP Unit, except under the circumstances listed in 8-M, Situations Not Covered by HIPP.

To make a referral to the HIPP Unit have the member, applicant, or parent contact the HIPP Unit as follows:

Toll-free phone: 1-888-346-9562
Local phone: (515) 974-3282
Fax: (515) 725-0725
Interoffice mail: IME/HIPP

NOTE: Refer to NJA0093, Cooperation for the process to enter a HIPP referral in ELIAS and/or the process when Medicaid has been requested and a noncompliance still exists.

Referral to the HIPP Program Not Needed

Legal reference: 441 IAC 75.21(5) and 75.21(14)"b"

A referral to the HIPP program is not needed when the only Medicaid-eligible member:

- Has Medicare.
- Is eligible for Medicaid only under one or more of the following coverage groups:
  - Medicaid for Kids with Special Needs (MKSN)
  - Medically needy
- Has health insurance maintained by another entity (e.g., an absent parent maintains insurance on the Medicaid member's children or the policyholder is not in the Medicaid household).
- Has an insurance plan designed to provide temporary coverage.
- Has an indemnity insurance policy that supplements the policyholder's income or pays a predetermined amount for medical services (e.g., $50 per day for hospital services instead of 80% of the charge).
- Has an insurance plan offered on the basis of school attendance or enrollment.
- Is the policyholder and an absent parent. CSS is responsible for obtaining cash and medical support for children in households where a parent is absent.
- Uses the health insurance premium as a deduction in computing the client participation.
- Is the policyholder or potential policyholder and is an undocumented alien.

Cooperation in Obtaining Medical Resources

Legal reference: 42 CFR 433.146-148 and 435.610; 441 IAC 75 (Rules in Process) and 75.14, 75.21(249A)

All applicants and members are required to cooperate with certain processes related to obtaining medical resources as a condition of eligibility for Medicaid, unless good cause exists for failure to cooperate. This includes pregnant minors living independently. The applicant's signature on the application form shall constitute agreement to the assignment.

Deny Medicaid benefits to an applicant who fails to cooperate in determining the availability of medical resources. However, do not deny Medicaid benefits of a child due to the failure of the child's parent or specified relative to cooperate.

This section covers procedures for:

- Cooperation with the Third-Party Liability Unit
- Good cause for failure to cooperate

Cooperation with the Third-Party Liability Unit

Legal reference: 42 CFR 433.138, 433.145-148, and 435.610(a); 441 IAC 75 (Rules in Process) and 80.3(2)

A Third-Party Liability Unit is part of the Iowa Medicaid Enterprise Revenue Collection Unit and the managed care contractors. The primary purpose of the Third-Party Liability Units is to identify and collect monies from any available medical resource that can pay all or part of a member's medical expense.

A member or a person acting on the member's behalf must cooperate with Third-Party Liability by providing information and verification about any medical or third-party resources by completing form 470-2826, Insurance Questionnaire.

Third-party resources include:

- Medicare
- Insurance policies
  - Private health insurance
  - Group health insurance
  - Liability insurance
  - Automobile medical insurance
  - Family health insurance carried by an absent parent

- Railroad Retirement benefits
- Worker's compensation
- Veterans Affairs benefits
- TRICARE (military health insurance)
- Liability lawsuits (tort action)
- Orders for restitution as a result of a criminal conviction

Send the completed **Insurance Questionnaire** to the IME Third-Party Liability Unit:

- By interoffice mail to RevCol/IME
- By fax to 515-725-1352
- By E-mail to revcol@hhs.iowa.gov

Collect and report all necessary information about an accident, including:

- The name of the insurance company.
- The policy number or claim number.
- The type of accident (motor vehicle, slip and fall, worker's compensation).
- The name and address of any attorney or insurance adjuster involved in the case.

NOTE: Refer to NJA0093, Cooperation for the process of a Third Party Liability noncompliance in ELIAS and/or the process when Medicaid has been requested and a noncompliance still exists.

Failure to Cooperate With Third-Party Liability Unit

Legal reference: 441 IAC 75 (Rules in Process)

When a person fails to cooperate with Third-Party Liability, a sanction must be applied to Medicaid eligibility.

EXCEPTION: See Good Cause for Failure to Cooperate.

Apply a sanction to a minor parent who does not cooperate. NOTE: Do not apply a sanction to a child when a parent or specified relative fails to cooperate.

A person under sanction counts in the household size.

Good Cause for Failure to Cooperate

Legal reference: 441 IAC 75.21, 75 (Rules in Process)

The Third-Party Liability or the IM worker may be responsible for determining if good cause for failure to cooperate exists. Good cause for failure to cooperate exists when the applicant, member, parent, or family has one or more of the following situations:

- Serious illness or death of a member of the family.
- A family emergency or a household disaster, such as a fire, flood, or tornado.
- Verified good cause reasons beyond the applicant, member, or parent's control.
- Not receiving a request for information for a reason that was not the member's or responsible parent's fault. A member or parent's failure to provide a forwarding address does not qualify.

Cooperation with Investigations and Quality Control

Legal reference: 441 IAC 75.29 and 76.8(249A)

Medicaid clients must cooperate with Quality Control reviewers when their case is selected for verification of eligibility. Apply a sanction to the Medicaid case if Quality Control sends you form **470-0479, Noncooperation Notice** on an active client.

Do not sanction children who are continuously eligible. See 8-F, Cooperation with DIAL and QC.

Department of Inspections, Appeals, and Licensing (DIAL) conducts front-end investigations of applicant and member cases. DIAL also conducts fraud investigations.

DIAL will send you the results of an investigation. Take into consideration the findings of the investigator. The evidence in the findings is considered verified information. Do not delay determining eligibility pending receipt of the investigator's report.

Apply a sanction to the Medicaid case if the DIAL report says the client is not cooperating. When a sanction is applied, Medicaid is not available until cooperation occurs.

EXCEPTIONS:

- Do not apply a sanction when the eligibility requirements under investigation or review would not result in the person being ineligible. (For example, do not apply a sanction to children on the case when the investigation involves resources, since resources are not considered when determining eligibility for children.)
- Do not apply a sanction if the DIAL investigation involves only the circumstances of someone whose income and resources do not affect Medicaid eligibility.
- If the report from DIAL involves an SSI recipient, do not apply a sanction unless the report is that the client moved out of state. Inform the Social Security Administration's district office of any reported findings that may affect SSI eligibility using form **470-0641, Report of Change in Circumstances--SSI-Related Programs**.

If you have sanctioned a case for failure to cooperate, do not re-establish eligibility until you are notified that the client is cooperating or that the client no longer needs to cooperate.

When a person under an existing DIAL sanction applies for Medicaid, do not determine eligibility until DIAL sends notification that the person has cooperated. Eligibility may then be determined beginning on the date of the application. NOTE: Remove the noncompliance in ELIAS.

NOTE: Refer to **NJA0093, Cooperation** for the process when Medicaid has been requested and a noncompliance still exists.

Cooperation with Child Support Services

Legal reference: 42 CFR 433.146-148 and 435.610, 441 IAC 75.14(249A)

Policy: Applicants and members in households with children must agree to cooperate in obtaining court-ordered medical support when there is an absent parent. The only exceptions are when good cause for refusal to cooperate exists. (See Good Cause for Refusal to Cooperate.) Applicants demonstrate their willingness by signing the application.

Applicants and members must cooperate in obtaining support for themselves and for any other person in the household when:

- Medicaid is requested for that person, and
- The applicant or member can legally assign rights to court-ordered medical support for that person.

A referral to CSS will be made only as listed in 8-B, Referrals to CSS.

> Mrs. J, age 40, is an SSI recipient. Her two children, ages 10 and 12, receive Medicaid coverage. Mr. J, the father of the children, is absent from the home. The children have court-ordered medical support from their absent father. Mrs. J is required to cooperate in obtaining support as a condition of her Medicaid eligibility.

Cooperation with Child Support Services (CSS) is **not** required when:

- The referred person is no longer considered a child by the program.
- A pregnant woman is eligible for Medicaid under the Mother and Children (MAC) coverage group. See Pregnant Women Who Are Exempt from Cooperation for more information.

Referrals are not required when:

- There is good cause for not cooperating. See Good Cause for Refusal to Cooperate for an explanation of client responsibilities, good cause, and what you need to do when a client claims good cause.
- The children in the household are not applying for or receiving Medicaid.

> Mrs. L is an SSI recipient. Her two children, ages 6 and 7, do not receive Medicaid. Mrs. L is not required to cooperate in obtaining support as a condition of her Medicaid eligibility.

- Children are living on their own and no parent or other caretaker is acting in a parental capacity over them.

The following sections contain more information on:

- What the client must do to cooperate
- Good cause for failure to cooperate
- Failure to cooperate
- If sanctioned parent decides to cooperate

What the Client Must Do to Cooperate

Legal reference: 441 IAC 75.14(1)“a”, “b”, “c”, and “d”

Unless good cause exists, clients must cooperate in the following areas:

- Identifying and locating the absent parent of a child for whom Medicaid is requested.

- Establishing the liability of the absent parent of a child for whom Medicaid is requested.
- Obtaining any court-ordered medical support payments for the client and for a child for whom Medicaid is requested.
- Supplying enough information about the absent parent, the receipt of court-ordered medical support, and the establishment of liability (when needed) to establish Medicaid eligibility and permit an appropriate referral to the CSS.
- Appearing at the CSS local office to provide verbal or written information to establish liability when needed and secure medical support for the children in the eligible group. This includes information or documentary evidence that the client knows about, possesses, or could reasonably obtain.
- Appearing as a witness at judicial or other hearings or proceedings.
- Providing information, or attesting to the lack of information, under penalty of perjury.
- Paying to the Department any medical support payments that the client receives after the date of decision.
- Completing and signing documents needed by the state's attorney for any relevant judicial or administrative purpose.

Child Support Services shall make the determination of whether or not the adult member has cooperated.

Special previsions apply to:
- Minors living independently of their parents.
- Pregnant women under the MAC coverage group.

Minors Living Independently of Parents

Legal reference: 441 IAC 75.14(249A)

When a minor and the minor's child are living independently of the minor's parents, the minor must cooperate with Child Support Services (CSS) only on the absent parent of the minor's child. Do not require the minor to cooperate in establishing liability or obtaining medical support from the minor's parents.

However, if the minor is living with an adult who is acting in a parental capacity, request the parent or other caretaker to cooperate with CSS.

1. The households consist of Ms. J; her daughter, Mary, age 17; and Mary's daughter Ann, age 2. This household receives Medicaid under the MAGI-related Medicaid coverage group. The worker requires Mary to cooperate with CSS on Ann's father. The worker also requires Ms. J to cooperate with CSS on Mary's absent father.
2. Mr. J, age 32, receives Medicaid for Larry, his nephew, age 4. The worker requires Mr. J to cooperate with CSS in obtaining medical support from Larry's parents, because Mr. J is acting in a parental capacity.

Pregnant Women Who Are Exempt from Cooperation

Legal reference: 441 IAC 75 (Rules in Process)

Pregnant and postpartum women who are eligible for Medicaid under the Mother and Children (MAC) coverage group do not have to cooperate in establishing liability and obtaining medical support for their Medicaid eligible born children.

Pregnant women eligible under a coverage group other than MAC must cooperate in establishing liability and obtaining support. If the woman fails or refuses to cooperate, cancel eligibility under her current coverage group, complete an automatic redetermination and establish eligibility under MAC.

1. Ms. D, age 32 and pregnant, receives Medicaid for herself and her two children, ages 6 and 8, as a household of four. Ms. D failed to cooperate with CSS. (Ms. D has an active CSS case).

   Ms. D's Medicaid eligibility is automatically redetermined under the MAC coverage group since cooperation is not an eligibility factor under MAC for pregnant women.

   Ms. D is informed that she will be required to cooperate when her postpartum period expires.
2. Ms. B, age 23 and pregnant, receives Medicaid for herself and her two children, ages 2 and 4, under MAC coverage group. Ms. B previously requested CSS services and a referral to CSS was made.

   Ms B has now failed without good cause to cooperate with CSS. The IM worker takes no further action, since no sanction can be applied until the postpartum period expires.

Good Cause for Refusal to Cooperate

Legal reference: 441 IAC 75.14(3) and (9)

Policy: Each applicant and member has the opportunity to claim good cause for refusing to cooperate with the CSS in establishing liability or securing medical support payments.

Procedure: Give applicants and members form **470-0169, Requirements of Support Enforcement**. This form explains the right to claim good cause as an exception to the cooperation requirement, and how to file a claim. Document in the case record that the form was provided.

Issue form **470-0170, Requirements of Claiming Good Cause** whenever the member:

- Asks for a copy, or
- Wants to make a claim of good cause, or.
- Indicates on the application that the member does not want to cooperate with CSS

The member has the burden of proof that good cause circumstances exist. To meet this requirement, the member must:

- Specify the circumstances claimed as good cause for not cooperating.
- Corroborate the good cause circumstances.
- Provide enough information to permit an investigation, when requested.

If an **applicant** claims good cause, do not act on the application until the time frame for providing the evidence has lapsed or until the applicant provides the evidence, whichever is sooner. You have good cause to delay the eligibility determination if the time frame for providing the evidence exceeds the time frame for processing applications.

If the applicant is making efforts but is unable to provide the evidence within the required time frame, continue pending the application until all members are eligible. Or, at the applicant's request, determine eligibility for the immediately eligible members. In the latter case, the date the ineligible person provides the required evidence is the date of application to add that person.

If a **member** claims good cause, continue Medicaid pending receipt of the evidence in the required time frame. If the member fails to provide the needed proof by the due date, cancel the member's Medicaid. See Failure to Cooperate in Obtaining Support.

Once the applicant or member has provided all necessary proof, process the good cause claim. See Making the Decision About Good Cause.

Comment: The following sections give more information on:

- Determining if good cause exists
- Evidence of physical and emotional harm
- Client responsibilities when filing a good cause claim
- Worker responsibilities when a good cause claim is filed
- Making the decision about good cause

Determining if Good Cause Exists

Legal reference: 441 IAC 75 (Rule in Process)

Good cause exists when cooperation in establishing liability and securing support is against the best interest of the child. Cooperation is against the best interests of the child only if one of the following exists:

- The child for whom medical support is sought was conceived as a result of incest or forcible rape.
- Legal adoption proceedings are pending before a court of competent jurisdiction.
- The applicant or member has been working with a public or licensed private social agency less than three months to decide whether to keep the child or relinquish the child for adoption.
- It is reasonably anticipated that cooperation would result in physical or emotional harm to the child for whom medical support is being sought.
- It is reasonably anticipated that cooperation would result in physical or emotional harm to the parent or other caretaker with whom the child is living which reduces the person's capacity to care for the child adequately.

Evidence of Physical and Emotional Harm

Legal reference: 441 IAC 75.14

Physical and emotional harm must be of a serious nature in order to justify a finding of good cause.

A finding of good cause because of emotional harm must be based on a demonstration of an emotional impairment that substantially affects the person's functioning. Consider the following when deciding if good cause exists based on anticipated **emotional** harm:

- The current and past emotional state of the person subject to emotional harm.
- The emotional health history of the person subject to the emotional harm.
- The intensity and probable duration of the emotional impairment.
- The degree of cooperation required.
- The involvement of the child in the liability establishment or medical support enforcement activity to be undertaken.

When a claim is based on the client's anticipation of **physical** harm, and corroborative evidence is not submitted in support of the claim, investigate the claim if you believe that:

- The claim is credible without corroborative evidence.
- Corroborative evidence is not available.
- Grant good cause if the claimant's statement and the investigation which is conducted provide sufficient evidence that the client has good cause for refusing to cooperate.
- Your immediate supervisor must approve or disapprove your decision. Record the findings in the case record.

Client Responsibilities When Filing a Good Cause Claim

Legal reference: 441 IAC 75.14

The client must prove the existence of good cause circumstances. Evidence must be provided within 20 days from the date of the claim. If your supervisor approves, you may allow more time in exceptional cases where the evidence is especially difficult to obtain.

A good cause claim may be supported with the following types of evidence:

- Birth certificates or medical or law enforcement records that indicate the child was conceived as the result of incest or forcible rape.

- Court documents or other records that indicate that legal proceedings for adoption are pending before a court of competent jurisdiction.
- Court, medical, criminal, child protective services, social services, psychological, or law enforcement records that indicate that the putative father or absent parent might inflict physical or emotional harm on the child, parent, or other caretaker.
- Medical records that indicate emotional health history and present emotional health status of the parent or other caretaker or the child for whom support would be sought.
- Written statements from a mental health professional indicating a diagnosis or prognosis concerning the emotional health of the parent or other caretaker of the child for whom support would be sought.
- Written statements from a public or licensed private social agency that the member is being assisted by the agency to resolve the issue of whether to keep the child or relinquish the child for adoption.
- Sworn statements from persons other than the member or applicant with knowledge of the circumstances that provide the basis for the good cause claim.

Written statements from the client's relatives and friends are not sufficient to grant good cause but may be used to support other evidence provided.

If requested, the member must also provide additional evidence that may be needed, and help with an investigation of good cause. Failure to meet these requirements is sufficient basis for determining that good cause does not exist.

Worker Responsibilities When a Good Cause Claim Is Filed

Legal reference: 441 IAC 75.14

Immediately notify Child Support Services whenever a client files a claim for good cause. Enter all information relating to the claim and determination of good cause into the case record.

When a client asks for help in getting evidence, offer suggestions about how to obtain the necessary documents. Make a reasonable effort to obtain necessary documents that the client has been unable to obtain.

Further investigation of good cause may be necessary if the client's claim and the supporting evidence are not enough to make a decision. Notify the client in writing if additional supporting evidence is needed, and what type of documents are needed.

If you need to contact the putative father or absent parent, notify the client first. The client can choose to:

- Give additional supporting evidence to avoid the need for the contact.
- Withdraw the application or have the case closed.
- Withdraw the good cause claim.

Consult Child Support Services before contacting an absent parent, and document details in the case record. If there is any indication the absent parent may try to harm the child or caretaker either physically or emotionally, be especially careful not to reveal any information about their location.

Confer with the CSS before making a final decision about good cause.

Making the Decision About Good Cause

Legal reference: 441 IAC 75.14

Within 45 days from the date the claim is filed, determine whether or not good cause exists. Determine each good cause claim at the earliest possible date. Do not use the 45-day time frame as a waiting period before determining good cause nor as a basis to deny the good cause claim.

Extend the time frame only if:

- You cannot obtain evidence needed to verify the claim within 45 days, or
- The client cannot provide supporting evidence within the 20-day limit.

Document any time extensions in the case record.

Grant good cause if the claimant's statement and the investigation which is conducted provide sufficient evidence that the client has good cause for refusing to cooperate. Your immediate supervisor must approve or disapprove your decision. Record the findings in the case record.

Notify Child Support Services within two working days after the final decision to deny or grant good cause has been made. Give Child Support Services the opportunity to participate in any appeal hearing.

Notify the client of your final decision in writing. This notification must explain the decision and the basis for the decision.

If the decision is that good cause does **not** exist, give the client the opportunity to cooperate. Notify the client that continued refusal to cooperate will result in the loss of Medicaid for the adult who fails to cooperate.

If the decision is that good cause **does** exist and a referral to CSS is required, consult with the CSS to decide whether medical support enforcement can proceed without risk of harm to the child, parent, or other caretaker if the enforcement activities do not involve their participation. (See 8-B, Referrals to CSS.)

When medical support enforcement activities will proceed without the cooperation of the parent or other caretaker, notify the client in writing.

At least once every six months, review the circumstances that led to the determination of good cause when the circumstances are subject to change.

If circumstances have changed and good cause no longer exists, notify the client in writing that child support enforcement activities will proceed, if a referral is required. Also, notify CSS within two working days of the determination that good cause no longer exists.

Failure to Cooperate in Obtaining Support

Legal reference: 441 IAC 75.14

Deny or cancel Medicaid benefits for an applicant or member whom CSS reports failed to cooperate in obtaining medical support or establishing liability without good cause. Sanction only the parent or other caretaker for failing to cooperate.

If the parent of a child who is receiving SSI or non-MAGI-related Medicaid fails to cooperate and that parent is receiving Medicaid on another case, cancel the parent's Medicaid coverage. If the parent cooperates on or after the effective date of cancelation, the parent will need to reapply.

1. Mrs. M, age 31, is receiving SSI and Medicaid. Without good cause, she fails to cooperate in obtaining medical support for her two children who are receiving Medicaid. Mrs. M's Medicaid is canceled. However, the children continue to receive Medicaid if otherwise eligible.

2. Ms. T receives Medicaid for herself and one child. Ms. T refuses without good cause to cooperate in obtaining medical support for the child. Ms. T's Medicaid is canceled for failure to cooperate. The child continues to be eligible.

If the Sanctioned Parent or Other Caretaker Decides to Cooperate

Legal reference: 441 IAC 76.12(1)"b"

A client who is not receiving Medicaid due to failure to cooperate may be eligible to receive Medicaid when the client indicates a willingness to cooperate. When adding the client back to an existing household, the date the client expresses a willingness to cooperate is the date of application. The parent or other caretaker may contact you or CSS to express willingness to cooperate. Contact with either office establishes the date of application.

NOTE: An application must be filed when the client cannot be added to an existing household.

If the client contacts you to indicate a willingness to cooperate, tell the client to contact CSS. State in writing that the client has ten calendar days to contact and cooperate with CSS. Make it clear to the client that the client cannot receive Medicaid benefits until the client has followed through on the action required by CSS.

Grant an extension if appropriate. If the client fails to cooperate by the due date, deny the application. The client remains ineligible for Medicaid.

Do **not** take action to approve the parent or other caretaker until CSS gives notice that the parent or other caretaker has cooperated. Approve the client's Medicaid beginning with the first day of the month that the client has cooperated with CSS. If the client is otherwise eligible and meets retroactive eligibility criteria as defined in 8-A, Definitions, approve Medicaid up to three months before the date of application.

When the client contacts CSS to indicate a willingness to cooperate, you may not find out that the client has cooperated until CSS notifies you. The notification from CSS will contain the date the client initially contacted CSS and expressed willingness to cooperate. If necessary, contact CSS to confirm the date the client first indicated a willingness to cooperate to determine the correct date of application.

Document details in the case record of any contact with the client or with CSS.

When the parent or other caretaker expresses a willingness to cooperate before the effective date of their loss of Medicaid, notify CSS. When CSS notifies you that the parent or other caretaker has cooperated, reinstate their Medicaid.

When the parent or other caretaker expresses a willingness to cooperate on or after the effective date of losing Medicaid, the earliest effective date they can be added and approved for Medicaid is the first day of the month in which the parent or other caretaker expressed a willingness to cooperate.

NOTE: Refer to NJA0093, Cooperation for the process when Medicaid has been requested and a noncompliance still exists.

1. On December 1, CSS notifies the IM worker that Mrs. A failed to cooperate. On December 3, the IM worker sends **Notice of Decision or Notice of Action** canceling Mrs. A's Medicaid effective January 1.

   On December 10, Mrs. A calls the IM worker and expresses her willingness to cooperate. On December 26, CSS notifies the IM worker that Mrs. A has cooperated. The IM worker reinstates Mrs. A's Medicaid effective January 1.
2. The same as Example 1, except CSS does not notify the IM worker until January 10 that Mrs. A has cooperated. The worker reinstates Mrs. A's Medicaid effective January 1 because she indicated her willingness to cooperate before the effective date of cancellation of her medical assistance.
3. Same as Example 1, except Mrs. A does not contact the IM worker until January 2 to express her intent to cooperate. On January 4, CSS notifies the IM worker that Mrs. A has cooperated. The worker reopens Mrs. A's Medicaid effective January 1.
4. Same as Example 3, except CSS does not notify the IM worker until February 1 that Mrs. A cooperated in January. The worker reopens Mrs. A's Medicaid effective January 1.

Sanctions and Appeals

Legal reference: 42 CFR 431.200, 431.220, and 433.147; 441 IAC 7.5(17A), 75 (Rules in Process), 75.14(249A), 75.21(249A), 76.8(249A), and 80.3(249A)

A sanction is a penalty for not cooperating with the Department. The penalty is the loss of Medicaid eligibility. A person may be sanctioned for failure to cooperate with:

- Child Support Services (CSS)
- Third-Party Liability (TPL) Unit
- Department of Inspections, Appeals, and Licensing (DIAL)
- Quality Control (QC)

When you reinstate or reopen a case that includes a sanctioned person, you will receive a **Notice of Decision or Notice of Action**. If you receive an appeal on this **Notice of Decision or Notice of Action**, you will need to include the following in your appeal summary:

- An explanation of when the sanction was originally issued,
- The original **Notice of Decision or Notice of Action** sanctioning the person, and
- The current **Notice of Decision or Notice of Action** reinstating or reopening the household.

The household has rights to appeal the sanction based only on the original **Notice of Decision** sanctioning the individual. However, the way Medicaid was calculated may be appealed, which is true for all decisions.

If a sanctioned person applies for Medicaid and the sanction has not been cured, the sanctioned person should receive a **Notice of Decision or Notice of Action** that gives the person the right to appeal the sanction.

Residency

Legal reference: 42 CFR 435.403 and 435.956(c), 441 IAC 75.10(249A), Iowa Code Section 249A.3

A person must be a resident of Iowa to be eligible for Iowa Medicaid. In general, a resident of Iowa is a person who is living in the state with the intent to remain permanently or for an indefinite period. However, other rules may apply, based on age, institutional or foster care status, ability to indicate intent, or disability.

How these factors affect residency is explained in this section. See Nonfinancial MAGI-Related Eligibility: Residency, for additional policies specific to MAGI cases.

Accept the person's statement, unless questionable. The person does not need to live in the state for a specified period nor maintain a permanent residence or fixed address. If a person in an institution satisfies the residency rules, eligibility cannot be denied because the person did not establish residency in Iowa before entering the institution.

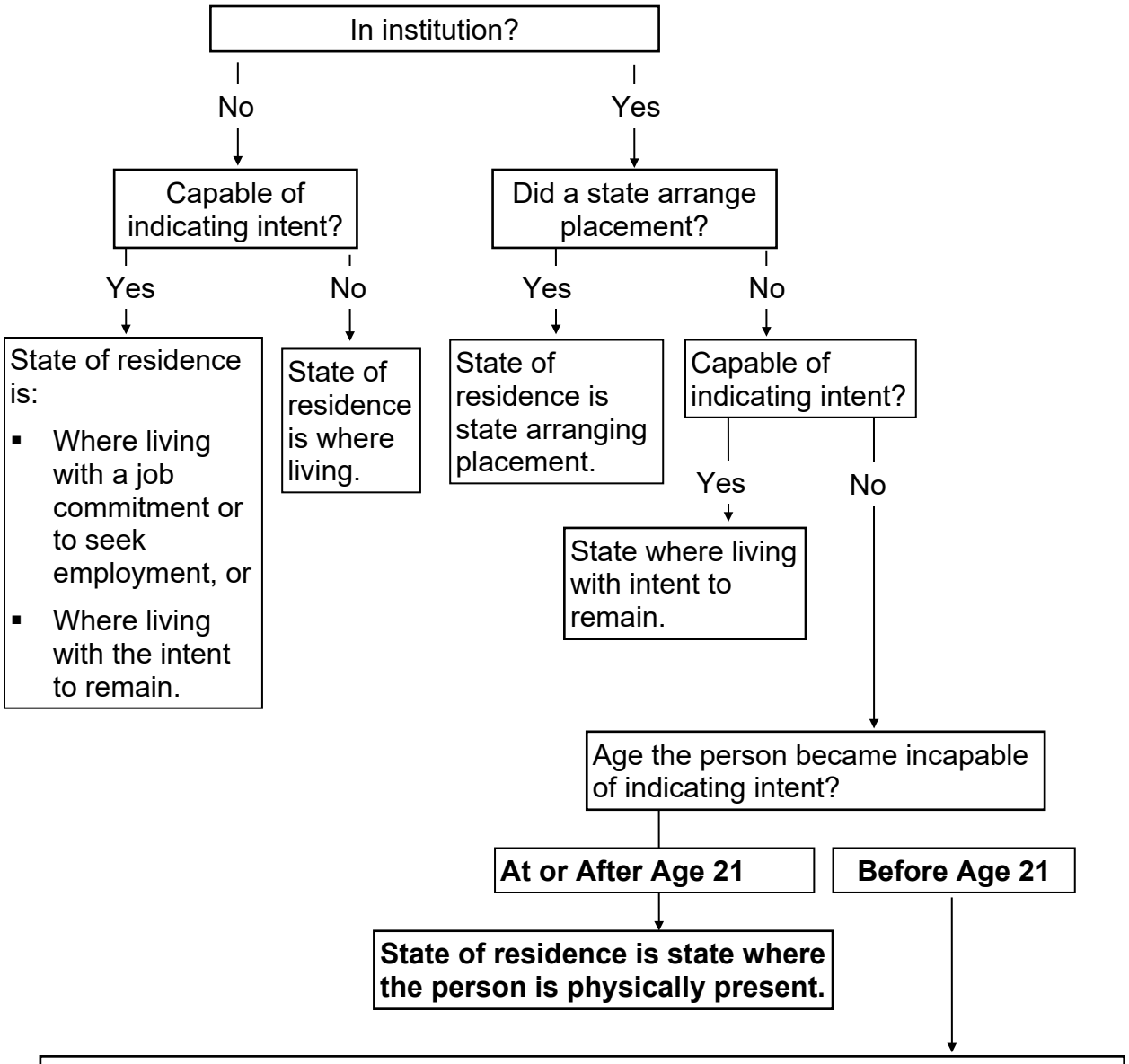
If two or more states cannot resolve a disagreement about which state is a person's state of residence, the state where the person is physically located is the state of residence. Before approval in Iowa, a person receiving care in another state must take all steps available to obtain Medicaid in that state, including appealing any adverse decision.

If the other state has denied an application or canceled benefits and is not currently providing Medicaid because the other state does not consider the person a resident of that state, the person is considered a resident of Iowa.

The discussion of residency policies is organized as follows:

- Two sections on the factors in determining residency for adults (aged 21 or over) and children.
- Four sections that further explain the concepts used in determining residency:
  - Living in Iowa for employment
  - Intent to live in Iowa
  - Incapability of expressing intent
  - State placements
- Two sections that address special situations:
  - Persons in medical institutions outside Iowa who claim Iowa residence
  - Persons receiving Medicaid from another state who move into Iowa

Determining Residency for Persons Aged 21 or Over



The state of residence is:

- Parent's or legal guardian's state of residence at the time of entry into living arrangement, or
- The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state or if the parents reside in separate states.
- The state where the person is institutionalized, if the person has been abandoned by his or her parents and a legal guardian has not been appointed.

Residency policies for persons aged 21 or over depend on whether the person lives in an institution.

Not in an Institution

Legal reference: 441 IAC 75.10(2)

If the person aged 21 or over is not in an institution, determine if the person is capable of expressing intent. (See Incapability of Expressing Intent.)

Capacity	State of Residence
Capable of expressing intent	State where the person is living: ▪ With a job commitment or seeking employment. (See Living in Iowa for Employment Purposes.) ▪ With intent to remain there permanently or indefinitely. (See Intent to Live in Iowa.)
Not capable of expressing intent	State where the person is living (i.e., physically present).

In an Institution

Legal reference: 42 CFR 435.403, 441 IAC 75.10

If the person aged 21 or older is in an institution, find out whether a state arranged placement.

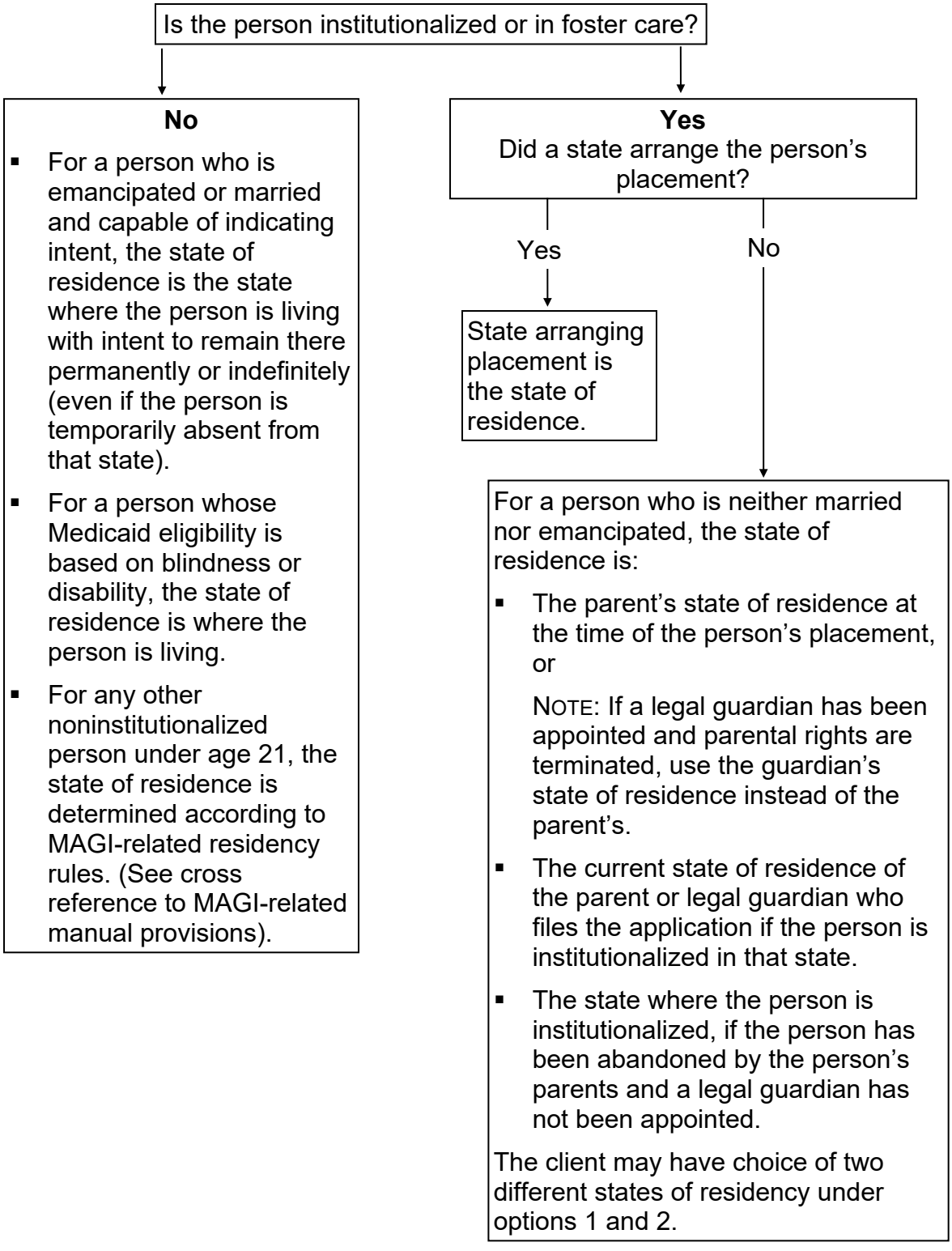
When a state arranged placement, the state of residence is the state making the placement. See State Placement.

When a state did **not** make the arrangement, state of residence is determined by whether the person is capable of expressing intent as explained in the following chart. See Incapability of Expressing Intent.

Capacity	State of Residence
Capable of expressing intent	State where the person is living with intent to remain there permanently or indefinitely. See Intent to Live in Iowa. (If the person was a resident of another state before being institutionalized in a second state, and the person intends to return to the first state, the state of residence is the first state.)
Not capable of expressing intent	▪ If the person was 21 or older when the person became incapable of expressing intent, state where the person is physically present. ▪ If the person was under 21 when the person became incapable of expressing intent: • The parent's or legal guardian's state of residence at the time of placement; or • The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state, or if the parents reside in separate states; or • The state where the person is institutionalized, if the person has been abandoned by the person's parents and a legal guardian has not been appointed.

Unless questionable, accept the statement of the representative regarding the age when the person became incapable of expressing intent.

Determining Residency for Persons Under Age 21



Residency policies for a person who is under aged 21 depend on whether or not the person lives in an institutional or foster care setting.

Not in an Institution or in Foster Care

Legal reference: 441 IAC 75.10(2)

When the person under age 21 is **not** institutionalized and is not in foster care, the state of residence depends upon the person's situation:

- For a person who is emancipated or married and capable of expressing intent, the state of residence is the state where the person is living with intent to remain there permanently or indefinitely. This applies even if the person is temporarily absent from that state.
- For a person whose Medicaid eligibility is based on blindness or disability, the state of residence is where the person is living.
- For children receiving adoption assistance under Title IV-E, the state of residence is the state where the child lives.

  A baby whose adoption is being done by an Iowa adoption agency is not considered an Iowa resident if neither the biological mother nor the adoptive parents are Iowa residents. But if either the biological mother or the adoptive parents are Iowa residents, the baby is an Iowa resident.

  Once adopted, the baby's residency is that of the adoptive parents.
- For any other noninstitutionalized person, use MAGI-related residency rules to determine state of residency. See Nonfinancial MAGI-Related Eligibility: Residency.

In an Institution or in Foster Care

Legal reference: 441 IAC 75.10

When the person under age 21 is institutionalized or in foster care, the state of residency depends upon whether or not a state arranged the placement:

- If a state arranged placement, the state of residency is that state. However, a Title IV-E-eligible child placed out of state by HHS is eligible for Medicaid from the other state. A Title IV-E-eligible child placed in Iowa by another state is eligible for Iowa Medicaid.
- If a state did **not** arrange the placement, the state of residence for an institutionalized person under 21 is:
  - The parent's or legal guardian's state of residence at the time of placement, or

- The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state, or
- The state where the person is institutionalized, if the person has been abandoned by the person's parents and a legal guardian has not been appointed.

NOTE: In the first and second options listed above, if parental rights have been terminated, use the guardian's state of residence instead of the parent's. Also, under the first and second options, the client may have a choice of two different states of residency.

Living in Iowa for Employment Purposes

Legal reference: 42 CFR 435.403, 441 IAC 75.10(2), Iowa Code Section 249A.3

When a person enters Iowa for employment purposes, this fact, in and of itself, qualifies the person as a resident of Iowa for Medicaid eligibility. Entering the state for employment purposes means either having a job commitment or coming to Iowa to seek employment.

> Ms. V moves to Iowa to look for a job. If she can find one in six months, she will stay in Iowa. Her intent is to live for a definite period for the purpose of seeking employment. She is an Iowa resident.

This provision applies even if:

- The person intends to return to another state once employment has ended, or
- The person retains ownership of a homestead in the other state.

A person could be eligible for Medicaid in two states at the same time. This occurs when a person is temporarily absent from a state and remains eligible in that state but is also eligible in another state where the person is living for employment purposes. However, a person cannot receive Medicaid in both states at the same time.

Discuss with the person the pros and cons of eligibility in Iowa as opposed to the other state (i.e., use of Medicaid card between states, coverage provisions, etc.). The person can choose in which state the person would prefer Medicaid eligibility.

Intent to Live in Iowa

Legal reference: 42 CFR 435.403, 441 IAC 75.10(249A)

Generally a person's state of residency is the state where the person is living with intent to remain there permanently or indefinitely. To make a determination of intent, evaluate all facts and circumstances surrounding the person's living arrangement. EXCEPTION: See Living in Iowa for Employment Purposes.

Following is a list of factors to consider:

- Location of personal and real property and intent to return to that property.
- Where the spouse and/or family live.
- Place of employment or business.
- Driver's license and automobile registration.
- Where state and local taxes are paid.
- Membership in unions, fraternal organizations, churches, clubs, and other associations.
- Voter registration and voting practices.
- Placement on waiting lists with medical facilities (for persons who were Iowa residents before entering an out-of-state facility).

Temporary Absence

A person who has been living in Iowa with intent to remain permanently or indefinitely continues to be an Iowa resident while temporarily out of the state if the person intends to:

- Return to Iowa and
- Remain in Iowa permanently or indefinitely.

Incapability of Expressing Intent

Legal reference: 42 CFR 435.403, 441 IAC 75.10(249A)

A person is considered incapable of expressing intent if:

- The person has an IQ of 49 or less or has a mental age of 7 or less, or
- The person has been declared legally incompetent by a court, or

- Medical documentation from a physician, psychologist, or other person licensed by the state in the field of intellectual disability indicates the person is incapable of expressing intent.

1. Ms. V, a 76-year-old woman, comes to Iowa to enter a nursing facility. She intends to return to Wisconsin. She is not an Iowa resident.
2. Mr. C, age 24, was living in Los Angeles when he is involved in a car accident. He remains in a coma. Mr. C is moved to a hospital in Iowa to be close to his parents. Mr. C becomes an Iowa resident. His residency is where he is living, because he became incapable of expressing intent after age 21.
3. Mr. M, a 25-year-old living in an Iowa ICF-MR, was injured at age 15. The court issued an order that he was not competent and appointed a legal guardian. After placing Mr. M in an ICF-MR, his guardian moved to Florida. Mr. M is an Iowa resident because his entry into the living arrangement occurred while his guardian was a resident of Iowa.

State Placement

Legal reference: 42 CFR 435.403, 441 IAC 75.10(249A)

"State placement" is an arrangement by any state agency, including an agency under contract with the state for such purposes, for a person to be placed in an institution in another state.

Providing information to the person or acting on behalf of a person is **not** state placement. Examples of actions that are not considered state placement are:

- Providing information about the availability of services or medical benefits in another state.
- Assisting the person in locating an out-of-state institution.
- Approving Medicaid eligibility for a person in an out-of-state facility.

If the person who is living out of state alleges placement by a state agency, obtain verification from the placing agency.

NOTE: If the person is an SSI recipient, use the state of residence as indicated on the SDX. If the SSI recipient has been placed by the State of Iowa in an out of state institution, the representative payee or the Social Worker who placed them in the out of state institution must make certain SSI is aware this is an out of state placement and the State of Iowa is the placing agency.

Generally, if HHS has not been declared the person's legal guardian or does not have some other legal relationship to the person, HHS does not arrange for a person's entry into an institution. Arrangements for a person to enter a facility are generally made by the person entering the facility or by someone acting on the person's behalf, such as a responsible relative or hospital staff.

If there is a question about whether HHS was the placing agency, check whether or not HHS was legally responsible for the person's welfare at the time the person entered the institution. If HHS was not legally responsible, then generally HHS could not be considered to have placed the person.

Eligibility in Out-of-State Medical Institutions

When a person wants Iowa Medicaid to pay for care in an out-of-state facility, the issue of residency must be decided. Under federal Medicaid regulations, when a person in an institution satisfies the residency requirements, no state can deny eligibility on the grounds that the person did not establish residency in the state before entering the institution.

If a person was not an Iowa resident before entering an out-of-state facility, Medicaid eligibility cannot be established until the person actually moves to Iowa, unless:

- The person was placed by Iowa, or
- The person is under 21 and residency must be determined by the residency of the person's parents.

When an Iowa resident enters an out-of-state facility, the person's intent for living out of state must be established:

- If the person expects to remain in that facility permanently or indefinitely, the person is considered to be a resident of the state in which the person is living.
- If the person entered the out-of-state facility with the intent of remaining in that facility but now wants to return to Iowa, the person must return to Iowa before Medicaid can be approved based on residency.
- If the person can establish that the person's intent when the person entered the facility was to return to Iowa, and the person still intends to return to Iowa, the person can be approved for Iowa Medicaid while in the out-of-state facility.

When a person uses the person's own funds or other resources to pay for care in a facility with the intention of living there permanently or for an indefinite period of time, then the person has made a commitment to that facility and it appears to be the person's home. If the facility is out-of-state, then that is considered the state of residence the person chose.

If the person applies for Iowa Medicaid and states a desire to return to Iowa, then the person must establish that the person always intended to return to Iowa, e.g., the person's name may be on a waiting list at an Iowa facility. Residency can also be established by actually returning to Iowa with intent to remain.

One of the main reasons for Iowa residents to seek out-of-state care is the lack of a reasonable alternative in Iowa. See Intent to Return to Iowa From an Out-of-State Facility and Guidelines for Discharge Planners.

Payment for out-of-state skilled care requires prior approval from central office. See Approval for Out-of-State Skilled Care.

When a person is approved for Iowa Medicaid in an out-of-state facility based on an intent to return to Iowa, the local office must periodically verify this intent.

Intent to Return to Iowa from an Out-of-State Facility

Legal reference: 441 IAC 75.10

If a person has a reasonable explanation for entering an out-of-state facility and has the intent to return to Iowa, the person can be approved for Medicaid based on residency. If there is no intent to return to Iowa, cancel the case with timely notice and refer the client to the state in which the client is living to apply for Medicaid.

If no reasonable nursing facility arrangement can be made for a person in Iowa, you can approve payment for an out-of-state facility if the person intends to return to Iowa. A "reasonable" nursing facility arrangement is one that a person who intends to return to Iowa would reasonably be expected to accept. Consider such factors as:

- Level of care.
- Location.
- Participation in Iowa Medicaid.

"Reasonable" does not mean within a certain mile range of an area, but location of available facilities may be a consideration in determining intent to return to Iowa. If a reasonable arrangement can be made in Iowa but the person chooses an out-of-state facility, this raises questions about the person's intent to return to Iowa.

If comparable Iowa facilities would accept the person but do not have a bed immediately available, the person should be put on a waiting list.

Clients do not have to put their names on waiting lists with every available facility and accept the first opening available. To show intent to return, they only have to put their name on waiting lists for the facilities of their choice that will accept them. Payment to the out-of-state facility would be approved until the bed in state becomes available.

Generally, you do not need to check each month with the facility named by the client to see if the facility has an opening for the client. However, if the facility is known to have frequent openings, track those cases and check with the facility monthly if there has been no report from the client.

Failure to go on waiting lists or to accept an opening indicates that the client no longer intends to return to Iowa. The client has chosen the other state as state of residence. Unless failure to comply can be explained, cancel Iowa Medicaid based on residence.

If no comparable Iowa facilities would accept the client, meaning the facility would not put the client on a waiting list, then payment in an out-of-state facility can be made if the client intends to return to Iowa.

Assess the availability of an in-state facility at the next annual review. The client may change intent about returning to Iowa after living in the out-of-state facility for some time. If so, the client loses Iowa residence.

Use "prudent-person" judgment to determine if the client really does intend to return to Iowa when:

- There is no acceptable facility in Iowa, or
- There appears to be a facility in Iowa that is comparable to the out-of-state facility but the client expresses no intent to return to Iowa if an opening occurs there.

To do this, discuss the following with the client or the client's representative and make a decision about intent:

- Reason for entry into the out-of-state facility.
- A statement of when the client intends to return.
- A statement of under what circumstances the client would return.
- A statement of why any available facilities in Iowa are not acceptable.

Guidelines for Discharge Planners

Advise local hospital social workers not to make any out-of-state placements of Medicaid members if the member wants to continue to receive Iowa Medicaid unless the local office has determined that Iowa Medicaid will pay the out-of-state facility.

For members who want to maintain Iowa residency, the first placement options should be in Iowa. The person's name should immediately be placed on the waiting list for an Iowa facility, so that when the person is ready for discharge from the hospital, the bed may be available.

For short-term placements, the member may choose an out-of-state facility, as long as the member intends to return to Iowa. Review these placements annually for intent to return to Iowa.

For long-term placements, the hospital should try to place the patient where the patient wants to live on a long-term basis immediately from the hospital. A patient who wants to apply and live in another state can be placed in that state.

If it is agreeable to the patient, the patient could be placed in another state until an in-state placement is available. The patient will need to return to Iowa to remain eligible for Iowa Medicaid. Patients and families intending to apply for Medicaid need to be advised of that requirement.

Approval for Out-of-State Skilled Care

Legal reference: 441 IAC 81.20

For fee-for-service, skilled care in an out-of-state facility requires approval from the Iowa Medicaid Enterprise (IME). For individuals under a Managed Care Organization (MCO), the MCO will make the approval.

Payment will be approved for out-of-state skilled care when the following criteria are met:

- The facility is eligible to participate in the Iowa Medicaid program.
- The facility has been certified for Medicare and Medicaid participation by the state where it is located.
- The placement is recommended because:
  - Moving the person back to Iowa would endanger the person's health,
  - Services are not readily available in Iowa, or
  - The out-of-state placement is cost-effective.
- The placement is temporary until services are available to the resident in Iowa or the program of treatment is completed.

When the type of skilled care needed is available from any skilled facility, out-of-state payment will not be approved if there is a skilled facility in the area that will accept the resident, unless the client can explain why that facility is not acceptable and how the client intends to return to Iowa.

When the out-of-state skilled care is designed for very specialized types of rehabilitation services, the placement may be approved on the basis that no appropriate facility is available in Iowa, if the client intends to return.

When a person is on Medicare, Medicare will pay for 100 days of skilled care. For a Medicare-covered skilled stay, members may go to any Medicare skilled facility they choose. However, if the person wants Medicaid to pay the cost of out-of-state care once the Medicare coverage is exhausted or otherwise wants Medicaid, the person would have to meet residency requirements and a determination of intent must be made.

When a Medicaid-Eligible Person Moves to Iowa

Legal reference: 441 IAC 75.10(2)

Policy: If a Medicaid-eligible person from another state becomes an Iowa resident, grant Iowa Medicaid eligibility beginning with the month of Iowa residency if:

- The person meets all eligibility criteria and
- The person surrenders the other state's medical card, if a card was issued for any months for which the person is requesting Iowa Medicaid.

EXCEPTION: The person does not have to surrender the other state's medical card if the person has good cause not to do so. Good cause exists when:

- The other state does not issue medical cards.
- The other state's medical card is a plastic magnetic strip or a computer chip card that contains more than Medicaid-related information.
- Some Medicaid-eligible members of the person's household in the other state did not move with the person to Iowa, and the card was left with those members.
- The other state's medical card was lost, mutilated, or destroyed.
- The other state's medical card was thrown away because of the person's impending move to Iowa, since the person assumed that the card would not be valid in Iowa.
- The other state's medical card was already surrendered to the other state.

Procedure: The case record must contain:

- A scanned copy of the medical card, or
- A scanned copy of the surrendered card and documentation of its return to the other state, or
- Sufficient documentation to show that the client did or did not have good cause for not surrendering the card.

When the person moves to Iowa in the middle of the month, grant Iowa Medicaid if Iowa eligibility exists in the month when the applicant lived in both states. If the applicant used the other state's card in Iowa before choosing Iowa Medicaid, an Iowa medical card may be issued.

Verify the effective date of cancellation of Medicaid in the other state. Use either the notice of decision or other documents issued by the other states or by a collateral contact with the other state's Medicaid agency.

1. Ms. W and her children move to Iowa on September 13 from Hawaii, where she and her children were eligible for Medicaid. She applies for Medicaid. She cannot find a provider to accept the Hawaiian medical card and surrenders it to the worker. Ms. W and her children are determined Medicaid eligible in Iowa beginning the month of September.

2. Mr. B, an SSI recipient, moves to Iowa from Texas on March 2. He applies for Medicaid in Iowa on March 8 and completes form **470-0364(M), SSI Medicaid Information**.

   The worker calls Texas on March 10 and verifies that Mr. B's case will be canceled effective April 1. When the worker asks for Mr. B's March medical card from Texas, he refuses to surrender it to the worker and when asked why, offers no good cause reason.

   Mr. B is not granted good cause in March for not surrendering the Texas medical card. The worker records this in the case file. If all other eligibility factors are met, Mr. B is determined Medicaid eligible in Iowa beginning the month of April.

3. Mr. and Mrs. A and their child move to Iowa from Missouri in May. They file a Medicaid application on May 20. The A's report their medical card from Missouri for May was lost during their move to Iowa. The worker verifies that the A's Medicaid in Missouri was canceled effective May 31.

   The A's are granted good cause for not surrendering the Missouri medical card and the worker documents this in the case file. If all other eligibility factors are met, the A's are determined Medicaid eligible in Iowa beginning with the month of May.

Residents of Institutions

An "institution" is an establishment that furnishes (in single or multiple facilities) food, shelter, and some treatment or services to four or more people unrelated to the proprietor. The following sections give policy information on:

- Residents of institutions for mental disease.
- Residents of public nonmedical institution.

For policies applicable to residents of medical institutions, see 8-I, Medical Institutions.

Residents of Institutions for Mental Disease

Legal reference: 42 CFR 435.1009(a)(2), 435.1009(c), 440.160, and 441.151

"Institutions for mental disease" include mental health institutions (MHIs) and psychiatric medical institutions.

A person who is over age 21 and under age 65 is not eligible for Medicaid when the person lives in an institution for mental disease.

EXCEPTION: A person who enters a psychiatric medical institution for children before turning age 22 may receive Medicaid through age 22.

When a Medicaid member who is over age 21 and under age 65 enters an institution for mental disease and is expected to remain for more than a calendar month, cancel the person's Medicaid.

EXCEPTION: Medicaid members enrolled with an MCO who are age 21 to 65 and are in an MHI for 15 or fewer days per month are eligible for payment to the MHI through the MCO. In this situation, do not cancel the member when they enter the MHI. Review the member's eligibility and if they continue to be eligible under the same coverage group, leave the case active. The MHI facility worker will need to add the MHI stay to ISIS.

Although a person who is between age 21 and age 65 and is living in an institution for mental disease may qualify for SSI benefits, the person is still categorically ineligible for Medicaid unless the exception listed in this section applies.

Residents of Public Nonmedical Institutions

Legal reference: 20 CFR 416.211, 42 CFR 435.1009-1010; 441 IAC 75.12(249A)

Policy: Federal Medicaid regulations prohibit the use of federal Medicaid funds for people who are inmates of a public, non-medical institution.

A "public institution is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. It includes, but is not limited to:

- Publicly operated penal institutions,
- Jails,
- Work release centers, or
- Wholly tax-supported care facilities, such as some county residential care facilities

Department of Corrections (DOC) prisons and county jails are public institutions.

EXCEPTION: A publicly operated community residence that serves fewer than 16 residents is not considered a public institution. For example, a county-owned and operated residential care facility that has fewer than 16 beds may be a publicly operated community residence.

To be a “publicly operated community residence,” the facility:

- Must provide some services beyond food and shelter, such as social services, help with personal living activities, or training in social and life skills.
- Must not be a jail, prison, or other holding facility for people who have been arrested or detained pending charges.
- Must not be located on the grounds of or immediately adjacent to any large institution or multiple-purpose complex.

Procedure: Effective January 1, 2012, members who have been incarcerated for 30 days or more and continue to retain their eligibility status while incarcerated are eligible to have their Medicaid benefits limited to inpatient hospital claims only.

Workers will be notified of members who are incarcerated for more than 30 days via a WISE alert. WISE alerts will also be generated when a member has been released. Medicaid may be reinstated without an application when a member is released from the public institution.

When an individual calls to report their release from incarceration, the worker should follow up to verify the date of release by checking online sources and/or contacting the facility to verify the date of release.

Full Medicaid is not available to individuals considered to be inmates. “Inmates” are people living in a public, non-medical institution regardless of whether they have been convicted or are awaiting trial, release, etc.

The following are considered to be inmates of a public institution, and **are not eligible for full Medicaid**:

- A Department of Corrections (DOC) inmate (regardless of the inmate’s status, i.e., convicted, awaiting trial, etc.).
- An inmate of a jail (regardless of the inmate’s status, i.e., convicted, awaiting trial, etc.).
- Someone who is on work release and living in a halfway house/residential facility.
- Someone who is serving a sentence in a halfway house/residential facility.

If someone is listed as serving a special sentence or you find something questionable, request additional information regarding their individual status. Regardless of the label attached to any particular custody status, an important consideration of whether an individual is an "inmate" is his or her legal ability to exercise personal freedom.

If full Medicaid benefits are paid while an inmate is incarcerated, HHS will seek repayment of the incorrect benefits paid from the member or provider.

In order to get either type of Medicaid, the person must also meet all other eligibility requirements for Medicaid, including, but not limited to:

- Income and asset limits.
- Citizenship and Identity
- Have a medical necessity for the service that is provided (i.e., if in a nursing facility, require the level of care provided by the facility.

An inmate of a public nonmedical institution is not eligible for **non-MAGI-related** Medicaid except as listed under Non-MAGI-Related Eligibility Under Levings Rule.

Halfway House

Legal reference: 42 CFR 435.1010

Some people in halfway houses (called "community residential facilities") are serving a prison sentence or have been placed on a work release program. Other people in halfway houses are on probation or parole and are ordered to live in a halfway house as a condition of the probation or parole.

People serving a prison sentence and those who have been placed on a work release program are considered inmates and are not Medicaid-eligible. But people placed on probation or parole who are living in a halfway house are not considered inmates and can be eligible for Medicaid, as long as they meet the other eligibility criteria.

To determine eligibility, you must verify whether the person living in a halfway house is serving a sentence, is on a work release program, or is on probation or parole.

Inpatient Medical Institutions

Legal reference: 42 CFR 435.1010

A “medical institution” is one that:

- Provides medical care
- 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
- Is authorized under State law to provide medical care; and
- Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services.

An inmate of a penal institution who is admitted as an inpatient of a medical institution (hospital, nursing facility, juvenile psychiatric facility) that is not on the grounds of the penal institution and is not owned or operated by the penal institution may be eligible for Medicaid. The person must meet the other eligibility criteria before Medicaid can be approved.

An inmate of a penal institution is not eligible for Medicaid when taken to a prison hospital or dispensary or when receiving outpatient care.

1. Ms. M is a disabled person who is serving a prison sentence. She received Medicaid before being incarcerated. She is taken by ambulance to the local, private hospital in a nearby town where she is treated and released, and then returned to prison.

   Ms. M is not eligible for Medicaid for her ambulance trip or treatment at the hospital because she was not admitted as an inpatient.
2. Mr. N is a prison inmate. Mr. N was eligible for Medicaid as a disabled person before being incarcerated. Mr. N is injured and must be treated as an inpatient in the prison hospital for several days. Mr. N is not eligible for Medicaid since he was treated in a hospital operated by the penal institution.
3. Mr. L is active on Medicaid. The worker receives a WISE alert that Mr. L has been incarcerated for more than 30 days. Mr. L’s Medicaid is limited to inpatient hospital claims until the worker receives an alert indicating Mr. L’s release.

Non-MAGI-Related Eligibility Under Levings Rule

Legal reference: AR-88-6(8), 604F.2d 591

For non-MAGI-related groups, an inmate of a public nonmedical institution is **not** eligible for payment of Medicaid services other than inpatient hospital. EXCEPTION: Due to a U.S. District Court ruling, *Levings vs. Califano*, residents of public nonmedical institutions can be eligible for SSI (and therefore also non-MAGI-related Medicaid) if they:

- Live in the institution on a voluntary basis and
- Are paying for the full cost of their care in the institution or will be paying for the full cost if SSI or State Supplementary Assistance is approved.

For the purposes of the Levings exception, assume the person is a voluntary resident unless there is evidence to the contrary. If the person has a legal guardian or court-appointed representative, the person is a voluntary resident if the guardian or representative has the right to remove the person from the institution.

If a court order instructs that a person be placed in a specific institution, the person is not living in the facility voluntarily. However, if a court instructs only that a person be placed in a facility providing a certain type of care (without indicating a specific facility), and the person chooses a public institution, the person's residence in the institution is voluntary, as long as the person retains the right to leave that institution.

A person is paying for "all of the institutional care" if the person pays the facility's usual charges for food, shelter, and other services. The person's payment to the facility must come from personal income or resources or from third-party payments to the institution (e.g., Medicare or private insurance payments).

Payment of all or part of the cost of care by a local government agency (e.g., county governments, state health or welfare agencies) is not considered a third-party payment under this exception.

The Social Security Administration has determined that State Supplementary Assistance payments are considered as personal income. This means that if a person is or will be paying the entire cost of RCF care with a combination of State Supplementary Assistance and other income, this exception applies.

Social Security Number

Legal reference: 42 CFR 435.910, 441 IAC 75 (Rules in Process)

A social security number or proof that an application for a number has been made is required for each person for whom Medicaid is being requested or received. This requirement does not apply to:

- A child in "newborn" status (see 8-F, Newborn Children of Medicaid-Eligible Mothers), or
- An unlawful alien, or
- Any person for whom Medicaid is not being requested or received, such as parents whose children receive Medicaid but who don't receive Medicaid themselves, or
- A person who is not eligible to receive a social security number as determined by the Social Security Administration, or
- A person who does not have a social security number **and** may only be issued a social security number for a valid non-work reason as determined by the Social Security Administration, or
- A person who is a member of a recognized religious sect who conscientiously opposes applying for or using a social security number.

As long as the applicant is cooperating in obtaining a number for a person, the person remains eligible for Medicaid. Cancel or deny Medicaid for clients who do not provide a valid social security number or who do not cooperate in obtaining a social security number.

A person who is not eligible to receive a social security number or a person who may only be issued a social security number for non-work reasons must provide verification from the Social Security Administration.

A person who will not apply for or use a social security number due to religious beliefs must provide verification from the church elder or other officiant that it is against the church doctrine.

The following sections explain:

- How clients can apply for a number
- Acting on an error report

How Clients Can Apply for a Social Security Number

Legal reference: 42 CFR 435.910"e", 441 IAC 75 (Rule in Process)

Assist the client to apply for a social security number as needed. There are several different ways to apply:

- The client can apply directly to the Social Security Administration (SSA).
- You can issue form **SS-5** or **SS-5-SP**, **Application for a Social Security Number Card** to the client to apply for a social security number. Either you or the client can submit the form.

  The Social Security Administration will automatically notify the Department when the number has been assigned, if form **SS-5** or **SS-5-SP** is completed as instructed in 14-G, Enumeration.
- The client can apply for a number for a newborn child at the hospital where the child was born, under the "Enumeration at Birth" project.

  Form **SSA-2853, Information About When You Will Receive Your Baby's Social Security Card**, is available through the hospital. Proof of an application for a social security number is not required for an infant that is born in a hospital and goes home with the mother.

The client must give you one of the following forms that are issued by the Social Security Administration as proof the an application has been made:

- Form **SSA-2853, Information About When You Will Receive Your Baby's Social Security Card**, when application is made through the "Enumeration at Birth" project.
- Form **SSA-5028, Proof of Application**.
- Form **SSA L669, Request for Evidence in Support of an SSN Application - U.S. Born Applicant**.
- Form **SSA L670, Request for Evidence in Support of an SSN Application - Foreign Born Applicant**.

The client must report the social security number to you within ten days of receipt.

If the client does not provide a number within two months, contact the client to determine the cause of the delay. You may also require verification from the Social Security Administration if it appears that the client is not cooperating.

Acting on an Error Report

Legal reference: 441 IAC 75 (Rules in Process)

Social security numbers are verified by the Social Security Administration. When a social security number entered into the system does not match its records, the Social Security Administration will indicate the reason there was not a match.

If you receive notification of an error, check the system and the case record to see if the discrepancy is the number, the name, or the date of birth.

If the social security number was correctly entered into the system but cannot be verified, first check that the name matches what the Social Security Administration has on its records.

If there is not a match, either HHS records or Social Security Administration records must change so that there is a match or the discrepancy is resolved. Issue a written notice to the client to contact the Social Security Administration and resolve the discrepancy.

If the applicant or member must apply for a new social security number, allow the person ten calendar days to provide form **SSA-5028, Proof of Application**. If the form is not provided within ten calendar days or if the person has not requested an extension, the person is ineligible for Medicaid due to failure to provide a valid social security number.

Nonfinancial Non-MAGI-Related Eligibility

In addition to the general Medicaid nonfinancial eligibility requirements listed above, applicants for non-MAGI-related Medicaid must also meet the categorical requirements of age, blindness, or disability and are subject to different policies regarding household size (eligible group). These policies are explained in the following sections:

- Household size.
- Presence of age, blindness, or disability.
- Department disability determination process.
- Disability denial.
- Presumptive disability.
- Disability determination on reapplications.

Household Size

Legal reference: 20 CFR 416.1160, 416.1163, 416.1166, and 416.1202; 441 IAC 75 (Rules in Process)

For non-MAGI-related Medicaid purposes, a person is always treated as an individual, unless the person has a spouse who is also an eligible person. In that case, treat the person and the spouse as a couple.

EXCEPTION: For the Medicaid for Employed People with Disabilities (MEPD) coverage group, determine countable income based on "family size." Family size is determined as follows:

- If the disabled person is under age 18 and unmarried, include parents, unmarried siblings under age 18, and children of the person who live with the person.
- If the disabled person is aged 18 or older, or is married, include the person's spouse and any children of the person or of the person's spouse who are living with the person, under age 18, and unmarried.

There may be situations where income is deemed to a non-MAGI-related eligible person from an ineligible spouse or parent. Also, in some instances when deeming from an ineligible spouse, an eligible spouse's income should be compared to the income limits for a couple. See 8-E, Deeming Non-MAGI-Related Income.

When a non-MAGI-related person is living with a spouse, consider the resources of the spouse (whether an ineligible or eligible spouse) and compare the couple's total resources to the resource limit for a couple. See 8-D, Non-MAGI-Related Resource Limits.

1. Child A is disabled and lives with his parents and a sibling, Child B, who is also disabled. To determine Child A's eligibility, his income and resources are compared to the eligibility limits for an individual (although income and resources from his parents may be deemed to him). Child B is also treated as an individual.
2. Mr. L, who is disabled, lives with Child D, who is also disabled. Mr. L's eligibility is determined by comparing his income and resources to limits for an individual. Child D's eligibility is also determined by comparing his income and resources (including any deemed income or resources) to the limits for an individual.

3. Mr. G, who is disabled, lives with Mrs. G, who is not aged, blind, or disabled (an ineligible spouse). Mr. G's worker determines that deeming from Mrs. G to Mr. G is not applicable. Mr. G's eligibility is determined by comparing his income to the limits for an individual. Mr. G's resource eligibility is determined by comparing both spouses' resources to the resource limit for a couple.

When a married couple who are both eligible for Medicaid separate, continue to treat them as a married couple for the month of separation. Beginning with the month after the month of separation, treat each spouse separately for Medicaid eligibility.

"Separation" means a change in living arrangement that results in the couple no longer living together. This includes one spouse moving to a nursing facility or medical institution.

If a married couple with only one Medicaid-eligible spouse separates for any reason, consider the spouses to be separate for eligibility beginning with the month after the month of separation.

When neither spouse is receiving Medicaid, and the spouses separate before application, treat them as separate individuals for application processing.

Mr. and Mrs. S live together. Mr. S receives Medicaid as a non-MAGI-related person. In June, he and Mrs. S separate. Mr. S is considered as an individual for July. Only his income and resources are considered. No income or resources owned exclusively by Mrs. S are considered for Mr. S's eligibility for July.

See 8-I, Income and Resources of Married Persons when one or both spouses are in a medical institution.

Presence of Age, Blindness, or Disability

Legal reference: 20 CFR 416.801 and 416.901; 42 CFR 436.540, 436.541; 441 IAC 50.2(1), 50.2(3)“d”,75.1(249A), and 75 (Rules in Process); Balanced Budget Act of 1997 (P. L. 105-33)

Policy: To be eligible for Medicaid under a non-MAGI-related coverage group, a person must:

- Be 65 years of age or older, or
- Be blind or disabled based on the criteria used for Supplemental Security Income (SSI).

The criteria for establishing disability for adults (over age 18) are:

- The person must be unable to earn income in the amount of “substantial gainful activity” because of a severe physical or mental impairment.

  EXCEPTION: This requirement does not apply to Medicaid for employed people with disabilities.

- The impairment must be medically documented and must be expected to last continuously for 12 months or result in death.

To be eligible for SSI on the basis of blindness, a person must have central visual acuity of 20/200 or less in the better eye with the use of corrective lens or visual field restriction to 20 degrees or less.

The criteria for establishing disability for children (under age 18) are:

- The child must be unable to earn income in the amount of “substantial gainful activity” because of a severe physical or mental impairment.
- The impairment must have a physical or mental disability that results in marked and severe functional limitation and must be expected to last continuously for 12 months or result in death.

Children who were receiving SSI as of August 22, 1996, but lost eligibility due to the change disability criteria made on that date may qualify as disabled if they continue to meet the criteria in effect before the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (P. L. 104-193).

When a person is applying on the basis of disability and the existence of a disability cannot be documented through receipt of federal disability benefits, the Department must determine whether the applicant is disabled.

Comment: The Social Security Administration (SSA) determines disability for claimants for SSI and Social Security Disability Insurance (SSDI). SSA makes no distinction between blindness and other disabilities when approving benefits.

The Department has a contract with the Disability Determination Services (DDS) Bureau of the Iowa Department of Education to determine disability using the same criteria as SSA uses to determine eligibility for SSI or SSDI.

Procedure: When the person is applying for benefits on the basis of **age**:

1. Check for verification of age through receipt of federal benefits as follows:

Situation	Action
The applicant is over 65 and has social security income.	Accept the Social Security Administration's verification that the person is age 65 or older.
The applicant claims to be at least 65 and has not applied for social security or SSI.	Refer the person to the Social Security district office to apply for benefits and give the person form **470-0383, Notice Regarding Acceptance of Other Benefits**.

2. If age is verified, process the application.

When the person is applying for benefits on the basis of **blindness or disability**:

1. Make sure the applicant's coverage group requires a disability determination. (Determination of blindness is not necessary if both eyes are missing.)

Groups that **do** require disability determination include:	Groups that **do not** require a disability determination include children under 21 in the 300% group applying for the following HCBS waivers:
▪ Medically Needy (if applying as disabled) ▪ Medicaid for Employed People with Disabilities ▪ Medicaid for Kids with Special Needs ▪ Ill and handicapped waiver ▪ Physical disability waiver ▪ Persons applying for the following HCBS waivers under **non-MAGI-related** eligibility • AIDS/HIV waiver • Brain injury waiver • Children's mental health waiver • Intellectual disabilities waiver	▪ AIDS/HIV waiver ▪ Brain injury waiver ▪ Children's mental health waiver ▪ Intellectual disabilities waiver

2. For all applicants claiming disability, determine whether the presence of disability can be verified through receipt of federal benefits by checking SDX and IEVS. For specific situations, see the following chart:

Situation	Action
The applicant is under 65 and gets SSI.	Verify the disability on the SDX screens in WISE. Electronic Data Sources (EDS) will verify disability in ELIAS.
The applicant is under 65 and gets SSDI.	Verify the disability on the IEVS TPQ2 screen if not verified by EDS.
The applicant is under 65 and gets Social Security survivor benefits.	Verify any disability on the IEVS TPQ2 screen if not verified by EDS. NOTE: A person does not have to be disabled to receive survivor benefits.
The applicant was canceled from SSDI due to losing disability status because of substantial gainful activity (SGA) but remains eligible for extended Medicare benefits.	The only coverage group the applicant can qualify for is MEPD, which skips the SGA requirement. Request a disability determination by the Bureau of Disability Determination Services.
The applicant qualifies under Railroad Retirement permanent disability benefits.	Send form **470-0461** or **470-0461(S), Authorization for Release of Information** to the Railroad Retirement Board to verify whether the person is getting benefits based on Social Security criteria for disability. Verify the type of RR benefits the person receives. Options include: ▪ Disabled former railroad worker ▪ Disabled adult child ▪ Disabled survivor of a railroad worker who is at least age 50 Consider the person disabled for Medicaid if the benefits are received due to permanent disability.

Situation	Action
The applicant has a Railroad Retirement benefit due to temporary inability to work.	Disability must be determined, because this person is not considered disabled according to Social Security requirements.
The applicant receives disability income from the Veterans Affairs Department but does not receive disability benefits from Social Security.	Disability may need to be determined, because this person does not automatically qualify as disabled according to Social Security requirements.

3. If age, blindness, or disability is verified, establish the correct Medicaid coverage group and process the application.
4. If disability is not verified, determine the status of any SSA activity. See When the Department Follows an SSA Disability Determination.
5. If the Department is not required to wait for an SSA disability decision, refer the applicant for a disability determination by the Department. See When the Department Determines Disability.

Comment: For more information on disability requirements and procedures, also see:

- 8-B, Concurrent Medicaid and Social Security Disability Determinations.
- 8-J, Disability Criteria.
- 8-F, People Ineligible for SSI (or SSA): Due to Reevaluation of Childhood Disability.

When the Department Follows an SSA Disability Determination

Legal reference: 20 CFR 416.901-999d

Policy: The Department is required to follow decisions on disability made by the federal Social Security Administration (SSA), with the following exceptions on denials:

- The Department does not rely on an SSDI denial to deny eligibility for Medically Needy. If the client does not meet the eligibility requirements for any other group except for Medically Needy, then the Department must determine disability.

- The Department will determine disability when the client is claiming that a new disabling condition or a worsening of the original condition has occurred after a final SSA denial.

Procedure: Always determine the status of any Social Security Administration activity before processing applications based on disability, regardless of the coverage group for which the person is applying. The SSA status may be:

- Benefits have been approved.
- The person has not applied with SSA for benefits.
- An application for benefits is pending.
- An application for benefits has been denied. (See SSA Disability Denial and Appeal Process for more information.)

When SSA-administered disability benefits have been approved, proceed with the Medicaid eligibility determination.

Use the following chart to determine what action to take based on the SSA status.

Status	Action
Client receives SSI	Determine Medicaid eligibility.
Client has **not** applied for SSI but agrees to file an SSI application within ten days.	Notify both SSA and DDS about the concurrent application with form **470-2631, Notice of Pending Medicaid Application** within 15 working days. Possible DDS responses are: ▪ Have SSA claim and are processing. If so, hold the Medicaid application until the determination has been made. ▪ Have SSA claim and recently completed disability determination. If so, check for an SDX message. ▪ Do not have a claim. If so, check for an SSI denial for reasons other than disability. If the client has not applied or SSA denies the client for reasons other than disability, proceed with a disability determination by the Department. Contact the client to explain that the Department will determine disability.
Client has never applied for SSI and is **not** willing to do so.	Proceed with disability determination by the Department if the client meets all other eligibility requirements.

Status	Action
Client **has** applied for disability benefits. Initial SSA decision is **pending**.	Notify both SSA and DDS about the concurrent application with form **470-2631, Notice of Pending Medicaid Application** within 15 working days. Possible responses are: ▪ Have SSA claim and are processing. If so, hold the Medicaid application until the determination has been made. ▪ Have recently completed a disability determination. If so, check for an SDX. ▪ Do not have a claim. If so, check for an SSI denial for reasons other than disability. If SSA denies the client for reasons other than disability, proceed with a disability determination by the Department. Contact the client to explain that HHS will determine disability.
Client **has** applied for disability benefits. SSA denied disability, but decision is **not** "final."	Deny the Medicaid application based on the SSA denial. Manually issue a **Notice of Action** using the language listed below this chart. Determine if Medicaid eligibility exists under another coverage group. See SSA Disability Denial and Appeal Process.
Client **has** applied for disability benefits. SSA denied disability and decision is "**final**." Client states there is no new disabling condition and the original has **not** worsened	Deny the Medicaid application based on the SSA denial. Manually issue a **Notice of Action** using the language listed below this chart. Determine if Medicaid eligibility exists under another coverage group. See SSA Disability Denial and Appeal Process. EXCEPTION: For an SSDI denial on a Medically Needy applicant, see 8-J, When a Client Has Been Denied Disability Benefits.

Status	Action
Client **has** applied for disability benefits. SSA denied disability within the last 12 months and decision is "**final**." Client states the disabling condition has **worsened** and claims a new 12-month disability period.	Ask the following questions: ▪ Has the SSA refused to reconsider the claim on the worsening of the condition? ▪ Has the client lost eligibility for SSI due to other factors (income, resources, etc.)? If the answer to both questions is "no," deny the Medicaid application based on the SSA decision and refer the client back to SSA. Manually issue a **Notice of Action** using the language listed below this chart. Determine if Medicaid eligibility exists under another coverage group. If the answer to either question is "yes," proceed with a disability determination by the Department if the client is otherwise eligible.
Client **has** applied for disability benefits. SSA denied disability within the last 12 months and decision is "**final**." Client states there is a **new** condition that is expected to last 12 months.	Determine whether the client has a different condition than those considered by SSA. ▪ Request a copy of the denial explanation from the applicant. ▪ Compare the information on the denial explanation to the disability information on the Medicaid application. If there is a new disabling condition, proceed with disability determination by the Department unless the client reapplies at SSA. If the client has reapplied at SSA, notify both SSA and DDS about the concurrent application with form **470-2631, Notice of Pending Medicaid Application,** within 15 working days.

Status	Action
Client has not applied for disability benefits but agrees to file an SSDI application within ten days.	Notify both SSA and DDS about the concurrent application with form 470-2631, Notice of Pending Medicaid Application within 15 working days. ▪ Have SSA claim and are processing. If so, hold the Medicaid application until the determination has been made. ▪ Have recently completed a disability determination. If so, check for an SDX. ▪ Do not have a claim. If so, check for an SSDI denial for reasons other than disability. If SSA denies the client for reasons other than disability, proceed with a disability determination by the Department. Contact the client to explain that HHS will determine disability.
Client has never applied for disability benefits and is **not** choosing to do so.	Proceed with disability determination by the Department if the client meets all other eligibility requirements.

Comment:

1. Ms. R applies for Medicaid on August 1. She was denied SSI benefits on June 15 because the SSA determined she was not disabled based on her reported disabilities of arthritis and shortness of breath. Ms. R is not claiming any new disabilities. She says the arthritis has gotten worse.

   This is a change in an existing condition that was considered by SSA. It does not represent a different condition or an addition to the conditions considered by SSA, so the SSI Medicaid application is denied based on the SSA decision. (This is assuming no other conditions apply, such as an SSA refusal to consider the worsening of her condition.)

   The IM worker refers Ms. R back to SSA to determine eligibility for SSI, because Ms. R claims a change in her arthritis (the original condition). If Ms. R were ineligible for SSI because of income or resources, a HHS disability determination would be done instead of referring Mrs. R. back to SSA.

2. Same as Example 1, except that Ms. R also has a broken leg that is expected to heal in six months. The broken leg is an additional condition to the conditions existing at the time of the SSA disability decision. However, since it does not meet the durational requirement of 12 continuous months, the worker denies Medicaid based on the previous SSA decision for SSI.
3. Same as Example 2, except the break is so severe that it is expected to be 16 months before Ms. R will be able to return to work. Because this is a different disabling condition than previously claimed with SSA and it meets the durational requirements of 12 months, the Department will determine disability unless Ms. R refiles a claim with SSA.

Presumptive Disability

Legal reference: 20 CFR 416.931-933, 441 IAC 50.2(1) and 75 (Rules in Process)

Policy: If all other eligibility criteria are met for Medicaid, eligibility for Medicaid begins with the month that a Social Security Administration (SSA) presumptive disability decision is made. Medicaid eligibility continues for up to six months or until a final determination of disability is made, if earlier.

Comment: "Presumptive disability" means a person has a medical condition indicating a high degree of probability that the person is disabled, but available evidence is not sufficient to quickly make a final determination of disability.

Procedure:

1. The SSA determines presumptive disability for SSI benefits and notifies the Department of this determination.

2. Approve the case under SSI Medicaid. Determine eligibility for the retroactive period, as defined in 8-A, Definitions, only **after** the **final** disability determination has been made. Manually issue a **Notice of Action** using the following language:

> Social Security found _____ to be presumptively eligible for disability. Medicaid is approved **/**/** through **/**/**. You will keep getting Medicaid after this date if Social Security finds you are disabled.
>
> Your Medicaid will end if Social Security finds that you are not disabled.
>
> EM 8-C Presumptive Disability; 20 CFR 416.931-933, 441 Iowa Admin. Code 50.2(1), 75 (Rules in Process).

3. When SSA makes the final determination that the person is disabled, establish ongoing eligibility for Medicaid benefits under the applicable coverage group.

   If the final decision is that the person was disabled during the retroactive period, as defined in 8-A, Definitions, issue a manual **Notice of Action** identifying:

   - Approval of ongoing eligibility.
   - Months of retroactive eligibility.
   - Any other months of eligibility when presumptive benefits were not received.

4. If SSA determines during the six-month presumptive period that the person is not permanently disabled, or if there is no decision by the end of the six-month period, cancel the case because SSA did not establish permanent disability.

   Manually issue a **Notice of Action** using the following language:

> ____ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.
>
> We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.
>
> EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

   Determine if Medicaid eligibility exists under another coverage group.

SSA Disability Denial and Appeal Process

Legal reference: 42 CFR 435.541; 441 IAC 50.1(249), 50.2(1), and 75 (Rules in Process)

Policy: The Department is required to deny Medicaid eligibility based on a final Social Security Administration (SSA) decision that an applicant is not disabled. EXCEPTIONS:

- Medically Needy eligibility cannot be denied based on an SSDI (Title II) denial of disability.
- The Department must make a disability determination on medical impairments when the SSA has denied disability benefits because the person is engaging in substantial gainful activity but the person could qualify under Medicaid for Employed People with Disabilities (MEPD).
- The Department will determine disability when the client is claiming that a new disabling condition or a worsening of the original condition has occurred after a final SSA denial.

Comment: There is a specific meaning for a "final" SSA decision. When the SSA determines that a claimant (applicant) is not disabled, the person may appeal the decision. There are four levels to the SSA appeal process:

Appeal Level	Process
1. Initial determination	The claimant has 65 days from the date the SSA denial is issued to request a reconsideration of the disability determination.
2. Reconsideration	The claimant has 65 days from the date the SSA reconsideration is issued to request an appeal hearing with a SSA administrative law judge (ALJ).
3. Decision by an SSA ALJ	The claimant has 65 days from the date the SSA appeal denial is issued to request a review by the SSA Appeals Council. In some cases the ALJ may not issue a decision, but instead may recommend a decision and send it on to the Appeals Council. Recommended decisions are not considered a new SSI decision for Medicaid purposes until acted on by the Appeals Council.

Appeal Level	Process
4. Review by the Appeals Council	The Appeals Council hears cases sent in by the ALJ or upon the request of a claimant. The Appeals Council decides if a request for hearing before the Council will be granted. The Appeals Council can, on its own, take a case from an ALJ before a hearing is conducted. If the Appeals Council denies the request for review, the decision of the ALJ becomes final. A decision on disability by the Appeals Council is the final decision for SSA.

Disability may be denied or approved at any level. The claimant may stop the appeal at any level if the claimant does not want benefits from SSA. A "final" decision is reached when either:

- The person has gone through the full SSA appeal process, been denied at all levels, and cannot go further in the SSA system.
- A denial was made at any level of the SSA appeal process and the person did not appeal to the next level within 65 calendar days.

Procedure: Use the following procedures when the SSA has made a disability denial:

Status	Action
SSA decision is not final.	Deny the Medicaid application issuing a manual **Notice of Action** using the language listed in the following chart. Determine if Medicaid eligibility exists under another coverage group.
SSA decision on SSDI is final but the applicant could be eligible for **Medically Needy** coverage	Proceed with Department disability determination. See When the Department Determines Disability.

Status	Action
SSA final decision denies disability based on substantial gainful activity but the applicant could be eligible for **MEPD** coverage	Check for SDX payment status code N44. Proceed with Department disability determination. See When the Department Determines Disability.
SSA decision is final. The original condition has **not** worsened and client does not claim a new 12-month period of disability	Deny the Medicaid application issuing a manual **Notice of Action** using the language listed in the following chart. Determine if Medicaid eligibility exists under another coverage group.
SSA decision is final. Client claims a **new** disabling condition that will last at least 12 months.	Determine whether the client has a different condition than those considered by SSA. ▪ Request a copy of the denial explanation from the applicant. ▪ Compare the information on the denial explanation to the disability information on the Medicaid application. If there is a new disabling condition, proceed with a disability determination by the Department unless the client reapplies at SSA.
SSA decision has been final for at least 12 months. Client claims a change or deterioration in the disability that is expected to last 12 months.	Proceed with a Department disability determination unless the client reapplies with SSA. See When the Department Determines Disability.

> _____ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.
>
> We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.
>
> EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

Status	Action
SSA decision is final within the last 12 months. Client claims a change or deterioration in the disability that is expected to last 12 months.	Ask the following questions: ▪ Has the SSA refused to reconsider the claim on the worsening of the condition? ▪ Has the client lost eligibility for SSI due to other factors (income, resources, etc.)? If the answer to both questions is "no," deny the Medicaid application based on the SSA decision and refer the client back to SSA. Determine is Medicaid eligibility exists under another coverage group. If the answer to either question is "yes," proceed with a disability determination by the Department if the client is otherwise eligible.

Comment: The only payment status code on the SDX that means disability was denied due to substantial gainful activity is N44.

Payment status codes of N31, N32, N42, or N43, indicate denials of disability based on "capacity for substantial gainful activity." This means that, despite a medical impairment, the person has the ability to perform sedentary, light, or medium work that would allow the person to return to customary past work or other work.

When SSA Denies Disability After Disability Approval By DDS or SSA

Legal reference: 441 IAC 75 (Rules in Process)

Policy: A member may have been approved for Medicaid or State Supplementary Assistance based on the Department's or the Social Security Administration's (SSA's) determination of disability but at a later date the Social Security Administration (SSA) makes a determination the person is not disabled. The Department is required to follow the final SSA decision.

Comment: Since the SSA allows 65 calendar days to file an appeal, an SSA decision cannot be considered final until the 65 day appeal period has expired. It is important to understand the difference between an SSA decision that is final and one that is not final, because they affect Medicaid eligibility differently.

Procedure: Use the procedures in the following chart for the correct action at each step in the decision process when the SSA denies disability for a Medicaid member who has been determined to be disabled by DDS or SSA:

Status	Action
HHS receives notification that SSA has denied disability for a person who was approved based on a DDS or SSA disability decision.	1. Continue Medicaid or State Supplementary Assistance for 65 days from the date of the SSA denial. 2. Set a reminder to track the 65 days. 3. On the 66th day, check to see if an SSA appeal has been filed.
If the member has **not** filed an appeal with SSA by the end of the 65 days, the SSA decision is a **final decision**.	Cancel benefits with timely notice using a manual **Notice of Action** with the language listed below.
If the member appeals the denial within 65 days, the SSA decision is not a final decision.	Continue benefits until there is a final decision from SSA. This could be either: ▪ A decision issued at the Social Security Appeals Council level; or ▪ The most recent decision that the member does not pursue to the next appeal level by the end of 65 days.

To cancel the Medicaid case, use the language below.

> The Social Security Administration has determined that ____ is no longer disabled.
>
> EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

See also:

- Reapplying After Cancellation for a Nondisability Reason
- SSA Disability Denial and Appeal Process
- 8-F, People Ineligible for SSI (or SSA): Due to Reevaluation of Childhood Disability

> Mr. C is determined eligible for Medicaid in November based on the Department's disability determination. In April of the following year, Mr. C applies for SSI but on June 5, he is denied SSI as not disabled.
>
> The worker continues Mr. C's Medicaid eligibility for 65 days until the time to appeal has expired (August 8). As of August 8, Mr. C has not filed an appeal. On August 9, the worker issues a timely notice canceling Medicaid benefits for Mr. C effective September 1 and determines if Mr C would be Medicaid eligible under another coverage group.

When the Department Determines Disability

Legal reference: 20 CFR 416.901, 416.971, 416.972, 416.973; 441 IAC 75 (Rules in Process)

Policy: The Department must determine an applicant's disability when the applicant:

- Is applying for a coverage group that requires a determination of disability according to Social security Administration (SSA) standards, and
- Has not been approved for disability through an SSA disability determination.

The Department must make a determination on disability within 90 calendar days of the date of application. The time can exceed 90 calendar days if:

- The applicant or examining physician causes a delay, or
- There is an emergency beyond the control of the Department or the applicant.

Procedure: The Department's process for determining disability is a **shared responsibility** of the IM worker and Disability Determination Services (DDS).

NOTE: When the applicant has also applied for disability benefits from the SSA, wait on the SSA disability decision unless the applicant is eligible for only Medically Needy and the SSA is looking at SSDI (Title II) eligibility only.

When the Department must determine disability, first decide if the person performs substantial gainful activity. EXCEPTION: Skip this step when determining eligibility under Medicaid for Employed People with Disabilities (MEPD).

Make this decision within 15 calendar days of the application date. See Substantial Gainful Activity for an Employee and Substantial Gainful Activity for a Self-Employed Person for instructions.

If the person **is not** engaged in substantial gainful activity (except for MEPD), send the medical evidence to the DDS. Do this no later than 15 calendar days from the application date. (See Submitting Medical Evidence to DDS.)

Follow the steps listed below when an HHS determination is required.

Step 1: IM worker determines if the client engages in substantial gainful activity (SGA). Clients whose current earnings are at or higher than the SGA level are earning too much to meet disability requirements.

Determination:

- **Yes**, the client engages in SGA.

  Deny disability. Determine if Medicaid eligibility exists under another coverage group.

- **No**, the client does not engage in SGA

  Go to step 2.

Step 2: DDS evaluates the client's medical impairments and compares them to a list of qualifying impairments published in federal regulations.

Determination:

- **Yes**, impairment is listed.

  Go to step 3.

- **No**, severe impairments

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

Step 3: DDS staff determines whether the client has an impairment of a severity that meets or equals the severity of impairments listed in the federal regulations.

Determination:

- **Yes**, impairment meets severity

  Go to step 4.

- **No**, impairment does not meet severity

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

Step 4: DDS staff determines whether the client has the ability to perform past work activities.

Determination:

- **Yes,** the client can do past work

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

- **No,** the client cannot perform past work

  Go to step 5.

Step 5: DDS staff determines whether the client is able to perform other work activities at the SGA level.

Determination:

- **Yes,** the client can do other work

  Deny Medicaid as not disabled. Determine if Medicaid eligibility exists under another coverage group.

- **No,** the client cannot perform other work activities

  Approve Medicaid based on disability if client meets all other eligibility requirements

Mr. J, age 50, applies for Medicaid on the basis that he is disabled. Mr. J's countable resources are over $2,000, he is single, he has no dependent children, and he is not employed. The worker determines that Mr. J may be eligible only for the Medically Needy coverage group based upon disability.

Mr. J provides proof that he has applied for SSDI and that disability was denied by the SSA four months earlier. The worker initiates a disability determination because the Department cannot rely on an SSA denial of disability for Medically Needy applicants.

The following sections give further instructions on:

- Determining substantial gainful activity for an employee
- Determining substantial gainful activity for a self-employed person
- Submitting medical evidence to DDS

Substantial Gainful Activity for an Employee

Legal reference: 20 CFR 416.974, Program Operations Manual System POMS 10505.020, 441 IAC 75 (Rules in Process)

The first test of disability determination is evaluation of "substantial gainful activity" (SGA). SGA means the performance of "significant" physical or mental activities in work for substantial pay or profit.

- "Significant physical or mental activities" are useful in a job or business and have economic value. Self-care, household tasks, unpaid training, therapy, school attendance, clubs, and social programs **are not** considered SGA.
- Work may pay either in cash or in kind.
- The current earnings threshold for determining "substantial" activity is $1,620.

A person who is engaged in SGA despite physical or mental limitations is not disabled (unless the person would qualify under MEPD).

Comment: There is no SGA if the person's former job made many job accommodations or the person became more incapacitated and cannot find another similar job. Loss of work detrimental to health does not result in SGA.

There may be SGA if the person worked for longer than six months despite the impairment, lost the job, and applied for Medicaid in the same month. If there is reasonable doubt, do not consider the person engaged in SGA.

Procedure: To determine SGA for an employed person, calculate the person's countable income by averaging gross income over the time the income was earned after the disability occurred. EXCEPTION: Do not consider the earned income limits under SGA for eligibility under the Medicaid for Employed People with Disabilities (MEPD) coverage group.

Use the following procedure to determine if an employed client's countable monthly income demonstrates SGA:

Step	Action
Determine average monthly earnings.	Count earnings from employment and self-employment. Determine seasonal income by averaging income over the season to arrive at a monthly countable income. See 8-E, Income Policies for Non-MAGI-Related Coverage Groups.
Determine excluded earnings.	Do not count: ▪ Earnings of volunteers under the Small Business and Domestic Volunteer Acts. ▪ Employer subsidies to an impaired person that are not earned through the person's productivity. Ask the employer to determine the subsidy. If the employer cannot calculate the subsidy, compare the work to similar work of an unimpaired person, and the value of that work by the prevailing wage scale.
Determine deductions.	Deduct work expenses related to the person's disability. See 8-E, Deduction for Impairment-Related Work Expenses.

Step	Action
Compare remainder to $1,620 per month.	When the countable earnings exceed $1,620 per month, the applicant does not meet the first requirement of being disabled under SSA standards. Deny Medicaid as not disabled. See When the Department Denies Disability. When the countable earnings are less than $1,620 per month, complete a disability determination, as the client is not engaged in SGA. When countable earnings are less than $1,620 per month and there is evidence that an individual may be engaging in SGA, or appears to be in a position to defer compensation, or by special arrangement, is able to suppress earnings, proceed to the next tests.
Do the Comparability Test.	Compare the client's work to that of unimpaired people in the area. Look at time, energy, skills, and responsibility. If the work is the same as that done by unimpaired people, the client has SGA and is not disabled.
Do the Worth Test.	Determine if the client's work activity is worth more than $1,620 per month. If so, the client is engaging in SGA, even if the client's work activity is not comparable to that of an unimpaired person. The value of work in the military must be compared to similar work in a nonmilitary setting. Military wages may continue and the client may be placed on limited duty. Ask your area income maintenance administrator or the HHS SPIRS Help Desk to contact Medicaid Policy to determine the actual value of the work.

Mrs. P applies for Medicaid based on disability. She states that her disability is fibromyalgia. The worker evaluates Mrs. P's employment status for SGA.

Mrs. P continues to work at the same job with the same duties (meeting the Comparability Test), but her medical condition has caused her to reduce her work schedule from 40 hours per week to 20 hours per week, which has cut her earnings in half (the Worth Test). Her hourly wage is $21 per hour. Her average monthly pay is $1,806.

The worker determines that Mrs. P does not meet the SGA test for disability for most Medicaid coverage groups because she continues to do the same work and her earnings were over $1,620.

However, because Mrs. P is still employed, she appears to be eligible for MEPD. The worker makes a referral to DDS for a disability determination; noting on the **Disability Transmittal** to skip the step of determining SGA.

Substantial Gainful Activity for a Self-Employed Person

Legal reference: 20 CFR 416.975, 441 IAC 75 (Rules in Process)

Policy: There are three tests for "substantial gainful activity" (SGA) for a self-employed person. If the person does not meet the criteria in **all three** tests, the person is **not** engaged in SGA, and a HHS disability determination must be done.

Name of Test:	What this means:
1. Significant services **and** substantial income	This test is met if significant services are **combined with** substantial income.
a. Significant services	When a person (with the exception of a farm landlord who rents farmland to another farmer) gives significant services by participating in the following: ▪ Gets a social security earnings credit on the federal income tax return. ▪ Advises or consults with the renter and inspects production periodically. ▪ Furnishes a large portion of the machinery and financing.

Name of Test:	What this means:
b. Substantial income	When a person has: ▪ Countable income over $1,620 per month. ▪ Countable income that meets the community standard of livelihood for a self-employed person with a similar business.
2. Comparability of work	If work activities are comparable to that of an unimpaired person in the community engaged in the same or similar business, the person is engaged in SGA.
3. Work activity	If the value of the work is more than $1,620 per month based on the amount an employer would pay any employee to do the same job, the person engages in SGA.

Procedure: To determine SGA for a self-employed person, consider the three tests in order, as explained in the following chart. EXCEPTION: Do not determine SGA for the Medicaid for Employed People with Disabilities (MEPD) group.

If the earnings are comparable to unimpaired people in the community in the same business, there is substantial income and the person engages in SGA.

If there is “material participation” and “substantial income,” this means there is SGA, unless material participation has been reduced or has stopped. Determine if the significant services are the same at the time of application as before the person’s impairment.

If the self-employment was less than six months and has stopped, or the income level indicating substantial gainful activity continued for less than six months, there is no SGA.

If there is reasonable doubt whether the person meets SGA, assume the person does not meet SGA criteria.

Test 1: Significant Services and Substantial Income

1. Use only the income of the person's productivity, not the productivity of the person's agent (employee or assistant).
2. Subtract any business expenses from the gross self-employment income. Also subtract:
   - Unpaid help by a spouse, children, or others.
   - Soil bank income if included in farm income from the tax return.
   - Impairment-related expenses if not deducted as a business expense.
   - Business expense paid for by a third party, such as business rent paid by Vocational Rehabilitation or space furnished by a third party.
3. Determine if the income is the same as before the onset of disability. To determine if the onset of disability affected the person's ability to engage in SGA, use the income of at least the last five years. If the person's income is the same as before the onset of disability, there is substantial income and the person engages in SGA.
4. If the person's income is not the same as before the onset of disability, then determine if the earnings are comparable to unimpaired people in the community in the same business. (For farming, add in the value of produce grown for home consumption.)

Test 2: Comparability of Work

Evaluate work activity using:

- Hours worked
- Skills
- Energy output
- Efficiency
- Duties
- Job responsibilities

Test 3: Work Activity

Evaluate by determining countable income:

- A person who earns more than $1,620 per month meets the criteria for engaging in SGA, which results in not being considered disabled.
- See the procedures for Substantial Gainful Activity for an Employee.

Comment:

Mr. Q applies for Medically Needy on the basis of disability. His wife is employed and her earnings put their joint income higher than the MEPD income limit of 250% of the federal poverty level.

Mr. Q explains that he is not able to work full time because of his heart condition, but he has a self-employment business building bookcases, which averages $600 per month net income after business expenses are deducted. He pays his adult son $50 per month to deliver the lumber to his home workshop and to deliver the finished bookcases.

The worker evaluates Mr. Q's self-employment for SGA by applying the three tests in order:

Test 1. Significant services **and** substantial income:

- Mr. Q is not able to do all the work for his business himself.
- Mr. Q earns less than $1,620 per month.
- Mr. Q's income has dropped significantly from his previous full-time earnings.
- There is no one else in the local community who builds custom bookcases, so the worker cannot compare Mr. Q's income to the same type of work done by others.

Test 2. Comparability of work:

- Mr. Q formerly worked at least 40 hours per week and often more due to overtime assignments.
- Mr. Q currently has to take frequent rest breaks as he tires easily due to the heart condition. He works an average of ten hours per week.

Test 3. Work activity: Mr. Q earns less than $1,620 per month.

The worker determines that Mr. Q does not engage in SGA, so he is referred for a Department disability determination.

Submitting Medical Evidence to DDS

Legal reference: 441 IAC 75 (Rules in Process)

Policy: If the applicant does not meet the requirements for substantial gainful activity, then the Department must make a referral to the Bureau of Disability Determination Services (DDS) for a disability determination.

Comment: DDS may request additional information from the applicant and may require the applicant to have a medical examination. DDS pays for medical information and transportation.

Procedure: Use the **Disability Determination Checklist, RC-0103** as a guide.

Submit to DDS:	Explanation:
Form **470-2465, Disability Report for Adults** or Form **470-3912, Disability Report for Children** (under 18)	The applicant or the applicant's representative completes the form, which includes a release of information. Check the report to make sure the correct person signed the form, as follows: ▪ If the release is for mental health information, only an applicant 18 years of age or older or a legal representative can sign the form. ▪ If the release is for substance abuse information, only the applicant can sign the form, regardless of age.
Form **470-2472, Disability Transmittal**	This form contains case-related information that helps DDS determine disability. For an MEPD applicant, check the status, "MEPD – SGA not considered" in first step of disability determination.

Submit to DDS:	Explanation:
Form **470-4459** or **470-4459(S) Authorization to Disclose Information to the Iowa Department of Human Services**	The release allows DDS to contact sources to get the information needed to determine disability. Send a signed release for each source listed on the applicable **Disability Report** and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.
Additional records, if available:	This could include: ▪ Supplemental vocational information. ▪ Any information from the Social Security Administration. ▪ Copies of medical reports or letters from a provider about the applicant's medical condition from the last 12 months. ▪ For an adult applicant, evidence about work activity, even if the work done was not SGA. ▪ For a child applicant: • School information • Any work history • Any involvement with vocational rehabilitation or other social services
Records about a deceased applicant	Send either: ▪ Medical records including a note certifying the cause and date of death signed by a medical practitioner, or ▪ A death certificate. (When a person dies at home and has no history of medical treatment for the cause of death, a death certificate is required.)

If an applicant moves before a disability determination is completed, provide the new address to DDS by entering it on a copy of the **Disability Transmittal, form 470-2472**, and sending the form to DDS.

If HHS denies a Medicaid application for nondisability reasons (over resources, no longer a resident, etc.) after a disability determination has been sent to DDS, notify DDS to stop the disability determination by using **Disability Transmittal, form 470-2472**.

Disability Approved by DDS

Legal reference: 441 IAC 50.1(249) and 75 (Rules in Process)

Policy: Disability Determination Services (DDS) makes the disability determination decision on behalf of the Department.

Comment: DDS must make a determination on disability within 75 calendar days of the referral from HHS. If DDS cannot complete the disability determination within 75 calendar days, DDS will notify the local office of the delay.

DDS issues the disability decision on form **470-2472, Disability Transmittal** which is returned to the IM worker along with the entire disability file. The finding that the applicant is disabled is entered in Part II, Item 1 on the form.

Procedure: When DDS determines the person is disabled, and all other eligibility requirements are met, approve the Medicaid case.

HHS Responsibility for Disability Review and Redetermination

Legal reference: 42 CFR 435.541, 441 IAC 75 (Rules in Process), P. L. 104-193; P. L. 105-33

Policy: When a member who is eligible for Medicaid because of disability is not receiving disability benefits through the Social Security Administration (SSA), the Department is responsible for:

- Conducting reviews of the disability if required, and
- Redetermining disability when the member reaches the age of 18.

Comment: When disability is established, a date for review of the disability may be established to determine if the person continues to meet the disability or blindness requirements. Redetermination is required when a disabled child turns 18, since disability must then be determined using adult criteria. This is a separate process from a disability review.

Procedure: No action is required when SSA is responsible for reviews unless SSA finds that the member is no longer disabled.

Member Status	Responsibility for Disability Review
Receiving SSI or SSDI cash benefits	The SSA processes the disability reviews.
Not receiving SSI or SSDI cash benefits	The income maintenance worker must schedule the disability review and initiate the review with Bureau of Disability Determination Services (DDS).

For detailed procedures when the Department is responsible, see the following sections:

- Disability Reviews
- Redetermination at Age 18

Disability Reviews

Legal reference: 42 CFR 435.541, 441 IAC 75 (Rules in Process), P. L. 104-193; P. L. 105-33

Policy: A review may be required to verify that the member continues to meet disability requirements.

Comment: DDS lists the review date in the "Diary Date" box on form 470-2472, Disability Transmittal. Diary dates are by month, year, and "reason," which is the number of years until the next review.

If disability was gained through an appeal of the Department's denial of medical assistance, a review date may be established in the final decision issued on the appeal. If the review date is not given on the final decision, contact the HHS SPIRS Help Desk.

The Social Security Administration (SSA) sends review dates to the states for children who were canceled from SSI due to the revised disability criteria under Public Law 104-193 but receive Medicaid due to the provisions of the Balanced Budget Act of 1997.

The Department's central office sends individual notices regarding review dates for children canceled due to revised disability criteria. Do not contact SSA for review dates for children in this coverage group.

Procedure: When the Department is required to complete a disability review, send a request for a disability review to DDS. Schedule the disability review at the Medicaid eligibility review date closest to the review date scheduled by:

- DDS for determinations made on behalf of the Department, or
- The SSA for a child qualified under previous disability criteria, or
- The administrative law judge in an appeal of the disability determination.

Use **RC-0103, Disability Determination Checklist**, as a guide to making the review referral to DDS. Include the following documents in a disability review referral:

Document:	Preparation:
A new form **470-2472, Disability Transmittal**	Notify DDS of the need for special review requirements by writing in the "Comment" section of the form: ▪ For MEPD disregard SGA, or ▪ For a child under the standards in effect before enactment of P. L. 104-193.
The previous form **470-2463, Explanation of Disability Determination**, or the Personalized Disability Explanation issued by DDS.	If this form is not available, note on the Disability Transmittal the reason it is not included.
Proposed Decision and Final Decision	If disability was approved through an appeal of a Medicaid denial, include a copy of the proposed and final appeal decisions.

Document:	Preparation:
A new form **470-2465, Disability Report for Adults**, or form **470-3912, Disability Report for Children** if the member is under age 18	Request a new report from the client or the person acting on the client's behalf. Check the report for completeness. Since the form includes a release of information, verify that the correct person signed it: ▪ If the disability is related to mental health, only a client 18 years of age or older or a legal representative can sign the form. ▪ If the disability is related to substance abuse, only the client can sign the form, regardless of age.
New copies of form **470-4459** or **470-4459(S), Authorization to Disclose Information to the Iowa Department of Human Services**	Send a signed release to allow DDS to get information from each source listed on the **Disability Report** and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.
A complete copy of the previous disability file.	If HHS does not have a copy of the previous disability file because the SSA made the previous disability determination decision, note on the **Disability Transmittal** the reason the file is not attached.

If DDS notifies you that the member no longer meets disability requirements, follow the procedure under When the Department Denies Disability to cancel the Medicaid case.

Redetermination at Age 18

Legal reference: 20 CFR 416.987, 441 IAC 75 (Rules in Process)

Policy: The Department must request a redetermination of disability based on adult criteria when a child reaches the age of 18 **unless** the child is receiving SSI.

If the child is found no longer disabled based on a redetermination using adult criteria, cancel medical assistance based on denial of disability no sooner than the month after the child's eighteenth birthday.

Procedure: For a disability redetermination, send the following information to DDS no earlier than 30 days before the child's 18th birthday:

Document:	Preparation:
A completed form **470-2472, Disability Transmittal**	Note that the SGA step should be skipped, if the redetermination is for the MEPD group.
The previous form **470-2463, Explanation of Disability Determination** or the Personalized Disability Explanation issued by DDS.	If this form is not available, note on the **Disability Transmittal** the reason it is not included.
A completed form **470-2465, Disability Report for Adults**	Request the report from the client or the person acting on the client's behalf. Check the report for completeness. Since the form includes a release of information, verify that the correct person signed it: ▪ If the disability is related to mental health, only a client 18 years of age or older or a legal representative can sign the form. ▪ If the disability is related to substance abuse, only the client can sign the form, regardless of age.
New copies of form **470-4459** or **470-4459(S), Authorization to Disclose Information to the Iowa Department of Human Services**	Send a signed release to allow DDS to get information from each source listed on the Disability Report and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.

Document:	Preparation:
A complete copy of the previous disability file	If HHS does not have a copy of the previous disability file, note on the Disability Transmittal the reason the file is not attached (such as, the SSA made the previous decision and the file is not available to HHS).

If DDS notifies you that the 18-year-old no longer meets disability requirements, follow the procedure under When the Department Denies Disability to cancel the Medicaid case.

Denial of Medicaid Based on Disability Denial

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Non-MAGI-related Medicaid eligibility can be denied based on a disability determination decision made:

- By the Social Security Administration (SSA). or
- By the Bureau of Disability Determination Services (DDS) on behalf of the Department of Health and Human Services.

Procedure: When the Medicaid denial is based on a denial of disability from the SSA, manually issue a **Notice of Action** using the language below.

Determine if Medicaid eligibility exists under another coverage group.

> ____ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.
>
> We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.
>
> EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75 (Rules in Process)

See the following sections for more procedures:

- When the Department Denies Disability
- Appeal of a Medicaid Denial Based on a Disability Denial
- When SSA Denial Is Reversed in an SSA Appeal

When the Department Denies Disability

Legal reference: 441 IAC 50.1(249), 50.2(1), 75 (Rules in Process)

Policy: Medicaid eligibility based on disability shall be denied or canceled when the Department determines that an applicant or member is not disabled.

Comment: When there is a DDS denial of disability, DDS issues the decision using form **470-2463, Explanation of Disability Determination** or a Personalized Disability Explanation. The form is sent to the IM worker along with the entire disability file. The finding that the client is not disabled is also entered in Part II, 2 of the **Disability Transmittal, form 470-2472**.

Procedure: Send the client:

- A copy of form **470-2463, Explanation of Disability Determination** or the Personalized Disability Explanation and
- A **Notice of Action** denying the application or cancelling assistance because the person is not disabled.

For an **applicant**, it is important to issue a manual **Notice of Action** using the following language.

> …you are not blind or disabled. You will get a separate letter that tells you about the disability decision.
>
> EM 6-B SSA Policies Applicable to All Programs; EM 8-C Presence of Age, Blindness, or Disability; EM 8-J SSI-Related Medically Needy; EM 8-J Age Criteria; 8-J Blindness Criteria; EM 8-J Disability Criteria; 441 Iowa Admin. Code 50.1(249), 50.2(1), 75 (Rules in Process).

If a member's disability is denied due to a **review** of disability or due to a **redetermination** of disability for an 18-year-old using adult criteria, cancel the Medicaid coverage group and redetermine to another coverage group.

Comment: For more information, see:

- Appeal of a Medicaid Denial Based on a Disability Denial
- When SSA Denies Disability After HHS Disability Approval
- When SSA Denial Is Reversed in an SSA Appeal
- Disability Reviews
- Redetermination at Age 18

Appeal of a Medicaid Denial Based on a Disability Denial

Legal reference: 441 IAC 7.8(17A)

Policy: An applicant has the right to appeal a denial of Medicaid based on the determination that the applicant is not disabled, according to the policies and procedures in 1-E, Appeals and Hearings.

Procedure: Use the following steps to process appeals regarding denial of Medicaid based on the denial of disability.

Step 1:	Send the appeal request along with a copy of the **Notice of Action** within 24 hours to the HHS Appeals Section at the following address: HHS Appeals Section Fifth Floor 1305 E Walnut Street Des Moines, IA 50319-0114
Step 2:	Within ten calendar days, submit a summary of the action taken to the Appeals Section. Include the following information: ▪ The non-MAGI-related coverage groups under which the person is eligible. ▪ The reason benefits were denied: either • A Social Security Administration (SSA) decision or • A DDS decision from an HHS referral. If benefits were denied based on an SSA decision, include: ▪ The date of the decision. ▪ Proof of the SSA denial of disability
Step 3:	If the disability determination was done by DDS for HHS, send a complete copy of the disability file to each of the following: ▪ HHS Appeals Section ▪ The appellant ▪ The appellant's representative ▪ DDS at the following address: Disability Determination Services Bureau Disability Hearing Unit, SW 5th Street, Suite D, Des Moines, Iowa 50309 NOTE: Keep the original disability determination file with the case record.

The Department of Inspections, Appeals, and Licensing (DIAL) notifies the HHS worker, the appellant, the appellant's representative, and DDS (if appropriate) of the hearing date.

The worker is the representative for the Department (HHS) and must attend the hearing to explain HHS procedures leading to the denial of Medicaid.

If DDS made the disability determination on behalf of HHS, the DDS representative attends the hearing to:

- Explain DDS procedures,
- Explain the disability determination decision, and to
- Answer questions from the administrative law judge, the appellant, or the appellant's representative.

On rare occasions, the administrative law judge (ALJ) may determine that additional medical examinations are required to make a decision. DDS is responsible for obtaining these services.

After the ALJ issues a written order to DDS describing the required tests or examinations, DDS requests the disability file from the local office. DDS may ask the worker to obtain signed releases from the appellant as needed. DDS will then schedule the tests, provide the results to the ALJ, and return the disability file to the local office.

If the Final Decision states that the appellant is disabled, and all other eligibility requirements are met, approve Medicaid. Under this circumstance, if a date is not given for a Continuing Disability Review (CDR), contact the HHS, SPIRS help desk for guidance.

When SSA Denial Is Reversed in an SSA Appeal

Legal reference: 441 IAC 50.2(1) and 75 (Rules in Process)

Policy: When an applicant reports that the Social Security Administration (SSA) appeal process has reversed the denial of disability and the person is now determined to be disabled, the Department must determine if this change affects Medicaid eligibility.

Procedure: If Medicaid was denied based on the Department's disability determination and not based on an SSI or Title II denial, the SSA reversal has no effect on the Medicaid denial. Advise the client to file a new Medicaid application.

If the SSA reverses an SSI denial, approve Medicaid based on the SSI eligibility. Determine Medicaid eligibility based on the date of the Medicaid application.

Compare the disability onset dates established by the SSA to the dates of the Medicaid application. Obtain the date of onset as follows:

- The IEVS Third-Party Query (TPQY) response lists a specific month, day, and year as the onset date for a SSDI (Title II) disability decision. See the last page of the TPQY.
- For SSI, the onset date is usually shown as the first day of the month that disability is established as shown on the SDX screen.

If SSA disability onset date is …	**Then…**
Before the date of the Medicaid application …	Allow applicable retroactive months of eligibility for individuals who meet a category of eligibility for the retroactive period as defined in 8-A, Definitions.
On or before the date of the Medicaid denial …	Allow applicable retroactive months of eligibility for individuals who meet a category of eligibility for the retroactive period as defined in 8-A, Definitions.
After the date of the date of the Medicaid denial notice …	The person is not entitled to Medicaid based on the denied Medicaid application. The person must file a new Medicaid application.

Comment:

Ms. L applies for Medicaid based upon disability in February 2008. The IM worker refers Ms. L for a Department disability determination because she has resources higher than the limit for non-MAGI-related coverage groups but lower than the limit for the Medically Needy program.

DDS evaluates Ms. L and determines that she does not meet the criteria for disability.

Ms. L applies for SSDI in July 2008. The SSA denies that she is disabled. Ms. L asks for all levels of the SSA appeal process. In the final level of appeal, Ms. L is approved for disability effective May 2008.

Although Ms. L is determined to be disabled by SSA, the Department requires a new application because the original denial was not based on the SSA disability denial.

Reapplications Based on Disability

Legal reference: 20 CFR 416.913, and 416.920; 441 IAC 50.2(1) and 75 (Rules in Process)

Policy: The Department must reevaluate the disability status of an applicant each time a Medicaid application is filed.

Procedure: Evaluate the current claim for disability when a person reapplies for Medicaid based on disability:

- After a denial because the person was not determined to be disabled, or
- After a cancellation due to the determination that the person is no longer disabled.

See the following sections:

- Reapplying After Disability Is Denied
- Reapplying After Cancellation for a Nondisability Reason

Reapplying After Disability Is Denied

Legal reference: 20 CFR 416.913 and 416.920; 441 IAC 50.2(1), 75 (Rules in Process)

Policy: When a person reapplies for Medicaid following a denial or cancellation based on a decision of disability or blindness by the Bureau of Disability Determination Services (DDS):

- HHS continues to use the initial denial of disability when the person does not claim a worsening of the disabling condition or a new disabling condition.
- A new referral to DDS must be made when the person claims a worsening of the condition or a new disabling condition.

Procedure: If the person claims a worsening of the disabling condition or a new disabling condition, send all previous disability reports to DDS along with any new material.

If the person claims there is no change in condition, no disability exists. Manually issue a **Notice of Action** using the language below. Determine if eligibility exists under another coverage group.

> _____ is not blind or disabled. If your medical condition gets worse or you have a new condition, then you may re-apply for Medicaid.
>
> EM 8-C, Reapplying after Disability is Denied; 441 Iowa Admin. Code 75 (Rules in Process), 20 CFR 416.913 and 416.920.

Comment:

Mr. K applies for Medicaid as a disabled person because of arthritis in May 2008. The worker makes a referral to DDS. In July 2008, DDS determines that Mr. K is not disabled due to the arthritis. The worker issues a **Notice of Action** in July 2008, denying Medicaid as Mr. K is not disabled. The worker determines if eligibility exists under another coverage group.

In January 2009, Mr. K again applies for Medicaid. He does not claim a new disabling condition nor a worsening of his arthritis. The worker denies his Medicaid application as not disabled.

Reapplying After Cancellation for a Nondisability Reason

Policy: In most instances, disability or blindness does not need to be reestablished for a person reapplying for Medicaid when the cancellation was done due to nondisability reasons.

A disability determination is required when:

- The person states there has been improvement in the condition.
- The person has turned age 18, which means the disability must be redetermined under adult disability standards.
- A review of disability or blindness is due or should have been completed during the period that the person was not on Medicaid. The review date may have been scheduled either by the Department or by the Social Security Administration.

Procedure: Follow procedure under When the Department Determines Disability to complete a referral for disability determination.

Nonfinancial MAGI-Related Eligibility

This section deals with additional nonfinancial eligibility policies specific to MAGI-related applicants and members. These additional requirements include:

- Absence
- Residency
- Specified relatives
- Verification of pregnancy

Absence

Legal reference: 441 IAC 75.53

Do not include in the eligible group any person who is absent from the home and does not meet the temporary absence provisions:

- Consider a parent to be absent from the home when the parent is committed, imprisoned, or admitted to an institution.
- Consider a parent to be absent from the home when the parent is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.

- Consider a parent to be absent from the home when the parent is absent because of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service.

  Mr. A is on active duty with the U.S. Army, based in another state. His wife, Mrs. A, and their children live in Iowa. Mr. and Mrs. A do not consider themselves estranged. Mr. A is absent only because of his active duty military service.

  If Mrs. A applies for Medicaid, Mr. A is not included in the eligible group and his income is considered only to the extent he makes it available. NOTE: Although Mr. A is considered "absent," a referral to CSS is not made. See 8-B, Referrals to CSS.

- Do **not** consider a parent to be absent from the home when the parent is absent solely because of a pattern of employment. Examples include salespeople and truck drivers.

  1. Mr. and Mrs. B receive Medicaid for themselves and their children. Mr. B takes a job as a truck driver. Due to the nature of the job, he will be home only one or two days a week and on the road the rest of the week.

     Mr. B is away solely because of his employment. He is not considered to be absent. He must be included in the eligible group and his income considered in determining eligibility for the family.

  2. Mr. C and Ms. D receive Medicaid for themselves and their common child. Mr. D takes a job with a carnival that will require him to be away from home for six months.

     Mr. C is away solely because of his employment. He is not considered to be absent. He must be included in the eligible group and his income considered in determining eligibility for the family.

Questionable Cases

Legal reference: 441 IAC 75 (Rules in Process)

In questionable cases, you may need verification before you can consider a parent absent and determine eligibility. Do not take action based on suspicion or complaint alone when you believe that an "absent parent" is not absent. Try to get several items that support your belief.

The following are examples of situations that could justify more verification:

- The case was recently denied or canceled because the "absent parent's" income or resources were considered.
- The absent parent moves in and out of the home frequently.
- Living expenses exceed income.
- The parent's absence occurs when the parent is on strike or during slack times for a self-employment business, etc.
- There is no verifiable residence for the absent parent.
- The verifiable residence for the absent parent is very close to the child's home.

The absent parent may be out of contact with the family, especially if the separation was recent. The client may verify the circumstance by providing a statement from the landlord, minister, lawyer, or other knowledgeable nonrelative. Apply the "prudent person" concept and document the basis for the decision on all questionable cases.

Temporary Absence

Legal reference: 42 CFR 435.403(j)(3), 441 IAC 75.53

Policy: Include in the eligible group the needs of a person who is temporarily out of the home, if otherwise eligible. A temporary absence exists when the person is:

- Out of the home to secure education or training.
- In a medical institution for less than a year as verified by a physician's statement.
- Out of the home for another reason and the person intends to return to the home within three months.

Document the temporary absence and request verification as needed.

Absence for Education

Legal reference: 441 IAC 75.53

Policy: Include in the eligible group a person who is temporarily out of the home for the purpose of education or training. “Education and training” means any academic or vocational training program which prepares the person for a specific professional or vocational area of employment.

Procedure: If a child was in the home before leaving for education or training, a temporary absence exists as long as the child remains a dependent. Continue assistance if the child remains a member of the relative’s family group.

When a child is attending Job Corps, the Iowa Braille and Sight Saving School, or the Iowa School for the Deaf, consider the child to be in a public educational or vocational training institution and include the child in the eligible group if otherwise eligible.

A parent or other caretaker who is temporarily out of the home for training or education may be included in the eligible group, provided the parent or other caretaker was in the home before leaving to secure education or training.

Absence in a Medical Institution

Legal reference: 441 IAC 75.53

Include in the eligible group a person who is temporarily absent from the home and in a medical institution. Assistance may be approved for a person who is confined to or living in a medical institution as long as the person:

- Is anticipated to be in a medical institution for less than a year, as verified by a physician’s statement.
- Will be returning directly to the home from the medical institution.

When determining the 12-month period, the first full calendar month after the person enters the medical institution is considered “month one.”

A “medical institution” is a facility that provides medical care, including nursing and convalescent care, in accordance with accepted standards as authorized by state law and as evidenced by the facility’s license.

A medical institution may be public or private. Medical institutions include:

- Hospitals
- Nursing facilities
- Intermediate care facilities for persons with an intellectual disability
- Psychiatric medical institutions for children
- Psychiatric institutions
- State hospital schools
- Mental health institutions

EXCEPTION: Children in a psychiatric medical institution for children (PMIC) who are in court-ordered foster care status are not considered in the eligible group at home.

A person, who enters a medical institution from foster care, or from any place other than the home, is not considered in the eligible group at home. This is true even if the person anticipates being in the medical institution for less than a year and returning to the home upon leaving the medical institution.

EXCEPTION: Include in the eligible group a child who has remained in a medical institution since birth, but is expected to enter the home in less than one year.

1. Mrs. A applies for assistance for herself and her child, who has been in the hospital for five months. The child left the home to enter the hospital and is expected to return to the home in two months.

   Mrs. A and the child are eligible, because the total time the child is expected to be out of the home and in a medical institution is less than one year.

2. Mrs. B applies for assistance for herself and her child who has been in a nursing facility for ten months. The child is expected to return to the home in four months.

   There is no MAGI-related Medicaid eligibility because the total length of time the child is expected to be out of the home is greater than one year.

3. Mrs. C applies for MAGI-related Medicaid for herself and a child. The child was in foster care for two months before entering the medical institution. The child is expected to return to the home within three months.

   There is no MAGI-related Medicaid eligibility, because the child did not enter the medical institution from the home.

If the person does not return within one year, remove the person's needs from the eligible group.

Absence for Less than Three Months

Legal reference: 441 IAC 75.53 and 75.12(249A)

Include in the eligible group a person who is temporarily absent from the home. A "temporary absence" exists when a person is out of the home for reasons other than in a medical institution or for education or training and it is expected that the person will return to the home within three months.

NOTE: A person who is expected to be absent from the MAGI-related eligible group for less than three months due to incarceration is still eligible for Medicaid. See Residents of Public Nonmedical Institutions.

A child may be out of the home for purposes such as visiting the absent parent or vacation. The child remains eligible if the child's absence is anticipated to last less than three months.

Even though the parent's or other caretaker's responsibility for care and control is lost, continue eligibility as long as the loss is temporary. For example, a child visiting the other parent can be included in the eligible group, as long as the absence is expected to be less than three months and all other factors of eligibility are met.

Assistance may be approved for a person when the total length of time the person is anticipated to be out of the home is less than three months. If the person does not return home within three months, remove the person's needs from the eligible group.

When determining the three-month period, the first full calendar month after the person has left the home is considered "month one." For applicants, the total length of time is from the date the person left the home (not the date of application) until the date the person is expected to return.

1. Jim, a member of the MAGI eligible group, leaves home on May 2 to visit his father. He is expected to return home August 29. His needs continue to be included in the MAGI eligible group.
2. Mrs. A applies for assistance for herself and four children. Three of her children live with her. The fourth child has been living with his father for the past two months and will be returning to Mrs. A's home in two months.

   Mrs. A is eligible to receive assistance for the three children living in the home. The fourth child is not eligible until he returns to the home because his total length of absence from the home is anticipated to be greater than three months.
3. Mrs. B applies for assistance for herself and one child. The child was living with her grandmother for one month. Before this, the child had been living with Mrs. B. The child will be returning to Mrs. B's home in one month.

   If the grandmother is not receiving assistance for the child, the worker continues assistance for Mrs. B and the child, because the total length of absence is anticipated to be less than three months.

MAGI Household Size

Legal Reference: 441 IAC 75 (Rules in Process)

For the purpose of determining financial eligibility, each applicant's or member's household size is determined individually based on federal tax policy and with regard to the applicant's or member's federal tax status.

The application and renewal forms ask whether an individual plans to file a tax return for the year. The individual's household is constructed based on their plan to file a federal income tax return, regardless of whether or not they actually file a return at the end of the year, or be claimed as a tax dependent. It is not necessary to have filed a federal income tax return in previous years.

Different households may exist within a single family, depending on each of the family members' familial and tax relationships to each other.

Applicant or Member is a Tax-Filer

Legal Reference: 441 IAC 75 (Rules in Process)

An applicant or member who expects to file a federal tax return for the year in which the applicant or member requests Medicaid and does not expect to be claimed as a tax dependent by another taxpayer is considered a "tax-filer". A tax-filer's Medicaid household size shall include:

a. The tax-filer,

b. The tax-filer's spouse (if living together), or if expected tax status is married filing jointly (regardless if a spouse is absent from the home or whether the absence meets the definition of temporary), and

c. Each dependent that the tax-filer expects to claim.

Applicant or Member is a Tax Dependent

Legal Reference: 441 IAC 75 (Rules in Process)

An applicant or member who expects to be claimed as a tax dependent on a federal tax return for the year in which the applicant or member requests Medicaid is a "tax dependent". A tax dependent's Medicaid household size is the same as the tax-filer who claims the dependent.

EXCEPTION: The dependent's household size is determined the same as a non-filer who is not claimed as a tax dependent when the dependent meets one of the following exceptions:

a. Expects to be claimed by someone other than a spouse or parent (biological, adoptive or step).

b. Is a child under 19 who expects to be claimed by one parent while living with both parents who do not expect to file a joint return.

c. Is a child under age 19 who expects to be claimed by a non-custodial parent in accordance with a:

- Court order or binding separation, divorce, or custody agreement establishing physical custody controls, or
- If there is no such order or agreement, or if there is a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

Applicant or Member is a Non-Filer (does not file taxes) and is Not Claimed as a Tax Dependent

Legal Reference: 441 IAC 75 (Rules in Process)

A non-filer who is not claimed as a tax dependent can be an applicant or member who:

- Does not expect to file a federal tax return for the year in which Medicaid is requested,
- Does not expect to be claimed as a tax dependent for the year in which Medicaid is requested, or
- Meets one of the following exceptions:

  a. Expects to be claimed by someone other than a spouse or parent (biological, adoptive or step).

  b. Is a child under 19 who expects to be claimed by one parent while living with both parents who do not expect to file a joint return.

  c. Is a child under age 19 who expects to be claimed by a non-custodial parent as described above in Applicant or Member is a Tax Dependent.

The household size shall consist of the applicant or member, and each of the following who is living with and in relation to the applicant:

1. Parent (natural, adopted and step) when the applicant or member is a child under the age of 19.
2. Spouse;
3. Child (natural, adopted and step) under the age of 19;
4. Sibling (natural, adopted and step) under the age of 19 when the applicant or member is a child under the age of 19.

Married Couples

Legal Reference: 441 IAC 75 (Rules in Process)

In the case of a married couple living together, each spouse will be included in the household size of the other spouse, regardless of federal tax status.

In the case of a married couple filing jointly, each spouse will be included in the household size of the other spouse, even when they are not living together.

Pregnancy

Legal Reference: 441 IAC 75 (Rules in Process)

In establishing eligibility for a pregnant woman or any person whose household includes a pregnant woman, the unborn child (children if more than one fetus exists) shall be considered when determining the number of persons in the household size.

The applicant's or member's attestation of the pregnancy, date of conception, due date, and number of children expected to deliver shall serve as verification unless questionable.

The composition of a MAGI household that includes a pregnant woman counts all eligible individuals, the pregnant woman, and the number of children she is expecting to deliver.

When the mother intends to place her child for adoption shortly after birth, the child shall be considered as living with the mother until custody is relinquished.

Applicant or Member Attestation of Federal Tax Status

Legal Reference: 441 IAC 75 (Rules in Process)

The department shall accept the applicant's or member's statement of their federal tax status and claimed dependents, or such statement from an adult who is living with and in the Medicaid household size of an applicant or member who is a child.

In cases where tax status or tax dependency cannot be established, the individual's household is determined following non-filer rules.

Determining If a Common-Law Marriage Exists

Legal reference: Legislative Guide to Marriage Law/Iowa Legislative Services Agency at https://www.legis.iowa.gov/docs/central/guides/marriage.pdf; IowaLegalAid.org at http://www.iowalegalaid.org/resource/common-law-marriage-in-iowa

When determining if someone is a parent or other caretaker, there may be situations where a common-law marriage exists or the applicant or member claims a common law marriage exists. Accept a couple's claim that a common-law marriage exists unless you have reason to question the claim.

If you question the claim, a common law marriage exists if **both** people:

- Are free to marry
- Have intended or have agreed to be married
- Continue to live together
- Publicly declare themselves to be husband and wife.

The following items can further indicate that a common-law marriage exists:

- Joint income tax forms
- Joint purchase of property (house, car, etc.)
- Mortgages or loans
- Insurance policies
- School records
- Employment records
- Birth records
- Joint bank accounts
- Statements to friends or relatives
- Hotel or motel registrations

Evidence must represent the couple as husband and wife. One item is not enough evidence, but several items might indicate a common-law marriage.

A common-law marriage is a legal and valid marriage. When a common-law marriage exists, treat the adults the same as any other married couple.

Adoption

Legal reference: 441 IAC 75 (Rules in Process)

When a mother intends to place her child for adoption shortly after birth, the child is considered as living with the mother until the legal release of custody is signed and custody is actually relinquished. Iowa law requires that when a child is voluntarily placed for adoption, a release of custody cannot be signed less than 72 hours after the child's birth.

The adoption does not sever a biological relationship.

Joint Custody

Legal reference: 441 IAC 75 (Rules in Process)

A child can receive Medicaid in one household only.

Living with a parent or other caretaker implies the existence of a relationship involving an accepted responsibility on the part of the caretaker for the primary care of the child. A non-parental caretaker must attest to having primary responsibility for the child's care.

In joint custody situations, the child shall be considered to be living with the custodial parent or other caretaker (which is determined as follows) when a child lives in the home of one parent or other caretaker some of the time and also lives in the separate home of the other parent or another caretaker:

- As specified in a court order or binding separation, divorce or custody agreement, or,
- If there is no such order, the parent or other caretaker with whom the child spends most nights shall be considered the custodial parent or other caretaker.
    - When a child spends equal amounts of time in the home of each parent and both parents apply for Medicaid for the child, the parents must decide which parent will continue with the application. Likewise, when a child spends equal amounts of time in the home of a parent and the home of another caretaker, the parent or other caretaker must decide which caretaker will continue with the application.
    - If the parents, or the parent and other caretaker, cannot reach a decision, the department will make the determination based on the totality of the available circumstances.

The following questions may be helpful when deciding who the child is living with if the child appears to be spending equal amounts of time in each home and the parents cannot decide who will receive Medicaid. This is not a complete or final list of questions but gives some general guidance.

- Which parent lives in the same school district as the child's school?
- Who purchases most of the child's clothing?
- Which parent does the school contact in an emergency?
- Where are most of the child's clothing and toys stored?
- Who does most of the child's laundry?
- Who maintains medical records and sets up medical appointments?
- Who has the final say as to what the child can or cannot do if there is a disagreement?

Upon the determination that a child is living with a parent or other caretaker, the Medicaid household for the child is determined as described above in MAGI Household Size.

Verification of Pregnancy

Legal reference: 441 IAC 75 (Rules in Process)

If a woman's eligibility is dependent upon pregnancy, accept a woman's statement, unless questionable, as verification for the following:

- The claim that she is currently pregnant.
- The probable date of conception to establish retroactive eligibility.

If the pregnancy is questionable, accept a signed statement from any of the following:

- A maternal health center
- A family planning clinic
- A physician's office
- A certified nurse midwife
- Another physician-directed provider, such as a rural health clinic or birthing center.