STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Employees' Manual
Title 8, Chapter J

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Medically Needy

Page

Overview

This chapter provides information specific to the Medically Needy coverage group. Medically Needy provides Medicaid coverage to people who have too much income or resources to qualify for SSI cash assistance or for other medical coverage groups but not enough for medical care. These people must also meet categorical criteria for eligibility. That is, they must be:

- Aged, blind or disabled, or
- Members of families with children, or
- Pregnant women, or
- Children under age 19.

People eligible for the Medically Needy coverage group are eligible for payment for all services covered by Medicaid except:

- Care in a nursing facility, including a Medicare-certified skilled nursing facility or NF/MI.
- Care in an intermediate care facility for persons with an intellectual disability.
- Care in an institution for mental disease.
- Rehabilitative treatment services for children (specified services in the family preservation, family-centered services, family foster care treatment, and group care programs).

The Medically Needy coverage group is authorized in Title XIX of the Social Security Act and described in the Code of Federal Regulations, Title 42, Chapter 4, Part 435. State authorization for the program is Iowa Code Chapter 249A. The portion of the Iowa Administrative Code dealing specifically with the Medically Needy coverage group is 441 IAC Chapters 75 and 76.

This chapter contains definitions for terms unique to the Medically Needy coverage group. You will also find descriptions of how people become eligible, the services for which they are eligible and other factors unique to Medically Needy, such as verifying medical expenses and the spenddown process.

Use this chapter in combination with Chapters 8-A, 8-B, 8-C, 8-D, 8-E, and 8-G to determine eligibility for the Medically Needy coverage group.

Definitions

Legal reference: 441 IAC 75 (Rules in Process)

"Applicant" means a person for whom assistance is being requested, including at recertification.

"Break in assistance" means more than three months between the end of the last certification period and the beginning of the next certification period.

"Categorically eligible" means a person meets the broad guidelines for the categories of people to whom Medicaid eligibility is provided.

To be FMAP-related categorically eligible, a person would be a child under age 21, a parent living with a child under age 18, or a pregnant woman.

To be SSI-related categorically eligible, a person would be aged, blind or disabled.

"Certification period" is the time period for which a person may be determined eligible for Medically Needy. A conditionally eligible person is certified for a period of no more than two consecutive months. **Note:** Recipients with no spenddown have ongoing eligibility, instead of certification periods.

"Conditionally eligible recipient" is a person who is approved for Medically Needy with a spenddown but has not yet met the spenddown.

"Considered person" is a person whose needs, income, and resources are considered in the Medically Needy eligibility determination but who is not eligible to receive benefits.

"Dependent child" is a child who meets the non-financial eligibility requirements of the applicable FMAP-related coverage group.

"Eligible recipient" is a Medically Needy person with zero spenddown or who has met spenddown. This person has income at or less than the medically needy income level (MNIL) or has reduced income through the spenddown process to the MNIL.

"FMAP-related" means people who would be eligible for the Family Medical Assistance Program (FMAP) except for income or resources.

"Incurred medical expenses" are:

- Medical bills paid by a recipient, a responsible relative, or a state or by a political subdivision program (other than Medicaid) during the certification period or retroactive certification period, **or**
- Unpaid medical expenses for which the recipient or responsible relative remains obligated to pay.

"Medicaid-covered services" are medical services payable through the Medicaid program.

"Medically needy income level (MNIL)" is 133% of the FMAP schedule of basic needs (payment level) based on family size.

"Medically needy person" means a person who:

- Is FMAP-related or SSI-related,
- Has resources within the $10,000 limit, and
- Has income no more than the MNIL or has income reduced to the MNIL by spenddown.

"Medically Needy subsystem" is a subsystem of the Medicaid Management Information System (MMIS) managed by the Iowa Medicaid Enterprise (IME) that applies verified medical expenses against the unmet spenddown obligation and notifies the ABC system when spenddown has been met.

"Necessary medical and remedial services" are medical expenses recognized under state law that are currently covered by the Iowa Medicaid program.

"Obligated medical expenses" are expenses for which the recipient or responsible relative continues to be legally liable.

"Ongoing eligibility" means eligibility continues for people with a zero spenddown. There is no certification period.

"Recertification" means establishing a new certification period when the previous period has expired and there has not been a break in assistance.

"Responsible relative" means a spouse, parent, or stepparent living in the household of the medically needy person. Responsible relatives are "considered" people.

"Retroactive certification period" is the period of up to three calendar months before the month in which a person applies for Medicaid and who meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. The retroactive certification period begins with the first month Medicaid-covered services are received and continues to the end of the month immediately before the month of application.

"Specified relative" is a person defined by FMAP policies. The specified relative must have a dependent child in their care.

"Spenddown" is the process in which a medically needy person obligates excess income for allowable medical expenses in order to reduce income to the household's MNIL.

"SSI-related" means aged, blind or disabled people who would be eligible for Supplemental Security Income (SSI) benefits except for excess income or resources.

Policies for FMAP-Related Coverage Groups Prior to MAGI Methodology

Nonfinancial FMAP-Related Eligibility Prior to MAGI Methodology

Age of Children

Legal reference: 441 IAC 75 (Rules in Process)

Age requirements for children differ, depending whether eligibility is established under:

- Family Medical Assistance Program (FMAP)
- Mothers and Children (MAC) program

A child who meets the program's age requirement is eligible in the month of birth, unless their birthday is the first day of the month.

The following sections explain the requirements for each group.

Family Medical Assistance Program (FMAP)

Legal reference: 441 IAC 75 (Rules in Process)

A child can receive Medicaid under the Family Medical Assistance Program (FMAP) until the age of 18 without regard to school attendance when a parent or needy specified relative in the child's eligible group also receives Medicaid under FMAP.

An 18-year-old child can receive FMAP if the 18-year-old is a full-time student in a secondary school, or in the equivalent level of vocational or technical training, and reasonably expected to complete the program before reaching age 19. See School Attendance later in this chapter.

A child can be determined eligible for a month if the child was eligible at any time during the month. For example, a child can be determined eligible if the child becomes 18 during the month, unless the birthday falls on the first day of that month. Refer to 8-F, *Family Medical Assistance Program (FMAP)*.

NOTE: Under FMAP, a child becomes an adult when the child gets married unless the marriage is annulled. The child remains an adult if divorced.

Mothers and Children (MAC) Program

Legal reference: 441 IAC 75 (Rules in Process)

Medicaid is available through the Mothers and Children (MAC) coverage group to people who have not reached the age of 19. Refer to 8-F, *Mothers and Children (MAC) Program*.

Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Certain people in a household *must* be in the FMAP-related eligible group; others *may* be included in the group.

- The people who must be included in the eligible group may vary depending upon the coverage group under which eligibility is being established.
- A single household may contain one or more eligible groups depending on the relationships of the household members.
- The household may voluntarily choose to exclude certain otherwise mandatory members of the eligible group when assistance is not wanted for them.

The following sections explain:

- Who must be in the FMAP eligible group
- Who may be in the FMAP eligible group
- Determining the number of eligible groups in a household
- Household composition examples

Procedure: Follow these steps to determine who to include in the FMAP-related eligible group:

STEP	ACTION
1	**Categorical eligibility:** Start with people for whom the household is requesting Medicaid. Identify the coverage groups for which each person is categorically eligible.
2	**Mandatory household members:** Include people in the eligible group according to the policies for the applicable coverage groups.
3	**Nonfinancial eligibility criteria:** If any person in the household is ineligible for nonfinancial reasons, determine if the person must still be included in the eligible group as a considered person.
4	**Voluntary exclusion:** Determine if there are any household members that the eligible group may voluntarily choose to exclude.
5	**Relationships:** Evaluate the effect that excluding the person has on the relationships of the remaining members of the eligible group.

Who Must Be in the FMAP Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Policy: The FMAP eligible group consists of all eligible people living together. The FMAP eligible group is considered a separate and distinct group, regardless of other people in the home and the relationship of these other people to the eligible group.

SSI recipients are never included in the FMAP eligible group. See State Supplementary Assistance Recipient for details on how to treat SSA or SSI recipients in the same household.

An eligible group must have at least one dependent child and one eligible specified relative to meet eligibility requirements for FMAP. EXCEPTIONS: The parent, the incapacitated stepparent married to the parent, or the needy specified relative may be the only FMAP-related eligible group member receiving Medicaid if:

- The only eligible child receives SSI, or
- The dependent child is ineligible for Medicaid, or
- The parent or needy specified relative voluntarily chooses to exclude the child or children in order to receive coverage for the parent or needy relative.

Include the following household members in the eligible group:

- The dependent child.
- Any brother or sister of the dependent child (of whole, or half-blood, or adoptive) who:
  - Is not an SSI recipient, and
  - Meets requirements under Age of Children and School Attendance.
- Any natural or adoptive parent of the dependent child, regardless if the parents are married to each other.
- Any household member who:
  - Receives home- and community-based waiver services,
  - Is not an SSI recipient, and
  - Meets the family relationship requirements.

The unborn child, when the pregnant mother is counted in the household. If the only child in the family receives Medicaid as a newborn, the mother cannot establish eligibility under the FMAP coverage group unless she requests that the child be removed from newborn status and added to her eligible group. See Unborn Children.

- A parent who is not eligible for Medicaid due to a nonfinancial reason. The parent must remain a part of the household size as a "considered" person. The parent's income and resources are counted toward the eligible group. See Whose Resources to Count, for instructions on how to treat the resources of an ineligible parent.

1. Ms. C, Mr. D, and their common child, Child E, apply for Medicaid for all three of them. Child E has no social security number. The parents indicate that they are not going to apply for one.

   Child E is not eligible for Medicaid and is not a "considered" person on his parent's cases.

   However, if they are otherwise eligible, Ms. C and Mr. D are each eligible as a household of one because they both have a dependent child in the home. They are not part of the same eligible group because they are not married and their common child is not receiving Medicaid.

2. Mr. F applies for assistance for himself and his two children, a boy, age 5, and a girl, age 7. Each child has a different mother and neither mother is in the home.

   Mr. F has social security numbers for himself and his son. He has not been able to apply for a social security number for his daughter. Since the girl is ineligible for Medicaid, the eligible group consists of Mr. F and his son.

The following sections explain specific exceptions to FMAP eligible group policy for:

- People who are voluntarily excluded
- Unborn children
- Siblings
- SSI recipients

People Voluntarily Excluded from the Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Policy: People who may be voluntarily excluded from the FMAP eligible group include:

- Self-supporting parents of an unmarried minor who are excluded by the minor parent in order to get Medicaid for the minor parent's child.
- The minor parent when the minor parent's self-supporting parents are voluntarily excluded. However, consider the minor parent's income and resources (if applicable) when determining eligibility for the minor parent's child.
- A stepparent.
- The biological parent and any common children when the stepparent is excluded in order to get Medicaid for a stepchild. Use the biological parent's income and resources when determining eligibility for the biological parent's child.

- An infant who is receiving Medicaid as a newborn child of a Medicaid-eligible mother.
- Whole, half, or adoptive siblings of eligible children.
- A person cannot receive Medicaid if that person is ineligible for a nonfinancial reason, such as no social security number, no verification of citizenship or identity, or a sanction.
    - When a **child** is not eligible for a nonfinancial reason, the child is **not** part of the household size. The child's income and resources are **not** counted toward the eligible group.
    - When a **parent** is not eligible for a nonfinancial reason, the parent must remain a part of the household size as a "considered" person. The parent's income and resources are counted toward the eligible group. See Whose Resources to Count, for instructions on how to treat the resources of an ineligible parent.

1. Mrs. X, a single parent, applies for Medicaid for herself. She has two children, Mary, age 6, who receives SSI, and Bobby, age 10. Bobby receives $375 a month social security benefits from his deceased father's account.

   Bobby may be voluntarily excluded from the eligible group, and Mrs. X may receive FMAP for herself only.

2. Ms. L, 36, has two children who receive social security benefits due to the death of their father. Ms. L was never married to her children's father and does not receive social security benefits. Ms. L has earned income from babysitting in her home.

   Ms. L does not want her children included in her eligible group, as their unearned income creates ineligibility. She voluntarily chooses to exclude the children. If her earned income does not exceed the FMAP standard for one person, Ms. L is eligible for FMAP.

3. When Mrs. E applies for FMAP, she has the following people living in her home: Bobby, a six-year-old child by a previous marriage; Mr. E, her husband; and Rick, their three-year-old common child.

   Mrs. E would like to apply for herself and Bobby only, but Rick must be included, since he is a half-brother to Bobby. Mrs. E may choose to exclude Rick voluntarily. If Rick is not voluntarily excluded, he is an eligible child and therefore, his father, Mr. E, must also be included in the eligible group.

4. Household composition:
   Ms. B, age 30, pregnant
   Unborn child
   Mr. R, age 32, unborn child's father
   Child T, age 10, Ms. B's child from a previous marriage

   Ms. B applies for Medicaid for herself because she is pregnant. Under MAC, the needs, income, and resources of the pregnant woman, the unborn child, the father of the unborn child, and any siblings of the unborn child are considered when determining eligibility for the pregnant woman.

   Ms. B states that she does not want to receive Medicaid for Child T because his resources create ineligibility for her. Therefore, Child T is voluntarily excluded, and eligibility for Ms. B is based on a three-member household. The worker refers Child T to the Hawki program.

Only the needs, income, and resources of Ms. B, the unborn child, and Mr. R are considered. Ms. B cannot voluntarily exclude the needs of her unborn child in order to avoid counting the income and resources of the Mr. R.

NOTE: If child T does not have resources and is not voluntarily excluded, eligibility should first be determined under the FMAP coverage group. If the unborn child is **not** included in the household size, Mr. R's needs, income, and resources are not considered toward Ms. B's eligibility.

5. Household composition:
   Mr. J and Mrs. J
   Child A, 17, married
   Baby A, Child A's child
   Child B, 17
   Child C, 15

   Mr. and Mrs. J apply for Medicaid coverage for their family. If the family income does not exceed FMAP limits for a four-member household, Mr. and Mrs. J, Child B, and Child C are eligible for Medicaid under FMAP. Since Child A is considered emancipated due to marriage, Child A and Baby A may be determined eligible for FMAP as their own eligible group.

6. Same as Example 5, except that Child A is not married. If the family's income does not exceed FMAP limits for a six-member household, the family is eligible under FMAP.

   Since Child A is not married, she must be included as part of the eligible group unless the household chooses to exclude her from the eligibility determination.

7. Same as Example 5, except Child A is 19 and is not in school. If the family's income does not exceed FMAP limits for a four-member household, Mr. and Mrs. J, Child B, and Child C are eligible for FMAP.

   Since Child A is 19 and cares for a child, she and Baby A may be determined eligible under FMAP as their own filing unit.

8. Household composition:
   Mrs. A, age 36
   Child, B, age 12, receives $600 per month Social Security
   Child C, age 8

   Child B's income exceeds the FMAP limit for a three-person household. Mrs. A chooses to exclude Child B from the eligible group in order to obtain Medicaid for herself and Child C.

   If the income and resources for Mrs. A and Child C do not exceed the FMAP limits for a two-member household, Mrs. A and Child C are eligible under FMAP.

9. Mr. J is severely injured in an auto accident and, as a result, lives in a nursing facility. Since Mr. J would be eligible for FMAP if not living in a medical institution, both the needs, income and resources of his family at home and of Mr. J are considered. They are compared to FMAP limits for a family size including Mr. J.

   If the family at home would be eligible for FMAP if Mr. J were included in the eligible group, Mr. J is entitled to receive Medicaid under the coverage group for people who would be eligible for FMAP if not in a medical institution.

Mr. J's three children each receive $150 per month in disability payments through his employer. By excluding two of the children, the household's income is below FMAP limits for three people (Mr. J, Mrs. J, and one remaining child). Therefore, Mr. J is eligible to receive Medicaid under this coverage group.

The determining factor in whether the family at home can actually receive Medicaid is whether the income and resources of the remaining household members meet FMAP limits.

10. Ms. N and her child Kelly apply for Medicaid. Kelly's absent father carries health insurance for her. Ms. N chooses not to apply for Medicaid for Kelly. Therefore, if all other eligibility factors are met, Ms. N can be eligible for FMAP or Medically Needy as a one-person household.

11. Household composition:
    Ms. Q, age 19, not pregnant
    Mr. B, Ms. Q's boyfriend, age 24
    Baby C, common child

    Mr. B has earnings of $3,000 per month. He carries health insurance for Baby C. Ms. Q has no health insurance and applies for Medicaid for herself.

    If Baby C is in newborn status, then Baby C is not considered part of Ms. Q's household and Ms. Q is not FMAP eligible. Ms. Q must establish eligibility in her own right without consideration of Baby C. Therefore, there is no relationship between Ms. Q and Mr. B and his income is not considered in her eligibility determination.

    If Baby C is not in "newborn" status, the household can voluntarily exclude Baby C. Since Ms. Q and Mr. B are not married, they are separate eligible groups of one because they both have a dependent child, Baby C.

    If all other eligibility requirements are met, Ms. Q is determined eligible under FMAP or FMAP-related Medically Needy, as a one-person household.

12. The household consists of Mrs. M and her four children, her husband, and their newborn common child. Mrs. M received Medicaid as a pregnant woman and her postpartum period has expired. She no longer wants Medicaid for herself.

    Even though Mrs. M no longer receives Medicaid, the common child continues to be eligible as a newborn child of a Medicaid-eligible mother.

    Mrs. M's four children also receive Medicaid. She does not want her husband's income to be used to determine Medicaid eligibility for them, so she voluntarily chooses to exclude him. Doing so also excludes Mrs. M's needs from her children's eligible group.

    Mrs. M will not receive Medicaid for herself, but Medicaid will continue for her four children. The four children are considered in the household size in determining eligibility for Medicaid. NOTE: Mrs. M's income is used to determine eligibility for the four children.

13. Same household composition as in Example 12, except that the newborn is now one-year-old. Mrs. M does not want her husband's income to be used to determine Medicaid eligibility for her children. Therefore, she chooses not to continue Medicaid for the one-year-old.

    The household size continues to be four. Mrs. M's income is used to determine eligibility for her four children in the eligible group.

14. Mr. and Mrs. Q have a 16-year-old daughter, Sally, who has a one-year-old child, Jason. Mr. and Mrs. Q's medical insurance covers Sally. They want Medicaid for Jason only. The household size is one. NOTE: Sally's income is used to determine eligibility for Jason.

Unborn Children

Legal reference: 441 IAC 75 (Rules in Process)

Policy: An unborn child may or may not be included in the FMAP-related eligibility group depending on the circumstances:

- If a pregnant woman is included in the household size (as an eligible, considered, or sanctioned person), the unborn child is also included in the household size unless the mother requests to exclude the unborn child. If the unborn child is included in the eligible group, use the income and resources of the unborn child's father.
- A pregnant woman whose Medicaid eligibility is not based on pregnancy may choose to exclude the unborn child from the household size.

Count the unborn child in the household size. (See 8-C, *Verification of Pregnancy*.) The pregnant mother may be an eligible, considered, or sanctioned person.

A woman whose Medicaid eligibility is not based on pregnancy may voluntarily exclude the unborn child from the household size. If the unborn child is included in the eligible group, you must also consider the income and resources of the unborn child's father.

Siblings

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Include in the household size all siblings that live together and meet the age criteria for the coverage group they are eligible under. Do not include siblings in the household size if they are:

- Emancipated due to marriage, unless the marriage is annulled;
- Voluntarily excluded; or
- In a "newborn status."

MAC and FMAP-Related Medically Needy Exception: Household members eligible under FMAP may be in a separate eligible group.

See Determining the Coverage Group, for more information on determining the eligible group.

SSI Recipient

Legal reference: 441 IAC 75 (Rules in Process)

Policy: Exclude the needs of a person who receives Supplemental Security Income (SSI). For this policy, the term "SSI" also includes mandatory or optional State Supplementary Assistance payments.

Include the needs of the potential SSI recipient in the eligible group. Remove the person's needs prospectively when the Social Security Administration office notifies you that the SSI application is approved.

FMAP ineligibility for a person with continuing SSI eligibility begins the month in which the person receives the SSI payment. Remove the person's needs effective the first of the following month.

State Supplementary Assistance Recipient

Legal reference: 441 IAC 50.2(1)

Policy: The term "SSI" also includes State Supplementary Assistance payments. This program supplements the income of aged, blind, or disabled people who receive SSI or would be eligible for SSI except for their income and who have a special need that is not covered by SSI.

One special need covered by this program is the needs of a dependent family member, such as a spouse or child, who is living in the home of the aged, blind, or disabled person and who is financially needy. See 6-B, *Dependent Person Program* for eligibility criteria.

For Medicaid, the State Supplementary Assistance recipient is considered the same as an SSI recipient. However, the person who is the "dependent" is not considered as an SSI recipient.

> Mr. H receives SSDI income and qualifies to receive State Supplementary Assistance cash support for his dependent wife. The couple has four-year-old twins. The family applies for Medicaid.
>
> Mr. H is not considered to be a part of the FMAP household because he is a State Supplementary Assistance recipient. Mrs. H and the two children are considered together for FMAP-related Medicaid.

Who May Be in the FMAP Eligible Group

Legal reference: 441 IAC 75 (Rules in Process)

Stepparents and needy relatives may be included in the eligible group and receive FMAP coverage, depending on the circumstances. The following sections explain the policies that apply to:

Incapacitated Stepparent

Legal reference: 441 IAC 75 (Rules in Process)

An incapacitated stepparent **may** be included in the eligible group if the person:

- Is the legal spouse of the natural or adoptive parent by ceremonial or common-law marriage, **and**
- Does **not** have a child in the eligible group.

When the incapacitated stepparent has a child in the eligible group, treat the stepparent as a parent. This means that the incapacitated stepparent **must** be included in the eligible group, unless the incapacitated stepparent is receiving SSI or is ineligible for a nonfinancial reason.

A stepparent is considered incapacitated when a clearly identifiable physical or mental defect has an obvious effect upon earning capacity or the performance of the homemaking duties required to maintain a home for the stepchild. The incapacity must be expected to last for a period of at least 30 days from the date of application.

When a stepparent recovers from the incapacity, remove the recovered stepparent from the eligible group the first month after recovery allowing a ten-day notice. Complete an automatic redetermination of eligibility to determine if the stepparent is eligible for Medicaid on some other basis.

Verifying Incapacity

Receipt of Social Security or SSI payments based on disability or blindness is considered proof of incapacity.

All other determinations involving incapacity must be supported by medical or psychological evidence. Participation in vocational rehabilitation services is not considered proof of incapacity, but it indicates that a disability may exist.

Obtain medical evidence from a physician (including a chiropractor) or from the Division of Rehabilitation Services. Evidence can be submitted either by a letter from the physician or on form 470-0447, *Report on Incapacity*.

When an examination is required but medical resources, such as county hospitals or free clinics, are not available, you may authorize a physician to perform the examination. The examination must be limited to verification of the specific illness or physical or mental disability upon which the determination of incapacity will be considered.

Issue form 470-0502, *Authorization for Examination and Claim for Payment*, to the physician to submit for payment of the claim.

Nonincapacitated Stepparent

Legal reference: 441 IAC 75 (Rules in Process)

The nonincapacitated stepparent may be included in the eligible group if:

- The stepparent is the legal spouse of the dependent child's natural or adoptive parent by ceremonial or common-law marriage, **and**
- The stepparent is required in the home to care for a child in the eligible group while the child's parent works, if it would be necessary to allow child care as a deduction if the stepparent were not available.

When the stepparent has a child in the eligible group, treat the stepparent as a parent. This means that the stepparent **must** be included in the eligible group unless the stepparent is receiving SSI or is ineligible for a nonfinancial reason.

1. Mrs. A receives FMAP for herself and her two children. Also in the home is Mr. A, the children's stepfather. Mrs. A pays her mother $300 per month for child care while she works. Mr. A is not employed.

   Mr. A's needs may be added to the FMAP group if he provides care for the FMAP children, thereby eliminating child care costs.

2. Mrs. C and one child get FMAP. Also in the home is Mrs. C's other child, who is on SSI, and Mr. C, the children's stepfather. Mrs. C pays $200 per month in child care for the SSI child while she works.

   Even if Mr. C begins providing child care for the SSI child, his needs cannot be added to the eligible group, because Mrs. C's child care costs are incurred for a child not included in the FMAP-eligible group and, therefore, are not allowed as a deduction.

Needy Nonparental Specified Relative

Legal reference: 441 IAC 75 (Rules in Process)

A needy nonparental specified relative who assumes the role of parent may be included in the eligible group if the specified relative's:

- Resources are within the resource limits, and
- Income is below the FMAP income standards for one person.

Aunt M, 46, applies for FMAP for her two nieces. She has unearned income of $125 a month and no resources. The two nieces have no income. Aunt M elects to have her needs included in the eligible group, because her income is under FMAP standards for one person and she will receive Medicaid.

When the nonparental specified relative has a spouse, determine the fact that one of them is needy by establishing that their combined income and resources are within FMAP standards for two people.

1. A grandmother applies for FMAP for her grandchild. She has no income, and her spouse has $200 per month income from Social Security. They have no resources. One of them may be considered needy, because their income and resources are under FMAP standards for two people.

   Regardless of which grandparent chooses to be considered as the needy specified relative, the eligible group will consist of the grandchild and the needy specified relative.

2. A grandmother receives Medicaid for her two grandchildren. She has medical bills and requests to be added to the eligible group as a needy specified relative. Also in the home is the grandfather, who has $900 gross earnings.

   Step 1. The worker determines if the grandmother is needy. (Ignore the children in the household. Compare the grandparents' income to the FMAP limits for two people.)

$ 900.00	Test 1
× .80	20% earned income deduction
$ 720.00	
× .42	58% work incentive deduction
$ 302.40	Test 3 ($302)

   The worker does not apply the standard of need test when adding a person to an existing FMAP-related case. Since the income is less than the FMAP limits, the grandmother is considered "needy" and added to FMAP.

   Step 2. The worker determines how much of the grandfather's income must be attributed toward the FMAP eligible group for the grandmother and grandchildren.

$ 900.00	Gross earnings
- 180.00	20% earned income deduction
- 183.00	Diversion for grandfather's needs
- 311.46	58% work incentive deduction
$ 225.54	Countable income

   NOTE: The countable $225.54 plus any gross nonexempt income of the eligible group must pass the 185% gross income test (Test 1) for the eligible group. Additionally, the $225.54 plus any income of the eligible group after allowable deductions must pass the benefit standard test (Test 3).

Needy Specified Relative and Parent

Legal reference: 441 IAC 75 (Rules in Process)

A needy specified relative who acts as the child's caretaker may be included in the eligible group when the parent is in the household but the parent is unable to act as the caretaker. The Medicaid case is still considered as a parental case, rather than a nonparental caretaker case.

"Unable to act as caretaker" means that the parent is physically or mentally incapable of caring for the child. There is no time limit on how long the needy specified relative who acts as a caretaker may be included in the eligible group. The parent could be permanently unable to act as caretaker (e.g., severe intellectual disability) or temporarily unable (e.g., hospitalized due to a car accident).

> Ms. A and her child are on FMAP. Ms. A is in an auto accident and is hospitalized. She will be unable to care for her child until she has recovered. Ms. A's mother moves into the home to take care of her grandchild in the interim.
>
> Even though Ms. A remains in the eligible group as an FMAP member, Ms. A's mother, if needy, may be added to the eligible group for as long as she acts as the child's caretaker.

Defining the Number of Eligible Groups in a Household

Legal reference: 441 IAC 75 (Rules in Process)

After deciding who **must** be in the eligible group and who **may** be in the eligible group, there are additional considerations involved in determining the composition of each eligible group.

The unborn child is generally considered in determining household size. However, if the unborn child is the only child, the parents cannot establish their own eligibility based on the unborn child.

When a pregnant woman is establishing eligibility under MAC, the father of the unborn child must be a part of the eligible group if he is living with the pregnant woman.

If parents are no longer income-eligible for FMAP, they are considered self-supporting parents.

The following sections explain how the relationships affect the eligible group for:

- Parents and married couples
- Minor parents
- Nonparental specified relatives

Parents and Married Couples

Legal reference: 441 IAC 75 (Rules in Process)

Parents and their children are one eligible group. However, when unmarried parents choose to voluntarily exclude their common children, the unmarried parents can no longer be part of the same eligible group.

Ms. A and Mr. B and their common child all live together and apply for Medicaid. Because the common child has a $25,000 savings account, Ms. A and Mr. B choose to voluntarily exclude the child so that they can receive Medicaid.

The only factor requiring Ms. A and Mr. B to be in the same eligible group is the common child. Since the child has been voluntarily excluded, Ms. A and Mr. B are now considered unrelated adults and can no longer be in the same eligible group.

However, Ms. A and Mr. B can both be eligible under FMAP as separate one-member eligible groups, since each of them has a child (the common child) in their care. The common child would not be eligible for Medicaid under any coverage group.

Only the income and resources of Ms. A are considered in Ms. A's eligibility determination, and only the income and resources of Mr. B are considered in Mr. B's eligibility determination. If Ms. A, Mr. B, or both are over income or over resources for FMAP, potential eligibility under FMAP-related Medically Needy should be explored.

Unmarried adults, their respective own children, and common children are one eligible group. Unmarried adults with their respective own children but no common children are two eligible groups.

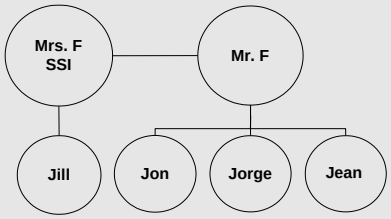
Ms. G has one child and Mr. S has one child. They are living together but are not married. FMAP eligibility is determined for two separate eligible groups.

A married couple and their respective own children are one eligible group if the parents both want Medicaid. A double stepparent household with no common children may request Medicaid for either the mother and her children or the father and his children.

1. Mr. B has two children by a previous relationship and Mrs. B has one child by a previous relationship. FMAP eligibility is determined for one five-member eligible group, since the parents are married.

   If only Mr. B and his two children want Medicaid, then Mr. B and his children would be one household and Mrs. B would be treated as a stepparent.

2. The household consists of:
   - Mrs. F, SSI recipient
   - Jill, Mrs. F's child from a previous relationship
   - Mr. F
   - John, Jorge, and Jean, Mr. F's children from a previous relationship



   a. Mrs. F requests Medicaid for Jill only. Because the F's have no common children, the eligible group can be a household of one for Jill. Mr. F is a stepparent and any income he has would first be diverted for his and his children's needs before being used for Jill's eligibility.

b. Mr. F requests Medicaid for himself, Jon, Jorge, and Jean only. Because the F's have no common children, the eligible group can be a household of four: Mr. F, Jon, Jorge, and Jean. Mrs. F's income is exempt since she's receiving SSI. Jill is not a required household member since she's not a sibling to Mr. F's children.

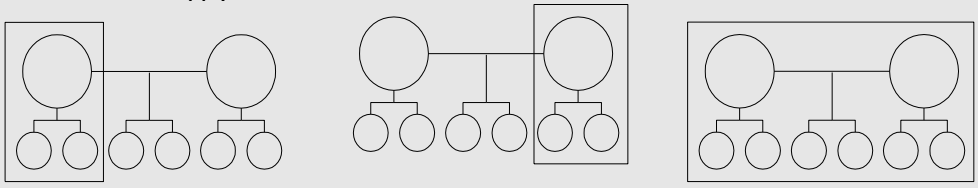
c. Mr. and Mrs. F request Medicaid for everyone in the household. Because everyone wants Medicaid and the parents are married, the family has two eligible groups. Mrs. F is a household of one, since she receives SSI. Mr. F, Jill, Jon, Jorge, and Jean are a household of five because they all want Medicaid.

d. The household size could be reduced if the Fs want to exclude any of Mr. F's children voluntarily. Those children would not be eligible for any other Medicaid coverage group. If the children were voluntarily excluded due to income or resources, they would be referred to Hawki.

A married couple, their respective own children, and their common children are one eligible group.

The household consists of a mother and her two children, a father and his two children, and two common children. The mother and father are married to each other. Possible groups are:

- The mother could apply for her two children if she excludes the common children.
- The father could apply for his two children, if he excludes the common children.
- Both could apply for the entire household.



3-member household Option 1 | 3-member household Option 2 | 8-member household Option 3

If Medicaid is requested for the common children, they must be in the same eligible group with their half-brothers and half-sisters.

Minor Parents

Legal reference: 441 IAC 75 (Rules in Process)

A minor parent and the dependent child in the minor parent's care are not required to live with the minor parent's adult parent or legal guardian to receive Medicaid.

A minor parent and the minor parent's children are one eligible group when living with self-supporting parents.

Ms. H, age 17, lives with her self-supporting parents. She has a baby and applies for FMAP. Ms. H and her baby comprise the eligible group.

A minor parent and children living with the adult parent who receives FMAP are in the same group with the adult FMAP parent.

Ms. X is 15 and lives with her mother, Mrs. X, who receives FMAP for Ms. X and her younger brother. In October, Ms. X has a baby. The baby is eligible as the newborn child of a Medicaid-eligible mother for one year.

If assistance is requested for the baby after the newborn period has expired, the eligible group will consist of Mrs. X, the brother, Ms. X, and her baby.

When the **minor parent turns 18**, **is in school**, and will complete the course of study before reaching age 19, the minor parent and the child remain in the adult parent's group until the course of study is completed.

Ms. W is a 17-year-old student who lives with her mother, who receives FMAP for herself, Ms. W, and Ms. W's baby. Ms. W will turn 18 in December. However, she is expected to complete her course of study in the following May, before she reaches age 19.

Ms. W and her baby remain in her mother's eligible group through May. Mrs. W loses FMAP eligibility effective June 1.

When the **minor parent turns 18**, and **is not in school**, or is in school but will **not** complete the course of study by age 19, the minor parent and the child are removed from the parent's FMAP eligible group and are set up as a separate FMAP eligible group. An application is **not** required.

Ms. Y is 17 and has a baby. They live with her mother, Mrs. Y, who receives FMAP for Ms. Y, Ms. Y's baby, and two of Ms. Y's siblings. The baby has been eligible as a newborn child of a Medicaid-eligible mother and is turning age one.

An automatic redetermination is completed for the baby as the newborn period expires. The eligible group will consist of Mrs. Y,
Ms. Y, Mrs. Y's two other children, and Ms. Y's baby.

Ms. Y will turn 18 on December 15. She is not in school. Since Ms. Y will not be eligible as a child past December, Ms. Y and her baby will be removed from Mrs. Y's eligible group effective January 1.

The worker completes an automatic redetermination and establishes that Ms. Y may receive FMAP for herself and her baby as a separate eligible group. An application is **not** required to be complete an automatic redetermination of eligibility.

When the minor parent is ineligible (e.g., subject to a sanction or an ineligible alien) cancel the minor parent's Medicaid. However, the minor parent will remain a part of the household size. See Who Must Be in the FMAP Eligible Group.

The minor parent remains ineligible for Medicaid until the sanction is fixed, if that is the reason the minor parent is ineligible.

> Ann is 16 years old. She has a baby and lives with her mother, Mrs. Z, who receives FMAP for Ann and the baby. In December, Ann fails to cooperate with CSRU.
>
> Ann is sanctioned and canceled from Medicaid. However, the household remains a three-member household.

When the minor parent is living with a nonparental specified relative or in an independent living arrangement, determine need in the same manner as if the minor parent had attained majority.

However, if the nonparental specified relative assumes a parental role over the minor parent, the nonparental specified relative may establish a caretaker case and may be included in the eligible group if needy.

See Minor Parents and Minor Pregnant Women.

Nonparental Specified Relative

Legal reference: 441 IAC 75 (Rules in Process)

Children in a nonparental home are one eligible group, whether or not they are siblings.

A needy nonparental specified **relative acting as caretaker** who has chosen to be included in the eligible group and the child are one eligible group. Once a nonparental specified relative is determined needy, the nonparental specified relative's needs are determined the same as a parental case. See Needy Nonparental Specified Relative.

When a nonparental caretaker has children on FMAP, this is a separate eligible group from the nonparental caretakers own children. The two groups are:

- The caretaker and the caretaker's own children.
- Children for whom the caretaker is responsible.

The parent, the needy nonparental specified relative who acts as caretaker when the parent is in the home but is unable to act as caretaker, and the children are one eligible group.

1. A sister, age 26, applies for her brother, age 15. She does not want her needs to be considered as a needy specified relative. The brother is eligible for FMAP if his income is within FMAP standards of a one-member eligible group.
2. An aunt applies for a niece and a nephew. She does not want her needs to be included. FMAP eligibility is granted if the niece's and nephew's income does not exceed the FMAP schedule of needs of $361 for a two-person household, whether or not they are siblings.
3. A grandmother who is needy applies for herself and two grandchildren. The IM worker determines that the grandmother is needy based on a household size of one.

   FMAP eligibility is granted if the income of the grandmother and her two grandchildren do not exceed the FMAP standard for a three-person eligible group. The grandmother must also be resource eligible based on the resources of the three household members.

When a minor nonparental specified relative is a caretaker and lives with self-supporting parents, the eligible group consists of only the child for whom the minor is caretaker.

When a minor nonparental specified relative is a caretaker and lives with an adult parent who receives FMAP, there are two eligible groups:

- The adult FMAP parent and children, including the minor nonparental specified relative who is a caretaker.
- The children for whom the minor caretaker is responsible. (The needs of the minor nonparental specified relative are not included in this eligible group.)

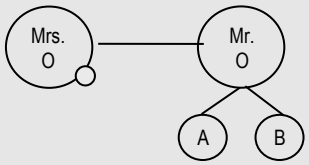
Do not include children in foster care in the eligible group with the family at home, regardless of the length of the foster child's absence. See 8-H, *Foster Care and Subsidized Adoption* when examining Medicaid eligibility for a foster child.

Children in subsidized adoption may be an eligible group of their own or may be included in the adoptive family's eligible group, whichever is most beneficial. See 8-H, *Foster Care and Subsidized Adoption*, when examining Medicaid eligibility for a child in subsidized adoption.

Include in the eligible group people who meet the definition of temporary absence, unless the people are voluntarily excluded. See 8-C, *Absence*. However, do not include adults or children confined to a penal institution, no matter how long they will be incarcerated.

Household Composition Examples

1. Household composition:



   - Mrs. O, aged 32, pregnant
   - Mr. O, aged 36, husband of Mrs. O and father of unborn
   - Child A, aged 12, Mr. O's child from previous relationship
   - Child B, aged 10, Mr. O's child from previous relationship

   The household applies for Medicaid for everyone.

   Mrs. O is a stepparent. She cannot be included in the FMAP eligible group because she is not incapacitated and has no born child living with her. Mr. O and his children are eligible under FMAP if countable income is within FMAP limits for a three-person eligible group and all other eligibility factors are met.

   Since Mrs. O is pregnant, she can be eligible under MAC if her countable income does not exceed 300% of poverty for a two-person eligible group (Mrs. O and unborn child), and all other eligibility factors are met.

   If Mr. O and his children are **over income** for FMAP, explore eligibility under MAC for the children and under Medically Needy for Mr. O. When determining eligibility under MAC and under Medically Needy, the eligible group includes all household members. Mrs. O and the children become part of the same MAC household.

   Mrs. O can be eligible under MAC if countable income does not exceed 300% of poverty for a five-person eligible group and all other eligibility factors are met. The children can be eligible under MAC if countable income does not exceed 133% of poverty for a five-person eligible group and all other eligibility factors are met.

   The Medically Needy spenddown is calculated for a five-person eligible group with Mr. O being the only potentially eligible person.

2. Same as Example 1, except that Mrs. O and Mr. O are not married. They apply for Medicaid for everyone.

   Mr. O and his children can be eligible under FMAP if countable income is within the FMAP limits for a three-person eligible group and all other eligibility factors are met.

   Since Mrs. O is pregnant, she can be eligible under MAC if her countable income does not exceed 300% of poverty for a two-person eligible group (Mrs. O and unborn child), and all other eligibility factors are met.

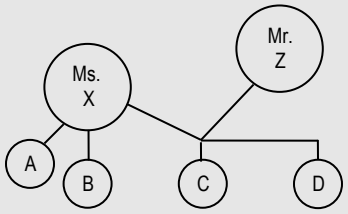
   If Mr. O and his children are over income for FMAP, eligibility under MAC should be explored for the children and eligibility under Medically Needy should be explored for Mr. O. When determining eligibility under MAC, the eligible group includes only Mr. O and his children.

   The fact that Mr. O and his children are over income for FMAP has an effect on Mrs. O's eligible group (Mrs. O, the unborn child and Mr. O), but not on Mrs. O's eligibility, because she is continuously eligible.

   Mr. O's children can be eligible under MAC if countable income does not exceed 133% of poverty for a three-person eligible group (Mr. O and his children) and all other eligibility factors are met.

   Mr. O can be potentially eligible under Medically Needy if all eligibility factors are met. The spenddown is calculated for a three-person eligible group with Mr. O being the only potentially eligible person.

3. Household composition:



Ms. X, age 35
Mr. Z, age 37
Child A, age 13, Ms. X's child from previous relationship
Child B, age 11, Ms. X's child from previous relationship
Child C, age 4, common child
Child D, age 2, common child

The household applies for Medicaid for everyone. All members are eligible under FMAP if countable income is within the FMAP limits for a six-person eligible group.

If the eligible group is over income for FMAP, eligibility under MAC should be explored for the children and under Medically Needy for the parents. When determining eligibility under both MAC and Medically Needy, the eligible group size is six.

The common children may be voluntarily excluded as a way to not count Mr. Z's income and resources in the eligibility determination for Ms. X, Child A, and Child B. The common children would not be eligible for Medicaid under any other coverage group.

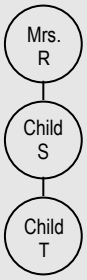
However, even if the common children are voluntarily excluded, Mr. Z may be eligible for Medicaid under FMAP or FMAP-related Medically Needy as a one-person eligible group.

4. Same as Example 3, except that Ms. X and Mr. Z are **married**. They apply for Medicaid for themselves and voluntarily choose to exclude the common children.

Ms. X and her two children can be eligible under FMAP if countable income is within FMAP limits for a three-member eligible group and all other eligibility factors are met. Mr. Z is a stepparent to this group and his income and resources are considered accordingly.

If the household voluntarily chooses to exclude Mr. Z's income from the eligibility determination of Ms. X's eligible group, Ms. X's needs are not included in the group.

5. Household composition:

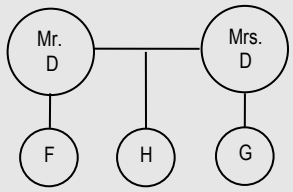


Mrs. R, self-supporting parent of Child S
Child S, turning age 18, minor parent of Child T
Child T, age 2

Child S and Child T are currently receiving Medicaid under MAC as a separate eligible group from Mrs. R. Mrs. R is allowed a diversion from her income. The remainder is being counted in the eligibility determination of Child S and Child T.

Child S turns 18 September 4. Beginning with the month of October, Mrs. R's income is not longer counted in the eligibility determination of Child S and Child T. Child S and Child T are still both under the age limit for children for MAC. They continue to be eligible under MAC if the income of the two-member eligible group does not exceed 133% of poverty level.

6. Household composition:
   Mr. D
   Mrs. D
   Child F, age 8, Mr. D's child from a previous relationship
   Child G, age 10, Mrs. D's child from a previous relationship
   Child H, age 5, common child

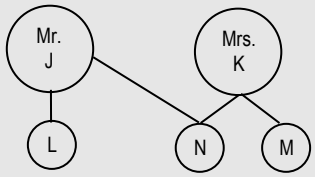


The household applies for Medicaid for everyone. In determining eligibility under FMAP, the eligible group size is five. If the eligible group is over income for FMAP, eligibility under MAC and Medically Needy should be explored and the eligible group size would continue to be five.

If the household chooses to exclude the common child, the eligible group size for FMAP, MAC and Medically Needy is four.

7. Household composition:

   Mr. J
   Ms. K
   Child L, age 8, Mr. J's child from a previous relationship
   Child M, age 10, Ms. K's child from a previous relationship
   Child N, age 5, common child



The household applies for Medicaid for everyone. The eligible group size for FMAP, MAC, and Medically Needy is five.

If the household chooses to exclude the common child, there are two separate eligible groups. One for Ms. K and Child M and the other for Mr. J and Child L. Child N is not eligible for Medicaid under any other coverage group.

School Attendance

Legal reference: 441 IAC 75 (Rules in Process)

A needy child can receive FMAP or FMAP-related Medically Needy until the age of 18 regardless of school attendance. FMAP is available to a needy 18-year-old child only if the child is:

- A full-time student (as defined below), and
- Reasonably expected to complete training before the child's nineteenth birthday or any time during the month of the nineteenth birthday, unless the birthday is on the first of the month. For example, a child turning 19 on May 2 and completing training on May 23 is eligible through May.

Obtain written verification from the school or institution of the date the student is expected to complete requirements for graduation. You need a signed release or form 470-1638, *Request for School Verification*, before contacting the school.

A person is in school full time if enrolled or accepted in a full-time elementary school, secondary school, or equivalent level of vocational, technical, or training school, including Job Corps. The school or program must lead to a certification or diploma. Do not allow correspondence school as a program of study.

Consider a person to be in school full time, regardless of any of the following:

- Official school vacation
- Training program vacation
- Illness
- Convalescence
- Family emergency

Consider a person to be attending school until officially dropped from the school record. Continue assistance for a reasonable period when a person's education is temporarily interrupted because of a change in the education or training program.

The school determines whether the student's hours of attendance are considered full time. Obtain a statement from school officials if there is a question about whether to consider a student full time who is:

- Working on a GED.
- Enrolled in a "drop-in" school.
- Enrolled in any other public educational program that has irregular or shortened hours.

Consider a child who receives home schooling the same as any other student, provided the home schooling arrangement is certified by the school system. Obtain any needed verification of student or attendance status from the school system that certified the arrangement. A signed release from the client is needed (the same as when a child is enrolled in a regular school setting).

NOTE: School attendance is not an eligibility factor for the MAC coverage groups.

Specified Relatives

Legal reference: 441 IAC 75 (Rules in Process)

For FMAP and FMAP-related Medically Needy coverage groups, a child must live with a specified relative. "Relative" includes persons related by blood or marriage. The child's home can be with either the specified relative or the spouse of the specified relative, even if the marriage is terminated by death or divorce.

The following is a list of persons who qualify as specified relatives:

- Father, adoptive father
- Mother, adoptive mother
- Grandfather, grandfather-in-law (the subsequent husband of the child's natural grandmother, i.e., step-grandfather), adoptive grandfather
- Grandmother, grandmother-in-law (the subsequent wife of the child's natural grandfather, i.e., step-grandmother), adoptive grandmother
- Great-grandfather, great-great-grandfather
- Great-grandmother, great-great-grandmother

- Stepfather, but not his parents
- Stepmother, but not her parents
- Brother, brother-of-half-blood, stepbrother
- Brother-in-law, adoptive brother
- Sister, sister-of-half-blood, stepsister
- Sister-in-law, adoptive sister
- Uncle, aunt (of whole or half blood)
- Uncle-in-law, aunt-in-law (the spouse of the child's natural uncle or aunt)
- Great uncle, great-great-uncle
- Great aunt, great-great-aunt
- First cousins, nephews, nieces

A relative of the "putative" father can qualify as a specified relative only after paternity has been established by the court or the putative father has acknowledged paternity with written evidence.

Written evidence can include an affidavit, a court document, a signed *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S). Use the prudent-person concept regarding written evidence. A favorable determination made by another government agency (e.g., the Social Security Administration, the Veteran's Administration) also constitutes reliable evidence of paternity.

The following sections give more information on:

- Determining who the natural father is.
- Determining if a child lives with a specified relative.

Determining the Natural Father

Legal reference: 441 IAC 75 (Rules in Process)

The term "natural father" refers to the male who can be considered the child's father for the purpose of determining eligibility. Consider a man as the natural father if he:

- Was married to the mother at the time of the child's conception or birth (unless the court has declared this man **not** to be the father), or
- Has been declared by the court to be the father, even though not married to the mother at the time of the child's conception or birth, or
- Claims to be the father, **unless** the child already has another legal father as described above.

When paternity has not been established through marriage or a court decision, allow a man claiming to be the natural father to be included in the eligible group if he:

- Signs a Medicaid application or provides a signed statement that he is the father of the child, and
- Attests to his citizenship on form 470-2549, *Statement of Citizenship Status*.

The "biological father" is the male responsible for the conception of the child. The "legal father" is the male considered the father under Iowa law. When the child's biological father is someone other than the child's legal father, consider the legal father to be the parent. Do so until the court establishes that the legal father is not the parent of the child. See also 8-B, *Referrals to CSRU*.

> Mrs. A, an FMAP member, is separated from Mr. A. She lives with Mr. K and has a child by him. Mr. A is considered the legal father of the child and must be referred to CSRU.
>
> Even though Mr. K is the child's biological father, he cannot be included in the eligible group until the court declares Mr. A not to be the child's father. Until such time, Mr. K's income and resources are not considered (other than any amounts he makes available to the eligible group).

Determining if Child Lives With a Specified Relative

Legal reference: 441 IAC 75 (Rules in Process)

When a specified relative accepts responsibility for the child's welfare and the child shares a household with the specified relative, the specified relative and child are considered "living with" each other.

A "home" is defined as an established family setting or a family setting that is in the process of being established. Evidence must show that the specified relative assumes and continues the responsibility for the child in this setting. This includes living together or sharing a household.

A "home" is considered suitable unless the court rules it unsuitable and removes the child. When you have reason to believe a home is unsuitable because of neglect, abuse, or exploitation of the child, refer the family to the Protective Service Unit for investigation. Make an oral report to the unit within 24 hours.

If the child or specified relative is **temporarily** absent from the household, the relationship continues to exist even **if** the specified relative temporarily loses responsibility for the care and control of the child.

A child may be under the jurisdiction of the court, or legal custody may be held by a person or agency, but the child does not **live** with the person or agency. There may be a court order specifying that public assistance should not be sought.

Regardless of existing legal documents, base eligibility on all factors in the child's current living arrangement. The child is considered to be "living with" the specified relative, as long as the child is either physically present or temporarily absent.

The following sections explain this policy in relation to:

- Adoption.
- Cases where parental rights are terminated.

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.

An adoption severs the legal relationship between the child who is adopted and that child's biological parents and biological siblings. However, the adoption does not sever their blood relationship.

Consequently, when a child who was adopted returns to the home of the biological parent, the biological parent is not considered the legal parent of the child but is still considered a specified relative to the child. Establish a nonparental case for the child, with the biological parent as caretaker. Treat the case like any other nonparental case.

If the biological parent requests assistance as well, include the biological parent on the case as a needy relative, if otherwise eligible. Treat the eligible group according to Needy Nonparental Specified Relative in this chapter.

If the biological parent's home also includes biological siblings of the child who was adopted out, and assistance is requested for everyone, establish two separate cases:

- A parental case for the biological parent and the biological siblings.
- A nonparental case for the child who was adopted.

Parental Rights Terminated

Legal reference: 441 IAC 75 (Rules in Process)

When parental rights have legally been terminated, but the child has *not* been adopted by another person, the parent is still considered a parent of the child for eligibility purposes. Therefore, establish a parental case when the child lives in the home of a parent whose parental rights were previously terminated.

FMAP-Related Resource Policies Prior to MAGI Methodology

Legal reference: 441 IAC 75 (Rules in Process)

Use FMAP-related policies regarding excluded resources, countable resources, and whose resources to consider when determining resource eligibility under FMAP-related programs.

Use FMAP-related policy to determine the value of the applicant's or member's property and consider the property for Medicaid eligibility. Exclude:

- Nonhomestead property that produces income that is consistent with its fair market value, and
- Nonhomestead property that is up for sale at a price that is consistent with its fair market value.

"Fair market value" is the gross price for which the property could be sold on the open market.

1. Ms. A and her children apply for Medicaid. Ms. A owns nonhomestead real property valued at $40,000. The worker explains to Ms. A that this property will be considered an accessible resource for her eligibility unless she either lists it for sale at a price that is consistent with the fair market value or it produces income which is consistent with the fair market value.

   Ms. A chooses to list the property for sale at a fair market value and is approved for Medically Needy, as she meets all other eligibility factors.

2. Mr. L and his children receive Medicaid through Medically Needy. Mr. L inherits nonhomestead real property valued at $25,000 and timely reports this to his worker. The property has been a rental property and currently has a tenant paying rent. The worker verifies that this property is producing income consistent with the fair market value. This property is exempt and Mr. L continues to receive Medicaid through Medically Needy.

3. Same as Example 2, except that this property is being rented to a relative and the income it is producing is not consistent with the fair market value. Mr. L chooses not to increase the rent.

   Mr. L's Medicaid assistance is canceled effective the first of the next month allowing a ten-day notice. However, Mr. L's children remain eligible since resources are not considered in determining Medically Needy eligibility for children.

Use general Medicaid policy on trusts. Even though a trust may not be considered for the FIP determination, persons eligible for FIP who have a trust may not be eligible for Medicaid.

Ms. C and her son apply for FIP and Medicaid. Ms. C reports she is the beneficiary of a trust with a current principle of $55,000. The trust principle is not countable as a resource for FIP and the trust is not paying out any income to Ms. C. However, the trust is a Medicaid qualifying trust and therefore, countable for Medicaid.

The application is approved for FIP, but, since Ms. C's countable resources exceed the resource limits of all Medicaid coverage groups, the application is denied for Medicaid for Ms. C. Ms. C's son would be eligible for Medicaid. It does not matter that Ms. C is a FIP participant.

A transfer of assets between persons who are not spouses results in ineligibility for Medicaid payment for all long-term-care services. See Transfer of Assets for more information about eligibility.

Since transfers between spouses do not result in a penalty, a transfer of assets made by the stepparent to the spouse in order to qualify the group for Medicaid does not disqualify the persons in the assistance unit from payment of nursing facility services.

A transfer of assets does not cause a period of ineligibility for specific Medicaid services for children when the children are eligible in a coverage group in which household resources are disregarded in determining children's eligibility.

Eligibility for Medicaid payment of nursing facility services for persons in the household is not affected by a transfer of assets made by self-supporting parents. The self-supporting parents' income is considered in determining Medicaid eligibility but their needs are not included in the eligibility determination. Remember, the resources of self-supporting parents are **not** included in the eligibility determination.

Parents who are not eligible for Medicaid, such as sanctioned parents, are included in the household size. Ineligible parent's assets are considered when determining Medicaid eligibility for adults. Therefore, if assets of ineligible parents are transferred to persons other than their spouse, the transfer affects the eligibility for certain Medicaid services, for adults in the assistance unit.

FMAP-Related Resource Limits

Legal reference: 441 IAC 75 (Rules in Process)

For FMAP-related Medically Needy, $10,000 in liquid resources is the resource limit.

When using the FMAP-related resource limits, apply the resource limit for each month of the retroactive period, as defined in 8-A, *Definitions*, and for the month of application (even if retroactive Medicaid eligibility is established).

The resource limits apply only to adults in the eligible group.

Countable Resources

Whose Resources to Count

Legal reference: 441 IAC 75 (Rules in Process)

Count the resources of all persons in the eligible group. Include the resources of a parent who is living in the home with the eligible children but who is not a member of the eligible group (e.g., excluded parent).

Do **not** consider the resources of:

- An ineligible stepparent living in the home.
- A Supplemental Security Income (SSI) recipient.
- A self-supporting parent when determining eligibility for the minor parent's child.
- An ineligible child living in the home. This means a child who is not included because the child receives subsidized adoption assistance.

What Resources to Count

Legal reference: 441 IAC 75 (Rules in Process)

Unless specifically exempt, all resources are considered countable. The following table lists examples of countable and exempt resources:

Resource	Medically Needy
Bank accounts used **solely** for a self-employment business	Exempt
Bonds (Use the redemptive value on date of decision or time of review.)	Countable
Cash on hand	Countable
Certificates of deposit	Countable
Checking or savings accounts	Countable
Employee's portion of a lump sum retirement fund payment when a client leaves employment, plus accumulated interest. (See 8-E, *Nonexempt Lump Sums* regarding the employer's share of the retirement fund.)	Exempt
Life insurance cash value (the amount the insurance company pays upon borrowing against or canceling the policy before death). Use form 470-0444, *Insurance Report*, to get authorization to verify the amount of cash value and that the client has ownership of or access to this cash value.	Exempt
Medicaid qualifying trust whether trustee makes it available or not. If principal can be made available under discretion of trustee.	Countable
Motor vehicles (see Vehicles)	Exempt
Mutual funds	Countable
Net market value of available nonhomestead real property (see Determining Net Market Value of a Countable Resource)	Exempt
Promissory notes, mortgages and contracts	Exempt
Retirement accounts (IRAs, Keoghs, 401(k)s, IPERS)	Exempt
Stocks (Use the closing price on the date of decision or time of review.)	Countable

Count a resource only when:

- The applicant or member owns the property in part or in full and has control over it (meaning it can be occupied, rented, sold, etc. at their discretion).
- The applicant or member has a legal interest in a liquidated sum and has the legal ability to make the sum available.

Determine the availability of a resource regardless of the equity (net market) value.

An applicant or member need not gain title and control of an unavailable resource. Consider a resource unavailable when they own it in part or in full but have no control over it.

Joint Ownership

Legal reference: 441 IAC 75 (Rules in Process)

When a resource is owned by more than one person, assume everyone has equal shares unless you have verification to determine that the shares are different.

If an applicant or member owns a resource with another person but indicates that ownership is not equal, get a release signed so you can ask the co-owner to provide a written statement specifying the intent, degree, and terms of the joint ownership.

The intent of the co-owner is important. If the co-owner does not intend to provide the client access, the resource is unavailable. Examples include:

- An elderly parent of an FMAP-related Medicaid member who has a joint account with the member in the event the parent becomes disabled.
- An adult child (an FMAP-related Medicaid member) who is added to the title of a parent's home for ease of transfer in the event the parent should die.

In cases such as these, ask the other owner to write a statement indicating whether or not the Medicaid member has access to the account. If the statement indicates no access to the resource, consider it unavailable. Periodically check the availability of the resource.

If the applicant or member has joint ownership or tenancy-in-common ownership:

1. Determine the equity (net market) value of the total resource. If the total value plus other resources owned by the client are less than resource limits, take no further action.
2. Determine the client's share of the total equity (net market) value of the jointly owned resource. If the client's share plus other resources owned by them are less than the resource limit, take no further action.
3. If the client's share of the equity value would affect eligibility, contact the co-owner to determine if the co-owner would be willing to sell the resource. If so, count the client's share of the total equity value.

4. If the co-owner refuses to cooperate in the sale of the property, determine the equity (net market) value of only the client's share. The applicant or member must provide a written estimate of the value from a knowledgeable source.

   The source must consider local market conditions as well as the condition and location of the resource. The source must also consider that the client has only a partial interest and that the co-owner refuses to sell.

   If the estimate provided by the client appears reasonable, accept it. If the estimate is questionable, get a signed release of information so that you can independently verify the estimate.

5. Approve assistance, if otherwise eligible, when the equity value of the client's share in combination with other resources does not exceed resource limits. Deny or cancel assistance if that equity value, in combination with other resources, exceeds resource limits.

If the client disagrees with your decision, ask the client to supply additional information regarding the availability or value of the property.

If you need assistance in determining availability, refer the case to the DHS, SPIRS Help Desk.

Determining Net Market Value of a Countable Resource

Legal reference: 441 IAC 75 (Rules in Process)

Determine the net market (equity) value of countable resources only. The net market value is the gross price for which an item or property can be sold on the open market, less any legal debts, claims, or liens against it.

Consider each resource separately. The value of one resource does not affect another. To determine the net market value:

1. Establish the gross sale price, called the "fair market value." Consider local market conditions and the condition and location of the property in determining the fair market value. For example:
   - A piece of real property may be worth less in one part of the state than a similar property is worth in another part of the state, due to a distressed local economy.
   - A piece of property may be worth less than it was previously because of depressed market conditions.
   - An item of real property may have a lower fair market value because of the location of that property (on a flood plain, remote location, etc.).

   Contact a source knowledgeable about similar property, such as a car dealer, stockbroker, realtor, or banker.

   If the client disagrees with the fair market value you determine, give the client an opportunity to provide written evidence of a different valuation.

2. Verify and subtract legal debts, claims, or liens, and document them in the case record. To be considered a lien or encumbrance against a resource, a loan or lien must give the creditor a legal right to satisfy the debt from the resource in question. In most cases, loans from family or friends do not meet this requirement.

   When there is a legal debt against a combination of exempt and nonexempt property, look at the terms of the loan to see if any of the debt is deductible.

   - When the terms of the loan require the proceeds from the sale of any part of the property to be applied to the balance of the loan, deduct the total legal debt from the fair market value of the nonexempt property.
   - When the terms of the loan place a lien against the exempt property only, there is no legal debt to apply in determining the net market value of the nonexempt property.

1. Mr. A owns a home on 80 acres of land outside a city plat. There is a lien of $20,000 on the **total** property. Proceeds from the sale of any part of the property must be used to reduce the balance of the loan. Deduct the entire $20,000 from the gross value of the nonexempt property.

2. Ms. B owns a home on **one** acre of land inside a city. There is a lien of $40,000 on the house and **one-half** acre. Do not deduct the $40,000 from the gross value of the non-exempt property.

The balance after subtracting debts from fair market value is the net market (equity) value. Count as "zero" a resource that has a negative net value (that is, the debt against the property is more than the fair market value). Do not assign a negative number to any resource.

Subtract the expenses in selling the property only after it is sold.

Contracts

Legal reference: 441 IAC 75 (Rules in Process)

The resource value of a mortgage or contract is the gross price for which it can be sold or discounted on the open market, minus any legal debts, claims, or liens against it.

In Iowa, mortgages and contracts are always legally transferable, even if the terms of the contract or mortgage prohibit it. Although such terms are not legally enforceable in Iowa, they may affect the current market value of the contract or mortgage.

If the mortgages or contracts have terms that, as a practical matter, prevent sale, do not count them as resources.

Ms. B owns a contract with her two sisters, Ms. C and Ms. D. The terms of the contract prohibit any transfer or sale of the contract without approval of all of the siblings. Neither Ms. C nor Ms. D is willing to sell her shares or to buy Ms. B's share.

In reviewing the contract, a knowledgeable source determines that the terms of the contract prevent the sale. Even though these terms are not legally enforceable, they affect the market value of the contract or mortgage. Therefore, the contract is considered to have a value of zero.

Consider any **principal** payments received on a mortgage or contract as a resource upon receipt. Consider the monthly interest portion of the payment as a resource effective the first of the month after the month of receipt. If the interest is prorated, exempt it for the number of months in which the interest is prorated.

Determining Contract Value

Ask the applicant or member for a written estimate of the mortgage or contract value. The estimate must be based on local market conditions and the condition and location of the property. If the estimate provided appears reasonable, accept that value.

If you have more than one valuation, average the values.

> Ms. A owns a contract. She obtained three written valuations: $925, $850, and $800. The worker averages the three evaluations ($925 + $850 + $800 = $2,575 divided by 3 = $858). The average value of $858 is considered the fair market value of the contract.

If you doubt the value of the estimate, or if the client cannot get one, ask the client to sign a release of information so that you can independently verify or obtain the estimate. Obtain one or more estimates of value from sources knowledgeable in the business of buying and selling contracts.

These sources do not need to be in the area where the property is located, but the source must consider local market conditions and the condition and location of the property when determining the value. Valuations must be based on the most complete information possible.

If the applicant or member disagrees with your estimate, allow them to provide additional information.

Vehicles

Legal reference: 441 IAC 75 (Rules in Process)

A vehicle is any motorized means of transportation that moves persons or articles from place to place. This includes automobiles, trucks, motorcycles, tractors, snowmobiles, recreational vehicles, campers, and motorized boats.

Vehicle Exemption

Legal reference: 441 IAC 75 (Rules in Process)

Exempt one motor vehicle without regard to its value. This exemption applies to each FMAP-related Medicaid eligible group. Count the value of any additional vehicles owned by the eligible group, as described in Equity Exclusion.

See Determining Net Market Value of a Countable Resource for instructions on how to calculate net market value of a vehicle. Use a current "blue book," such as *National Automobile Dealers Association* (NADA) *Used Car Guide Book* to determine value of a vehicle.

Find the amount listed in the left-hand column, entitled "Average Trade-In Value." Do not increase the value because of low mileage or optional equipment. This is the value to use unless the applicant or member can establish a lower value.

If the vehicle is not listed in the Blue Book, contact a motor vehicle dealer in the community. Ask the dealer what the cash value would be of the same make, model, size, material, or condition as the client's vehicle.

Special equipment that modifies a vehicle for a disabled person does not increase the value of the vehicle.

Equity Exclusion

Legal reference: 441 IAC 75 (Rules in Process)

Exclude the equity value up to $5,874 per vehicle of each adult (including a needy nonparental relative) and working teenaged child whose resources must be counted in determining eligibility. (The equity value limit changes each July 1 to reflect the latest increase in the consumer price index for used vehicles.)

The exclusion applies regardless of who owns the vehicle, as long as the owner is a person whose resources must be counted. Do not allow an exclusion for additional vehicles over and above the number of exclusions to which the eligible group is entitled.

When a person whose resources must be counted has multiple vehicles, apply the exclusion to the vehicle with the highest equity value. Allow the exclusion for a working teenager regardless of the teen's age, whether the teen has a driver's license or whether the car is needed for the teen to drive to work.

The exclusion for the teen continues when the teen is temporarily absent from the job for illness, vacation, between jobs or due to the nature of employment (for example, if the teenager works only during summer vacation). The exclusion does not apply to a teenager who is looking for work but has not been employed in the past.

Ms. A receives Medicaid for herself and three children. One teenaged daughter is employed. The family owns four vehicles; the equity values are $10,000, $8,000, $5,000, and $500. The family has no other resources.

	Vehicle 1	Vehicle 2	Vehicle 3	Vehicle 4
Equity value	$ 10,000	$ 8,000	$ 5,000	$ 500
Exemption/exclusion	- 10,000	5,874	- 5,874	- 0
Excess resources	$ 0	$ 2,126	$ 0	$ 500

- The motor vehicle with the highest equity value is exempt.
- The vehicle exclusion for Ms. A and the employed teen is deducted from the two vehicles with the next highest equity values.
- Count the equity value of the lowest valued vehicle since there is no exclusion.

Ms. A's countable resources are within the $10,000 limit for Medically Needy.

When the household has a vehicle that is used for a self-employment enterprise and also used for personal use, apply the one motor vehicle exemption policy, the $10,000 exemption for capital assets, and the vehicle exclusion. See Self-Employment Assets.

Ms. A receives Medicaid. She has the following resources: One camper valued at $12,000, one car valued at $6,000, $1,000 in savings, $200 cash value in a life insurance policy, and $5,000 equity in tools needed for her self-employment.

Countable Resources		Exempt Resources	
$ 1,000	Savings	$12,000	Camper (exempt one motor vehicle)
200	Cash value of insurance		
	Excess equity in car	$5,000	Equity in tools
+ 196	Countable resources	$ 5,874	Car equity exclusion
$ 1,396			

Ms. A is resource-eligible for Medicaid under FMAP-related Medically Needy.

Exempt Resources For FMAP

Legal reference: 441 IAC 75 (Rules in Process)

Some resources are always exempt under FMAP-related Medicaid. However, for other resources the exemption lasts only for the month of receipt and the month following. Any resources remaining are then counted towards the maximum resource limit.

The following resources are exempt in the month of receipt and perhaps in the following month of receipt. See individual sections for more information.

- Corrective payments
- Earned income credit (EIC) payments
- Property settlements
- Insurance settlements and damage judgments

A listing of exempt resources follows. These resources are **totally exempt** for FMAP-related Medicaid. Count any resources not on the exempt list as well as the value of any resources exceeding the excluded amounts toward the resource limit.

AIDS/HIV Settlement Payments 441 IAC 75 (Rules in Process)	Exempt settlement payments from any fund established pursuant to the class action settlement of Susan Walker v. Bayer Corporation et al, 96 C5024(N.D. Ill.), as a resource. Some settlement payments were made in lieu of the class action settlement. These payments are also exempt as a resource. These settlements were signed on or before December 31, 1997. These funds must be kept in a separate, identifiable account.

AmeriCorps
Public Law 103-82,
441 IAC 75 (Rules in Process)

Exempt as a resource the living allowance (stipend) payments made to participants in the AmeriCorps*VISTA program as long as the Director of ACTION determines that the value of all such payments is less than either the federal or state minimum wage when divided by the number of hours the volunteer is serving. To date, no AmeriCorps*VISTA payments have exceeded this standard.

Exempt the educational award as a resource, because the award is issued directly to the educational institution or the holder of the loan and is not considered available to the recipient.

Also exempt as a resource the health insurance, reasonable accommodations, supplies, and services made available for AmeriCorps participants who have disabilities.

Burial Plot
441 IAC 75 (Rules in Process)

Exempt one burial plot for each member of the eligible group. A burial plot is a gravesite, crypt, mausoleum, urn, or other repository customarily used for the deceased's remains.

When the client owns more than one plot for each member of the eligible group, count the net market value of the excess plots toward the resource limit. Also count the net market value of a burial plot for an ineligible person whose resources must be considered (e.g., an excluded parent).

Burial Trusts or Funeral Contracts
441 IAC 75 (Rules in Process)

Exempt equity not to exceed $1,500 in one burial trust or funeral contract for each member of the eligible group. Count any amount over $1,500 towards the resource limit, unless the contract or trust is irrevocable. ("Irrevocable" means that the contract or trust cannot be terminated or amended unless both parties to the contract or trust agree.)

Count burial trusts and funeral contracts held by an ineligible person whose resources must be considered (e.g., an excluded parent).

Child Support $50 Exemption
441 IAC 75 (Rules in Process)

Exempt the first $50 of a current monthly support obligation or a voluntary support payment from a parent of a child in the eligible group or from a person who is under court order to pay support for a member of the eligible group. (A parent of a child is considered legally responsible, whether or not that parent is ordered to pay support.)

The maximum exempt amount is the lowest of the following:

- $50.
- The amount paid.
- The monthly obligation.

Corrective Payments
441 IAC 75 (Rules in Process)

Exempt retroactive FIP payments in the month received and in the following month.

Current Month's Income
441 IAC 75 (Rules in Process)

Do not add current month's income to the total countable resource amount for that month. This includes situations when you prorate lump-sum or self-employment income and project it as future months' income. Exclude the prorated income from consideration as a resource during the period of months over which you prorate it and count it as income.

When you verify that a liquid resource amount includes current month's income, subtract the income from the resource amount you count for the month. Count any income remaining after the month of receipt as a resource.

Disaster and Emergency Assistance Payments
441 IAC 75 (Rules in Process)

Exempt disaster and emergency assistance payments as provided under the Disaster Relief Act of 1974, as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988.

This policy covers:

- Payments provided by the Federal Emergency Management Agency (FEMA), including payments from the Individual and Family Grant Program.
- Disaster unemployment benefits provided under the 1988 amendments to the Disaster Relief Act of 1974. Under this Act, unemployment benefits are provided to persons who are out of work due to a major disaster, including self-employed persons and others who are not covered under regular unemployment insurance benefits.
- Disaster and emergency assistance provided under the 1988 Amendments to the Disaster Relief and Emergency Assistance Act of 1974 and comparable assistance provided by states, local governments, and disaster assistance organizations.

Exempt vendor payments made under Iowa's Emergency Assistance program.

Before exempting the payments verify the source.

Domestic Volunteer Services Act
441 IAC 75 (Rules in Process)

Exempt payments from programs under Titles II and III of the Domestic Volunteer Services Act made to volunteers for support services or reimbursement of out-of-pocket expenses.

Programs under this act include:

- University Year for Action (UYA)
- Service Corps of Retired Executives (SCORE)
- Active Corps of Retired Executives (ACE)
- Foster Grandparents

Earned Income Credit (EIC) Payments
441 IAC 75 (Rule in Process); Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010, P. L. 111-31

Exempt Earned Income Credit (EIC) payments in the month received as well as in the following month. Exempt payments in these two months whether they are received with a regular paycheck or in a lump sum as part of a federal income tax refund. Funds remaining are countable resources after the end of the second month.

NOTE: Exclude for 12 months from the date of receipt all EITC payments received as part of federal tax refund between January 1, 2010, and December 31, 2012.

Education Assistance
441 IAC 75 (Rules in Process)

Exempt all earned and unearned financial assistance for education or training.

Energy Assistance Payments
441 IAC 75 (Rules in Process)

Exempt energy assistance payments made to eligible households through the Division of Community Action Agencies of the Department of Human Rights under the Low-Income Home Energy Assistance Act of 1981 (LIHEAP). LIHEAP covers costs such as:

- Insulation.
- Home energy assistance.
- Emergency lodging because utilities have been shut off.
- Winterizing old or substandard dwellings. (Neither the cost of the materials nor the cost of labor is counted as a resource.)

Exempt other support and maintenance energy assistance when the assistance is based on need and is furnished by a:

- Supplier of home heating gas or oil, whether in cash or in kind.
- Municipal utility providing home energy, whether in cash or in kind.
- Private nonprofit organization, but only if the assistance is in-kind.
- Rate-of-return entity providing home energy, whether in cash or in kind. "Rate-of-return" means that revenues are primarily received from charges to the public for goods or services, and the charges are based on rates regulated by a state or federal agency.

"Support and maintenance" assistance is any assistance designed to meet day-to-day living expenses. This includes assistance to pay for heating or cooling a home.

"Based on need" means that assistance is issued to or on behalf of a person according to income limits at or below 150 percent of the federal poverty level.

There may be other assistance for home energy costs provided to FMAP-related households. When other assistance meets the criteria above, that assistance is also exempt.

Family Support Subsidy Program 441 IAC 75 (Rules in Process)	Exempt Iowa Family Support Subsidy payments made to families with children who have special educational needs due to physical or mental disabilities. The purpose of the program is to reduce the need for out-of-home placements or to facilitate the return of the child from an out-of-home placement.
Federal Tax Refunds Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010, P.L. 111-312. P.L. 112-240	Federal tax refunds are excluded for 12 months from the date of receipt.
Food Programs 441 IAC 75 (Rules in Process)	Exempt the value of: ▪ Benefits received under the Food Assistance program. ▪ Commodities donated by the U.S. Department of Agriculture. ▪ Supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended, (Public Laws 92-433 and 93-150). ▪ Congregate meals or other benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act of 1965.
Grants 441 IAC 75 (Rules in Process)	Exempt grants obtained and used under conditions that preclude their use for current living costs.
Home Produce for Personal Consumption 441 IAC 75 (Rules in Process)	Exempt the value of home-produced garden products, orchards, animals, etc., that are eaten by the household. When home produce is raised for sale or exchange, consider it a business operation and treat it as self-employment income.
Homestead 441 IAC 75 (Rules in Process)	Exclude the applicant's or member's homestead without regard to its value. A homestead is any house, mobile home, or similar shelter used as the applicant's or member's home. It may contain one or more adjacent lots or tracts of land, including buildings and equipment.

A homestead may contain any type or number of buildings within the land limits described including:

- A duplex. (Exempt the entire duplex.)
- An apartment. (If the client lives in the building and does not sell any of the apartments, exempt the entire apartment house. Apartments include both standard buildings and single-family houses converted to apartments.)
- A family home containing a room or apartment. (If the client lives in one of the units, exempt the home.)
- A condominium or row house occupied by the client. (Exempt only the unit occupied by the client.)

There is a limit on the amount of land that may be exempted as part of the homestead:

- When outside a city plat, exclude no more than a total of 40 acres of land.
- Within the city plat, exclude no more than one-half acre of land.

To determine if the homestead within a city plat is within size limits, multiply the length of the property by the width to calculate the square footage. Compare this figure to 21,780 (the number of square feet in one-half acre). If necessary, obtain courthouse or tax records to find the legal descriptions of the property.

Property that exceeds the allowable limit is counted as a resource.

Exempt a homestead when an applicant or member temporarily leaves if they:

- Are absent for a defined purpose, **and**
- Lived in the home immediately before the absence, **and**
- Intend to return when the purpose of the absence has been accomplished.

Regularly document the client's intentions to return home. If the client does not intend to return home, the homestead becomes a countable resource.

Do not apply the homestead exemption to nonhomestead property which the household acquires intending to make the property its homestead in the future.

Homestead for People Requesting Long-Term Care Payments
441 IAC 75 (Rules in Process)

Effective January 1, 2006, a person is not eligible for payment of nursing facility services or other long-term care services if the person's equity interest in the person's home exceeds $500,000. For more information, see Property in a Homestead for People Requesting Long-Term Care.

Household Goods and Personal Effects
441 IAC 75 (Rules in Process)

Exempt household goods and personal effects without regard to their value. Household goods are items used in and about the house in connection with home occupancy. They are items used to maintain the home as well as to accommodate, comfort, and entertain the occupants.

"Personal effects" are the belongings of family members, including clothing, books, grooming aids, jewelry, hobby equipment, and similar items.

Animals, pets, and collections are **not** excluded and must be counted.

Inaccessible Resources
441 IAC 75 (Rules in Process)

Exempt resources that are not available to the applicant or member. Examples of instances in which a resource is **not** available include:

- Property jointly owned by spouses involved in a divorce proceeding. The property is not available until a decision on property distribution has been made.
- Real or personal property in which the terms of the joint tenancy or tenancy in common make the property unavailable. See Joint Ownership.
- Nonhomestead property jointly owned by a FMAP-related Medicaid parent and a separated or divorced spouse or a deceased spouse's estate, when the parent is not able to have control of it. This may occur because the other owner has possession of the property or because it is in litigation.
- Nonhomestead property for so long as the property is publicly advertised for sale at an asking price consistent with its fair market value. To verify that the property is up for sale at fair market value, use collateral contacts and documentation, such as newspaper ads or real estate broker listings.

Income in Kind
441 IAC 75 (Rules in Process)

Exempt as a resource unearned income-in-kind such as money paid on an applicant's or member's behalf to a third party (vendor payments). Also exempt earned income in-kind, such as meals, reduced rent received in exchange for performing work or a service.

Indian Tribe Judgment Funds
441 IAC 75 (Rules in Process)

Exempt as a resource Indian tribe judgment funds that have been or will be distributed to each member or held in trust for members of any Indian tribe.

When all or part of the payment is converted to another type of resource, also exempt that resource. If this resource decreases in value, the exemption applies to the remaining value of the resource. If the resource appreciates in value, only the original amount is exempted.

Individual Development Accounts
441 IAC 75 (Rules in Process)

Individual Development Accounts (IDAs) are optional, interest-bearing accounts much like IRAs. IDAs encourage families to save and plan for the future, without the savings affecting eligibility for assistance. The accounts allow withdrawal without penalty for items such as educational expenses, business start-up, home ownership, and emergencies.

Exempt the balance in an IDA and any interest applied to the account.

Insurance Settlements and Damage Judgments
441 IAC 75 (Rules in Process)

Consider insurance settlements and damage judgments received for damage or destruction of an **exempt or nonexempt** resource as liquidating a resource and not as income.

When the applicant or member intends to repair or replace the resource, and signs a legal, binding commitment no later than the month after the payment is received, exempt the payments for the duration of the commitment (up to eight months following the commitment date).

For example, if a homestead is damaged by fire, the applicant or member must commit any settlement funds in excess of resource limits in a binding contract to rebuild or repair the home to avoid being over the resource limit.

Document the settlement and the legal commitment in the case record.

If the applicant or member does not intend to repair or replace the home, or the payments are for a **nonexempt** resource, count the amount of the settlement as a resource in the month following the month payment was received.

Life Estates
441 IAC 75 (Rules in Process)

Exclude a life estate of the life estate holder. A life estate is defined as the ownership of the right to live on, use, or receive income from a property in which the person does not have full rights of disposition. The life estate holder may use the property but may not alter or transfer it.

Exclude any interest in a property held by an applicant or member when another person holds the life estate until the holder dies or surrenders the life estate to the applicant or member.

Life Insurance With No Cash Surrender Value
441 IAC 75 (Rules in Process)

Exclude any types of life insurance that have no cash value, such as term insurance or group insurance. The owner of the life insurance policy is the person paying the premium who has the right to change the policy.

The cash surrender value of insurance is generally available to the premium payor, unless it is assigned or in some other manner actually transferred on the records of the insurance company to the insured or other named person. Do not automatically assume that the applicant or member does not own the policy simply because another person is paying the premium.

Loans
441 IAC 75 (Rules in Process)

Exempt bona fide loans. A bona fide loan is one that includes an agreement between the lender and the borrower that the money is a loan. This agreement may be oral or in writing, as long as it indicates an intent to repay the money.

Lump Sum (Nonrecurring)
441 IAC 75 (Rules in Process)

Exempt the amount of a nonrecurring lump sum that is reserved for current or future month's income. See FMAP-Related Lump Sum Income for more information about how to treat lump sums.

Medical Expense Settlement
441 IAC 75 (Rules in Process)

Exempt settlements for payment of medical expenses.

Other Excluded Federal Payments
441 IAC 75 (Rules in Process)
P.L. 106-398

Exclude the following federal payments:

- Payments received through the Agent Orange Settlement Fund or any other fund established because of the settlement in the "In re Agent Orange product liability litigation, M.D.L. No. 381 (E.D.N.Y.)." NOTE: This settlement fund is now closed as all funds have been distributed.
- Payments made by the U.S. government under Public Law 92-203, the Alaskan Native Claims Settlement Act. Exempt the tax-exempt portions.
- Payments made by the U.S. government to individual Japanese-Americans (or their survivors) who were interned or relocated during World War II.
- Payments made to eligible civilian Aleuts under section 206 of Public Law 100-383. This payment is available only to those Aleuts who were living on August 10, 1988, the date Public Law 100-383 was enacted.
- Payments made under the Radiation Exposure Compensation Act, Public Law 101-426 which compensates persons for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person's death, payments are made to the surviving spouse, children, or grandchildren.

- Payments received under the Energy Employees' Occupational Illness Compensation Program. Payments are made to former employees or their families. Members may receive one or two lump sum payments. Award letters are sent to the recipient from the Department of Labor.
- Payments from the Experimental Housing Allowance Program under annual contribution contracts entered into before January 1, 1975, under section 23 of the U.S. Housing Act of 1936, as amended.
- Payment received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968. The federal government makes these payments to persons displaced when the government acquires their property for a federal or federally assisted project. Local poverty agencies administer these programs.

Property Producing Income Consistent with Fair Market Value
441 IAC 75 (Rules in Process)

Exempt the resource value of nonhomestead property producing income consistent with the property's fair market value, such as when income from rental property is consistent with rental income for similar rental properties in the area. Allow the exemption even when the property produces the income on a seasonal basis.

If the property does not produce income consistent with its fair market value, count the net market (equity) value of the property toward the resource limit.

NOTE: If the household uses the real property for self-employment purposes, consider the exemptions as described under Tools of the Trade.

See Determining Net Market Value of a Countable Resource for information determining net as well as fair market (gross) value. Also see Inaccessible Resources to determine availability of the nonhomestead property.

Property Settlements
441 IAC 75 (Rules in Process)

Exempt property settlements that are part of a legal action in the dissolution of marriage or palimony suits, regardless if received as a lump sum or in periodic payments. Exempt settlements for the month of receipt and the following month.

Property Sold Under Installment Contract
441 IAC 75 (Rules in Process)

Exempt property sold under an installment contract or held as security in exchange for a price consistent with its fair market value. Also exempt the value of the installment contract.

If the price is not consistent with the fair market value, count the net market (equity) value of the installment contract (rather than the equity value of the property) toward the resource limit. See Determining Net Market Value of a Countable Resource for information on determining contract value.

Prorated Income
441 IAC 75 (Rules in Process)

Exempt prorated income during the period of months over which you prorate it. See Current Month's Income.

Self-Employment Assets
441 IAC 75 (Rules in Process)

See FMAP-Related Self-Employment Income for information on how to determine if an enterprise is considered self-employment.

Exempt **inventory** and **supplies** that are needed for self-employment.

"Inventory" is defined as all unsold items, whether raised or purchased, that are held for sale or use. Examples are:

- Merchandise
- Grain held in storage by a farmer
- Livestock raised for sale
- Antiques held by a dealer
- Cosmetics held by a beautician

> Mr. A is a self-employed toy maker. His unsold toys (his inventory), as well as his lumber, glue, varnish, and other supplies are exempt as inventory.

"Supplies" are items that are necessary for the operation of the business like lumber, paint, seed, and fertilizer.

Capital assets are not considered to be inventory or supplies. These are assets that, if sold at a later date, could be used to claim capital gains or losses for federal income tax purposes. (See below.)

Capital gains result from sale of a resource and are a resource upon receipt.

Continue to exempt self-employment inventory or supplies if the self-employment is temporarily interrupted due to circumstances beyond the control of the household (such as illness). There must be a defined purpose for the interruption and an intent to return to the self-employment. Apply prudent-person guidelines to determine if this is a situation where you can expect the person to return.

Subsidized Guardianship Payments
441 IAC 75 (Rules in Process)

Payment made under a subsidized guardianship program are exempt as a resource.

Tools of the Trade
441 IAC 75 (Rules in Process)

Exempt up to a total of $10,000 in equity (net market) value for **tools of the trade or capital assets** for self-employed households. First deduct what the applicant or member owes on the tools. Then count any equity value over $10,000.

The $10,000 limit applies to the entire household, regardless of how many members are self-employed.

Tools of the trade and capital assets are those items that, if sold, could be used to claim gains or losses for federal income tax purposes. A capital asset usually has a life span of more than one year. It can include real as well as personal property.

Examples include:

- Farm equipment of a farmer
- Farm land
- Hair dryers of a beautician
- Tools of a mechanic
- Electric saw and sander of a toy maker
- Computer and other equipment of a word processor
- Stoves and ovens of a baker
- Photocopy machines in a copy center

Livestock used for breeding, show, or dairy purposes are capital assets if depreciated for federal income tax purposes. If not, the livestock is considered inventory and is entirely exempt.

When the household has a vehicle that is used for the self-employment enterprise and also for personal use, apply the motor vehicle exemption policy, the $10,000 exemption for capital assets, and the vehicle exclusion. See Vehicles.

The tools of the trade exemption also applies when:

- The household is in the process of setting up a business, and provides verification, or
- A member's self-employment is temporarily interrupted because of circumstances beyond the control of the household (for example, because of illness or training directly related to self-employment).

The $10,000 exemption no longer applies when the self-employment ends or when the applicant or member files Chapter 7 bankruptcy. The household loses this exemption beginning the month after the self-employment ends.

Transfers to Minors
Iowa Code 565B
441 IAC 75 (Rules in Process)

When a child has assets in an account set up under the Uniform Transfers to Minors Act (Iowa Code Chapter 565B), an adult is named as custodian of the account. The adult has discretion in withdrawing money from the account to give to the child (or spend for the child).

When the custodian of the account lives with the FMAP-related Medicaid household, consider the money in the account as a countable resource, regardless whether the custodian receives Medicaid with the other household members. If the custodian is a parent in the eligible group, count the money as available even if the parent is temporarily absent.

When the custodian is someone who does **not** live with the FMAP-related Medicaid household (other than a parent who is temporarily absent), count as an available resource only the amount the custodian is willing to make available to the household.

Obtain a signed statement from the custodian to determine the amount the custodian is willing to make available to the FMAP-related Medicaid household. Consider the remainder in the account as an unavailable resource.

The Act specifies that the custodianship terminates and the property is distributed when the minor turns 21.

VISTA Payments
441 IAC 75 (Rules in Process)

Exempt as a resource Title I VISTA volunteer payments, as long as the value of all payments is less than either the federal or state minimum wage when dividing the payments by the hours of service.

To date, no VISTA payments have been determined by the Director of ACTION to equal or exceed the minimum wage.

Women, Infants and Children (WIC) Nutrition Program
441 IAC 75 (Rules in Process)

Exempt the value of food assistance received through the Women, Infants, and Children Nutrition Program administered by the Department of Public Health through local health agencies.

Income Policies for FMAP-Related Coverage Groups Prior to MAGI Methodology

Legal reference: 441 IAC 75 (Rules in Process)

Income must be within FMAP-related program limits, unless otherwise specified by the coverage group under which the person is applying or eligible. Treat the income for people whose Medicaid eligibility is FMAP-related according to the policies in this chapter, except where noted.

The following sections explain:

- Income considered.
- Treatment of minor parents and minor pregnant women.
- Budgeting for FMAP-related households.
- The work transition period.

Income Considered

Legal reference: 441 IAC 75 (Rules in Process)

Consider all unearned and earned income when determining initial and continuing FMAP-related Medicaid eligibility except when the income is specifically:

- Exempted
- Disregarded
- Deducted
- Diverted

See Taxes.

Unearned income is any income in cash that is not gained by labor or service. Examples of unearned income are:

- Investment income, such as dividends from stocks or bonds.
- Alimony or child support.
- Nonrecurring lump-sum payments.
- Rent from property handled by an agent.
- Interest income.
- Worker's compensation.
- Extended disability payments paid by an insurance company. See Disability Benefits for more information.
- Benefits or rewards for service, or compensation for lack of employment, such as Social Security benefits, Railroad Retirement, VA pensions, unemployment insurance, and strike pay.

Earned income is income earned by the person's own efforts. Examples of earned income are:

- Net profit from self-employment. See FMAP-Related Self-Employment Income.
- Income from Job Corps.
- The total gross amount of salary, wages, tips, bonuses, or commissions earned as an employee, including vacation and sick-leave pay, regardless of any employment-related expenses.

Earned income includes income from managerial responsibilities, such as the management of capital investments in real estate. However, in a capital investment where the owner carries no responsibility (such as where rental properties are in the hands of rental agencies and the check is forwarded to the owner), the income is classified as unearned income.

Whose Income Is Not Counted

Legal reference: 441 IAC 75 (Rules in Process)

Do not count the income of the following people:

- SSI recipients.
- Ineligible or voluntarily excluded children. (Also exempt their resources.)
- Minor parents in foster care when determining FMAP-related eligibility of the minor's dependent child.
- Nonparental relatives who are not in the eligible group. (When the relative is needy and is included in the eligible group, treat the relative's income the same as the income of a parent.)

Income Under a Shared Living Arrangement

Legal reference: 441 IAC 75 (Rules in Process)

When an FMAP-related parent shares the responsibility for paying household expenses with another family or person, consider as income only the funds made available to the FMAP-related eligible group exclusively for their needs. Do not consider as income funds that are combined to meet mutual obligations for shelter and other basic needs.

Obtain a statement from the client that specifies the living arrangement, signed by both the person making the contribution (if possible) and by the client.

Minor Parents and Minor Pregnant Women

Legal reference: 441 IAC 75 (Rules in Process)

Treat a pregnant minor (under age 18, never married or marriage was annulled) in the same way as a minor parent. When a minor parent is living independently or with a nonparental relative, treat the minor parent's income as if that person has turned 18 years old.

When a parent under the age of 19 who is in high school and is expected to finish by age 19 lives with that person's adult parent, treatment of the household's income depends on whether the adult parent receives Medicaid under FMAP or is self-supporting. See Minor Parents for more information.

The following sections give more information on:

- Living with a parent who receives FMAP.
- Living with a self-supporting parent.
- Treatment of income of the self-supporting parent.
- Treatment of income of the spouse of the self-supporting parent.

Living with a Parent Who Receives FMAP

Legal reference: 441 IAC 75 (Rules in Process)

Treat the income of a parent under age 19 who is also receiving Medicaid under FMAP with their adult parent in the same way as the income of any other eligible child in the adult parent's eligible group. See Age of Children.

The same policy applies when the minor parent lives with a nonparental relative who assumes a parental role over the minor parent. If needy, the nonparental relative may be included in the eligible group. See Specified Relatives.

> Sue is 17 years old. She and her baby live with her mother, Mrs. Y, who receives Medicaid under FMAP. The needs of Sue and her baby are included in Mrs. Y's eligible group. The income of both Sue and the baby is given the same consideration as that of any other eligible child.
>
> This would also be true if Sue were 18, full time in secondary school or its equivalent, and expected to complete the program before turning 19.

Treat an ineligible minor parent in the same manner as any other ineligible parent:

- Treat the income of the minor parent the same as any other ineligible parent's income when you are determining eligibility for the baby.
- A sanctioned minor parent remains ineligible for Medicaid until the condition that caused the sanction is fixed.
- An ineligible minor parent continues to be counted in the household size as a "considered" person.

If there are no other eligible children in the home, the adult parent may remain eligible as the specified relative of a dependent child.

> Ann is 16 years old. She has a baby and lives with her mother, Mrs. Z, who receives Medicaid under FMAP for herself, Ann, and the baby. In December, Ann fails to cooperate with CSRU. Ann is sanctioned and becomes ineligible for Medicaid.
>
> Mrs. Z can continue to receive Medicaid under FMAP because she is the specified relative of a dependent child (Ann). Ann's income continues to be used in determining eligibility for Mrs. Z and Ann's baby. Ann is a "considered" person on the case and the household size remains three.

Living with a Self-Supporting Parent

Legal reference: 441 IAC 75 (Rules in Process)

When a minor parent lives with one or both self-supporting parents not receiving Medicaid under FMAP, consider the income of each self-supporting parent in the household to be available when determining eligibility for the minor parent and the minor's child. See Self-Supporting Parent's Income.

Treat the income of the minor parent in the same way as any other parent. Treat the income of the minor parent's child in the same way as the income of any other child receiving Medicaid under FMAP.

Exempt the self-supporting parent's income when the minor parent turns 18, marries, or a court determines the minor to be emancipated, regardless of the minor parent's school attendance.

> Ms. B is 17 years old and a full-time student. She lives with her self-supporting parents. Ms. B has a baby, aged 2. She is also employed and earns $400 a month.
>
> Because Ms. B is the parent of the dependent child, she is included in the eligible group with the baby. Ms. B's income is exempt because she is a full-time student. However, the income of her self-supporting parents is considered in determining eligibility for Ms. B and the baby.
>
> Ms. B turns 18 on September 8. Beginning with the month of October, the income of Ms. B's self-supporting parents is no longer considered.

Remember that restricted income (Social Security, Veteran benefits, etc.) paid to a self-supporting parent on behalf of the minor parent is considered unearned income to the minor parent, unless the representative payee is living outside the home. See Representative Payee Income.

1. Ms. X is a minor parent who lives with her self-supporting parents. Her parents receive Social Security retirement benefits that include $150 a month for Ms. X. The $150 paid to Ms. X's parents on her behalf is considered as income when determining eligibility for the eligible group, regardless of the amount actually made available to the eligible group.
2. Ms. Q is a minor parent who lives with her self-supporting father. Her mother, who is not in the home, receives Social Security benefits of $126 for Ms. Q. Ms. Q's mother gives $100 to Ms. Q each month. She puts the rest of the money in a bank account for Ms. Q's education. Ms. Q does not have access to the bank account.

   Because Ms. Q's mother is the representative payee and is living outside the home, only the amount of Social Security that she actually makes available ($100) is considered as income when determining eligibility for the eligible group.

Consider child support payments received by a self-supporting parent on behalf of the minor parent as unearned income of the minor parent, and subject to the $50 support exemption.

Ms. A is a 17-year-old parent who lives with her self-supporting mother. Ms. A's mother is the payee for child support for Ms. A. She receives $200 a month. Only $150 ($200 - $50) is counted as income to Ms. A.

The same would be true if Ms. A were 18 years old, because child support is income to the person for whom the support is paid, regardless of that person's age.

Self-Supporting Parent's Income

Legal reference: 441 IAC 75 (Rules in Process)

When a minor parent under age 18 lives with one or both self-supporting parents, treat the income of each self-supporting parent according to stepparent policies. See Treatment of Stepparent Income.

Apply the same deductions to the gross income that apply to stepparents' income, except as otherwise specified. Treat nonrecurring lump-sum income the same way as if received by a stepparent.

1. Zoe applies for FMAP. She is 17 years old and has a one-year-old baby. She lives with her self-supporting parents, Mr. and Mrs. Z, and her two younger brothers. Zoe and her brothers have no income. Mr. Z has projected gross earnings of $1,500 and Mrs. Z has projected gross earnings of $500. Mr. Z pays $250 in child support for a child not in the home.

$1,500.00	Mr. Z's projected gross earnings	$500.00	Mrs. Z's projected gross earnings
- 300.00		-100.00	
$1,200.00	20% earned income deduct.	$400.00	20% deduction Mrs. Z's projected net income

- 250.00	Child support deduction
$ 950.00	Mr. Z's projected net income
400.00	Mrs. Z's projected net income
$1,350.00	
- 986.00	Diversion for Mr. and Mrs. Z and their other two children
$ 364.00	
- 211.12	58% deduction
$ 152.88	Attribute as unearned income to the FMAP eligible group

NOTE: Mr. and Mrs. Z and their two sons constitute one unit. It is not appropriate to split the diversion for their needs. Thus, their respective income that remains before the diversion is combined, and the 58% deduction applied to the remainder.

2. The household consists of:

Mrs. G, age 43, self-supporting
Fanny, age 19, Mrs. G's daughter
Hannah, age 16, Mrs. G's daughter
Ben, age 1, Hannah's son

Mrs. G is employed and has gross earnings of $1,300 per month. The following shows the calculation if everyone wants Medicaid.

FMAP

$1,300.00	Gross earnings
- 260.00	20% earned income deduction
$1,040.00	
- 365.00	Diversion for Mrs. G
$ 675.00	
- 391.50	58% deduction
$ 283.50	Countable income <$361.00

Hannah and Ben are FMAP-eligible.

Medically Needy

$1,300.00	Gross earnings
- 260.00	20% earned income deduction
$1,040.00	
- 283.50	Diversion for the FMAP group
$756.50	
- 483.00	MNIL for one person
$ 273.50	
x 2	months
$ 547.00	Spenddown for Mrs. G and Fanny

Spouse of the Self-Supporting Parent

Legal reference: 441 IAC 75 (Rules in Process)

A self-supporting parent's self-supporting spouse is the stepparent of the minor parent. When the self-supporting spouse is also living in the home, treat the spouse's income in the same way as a stepparent's income for the eligible group.

Consider the self-supporting parent and any dependent of that parent as **one** unit. Consider the self-supporting spouse and any dependent of the spouse (other than the self-supporting parent) as **one** unit.

Attribute the spouse's income to the self-supporting parent in the same way that the income of a stepparent is determined for the eligible group. Allow the same deductions as for a stepparent.

Treat nonrecurring lump-sum income of the spouse in the same way as nonrecurring lump-sum income received by a stepparent.

Determine the unmet needs of the self-supporting spouse's ineligible dependents the same as you treat the dependents of a stepparent. Although the income of an ineligible dependent of the spouse is not attributable to the self-supporting parent, consider the income of the dependent in determining if the dependent has unmet needs.

Do not divert income of the spouse to meet the needs of the self-supporting parent. However, you may divert income of the self-supporting parent to the spouse, if the parent claims or could claim the spouse for federal income tax purposes.

Perform a double stepparent calculation to determine the income that is attributable to the eligible group.

Ms. B is 17 years old and applies for Medicaid for herself and one child. She lives with Mrs. Y, her self-supporting mother, Mr. Y, her stepfather and her two younger sisters and her stepbrother. Mr. Y has $1,150 projected gross monthly earnings. He pays $100 per month child support for a child not in the home. Mrs. Y has projected gross earnings of $1,080 per month.

Step 1. Determine the income of Mr. Y that is attributable to Mrs. Y.

$ 1,150.00	Mr. Y's projected gross income
- 230.00	20% deduction
$ 920.00	
- 100.00	Child support
$ 820.00	
- 719.00	Diversion for Mr. Y and his child
$ 101.00	
- 58.58	58% deduction
$ 42.42	Attribute as unearned income to Mrs. Y for the eligible group.

Step 2. Determine income of Mrs. Y to be attributed to the FMAP group.

$ 1,080.00	Mrs. Y's projected gross income
- 216.00	20% deduction
$ 864.00	
- 849.00	Diversion for Mrs. Y and her two children
$ 15.00	
- 8.70	58% deduction
$ 6.30	Mrs. Y's countable projected income
+ 42.42	Income attributed from Mr. Y
$ 48.72	Total unearned income attributed to the FMAP group.

Budgeting for FMAP-Related Households

Legal reference: 441 IAC 75 (Rules in Process)

Determine FMAP-related Medicaid eligibility for each month of the application period separately. Determine eligibility for the people who are in the home during each month of the application period. Determine eligibility for any retroactive months separately unless eligibility is being established under Medically Needy.

Base initial and ongoing FMAP-related eligibility on projected income. If the projected future income is not valid for the month of application, month of decision, or any months in between, use the actual income received in the month to determine eligibility for that month.

Projecting Income

Legal reference: 441 IAC 75 (Rules in Process)

For all FMAP-related coverage groups, always count income prospectively.

Use and project as future income all nonexempt earned and unearned income received by the eligible group. Any of the following may be used as a guideline:

- Income received in the 30 days before receipt of an application or review form.
- Income received in a different 30-day period that is indicative of future income.
- Income received in a longer period of time that is indicative of future income.
- One pay stub that is indicative of future income.
- Self-employment tax returns or books if indicative of future income. (This may include the past three years' average.)
- Income verification obtained from the income source.

1. Mr. and Mrs. B apply for Medicaid for their children on August 21. In order to project income, the worker requests verification of all income received by the eligible group in the 30 days before August 21, the date of application if it is indicative of future income.
2. Mr. C files an application for Medicaid on July 27. Most of the application is blank but it does list Mr. C and his children. Several unsuccessful attempts are made to contact Mr. C to gather information and determine if the application is for only the children or for all household members.

   Although an interview is not required, the worker decides to schedule an interview for August 9. In order to project income, the worker requests verification of all income received by the eligible group in the 30 days prior to the application date.

   At the interview, the worker and Mr. C decide that this 30-day time frame is not a good indicator of future income. They explore whether a different or longer time frame would be indicative of future income, or whether verification from Mr. C's employer would be the best information.
3. Ms. E applies for Medicaid for herself and her children on September 25. The worker requests information in order to process the application. When the information is received, the worker contacts Ms. E again to clarify some information.

   During this conversation, it is determined that the 30-day period before the application is not a good indication of future income. The worker sends another request to Ms. E to verify income based on their conversation and the time frame that Ms. E felt would be a good indication of future income.

Accept the statement of the client as to what time frame is representative of future income.

The decision on whether to use a longer period of time or to request verification of future income from the income source should primarily be the client's. However, when the client is unsure of which would be the best indicator of future income, request verification from the income source.

Also, if the client does not have proof of income, request verification from the income source.

1. Ms. E applies for Medicaid for only her children. The application date is September 21. The only income received by the eligible group is earned income from Ms. E's job. She states that the income she received in the 30 days before September 21 is indicative of future income. The worker requests Ms. E to provide verification for that period of time.
2. Mr. and Mrs. F and their children apply for Medicaid on July 16. The only income received by the eligible group is from Mrs. F's part time job.

   Mrs. F is unsure if her past income is indicative of future income, since her employer just informed her that she will likely be working fewer hours than she has in the past. The worker requests verification of future income from Mrs. F's employer.

When a third or fifth check occurs during the period being used to project income, do not ignore it. Instead, add all check amounts together, divide the total by the number of checks, and multiply that result by four, if the income occurs weekly, or by two, if the income occurs biweekly.

Ms. G applies for Medicaid for her children on September 1. Ms. G is employed and is paid biweekly. She says her income in the 30-day period before the application date is indicative of future income. During the 30 days before the application date, she received three paychecks. Her projected income is calculated as follows:

$	653.45	August 3 pay
	628.89	August 17 pay
+	637.44	August 31 pay
$	1,919.78	Total income for the 30-day period
÷	3	
$	639.92	Average biweekly pay
x	2	
$	1,279.84	Projected monthly income

The projection of $1,279.84 is used in determining the Medicaid eligibility for Ms. G's children beginning with the month of September.

Rounding Down

Legal reference: 441 IAC 75 (Rules in Process)

When the need standard or benefit amount is not a whole dollar, round down to the next whole dollar. Round down the Standard of Need in:

- The 185 percent test.
- The standard of need test.
- The allowance for the needs of a stepparent and dependents.
- The allowance for the needs of self-supporting parents and dependents when deeming income to unmarried parents under age 18.

- The allowance for the needs of an alien's sponsor and dependents when deeming income to the alien.
- Determining the period proration resulting from receipt of a nonrecurring lump sum.

Do not round down the Schedule of Basic Needs.

Dropping the Third Digit

Legal reference: 441 IAC 75 (Rules in Process)

Drop the third digit to the right of the decimal point in any computation of income, hours of employment, or work expenses for care costs. EXCEPTION: When an employer's rate of pay contains a third digit to the right of the decimal (e.g., hourly rate of $3.567), do not drop the third digit until a computation is performed (e.g., $3.567 x 36 hours = $128.412, which becomes $128.41).

Applying Income Tests for FMAP

Legal reference: 441 IAC 75 (Rules in Process)

When processing Medicaid applications under FMAP, it is critical to identify the proper relationship of the household members to each other, so that the system can apply the proper deductions, disregards, and diversion on the three income tests. This is true whether or not the people are included in the eligible group.

Determine the FMAP eligibility by subtracting the countable net income in the month of decision from the Benefit Standard for the eligible group.

Remember, the income tests apply to **each person** in a FMAP household whose income must be considered in order to determine total countable income for the entire household.

Use the schedule of basic needs to determine the basic needs of people whose needs are included in the eligible group. Also use the schedule of basic needs to determine the needs of certain people not included in the eligible group, such as an ineligible child of the FMAP parent (e.g., one who does not have a social security number).

The following sections explain:

- The 185% eligibility test
- The standard of need eligibility test
- The benefit standard eligibility test

Step 1: 185% Eligibility Test

Legal reference: 441 IAC 75 (Rules in Process)

Apply the 185% test on case applications and also when a new person whose income must be considered enters an existing FMAP household.

Determine the nonexempt gross earned and unearned income the eligible group has received and expects to receive in the month of decision.

Use **gross** nonexempt income of:

- People included in the eligible group.
- Parents who are not eligible for Medicaid due to sanction.
- Parents who are **not** sanctioned but who are ineligible for Medicaid, such as ineligible adult aliens and adults with no social security number.

For self-employed people, use the net profit figure.

For ineligible stepparents and self-supporting parents in minor parent cases, use income that remains after deducting the following, **if applicable**:

- 20 percent earned income deduction.
- Adult/child care expense.
- Diversion for people not in the home.
- Diversion for ineligible or voluntarily excluded people in the home.

Compare the countable gross income to the 185% of the standard of need **for the size of the eligible group**.

185% of Schedule of Living Costs	
Number of People in Eligible Group	Income Limit
1	$675.25
2	$1,330.15
3	$1,570.65
4	$1,824.10
5	$2,020.20
6	$2,249.60
7	$2,469.75
8	$2,695.45
9	$2,915.60
10	$3,189.40
Each Additional Person	$320.05

See Rounding Down for instructions on when rounding applies in this test.

When the countable gross income **exceeds** the 185% test, deny the application for that month. If the application is denied, there may be eligibility for Medicaid for a retroactive month, if the individual meets a category of eligibility for the retroactive period, as defined in 8-A, *Definitions*.

When the applicant household's gross nonexempt earned and unearned income is **below or equal to** the 185% eligibility test, determine the household's eligibility under the standard of need test.

Step 2: Standard of Need Eligibility Test

Legal reference: 441 IAC 75 (Rules in Process)

The standard of need test determines eligibility for the 58 percent work incentive deduction.

Apply the standard of need test (test 2) only to case applications and reapplications. On reapplications, apply the standard of need test regardless of how much time has passed since the previous period of eligibility.

Ms. B receives Medicaid under FMAP. She is employed and receives the 20 percent earned income deduction and the 58 percent work incentive deduction when the system calculates her Medicaid eligibility.

Ms. B's Medicaid is canceled effective March 1 for failure to return the January RRED. She reapplies March 3. Ms. B is subject to the standard of need test (test 2) without the 58 percent work incentive deduction in processing her reapplication.

Discontinue application of the standard of need test beginning with the month after the month of decision.

March 1	Date of application
March 1	Effective date of assistance
May 2	Date of decision

Apply the standard of need to the months of March, April, and May. Stop applying the test effective with the month of June.

Do not apply the test when determining initial eligibility for a new person who enters an existing Medicaid household.

Do not apply the standard of need test when **reopening** a case or when the time frames for reinstatement have lapsed when an application is not involved.

To apply the standard of need test:

1. Calculate the countable gross nonexempt earned and unearned income received or expected to be received in the month of decision by any person whose income must be considered.
2. Apply the following deductions, disregards, and diversions, **if applicable**:

   - 20% earned income deduction.
   - Adult/child care expense.
   - Diversions for people not in the home.
   - Diversions for ineligible or voluntarily excluded people in the home.

   Apply these first to the **earned** income of:

   - People included in the eligible group.
   - Parents who are not eligible for Medicaid due to sanction.
   - Parents who are not sanctioned but who are ineligible for Medicaid, such as ineligible adult aliens and adults with no social security number.
   - Ineligible stepparents and self-supporting parents in minor parent cases.
3. Determine the total countable income for each person whose income must be considered:

   - When a person has both earned and unearned income, and earnings are less than the allowable deductions and diversions, subtract any unused portion of the diversions for people in and outside the home from the unearned income. Consider the balance as countable income.
   - When a person has both earned and unearned income, and earnings remain after applying the allowable deductions and diversions, add the unearned income to the remaining earned income. Consider the total as countable income.
4. Compare the total countable income of the eligible group to the Standard of Need for an eligible group of that size, which is the total need of the eligible group as determined by the Schedule of Living Costs.

Schedule of Living Costs (Standard of Need)	
Number of People in Eligible Group	Income Limit
1	$365.00
2	$719.00
3	$849.00
4	$986.00
5	$1,092.00
6	$1,216.00
7	$1,335.00
8	$1,457.00
9	$1,576.00
10	$1,724.00
Each Additional Person	$173.00

See Rounding Down for instructions on when rounding applies in this test.

When the remaining income in the month of decision is **below** the standard of need **for the eligible group**, the applicant is eligible for the 58 percent work incentive deduction. Go on to determine the household's eligibility under the benefit standard test.

When the remaining income in the month of decision **equals or exceeds** the standard of need for the eligible group, deny the application for that month. There may be eligibility for a retroactive month if the individual meets a category of eligibility for the retroactive period, as defined in 8-A, *Definitions*.

Step 3: Benefit Standard Eligibility Test

Legal reference: 441 IAC 75 (Rules in Process)

When the applicant household is eligible under both the 185% test and the standard of need test, determine the household's eligibility under the benefit standard test. To determine eligibility under the benefit standard test:

1. Calculate the countable gross nonexempt earned and unearned income received or expected to be received in the month of decision by any person whose income must be considered.
2. Apply the following deductions, disregards, and diversions, **if applicable**:

   - 20% earned income deduction.
   - Adult/child care expense.
   - Diversion for people not in the home.
   - Diversion for ineligible or voluntarily excluded people in the home.
   - 58% work incentive deduction.

   Apply these first to the **earned** income of:

   - People included in the eligible group.
   - Parents who are not eligible for Medicaid due to sanction.
   - Ineligible stepparents.
   - Self-supporting parents in minor parent cases.
   - Parents who are not sanctioned but who are ineligible for Medicaid, such as ineligible adult aliens and adults with no social security number.
3. Determine the total countable income of each person whose income must be considered:

   - When a person has both nonexempt earned and unearned income, and the earnings are less than the allowable deductions and diversions, subtract any unused portion of the diversions (for people in or outside the home) from the unearned income. Consider the balance as countable income.

   - When a person has both nonexempt earned and unearned income, and earnings remain after applying the allowable deductions and diversions, add the unearned income to the remaining earned income. Consider the total as countable income.

4. Compare the total countable income of the eligible group to the Benefit Standard for a group of that size, which is the total need of the eligible group as determined by the Schedule of Basic Needs.

Schedule of Basic Needs (Benefit Standard)	
Number of People in Eligible Group	Income Limit
1	$183
2	$361
3	$426
4	$495
5	$548
6	$610
7	$670
8	$731
9	$791
10	$865
Each Additional Person	$87

Do not round down the Schedule of Basic Needs.

Approve the application if the countable net earned and unearned income in the month of decision is less than the benefit standard for the eligible group. Approve the application even in situations where information indicates the applicant may be ineligible the month following the month of decision.

Deny the application for the month if the countable net earned and unearned income in the month of decision is equal to or exceeds the benefit standard for the eligible group. There may be eligibility for a retroactive month if the individual meets a category of eligibility for the retroactive period, as defined in 8-A, *Definitions*.

Work Transition Period (WTP)

Legal reference: 441 IAC 75 (Rules in Process)

Exempt the earnings from new employment of any person whose income is considered when determining eligibility for the first four months of the new employment if all of the following criteria are met:

- The new job starts after the date of application.
- The new job is timely reported.
- The person with the new job has not already received the WTP in the past 12 months.
- The person with the new job had less than $1,200 in earnings in the 12 calendar months before the month in which the new job begins. The $1,200 limit applies to gross income, without any exemptions, disregards, work deductions, diversions, or allowances for the cost of doing business used in determining net profit from self-employment.

Do not allow the work transition period during the retroactive period.

1. Ms. R and her two children receive FMAP. In October, Ms. R begins a part-time job and is approved for the work transition period for FMAP for October through January.
2. Ms. J, age 18 and pregnant, applies for FMAP on January 11 for herself and her 13 month old child. She also requests retroactive Medicaid eligibility for October, November, and December. On October 22, Ms. J began a part-time job baby-sitting. She is not eligible for the work transition period because the job started during the retroactive period.

People eligible for the WTP may include members in the eligible group, as well as ineligible people whose income must be considered (ineligible stepparents, parents who are not eligible for Medicaid due to a sanction, ineligible aliens, etc.). The exemption continues when the person on a WTP is added to another Medicaid case.

If a person whose income is considered enters the household, the new job must start after the date the person enters the home or after the person is reported in the home, whichever is later, in order for that person to qualify for the exemption.

When a change results in considering the income of a person living in the home whose income was not considered previously, that person may qualify for the WTP. The person's new job must start after the date of the change that caused the person's income to be considered in order for that person to qualify for the exemption.

The following sections explain:

- Qualifying employment
- Verification of eligibility for WTP
- Exemption period

Qualifying Employment

Apply the WTP regardless if the new earnings are from an exempt source (e.g., exempt work study, exempt earnings of a student, etc.).

Promoting or switching to a different position with the same employer does not constitute a new job. This includes when a client changes jobs from one state agency to another. However, being laid off from a job and subsequently recalled by the same employer may be considered a new job, depending on the length of the layoff.

A leave of absence without pay (e.g., maternity leave, unpaid vacation or sick leave), with a subsequent return to the job may also be considered a new job, depending on the length of the absence. Consider a job to be "terminated" when income that was received on a monthly or more frequent basis will not be received again for the remainder of the month in which the job terminated or the following month.

Allow the WTP if the new employment or self-employment enterprise is considered intermittent in nature. "Intermittent" includes, but is not limited to, working for a temporary agency that places the person in different job assignments on an as-needed or on-call basis, or self-employment from providing child care for one or more families.

However, a person is not considered as starting new employment or self-employment each time intermittent employment re-starts or changes, such as when the same temporary agency places the person in a new assignment, or a child care provider acquires another child care client.

Verification

If the information in the case record indicates that the client is not eligible for the WTP, there is no need to pursue eligibility for the WTP any further. Consider the new earnings in the usual manner. No additional notification to the client is required.

When it is not clear from the case record whether the person had earnings of less than $1,200 in the 12 months before the month the earnings from the new employment were received, the client must provide that information. Accept the client's statement with respect to the $1,200 earnings in the past 12 months unless there is other evidence to the contrary. If so, pursue verification in the usual manner.

Failure to provide information needed to determine eligibility for the WTP (i.e., not providing information on the amount of earnings in the previous 12 months when requested) results in ineligibility for the WTP only. However, failure to provide verification of the beginning date of employment or failure to provide the date self-employment began, results in ineligibility for Medicaid.

If information needed to determine eligibility for WTP is returned after the due date, grant WTP for the months remaining in the WTP period if there is eligibility.

Exemption Period

The exemption period begins on the first day of the month in which the client receives the first pay from the new employment. It continues through the next three benefit months, regardless if the job ends during the four-month period. Earnings from the new employment are exempt for the entire four-month period and are not considered in any income tests.

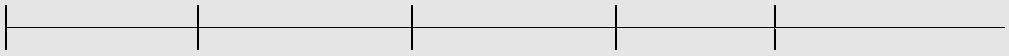
If another new job or self-employment enterprise starts while the WTP is in progress, the exemption also applies to earnings from the new source that are received during the original four-month period, provided that:

- The new job is timely reported, and
- The earnings were less than $1,200 in the 12-month period before the month the other new job or self-employment enterprise begins.

A person is allowed the four-month exemption period only once in a 12-month period. An additional four-month period shall not be granted until the month after the previous 12-month period has expired.

Ms. M receives FIP and FMAP for herself and three children. She timely reports her new job. The worker determines that Ms. M is prospectively ineligible for FIP and that she is eligible to receive the WTP for Medicaid. The family remains eligible for FMAP because income from the new employment is not considered for four months.

When the WTP ends, the family is over income for FMAP. Since FMAP eligibility ended due to earned income and they had received FMAP three out of the past six months, the family is eligible for Transitional Medicaid.



July	August	September	October	November
Ms. M reports new job began 7/8. First pay received 7/24.	FIP canceled effective 8/1 prospectively			Anticipated November income creates November ineligibility.
1st month WTP	2nd month WTP	3rd month WTP	4th month WTP	Transitional Medicaid begins

Types Of FMAP-Related Income

Adolescent Pregnancy Prevention Payments
441 IAC 75 (Rules in Process)

Exempt as income payment from state funded-adolescent pregnancy prevention programs, such as the "Dollar-A-Day" program. These programs focus on preventing subsequent pregnancies for mothers who are 18 or younger by providing a monetary incentive.

The recipients are required to attend weekly support meetings that concentrate on preventing another pregnancy during the adolescent years, as well as meeting the social and economic needs of the recipient. As long as the mother attends the weekly sessions and does not become pregnant, she receives an incentive payment.

Adoption Subsidy
441 IAC 75 (Rules in Process)

Do not count the income and resources of a child who is not included in the FMAP-related eligible group because the child receives subsidized adoption assistance.

Count subsidized adoption assistance as unearned income if the child is included in the eligible group.

A subsidized adoption payment for one person may be greater than the income limit for FMAP for one person. Consequently, in most cases, a child receiving subsidized adoption payments will not be included in the eligible group.

However, if this is the only eligible child in the home and the parents are requesting Medicaid for themselves, the parents and the child may be one eligible group or they may choose to be separate eligible groups.

If the parents choose to be a separate eligible group, establish eligibility for the parents in the same way as you would for parents who chose to voluntarily exclude their only child.

1. Mr. and Mrs. A receive an adoption subsidy payment of $198 for their only child, Mary. They have no income and apply for Medicaid. Mary is included in the eligible group. The parents are eligible for Medicaid under FMAP.

   Several months after the FMAP approval, Mr. A begins receiving unemployment of $125 a week. The $500 projected monthly income exceeds the FMAP income limit for a three-person eligible group. Mr. and Mrs. A's FMAP benefits are canceled, and Mary reverts to an eligible group of one.

   An automatic redetermination is completed for Mr. and Mrs. A. Eligibility for Medically Needy as a two-person eligible group is explored.

2. Mrs. C receives subsidy payments of $198 for her son Sam and $300 for her son Steven. Mrs. C is eligible for FMAP as a one-person eligible group because she has dependent children in her care. Neither Sam nor Steven must be included in Mrs. C's eligible group in order for her to be eligible under FMAP.

Alimony
441 IAC 75.14(249A), 441 IAC 75 (Rules in Process)

Although alimony is assigned to the Department, CSRU does not pursue enforcement of alimony. Do not allow the $50 exemption on alimony payments received directly by an FMAP-related applicant or recipient. However, exempt the first $50 when the direct support payment includes both child support and alimony.

AmeriCorps
Public Law 103-82, 441 IAC 75 (Rules in Process)

The National and Community Service Trust Act of 1993 amends the National and Community Service Act of 1990 and establishes a Corporation for National Community Service. The Corporation administers national service programs including AmeriCorps.

AmeriCorps is designed to engage Americans in a year or two of national service in exchange for an educational award for each year of completed service. It includes three programs:

- AmeriCorps*USA for participants 17 years and older
- AmeriCorps*VISTA for participants 18 years and older
- AmeriCorps*NCCC for participants 16 to 24 years of age

In addition to the educational award, payments to AmeriCorps participants may include a living allowance and a child care allowance, if child care is needed to participate in the program.

Participants may be provided health insurance if not otherwise covered by health insurance. People with disabilities are provided reasonable accommodations, supplies and services they may need to participate in AmeriCorps.

Exempt as income and as a resource the living allowance payments made to participants in the AmeriCorps VISTA program, as long as the Director of ACTION determines they do not exceed the minimum wage. See VISTA Payments.

Count payments made to participants in other AmeriCorps programs as follows:

- Treat the living allowance (stipend) as earned income. Apply all the usual income deductions and disregards. If the AmeriCorps participant is a child by FMAP-related Medicaid definition, treat the earnings as described in Child's Earnings.

- Do not consider the child care allowance as income, but also do not allow a deduction for child care, unless the allowance is less than the actual child care expense. Then allow the excess expense as a deduction, subject to the child care maximum.
- Exempt the educational award as income and as a resource.
- Exempt as income and as a resource the health insurance, reasonable accommodations, supplies and services made available for AmeriCorps participants who have disabilities. These are treated as unearned in-kind benefits, and therefore, exempt.

Blind Training Allowance
441 IAC 75 (Rules in Process)

Exempt as income a training allowance issued by the Department for the Blind to cover the cost of training, such as tuition, books, transportation, lodging away from home, and other related items.

Blood Plasma
441 IAC 75 (Rules in Process)

Count the sale of blood plasma as earned income. The plasma center is considered the employer.

Cafeteria or Flexible Benefit Plans
441 IAC 75 (Rules in Process)

Cafeteria or flexible benefit plans use either the employee's or employer's money to pay certain expenses, such as child care, medical expenses, health insurance, annual leave, or sick leave. (These benefits are not displayed in the same way on all pay stubs. The best source of information regarding them is the employer.)

Count as earned income the employee's gross wages, including any amount withheld for these plans, even if the employee loses any money left over at the end of the year.

Count as earned income any cash an employee receives of the employer's money because the employee did not use all of the money for benefits covered by the plan.

Car Pool Payments
441 IAC 75 (Rules in Process)

Exempt as income payments to FMAP-related Medicaid applicants or recipients from a passenger in a car pool.

Census Earnings
441 IAC 75 (Rules in Process)

Exempt as income for eligibility all census earnings received by temporary workers from the Bureau of Census.

Exempt as income reimbursements for travel expenses. See Reimbursements for more information.

Child's Earnings
441 IAC 75 (Rules in Process)

Earnings of a child who is not a full-time student are countable income, subject to applicable earned income exemptions, deductions, or diversions. Count the earnings when determining eligibility under all three tests. See Student Earnings for more information.

Corporation Income
441 IAC 75 (Rules in Process)

All corporations are separate legal entities. A closely-held corporation is one that has only a few shareholders. An owner or employee of a corporation is not a self-employed person. A person who receives a salary from a corporation is an employee of the corporation.

The corporation is responsible for its debts and obligations. The income and resources of a corporation belong to the corporation.

Crime Victim Compensation
Public Law 103-322

Exclude as income and as a resource payments received from a crime victim compensation program that is funded by the Crime Victim's fund under Public Law 103-322.

Department of Labor Payments
441 IAC 75 (Rules in Process)

Earnings or compensation paid instead of wages under a U.S. Department of Labor program is counted as earned income. Apply the policies under Student Earnings when a full-time student under age 20 receives this payment.

Exempt as income any training expenses issued through a U.S. Department of Labor program. They may help pay for child care, meals, and transportation.

Disability Benefits
441 IAC 75 (Rules in Process)

Count the amount of an employee's disability benefits as **unearned** income when the payment comes from an insurance company.

Count an employee's disability payments as **earned** income when the payment is paid out of the employer's funds.

Disaster and Emergency Assistance
441 IAC 75 (Rules in Process)

Exempt as income and as a resource disaster and emergency assistance payments as provided under the Disaster Relief Act of 1974, as amended by Public Law 100-707, the Disaster Relief and Emergency Assistance Amendments of 1988. This exemption includes:

- Payments provided by the Federal Emergency Management Agency (FEMA), including payments from the Individual and Family Grant Program.
- Disaster and emergency assistance under the 1988 Amendments to the Disaster Relief and Emergency Assistance Act of 1974, and comparable assistance provided by states, local governments, and disaster assistance organizations.

Exempt as income and as a resource vendor payments made under Iowa's Emergency Assistance program. Verify the source of the payments before exempting them.

Diversion Programs
441 IAC 75 (Rules in Process)

Exempt as income financial assistance from the diversion programs operated in certain areas of the state, including cash payments to the family.

The diversion programs provide immediate, short-term financial assistance or services to enable families to become or remain self-sufficient by removing barriers to obtaining or retaining employment. The programs are intended to:

- Help families to avoid the need for ongoing FIP assistance.
- Allow FIP participants to leave the program sooner.
- Help families who are leaving FIP stabilize their employment status and reduce the likelihood of returning to FIP.

Participation in the diversion programs is voluntary. They are designed to divert families only from cash assistance under FIP. They are not designed to divert families from other types of benefits, such as Medicaid and Food Assistance.

However, **cash** assistance provided to a family from the program results in a period of ineligibility for FIP for the family. The local DHS office that provided the diversion cash assistance determines the period of ineligibility. But there is no period of ineligibility for Medicaid.

Dividend Income
441 IAC 75 (Rules in Process)

See Interest Income.

Domestic Volunteer Services Act
441 IAC 75 (Rules in Process)

Exempt as income and as a resource payment from programs under Titles II and III of the Domestic Volunteer Services Act made to volunteers for support services or reimbursement of out-of-pocket expenses. Programs under this act include:

- University Year for Action (UYA)
- Service Corps of Retired Executives (SCORE)
- Active Corps of Retired Executives (ACE)
- Foster Grandparents

Earned Income Credit
441 IAC 75 (Rules in Process)
Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P. L. 111-312)

Exempt as income an Earned Income Credit, whether received with regular paychecks or as a lump sum included with the federal income tax refund.

NOTE: Exclude for 12 months from the date of receipt all EITC payments received as part of a federal tax refund between January 1, 2010 and December 31, 2012.

Energy Assistance Support and Maintenance
441 IAC 75 (Rules in Process)

Exempt as income and as a resource energy assistance support and maintenance when the assistance is based on need and is furnished by a:

- Supplier of home heating gas or oil, whether in cash or in kind.
- Municipal utility providing home energy, whether in cash or in kind.
- Rate-of-return entity providing home energy, whether in cash or in kind. "Rate-of-return" means that revenues are primarily received from charges to the public for goods or services, and the charges are based on rates regulated by a state or federal governmental agency.
- Private nonprofit organization, but only if the assistance is in kind.

"Support and maintenance" assistance is any assistance designed to meet day-to-day living expenses. This includes home energy assistance to pay for heating or cooling a home.

"Based on need" means that assistance is issued to or on behalf of a person according to income limits at or below 150% of the federal poverty level.

There may be other assistance for home energy costs provided to FMAP-related Medicaid households. When other assistance meets the criteria above, that assistance is also exempt.

Family Investment Program Assistance
441 IAC 75 (Rules in Process)

Exempt as income any FIP cash assistance received by the FMAP-related Medicaid eligible group.

Family Self-Sufficiency Grants
441 IAC 75 (Rules in Process)

Exempt as income PROMISE JOBS payments through Family Self-Sufficiency Grants. These are intended to help PROMISE JOBS participants with employment-related expenses. Assistance is intended to enable recipients to overcome barriers to employment and become self-sufficient.

While the payments are not PROMISE JOBS expense allowance payments, they are considered in the same way. They are exempt as income, including when in the form of cash payments made directly to the family.

Family Support Subsidy
441 IAC 75 (Rules in Process)

Exempt as income and as a resource payments made through the Iowa Family Support Subsidy Program to families with children who have special educational needs due to physical or mental disabilities. The purpose of the program is to reduce the need for out-of-home placements or to facilitate the return of the child from an out-of-home placement.

Federal Payments

441 IAC 75 (Rules in Process);
P.L. 105-78 (H.R. 2264) Section 606, P.L. 106-398

Various specialized types of federal payments are excluded. Exempt as income and as a resource:

- Distributions by a Native Corporation established under the **Alaska Native Claims Settlement Act**, Public Law 92-203 when distributed to an Alaskan Native or a descendent of an Alaskan Native. The exemption applies to the following:
  - Cash payments up to $2,000 per year. Count any excess.
  - Stock (including stock issued or distributed by a Native Corporation as a dividend or distribution on stock).
  - A partnership interest.
  - Land or any interest in land (including land received by a Native Corporation as a dividend or distribution of stock).
  - An interest in a settlement trust.
- **Energy Employees Occupational Illness Compensation Program** payments. These payments are made to former employees or their families. Recipients may receive one or two lump sum payments. Award letters are sent to the recipient from the Department of Labor.
- **Experimental Housing Allowance Program** payments under annual contribution contracts entered into before January 1, 1975, under Section 23 of the U.S. Housing Act of 1936, as amended.
- **Wartime Relocation of Civilians** payments made under Public Law 100-383 to:
  - Certain United States citizens of Japanese ancestry (Section 105)
  - Certain eligible Aleuts (Section 206)
- **Radiation Exposure Compensation Act** payments made under Public Law 101-426. The program compensates people for injuries or deaths resulting from exposure to radiation from nuclear testing and uranium mining. After the affected person's death, payments are made to the surviving spouse, children, or grandchildren.
- **Relocation Assistance** payments received under Title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 and the Federal-Aid Highway Act of 1968.
- **Vietnamese Commando Compensation** payments. The Secretary of Defense under the National Defense Authorization Act makes these payments for Fiscal Year 1997 (Public Law 104-201).

Federal Tax Refunds
Tax Relief, Unemployment Insurance Reauthorization, and Job Creation Act of 2010 (P. L. 111-312)

Federal tax refunds received between January 1, 2010, and December 31, 2012, are excluded for 12 months from the date of receipt.

Financial Assistance for Education or Training
441 IAC 75 (Rules in Process)

Exempt as income and as a resource all earned and unearned financial assistance received for education or training including work-study income. Apply the exemption to educational assistance of an undergraduate, graduate student, or person in training.

Any extended social security or veterans benefits received by a parent or nonparental relative, conditional to school attendance, shall be exempt. However, any additional amount received for the person's dependents who are in the eligible group shall be counted as nonexempt income.

Focus Group, Survey or Study Income
441 IAC 75 (Rules in Process)

- Count as income payments received for participating in a focus group, survey, or study unless the payment is a reimbursement or a gift certificate. Whether it is considered earned or unearned income depends on how the payment is described by the entity providing it. Also see Welfare Reform Evaluation Payments.

Food Programs
441 IAC 75 (Rules in Process)

Exempt as income and as a resource the value of:

- Food Assistance.
- Commodities donated by the U.S. Department of Agriculture.
- Supplemental food assistance received under the Child Nutrition Act of 1966, as amended, and the special food service program for children under the National School Lunch Act, as amended (Public Laws 92-433 and 93-150).
- Benefits received under Title III-C, Nutrition Program for the Elderly, of the Older Americans Act of 1965, such as the Congregate Meals Program administered through the Iowa Department of Elder Affairs.

Food Stamp Employment and Training Allowance
441 IAC 75 (Rules in Process)

Exempt as income the Food Stamp Employment and Training (FSET) component allowances.

Foster Care Payments
441 IAC 75 (Rules in Process)

Exempt as income foster care payments, including therapeutic foster care payments, made to an FMAP-related family operating a licensed foster family home. "Therapeutic foster care" payments are higher payments made on behalf of special needs foster children.

Gambling Winnings
441 IAC 75 (Rules in Process)

Count recurring winnings from gambling (such as winnings from casino gambling) as unearned income in the budget month received. Do not offset the winnings with any amount lost.
(See Nonrecurring Lump Sum for treatment of one-time winnings, such as lottery winnings.)

General Assistance
441 IAC 75 (Rules in Process)

Exempt as income general assistance from county funds if:

- Does not duplicate any basic need under FMAP-related, or
- Is a duplication of an FMAP-related basic need but is made on an emergency basis, not as ongoing supplementation.

Gifts
441 IAC 75 (Rules in Process)

Exempt as income a nonrecurring monetary gift (for Christmas, birthdays, etc.) not to exceed $30 per person per calendar quarter. A calendar quarter is a period of three consecutive months, ending on March 31, June 30, September 30, or December 31.

When a gift from a single source exceeds $30, count the entire amount as unearned income. When monetary gifts from several sources are each $30 or less, but the total of all gifts exceeds $30, count only the amount in excess of $30 as unearned income.

When a gift is given to the entire eligible group, it may be divided among the members of the group in the most advantageous way to the client. When a gift is given to one member of the group, the gift may be divided among the members of the group if the participant claims the gift is intended for the entire group.

Verify gifts over $30 per person per calendar quarter. Allow the $30 exemption for any person whose income must be counted, even if that person is not actually receiving medical assistance (e.g., ineligible parents, and ineligible stepparents).

1. Ms. A receives $50 from her mother in December as a Christmas gift. Since this exceeds $30 from a single source, the entire $50 is considered unearned income to Ms. A.
2. Bobby, an FMAP child, receives $25 in October for his birthday and $25 in December as a Christmas gift. The $25 that Bobby received in October is exempt. Since $25 had already been exempted for Bobby for the quarter ending December 31, only $5 of the gift he received in December is exempt. $20 is considered unearned income to Bobby in December.
3. Ms. C and her three children received a Christmas gift of $100. As the gift was intended for the entire family of four, $25 is considered to be a gift to each person. If no other gifts were received during the quarter, the entire gift is exempt.

Grants Precluded From Use for Current Living Costs
441 IAC 75 (Rules in Process)

Exempt as income and as a resource grants obtained and used under conditions that preclude their use for current living costs.

Home Produce for Personal Consumption
441 IAC 75 (Rules in Process)

Exempt as income and as a resource the value of home-produced garden products, orchards, domestic animals, etc., which are eaten by the household. When home produce is raised for sale or exchange, consider it a business operation and treat it as self-employment income.

Housing Supplements
441 IAC 75 (Rules in Process)

Exempt as income housing supplements received as a result of an urban renewal or low-cost housing project from any governmental agency (federal, state or local).

Housing supplement payments or subsidies may be issued to help meet the costs of both shelter and utilities. Those payments are exempt as income regardless of whether they are paid to a vendor or directly to the client. The most common housing supplement payments are issued by Low Rent Housing or HUD.

Income Tax Refunds
441 IAC 75 (Rules in Process)

Income tax refunds are considered a nonrecurring lump sum, and are exempt as income.

Indian Tribe Judgment Funds
441 IAC 75 (Rules in Process)
CFR 233.20(a)(4)(ii)(n) and (o)

Exempt as income and as a resource Indian Tribe Judgment funds that have been or will be distributed to each member or held in trust for members of any Indian tribe.

Individual Development Accounts
441 IAC 75 (Rules in Process)

Exempt as income and as a resource regular monthly deposits to an Individual Development Account (IDA) when determining FMAP-related Medicaid eligibility.

An IDA is an optional, interest-bearing account much like an IRA (but it is not a pension plan). FIP encourages clients to start IDAs to save for long term goals without the savings affecting eligibility or benefit amount. The client may keep the IDA and continue to contribute to it after FIP eligibility ends.

IDAs are established and managed by DHS-approved organizations. IDAs are opened in financial institutions and are set up in an individual's name. Any Iowan whose family income is below 200% of the federal poverty level and who lives in an area where there is an IDA project can open an IDA.

Withdrawals are allowed for approved purposes only and must be authorized by the operating organization. "Approved purposes" are post-secondary education or job training, starting a small business, buying a home or home improvement, or medical emergencies.

Withdrawals may be in the form of a two-party check (in the name of the vendor and the client) or solely in the vendor's name. Either way, consider the withdrawals as an unavailable resource (not income).

The account holder, another household member (regardless of the person's FIP or Medicaid status), or a source outside the household can make deposits. Deposits can be from earned or unearned income.

Allow a deduction to income only when the deposit is made from income of the particular household member who is the account holder and whose income must be counted. EXCEPTIONS: Do not deduct the deposit from:

- Income that is exempt.
- FIP grant.
- The client's *assigned* child support.

However, allow a deduction from child support received while the application is pending, when an assignment is not yet in effect.

Ask the client to provide verification of the amount and date of the first deposit. Do not require verification of each regular monthly deposit. Accept the client's word that the deposits will be made monthly, unless questionable.

To allow the deduction, the county office must receive verification of the deposit by the end of the month after the month in which the first deposit was made or by the extended filing date, whichever is later.

Accept the client's word with respect to whose income was deposited. If the client's statement appears questionable, obtain further information or verification. If the client fails to provide needed information or verification, do not allow a deduction.

Deduct the deposit from nonexempt earned or unearned income or the net profit from self-employment when projecting income for the months in which the deposit is anticipated to be made. If the client has both nonexempt earned and unearned income, subtract the deposit from the nonexempt unearned income first.

IABC cannot make this deduction. You must manually subtract the deposit **before** you enter the remaining income on BCW2.

Mrs. A, an FMAP recipient, begins depositing $200 per month into her IDA in March. She has $850 projected gross earnings, $50 of projected in-kind income, and $100 projected unearned income in March.

The worker first subtracts $100 of the IDA deposit from the unearned income and then subtracts the remaining $100 from the earnings. Income entered on BCW2 is $750 earnings. (The IDA deposit is not subtracted from the in-kind income, because it is exempt income.)

Allow applicable earned income deductions to the client's nonexempt earnings from employment or net profit from self-employment that remains after subtracting the amount of the deposit.

Apply allowable deductions to any nonexempt unearned income that remains after subtracting the amount of the deposit. See FMAP-Related Deductions and Diversions.

If the client receives a deduction for a deposit in error, redetermine Medicaid eligibility and recoup if ineligible.

1. Mr. and Mrs. A and their children receive Medicaid under FMAP. Mrs. A has an IDA. Mr. A is employed, and Mrs. A has no income. In March, Mr. A begins depositing $200 per month into his wife's IDA. Mrs. A states she also will begin making monthly deposits of $50.

   Mr. A is not allowed a deduction from his earnings, because he is not the account holder. Mrs. A is not allowed a deduction, as she has no income.

2. Ms. B and her son receive Medicaid under FMAP. Ms. B is employed. Her son has an IDA, and he receives social security benefits from a deceased parent. In April, Ms. B begins depositing $100 per month from her earnings plus $20 from her son's social security benefits into her son's IDA.

   The $20 deposits are allowed as a deduction, because they come from income of the account holder. The $100 deposits are not allowed as a deduction, because they come from Ms. B's income and she is not the account holder.

3. Mr. and Mrs. G receive Medicaid under FMAP. Mr. G receives social security disability income and has an IDA. In March, he receives a $5,000 nonrecurring social security lump sum and deposits all of it into his IDA. The entire $5,000 is exempt.

4. Mrs. E and her children receive FIP and FMAP. Mrs. E has an IDA. In March, she receives $110 direct child support from the absent parent. Rather than refunding the support, she deposits the $110 into her IDA.

   A deduction is not allowed for FMAP, since the child support is assigned to DHS while Mrs. E is on FIP. (The same would be true if the absent parent had properly sent the support payment to CSRU but CSRU released the payment to Mrs. E in error.)

   If Mrs. E was receiving only FMAP and not FIP, the child support would not be assigned. She would be allowed a $60 deduction. (The first $50 of child support is exempt.)

5. Mrs. T and her child receive FMAP. Also in the home is Mr. T, a stepparent. He is employed and has an IDA. In April, he begins depositing $300 into his IDA. He is allowed a $300 deduction from his earnings. If Mrs. T were the account holder, Mr. T would not be allowed a deduction.

6. Mr. D, an FMAP recipient, is employed and has an IDA. In April, the children's grandmother begins depositing $100 into Mr. D's IDA. The deposit is exempt as income. Mr. D does not get a deduction for the deposits, because they were not made from his income.

In-Kind Earned Income
441 IAC 75 (Rules in Process)

Exempt earnings in kind as income and as a resource. "In-kind" earnings means:

- The client performs a service and, in exchange, receives something the client would normally have to pay for, and
- The person for whom the service is provided would normally have to pay for the service.

1. Mrs. T works in a restaurant and receives meals as part of her salary. Her paycheck stub lists the value of the meals as $10 per week. Exempt the $10 as earned income in kind.
2. Mr. K receives reduced rent in exchange for managing an apartment building. His apartment would normally rent for $350, but Mr. K pays only $200. Exempt the difference of $150 as earned income in kind.

In-Kind Unearned Income
441 IAC 75 (Rules in Process)

Exempt unearned income in kind as income and as a resource. Consider monies paid to a third party on the client's behalf as unearned income in kind.

1. Ms. A's mother pays Ms. A's rent directly to Ms. A's landlord. This is unearned income in-kind and is not considered in determining eligibility for Ms. A.
2. Ms. B's mother, who does not live with Ms. B, gives Ms. B $200 to use to pay her rent. Ms. B pays this money to her landlord. However, since this money passed through Ms. B's hands, count it as a gift when determining her eligibility.

Interest Income
441 IAC 75 (Rules in Process)

Exempt as income interest and dividend income such as:

- Interest from savings.
- Interest on payments from property sold on contract.
- Interest payments from conservatorships and trusts.

1. Ms. A has a savings account that pays $5 interest per month. This interest is exempt as income.
2. Ms. B receives $400 each month from property sold on contract. Of the payment, $250 is interest income. The remaining $150 is payment on the principal. Both the principal and the interest part of the payment are exempt as income (but not as a resource).

   NOTE: The contract itself must still be evaluated for its resource value. See Determining Net Market Value of a Countable Resource for more information.

Exempt any amount that is **identifiable** as interest or dividend income. If the interest portion is not identified separately, but the client indicates that the payment includes interest, ask the client to provide necessary verification to exempt the interest portion. Unless the interest portion is identified, count the entire payment as income.

Job Corps
441 IAC 75 (Rules in Process)

Job Corps participants may work toward a GED or high school diploma or be involved in postsecondary education or vocational pursuits.

Participants receive room and board, and a monthly salary. Part of the salary is received when it is earned, and part of it withheld until the participant completes or otherwise leaves the program after at least a six-month stay. In addition, participants may receive a bonus based on their performance in the program.

Exempt the value of the room and board. Count the ongoing part of the salary as earned income and project forward if it is indicative of future income.

Count both the lump-sum salary payout and the performance bonus as earned income in the month in which the payments are received. (See Recurring Lump Sum for details.)

Job Corps participants also receive a clothing allowance. However, Job Corps makes payment directly to the stores. Thus, exempt the clothing allowance as a vendor payment.

NOTE: Job Corps participants are considered full-time students. However, participants may be in high school or post-secondary education. Accept the client's word as to which it is.

If the client's statement is questionable, require the client to obtain verification from Job Corps. Exempt only the earnings of participants 19 or younger who are in high school education. See Student Earnings for more details.

Jury Duty Pay
441 IAC 75 (Rules in Process)

Count compensation for jury duty as earned income.

Lien Recovery Payments
441 IAC 75 (Rules in Process)

The Iowa Medicaid Enterprise (IME) will notify you on form 470-4309, *Notice of Lien Settlement Payment to Medicaid Member*, when a member receives a lien recovery payment. The IME Revenue Collections Unit has verified the information reported with the third party insurer.

Treat the lien recovery funds received according to the terms of the settlement as reported on form 470-4309. Obtain any additional information needed from the sources listed on the form.

Loans
441 IAC 75 (Rules in Process)

Exempt as income bona fide loans from any source, including undergraduate and graduate student loans. Check that the loan is from an institution or person engaged in the business of making loans and that there is a written agreement to repay the money within a specified time.

When the loan is from a person not normally engaged in the business of making loans, use at least one of the following criteria to establish that the loan is legitimate or bona fide:

- There is a borrower's acknowledgment of obligation to repay (with or without interest).
- The borrower expresses intent to repay the loan when funds become available.
- There is a timetable and a plan for repaying the loan.

For money received to be considered a bona fide loan, there must be an agreement between the person making the loan and the borrower that the money is a loan. This agreement may be oral or in writing, but there must be an intent to repay the money.

Low Income Home Energy Assistance Payments (LIHEAP)
441 IAC 75 (Rules in Process)

Exempt as income and as a resource energy assistance benefits paid to eligible households under the Low-Income Home Energy Assistance Act of 1981. This program is administered through the Department of Human Rights, Division of Community Action Agencies. It covers costs such as:

- Insulation
- Home energy assistance
- Emergency lodging because utilities have been shut off
- Winterizing old or substandard dwellings (neither the cost of the materials nor the cost of labor is counted as income)

Medical Expense Settlement
441 IAC 75 (Rules in Process)

Exempt as income and as a resource settlements for payment of medical expenses. Some insurance settlements may also include amounts for the repair or replacement of a resource or for pain and suffering.

When a specific amount for a pain and suffering settlement is not designated, only the amount of the settlement actually spent for medical expenses or repair or replacement of a resource is exempt as income. See also Nonrecurring Lump Sum.

When a specific amount is identified for the replacement of a resource, also exempt that portion of the settlement, whether or not it is actually used to replace the resource.

Mortgages
441 IAC 75 (Rules in Process)

Exempt as income mortgage or contract payments. The part of any payment received that represents principal is a resource upon receipt. The interest portion of the payment is a resource the month following the month of receipt. For more information, see:

- Property Producing Income Consistent with Fair Market Value
- Property Sold Under Installment Contract, and
- Determining Net Market Value of a Countable Resource

Preparation for Adult Living (PAL) Stipend
441 IAC 75 (Rules in Process)

Exempt as income payments from the preparation for adult living (PAL) program. PAL provides additional financial support to youth who:

- Are no longer eligible for voluntary foster care placement;
- Have left state-paid foster care on or after their eighteenth birthday and have been in foster care for at least 6 of the previous 12 months;
- Attend school, job training, or work full-time at least 30 hours per week;
- Live in an approved living arrangement, other than the parental home; and
- Participate in aftercare services.

PROMISE JOBS Payments
441 IAC 75(Rules in Process)

Exempt as income payments from the PROMISE JOBS program for child care or transportation expenses that are incurred as a result of participating in PROMISE JOBS.

However, PROMISE JOBS payments paid to a Medicaid recipient who provides child-care services for a PROMISE JOBS participant are considered self-employment earned income to the child care provider. See the *PROMISE JOBS Provider Manual* for a description of the payments made by this program.

Property Sold on Contract
441 IAC 75 (Rules in Process)

See Mortgages.

Refunds from Rent or Utility Deposits
441 IAC 75 (Rules in Process)

Exempt as income refunds of security deposits on rental property or utilities.

Reimbursements
441 IAC 75 (Rules in Process)

- **Job-Related:** Exempt as income reimbursements from the employer for job-related expenses, including travel expenses, food, and uniform allowances.
- **Third Party:** Exempt as income third-party reimbursements when the payment is to pay or repay the client for an expense that was billed to the client, but owed by the third party.

  The payments are exempt whether the third party is living in the home or out of the home. Examples include reimbursement for long distance calls made by a friend using the client's phone, and payments on utilities by a person in a shared living arrangement.

  Exempt as income payments received from other public and private assistance programs when the payments represent reimbursement for expenses incurred for participating in these programs. Reimbursable expenses may include rent reimbursement, travel, child care, meals, and lodging.

  Verify the purpose of the program with the source of the payments before applying the exemption. Document your action in the case record.

Representative Payee Income
441 IAC 75 (Rules in Process)

Exempt any income restricted by law or regulation that is paid to a representative payee living outside the home (other than a parent who is the applicant or recipient), unless the representative payee actually makes the income available to the client.

Social Security and other federal benefits are sometimes required by law or regulation to be paid to a representative payee (for example, when the beneficiary is a minor).

The representative payee is to use the funds in the best interest of the beneficiary. The payee may decide to save the money for future use or may make only a part of the funds available for the current needs of the eligible group.

When such income is paid to a representative payee who lives outside the home, consider only the amount actually made available to the applicant or recipient. Obtain a signed statement from both parties to verify the amount of income the payee makes available.

When the representative payee is a parent, count the total income, even if the parent is temporarily absent from the home. If the representative payee is living with the FMAP-related Medicaid household, count the total income when determining eligibility.

If the source of the income is child support, apply the $50 support exemption.

1. Ms. A, who is 15 and lives with her aunt, applies for FMAP for herself and a baby. The aunt receives a $250 monthly Social Security payment for Ms. A. She keeps $150 each month in an emergency account in the aunt's name and gives Ms. A $100.

   Because Ms. A is living with her representative payee, consider the total $250 Social Security per month as available to Ms. A.

2. Ms. B, who is 17 and lives alone, applies for FMAP for herself and a baby. Ms. B's grandmother receives $200 a month Social Security for Ms. B. The grandmother keeps $100 each month in an account for Ms. B's college education and gives Ms. B $100. This $100 is countable income to Ms. B.

3. Ms. C is 18 years old. She and her child live with her self-supporting mother, who is the payee for child support for Ms. C. Ms. C's mother receives $200 child support for Ms. C. Only $150 ($200 - $50) is counted as income to Ms. C. (The same would hold true if Ms. C were under age 18.)

Retirement Benefits
441 IAC 75 (Rules in Process)

Treat retirement payments received on a monthly or more frequent basis as unearned income to determine eligibility. See 8-C, *Benefits From Other Sources*, for information on client responsibility to apply for and accept benefits.

Medicare premiums are withheld from Black Lung and Railroad Retirement benefits. However, Medicare premiums are not taken out of civil service pensions. These benefits may be further reduced due to recovery of an overpayment. Count only the actual income received (plus the Medicare premium, if applicable).

When the client receives an early lump-sum payment from a retirement fund, determine which portion of the payment represents the client's contribution plus accumulated interest, and which portion represents the employer's contribution.

Consider the employer's portion as nonexempt nonrecurring lump-sum income. See Nonrecurring Lump Sum.

When a client who is under age 55 leaves public employment covered by IPERS, the *employer's* contribution to the IPERS fund reverts to the employer when the employee requests an early withdrawal of the benefits.

When a client who is age 55 or over leaves public employment covered by IPERS and has 4 years or more of service, the person **must** apply for early retirement to be eligible for FMAP (unless the funds have been withdrawn).

Retroactive Corrective Payments
441 IAC 75 (Rules in Process)

Exempt as income retroactive corrective FIP payments.

Retroactive SSI Payments
441 IAC 75 (Rules in Process)

A retroactive SSI payment is considered a nonrecurring lump sum. It is exempt as income and as a resource, whether or not the client is an SSI recipient when the lump sum is received.

Severance Pay
441 IAC 75 (Rules in Process)

Count severance pay as a non-exempt unearned lump sum payment. Depending on how it is paid out, it could be a recurring or non-recurring lump sum payment.

Sick Pay
441 IAC 75 (Rules in Process)

Count sick pay as earned income if the person gets it while employed. See Recurring Lump Sum for treatment of unused sick leave payout after employment has ended.

When coworkers donate their sick leave time, count the payment the same as if it was the person's own sick pay when determining eligibility of the person to whom the sick pay was donated.

Social Security Income
441 IAC 75 (Rules in Process)

Count social security benefits as unearned income when determining eligibility.

Consider social security benefit amounts reported on the Bendex as verified. (You must enter the correct social security claim number into the system to get a Bendex report.)

When a social security recipient is enrolled in Medicare Part B, the premium is deducted from the person's entitlement. Use the gross amount of the entitlement before a Medicare premium is withheld.

If the Department pays the Medicare premium ("buys in"), the recipient receives the full social security entitlement and a refund for the months the participant paid the premium while included in the FMAP eligible group. Do not count the refund as income.

> Mr. Z's Social Security payment decreased when he enrolled in Medicare, Part B. However, the amount before the decrease is used to determine Medicaid eligibility while the buy-in procedure is in process.
>
> When the buy-in takes place, Mr. Z's Social Security check increases, and he receives a refund for the number of months he was in the eligible group and paid his own premium. The refund is not considered as income, since the amount before the decrease was used to determine Medicaid eligibility during the buy-in process.

If the Social Security Administration is recouping for a prior overpayment, count only the amount the client actually receives (plus the Medicare premium, if applicable).

Amounts may be deducted from social security payments for a child support arrearage. The gross and net social security payment amounts on IEVS reports may not reflect the correct social security payments in these cases. Count the gross social security income and allow a deduction, if appropriate.

See Diversion for People Not in the Home and 14-G, *BENDEX* for more information.

Social Security Benefits Extended for Education
441 IAC 75 (Rules in Process)

A person aged 18 can receive extended Social Security benefits based on disability or death of a parent if attending high school full time.

The benefits stop at the end of the fourth month after the month the person turns 19 or completes high school, whichever occurs first. If the person's birthday falls on the first day of the month, the person is considered to have reached age 19 in the previous month.

When a child in the eligible group receives extended Social Security benefits, consider the entire amount of the benefits as unearned income available to meet the needs of the eligible group.

When the person aged 19 or younger receiving the extended Social Security benefits is also a parent, the extended Social Security amount is exempt as income.

> 1. Bob is an 18-year-old child receiving FMAP. He receives $95 a month in extended social security benefits while in high school. Because he is a child, the $95 is counted against the needs of the entire eligible group.

2. Susan, an 18-year-old, has a child and is receiving FMAP as a parent. She is receiving $150 a month in extended Social Security benefits while she attends high school. The entire $150 is exempt.
3. Mary, an FMAP parent with two children, receives $200 per month in extended social security benefits while attending college. The entire $200 is exempt.

Strike Benefits or Picket Pay
441 IAC 75 (Rules in Process)

Count strike benefits as unearned income.

If a union on strike considers picket pay to be payment for work performed (such as walking the picket line), count the income as earned. If the union does not consider the picket pay to be payment for work performed, it is a strike benefit and is unearned.

Student Earnings
441 IAC 75 (Rules in Process)

Exempt earnings of a person aged 19 or younger who is a full-time student in high school or in an equivalent program. **Note:** A person who has completed high school and is a student in postsecondary education is not eligible for this exemption.

Exempt the earnings when determining eligibility under all three income tests. Exempt the earnings when the student is a child or a parent, regardless of the student's living arrangement. See Minor Parents and Minor Pregnant Women for more information.

Employment does not alter a student's status. The person may be employed during school vacation periods. If the person qualified as a full-time student in the term preceding the vacation period, exempt the earnings. This exemption does not apply if the student has completed the program and will not return to school.

When a full-time student completes high school or an equivalent curriculum, drops out of school, or begins attending less than full time, consider the person a student for that entire month. Exempt the earnings through the month in which the person completes high school, drops out, or decreases attendance.

Likewise, when a person under age 20 who has earnings **becomes** a full-time student, exempt the earnings beginning with the first month after the person becomes a full-time student.

Apply the student exemption for the entire month of the person's twentieth birthday unless it falls on the first day of the month.

The particular school defines "full-time" student status. See School Attendance, for more information.

Subsidized Guardianship Payments
441 IAC 75 (Rules in Process)

Exempt payments made under a subsidized guardianship program of Iowa or another state.

Taxes
441 IAC 75 (Rules in Process)

Do not count taxes (FICA, state, and federal income taxes) that are actually withheld from unearned income. Count the net amount of income after the taxes were withheld. Do not count taxes when determining eligibility.

Some types of unearned income may be taxable but do not have taxes withheld. Do not allow a deduction for this type of tax.

Tip Income
441 IAC 75 (Rules in Process)

Count the amount of tips an applicant or recipient anticipates receiving.

Any reasonable form of verification is acceptable. Examples of documents verifying tip income include:

- Pay stubs
- Employee's statement
- Employer's statement

Verify tip income at the time of the annual review, even if the anticipated amount has not changed.

Trust Payments
441 IAC 75 (Rules in Process)

Count payments from trusts or conservatorships that are available for basic or special needs as unearned income in the month received.

Unemployment Insurance Benefits
441 IAC 75 (Rules in Process)

Count unemployment insurance benefits as unearned income as noted below. If unemployment benefits are reduced due to recoupment, count the actual amount the person receives.

- Unemployment Insurance Benefits (UIB) or UIB extension: count for eligibility.
- Trade Readjustment Act (TRA): count for eligibility.
- Training Extension Benefit (TEB): exempt as financial aid.
- $25 stimulus: exempt as income.

Vacation Pay 441 IAC 75 (Rules in Process)	Count pay for vacation taken while the person is employed as earned income in the month received. See Recurring Lump Sum for information on vacation payout in lieu of taking vacation or payout of unused vacation after employment has ended.
Vendor Payments 441 IAC 75 (Rules in Process)	Exempt as income and as a resource vendor payments made to a third party on the client's behalf.
Veterans' Benefits 441 IAC 75 (Rules in Process)	Count veteran's benefits as unearned income. If a VA benefit is reduced due to recoupment, count only the actual amount the client receives. However, exempt as income payments made under the Aid and Attendance program or the housebound allowance, or the amount attributable to unusual medical expenses.
Veterans' Benefits for Education or Training 441 IAC 75 (Rules in Process)	A person eligible for financial assistance under the GI Bill may also receive additional assistance for each dependent. Exempt the amount designated for the veteran's education. Count the amount for the dependents who are included in the FMAP-related Medicaid eligible group as nonexempt, unearned income to determine eligibility.
VISTA Payments 441 IAC 75 (Rules in Process)	Exempt Title I VISTA volunteer payments, as income and as a resource as long as the Director of ACTION determines the value of all such payments is less than the federal or state minimum wage when dividing payment by the hours of service. To date, the Director of ACTION has determined no VISTA payments to equal or exceed the minimum wage. Central office will notify county offices when these payments are no longer exempt. VISTA payments are considered as unearned income. This is because recipients are considered volunteers rather than employees. When VISTA payments exceed the minimum wage limit, count the entire amount.
Vocational Rehabilitation Training Allowance 441 IAC 75 (Rules in Process)	Exempt as income a training allowance issued by the Division of Vocational Rehabilitation Services of the Department of Education. The vocational rehabilitation counselor establishes an allowance amount that meets the client's needs for items relating to the rehabilitation program, such as tuition, books, transportation, lodging away from home, and similar items.

Wages
441 IAC 75 (Rules in Process)

Count all wages and salaries as earned income. Consider earnings received on the date the employer distributes payroll.

When the employer distributes payroll to the employees on a date other than the regular payday, consider the date distributed as the date of receipt. For example, regular payday is on January 1. The employer distributes payroll on December 31 because January 1 is a holiday. Consider December 31 as receipt date.

If the employer merely grants an exception for a particular employee to pick up the paycheck early, consider the regular payday as the date of receipt.

When an employer **holds** wages at the employee's request, count the wages as income in the month the wages would normally be paid by the employer. However, when the employer holds wages as a general practice, count the wages as income in the month the household actually receives them.

Count wage **advances** as income only if the wage advance is anticipated to continue and is representative of future income.

Welfare Reform Evaluation Payments
441 IAC 75 (Rules in Process)

Exempt as income any payments made to FMAP-related Medicaid households for participating in the Iowa welfare reform evaluation conducted by Mathematica Policy Research, Inc. Randomly selected people who agree to participate may be interviewed, participate in focus groups and complete surveys.

Welfare to Work Payments
441 IAC 75 (Rules in Process)

Welfare-to-Work are federally funded grants made available to states and local communities by the U.S. Department of Labor.

The purpose of the grants is to create additional job opportunities for the hardest-to-employ welfare recipients, such as long-term welfare recipients, school drop-outs, teen parents, people with a poor work history, or those who are within 12 months of reaching the state's time limit for assistance. (In Iowa, this is the 60-month limit of FIP assistance.)

The grants can be used for a number of activities, such as community service and work experience programs, job creation through wage subsidies, on-the-job training, contracts, and vouchers for services for job readiness, placement, job retention, and other services.

As in any other situation, to determine treatment of Welfare-to-Work payments that FMAP recipients who are also FIP participants may receive, first find out the source of the payment and what the payment represents.

- For example, exempt the payment if it:
- Represents a reimbursement (for child care, transportation, meals and other miscellaneous expenses the client has).
- Is provided in the form of a gift certificate or gift card.

If the payment does not represent a reimbursement or is not in the form of a gift certificate, count the payment as income unless the payment is exempt under another program policy. (For example, earnings of a person under age 20 and in high school or equivalent program full-time are exempt.)

Whether to consider the payment as earned or unearned income depends on program policy and how the payment is described **by the entity issuing it**.

FMAP-related Medicaid recipients who are also FIP participants may be in the Welfare-to-Work experience program and be paid or reimbursed through the U.S. Department of Labor. In that case, consider the payments as earned income (unless the student exemption above applies).

Whether or not the payments are exempt, FMAP-related Medicaid recipients are required to report the payments.

Work Force Investment Project Incentive Allowance Payments
441 IAC 75 (Rules in Process)

Exempt as income incentive allowance payments received from the Work Force Investment Project, a state-funded program administered by the Department of Economic Development.

The purpose of the program is to provide support services to pregnant teens and teen parents. It serves people who are traditionally underrepresented in the labor force, and people who usually have great difficulty entering the labor force. Recipients attend high school, GED classes, workshops, and training at program work experience sites.

When recipients successfully achieve the objectives of their training program, they receive an incentive allowance. For example, a recipient can receive an incentive allowance for perfect attendance at school and program workshops during a 15-day period.

Worker's Compensation
441 IAC 75 (Rules in Process)

Count workers compensation payments as unearned income.

See Nonexempt Lump Sums for information on retroactive payments.

Child Support for Composite FIP and FMAP Households

Legal reference: 441 IAC 41.27(1)"h", 441 IAC 41.27(6)"o", and 441 IAC 75 (Rules in Process)

"Child support" means money that a legally responsible person pays for the support of a child. "Legally responsible person" means either:

- A legal parent of the child whether or not ordered to pay support, or
- Any other person who is ordered to pay support for the child.

A person may pay child support voluntarily or may be obligated to pay support under an order established through a judicial process or through an administrative process by the Child Support Recovery Unit. The monthly amount payable according to the terms of either an administrative order or a court order is usually referred to as the "monthly obligation."

When an absent parent makes payments to a third party for a family's current basic or special needs, the payments are exempt as unearned income in kind. The payments are exempt even when made in compliance with a court order for support. See In-Kind Earned Income. Treat payments made to the eligible group by friends or other relatives as a gift and not as child support. See Gifts in this chapter.

FMAP-related Medicaid recipients who also are FIP participants have assigned to the Department their rights to support payments made for members of the eligible group. The assignment remains effective for the entire period for which FIP assistance is paid. See 8-C, *Assignment of Medical Support*.

Support that is assigned to the Department is collected by the Collection Services Center (CSC). Contact the Child Support Recovery Unit if you have questions about the amount of support ordered.

Consider support assigned as of the date the local office successfully enters the FIP eligibility into the ABC system.

The following sections give more information on:

- The $50 exemption for cash support income
- Treatment of support for applicants
- Treatment of support for recipients
- Support for the first month of ineligibility
- Support for an ineligible or excluded child

$50 Exemption

Legal reference: 441 IAC 75 (Rules in Process)

Exempt as income and as a resource the first $50 of a current monthly support obligation or a voluntary support payment paid by a legally responsible person for a child in the eligible group. Apply the exemption only when an applicant or recipient anticipates **receiving and keeping** cash support.

The maximum exempt amount is either $50 or the amount paid or the monthly obligation, whichever is less, regardless of how many absent parents pay support.

Ms. Z and her three children are FMAP recipients. Each child has a different father, and each father has been paying $100 per month court-ordered support for his child. Ms. Z anticipates the support to continue. Ms. Z is allowed only one $50 exemption.

If the anticipated direct support payments represent a delinquent support obligation, the $50 exemption does not apply. When a responsible person is anticipated to pay for the current month plus past months all in the same month, allow an exemption up to $50 only from the support applied to the current month.

1. $200 is the monthly obligation
   $100 is anticipated to be paid to the client for the current month
   $50 is exempt
2. $40 is the monthly obligation
   $50 is anticipated to be paid to the client, including $10 for delinquent support
   $40 is exempt
3. $200 is the monthly obligation
   $45 is anticipated to be paid to the client for the current month
   $45 is exempt

When a legally responsible person is anticipated to be pay support for dependents who are in different FMAP-related Medicaid eligible groups, each eligible group is entitled to an exemption up to $50 of the monthly support payments the group receives and keeps.

1. The monthly obligation for two children is $200. One child lives with the mother and the other child lives with the grandmother. Both the mother and the grandmother apply for Medicaid for the children on separate cases. The father is anticipated to pay $100 support each to the mother and the grandmother. Each eligible group is entitled to a $50 exemption.
2. Same as Example 1, except the father is ordered to pay $50 per month support for both children. It is anticipated that he will pay $25 support each to the mother and the grandmother. Each eligible group is entitled to a $25 exemption.

Treatment of Support for Applicants

Legal reference: 441 IAC 75 (Rules in Process)

When determining Medicaid eligibility for applicants, count as unearned income any nonexempt cash support payment for a member of the eligible group that is made or anticipated to be made while the application is pending.

Count the entire nonexempt support payment received or anticipated to be received up through the date of the eligibility decision, regardless whether the support payment:

- Is for current or past support or a combination of the two, or
- Exceeds the monthly obligation.

Apply the $50 exemption to the month in which the applicant receives or is anticipated to receive the support. (See Establishing the Date of Receipt for details.) Manually deduct the exempt amount before entering the countable support on the system.

> Mr. G files an FMAP-related Medicaid application on September 1. On August 28, CSC received a $100 child support payment, which was mailed to Mr. G. He receives the payment on September 3.
>
> Although the $100 represents an August payment, $50 is exempted for September because this is the month in which Mr. G received the payment. The remaining $50 is counted as income in determining September FMAP-related eligibility.

Do not count as income, nor enter onto the system, support expected to be received after the date of decision for a composite FMAP/FIP household. This is because support is assigned to the Department when the person is approved. Any cash support payment the **recipient** receives after the date of decision must be refunded to CSC.

> Mrs. D applies for FIP and FMAP-related Medicaid on February 2. Mr. D is ordered to pay $50 support per week, which Mrs. D receives every Friday. It is anticipated that Mr. D will pay the total $200 in February.
>
> On February 23, the IM worker approves the application with an effective date of February 1 for FMAP-related Medicaid and February 9 for FIP. Up to the date of decision, Mrs. D had received $50 support payments on February 6, 13, and 20. Therefore, the worker enters $100 income ($150 received - $50 exemption) for eligibility for February.
>
> Ms. D is required to refund the entire amount of any support she receives after February 23. Any support received after February 23 will not be entered onto the system for eligibility, because support is assigned as of February 23.

If the amount received up through the date of decision includes ordered support for **prior** months, treat the retroactive amount as a nonrecurring lump sum. To determine the retroactive portion, deduct the amount of the current support obligation from the total support payment the applicant received.

The $50 exemption applies only to **current** support. If there is no court order, consider the **entire** support payment the applicant receives as **current** support, subject to the $50 exemption.

If there is a court order, consider only up to the amount of the obligation as current support, subject to the $50 exemption. Consider any amount that exceeds the ordered amount as **past** support and treat it as a nonrecurring lump sum. Do **not** apply the $50 exemption to that portion.

> 1. An FMAP-related Medicaid applicant gets a $350 support payment. There is no court order. Thus, the entire payment is considered as voluntary support. The first $50 is exempt. The remaining $300 is counted as unearned income in the month the applicant receives the payment.
> 2. An FMAP-related Medicaid applicant gets a $650 support payment. There is a court order for $200 monthly support. Therefore, $200 of the $650 payment is considered as **current** support, and the $50 exemption is applied to that portion. The remaining $450 is considered as past support and treated as a nonrecurring lump sum.

If support the applicant **receives or is anticipated to receive** represents future court-ordered support, prorate the payment over those future months the payment is intended to cover. Use the nonexempt portion to determine FMAP-related Medicaid eligibility for each month. Apply the $50 exemption to each future month when the future month arrives.

Establishing the Date of Receipt

When support payments are made to CSC, which, in turn, forwards the payments to the applicant, check the dates recorded under the DISTR DATE column on the ICAR PAYHIST screen.

Consider the payment as income in the month in which the **applicant** receives the payment. The date under DISTR DATE reflects the date CSC received and processed the payment (and is **not** the date the applicant received it).

The payment is mailed two working days after the DISTR DATE on ICAR. Allow two additional days for mailing, excluding days when there is no mail delivery, such as holidays or Sundays. In other words, add a minimum of four days to the DISTR DATE on ICAR to determine when the applicant may have received the payment.

If the applicant disputes your calculated date, accept the applicant's statement as to the date of receipt, if that date appears plausible.

1. A $400 payment shows on PAYHIST with a 5/28 DISTR DATE. Unless the applicant states otherwise, the payment is considered to have been received in June. The payment is considered as June income to the applicant regardless of what month CSC applies the payment.
2. Same as Example 1, except that the DISTR DATE shows 5/20. The payment is considered to have been received in May, unless the applicant states otherwise. The payment is considered as May income to the applicant, regardless of what month CSC applies the payment.

When the applicant receives support payments from another source, e.g., directly from the absent parent or from a clerk of court, ask the applicant for verification of receipt dates and amounts.

If payments were mailed to the applicant, allow at least two mailing days to arrive at a possible receipt date. If the applicant disputes your calculated receipt date, accept the applicant's statement, if plausible.

Treatment of Support for Recipients

Legal reference: 441 IAC 75 (Rules in Process)

Exempt as income assigned support that is collected and retained by the Department. Do not use any part of the support amount collected and kept by the Department when determining FMAP-related Medicaid eligibility for recipients.

1. Mrs. K. is employed and has $400 projected monthly countable earnings. She receives FIP and FMAP-related Medicaid for herself and her two children. In March, the children's father starts to pay $150 per month child support to CSC. The entire $150 retained by CSC is exempt and is not used to determine Mrs. K's FMAP-related Medicaid eligibility.
2. Mr. T receives FIP and FMAP-related Medicaid for himself and one child. The child's mother pays $200 child support per month to CSC. Mr. T gets a new job, and his projected monthly countable income is $350. The $200 support amount retained by CSC is exempt and is not used to determine Mr. T's FMAP-related Medicaid eligibility.

See Direct Support Not Refunded by the Client for instructions when a recipient receives direct support and fails to refund it.

At the point that the collected support exceeds the entire amount of FIP assistance paid out to the family, CSC will release the overage to the family the following month. If the absent parent has been paying support to CSC regularly, it can be expected that support collections will continue to exceed the total FIP paid out. Since overage payments to the recipient are expected to continue, use the overage as projected income.

However, if the absent parent has a history of paying support only sporadically, and overage payments are not likely to continue, do not use the overage as income in the month received. Do not use the overage as projected income.

Ms. B has received $1,500 FIP benefits over the past several months. The absent parent does not pay support regularly. When CSC receives the February child support payment from the absent parent, the total support collected comes to $1,600. In March, CSC sends the $100 overage to Ms. B. The $100 is not used to complete a new projection of income, since it represents a one-time payment.

Consider any **countable** support payment as income in the month in which the recipient receives or anticipates receiving the payment. See Establishing the Date of Receipt for information on how to determine when the recipient may have received a support payment from CSC (or from another source).

Other circumstances that can result in CSC releasing child support to a FMAP/FIP recipient include:

- Support is collected for a child who is not in the eligible group.
- Release of the payment could not be prevented due to the timing of the FMAP/FIP approval or reinstatement.

To determine how to treat the payment, it is important to know the reason CSC released the payment. If the payment represents support for an ineligible child, consider the policies under Support for an Ineligible or Voluntarily Excluded Child. Confer with the child support recovery officer if you have questions on the reason CSC released the support to the recipient.

Direct Support Not Refunded by the Client

Legal reference: 441 IAC 75 (Rules in Process)

FMAP/FIP recipients must report and refund to the Department **the entire amount of** direct support payments received from the absent parent or any other source. If the client returns the support payment to you, forward the payment to CSC.

Use actual countable support payments received in a past month for which eligibility is being determined. Use support payments anticipated to be received in future months to determine eligibility for future months.

When support payments stop before the eligibility decision on an application, use the support payments received (or anticipated to be received) in each month to determine FMAP-related Medicaid eligibility for the month of decision and any prior months.

Manually deduct the exempt amount and count as unearned income any remaining direct support that the client refuses or fails to refund.

If the direct support can be anticipated to continue, use the nonexempt portion of the direct support payment as unearned income in the month received to determine eligibility.

When determining whether direct support can be anticipated to continue, consider the past payment history, the statement of the recipient, and when available, the statement of the absent parent. However, do not **require** a statement from the absent parent.

> An FMAP/FIP recipient receives $100 direct support that is released by CSC in error. The recipient fails to refund the support. The IM worker does not use the direct support for FMAP-related Medicaid, since it cannot be anticipated to continue.

Support for the First Month of Ineligibility

Legal reference: 441 IAC 75 (Rules in Process)

When the support assignment is not terminated at the same time as the family's FIP eligibility is canceled, support payments may be made to CSC in error. CSC must refund these payments to the client.

Exempt as income for FMAP-related Medicaid eligibility support refunded for the first month of FIP ineligibility, if the family remains off FIP for the entire month. The refunds are exempt as income regardless of when the family receives the support, as long as the family remains off FIP assistance for the month.

1. Ms. A's FIP assistance is canceled effective July 1. CSC receives support payments of $15 on July 10 and $25 on July 25. Ms. A reapplies for FIP on August 5. She receives the $40 July support refund on August 10. This $40 is exempt as income.
2. Ms. B is canceled from FMAP and FIP effective July 1. CSC continues to receive support payments in July ($60) and August ($120). Ms. B reapplies for FMAP and FIP September 7. She receives an abstract from CSC for $180 on September 12. The $60 portion for July is exempt as income, but the $120 portion for August is countable income.

This exemption applies only to cases that are canceled from FIP. It does not apply to families still considered FIP participants who do not get a grant due to rounding down or due to the restriction on payments of less than $10.

This exemption does not apply when the family reapplies and is found eligible for the first month following the termination.

Support for an Ineligible or Voluntarily Excluded Child

Legal reference: 441 IAC 75 (Rules in Process)

For FMAP-related Medicaid purposes, child support is considered income of the child. The income and resources of an ineligible or voluntarily excluded child are exempt for FMAP-related Medicaid.

When an FMAP-related parent receives child support for a child who is not in the FMAP-related eligible group, consider the support payment as follows:

- If the ineligible or voluntarily excluded child **lives in the home** with the eligible group, do not count the support payment as income or as a resource toward the eligible group, even if the FMAP-related parent has access to the payment. As long as the FMAP-related parent provides care and support for the ineligible or voluntarily excluded child, it is reasonable for the parent to use the support payment to do so.
- If the child is **not living in the home** with the eligible group and the FMAP-related parent uses the support for the needs of the eligible group, then count the support as unearned income to the eligible group. Do not allow the $50 support exemption, because the exemption applies only to current support paid **for a member of the eligible group**.

If the FMAP-related parent claims to make the support payment available to the intended person, obtain written verification from both the FMAP-related parent and the intended person, or a responsible person with whom the intended person lives.

FMAP-Related Lump-Sum Income

Discussion of lump sums is divided into:

- Recurring lump sums, which may be earned or unearned income
- Nonrecurring (one-time) lump sums, which are always unearned income, in the nature of a windfall or a retroactive payment of benefits.

Recurring Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Examples of **recurring** lump-sum income are:

- Vacation pay instead of taking vacation, or payout for unused vacation when employment ends.
- Sales commission.
- A bonus.
- Profit sharing based on the employer's profits, when received while the client is employed with the company. NOTE: Profit sharing received after termination of employment is considered a nonexempt, nonrecurring lump sum.
- Past due wages (if the wages cover more than one month).

Consider recurring lump-sum income if it is received or is anticipated to be received at any of the following times:

- Any time during the receipt of assistance.
- In the month of application or any subsequent month, before the date of decision.
- Before the month of application when the income is anticipated to recur. (If it is not anticipated to recur, do not consider any lump sum received before the month of application.)

Except for self-employment income, prorate recurring lump sum earned and unearned income over the number of months for which the income is received. If the lump sum is earned income, apply applicable disregards, deductions, and diversions.

Consider the prorated amount when projecting future income for both applicants and recipients. Use the prorated amount to determine eligibility for the same number of months as the recurring lump sum covers.

For applicants, the month in which the lump sum was received is the first month for which a prorated amount will count.

For ongoing cases, if the lump sum is reported timely, the first month in which a prorated amount will be used is the first month following a ten-day notice. If the lump sum is not reported timely, redetermine eligibility using the prorated amount beginning with the month following the month of receipt.

1. Mr. and Mrs. G apply for Medicaid for their children on January 30. The worker is processing the application March 3. Mr. G reports and verifies he received a quarterly bonus of $300 on January 28. Since it is expected to continue, the recurring lump sum is prorated over the months it is intended to cover. $100 is counted when projecting future income, beginning in January.

2. Same as Example 1, except that Mr. G's employer has discontinued the bonuses and the one received in January is the last one. The bonus is prorated and counted when projecting income for the months of January, February, and March. No recurring lump-sum income is counted any month following March.

3. An active case consists of Mrs. B and her five children. Mrs. B receives sales commission income in the amount of $300 every quarter. The worker applies $100 to the needs of the family on a monthly basis.

4. Same as Example 3, except Mrs. B applies for FMAP on October 3. The worker is determining eligibility October 28. Mrs. B received her $300 quarterly sales commissions in September, the month before the month of application. If commissions are anticipated to continue, the worker counts $100 in October and subsequent months.

5. Ms. A is a current recipient. At her annual review in December, Ms. A reports that she will begin receiving sales commissions in a lump sum every four months, in addition to her base pay. Ms. A's employer estimates the lump-sum amounts to be approximately $240. She will receive the first commission check in January.

   In projecting Ms. A's future income, $60 per month ($240 ÷ 4 months) is counted as earned income in addition to her base pay, beginning with the month of January.

6. Mr. Z reports on June 18 that he received two paychecks June 10. One paycheck was his regular weekly earnings and the other was two weeks of vacation pay in lieu of taking annual vacation. The vacation pay is lump-sum income.

   The total lump sum is not added with other June earnings, but is prorated over the 12 months it represents and is added to the projected income used to determine eligibility. If timely notice can be given, the prorated amount will be used beginning in July.

7. Mrs. T, an applicant, receives her annual profit-sharing bonus on October 1. She applies for Medicaid on October 12. The date of decision is November 2, with an October 1 effective date. The bonus is prorated over 12 months and included in the income projection.

8. Ms. Q receives Medicaid. On July 16, she begins receiving quarterly bonuses of $60 in addition to her regular earnings. Ms. Q reports the quarterly bonus on July 18. The worker requests verification, which Ms. Q provides on July 23.

   The worker completes a new projection of monthly income using $20 monthly bonus income ($60 ÷ 3 months). The first month for which the new projected monthly income is considered is September, the first month following the ten-day notice.

9. Same as Example 8, except that Ms. Q does not report receipt of the quarterly bonuses until at her annual review in November. Ms. Q also reports she received a 50-cent-per-hour raise in August. The worker requests verification of both the quarterly bonuses and the rate of pay increase, which Ms. Q provides on November 22.

   The worker recalculates the projected income for August (the month after the month of receipt) through November by adding $20 ($60 ÷ 3 months) to the projected income used for those months. Recoupment is established, if appropriate, since starting to receive recurring lump-sum income is considered to be beginning income.

   The worker also completes a new projection of income for the months of December through November, using the prorated amount of the bonus along with the new rate of pay. No recoupment is established for failure to report the rate of pay increase at the time it occurred. Since the rate-of-pay increase is not considered beginning income, it is only required to be reported at the annual review.

When the recurring lump-sum income is **expected to continue at the same rate**, the prorated amount will continue to be part of the projection of future income until the client reports a change.

When the recurring lump-sum income is **expected to continue but at an unknown rate**, the client will be required to timely report the receipt of each lump sum payment.

When the recurring lump-sum income is **ending and not expected to continue**, the lump sum will be prorated and used in the projection of future income for only the same number of months that the final lump sum covers.

Income from Contract Employment

Legal reference: 441 IAC 75 (Rules in Process)

If income from contract employment is received on a recurring lump-sum basis, determine the period covered by the contract. Calculate the total amount payable under the contract and prorate it over the number of months the contract covers.

Count the prorated monthly amount as part of the income projection. If the contract income is timely reported, begin using the prorated amount in the month following a ten-day notice. If the income is not reported timely, begin using the prorated amount in the month after the month in which the lump sum is received.

1. Ms. A, is a Medicaid recipient. In April, Ms. A timely reports that she began contract employment in March and that she received $300 in April that covers the months of March, April, and May. $100 prorated income ($300 ÷ 3 months) is counted for the months of May, June, and July.
2. Mr. B is employed under contract and receives $600 in January. The contract period is January through June. On April 5, Mr. B applies for Medicaid. On April 26, the Medicaid application is approved. $100 prorated income ($600 ÷ 6) is counted in the income projection for the months of April, May, and June.

Treat income from contractual employment received on a regular basis (weekly, biweekly, etc.) in the same manner as the earnings of a noncontractual employee.

Periodic or Intermittent Income

Legal reference: 441 IAC 75 (Rules in Process)

Prorate income received at periodic intervals or intermittently over the period covered by the income, and apply the prorated amount to the eligibility determination for the same number of months. (Do not apply this policy to income from self-employment.)

> Ms. A applies for Medicaid. She works part-time for a small company. She keeps her own time sheet and is paid when she turns it in. On May 15, Ms. A turns in a time sheet covering the preceding four months. She timely reports income of $240 received in May. The worker divides this income by four and includes $60 monthly income in the projection for four months, beginning with May.

Nonrecurring Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Give pamphlet Comm. 24 or Comm. 24(S), *One-Time Payments*, to each applicant. Also issue the pamphlet to each member who reports receipt or possible receipt of a nonrecurring lump sum, or when you believe the member may receive such sums.

When a client reports receipt of a lump sum, document in the case record:

- The date you issued the pamphlet.
- The date the lump sum was received.
- How it was reported.
- The amount of the sum.
- The source of verification.
- How it was determined that it is a lump sum.
- That the client was informed of the effect of receiving the lump sum.

Count the nonrecurring lump-sum income if received by:

- Any person in the eligible group.
- A parent who is in the home but is not eligible for Medicaid due to sanction.
- A parent in the home who is otherwise ineligible for Medicaid (e.g., ineligible alien).

Do **not** count the lump-sum income of a person who is receiving SSI or is voluntarily excluded.

NOTE: When an SSI recipient or voluntarily excluded person acts as a representative payee for another person in the home, the income received for the other person is considered to be income of that person, not income of the representative payee. If the other person is a member of the Medicaid eligible group, count the income as appropriate.

1. Ms. A receives SSI for herself and FMAP for her child. Ms. A is in an accident and receives a lump sum insurance settlement as a result. The lump sum is exempt in determining the child's Medicaid eligibility because Ms. A is an SSI recipient.
2. The same situation as Example 1, except it is Ms. A's child who is in an accident, and Ms. A receives a lump sum insurance settlement for the child. The lump sum is countable in determining the child's Medicaid eligibility. Although Ms. A receives the lump sum as representative payee for her child, the lump sum is intended for the child's needs.

Consider nonrecurring lump sums received by the following people as income in the month of receipt only.

- An ineligible stepparent.
- A self-supporting parent.
- A spouse of a self-supporting parent.

Refer to Treatment of Stepparent Income and Minor Parents and Minor Pregnant Women for more information.

The following sections give more information on:

Exempt Lump Sums

Legal reference: 441 IAC 75 (Rules in Process)

Exempt as income the following types of nonrecurring lump sums:

- State or federal income tax refunds (including earned income credit).
- Retroactive SSI benefits.
- Settlements for payment of medical expenses (also exempt as a resource).
- Refunds of security deposits on rental property or utilities.
- The part of the lump-sum payment that is both received and spent on funeral and burial expenses.
- The part of the lump-sum payment that is considered a reasonable income producing cost (such as attorney fees that have been paid).
- That part of the lump-sum payment that is both received and expended for a replacement of a resource. When a part of a lump sum is designated for the repair or replacement of a resource, that part of the payment is exempt as income whether or not the client actually uses it to repair or replace the resource.

When the amount of the damage and pain and suffering settlements are not designated, only the amount actually expended for repair or replacement of the resource is exempt as income. See Insurance Settlements and Damage Judgments.

- Sums received by people whose income is not considered (such as nonparental specified relatives not in the eligible group and SSI recipients).
- The employee's share of a lump-sum retirement payout. (If the sum was produced by payroll deduction, consider it a resource upon receipt.)
- Cash payments from the DHS diversion programs.

See Lump Sum (Nonrecurring), for treatment of these nonrecurring lump sums as a resource. Also see Property Settlements, for treatment of property settlements as a resource rather than income.

Nonexempt Lump Sums

Legal reference: 441 IAC 75 (Rules in Process)

Nonrecurring lump sums that are **not** exempt include:

- Inheritances.
- Insurance settlements for pain and suffering.
- Insurance death benefits.
- Lawsuit settlements.
- Countable gifts.
- One-time winnings (such as lottery winnings). Deduct the cost of the ticket, bingo card, etc., but do not deduct prior losses.
- Retroactive payments of benefits such as Social Security, veterans' benefits, workers' compensation, job insurance, and child support.
- Severance pay (unearned income is amount received).
- The employer's share of a lump-sum retirement fund which is paid to the employee.

When to Count the Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Policy: The date a nonrecurring lump sum is received determines whether the lump sum is considered. The lump sum does not affect eligibility if:

- It was received while the person receiving it was living in another state. (Check on resources due to receipt of the lump sum.)
- It is received **before** the month of application and the applicant does not request retroactive Medicaid eligibility.
- The assistance issued for the month the lump sum is received is subject to recoupment because the person receiving the lump sum is ineligible for other reasons. Consider the lump sum if at least one person was eligible in the month of receipt and the ineligible person is a parent remaining in the home.

- The recipient requests cancellation before the first day of the month that the lump sum will be received. However, once the lump sum is received, the household cannot later voluntarily exclude the member of the eligibility group who received the lump sum to refigure and reduce the lump-sum proration.

Procedure: When the amount of the lump sum was reported before the month of receipt and the cancellation of the coverage was completed before timely notice, no recoupment will be needed.

When receipt of the lump sum was not reported timely or the cancellation of the coverage was not completed before timely notice, begin recoupment of Medicaid claims with the month of receipt of the nonrecurring lump sum.

Budgeting the Lump Sum

Legal reference: 441 IAC 75 (Rules in Process)

Consider a nonrecurring lump sum as unearned income in the month received and count it in determining eligibility during the period of proration. (See Exempt Lump Sums and Gifts for more information.)

Reduce the lump sum by the cost of producing the income, such as attorney fees, taxes, etc.

Mr. W receives a $5,000 nonrecurring lump sum directly. He provides verification that his attorney fees were $1,000. Mr. W paid his attorney $700 and still owes him $300. Only the $700 actually paid is allowed as a deduction. When Mr. W provides proof that he has paid the other $300, the period of proration is recalculated.

1. Ms. A is receiving FMAP. On June 14, she timely reports that she received a nonexempt, nonrecurring, lump-sum payment on June 8. The first month of the period of proration is June. Eligibility is determined using a prorated portion of the lump sum beginning with the month following a notice of adverse action.
2. Ms. B applies for Medicaid on June 8. On June 17, she receives a nonrecurring lump-sum payment of $5,000. On July 1, the worker determines Ms. B eligible for FMAP effective June 1. On July 6, Ms. B reports the lump-sum payment. The worker must determine the period of proration, refigure the projection of income, and redetermine Medicaid eligibility beginning with June.
3. Ms. C applies for Medicaid on November 20 for herself and her son. Ms. C receives a $2,500 nonrecurring lump sum on November 27, and timely reports it on December 2. The worker processes the application on December 10. The worker determines the period of proration to be four months ($2,500 ÷ 719).

   Eligibility for both Ms. C, under Medically Needy and Ms. C's son, under MAC, will be determined using the prorated amount beginning with November. In February, the remainder of $343 will be used.

For purposes of the lump-sum policy, the "eligible group" is defined as all eligible people and any other person whose income is considered in determining Medicaid eligibility. If the unborn child is being counted in the household size at the time of receipt of the lump sum, the unborn child is also counted in determining the appropriate standard of need to prorate the lump sum.

If an ineligible parent receives the nonrecurring lump sum, count the lump sum, since the parent is included in the eligible group as a "considered" person.

1. Ms. A has two children for whom she receives Medicaid. Ms. A is not receiving Medicaid because she failed to cooperate with CSRU. Ms. A receives a $5,000 nonrecurring lump sum. The worker divides $5,000 by the three-person FMAP Standard of Need amount to prorate the lump sum.
2. Same as Example 1, except the lump sum is received by one of Ms. A's children. Prorate the lump sum using a three-person Standard of Need amount.
3. Mr. and Mrs. T receive Medicaid for their three children. Mr. and Mrs. T are not eligible for Medicaid because they are ineligible aliens. Mr. T receives a nonrecurring lump sum. Because Mr. and Mrs. T are considered persons on the Medicaid case, the worker uses the five-member FMAP Standard of Need in prorating the lump sum.

If a person who is voluntarily excluded receives the lump sum, the lump sum is not counted toward the eligible group.

Ms. M has three children. She voluntarily chooses to exclude Child C because Child C receives child support and is covered under the father's health insurance. Ms. M is approved for Medicaid effective October 1 for FMAP for herself, Child A, and Child B.

Child C receives a nonrecurring lump sum on November 20. The lump sum is not used in determining eligibility for the FMAP household.

When, due to the untimely report of a nonrecurring lump sum, Medicaid eligibility is being redetermined for the first month of the period of proration, only use the prorated amount of the lump sum. This is because all countable monthly income was added to the nonrecurring lump sum before the proration calculation.

When Medicaid eligibility is being redetermined for any month of the period of proration other than the first month, use the prorated amount of the lump sum plus any projected monthly income.

Period of Proration

Legal reference: 441 IAC 75 (Rules in Process)

The months in which any prorated portion of the lump sum will be counted are called the period of proration.

To determine the months in which the lump-sum income will be counted, divide the total countable income in the month of receipt including the countable lump-sum income, by the FMAP Standard of Need (Test 2) for the eligible group.

Ms. X receives Medicaid under FMAP for herself and her two children. She receives a $1,704 nonrecurring lump sum in February, which she timely reports. The worker is currently using a monthly projection of $200 in other unearned income.

$1,704 + $200 = $1,904 divided by $849 (the three-person FMAP Standard of Need) = 3 months of proration

If the applicant withdraws an application (or is denied assistance for a reason other than the lump sum), establish a period of proration if the lump sum is received in the **same** month as the withdrawal or denial, even if that month is the application month.

To determine the number of months in which lump-sum income will be counted:

- For applications, divide the total of the countable lump-sum income and other countable income received for the same month by the Standard of Need (Test 2). Do not consider assigned support collected and retained by the Department for the month the lump sum is received.
- For ongoing cases, divide the total of the countable lump-sum income and other countable income projected for the same month by the Standard of Need (Test 2).

1. Ms. A applies for Medicaid on April 3 for herself and her three children. On April 10, Ms. A reports receiving a $3,000 nonrecurring lump sum on April 8. The only other income Ms. A or her children have is Ms. A's earned income.

   Ms. A states that the 30-day period before the date of application is indicative of her future income. In that 30-day period, Ms. A received four weekly paychecks for a gross monthly income of $801.54. So, $801.54 will be the projected gross earned income.

   First, determine the countable projected earned income.

$	801.54	Gross earned income received in the 30 days before April 10
-	160.30	(20% earned income deduction)
$	641.24	
-	250.00	Child care
$	391.24	Countable projected earned income

   Prorate the lump sum as follows:

$	3,000.00	Nonrecurring lump sum
+	391.24	Countable April income
$	3,391.24	
÷	986.00	FMAP Test 2 for four people
$	3.44	Months of proration

The following income is used to determine eligibility:

April	May	June	July	August and on
$986.00	$1,377.24 ($986.00 + $391.24)	$1,377.24 ($986.00 + $391.24)	$824.48 ($433.24 lump sum remainder + $391.24)	$391.24

2. Mrs. B applies for Medicaid on May 21 for her two children. She does not request Medicaid for herself. On June 2, Mrs. B receives a $1,800 nonrecurring lump sum, which she reports on June 3. The application is processed June 6. The only other income Mrs. B and her children have is Mrs. B's earned income.

   Mrs. B states that the 30-day period before May 21 is indicative of her future income. In that 30-day period, Mrs. B received two biweekly paychecks, for a total of $1,126.74 gross monthly income.

   First, determine the countable projected earned income.

$ 1,126.74	Gross earned income received in the 30 days before May 21
- 225.34	20% earned income deduction
901.40	
- 300.00	Child care
601.40	Countable projected earned income

   Prorate the lump sum as follows:

$ 1,800.00	Nonrecurring lump sum
+ 601.40	Countable June income
2,401.40	
÷ 849.00	FMAP Test 2 for three people
2.82	Months of proration

   The following income is used to determine eligibility:

May	June	July	August	September on
$601.40	$849.00	$1,450.40 ($849.00 + $601.40)	$1,304.80 ($703.40 lump sum remainder + $601.40)	$601.40

3. Mr. C receives Medicaid for himself and his son. On May 16, Mr. C receives a $1,500 nonrecurring lump sum, which he reports May 23. Current Medicaid eligibility is being determined using $306 in countable projected earned income. The first month of the period of proration will be May.

   Prorate the lump sum as follows:

$ 1,500.00	Nonrecurring lump sum
+ 306.00	Countable projected May earned income
1,806.00	
÷ 719.00	FMAP Test 2 for two people
2.51	Months of proration

Timely notice is sent May 25 effective July 1. May and June are included in the period of proration. However, because the lump sum was timely reported, no recoupment is established for either month. This leaves a $368 remainder to be counted in determining eligibility for July in addition to the monthly projected earned income.

NOTE: The change in income for July is **not** treated as a one-time change in income because it is part of a period of proration.

If countable income, including the countable lump-sum income, is **less** than the Test 2 income limit of the eligible group, consider the lump sum as a one-time change in income. Remember that a one-time change in income is not used in the projection of income since it is not representative of future income.

A $100 lump-sum payment is received in August and is timely reported. The $100 lump sum, combined with other countable income received in August, does not exceed the income limit of the eligible group. Since the $100 nonrecurring lump sum is a one-time change in income and is not indicative of future income, it does not affect the projected amount of monthly income.

If countable income is **equal** to or **more** than the Test 2 income limit of the eligible group, determine the number of months the lump-sum income will be prorated.

Ms. C receives Medicaid for her two children under MAC. Ms. C is a considered person on the MAC case. She does not receive Medicaid for herself. Ms. C receives a $300 nonrecurring lump sum in September and timely reports it. Countable projected September income is $549.

In order to determine if there will be a period of proration, the nonrecurring lump sum and other countable income are added together. $300 + $549 = $849. The Test 2 limit for a three-member eligible group is $849. Since the countable income, including the nonrecurring lump sum is equal to the Test 2 limit, the period of proration will be one month.

The first month of the period of proration is always the month in which the lump sum is received.

If the nonrecurring lump sum was reported timely, do not establish recoupment for the months of the period of proration in which a portion of the lump sum could not be used due to timely notice requirements.

Ms. T receives Medicaid for her three children. Ms. T does not receive Medicaid for herself. Ms. T receives a $3,000 nonrecurring lump sum October 9. Ms. T timely reports receipt of the lump sum October 14. The worker requests additional information and Ms. T supplies it by the due date of October 24.

The first month of the period of proration is October. Timely notice is issued October 26 effective December 1. Because the lump sum was timely reported, no recoupment will be established for October or November. The first month in which a prorated portion of the lump sum will be used to determine eligibility will be December, the third month of the period of proration.

If the nonrecurring lump sum was reported **untimely**, establish recoupment for the months of the period of proration in which the portion of the lump sum could not be used due to timely notice requirements.

Ms. T receives Medicaid for her three children. Ms. T does not receive Medicaid for herself. Ms. T receives a $3,000 nonrecurring lump sum May 9. Ms. T reports receipt of the lump sum May 21. The worker requests additional information and Ms. T supplies it by the due date of May 31.

The first month of the period of proration is May. Timely notice is issued June 2 effective July 1. Because the lump sum was **not** timely reported, Medicaid eligibility will be redetermined for the months of May and June. If any of the children were only conditionally eligible for Medically Needy with a spenddown, recoupment will be established for May or June.

NOTE: Any of Ms. T's children who are only conditionally eligible for Medically Needy with a spenddown should be considered for Hawki.

Do not establish a period of proration if the application is withdrawn (or denied for another reason) before the first of the month in which the lump sum is (to be) received.

1. Mrs. A applies for Medicaid on April 14. She expects to receive a nonrecurring lump sum on April 27 and requests withdrawal of her application on April 20. A period of proration is still established, because the request did not occur before the first day of the month in which Mrs. A expects to receive the lump sum.
2. Ms. B applies for Medicaid on April 14. She expects to receive a nonrecurring lump sum on May 8. On May 2, she requests withdrawal of her application. A period of proration is still established, because the request did not occur before the first day of the month in which Ms. B expects to receive the lump sum.
3. Mr. H applies for Medicaid on April 14. He expects to receive a nonrecurring lump sum on May 2. On April 28, he withdraws his application. A period of proration is **not** established, because the request occurred before the first day of the month in which Mr. H expects to receive the lump sum.

   If the worker has all needed information to approve the application on April 28, the worker should inform Mr. H that Medicaid can be approved for April only and canceled for May. In either case, a period of proration is not established.

Assistance may be denied or canceled for another reason, delaying the lump sum period of proration. When enough information is available, send a letter specifying the period of proration. If there is insufficient information available because the lump-sum income was not verified, send a letter to inform the client about the period of proration due to receipt of lump-sum income.

When either letter is sent, enclose Comm. 24 or Comm. 24(S), *One-Time Payments*. Document in the case record that you sent the letter and the pamphlet. In addition, make an entry in the ABC system (the TD01 screen's, Info line) to flag the prior receipt of lump-sum income if the client reapplies.

Receipt of Another Lump Sum During a Period of a Proration

Legal reference: 441 IAC 75 (Rules in Process)

When a household receives another nonrecurring lump sum during a period of proration, establish a separate period of proration.

Count the new lump sum in the month it is received and add it to that month's income, including the initial lump sum prorated amount. Divide the total by the FMAP Standard of Need for the household size. The period of proration for the second lump sum runs concurrently with the period of proration for the first lump sum.

Ms. R receives FMAP for herself and her two children. She is employed and has projected countable earned income of $400 per month. Ms. R receives a $7,500 nonrecurring lump sum in March, which she timely reports and verifies March 8.

To determine the period of proration, the $7,500 is added to her countable earned income of $400 and divided by the FMAP Standard of Need for a three-person eligible group. ($7,500 + $400 = $7,900 ÷ $849 = 10 months) The period of proration will be March through December, with $259 being considered for December. Timely notice is issued March 15. The first month in which a prorated amount of the lump sum will be used is April, the second month of the period of proration.

In August, Ms. R receives a $10,000 inheritance from her grandmother's estate which she timely reports and verifies August 10.

The $10,000 is added to the $400 countable monthly income and the $849 prorated lump sum and divided by the FMAP Standard of Need. ($10,000 + $400 + $849 = $11,249 ÷ $849 = 14 months) The period of proration for this second lump sum will be August through September of the following year, with $212 remaining for September. Timely notice is issued August 17. The first month in which a prorated amount of the second lump sum will be used is September, the second month of the period of proration.

In September through November, $849 from the first lump sum and $849 from the second lump sum are used in addition to any other monthly income. In December, the remaining $259 from the first lump sum and $849 from the second lump sum will be used. Beginning in January, only the $849 from the second lump sum will be used.

Members Entering the Household During a Period of Proration

Legal reference: 441 IAC 75 (Rules in Process)

When new members who were not in the eligible group when the lump-sum income was received enter the household during the period of proration, they may be eligible for Medicaid as a separate eligible group. The new members must meet all program requirements.

Count the nonexempt income of the new members. Allow all applicable deductions, disregards, and diversions. People who were in the eligible group when the lump sum was received, including any unborn children, remain subject to the period of proration.

1. Ms. B is receiving FMAP for her daughter, Sue, and herself. Ms. B is employed. She receives a nonrecurring lump sum in September, which she timely reports. It creates a period of proration for ten months beginning in September. In November, she applies for Medicaid for her son, Johnny, who has come to live with her.

   Ms. B's earnings (but not the prorated amount of the lump sum) are considered available to Johnny and used in determining Johnny's Medicaid eligibility as a household size of one. There is no diversion of income to meet Ms. B's needs, because the lump sum is for this purpose.

2. Ms. C is pregnant and receives FMAP for herself and her child, Jill. The unborn child is included in the household size because Ms. C reported her pregnancy.

   Ms. C receives a nonrecurring lump sum in April which she timely reports and verifies April 25. The lump sum is divided by the FMAP Standard of Need for a household of three and is prorated for 12 months beginning in April. Ms. C is granted continuous eligibility under MAC. Eligibility under MAC or Medically Needy is explored for Jill with a household size of three.

   In September the baby is born. The baby can be granted Medicaid as either a newborn child of a Medicaid-eligible mother or as part of the existing eligible group.

   In granting newborn status, Ms. C's household size is reduced to two. However, the prorated income remains the same. This could cause Jill to lose MAC eligibility or increase the amount of spenddown. It may be to the household's advantage to continue to include the newborn in the household size and explore eligibility under MAC.

   Regardless of the household's decision, the newborn cannot be granted Medicaid eligibility as a new member entering the household during the period of proration, because the newborn was included in the original Medicaid eligible group when the lump sum was received.

3. Ms. D is pregnant and receives FMAP for herself and her child, Ann. The unborn child is <u>not</u> included in the household size, because Ms. D did not report her pregnancy to her worker.

   Ms. D receives a lump sum in April, which she timely reports and verifies April 10. The lump sum is divided by the FMAP Standard of Need for a household size of two and is prorated for 15 months beginning in April. Ms. D's eligibility is explored under Medically Needy and Ann's eligibility is explored under MAC or Medically Needy, both as households of two.

In July the baby is born. If Ms. D is receiving Medicaid when the baby is born, the baby may receive Medicaid as a newborn child of a Medicaid-eligible mother.

However, if Ms. D is not receiving Medicaid, the baby is a new member entering the home and may receive MAC as a household of one. Ms. D's income (not counting the lump sum) is used to determine the baby's eligibility. There is no diversion of income to meet Ms. D's needs. The lump sum is for this purpose.

4. Mrs. E is receiving Medicaid under FMAP for herself and one child. She receives a nonrecurring lump sum that creates a period of proration of 12 months beginning in October. Mr. E, the child's father, enters the home in December and applies for Medicaid.

   The worker determines that Mr. E meets all eligibility requirements of the FMAP coverage group. Even though there is no child in Mr. E's eligible group, he can receive FMAP as a separate one-person eligible group because he has a dependent child in his care.

   When determining Mr. E's eligibility, the worker considers his income and any income Mrs. E has other than the lump sum. There is no diversion for Mrs. E's needs, because the lump sum is for this purpose.

Conditions for Shortening the Period of Proration

Legal reference: 441 IAC 75 (Rules in Process)

The period of proration can be shortened when:

- The FMAP Standard of Need increases. Recalculate based on the new amounts.
- All or a part of the lump sum is lost or stolen. The client must provide documentation of the loss or theft. Filing a report with law enforcement officials is acceptable documentation.

  Ms. B and her child were receiving FMAP when Ms. B received a $3,595 lump sum. The lump sum was prorated and will be used for six months. An automatic redetermination is completed. Ms. B's child is eligible under MAC. Ms. B declines Medically Needy.

  Ms. B reports and documents that $1,200 of the lump sum was stolen. The period of proration is recalculated as follows ($3,595 - $1,200 = $2,395; $2,395 divided by $719 = 4 months).

- The person controlling the lump sum no longer lives with the eligible group, and the lump sum is no longer available to the group. Recalculate the period of proration and disregard any amount taken by the person who left the home. However, use the same standard of need figure for the recalculation that was used to calculate the original period of proration.

1. Mr. and Mrs. C and their two children were FMAP recipients in May when they received a lump-sum payment of $4,032. The lump sum was timely reported and verified May 15. The lump sum was prorated for five months, May through September ($4,032 divided by 986 = 4 with a remainder of $88).

   In July, Mrs. C left the home and took $800 of the lump sum with her. The period of proration is shortened by subtracting $800 from $4,032.

   The remaining $3,232 is divided by $986 to determine the new period of proration ($3,232 divided by 986 = 3 months with a remainder of $274). The new period of proration is May through August. $274 will be applied against the August eligibility.

2. Same as Example 1, except that Mrs. C did not take any of the lump sum with her when she left because it was all spent before she left home. The period of proration remains unchanged.

- The client uses the lump sum for one of the following expenditures (unless there is insurance to cover the expense):
  - To pay for medical services for the eligible group or their dependents that are allowable under Medicaid at the time the expense is reported. ("Dependents" are people who could be claimed as such for federal income tax purposes.)
  - To pay the cost of repairs to the homestead exceeding $25 per incident which are necessary to keep the house habitable.
  - To replace exempt resources due to fire, tornado or other natural disasters.
  - To pay funeral or burial expenses. (Allow the expenditure whether or not the expenditure is for a person who could be claimed as a dependent.)

Verify these expenditures. "Expenditures" means the amount actually spent on the items, rather than the amount owed.

Document in the case record the calculation of the new period of proration. Obtain and record your supervisor's approval of the expenditures and the new period of proration. Determine availability of insurance. Insurance must be used before applying the prorated funds.

1. A two-member eligible group (with no other income) receives a $4,050 lump sum. ($4,050 divided by 719 = 5 months with $455 to apply to the sixth month) Allowing a medical expense of $850 results in the proration period being reduced to four months with $324 left over to apply to the fifth month. ($4,050 - $850 = $3,200 divided by $719 = 4 months with a remainder of $324).
2. Same as Example 1, except there is insurance available to pay $200 of the expense. The insurance is used to reduce the cost of the medical expense to $650. ($4,050 - $650 = $3,400; $3,400 divided by $719 = 4 months with a remainder of $524 to apply to the fifth month).

FMAP-Related Self-Employment Income

Legal reference: 441 IAC 75 (Rules in Process)

Treat countable income (net profit) from self-employment the same way as earnings of an employee. After establishing that the client is self-employed (see Determination of Self-Employment), calculate net profit based on the type of self-employment enterprise (see Determination of Net Profit).

How you apply the net profit depends upon when the income is received and when allowable expenses are incurred. (See How to Treat Self-Employment Income.) Do not offset the loss from one self-employment enterprise against the profit of another one.

FMAP-related Medicaid policy differentiates between home-based and non-home-based self-employment enterprises. A client who provides a service in the client's home or whose business office is in the home is involved in a home-based enterprise.

The office does **not** need to be a separate room to meet this qualification. Also, a client can be allowed the appropriate deduction for a home-based business regardless of whether or not the client is actually required to pay shelter costs.

Determination of Self-Employment

Legal reference: 441 IAC 75 (Rules in Process)

The federal and state revenue departments use the following guidelines. Consider a person to be self-employed when that person:

- Is not required to report to the office regularly except for specific purposes, such as sales training meetings, administrative meetings, or evaluation sessions.
- Establishes the person's own working hours, territory, and methods of work.
- Files quarterly reports of earnings, withholding payments, and FICA payments to the Internal Revenue Service.

If it is difficult to identify whether a person is an employee or self-employed, ask the client to provide a written statement from the person or agency for whom the client works. If the person or agency considers the client to be self-employed, compute the income as self-employment income. You can also contact the IRS to determine if the IRS would consider the individual to be self-employed or an employee.

If a person has income from self-employment other than farming, complete form 470-0313, *Work Sheet Determining Income of Self-Employed Business*. When a person is self-employed as a farmer, complete form 470-0312, *Work Sheet Determining Income of Farm Operators*. Also evaluate all self-employment enterprises in terms of resource limits.

Frequently a new employee is considered to be in an employee-employer relationship until that employee gains sufficient experience and knowledge of the company's mode of operation. The employee may then move to the status of a self-employed person.

A self-employed person may not file quarterly reports or an income tax return, but that does not change the person's self-employed status. For example, people who baby-sit in their own home are considered self-employed, even though they may not file any reports.

Determination of Net Profit

"Net profit" means gross earnings minus allowable business expenses. Determine the net profit of self-employment income through a review of past books or through records of the previous year's federal income tax report. If neither books nor tax records are available, do not allow expenses related to the production of self-employment income. Document the method used to determine the net profit in the case record.

NOTE: The FMAP-related Medicaid program does not follow all IRS regulations in determining whether a given expense is deducted as an expense in the production of self-employment income.

After you have determined the net profit, enter the figure into the system as appropriate, showing the applicable disregards and work expenses. Apply allowable earned income deductions to the net profit figure. Do not deduct a loss from self-employment from other income or a separate self-employment business.

Net profit is determined differently for home-based and non-home-based operations. Discussion of home-based operations is further divided into the following sections:

- Renting apartments in the client's home
- Providing room and board, family-life home care, or nursing care
- Providing child care in the client's home
- Other types of businesses operated from the home

Renting Apartments in the Client's Home

Legal reference: 441 IAC 75 (Rules in Process)

When the client is renting out apartments in the client's own home, determine the net profit by deducting the following from the gross rentals received:

- The shelter expense over the amount listed on the *Schedule of Needs, Chart of Basic Needs Components*, RC-0002 (in 6-Appendix) for the eligible group.

  The part of the expense for utilities furnished to tenants that is over the amount listed on the *Chart of Basic Needs Components* for the eligible group. The utility expense in excess of the amount of utilities is an allowable deduction, even when the client pays only a portion of the utility costs for the tenant.

- 10% of gross rentals to cover the costs of upkeep.

The eligible group consists of a mother and two children. The client rents out two apartments in her home. The monthly gross rentals for the apartments (including utilities) total $400.

Mortgage payment	$ 175.00
Shelter expense for 3 (3 x $47.10)	- 141.30
	$ 33.70
Actual utility cost	$ 110.00
Utilities for 3 (3 x $11.77)	- 35.31
	$ 74.69
10% of gross rentals ($400 x .10)	$ 40.00
Gross rentals	$ 400.00
Total deductions ($33.70 + $74.69 + $40)	- 148.39
Profit	$ 251.61

The $251.61 is subject to the appropriate earned income expenses and deductions.

Providing Room and Board, Family-Life, or Nursing Care

Legal reference: 441 IAC 75 (Rules in Process)

When a client furnishes room and board for compensation, operates a family-life home, or provides nursing care, deduct the following amounts from the payments received:

- $41 plus the amount equal to the maximum monthly Food Assistance allotment for a one-member household for each boarder and roomer (a person to whom the client provides **both** meals and lodging) **or** each person in the home to receive nursing care.
- $41 for a roomer (a person to whom the client furnishes only lodging, but not meals). The person lives in a room of the home and usually has privileges in the rest of the home.
- An amount equal to the maximum monthly Food Assistance allotment for a one-member household for a boarder (a person to whom the client furnishes only meals, not lodging).
- 10% of the total payment to cover the costs of upkeep for people receiving a room or nursing care. (Do not allow the 10% deduction for upkeep for boarders.)

Providing Child Care in Own Home

Legal reference: 441 IAC 75 (Rules in Process)

When the client provides child care services in the client's own home, determine net profit by deducting 40% of the total gross income received to cover the cost of upkeep of the home and producing the income.

Gross income from providing child care in the client's own home includes the total payment received for the service, plus any payment received under the Child Nutrition Amendments of 1978 for the cost of providing meals to children. However, exempt as income and as a resource any portion of the payment for the client's cost of providing meals to the client's own children in the home.

When the client claims to have expenses in excess of the 40% and asks to have actual expenses considered, determine net profit in the same manner as outlined in Other Home-Based Operations.

NOTE: Use actual expenses **only** at the client's request and only when they exceed 40% of the gross income. This may require a computation of net income using both methods to determine which is to the client's advantage. When you use the 40% deduction, do not allow 10% deduction for upkeep.

Income received from the Child Nutrition Amendments of 1978 must be reported and verified. Tell the client about this responsibility.

Other Home-Based Operations

Legal reference: 441 IAC 75 (Rules in Process)

Other home-based self-employment operations may include party sales, mechanic, painter, craftsperson, and beauty operator.

When the client operates a self-employment enterprise in the home (other than providing room and board, renting apartments, or providing child care services in the home), deduct the following expenses from the income received:

- The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption and raw materials.
- Wages, commissions, and costs (including cost for health insurance) relating to the wages for employees of the self-employed person. When the employee is a member of the eligible group, allow the person's wages as a deduction for the self-employed person but also count the employed person's wages as income.
- The cost of machinery and equipment in the form of rent, interest on a mortgage or contract payment, and any insurance on such machinery and equipment.
- 10% of the total gross income to cover the costs of upkeep when the work is performed in the home.
- Any other direct cost involved in the production of the income.

Do not allow a deduction for the purchase of capital equipment and payment on the principal of loans for capital assets and durable goods, or any cost of depreciation.

Non-Home-Based Operations

Legal reference: 441 IAC 75 (Rules in Process)

Determine the net profit from self-employment income in a business that is not based in the client's home by deducting only the following expenses that directly relate to the production of such income:

- The cost of inventories and supplies purchased that are required for the business, such as items for sale or consumption, and raw materials.

- Wages, commissions, and costs (including cost for health insurance) relating to the wages for employees of the self-employed person. When the employee is a member of the eligible group, allow the person's wages paid as a deduction for the self-employed person, but also count the employed person's wages as income.
- The cost of shelter in the form of rent, the interest on mortgage or contract payments, taxes, and utilities.
- The cost of machinery and equipment in the form of rent, or the interest on mortgage or contract payments.
- Insurance on the real or personal property involved.
- The cost of any needed repairs.
- The cost of any required travel (other than the cost of travel from the home to the business).
- Any other expense that is directly related to producing income for the client.

Do not allow a deduction for:

- The purchase of capital equipment.
- Payment on the principal of loans for capital assets and durable goods.
- Any cost of depreciation on equipment, vehicles, or property.

How to Treat Self-Employment Income

The treatment of self-employment income differs depending on whether the income and expenses are received regularly or irregularly, and whether irregular income has been received for less than a year.

Income and Expenses Received Regularly

Legal reference: 441 IAC 75 (Rules in Process)

Treat countable income (net profit) received on a regular basis from self-employment in the same way as the earnings of an employee.

Expenses must be incurred on the same regular basis as the income; that is, if the income is received monthly, the expenses must also be incurred monthly. If expenses are incurred less often than the income (for example, insurance, license fees, etc.), annualize the self-employment income.

Self-employment received on a regular basis is any income that is anticipated to be received on a daily, weekly, biweekly, semimonthly, or monthly basis. Some types of self-employment income that may be received on a regular basis are income from:

- Baby-sitting in the client's home
- Renting apartments in the client's home
- Providing room and board
- Collecting bottles and cans for deposit refunds
- Sporadic spot labor (such as mowing lawns, shoveling snow, etc.)

Annualizing Income Received Irregularly

Legal reference: 45 CFR 233.20(a)(3)(iii), 441 IAC 75 (Rules in Process)

Average annual self-employment income that is received on an irregular basis over a 12-month period of time, even if the income is received only within a short period in that 12 months. Apply this policy when the income is received:

- Before the month of decision and expected to continue. (If it is not expected to continue, do **not** consider any self-employment income received before the month of application.)
- In the month of decision.
- After assistance is approved.

Annualize self-employment income over 12 months, even if income is received from other sources in addition to self-employment. The annualized self-employment income is used for a specific 12-month period of time that is called the annualized period. To determine the annualized income:

- Average the past 12 months of income, ending with the month before the month of decision or the month of annual review, **or**
- Use the client's income tax return, if the return covers a full year of self-employment and covers the calendar year before the year in which the computation is being done.

If you use the income tax form, establish the annualized period to coincide with the filing of the tax return. Filing of a tax return is not a change as defined in earned income. It is your responsibility to follow up and request a copy of the new tax return when the previously determined annualized period is about to expire.

For an **applicant**, an annualized period can be established to begin before the application. When a **recipient** becomes subject to annualizing, you can make the initial "annualized period" for less than a full tax year, so that, from then on, the end of the annualized period coincides with the filing of the tax return.

If the household experiences a significant increase or decrease in the self-employment business income that is subject to annualization, the tax return will not provide a good projection. In these cases, work with the household to arrive at the best estimate of future income.

1. Mr. X has been a farmer for the last two years. He applies for Medicaid in July. The eligible group is within resource limits. The worker uses the income tax return covering the previous year to determine the income to be considered for the month of decision and prior months of eligibility (if applicable) and to establish ongoing eligibility for Mr. X and his children.

   Mr. X's income tax form was filed in February, and this is the month he anticipates filing each year. There are several options for establishing the annualized period, such as February through January of the next year, March through February of the next year, or beginning with a later month. If Mr. X is eligible, the monthly amount established is considered accurate until the annualized period ends.

2. Mr. Y ends his self-employment on October 15 due to a lack of business and applies for Medicaid on October 28. The worker processes the application on November 4. No income from self-employment is counted in determining Mr. Y's Medicaid for November.

   If Mr. Y requests Medicaid for October, and if Mr. Y's self-employment experienced a significant decrease in business income preceding the termination, use the best information available to arrive at the net profit for October.

Income Received Irregularly for Less Than a Year

Legal reference: 441 IAC 75 (Rules in Process)

If a client is self-employed in a business that does not produce a regular income, and the business has been in existence for less than a year, average the income over the period the business has been in existence. Project the monthly amount for the same period of time that the business has been in existence.

If the business has been in existence for only a short time and there is little income information, establish a reasonable estimate of income and expenses with the client's help. Use this estimate for the first three months.

Average the actual income from the first three months, and use that amount for the second three months. Use this method regardless of the day of the month the enterprise started, or when the first income was received.

Average the actual income from the first six months, and use that amount for the next six months. Then start annualizing for the next year. Use the projected monthly income to determine initial and ongoing eligibility.

Self-employment begins in November for an active Medicaid case. The projected income is used to determine eligibility for November, December, and January.

Change in the Cost or Nature of Self-Employment

Legal reference: 441 IAC 75 (Rules in Process)

Recalculate expenses when there is an established, permanent, ongoing change in operating expenses, such as an increase or decrease in rent payments, or in the cost of supplies.

When the cost for supplies increases, recalculate only if the client does not increase the cost of the service or product, thereby experiencing a loss in profit. There is no need to recalculate if the client increases the cost of the product or service because of the increased costs of supplies.

Recalculate income and expenses when there is a change in the nature of the business, such as a salesman switching from selling one company's product to selling another company's product, or an insurance salesman decreasing or increasing the types of policies offered.

FMAP-Related Deductions and Diversions

Legal reference: 441 IAC 75 (Rules in Process)

Allowable deductions under FMAP-related coverage groups include:

- The cost of producing unearned income.
- 20% deduction from earned income.
- Adult or child care expenses.
- Applicable diversions for people not in the home.
- Diversions for an ineligible or voluntarily excluded person's needs, if appropriate.
- 58% work incentive deduction (except for MAC or Medically Needy cases).

Project deductions as you project income. Subtract these deductions in the order listed from earned income first.

1. 20% earned income deduction.
2. Adult or child care expenses. (Allow the deduction from earnings of ineligible stepparents or self supporting parents in minor parent cases.)
3. Applicable diversions for people not in the home (for example, child support and alimony payments).
4. Diversions for an ineligible or voluntarily excluded person's needs, if appropriate.
5. 58% work incentive deduction. NOTE: Do not allow the 58% deduction when determining initial eligibility under the Standard of Need test (test 2).

When the person whose income must be considered has both nonexempt earned and unearned income, and earnings remain after applying the allowable deductions, add the unearned income to the remaining earned income. Consider the total as countable income.

NOTE: Diversions for people not in the home (such as child support and alimony payments) and diversions for an ineligible or excluded person's needs are allowable for either earned or unearned income. When a person has both nonexempt earned and unearned income, and the earnings are less than the allowable deduction, subtract any unused portion of either diversion from unearned income. Consider the balance to be countable income.

Income Subject to Comparison to the Three Income Tests

Test 1 (applicants and members):
Gross income (Include nonexempt earnings of a child who is less than a full-time student. If the person is self-employed, use the net profit figure. For income of stepparents, see Treatment of Stepparent Income. For income of self-supporting parents, see Self-Supporting Parent's Income.)

Test 2 (applicant cases):
Gross earnings (Include earnings of a child who is less than a full-time student.)
Minus the 20% earned income deduction
Minus the child/adult care deduction
Minus applicable diversions for people **not** in the home
Minus applicable diversions for people **in** the home
Plus any unearned income
Do not allow the 58% work incentive deduction

Test 3 (applicants and members):

Gross earnings (Include earnings of a child who is less than a full-time student.)
Minus the 20% earned income deduction
Minus the child/adult care deduction
Minus applicable diversions for people **not** in the home
Minus applicable diversions for people **in** the home
Minus the 58% work incentive deduction
Plus any unearned income

If eligible for these deductions, people in FMAP-related coverage groups may have these deductions applied when their retroactive eligibility is examined.

1. Household consists of:
   Mrs. Z, 32
   Child A, Mrs. Z's child
   Mr. Z, 39
   Child C, common child

   The family applies for Medicaid for Mrs. Z and Child A. Mrs. Z has no income. Mr. Z has earnings of $1,230 per month. The worker explains who must be in the eligible group and who may be voluntarily excluded. Eligibility is determined as a household of four. The worker determines eligibility as follows:

$	1,230.00	Mr. Z's earnings
-	246.00	20% earned income deduction
$	984.00	
-	570.72	58% work incentive deduction
$	413.28	Net countable income.

   If all other eligibility factors are met, the family is eligible for FMAP.

2. The household consists of Mr. W and his two children who receive Medicaid under FMAP. Mr. W has $300 per month in earned income. Each child has unearned income of $100, for a total of $200. Mr. W fails to cooperate with the Third-Party Liability Unit, and he is sanctioned and not eligible for Medicaid effective first of the next month allowing a ten day notice. Mr. W will be a "considered" person.

   The worker determines Medicaid eligibility for the children as follows:

$	300.00	Mr. W's gross earnings
-	60.00	20% earned income deduction
$	240.00	
-	139.20	58% work incentive deduction
$	100.80	Mr. W's income used towards the eligible group
+	200.00	Unearned income of children
$	300.80	Net countable income

   If all other eligibility factors are met, the children are eligible for Medicaid.

3. The household consists of Mrs. P, her two children from a previous marriage, Mr. P, and their common 12-year-old child. Mr. P has projected earnings of $800 per month and pays $50 per month in child support outside the home. Mrs. P and her children have no income. The household wants Medicaid for the family.

   The worker determines FMAP eligibility as follows:

$	800.00	Mr. P's projected gross monthly earnings
-	160.00	20% earned income deduction
-	50.00	Child support paid to child outside the home
$	590.00	
-	342.20	58% work incentive deduction
$	247.80	Net countable projected income

   If all other eligibility factors are met, the family is eligible for FMAP.

The following sections explain:

- Deductions from unearned income
- Deductions from earned income
- Diversion for people not in the home
- Diversion for needs of an ineligible or voluntarily excluded person
- Treatment of a stepparent's income
- Deductions for ineligible parents

Unearned Income Deductions

Legal reference: 441 IAC 75 (Rules in Process)

Deduct reasonable income-producing costs from the gross unearned income to determine net unearned income from investments and nonrecurring lump-sum payments. "Costs" means the amount actually spent to produce the income, rather than the amount owed. Consider the income left after this deduction as gross income available to the eligible group.

Examples of investments are stocks, bonds, trusts, and rental property that is not owner-operated. (Be sure the nonexempt value of the investment plus other countable resources does not exceed the resource limit.)

Examples of income-producing costs are brokerage fees, a property manager's salary, and maintenance costs. The most common type of income-producing cost for a nonrecurring lump sum is an attorney fee.

Allow a deduction for attorney fees when automatically deducted from unearned income when the attorney was hired to obtain the payment.

Also allow a deduction for taxes as described under Taxes earlier in this chapter. When the owner manages rental property, determine the income according to instructions in FMAP-Related Self-Employment Income.

Also, deduct from unearned income diversions for people not in the home (for example, child support and alimony payments) and diversions for an ineligible or voluntarily excluded person's needs. See Diversion for People Not in the Home and Diversions for the Needs of an Ineligible or Voluntarily Excluded Person, for more information.

Earned Income Deductions

Legal reference: 441 IAC 75 (Rules in Process)

The following sections explain the allowable earned income deductions:

- 20% earned income deduction
- Adult or child care expenses
- 58% work incentive deduction (not allowed for MAC or Medically Needy coverage groups).

20% Earned Income Deduction

Legal reference: 441 IAC 75 (Rules in Process)

Apply a 20% deduction to the gross nonexempt monthly earned income of each person whose income must be considered when determining eligibility. This deduction is intended to include all work-related expenses other than child or adult care, such as:

- Taxes
- Transportation
- Meals
- Uniforms

Deduction for Child or Adult Care Expense

Legal reference: 441 IAC 75 (Rules in Process)

Each person whose income is considered is entitled to a deduction for care expenses as follows:

- **From earnings of people in the eligible group and ineligible parents**, allow child or adult care expenses for care of a person in the eligible group.

  Do not allow care expenses for a child living in the home who is not in the eligible group, such as a sanctioned child or a child who receives SSI.

  Do allow care expenses for a child not in the eligible group because the child receives Medicaid as the newborn child of a Medicaid-eligible mother.

- **From earnings of ineligible stepparents**, allow child-care expenses for care of the stepparent's ineligible dependents, including the common but ineligible child. Do not allow care expenses for an FMAP-related child.

- **From earnings of self-supporting parents**, allow child-care expenses for care of their ineligible dependents.

Allow the deduction without regard to whether the care is provided by a licensed facility. Do not allow the deduction when the expense is paid to a parent of the child, to another member of the eligible group or to any person whose needs are met by diversion of income from any person in the eligible group.

Allow a deduction for a grandparent paying the expenses for care of a grandchild who is in the same eligible group as the grandparent's own child, e.g., a three-generation FMAP-related case. Also allow the deduction for a child on a nonparental case when the nonparental relative also has a separate parental case, provided child care is needed for the nonparental child.

Guidelines for Applying the Child/Adult Care Deduction

Legal reference: 441 IAC 75 (Rules in Process)

Policy: When both parents are in the home, adult or child care expenses will not be allowed when one parent is unemployed and is physically and mentally capable to provide the care.

An applicant or member may receive a deduction for care expenses that have been billed or otherwise are anticipated to become due in the month. It is not required that the person actually pay the bill before it can be allowed as an expense. Accept the client's statement as to the amount of the expense. A receipt or signed statement from the care provider may be requested when the expense is questionable.

Procedure: Project and use the cost of care as a deduction only when it covers:

- The actual hours of the person's employment plus a reasonable period of time for commuting, or
- The period of time that the person who would normally care for the child or incapacitated adult is sleeping because the person's work schedule is such that the person must sleep during the waking hours of the child or incapacitated adult. Exclude any hours a child is in school.

Project and use the actual expense due in the month not to exceed the following:

- $175 per month per child for children age two or older.
- $200 per month per child for children under age two. (Allow $200 for the month the child turns two unless the birthday falls on the first of the month.)
- The going rate in the community if the going rate is less than the $175 or $200 limit.

Comment: Consider any special needs of a physically or mentally handicapped child or adult when determining the deduction. However, do not exceed the maximum allowable deduction amounts.

When the payment for care outside the home includes meals, consider the cost for the meals as part of the expense.

Do not deduct any part of the expense that is paid by a third party, such as the Child Care Assistance Program. Deduct only the part of the expense that was not paid by a third party, up to the allowable maximum amount.

1. Ms. A and her two children apply for FIP and Medicaid. Ms. A has $1,200 projected gross monthly earnings and pays $300 per month for child care. Ms. A has applied for Child Care Assistance (CCA) and wants to know how that will affect her eligibility. The worker uses the following calculations to help Ms. A decide whether to participate in the CCA program.

   Medicaid eligibility with a child care deduction:

$	1,200.00	Projected gross earnings
-	240.00	20% earned income deduction
-	300.00	Projected child care paid by Ms. A
$	660.00	
-	382.80	58% deduction
$	277.20	Projected net income (less than limit for three people)

   Ms. A and her two children would be eligible for Medicaid under FMAP.

   Medicaid eligibility without a child care deduction:

$	1,200.00	Projected gross earnings
-	240.00	20% earned income deduction
$	960.00	(Compared to Test 2; exceeds limit for three people)

   Ms. A and her two children would not be eligible for Medicaid under FMAP without a child care deduction. The two children could be eligible under MAC and Ms. A would be conditionally eligible under Medically Needy.

   Medically Needy spenddown calculation for Ms. A:

$	1,200.00	Projected gross earnings
-	240.00	20% earned income deduction
$	960.00	
-	566.00	MNIL for three people
$	394.00	x 2 months = $788 spenddown for Ms. A

   Ms. A states she has no other health insurance and needs her medical card. She chooses to continue to pay her own child-care expenses and not participate in the CCA program. Ms. A and her two children are eligible for Medicaid under FMAP.

2. Ms. B and her two children (over the age of two) receive FIP and FMAP. Her projected gross income is $1,400 per month and her projected monthly child care is $440. The worker uses the following calculations to help Ms. B decide whether or not to participate in the CCA program.

   Medicaid eligibility with a child care deduction:

$	1,400.00	Projected gross earnings
-	280.00	20% earned income deduction
-	350.00	Projected child care ($175 max per child)
$	770.00	
-	446.60	58% deduction
$	323.40	Projected net income (less than limit for three people)

   Ms. B and her children would continue to be eligible under FMAP.

Medicaid eligibility without a child care deduction:

$ 1,400.00	Projected gross earnings
- 280.00	20% earned income deduction
$ 1,120.00	(Compared to 133% of poverty for a MAC determination)
- 649.60	58% deduction
$ 470.40	Projected net income (exceeds limit for three people)

Ms. B and her children would not continue to be eligible for Medicaid under FMAP without a child-care deduction. The children could be eligible under MAC and Ms. B would be conditionally eligible under Medically Needy.

Medically Needy spenddown calculation for Ms. B:

$ 1,400.00	Projected gross earnings
- 280.00	20% earned income deduction
$ 1,120.00	
- 566.00	MNIL for three people
$ 554.00	x 2 months = $1,108 spenddown for Ms. B

If Ms. B chooses to participate in the CCA program, it will pay the entire $440 monthly child care costs, but she will only be conditionally eligible for Medically Needy with a spenddown. The children would be redetermined to the MAC coverage group.

If Ms. B chooses not to participate in CCA, they all remain eligible under FMAP, but she will be allowed only the maximum child care deduction of $350 when she actually projects paying $440 per month.

58% Work Incentive Deduction

Legal reference: 441 IAC 75 (Rules in Process)

After deducting the 20% earned income deduction, care expenses, and diversions, deduct 58% of the total remaining monthly nonexempt earned income of each person whose income must be considered in determining eligibility.

Follow FMAP-related policies when determining applicable deductions. If a person is eligible for these deductions also apply them when determining retroactive Medicaid eligibility under FMAP-related coverage groups.

Ms. A receives FMAP for herself and one child. Also in the home is another child who is not in the eligible group due to the lack of a social security number.

Ms. A's projected gross earnings are $700. She has $100 projected unearned income per month and projected child-care expenses of $175 per month for the child on FMAP. Ms. A has chosen not to participate in the Child Care Assistance (CCA) program.

$	700.00	Projected gross earnings
-	140.00	20% earned income deduction
$	560.00	
-	175.00	Projected child care expenses for the FMAP child
$	385.00	
-	65.00	Diversion for the ineligible child ($426 - $361 = $65)
$	320.00	
-	185.60	58% work incentive deduction
$	134.40	Projected countable earnings
+	100.00	Projected unearned income
$	234.40	Combined projected earned and unearned countable income
		Eligible for FMAP

Do not apply the 58% deduction in the 185% test (Test 1).

Do not apply the 58% deduction in the standard of living cost test (Test 2) when determining initial eligibility, regardless whether the person with the countable earnings is included in the eligible group.

1. Ms. B applies for Medicaid. She has two children. Her gross monthly earnings are projected at $1,200, and her child-care expenses are projected at $200 per month. She has chosen not to participate in Child Care Assistance (CCA).

   Test 1

   $1,200 projected gross income is less than the 185% standard of need for three. The household is eligible under Test 1.

   Test 2

$	1,200.00	Projected gross income
-	240.00	20% earned income deduction
-	200.00	Projected child care expenses
$	760.00	Less than $849 FMAP standard of living cost for three

   The household is eligible under Test 2.

   Test 3

$	1,200.00	Projected gross income
-	240.00	20% earned income deduction
$	960.00	
-	200.00	Projected child care expenses
$	760.00	
-	440.80	58% work incentive deduction
$	319.20	Less than the FMAP income limit for three

   The household is eligible under Test 3.

2. Household consists of: Mrs. Z, 32, no income
Child A, Mrs. Z's child
Mr. Z, 39, projected earnings of $1,230 per month
Child C, a common child

The family applies for Medicaid for Mrs. Z and Child A. Eligibility is explored for a four-member eligible group. The worker determines eligibility as follows:

$ 1,230.00	Mr. Z's projected earnings
- 246.00	20% earned income deduction
$ 984.00	
- 570.72	58% work incentive deduction
$ 413.28	Less than FMAP standard of need for four.

If they meet other eligibility factors, the Zs are eligible for Medicaid under FMAP.

3. Household consists of: Ms. T, 28, $500 projected monthly earned income
Child A, 5, Ms. T's child
Mr. R, 30, $1,000 projected monthly earned income
Child C, 3, a common child

Ms. T and Mr. R are not married. They apply for Medicaid for Ms. T, Child A, and Child C. The worker explains that because they want Medicaid for Child C, Mr. R must be included in the FMAP-related Medicaid eligible group. The household projects a $100 per month child care expense for each child. The worker determines FMAP-related Medicaid eligibility as follows:

Test 1

$ 1,000.00	Mr. R's projected earnings
+ 500.00	Ms. T's projected earnings
$ 1,500.00	Less than the FMAP 185% limit for four people

Test 2

$ 1,000.00	Mr. R's projected earnings
+ 500.00	Ms. T's projected earnings
$ 1,500.00	
- 300.00	20% earned income deduction
$ 1,200.00	
- 200.00	Projected child care for Child A and Child C
$ 1,000.00	Greater than the FMAP standard of need for four people

The eligible group is not eligible for Medicaid under FMAP. However, since $1,000 is less than 133% of poverty for four people, Child A and Child C are eligible for Medicaid under MAC. Ms. T and Mr. R are conditionally eligible for Medicaid under Medically Needy with a spenddown. The worker calculates the spenddown as follows:

$ 1,500.00	Combined projected earnings of Ms. T and Mr. R
- 300.00	20% earned income deduction
- 200.00	Projected child care for Child A and Child C
$ 1,000.00	Projected countable monthly income
$ 2,000.00	Projected countable monthly income for two months
- 1,332.00	$666 four person MNIL for two months
$ 668.00	Spenddown for Ms. T and Mr. R

4. Household consists of: Mrs. P, 38
Child A, 15, Mrs. P's child
Child B, 13, Mrs. P's child
Mr. P, 40, $800 projected monthly earned income
Child C, a common child

The family applies for Medicaid. Mr. P projects a $50 per month child support payment for a child outside the home. Mrs. P, Child A, and Child B have no income. The worker determines Medicaid eligibility as follows:

Test 1

$800.00	Mr. P's projected earnings are less than the FMAP 185% limit for five people.

Test 2

$ 800.00	Mr. P's projected earnings
- 160.00	20% earned income deduction
$ 640.00	
- 50.00	Projected child support paid by Mr. P
$ 590.00	Less than the FMAP standard of need for five people

Test 3

$ 800.00	Mr. P's projected earnings
- 160.00	20% earned income deduction
$ 640.00	
- 50.00	Projected child support paid by Mr. P
$ 590.00	
- 342.20	58% work incentive deduction
$ 247.80	Less than the FMAP income limit for five people

If all other eligibility factors are met, the five-member eligible group is eligible for Medicaid under FMAP.

5. Household consists of: Mrs. D, 28, no income
Child A, 5, Mrs. D's child, no income
Child B, 3, Mrs. D's child, no income
Mr. P, 40, $1,800 projected monthly earned income
Child C, a common child

The family applies for Medicaid for everyone. Mr. P projects a $50 per month child support payment for a child outside the home. The worker determines eligibility as follows:

Test 1

$ 1,800.00	Mr. P's projected monthly earnings are less than the FMAP 185% limit for five people.

Test 2

$ 1,800.00	Mr. P's projected monthly earnings
- 360.00	20% earned income deduction
- 50.00	Projected child support paid by Mr. P
$ 1,390.00	Greater than the FMAP standard of need for five people

Medicaid eligibility under FMAP does not exist because the projected countable income before the 58% earned income deduction exceeds the FMAP standard of need for five people. However, the three children are eligible for Medicaid under MAC, because the projected countable income of $1,390 is less than the MAC income limit at 133% of poverty for five people.

Mr. P and Mrs. D are conditionally eligible under Medically Needy with a spenddown. The worker determines the spenddown as follows:

$ 1,800.00	Mr. P's projected monthly earnings
- 360.00	20% earned income deduction
- 50.00	Projected child support paid by Mr. P
$ 1,390.00	Projected countable monthly income
$ 2,780.00	Projected countable monthly income for two months
- 1,466.00	$733 five person MNIL for two months
$ 1,314.00	Spenddown for Mr. P and Mrs. D

6. Household consists of: Mrs. F, 25, $400 projected monthly earned income
Child A, 6, Mrs. F's child
Mr. F, 27, $800 projected monthly earned income
Child B, a common child

The family applies for Medicaid. The worker determines eligibility as follows:

Test 1

$ 1,200.00	Mr. and Mrs. F's projected monthly earnings are less than the FMAP 185% limit for four people.

Test 2

$ 1,200.00	Mr. and Mrs. F's projected monthly earnings
- 240.00	20% earned income deduction
$ 960.00	Less than the FMAP standard of need for four people

Test 3

$ 1,200.00	Mr. and Mrs. F's projected monthly earnings
- 240.00	20% earned income deduction
$ 960.00	
- 556.80	58% work incentive deduction
$ 403.20	Less than the FMAP income limit for four people

If all other eligibility factors are met, the entire eligible group is eligible for Medicaid under FMAP.

Diversion for People Not in the Home

Legal reference: 441 IAC 75 (Rules in Process)

When the parent is actually making payments, divert nonexempt earned and unearned income of the FMAP-related parent to permit payment of court-ordered support to children (of the parent) who are not living with the parent.

Allow the diversion for back child support as well as current child support. Allow the diversion regardless whether the parent is in the eligible group (e.g., for an ineligible parent or the ineligible companion in the home).

Do not allow a diversion from the income of the FMAP-related parent for court-ordered alimony payments.

In some situations, child support can be deducted directly from social security disability income. The gross and net amounts on Data Sources may not reflect the child support payment. Verification other than Data Sources is necessary in these cases.

Diversion for the Needs of an Ineligible or Voluntarily Excluded Person

Legal reference: 441 IAC 75 (Rules in Process)

The following sections explain:

- How to divert income for the needs of an ineligible of voluntarily excluded child
- How to determine the needs of a common ineligible child
- How diversion applies to ineligible parents
- How diversion applies to voluntarily excluded parents

Ineligible or Voluntarily Excluded Child

Divert nonexempt earned and unearned income of the FMAP-related parent to meet the unmet needs of that parent's ineligible or voluntarily excluded dependent children who live in the family group. Ineligible children for whom a FMAP-related parent may divert income include:

- Ineligible common children.
- Children who are ineligible aliens.
- Children without social security numbers.
- Children voluntarily excluded for reasons other than excess income.

Do **not** divert income to meet the needs of a child who:

- Has been voluntarily excluded due to excess income.
- Is required to be in the eligible group but who has failed to cooperate, (e.g., a child who fails to apply for benefits from other sources such as unemployment benefits).

1. The Medicaid household consists of Mrs. C and her two children, Bob and Tom. Mrs. C is employed. Tom is ineligible because he does not have a social security number. Mrs. C's income from her earnings is diverted to meet Tom's needs.
2. The Medicaid household consists of Mrs. B, her son Jim, age 5, and her son Tony, age 17. Tony is not in school and he refuses to apply for unemployment (he was previously employed). Income is not diverted from Mrs. B to meet Tony's needs.
3. The Medicaid household consists of Ms. D and her three children. Ms. D voluntarily chooses to exclude Child A because Child A receives child support that would affect Ms. D's FMAP-related Medicaid eligibility. Income is not diverted from Ms. D to meet Child A's needs because the child support meets child A's needs.

Determine if a child has unmet needs before allowing a diversion from the FMAP parent's income. NOTE: A system-generated cancellation of a child due to the expiration of the 90-day reasonable opportunity period for verifying citizenship will convert the child to "considered" person status on the ABC system. The ineligible child is not allowed a diversion in this situation.

The maximum income that can be diverted to meet the unmet needs of the dependent ineligible children is the difference between:

- The needs of the eligible group with the ineligible children **included**, and
- The needs of the eligible group with the ineligible children **excluded**.

Use this formula for all FMAP-related programs, including MAC and Medically Needy.

Determining Needs of the Common Ineligible Child

This section applies to two-parent households with a common ineligible child and one or more children from a parent's previous relationship.

The household consists of Ms. A and Mr. B, their common child, and Ms. A's child from a previous relationship. The common child is not eligible for Medicaid because he does not have a social security number. Ms. A and her child are a two-member eligible group and Mr. B is a separate one-member eligible group. Mr. B is eligible for Medicaid because he has a child (the common child) in his care.

Either FMAP-related parent can divert income to the ineligible common child. The family should make the decision regarding which parent will divert income to the ineligible common child, based on the most advantageous situation for their circumstances.

Use the income of each ineligible child to meet only that child's needs.

The maximum income divertible to meet the needs of the common ineligible child is the standard of need for the child minus any countable income of the child.

Ineligible Parent

Ineligible parents remain part of the Medicaid-eligible group as "considered persons." No diversion is necessary to meet their needs.

Voluntarily Excluded Parents

Parents who are voluntarily excluded for the following reasons are not part of the Medicaid-eligible group. However, no diversion is allowed to meet the needs of these voluntarily excluded parents.

- The biological parent whose needs are voluntarily excluded because the income of a stepparent has been voluntarily excluded in order for a stepchild to establish Medicaid eligibility.
- The minor parent whose needs are voluntarily excluded because the income of the minor parent's self-supporting parents has been voluntarily excluded in order for the minor parent's child to establish Medicaid eligibility.

Treatment of Stepparent Income

Legal reference: 441 IAC 75 (Rules in Process)

When a stepparent is not included in the eligible group but is living with the parent **in the home of the eligible children**, treat the stepparent's income as you would the income of a natural parent, except as otherwise specified.

When the stepparent living in the home is not included in the eligible group, consider the eligible group and any dependent, but ineligible children of the parent, as one unit. Consider the stepparent as a separate unit. The common ineligible child is part of the stepparent's unit.

When the household consists of an SSI parent, the SSI parent's children, and a stepparent, the stepparent should be voluntarily excluded to avoid using the stepparent's income in determining eligibility of the children. The SSI parent's Medicaid is not affected by the stepparent being voluntarily excluded.

Count a nonrecurring lump sum received by a stepparent as income in the month received. Any income remaining after the stepparent's deductions are subtracted is considered unearned income available to meet the needs of the eligible group.

Consider any part retained by the stepparent in the month following the month of receipt to be a resource to the stepparent. Do not calculate a period of ineligibility due to receipt of the lump sum unless the *stepparent* is included in the eligible group.

The following sections explain:

- Income deductions allowed for stepparents
- Treatment of the parent's income in a stepparent case

Deductions

Legal reference: 441 IAC 75 (Rules in Process)

Allow the following deductions from the stepparent's monthly nonexempt gross earned income earned as an employee or the net profit from self-employment:

1. A 20% earned income deduction.
2. Adult or child-care expenses for the stepparent's ineligible dependents in the home, including the common child. Do not consider the stepparent's spouse (the FMAP-related parent) as a dependent of the stepparent.
3. The stepparent's alimony and child support payments, made to people not living in the home with the stepparent. The payments do not have to be court-ordered.

   If these payments have been made in the past and the stepparent is projecting child support and alimony payments will continue in the same manner, verify that the payments have been made and project accordingly.

   If these payments have not been made in the past or the stepparent is projecting payments in a manner different than they have been made in the past, obtain a signed and dated statement from the stepparent regarding the amount and frequency the stepparent anticipates making the payments.
4. Any verified amounts the stepparent pays to people who are not living in the home, but who are claimed (or could be claimed) by the stepparent as dependents for federal income tax purposes.

   If these payments have been made in the past and the stepparent is projecting the payments will continue in the same manner, verify that the payments have been made and projected accordingly.

   If these payments have not been made in the past or the stepparent is projecting payments in a manner different than they have been made in the past, obtain a signed and dated statement from the stepparent regarding the amount and frequency the stepparent anticipates making the payments.
5. From the income that remains after deductions 1-4, allow a diversion for the needs of the stepparent and the stepparent's ineligible dependents living in the home whom the stepparent claims or could claim for federal income tax purposes (including the ineligible common child).

   Determine the need of the stepparent and the stepparent's ineligible dependents in the home according to the Standard of Need for that size family.
6. Apply a 58% work incentive deduction to earnings that remain after deductions 1-5 have been subtracted from earnings.

   EXCEPTION: Do not allow the 58% work incentive deduction when determining:

   - Initial eligibility under the 185% test,
   - Initial eligibility under the standard of need test, or
   - Eligibility under MAC and Medically Needy.

Household consists of:
Mrs. M
Mr. M, stepparent
Child A, Mrs. M's child from a previous relationship
Child B, Mrs. M's child from a previous relationship

Mr. M has $800 gross earnings. He has no diversions except for his own needs. The family has no other income. They have applied for Medicaid. To determine eligibility under FMAP for Mrs. M and her two children, follow the following procedures:

1. 185% Test (test 1): Compare the gross figure for a three-person FMAP-eligible group to $800 gross earnings, minus 20%, the income deduction, minus $365, the diversion for Mr. M's needs. ($800 - $160 = $640 - $365 = $275 < $1,570.65)
2. Standard of Need Test (test 2): Compare the standard of need for a three-person FMAP-eligible group to $800 gross earnings, minus 20%, the income deduction, minus $365, the diversion for Mr. M's needs. ($800 - $160 = $640 - $365 = $275 < $849)
3. Benefit Standard Test (test 3): Compare the benefit standard for a three-person FMAP-eligible group to $800 gross earnings, minus 20%, the income deduction, minus $365, the diversion for Mr. M's needs, minus 58%, the work incentive. ($800 - $160 = $640 - $365 = $275 - $159.50 (58% of $275) = $115.50 < $426)

When the stepparent has both nonexempt earned and unearned income, and the earnings are less than the allowable deductions, subtract any remaining portion of deductions 3 through 5 from the unearned income. Apply any income that remains as unearned income to the eligible group.

If the stepparent has earned income that remains after allowable deductions, add any unearned income to the remaining earnings.

Apply the total remaining income of the stepparent after allowable deductions as unearned income to the eligible group. Except as noted in item 5, this is also the income that is applied to the eligible group when determining eligibility under the 185% standard, initial eligibility, and continuing eligibility.

Mrs. A receives FMAP for herself and her two children. Mr. A is the stepparent. Mrs. A has no income. Mr. A has projected gross earnings of $850 per month.

$ 850.00	Mr. A's projected gross income
- 170.00	20% deduction
$ 680.00	
- 365.00	Diversion for the stepparent
$ 315.00	
- 182.70	58% work incentive deduction
$ 132.30	Projected countable income

$132.30 is within the 185% FMAP income limit for the three-person eligible group.

Do not consider the income of the stepparent's dependents to be available to the eligible group. However, consider dependents' income when determining the amount of their unmet needs.

When determining unmet needs, treat the income of the dependents in the same way as the income of a person in the eligible group is treated.

> A mother and one child receive FMAP. They live with the stepparent and a voluntarily excluded common child. The stepparent has projected unearned income of $350 each month. The common child has projected unearned income of $356 each month.
>
> The common child's needs are $354 ($719 - 365). However, the child's $2 excess income cannot be used to meet the needs of the FMAP eligible group. Since there is no unmet need, none of the stepparent's income is used to meet the needs of this child.

In all calculations, determine the needs of the stepparent's unit, including the needs of the common child, based on the Standard of Need schedule.

To determine the needs of any person (or group of people) in either household unit, take the difference between the unit's needs with that person's needs included and the unit's needs with the person's needs excluded.

> The household consists of Mrs. P, her three children by a previous relationship, Mr. P, and their common child.
>
> If this household of six is not eligible as one unit, the group may become two units. Mrs. P and her three children comprise the parent's unit. Mr. P and the common child comprise the stepparent's unit. The children's needs are determined as follows:
>
> - The common child's needs are based on the standard of need (Test 2). Start with the standard of need for two people, Mr. P and the common child. Subtract the needs of Mr. P. ($719 minus $365 = $354).
> - If any of Mrs. P's other children are ineligible, start with the basic needs of all three children and Mrs. P (Test 3 for a four-member group). Subtract the needs of the ineligible children. For example, if two children were not eligible because they did not verify citizenship, their needs would be $134 ($495 minus $361 = $134).

Parent's Income in Stepparent Cases

Legal reference: 441 IAC 75 (Rules in Process)

When the income of a stepparent who is not in the eligible group is not enough to meet the needs of the stepparent and the dependent but ineligible children living in the home, divert the parent's income to meet the unmet needs of the children of the current marriage.

See Determining Needs of the Common Ineligible Child for exceptions when the FMAP parent cannot divert income to an ineligible common child.

The household consists of Mrs. J, her husband, a common child, and Mrs. J's child. The stepparent has projected countable income of $500. Mrs. J's income after allowable work expenses is $248. The worker diverts from Mrs. J's income to meet the needs of the common child.

$ 719.00	Needs of stepparent and common child
- 500.00	Stepparent's projected income
$ 219.00	Unmet needs of the common child
$ 248.00	Parent's projected net income
- 219.00	Diverted to meet the unmet needs of the common child
$ 29.00	Use for needs of eligible group

Do not divert the parent's income to meet the needs of the ineligible stepparent or the stepparent's dependent children living in the home.

The household consists of the parent, the stepparent, stepparent's child (not in the eligible group), and the parent's child. The stepparent has $250 projected countable income. The parent has $100 projected income after work expenses. None of the parent's income can be diverted to meet the unmet needs of the stepparent and the stepparent's child.

Ineligible Parent Deductions

Legal reference: 441 IAC 75 (Rules in Process)

If the ineligible parent's income, along with any other income of the eligible group, passes the 185% eligibility test (Test 1) for the size of the eligible group:

1. Deduct the 20% earned income deduction.
2. Deduct child and adult care expenses.
3. Divert for people not in the home (for example, court-ordered child support).
4. Divert for an ineligible or voluntarily excluded person's needs. See Diversion for the Needs of an Ineligible or Voluntarily Excluded Person.

   Remember: Use the Schedule of Living Costs (Test 2) for the standard of need test and the Schedule of Basic Needs (Test 3) for the eligibility test.
5. Apply a 58% work incentive deduction from earnings that remain after deductions 1 through 4 have been subtracted from the earnings. EXCEPTION: Do not allow the 58% work incentive deduction when determining initial eligibility under the standard of need test (Test 2) for the eligible group.

When the ineligible parent has both nonexempt earned and unearned income, and earnings remain after applying allowable deductions, add the unearned income to the remaining earned income. If the earnings are less than the allowable deductions, subtract any unused portion of the diversion for people not in the home or voluntarily excluded persons from the unearned income. Consider the balance to be countable income.

Apply all remaining income of the ineligible parent in determining eligibility for the eligible group.

1. Mr. A receives Medicaid for his two children. Mr. A is sanctioned for failure to cooperate with CSRU. He has projected gross earnings of $800, projected child-care expenses of $374 per month, and projects $100 monthly child support for a child not living with him.

$	800.00	Projected gross earnings
-	160.00	20% earned income deduction
$	640.00	
-	374.00	Projected child care deduction
-	100.00	Projected child support
$	166.00	Projected countable earnings
-	96.28	58% work incentive deduction
$	69.72	Projected countable income
$	426.00	Schedule of basic need for three (Mr. A is "considered")
-	69.72	
$	356.28	Medicaid eligible for the two children

2. Household composition: Mrs. E, who is employed, and her three children. Mrs. E's deceased husband was a veteran, but she refuses to apply for Veterans Benefits. Mrs. E is sanctioned and is no longer eligible for Medicaid. However, the eligible group remains a household of 4.

3. Mr. and Mrs. F apply for Medicaid on June 24, listing themselves and Mrs. F's four children from a previous relationship. Mrs. F is not eligible for Medicaid because she is an ineligible alien but she is included in the eligible group as a "considered" person. Mrs. F has projected gross monthly earnings of $1,000 and $100 projected child care costs per month. The family has no other income.

   Step 1: 185% Eligibility Test (Test 1)
   Mrs. F's $1,000 projected monthly gross earned income is less than the gross income limit of $2,020.20 for a five-person eligible group. Income passes Test 1.

   Step 2: Schedule of Living Costs (Test 2)

$	1,000.00	Mrs. F's projected monthly gross earnings
-	200.00	20% earned income deduction
$	800.00	
-	100.00	Monthly projected child care
$	700.00	Projected countable income

   Income passes Test 2. Projected countable income is $700 and the Schedule of Living Costs for five is $1,092.

   Step 3: Basic Needs Test (Test 3)

$	1,000.00	Mrs. F's projected monthly gross earnings
-	200.00	20% earned income deduction
$	800.00	
-	100.00	Monthly projected child care
$	700.00	
-	406.00	58% work incentive deduction
$	294.00	The four children are eligible for Medicaid since the projected countable income is less than the Basic Needs for five people.

Processing Medically Needy Applications

This section explains different or additional requirements for Medically Needy that do not apply to other coverage groups. Use the general guidelines provided in 8-B unless a unique requirement is listed in the following sections:

- Applications
- Recertifications
- Interviews
- Time limits
- Effective date of assistance
- Retroactive eligibility

Applications

Legal reference: 441 IAC 76.1(249A)

Use form 470-5170 or 470-5170(S), *Application for Health Coverage and Help Paying Costs*. See 8-B, *Which Application Form to Use*.

If it is necessary to determine Medically Needy eligibility for the period before a member's SSI eligibility was approved, accept the member's statement regarding the day of onset of blindness or disability unless there is evidence to the contrary. Examine retroactive eligibility for an SSI recipient the same as you would any other applicant.

Use form 470-5170 or 470-5170(S) to determine eligibility for SSI-related Medically Needy when an SSI member becomes ineligible for SSI due to income or resources after the effective date of the SSI eligibility approval.

An applicant may withdraw the application for the month filed if the applicant wants to have the certification period begin the following month. Issue a *Notice of Decision* for the month the applicant withdrew. Process the application for the two following months.

> Mr. T files an application on October 28. When the IM worker contacts Mr. T, he states that he does not have any medical expenses for the month of October and requests that his certification period begin with the month of November.
>
> The IM worker issues a *Notice of Decision* stating that the client withdrew the application for October. The IM worker processes the same application for the certification period of November and December.

See 8-B, *Grace Period Following the Denial of an Application*.

Recertifications

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

Policy: Recertification is the process to establish a new certification period when the previous period has expired. The member must complete form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review,* for a recertification.

Recertifications can be completed as long as there is no break in assistance (more than three months between the end of the last certification period and the beginning of the next certification period). If there is a break in assistance, the client must complete a new application to be recertified.

Comment: Recertification is not done for people with ongoing eligibility, but an annual review is required. No grace period is allowed for recertifications.

It is not a requirement that the Department send the *Medicaid/State Supp Review* to a person whose two-month certification period ends. If a person does not have enough medical expenses to meet the spenddown for a certification period, it is not recommended that the person complete the *Medicaid/State Supp Review*.

Medical expenses that occurred in a certification period when spenddown is not met cannot be moved forward to the next certification period. Depending on the situation, it may be better for the person to wait and apply when there are old bills that can be used to meet a spenddown.

Interviews

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

An interview is not required when determining Medicaid eligibility for FMAP-related or SSI-related applicants or members unless you determine an interview is necessary to:

- Clarify information on the application,
- Clarify questionable information, or
- Ensure there is a better understanding of programs.

It is important to treat applicants and members equitably and to use the "prudent person concept." See 8-A, *Definitions* for "prudent person concept."

An interview shall not be required for children as defined by the Medicaid program. Grant an interview if the applicant, member, or authorized representative request one.

It may be necessary to contact the applicant to explain the differences in the Medically Needy program policies for Family Medical Assistance Program (FMAP)-related and Supplemental Security Income (SSI)-related coverage groups when a person would qualify under more than one coverage group.

If an applicant is ineligible for FMAP, provide the applicant an explanation of the Medically Needy program and process the application.

Ms. A, age 70, is approved for Medically Needy August 15. She continues to reapply every two months. The worker determines there is some information that needs to be clarified and schedules an interview. Ms. A informs her worker that her health does not allow her to go to the office.

As Ms. A does not have any family members or other persons that can represent her at the interview, the worker sets a time with Ms. A for either an interview by telephone or a home visit.

Procedure: To require a face-to-face interview or a phone interview, you must request a scheduled time with the applicant or member. When an interview is needed or is requested by an applicant, a member, or an authorized representative, schedule a date, time, place, and method of the interview (in the local office, home visit, or by phone, etc.).

Grant requests to reschedule when you determine that the applicant, member, or authorized representative is making every effort to cooperate with the interview process. Interviews rescheduled at the request of the applicant, member, or authorized representative may be agreed upon verbally and documented without written confirmation.

Failure to attend the interview you requested, including a scheduled phone interview, is cause to deny or cancel the adults on the application.

Contact the applicant or member whenever you need to clarify information in order to determine eligibility.

When you ask a client to come in to the local office for an interview, do not deny or cancel the children if the adult fails to attend the interview. However, if you request information at the same time as you set up an interview and the information is not provided within ten days, you may cancel or deny the entire household for failure to provide requested information.

Program Information

Legal reference: 42 CFR 435.905, Iowa Code Chapters 217 and 249A

In addition to the requirements listed under Interviews, you must also explain either orally or in writing the following to clients, prospective clients, and anyone asking about the Medically Needy program:

- The definition of "conditionally eligible" and "responsible relative."
- The use of the income and resources of all conditional eligibles and responsible relatives to determine eligibility.
- Resource guidelines.
- The Medically Needy income level.
- The spenddown process and the medical expense verification form.

Time Limit for Eligibility Decision

Legal reference: 42 CFR 435.912(c)(3)(i)-(ii), Iowa Code Section 249A.4

The applicant must receive a written notice of approval, conditional eligibility, or denial as soon as all information is available, but no later than 45 days from the date of application. Extend the notice deadline to 90 days from the date of application if an SSI-related applicant applies for benefits based on blindness or disability and a disability determination has not yet been made. See 8-B, *Processing Standards* for what to do if the determination exceeds 90 days.

Follow the guidelines in 8-B, *Processing Standards* regarding the extension of the time limit for sending a *Notice of Decision* when the applicant and county office make every reasonable attempt to obtain the necessary information and conditions exist that are beyond their control.

Effective Date of Assistance

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

Eligibility begins on the first day of the first month of the certification period in which the client's income is reduced to the Medically Needy income level or the client was determined to have ongoing eligibility.

Enter all Medically Needy applications onto the Automated Benefit Calculation (ABC) system. Cases that are approved and have zero spenddown in the retroactive certification period or have ongoing eligibility are maintained by the ABC system and are not passed to the Medically Needy Subsystem. People with active fund codes are automatically eligible for Medicaid.

Cases that have a spenddown in either the retroactive or the prospective certification period have information passed to the Medically Needy Subsystem. When the spenddown obligation is met, the Medically Needy Subsystem issues a *Notice of Spenddown Status* (NOSS).

Retroactive Eligibility

Legal reference: 441 IAC 75 (Rules in Process), 76 (Rules in Process)

A client may be eligible for retroactive Medically Needy benefits for a period of one, two, or three months preceding the month when the application was filed. The applicant does not need to be eligible in the month of application to be eligible for the retroactive period. To be eligible for retroactive benefits, the applicant must meet the following:

- Have incurred medical expenses for Medicaid-covered services that were received during the retroactive period. These expenses may be paid or unpaid.
- Would have been eligible for Medicaid benefits in the month services were received if application had been made (even if the applicant is not alive when the application is filed).
- Meet a category of eligibility for the retroactive period as defined in 8-A, *Definitions*.

The retroactive certification period begins with the first of these three months in which the client received Medicaid-covered services. It continues to the end of the month immediately before the month of application.

Exclude from the Medically Needy certification period any month in which the client received Medicaid or if the applicant would have been eligible for Medicaid under another coverage group. (See Eligibility Under Another Coverage Group.)

Mrs. Z applies for Medically Needy for her family on September 19. They have previously received FMAP January through June. Mrs. Z has paid for medical services that she incurred in July. She has an unpaid medical bill for services her 11-month-old daughter received in August. The retroactive period for Medically Needy is established for only one month, August, and only for her daughter.

May	June	July	August	September	October
FMAP	FMAP	No eligibility	Retroactive period for Medically Needy for daughter	Current certification period	

If there are medical expenses for Medicaid covered services (either paid or unpaid) in any month of the retroactive period, complete a spenddown calculation. If there are no medical expenses in all months of the retroactive period, you do not need to do a spenddown calculation.

Mrs. J, a pregnant woman, applies for Medicaid May 4 and requests retroactive eligibility. She paid a medical bill on March 15. The medical expense was for Medicaid-covered services received in January. Mrs. J did not incur any medical expenses in the retroactive months of February, March, or April.

Retroactive eligibility is denied, because Mrs. J did not incur any medical expenses in the retroactive months of February, March, or April.

See Income and Spenddown in the Retroactive Period for more information on calculating spenddown.

Eligibility Under Another Coverage Group

Retroactive periods may involve eligibility determinations for several coverage groups. Therefore, before determining Medically Needy eligibility, establish that the applicant is ineligible for all other Medicaid coverage groups. Send form 470-0397, *Request for Special Update*, to Quality Assurance (QA) to update the Medicaid eligibility file in the following situations:

- Situation: The state ID does not show on SSNI. The client is eligible for Medically Needy in the current month or for ongoing eligibility and is eligible for the retroactive months under another coverage group. Enter the Medically Needy case on ABC. After ABC updates, send Quality Assurance a *Request for Special Update* for the retroactive months that are under another coverage group.
- Situation: The state ID does not show on SSNI. The client is not eligible for the month of application or ongoing eligibility, but is eligible for retroactive Medicaid. Process the denial for the current or ongoing eligibility on ABC. In this situation, QA builds an SSNI file for the retroactive months. QA needs the following to build an SSNI file:
  - Memo with all case and individual information.
  - *Request for Special Update* showing the aid type and months in which eligibility exists.

- Situation: Ongoing Medicaid eligibility does not exist. An individual eligibility record exists on SSNI. Enter retroactive periods that involve another coverage group and a Medically Needy zero spenddown period via the *Request for Special Update*.

Ms. T, age 32 and pregnant, applies for Medically Needy on October 6 for herself and child A, age 11 months. She reports unpaid bills for Medicaid-covered services received in July and August. She has never received Medicaid before. The worker determines Ms. T's eligibility in the retroactive period as follows:

July	**August**	**September**
Eligible for retroactive FMAP	Retroactive eligibility for Medically Needy	Retroactive eligibility for Medically Needy

Ms. T is eligible for retroactive Medicaid through the Family Medical Assistance Program (FMAP) coverage group for July if unpaid or paid medical expenses exist for Medicaid-covered services received in July.

The Medically Needy retroactive period is August and September, even though unpaid medical expenses exist only in August. July's income is not included in the Medically Needy retroactive period, since eligibility existed under another coverage group (FMAP).

Ms. T has a spenddown for the August-September Medically Needy retroactive period.

Her state ID does not show on the SSNI screen, since she has never received Medicaid. Therefore, Quality Assurance cannot enter her July Medicaid eligibility through a *Request for Special Update*.

The worker first processes Ms. T's case in ELIAS reflecting income of the family for the months of July, August, and September for the retroactive period, the month of application, and future months, as required.

Once ELIAS has processed this information, the worker enters Medically Needy eligibility information in the ABC system for the August-September Medically Needy retroactive period.

Determining the Coverage Group

Legal reference: 441 IAC 76.1(249A)

Screen the application to determine if there are other Medicaid coverage groups for which the client would be eligible, including State Supplementary Assistance dependent person. (The income limits of the dependent person coverage group are higher than the MNIL.) Document in the case record that the application was screened for other coverage groups.

Do not grant Medicaid eligibility under Medically Needy if the person could be determined eligible under another coverage group.

When determining if a person is eligible under another coverage group, consider whether the person is eligible for SSI. If a person who would be eligible for SSI wants to apply for cash assistance and Medicaid, refer the person to the Social Security Administration to apply for SSI benefits.

See the following sections for more information on:

- Groups who are eligible for Medically Needy
- Who is not eligible for Medically Needy
- People who are concurrently eligible under Medically Needy and also under QMB or SLMB

Who Is Eligible for Medically Needy

Legal reference: 441 IAC 76.1(249A); 75 (Rules in Process)

The Medically Needy coverage group is available only to people who are not eligible under other Medicaid coverage groups because of excess income or resources.

People eligible for the Medically Needy coverage group are:

- Children under the age of 19 who would be eligible for FMAP or SSI except that their income exceeds the limits.
- Relatives caring for a dependent child who have income or resources exceeding the FMAP limits and who meet the FMAP definition of specified relative.
- Pregnant women over income limits for MAC.
- Pregnant women not eligible for continuous eligibility for pregnant women.
- Women in the postpartum period.
- Newborn children of Medically Needy Medicaid-eligible mothers.
- Persons who are aged, blind, or disabled and who would be eligible for SSI except that their income or resources exceed the limits.
- Children in subsidized guardianship.

Residents of residential care facilities (RCFs) whose income is over the State Supplementary Assistance limits are eligible through the Medically Needy coverage group if they are categorically eligible, e.g., under 19, pregnant, aged, blind, or disabled. The Medically Needy coverage group does not pay for RCF care, but it does pay for other Medicaid-covered services the client receives if spenddown is met.

Applicants have the choice whether to have eligibility determined as SSI-related or FMAP-related, if the person would qualify under more than one group.

Household composition: Mr. and Mrs. S and their child, Sarah, age 13.

Mr. S is employed full time and earns $4,000 per month. Mrs. S is legally blind and works part time for the Blind Commission. She earns $500 per month and receives $2,100 social security disability benefits. The household is over income for FMAP. Mrs. S is not income-eligible for SSI and is over income for MEPD. The application is processed for Medically Needy.

The worker determines whether it is to Mrs. S's advantage to be SSI-related or FMAP-related in determining eligibility.

SSI-related: Follow the procedures for deeming income from a spouse (see 8-E).
FMAP-related: Include Mrs. S's income and treat according to FMAP policy.

If it is to Mrs. S's advantage to be treated as SSI-related, Mrs. S remains a considered person on the FMAP-related case, since she is a parent. If Mrs. S is on the SSI-related case, she cannot be excluded from the FMAP-related case. Mrs. S's medical bills would be used to meet spenddown on both cases. (See SSI-Related, FMAP-Related Composite Households later in this chapter.)

Who Is Not Eligible for Medically Needy

Legal reference: 441 IAC 76.1(249A); 75 (Rules in Process)

A person is not eligible for the Medically Needy coverage group if the person is eligible for another coverage group, with **two exceptions**:

- A client does not have to apply for any home-based or community-based services waiver to be eligible for the Medically Needy program. Allow a client who is eligible for either the Medically Needy coverage group or a waiver program to choose in which program to participate. Certain waivers allow Medically Needy coverage group when the person needs hospital level.
- A client may receive Medicaid under the qualifying Medicare beneficiary coverage group or the specified low-income Medicare beneficiary coverage group and be concurrently eligible for the Medically Needy coverage group. (See Concurrent Eligibles.)
- A person who qualifies both for Medicaid for employed people with disabilities (with or without a premium) and for Medically Needy (with or without a spenddown) may choose which coverage group eligibility is established under. (See 8-F, *Medicaid for Employed People with Disabilities: Relationship to Medically Needy*.)

A person with income less than FMAP-related limits or SSI limits (depending on the coverage group under which the person would be eligible) is not eligible for the Medically Needy coverage group unless resources exceed other Medicaid program limits.

If a person who would be eligible for SSI wants only Medicaid and not cash assistance, grant Medicaid eligibility under the coverage group for persons eligible for but not receiving SSI or SSA cash benefits -- not under the Medically Needy coverage group.

Concurrent Eligibles

Legal reference: Social Security Act, Sections 1902(a)(10)(E)(iii) and 1905(p)(1)

Clients who meet the eligibility requirements for qualified Medicare beneficiary (QMB) or specified low-income Medicare beneficiary (SLMB) may also be concurrently eligible for Medically Needy.

Expanded specified low-income Medicare beneficiaries (E-SLMB) may also be determined conditionally eligible for Medically Needy.

NOTE: Clients who are eligible for E-SLMB are not eligible for other Medicaid coverage groups. If a client who has been determined eligible for E-SLMB meets spenddown for Medically Needy, the Medicare Part B premium will be paid for as a Medically Needy recipient. However, do not cancel the client's E-SLMB case when the client meets spenddown.

QMB and SLMB clients who are concurrently eligible for Medically Needy and E-SLMB clients conditionally eligible for Medically Needy must have two cases:

- One case with a QMB, SLMB, or E-SLMB aid type (90-0, 90-1, or 92-0).
- A second case with a 37-E aid type.

Children in Subsidized Guardianship

Medicaid is available under the Medically Needy program to children in subsidized guardianship for whom Iowa has financial responsibility and who:

- Are not eligible for SSI or IV-E; and
- Are under age 21.

There is no financial test (income and resources) when determining eligibility for subsidized guardianship children.

Medically Needy will not pay for facility level-of-care. The child would have to qualify under some other coverage group that will pay the cost of facility care.

Nonfinancial Eligibility

Most nonfinancial eligibility requirements for Medically Needy eligibility are comparable to those of the underlying categorical eligibility groups. Exceptions and explanations of how these requirements apply in Medically Needy cases are included in the following sections:

- Determining the eligible group (for all coverage groups)
- Requirements for FMAP-related Medically Needy groups
- Requirements for pregnant and postpartum women and newborns
- Requirements for SSI-related Medically Needy groups

Determining the Eligible Group

Legal reference: 441 IAC 76 (Rules in Process)

Medically Needy households may include members who are FMAP-related and SSI-related. Each categorically related Medically Needy coverage group requires that certain household members be included in or excluded from the eligible group.

For **any** coverage group, exclude from the Medically Needy eligible group:

- People receiving FMAP or SSI. Do not count their income in the Medically Needy spenddown calculation. A "1619b" person is considered an ineligible spouse. The 1619b person has medical coverage under the SSI coverage group. See 8-F, *People Ineligible for SSI (or SSA): Due to Earnings Too High for an SSI Cash Payment (1619b Group)*.
- An unlawful alien who is not categorically eligible.
- For SSI-related households, establish an eligible group for a spouse who enters a medical institution expecting to stay 30 or more days and another eligible group for the community spouse. Refer to 8-I, *Income and Resources of Married Persons*.

When determining the eligible group for FMAP-related Medically Needy:

- Follow the guidelines listed under Eligible Group.
- Determine which members must be included or excluded.

- Include in the household size those people in the household who are:
  - Categorically eligible under FMAP-related Medically Needy.
  - Any additional people required to be considered.
- Remove any household members who are voluntarily excluded.
- Do not include in the Medically Needy eligible group:
  - A stepparent who is not the parent of any of the children living in the household unless the stepparent is incapacitated or needed to care for the children in the home. See Households With a Stepparent.
  - A legalized alien who is a considered person for the eligible group but is not categorically eligible.
  - An unlawful alien who is a considered person for the eligible group and is categorically related **unless an emergency medical service is needed**.

An adult alien who is ineligible for Medicaid, but is a "considered" person, is included in the household size.

When the household requests to add the voluntarily excluded person to the eligible group that has been certified, the voluntarily excluded person is not eligible until the month following the month of the request.

Voluntarily excluded people are **not** considered as responsible relatives. When a person is voluntarily excluded from the Medically Needy household, do not use that person's paid or unpaid medical expenses in meeting the household's spenddown.

1. The household consists of Mr. A, 60, and Mrs. A, 65. Mr. A receives Medicaid through in-home health-related care (IHHRC) program, but does not receive SSI. Mrs. A applies for SSI-related Medically Needy.

   Mr. and Mrs. A are both in the Medically Needy household. Mr. A is a responsible relative (he has income deemed to Mrs. A). Mrs. A is eligible or conditionally eligible individual. If a spenddown exists, Mr. A's IHHRC client's participation is an allowable medical expense in meeting Mrs. A's spenddown.

2. The household consists of Mr. T, age 41, and his children, Tom, age 20; Tim, age 15; and Ted, age 10. Mr. T is employed full time. After the 20% earned income deduction, his monthly net income is $2,500. Mr. T is over income for FMAP and other Medicaid coverage groups. His application is processed for Medically Needy.

   Tom is also employed. Mr. T can voluntarily elect to exclude Tom and request Medicaid eligibility only for the FMAP-related household members.

3. The household consists of Mr. and Mrs. Q and their children, K, age 20, X, age 10, and Y, age 5. The household is over income for FMAP. Child K has no income or resources. Since Mr. and Mrs. Q are not on FMAP, they are considered self-supporting parents and their income is used to determine eligibility for all of their children.

   A Qs' income is within the income limits for a household size of four for MAC. X and Y receive Medicaid coverage under MAC. X and Y are eligible for Medicaid coverage under MAC because the Q's income is within income limits for MAC.

People Who Have a Choice of Coverage Groups

Legal reference: 42 CFR 435.404, 441 IAC 76 (Rules in Process)

A person in the FMAP-related household who could also be SSI-related has a choice of being FMAP-related or SSI-related. Explain program guidelines of the options available, so the client can decide what is best for the household.

If a person in the household could be eligible as either FMAP-related or SSI-related, allow the client to choose under which program to be considered based on:

- The amount of spenddown for each case.
- Which family members usually incur medical bills.
- Which family members have unpaid bills incurred before the certification period.

If a client chooses to be FMAP-related, establish one case for all FMAP-related household members. If the household chooses for some of the members to be SSI-related, establish an SSI-related case and an FMAP-related case with separate FBUs. For more information on calculating spenddown in these cases, see SSI-Related, FMAP-Related Composite Households.

The household composition is Mr. and Mrs. J, Child A (SSI-related), and Child B (FMAP-related). The Js made the choice to have Child A considered as SSI-related rather than as FMAP-related. If the Js want Medicaid for both children, there will be an SSI-related case and an FMAP-related case.

The SSI-related case is a one-person household for Child A. The parents' income is used to determine eligibility following SSI policy. The parents are not responsible relatives on the SSI-related case. (NOTE**:** Following SSI policy, the parents receive a living allowance as a deduction.)

The FMAP-related case is a four-person household for Child B, Mr. and Mrs. J, and Child A, as a considered person on the case.

If the parents want Medicaid only for Child A, there will be an SSI-related case with a household size of one. NOTE**:** The Js may apply later for Child B as an FMAP-related child. If they do, Child A has to be included as a considered person on Child B's FMAP-related Medically Needy case.

If the parents want Medicaid only for Child B, there will be a FMAP-related case with the parents as responsible relatives with a household size of three. (Child A is excluded and there would not be an SSI-related case.)

FMAP-Related Medically Needy

Legal reference: 441 IAC 75 (Rules in Process), 75.14(249A)

Use the following FMAP policies to determine a client's eligibility for the FMAP-related Medically Needy coverage group when resources or income exceeds FMAP limits:

- Specified relative.
- Income, but not the FMAP income limits or the 58% work incentive deduction.
- Liquid resources, but not the nonliquid resource policies or resource limit.

Assignment of medical support is required. See 8-C, *Failure to Cooperate in Obtaining Support*.

FMAP-related specified relatives and their children may be eligible or conditionally eligible members of the Medically Needy household. Specified relatives must be over income or resources for FMAP to be eligible for Medically Needy.

The FMAP-related specified relative must have a child in the household. However, the child does not need to be included in the Medicaid-eligible group for the parent to be eligible or conditionally eligible for Medicaid. The family may choose to voluntarily exclude the child of a specified relative.

For FMAP-related Medically Needy applications or automatic redetermination:

- First consider eligibility for all other FMAP-related Medicaid coverage groups.
- If the case is not eligible under any FMAP-related coverage group, examine the children's eligibility for Medicaid under the FMAP-related Medically Needy coverage groups and consider the child for Healthy and Well Kids in Iowa (***Hawki***).

Complete an automatic redetermination for the Mothers and Children (MAC) or Medically Needy coverage group when transitional medical ends for an FMAP case.

An FMAP-related Medically Needy household may consist of people under different coverage groups such as:

- One or more children on MAC.
- One or more children on Medically Needy.
- Pregnant woman on MAC.
- Parents on Medically Needy.

1. Household composition is Ms. J, age 25, and her children, Jimmy, age 6, and Jill, age 5. Ms. J is employed full time. She applies for FMAP. Ms. J's income exceeds the FMAP income limit.

   Ms. J is over income for FMAP, and other Medicaid coverage groups. Her application is processed for FMAP-related Medically Needy. . The children are both eligible for MAC. Ms. J is conditionally approved for Medically Needy.

2. The household consists of Mr. and Mrs. E and their two children, ages 2 and 4. The family applies for Medicaid on July 7. Mr. E works and the household is determined to be over income for FMAP. The children are determined to be eligible for MAC. Mr. and Mrs. E are conditionally eligible for Medically Needy for July and August.

FMAP-Related Nonparental Relative

Legal reference: 441 IAC 75 (Rules in Process), 75.14(249A)

Only one needy specified relative can be a member of the Medically Needy household. See Who May Be in the FMAP Eligible Group, for more explanation of needy specified relative.

A child living with a needy specified relative may qualify for FMAP based on the child's income. If the needy specified relative's income and resources exceed the limits for the needy specified relative to qualify for FMAP, determine eligibility for FMAP-related Medically Needy.

When the needy specified relative is over income or over resources for FMAP, consider income for a needy specified relative using FMAP policies, but do **not** allow the 58% work incentive deduction.

Divert the income of the needy specified relative to other members of the household using the FMAP Schedule of Basic Needs. The needy specified relative's spouse and children are responsible relatives and need to be on the ABC system.

The child can be on the Medically Needy case if the child's income exceeds FMAP limits or the MAC limit.

Household composition: Mr. and Mrs. H and their grandson.

Mr. H has income of $1,000 unemployment insurance benefits, and Mrs. H has income of $350 unemployment insurance benefits. Their grandson is eligible for FMAP and receives FIP. When this household applies, they request that Mrs. H be considered for FMAP "needy specified relative" and for Medicaid because she is experiencing health problems.

Mrs. H is not disabled or aged. Her eligibility for FMAP is calculated as follows:

$ 1,000.00	Mr. H's UIB
+ 350.00	Mrs. H's UIB
$ 1,350.00	Total gross income

There is no eligibility for FMAP for Mrs. H as a needy specified relative.

The next step is to determine eligibility under the Medically Needy coverage group as follows:

$ 1,350.00	Gross income for Mr. and Mrs. H
- 183.00	Diversion for Mr. H (Schedule of Basic Needs for 1)
$ 1,167.00	Monthly countable income considered as available to Mrs. H
$ 2,334.00	$1,167 income × 2 months
- 966.00	$483 MNIL (for Mrs. H only) × 2 months
$ 1,368.00	Spenddown

Mrs. H is entered on the ABC system as a Medically Needy FMAP-related specified relative. Mr. H is entered as a responsible relative. The grandson is not part of the Medically Needy household because he receives FIP.

Pregnant and Postpartum Women and Newborns

Legal reference: 441 IAC 75 (Rules in Process)

Pregnant women are eligible for Medically Needy when they would be categorically eligible for MAGI-related Medicaid (including MAC) or NonMAGI-related Medicaid except that income or resources exceed limits.

> Household composition: Mr. Z, age 27, and Mrs. Z, age 31, pregnant. Mrs. Z applies for Medicaid. Mrs. Z is employed full time. Mr. Z is not employed.
>
> Mrs. Z. is over income for MAC coverage. Her application is processed for FMAP-related Medically Needy. Mr. Z is not conditionally eligible for Medicaid.

NOTE: Do not put a pregnant woman who becomes over income for a Medicaid coverage group on Medically Needy. The woman remains continuously eligible for Medicaid through the pregnancy and postpartum period without regard to any changes in family income. See 8-F, *Continuous Eligibility for Pregnant and Postpartum Women*.

The 60-day postpartum period begins with the last day of pregnancy and continues through the last day of the month in which the sixtieth day falls. Medically Needy coverage group continues to be available for the postpartum period. Spenddown must be met for the woman to be eligible for the postpartum period. Spenddown can be met after the pregnancy ends.

Form 470-5482, 470-5482(S), 470-5482(M), or 470-5482(MS), *Medicaid/State Supp Review*, may be required for Medically Needy eligibility in the postpartum period if the woman's certification period expires before the postpartum period ends.

> Household composition: Mrs. F, age 25, pregnant, and Mr. F, age 29, works full-time
>
> Mrs. F is currently receiving Medicaid under the Medically Needy program for an October-November certification period. The baby is born October 15. Mrs. F continues to remain eligible for Medicaid for November.
>
> Mrs. F must reapply for Medically Needy if she wants to continue to receive postpartum eligibility for December, because her certification period has expired. She must meet spenddown for the new certification period, if applicable, before receiving Medicaid under the postpartum coverage group for December.

Medicaid is available to newborn children if the mother establishes Medically Needy eligibility, including emergency services, by meeting spenddown for the month of the child's birth. An application is not required for the newborn. Open the newborn on a Mothers and Children case.

Newborn coverage begins with the month of the birth and extends through the month of the child's first birthday if the child remains an Iowa resident. Determine eligibility when the child reaches one year of age.

SSI-Related Medically Needy

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for the Medically Needy coverage group as SSI-related, the client must meet the SSI criteria for age, blindness, or disability. The person must also be over income or over resources for SSI and other NonMAGI-related Medicaid coverage groups.

Applicants with income and resources less than the SSI standard or those who have applied for SSI and are waiting for an eligibility decision are **not** eligible for the SSI-related Medically Needy coverage group. Determine if eligibility exists under one of the other NonMAGI-related coverage groups.

> A married couple has income greater than the MNIL for a couple but less than the SSI benefit for a couple. This means the couple is not covered under Medically Needy. The worker examines eligibility under SSI-related coverage groups, such as State Supplementary Assistance dependent person.

Age Criteria

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for SSI-related Medically Needy as an aged person, the applicant must be age 65 or older. See 8-C, *Presence of Age, Blindness, or Disability* for more detailed information about the SSI or social security criteria for age.

Blindness Criteria

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for SSI-related Medically Needy as a blind person, the applicant must meet the SSI or social security criteria for blindness. See 8-C, *Presence of Age, Blindness, or Disability* for detailed information.

A state disability determination may need to be done by the Bureau of Disability Determination Services in the Department of Education if the applicant:

- Has been denied social security (Title II) benefits only (not SSI) by the Social Security Administration as not disabled due to blindness, or
- Is in the process of applying for benefits.

Disability Criteria

Legal reference: 441 IAC 75 (Rules in Process)

To be eligible for SSI-related Medically Needy as a disabled person, the applicant must meet SSI or social security criteria for disability. See 8-C, *Presence of Age, Blindness, or Disability* for detailed information.

To be eligible for SSI-related Medicaid based on disability, a person must be unable to engage in any "substantial gainful activity" because of a physical or mental impairment. (See 8-C, *When the Department Determines Disability* for more information.) The impairment must be medically documented and must be expected to last continuously for 12 months or result in death.

People are considered disabled when they receive Title II (social security disability) benefits or receive Railroad Retirement benefits that were based on the same criteria that the Social Security Administration uses to determine social security disability.

For Medically Needy, the Department is required to follow federal Social Security Administration decisions on disability for **SSI** with certain exceptions on denials by the Social Security Administration.

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. Possible statuses are:

- The person did not apply with Social Security for benefits.
- Benefits have been approved.
- An application for benefits is pending.
- An application for benefits has been denied. See 8-C, *SSA Disability Denial and Appeal Process*.

Based on Social Security Administration activity, either:

- Approve or deny Medicaid benefits.
- Request a separate disability determination. See 8-C, *When the Department Determines Disability*.

A state disability determination needs to be done by the Bureau of Disability Determination Services in the Department of Education if the applicant:

- Has not been determined disabled by the Social Security Administration.
- Has applied for social security disability benefits and a decision hasn't been made.
- Is in the process of appealing an earlier denial of social security disability benefits.
- Has been denied by the Social Security Administration for social security disability (Title II) as not disabled. NOTE: Medically Needy **cannot** rely on a Title II denial, but must do an independent determination.

To determine disability, obtain form 470-2465, *Disability Report for Adults*, or form 470-3912, *Disability Report for Children*, completed by the applicant or the applicant's representative. Also obtain one form 470-4459 or 470-4459(S), *Authorization to Disclose Information to the Department of Human Services.* For more information on these forms, see 6-Appendix.

Send all reports and authorizations to DDS along with form 470-2472, *Disability Transmittal*, which is a cover memo to help DDS in determining disability.

When a Client Has Been Denied SSI Disability Benefits

Legal reference: 42 CFR 435.541, 441 IAC 75 (Rules in Process)

Check Data Sources in WISE for an SSI denial or approval when you receive a Medicaid application based on disability. If there has been a disability denial, check the appeal coding to determine if an appeal has been denied. A denial based on disability is an indication that the applicant is not over income or over resources, and therefore does not qualify for Medically Needy.

If a person has been denied SSI benefits based on disability, check to see if the decision is final. (See 8-C, *SSA Disability Denial and Appeal Process* for an explanation of the SSA appeal process.) A Social Security decision is final when:

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

If the decision is not final, deny the application based on the SSI denial.

If the decision is final, determine if the person has a different condition than that considered by the Social Security Administration. Request a copy of the denial explanation from the applicant. Compare the information on the denial explanation to the information on the *Application for Health Coverage and Help Paying Costs*, form 470-5170 or 470-5170(S).

If there is a different condition that is expected to last 12 months, do a disability determination. See 8-C, *When the Department Follows an SSA Disability Determination*. If there is no different disabling condition, check if 12 months have passed since the final decision.

If 12 months have passed and the person alleges a change or deterioration in the disability that is expected to last 12 months, do a disability determination. See 8-C, *When the Department Follows an SSA Disability Determination*. If the condition has not changed or deteriorated, and the person does not claim a new 12-month period of disability, deny the application based on the SSI decision.

If a decision has not been final 12 months, and the person claims the condition has worsened and claims a new 12-month disability period, ask the following questions:

- Has the Social Security Administration refused to reconsider the claim on the worsening of the condition?
- Does the person no longer qualify for SSI based on nondisability requirements, but qualifies for Medicaid based on nondisability requirements?

If the answer to either of these questions is "yes," complete a disability determination. If both answers are "no," deny the application based on the SSI decision and refer the person to the Social Security Administration.

Disability Determination on Reapplication

Legal reference: 441 IAC 75 (Rules in Process)

When a client reapplies for SSI-related Medically Needy based on disability, disability is redetermined as follows:

- If the client is currently receiving social security disability benefits, no further disability determination is required.
- If the Department determined the person's disability, no further disability determination is required unless reexamination is specified in the original disability determination.

  A new determination is not necessary if the person alleges that the condition has not changed (improved), and DDS has not established a review for the time that the person was canceled.
- When reexamination was specified in the original disability determination, send DDS:
  - A current form 470-2465, *Disability Report for Adults*, or form 470-3912, *Disability Report for Children*.
  - A current form 470-4459 or 470-4459(S), *Authorization to Disclose Information to the Iowa Department of Human Services*.
  - A current form 470-2472, *Disability Transmittal*.
  - All appeal documents (if eligibility is gained through a successful appeal of disability).
- If a person reapplies for Medicaid following rejection or cancellation based on a Department disability decision and alleges no change, deny the application on the basis of not meeting disability requirements.

Resource Policies

Legal reference: 441 IAC 75 (Rules in Process)

Count the resources of all responsible relatives and all eligible or conditionally eligible people living together. The resource limit for Medically Needy households is $10,000.

Disregard all liquid resources of all responsible relatives and all eligible or conditionally eligible people living together when determining eligibility for FMAP-related children.

FMAP-related people are resource-eligible if their resources are determined to be within the resource limits any time during the month before the eligibility is determined.

For FMAP-related households, count liquid resources such as:

- Cash.
- Checking and saving accounts.
- Stocks, bonds, and certificates of deposit.
- The available principal of Medicaid qualifying trusts.

Exempt for FMAP-related households:

- Retirement plans as defined by the Internal Revenue Service, such as:
  - IRAs.
  - Keoghs.
  - 401Ks.
  - 457 plans.
  - Deferred compensation accounts.
  - IPERS.
- Annuities.
- Bank accounts solely used for a self-employed person's business.

Do not count nonliquid resources for FMAP-related households.

Disregard the resources of all responsible relatives and eligible or conditionally eligible people living together when determining eligibility for SSI-related children.

Count resources of an SSI-related person as of the first day of the month. Treat the resources of SSI-related households according to SSI policy. (See Chapter 8-D, *Resources*.)

For all clients, count only the unobligated balance of a checking account. The unobligated balance is the balance listed in the checking account as of the date of decision for FMAP-related clients. Subtract any checks that have been written, as indicated on the registry by the client. Use the balance as of the first moment of the first day of the month for SSI-related clients.

Use the "prudent person" concept to determine whether to use the checking account register or to verify the balance with a financial institution. If the verified balance combined with other resources is close to the limit, you may verify any checks the client claims to have written. If necessary, request canceled checks or receipts showing payment made or obtain a specific release of information for the person to whom the check was written.

Follow Medicaid policies in 8-D, *Transfer of Assets* if assets were disposed of for less than the fair market value.

Examine Medically Needy eligibility when a household is ineligible for FMAP or as an SSI recipient because of available resources from a trust.

If the available resources from the trust exceed $10,000, deny. If the available resources from the trust are $10,000 or less, include them with other resources to determine resource eligibility. Also count the beneficiary's income, including income from the trust to determine the amount of the spenddown.

1. Mr. and Mrs. K and their two children apply for Medically Needy on July 10. Mr. K is disabled and asks to be considered an SSI-related person. Mrs. K is considered an FMAP-related person because the family asks for Medicaid for the children.

   Mr. and Mrs. K have a joint savings account. On July 29, the date of decision, the account balance is $1,000. As of July 1, the account had a balance of $22,000. Mr. K has a money fund account with a balance of $2,000 on July 1 and July 29.

   Mr. and Mrs. K's resources of $24,000 exceed the $10,000 resource limit for SSI-related Medically Needy. Mr. K is not eligible for Medicaid in July as an SSI-related person.

   Mr. K is considered as an FMAP-related person for July in determining Medicaid eligibility for the family, because they meet the resource limit on July 29 by applying the FMAP-related policies.

   Mr. K then has the choice of being SSI-related beginning the month of August. If he chooses to be SSI-related, he is a responsible relative on the FMAP-related case and his resources are used to determine eligibility for the FMAP-related case.

2. Mr. B receives SSD and he has a savings account of $5,000. His child has a savings account of $1,500. Mr. B wants to be considered as an SSI-related person. His resources of $5,000 are considered against the resource limit for Medically Needy for the SSI-related case.

   His child is considered as an FMAP-related person. Mr. B is a responsible relative on the FMAP-related case. The household's resources are not considered in determining eligibility for the child on the FMAP-related case.

If a resource is jointly owned by FMAP-related clients and SSI-related clients, use the policies of the program for which each client is eligible. That is, treat SSI-related clients on the SSI-related case according to SSI resource policies. Treat the FMAP-related clients and responsible relatives on the FMAP-related case according to FMAP policies.

The B family has two cases:

- The SSI-related household consists of Mr. B (the eligible spouse) and Mrs. B (the ineligible spouse).
- The FMAP-related household consists of Mr. B (the responsible relative), Mrs. B (the specified relative), and Bobbie and Barbie (FMAP-related children).

The B family's resources are as follows:

Mr. B:	Car equipped for his disability
	$1,400 life insurance with cash value of $200
Mrs. B:	Car with $4,600 equity value
Bobbie:	$10 savings account
Barbie:	$15 savings account

Countable resources are computed as follows:

SSI-related household:

The car equipped for Mr. B's handicap is excluded.
Mr. B's life insurance is exempt, as its face value is less than $1,500.
The equity value of Mrs. B's car is countable.
Countable resources are $4,600.

FMAP-related household (to determine eligibility for Mrs. B):

Mr. B's car is exempt.
Mrs. B's car is exempt.
Mr. B's life insurance policy is exempt.

$	10	Bobbie's savings
+	15	Barbie's savings
$	25	Total resources for FMAP-related HH members

The B family's SSI-related household and FMAP-related household are both resource-eligible for Medically Needy.

Income Policies

Legal reference: 441 IAC 75 (Rules in Process)

Treatment of income in a Medically Needy case varies depending on whether the person is:

- FMAP-related
- SSI-related
- In a medical institution

After calculating the eligible group's countable income, compare it to the Medically Needy income level (MNIL). The MNIL is calculated according to the federal formula, based on 133% of the FMAP schedule of basic needs as of July 16, 1996. The MNIL is based on family size, as follows:

Number of people	1	2	3	4	5	6	7	8	9	10	Each additional
MNIL	$483	$483	$566	$666	$733	$816	$891	$975	$1058	$1158	add $116

People whose net countable income is **equal to or below the MNIL** are eligible for Medically Needy without meeting a spenddown. People with a zero spenddown are approved for ongoing eligibility.

People whose net countable income is **above the MNIL** have a spenddown to meet and are conditionally eligible for Medically Needy. The spenddown amount is the difference between the net countable income and the MNIL.

"Spenddown" is the process by which a Medically Needy person's excess income is obligated for allowable medical expenses to reduce countable income to the applicable MNIL. When allowable medical expenses reduce income to the applicable MNIL, the conditionally eligible person is then eligible for Medicaid for the certification period. See Applying Medical Expenses to Spenddown.

When you have determined eligibility and spenddown status, send form 470-2330, *Notice of Decision for Medically Needy*, to the client.

- If the client has ongoing eligibility, the notice must contain:
  - The client's name and address.
  - The name of the eligible persons.
  - Manual and rule references.
  - The effective date.
- When the client has a spenddown, the notice must contain:
  - The client's name and address.
  - The names of the conditionally eligible persons.
  - The names of any responsible relatives.
  - The beginning and ending dates of the certification period.
  - The amount of the spenddown.
  - Manual and rule references.
  - The last date that claims can be submitted to meet spenddown for this certification period.
- Send a copy of the applicable *Medically Needy Spenddown Computation Worksheet* with the notice. (See the following sections for the forms applicable to each coverage group.)

The following sections describe:

- Income and spenddown calculation for FMAP-related cases
- Income and spenddown calculation for SSI-related cases
- Income and spenddown calculation for the retroactive period for all types of cases
- Treatment of income when a person is in a medical institution, for all types of cases

FMAP-Related Cases

Legal reference: 441 IAC 75 (Rules in Process)

Follow FMAP income policies for FMAP-related eligibles (but **do not** apply the income limit and the 58% work incentive deduction).

For FMAP-related cases, count all unearned and earned income of all responsible relatives, eligible persons, and conditionally eligible persons living together to determine eligibility, unless the income is specifically exempted, disregarded, deducted for work expenses or diverted.

To determine countable income of the Medically Needy eligible group, do not consider:

- The income of any person receiving FMAP or SSI.
- The income of any person who is voluntarily excluded unless the voluntarily excluded person is the parent.
- The income of a responsible relative that has been diverted to an FMAP household.

Complete the income computations on form 470-3088, *FMAP-Related Medically Needy Spenddown Computation Worksheet*.

Prospectively calculate the income of all responsible relatives and conditionally eligible persons. Use the projected income unless actual income is available. Use the following guides in determining what income to use:

- Base initial and ongoing FMAP-related Medically Needy eligibility on projected income. If the projected future income is not valid for the month of application, month of decision, or any months in between, use actual income received in the month to determine eligibility for that month.
- For applications, recertifications, or reviews, project income using all nonexempt income. See Projecting Income for more information on FMAP-related policies.
- Accept the statement of the client as to whether the 30-day period is representative of future income. If the client states that the 30-day period is not a good indicator of future income, use either a longer period of time that is a good indicator of future income or verification of future income from the income source.
- The decision on whether to use a longer period of time or to request verification of future income from the income source should primarily be the client's. However, when the client is unsure of which would be the best indicator of future income, request verification from the income source. Also, if the client does not have pay stubs from either the 30-day period or from a longer time period, request verification from the income source.
- When a third or fifth check occurs during the period being used to project income, do not ignore it. Instead, add all check amounts together, divide the total by the number of checks, and multiply that result by four, if the income occurs weekly, or by two, if the income occurs biweekly. See Projecting Income.
- For people who are self-employed, determine income from the previous year's income tax return. If the enterprise has been in business for less than a year, average income over the period of time the enterprise has been in existence.

  Project the monthly amount for the same period of time. See additional information on determining self-employment income in FMAP-Related Self-Employment Income.

The following sections describe:

- General instructions for calculating an FMAP-related spenddown.
- More specific instructions on income and spenddown for:
  - Households with a stepparent
  - Households with a newborn child
  - Households with an alien member
  - Households with lump-sum income
  - Household members who are sanctioned for failure to cooperate

FMAP-Related Spenddown Calculation

Legal reference: 441 IAC 75 (Rules in Process)

To calculate spenddown on an FMAP-related case:

1. Apply all allowable deductions to each month's income.
2. Add each month's net income together for the two-month certification period. (The certification period is usually the month of application and the following month. Establish a certification period of only one month when a client is eligible for benefits in another coverage group in the second month or the client is ineligible for Medicaid in one month.)
3. Determine the household size by including all responsible relatives and conditionally eligible persons for whom income is considered. Include all unborn children for FMAP-related households if pregnancy has been verified in writing.
4. Determine the MNIL for the certification period by adding each month's MNIL to arrive at a total.
5. Compare the total net countable income for the certification period to the total MNIL for the certification period for the family size.
6. Assign a two-month certification period if net countable income **exceeds** the MNIL in the two prospective months. The client is not eligible for Medicaid payment until the incurred medical expenses equal or exceed the difference between the net income and the MNIL.

   The spenddown amount is the difference between the net countable income and the MNIL. People with a spenddown are "conditionally eligible recipients." They are not eligible for Medicaid until they have incurred or paid medical expenses that equal the spenddown amount.

Household composition:	Mr. and Mrs. B and Baby B (FMAP-related group)	
Certification period:	January and February	
Net countable income:	$600 + $666 =	$ 1,266
MNIL	$566 + $566 =	– 1,132
Spenddown		$ 134

Because income exceeds the MNIL, the B family must incur $134 in medical expenses before they are eligible for Medicaid in January or February for the family. NOTE: Baby B is MAC-eligible and is a considered person for Medically Needy.

7. If the household's income **is equal to or less than** the MNIL in the two prospective months, the client has a zero spenddown. An FMAP-related client with a zero spenddown is approved for ongoing eligibility.

   Review the case at least once every 12 months. The client completes form 470-5482 or 470-5482(S), *Medicaid/State Supp Review*, as the review form. NOTE**:** If the *Medicaid/State Supp Review* is returned late, see 8-G, *Grace Period*.

   If the FMAP-related person's net countable income exceeds the MNIL in any month, redetermine spenddown. Assign a two-month certification period effective the month income exceeds the MNIL or the first month after timely notice has been given.

Ms. B applies for Medically Needy on October 15. She has two children eligible for MAC. Ms. B receives $300 child support for each child.

$	550.00	October ($600 - $50 exemption)
+	550.00	November ($600 - $50 exemption)
$	1,100.00	
–	1,132.00	MNIL ($566 × 2)
$	0.00	Spenddown

Her application is approved on November 1, effective October 1. Since Ms. B has zero spenddown, she has ongoing eligibility for FMAP-related Medically Needy.

On February 1, Ms. B reports that she began working on January 29 and will receive her first paycheck February 9. On February 12, Ms. B verifies that her income will be $280 per week and that she will receive three checks in February and five checks in March.

$	550.00	February ($600 - $50 exemption)
+	840.00	$280.00 × 3 checks
–	168.00	20% earned income deduction
$	1,222.00	Net countable income

$1,222 exceeds the MNIL of $566. On February 16 the worker sends a *Notice of Decision* assigning Ms. B a two-month certification period for March and April. (**Note:** To determine the March earned income and the April earned income, the worker projects four paychecks of $280 each, based on the verification from the employer.)

8. Determine eligibility for the retroactive period if the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. See Income and Spenddown in the Retroactive Period.

Households With a Stepparent

Legal reference: 441 IAC 75 (Rules in Process) and 75.14(249A)

In a stepparent household in which there are no common children and the stepparent has no children, do not include the stepparent when determining the Medically Needy household size, unless the stepparent is incapacitated or needed to care for the children in the home.

Use the FMAP standard of need to calculate how much to divert to the stepparent's needs. If income remains after diverting the FMAP standard of need to the stepparent, use the remaining income to calculate spenddown.

Include the stepparent as a financially responsible relative to allow the stepparent's medical bills to meet spenddown if any of the stepparent's income has been used to determine the spenddown amount.

The household consists of Mr. and Mrs. S and her two children from a previous marriage. Spenddown is computed as follows:

$ 3,000.00	Mr. S's gross earned income
- 600.00	20% earned income deduction
$ 2,400.00	
- 365.00	Diversion to meet needs of Mr. S, based on the FMAP standard of need
$ 2,035.00	
	Deduction for child support for a dependent outside the household
- 100.00	Amount considered towards spenddown
$ 1,935.00	

The $1,935 is compared to the MNIL for a three-member household. Mr. S is not included in the household size in determining the MNIL. However, he is coded as a responsible relative on the system, because he has income that is countable for the Medically Needy household.

Consider the children for ***Hawki***.

When the family chooses to voluntarily exclude the stepparent's income, the natural or adoptive parent is excluded from the eligible group. The income of the stepparent is not counted, and bills of the stepparent cannot be used to meet spenddown. Income of the natural or adoptive parent must be counted for the eligibility determination, and bills of the parent can be used to meet spenddown.

When there is a common child, or the stepparent has a child, the stepparent can be included in the Medically Needy household.

The household consists of Mrs. T and Mr. T, their common child, and Mrs. T's child. Mr. T, the stepparent, has gross income of $1600. Mrs. T does not have income. The family is ineligible for FMAP.

The children are determined to be eligible for MAC.

Mr. and Mrs. T also want medical assistance.

$ 1,600.00	Mr. T's gross income
- 320.00	20% earned income deduction
$ 1,280.00	Net countable income
$ 2,560.00	Countable income ($1280 × 2 months)
- 1,332.00	MNIL for a four -person household ($666 × 2 months)
$ 1,228.00	Spenddown

Households With a Newborn

When there is a newborn common child in a stepparent household, divert from the stepparent's income to meet the newborn's needs. The amount to divert is the difference between the standard of need with the ineligible newborn child included and the ineligible newborn excluded.

The household consists of Mr. and Mrs. K, Mrs. K's child, A, and their child, C. C is a newborn child of a Medicaid-eligible mother and continues to have a newborn status. Mr. K's gross earned monthly income is $2000. Mrs. K's gross earned monthly income is $1550. Their income is considered as follows for determining the spenddown:

$ 2,000.00	Mr. K's gross earned income
- 400.00	20% earned income deduction
$ 1,600.00	
- 354.00	Diverted to meet the needs of the newborn (difference between a two-person and a one-person standard of need: $719 - 365 = $354)
$ 1,246.00	Diverted to meet the needs of the stepparent (standard of need for one person).
- 365.00	
$ 881.00	Income considered towards the FMAP-related Medically Needy group
$ 1,550.00	Mrs. K's gross earned income
- 310.00	20% earned income deduction
$ 1,240.00	
+ 881.00	Income from Mr. K
$ 2,121.00	Net countable income
$ 4,242.00	Countable income ($2121 × 2 months)
- 1,132.00	MNIL ($566 × 2 months)
$ 3,110.00	Spenddown

If the newborn common child is not in a stepparent household, do not divert to meet the newborn's needs.

The household consists of Mrs. P and her two children (A and B), Mr. T, common child C, and newborn common child D. D is a newborn child of a Medicaid-eligible mother and continues to have newborn status.

The Medically Needy FMAP-related household consists of all household members except the newborn, child D. Mrs. P and Mr. T cannot divert any income to child D, as they are both part of the eligible group.

Households With an Alien Member

Legal reference: 441 IAC 75 (Rules in Process) and 75.14(249A)

Include in the Medically Needy eligible group an alien who is eligible for Medicaid. See 8-L, *Aliens*.

If the ineligible alien is an adult and meets all other eligibility criteria:

- Include the ineligible alien in the household size as a "considered" person.
- Count the income and resources of the ineligible alien.
- Use bills of the ineligible alien "considered" person to meet the spenddown for the eligible group.

If the ineligible alien is a child:

- Do not include the child in the eligible group.
- Exclude the income of the child.
- Do not use bills of the child to meet spenddown for the eligible group.

An ineligible alien may be eligible for Medicaid if an emergency medical condition exists. When the three days of emergency medical services occur during one month, the Medically Needy certification period is one month. When the three days of emergency medical services spans two months, the Medically Needy certification period is two months. See 8-L, *Limited Eligibility for Certain Aliens*.

Households With Lump-Sum Income

Legal reference 441 IAC 75 (Rules in Process)

Receipt of a lump sum does not make a person ineligible for the Medically Needy coverage group. Treat the receipt of a lump-sum payment according to FMAP policies.

Add lump-sum income and any prospective countable income for FMAP-related Medically Needy together. Prorate the total by the FMAP schedule of living costs based on household size.

If the client received the lump sum in a retroactive month and wants retroactive benefits, prorate the lump sum plus any other countable income received in that month and use it beginning in the month of receipt.

Remember:

- Use the prorated lump sum to determine countable income for the certification period.
- A break in assistance does not affect the prorated amount or the period of time the lump sum is counted as income for FMAP. If the client later applies for FMAP, remember to consider the period of ineligibility because of the lump sum. For Medically Needy, continue to use the prorated amount for all months as originally determined.

Use FMAP policies, Conditions for Shortening the Period of Proration, to shorten the period of time the lump sum is counted as income.

Household composition: Mr. and Mrs. E and their three children (FMAP-related)

Certification period: January and February
Lump sum inheritance: $10,500 received January 5

Mr. E has net countable earned income of $650 for January and $800 for February. Mrs. E has unearned income of $500 for January and $700 for February.

Total lump sum and January income: $11,650

Proration of lump sum and January income:
$11,650 ÷ 1,092 = 10.66 months to consider the lump-sum income

			January and February		
Prorated lump sum	$1,092		$1,092		
Mr. E's income			+ 800		
Mrs. E's income			+ 700		
Total for certification period	$1,092	+	$2,592	=	$3,684

NOTE: The children are eligible for MAC in the month of January. The children are responsible relatives on the Medically Needy case for the month of January. The parents have been on Medically Needy before and there has not been a break in assistance.

Noncooperation

When the parent or specified relative who is conditionally eligible does not cooperate (e.g., with support recovery, Quality Control, or the Third-Party Liability Unit), that person is ineligible for Medicaid. However, the person remains a member of the household as a "considered" responsible relative for the purpose of establishing household size.

Use the ineligible person's income and allow the work expense deduction to determine the amount of spenddown.

Use the unpaid medical expenses of the parent or specified relative who has failed to cooperate to meet the spenddown.

SSI-Related Cases

Legal reference: 441 IAC 75 (Rules in Process)

When determining eligibility, consider the income of all responsible relatives and all conditionally eligible persons living together. Do not consider the income of:

- A responsible relative that has been diverted to a FIP household.
- A responsible relative that has been deemed to a person receiving SSI.
- Any person receiving FMAP or SSI. (NOTE: A 1619b person is not considered an SSI recipient for Medically Needy.)

Follow SSI policy to determine the amount of income to be deemed from the ineligible spouse, parent, spouse of a parent, or ineligible child.

Mr. and Mrs. Z are both disabled. Mr. Z receives Medicaid as a 1619b person. He works and receives social security disability. Mrs. Z has no income. Mrs. Z applies for Medicaid. The household size is two. The worker calculates the spenddown based on the couple's combined income, using SSI policies.

Complete the earned income computations on either:

- Form 470-2341, *SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet*, or
- Form 470-2626, *SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet.*

Prospectively calculate the income of all responsible relatives and conditionally eligible persons. Use the best estimate, unless actual income is available. Follow SSI policy to determine the amount of income to consider. Use the following guides in determining what income to use:

- For applications or reviews, project income using all nonexempt income. See 8-E, *Projecting Future Income*, for more information on SSI-related policies.
- Convert weekly income to monthly income by multiplying by 4.3 and convert biweekly income to monthly income by multiplying by 2.15.
- If income fluctuates, use an average over a longer period of time if that would more accurately reflect the household's income. However, consider past circumstances only to the extent that they reasonably reflect what can be expected to occur in the future. Base projections of future circumstances on the best information available at the time of decision.
- When an income change has occurred or is anticipated, obtain a statement from the employer regarding future income.
- For persons who are self-employed, determine income from the previous year's income tax return. If the enterprise has been in business for less than a year, average income over the period of time the enterprise has been in existence. Project the monthly amount for the same period of time. See additional information on determining self-employment income in 8-E.

If an SSI-related person receives a lump sum payment, treat it as described in 8-E, *Lump-Sum Income*. If the lump-sum is received on a one-time basis and is over $10 and is earned income, or is over $20 and is unearned income, consider it as income in the month of receipt.

The following sections describe:

- General instructions for calculating an SSI-related spenddown
- More specific instructions on income and spenddown for households with an ineligible spouse and children

SSI-Related Spenddown Calculation

Legal reference: 441 IAC 75 (Rules in Process)

To calculate spenddown on an SSI-related case:

1. Apply all allowable deductions to each month's income.

   Mr. E, 65, SSI-related, receives each month $800 in social security benefits, $125 in Veterans aid and attendance, and $100 IPERS. (Veteran's aid and attendance is not countable income for Medicaid eligibility determination.)

$	800.00	Social security
+	100.00	IPERS
$	900.00	Gross income
-	20.00	Disregard (SSI-related)
$	880.00	Net income (used to determine the spenddown for a one-member household)

2. Add each month's net income together for the two-month certification period. (The certification period is usually the month of application and the following month. Establish a certification period of only one month when a client is eligible for benefits in another coverage group in the second month or the client is ineligible for Medicaid in one month.)
3. Determine the household size by including all responsible relatives and conditionally eligible persons for whom income is considered.
4. Determine the MNIL for the certification period by adding each month's MNIL to arrive at a total.
5. Compare the total net countable income for the certification period to the total MNIL for the certification period for the family size.
6. Assign a two-month certification period, if net countable income **exceeds** the MNIL in the two prospective months. The client is not eligible for Medicaid payment unless the incurred medical expenses equal or exceed the difference between the net income and the MNIL.

   The spenddown amount is the difference between the net countable income and the MNIL. Persons who have a spenddown are "conditionally eligible clients." They are not eligible for Medicaid until they have incurred or paid medical expenses that equal the spenddown amount.

Household composition:	Mrs. B (SSI-related)			
Certification period:	January and February			
Net countable income:	$800	+ $866	=	$ 1,666
MNIL:	$483	+ $483	=	- 966
Spenddown:				$ 700

   Because income exceeds the MNIL, Mrs. B must incur $700 in medical expenses before she is eligible for Medicaid in January or February.

7. If the household's net countable income is **equal to or less than** the MNIL in the two prospective months, the member has zero spenddown. An SSI-related member with a zero spenddown is approved for ongoing eligibility.

   Review the case at least once every 12 months. The member completes form 470-5482 or 470-5482(S), *Medicaid/State Supp Review*, as the review form. NOTE: If the *Medicaid/State Supp Review* is returned late, see 8-G, *Grace Period*.

   If the SSI-related member's net countable income exceeds the MNIL plus insurance deductions in any month, redetermine spenddown. Assign a two-month certification period effective the month income exceeds the MNIL or the first month after timely notice has been given.

8. Determine eligibility for the retroactive period if the individual meets a category of eligibility for the retroactive period as defined in 8-A, *Definitions*. See Income and Spenddown in the Retroactive Period.

1. Ms. A, age 45, applies for Medically Needy on August 8. Her monthly gross social security disability check is $800. Ms. A does not have Medicare.

$	800.00	August social security
+	800.00	September social security
$	1,600.00	
-	40.00	General income exclusion ($20 × 2)
$	1,560.00	
-	966.00	MNIL ($483 × 2)
$	594.00	Spenddown
-	600.00	Health insurance premium ($300 × 2)
$	0.00	Spenddown after insurance

On August 15, her application is approved effective August 1. Since Ms. A has a zero spenddown, Ms. A has ongoing eligibility for SSI-related Medically Needy.

On January 5, Ms. A reports to her worker that her social security disability increased to $846 and that she no longer has health insurance. The worker determines that the January social security disability increase ($846 - $20 general disregard = $826) exceeds the MNIL of $483. Ms. A is assigned a two-month certification period for February and March.

Ms. A continues to complete the *Medicaid/State Supp Review* every two months to reapply.

2. Mr. B, age 75, applies for Medically Needy on August 2. His monthly gross social security income is $775. Mr. B is also QMB-eligible. Medicaid pays his Medicare Part B premium.

$	755.00	August social security ($775 - $20 general exclusion)
+	755.00	Sep. social security ($775 - $20 general exclusion)
$	1,510.00	
-	966.00	MNIL ($483 × 2 months)
$	544.00	Spenddown
-	80.00	Dental insurance (40 × 2 months)
-	500.00	Nursing home insurance ($250 × 2 months)
	0.00	Remaining spenddown

Mr. B has a zero spenddown and, therefore, has ongoing eligibility.

Data Sources in WISE at the end of November indicates that Mr. B's social security increases to $787 effective January 1. Mr. B also reports that he will start receiving an annuity payment of $100 per month beginning January 5. The worker determines that Mr. B's income will exceed the MNIL for a one-person household in January.

$	787.00	January social security
+	100.00	Annuity income
-	20.00	General income exclusion
$	867.00	
-	483.00	MNIL
$	384.00	Spenddown
-	40.00	Dental insurance
-	250.00	Nursing home insurance
	94.00	Spenddown after deducting insurance

Mr. B is redetermined to be eligible for Medically Needy with a spenddown. The worker calculates the spenddown for the two-month certification period of January and February. The worker issues a timely notice of decision in December to Mr. B explaining that he is now certified for a two-month certification period, that his spenddown is $188, and that he will need to reapply for the month of March. (Mr. B continues to be QMB-eligible.)

3. Mrs. C, age 70, applies for Medically Needy August 18. Mrs. C receives $800 gross social security and is also QMB-eligible. Medicaid pays her Medicare Part B premium. Mrs. C also pays $300 monthly for a Medicare supplemental insurance policy.

$	780.00	Aug. social security ($800 - 20 general income excl.)
+	780.00	Sep. social security ($800 - $20 general income excl.)
$	1,560.00	
-	966.00	MNIL ($483 × 2 months)
$	594.00	Spenddown
-	600.00	Health insurance premium ($300 × 2 months)
$	0.00	Spenddown after health insurance premium

Mrs. C has ongoing eligibility for Medically Needy.

On October 1, Mrs. C reports that she no longer has a Medicare supplement. The worker redetermines Mrs. C's Medicaid eligibility.

$	800.00	October social security
-	20.00	General income exclusion
$	780.00	
-	483.00	MNIL
$	297.00	Spenddown

Mrs. C no longer has ongoing eligibility. The worker calculates the spenddown for November and December. The worker notifies Mrs. C with a timely notice in October that she has been redetermined to be eligible for Medically Needy with a spenddown of $594 for the certification period of November and December. (Mrs. C continues to be eligible for QMB.)

4. Child A is under age 18 and disabled. His mother receives $999 social security disability per month. His father earns $1,071 per month. Child A's social security income is $500.

   Child A and Mrs. A will be on separate SSI-related Medically Needy cases.

   First, determine the amount of spenddown for Mrs. A. Follow instructions in 8-E for deeming from an ineligible spouse. Child A is treated as an ineligible child in this determination. Child A's income exceeds $472, so no income of the father can be allocated to child A. ($472 is the maximum amount to deem to an ineligible child.)

$ 999.00	Mrs. A's SSD income
- 20.00	General income exclusion
$ 979.00	Countable unearned income
$ 1,071.00	Mr. A's earned income
- 65.00	Work exclusion
$ 1,006.00	
- 503.00	½ the remainder
$ 503.00	Countable earned income
$ 979.00	Countable unearned income
+ 503.00	Countable earned income
$ 1,482.00	Total countable income
$ 2,964.00	$1,482.00 × 2 months
- 966.00	$483 × 2 months (MNIL for 2)
$ 1,998.00	Spenddown

   Second, determine eligibility for child A. Follow instructions in 8-E for deeming from an ineligible parent to an eligible child. In this situation, Mrs. A is treated as an ineligible parent, as she is not receiving SSI. Use both parents' income to determine the amount of spenddown for child A.

$ 999.00	Mrs. A's SSD income
- 20.00	General income exclusion
$ 979.00	Countable unearned income
$ 1,071.00	Mr. A's (father's) earned income
- 65.00	Work exclusion
$ 1,006.00	
- 503.00	½ the remainder
$ 503.00	Countable earned income
$ 979.00	Countable unearned income
+ 503.00	Countable earned income
$ 1,482.00	Total countable income
- 1,415.00	Parental exclusion
$ 67.00	Deemed to child A
$ 500.00	Child A's income
- 20.00	General income exclusion
$ 480.00	Child A's countable income
+ 67.00	Income deemed from parents
$ 547.00	Total countable income
$ 1,094.00	$547.00 × 2 months
- 966.00	$483 × 2 months (MNIL for 1)
$ 128.00	Spenddown

Households With Ineligible Spouse or Children

Legal reference: 441 IAC 75 (Rules in Process)

If the household includes the SSI-related person's spouse who is not aged, blind, or disabled, determine whether the ineligible spouse is a responsible relative.

If the case does not include children, deem income from the ineligible spouse to the SSI-related person. Do the deeming on form 470-2341, *SSI-Related (No Children) Medically Needy Spenddown Computation Worksheet*. If the ineligible spouse does not have income to deem, the ineligible spouse is not a responsible relative for Medically Needy. Use the MNIL for a one-member household.

If the income of the ineligible spouse is deemed to the eligible spouse, use the MNIL for a two-member household. The ineligible spouse is a responsible relative on the Medically Needy case. Use the ineligible spouse's medical bills to meet spenddown.

If the household includes children, use form 470-2626, *SSI-Related (Children in Household) Medically Needy Spenddown Computation Worksheet*. First, deem income from the ineligible spouse's income to meet the needs of each child. Calculate the needs of each child at $457 minus any income of the child. Then determine if there is income from the ineligible spouse to deem to the eligible spouse.

If there is income to deem, use the MNIL for a two-member household. The ineligible spouse is a responsible relative on the Medically Needy case. The ineligible spouse's medical bills can be used to meet the spenddown.

If the ineligible spouse does not have income to deem to the eligible spouse, the ineligible spouse is not a responsible relative for Medically Needy. Use the MNIL for a one-member household.

Examine the case to determine if the ineligible spouse and children are eligible as an FMAP-related case. If the SSI-related person is a responsible relative on the FMAP-related case, apply FMAP policy to the person's income and resources to determine eligibility for the FMAP-related household members. See SSI-Related, FMAP-Related Composite Households.

1. Household composition:

   Mr. C, 70, has monthly unearned income of $1,006
   Mrs. C, 60, not blind or disabled; has monthly earned income of $816

   Mr. C's income exceeds SSI standards and he is requesting Medicaid eligibility through the Medically Needy program. The Medically Needy spenddown calculation is as follows:

   Step 1: Determine if Mrs. C will be a responsible relative (if she would have income deemed to Mr. C). Mrs. C's gross income of $816 exceeds $472. Proceed with the deeming process.

   Step 2: Determine how much of Mrs. C's income to deem to Mr. C.

$	816.00	Mrs. C's earned income (ineligible spouse)
-	65.00	Work exclusion
$	751.00	
-	375.50	1/2 remainder
$	375.50	Countable earned income available to Mr. C

   Step 3: Determine Mr. C's spenddown.

$	1,006.00	Mr. C's unearned income
-	20.00	General income exclusion
$	986.00	Mr. C's countable income
+	375.50	Mrs. C's income deemed to Mr. C
$	1,361.50	Total monthly countable income
$	2,723.00	$1,361.50 (monthly income) × 2 months
-	966.00	MNIL for 2 (483 × 2 months)
$	1,757.00	Spenddown

   Therefore, Mr. C is considered a conditionally eligible person and Mrs. C is considered as a responsible relative as she deemed income to Mr. C.

2. Mr. M has applied for Medicaid. He receives $990 social security disability benefits. Mrs. M receives unemployment insurance benefits (UIB) of $600. They have two children, Y and Z. Each child receives $185 social security benefits.

$	990.00	Unearned income of Mr. M
-	20.00	General income exclusion
$	970.00	Countable unearned income
$	943.00	SSI benefit for one person
-	970.00	Mr. M's countable income
$	0.00	

   Mr. M's income does create ineligibility for SSI. Proceed to the deeming process for SSI-related Medically Needy:

$	600.00	Mrs. M's unearned income
-	287.00	Allocation for ineligible child Y ($472 - 185 = $287)
-	287.00	Allocation for ineligible child Z ($472 - 185 = $287)
$	26.00	Mrs. M's countable unearned income

   $26 does not exceed $472. As the income is less than $472, there is no income available to deem to Mr. M.

   Mr. M's countable income of $970 is compared to the MNIL for a household size of one to determine the spenddown amount. Mrs. M is not a responsible relative on Mr. M's case.

SSI-Related, FMAP-Related Composite Households

Legal reference: 441 IAC 75 (Rules in Process)

An SSI-related client is a responsible relative or considered person on the FMAP case if the client is a:

- Parent of a child on the FMAP-related case.
- Sibling of a child on the FMAP-related case.
- Child of a parent on the FMAP-related case.

This is a composite case. Treat the person's income and resources according to SSI policy on the SSI-related case. Treat the person's income and resources according to FMAP policy on the FMAP-related case.

Use the same medical bills to meet spenddown on both cases when a person is conditionally eligible on one case and a responsible relative on the other case. Use only the portion of the medical bill that will not be paid by Medicaid to meet spenddown.

1. Household composition:

   Mr. B, 60, receives $950 per month in social security disability benefits
   Mrs. B, 55, receives $1,340 gross earned income each month
   Their children: Bobbie, 10, receives $240 social security.
   Barbie, 9, receives $240 social security.

   The B family requests Medicaid for all members. Mr. B chooses to be SSI-related, due to his verified disability. Mrs. B is an FMAP-related specified relative. Bobbie and Barbie are FMAP-related children. There are no child care costs.

   This household has two cases:

   - The SSI-related household consists of Mr. B (the eligible spouse) and Mrs. B (the ineligible spouse).
   - The FMAP-related household consists of Mr. B (the responsible relative), Mrs. B (the specified relative), and Bobbie and Barbie (FMAP-related children).

   The **SSI-related income calculation** for the B family is as follows:

   To determine if Mrs. B will be a responsible relative for Mr. B's SSI-related case, determine if she would have income deemed to Mr. B following SSI policy.

$	1,340.00	Mrs. B's gross earnings
-	232.00	Allocation for Bobbie's unmet needs ($472 - 240)
-	232.00	Allocation for Barbie's unmet needs ($472 - 240)
$	876.00	

   $876 exceeds the difference of the SSI benefit rate for an eligible couple and the SSI benefit rate for an individual ($472). Proceed to deeming calculation step. (If Mrs. B's income at this point were less than $472, deeming would not be applicable.)

$	876.00	Mrs. B's remaining earned income
-	65.00	Work exclusion
$	811.00	
-	405.50	1/2 the remainder
$	405.50	Amount of Mrs. B's income deemed to Mr. B

$	950.00	Mr. B's unearned income
-	20.00	General income exclusion
$	930.00	Mr. B's countable unearned income
+	405.50	Mrs. B's income deemed to Mr. B
$	1,335.50	

$	2,671.00	Income for the certification period ($1,335.50 × 2 months)
-	966.00	MNIL for the certification period ($483 × 2 months)
$	1,705.00	Spenddown

   The MNIL is for a two-person household. Mrs. B is a responsible relative on the SSI-related case, as she deemed income to Mr. B.

The **FMAP-related income calculation** for the household is:

Unearned income:

$ 950.00	Mr. B's social security disability
+ 240.00	Bobbie's social security
+ 240.00	Barbie's social security
$ 1,430.00	

Earned income:

$ 1,340.00	Mrs. B's gross earnings
- 268.00	20% earned income deduction
$ 1,072.00	Countable earned income

Total income:

$ 1,430.00	Total unearned income
+ 1,072.00	Countable earned income
$ 2,502.00	Total countable income

$ 5,004.00	Income for the certification period ($2,502 × 2 months)
- 1,332.00	MNIL for the certification period ($666 × 2 months)
$ 3,672.00	Spenddown

MNIL is for a four-person household. Mr. B is a responsible relative on the FMAP-related case. Spenddowns for the family in Example 1 are:

$1,705 for the SSI-related Medically Needy case.
$3,672 for the FMAP-related Medically Needy case.

NOTE: Bobbie and Barbie are eligible for MAC and are considered people on the FMAP-related case.

2. Mr. B from Example 1 has ongoing medical expenses of $2,500 per month.

   The worker advises the Bs to have two cases: SSI-related and FMAP-related. With an SSI-related case, Mr. B will have $795 of his medical expenses paid after he meets the spenddown. The FMAP-related case will not meet spenddown. Therefore, Mr. B would not want to be a conditionally eligible person on the FMAP-related case. (NOTE: Mr. B is a responsible relative on the FMAP-related Medically Needy case.)

3. Bobbie from Example 1 has a hospital bill of $16,800 that occurred before the certification period and remains unpaid. This bill has not been used before to meet spenddown. Mr. B has ongoing medical expenses of $1,250 per month.

   The worker advises Mr. B to be a conditionally eligible person on the FMAP-related case for five certification periods. They would not be able to use Bobbie's old medical bill to meet spenddown on the SSI-related case.

   As a conditionally eligible person on the FMAP-related Medically Needy case, Mr. B could have Medicaid pay all of the medical expenses that he incurs during the first five certification periods.

   During the sixth certification period, Mr. B would need to have an SSI-related case, as he would have more medical expenses paid.

4. Mrs. B from Example 1 requires minor surgery during the certification period. For this certification period, Mr. B has only $250 in medical expenses per month.

   Since Mr. B does not have enough medical expenses to meet spenddown on an SSI-related Medically Needy case, the worker advises Mr. B to be conditionally eligible on the FMAP-related case. More medical bills would be paid for the family.

   Because there are no unusual expenses expected for the B family in the next certification period, the worker advises the Bs to have both an SSI-related and an FMAP-related case.

5. Household composition:
   Mr. G, 65, receives $1,000 monthly social security
   Mrs. G, 56, receives $250 monthly social security
   George, 15, is in school and receives $250 social security

   The categorical relationship of each person is:
   Mr. G: SSI-related (aged)
   Mrs. G: FMAP-related specified relative
   George: FMAP-related child

   The certification period is for May and June.

   The household chooses to receive Medically Needy benefits for the SSI-related member and the FMAP-related group. This household has two cases.

   SSI-related Medically Needy household:

   To calculate spenddown for Mr. G, first determine if Mrs. G will be considered a responsible relative and if any of Mrs. G's income will be deemed to Mr. G.

   George's income: $ 250.00

Mrs. G's income:	$	250.00	Social security
	-	222.00	George: Allocation for ineligible child ($472 - 250)
	$	28.00	

   $28 is less than $472. Therefore, Mrs. G's income is not deemed to Mr. G, and she is not a responsible relative.

$ 1,000.00	Mr. G's social security income
- 20.00	General income exclusion
$ 980.00	
× 2	Months
$ 1,960.00	
- 966.00	MNIL for a one-person household ($483 × 2 months)
$ 994.00	Spenddown

   Mr. G is conditionally eligible for SSI-related Medically Needy. Medical expenses for Mrs. G and George are not usable in meeting the spenddown for Mr. G's Medicaid eligibility. Mrs. G and George are not coded on the ABC system as responsible relatives for the SSI-related case.

FMAP-related Medically Needy household:

The FMAP-related Medically Needy household is Mr. G, Mrs. G, and George. The household has the option of excluding George. The Gs do not exclude George.

The spenddown for the three-member FMAP-related household is calculated as follows:

Mr. G	$ 1,000.00	Responsible relative (parent)
Mrs. G	+ 250.00	FMAP specified relative
George	+ 250.00	FMAP-related child
	$ 1,500.00	Monthly net income to be considered for spenddown

$ 3,000	Income for two months ($1,500 × 2)
- 1,132	MNIL for a three-person household ($566 × 2 months)
$ 1,868	Spenddown

Mr. G has a choice of receiving Medicaid as SSI-related or FMAP-related. In this situation, it is to Mr. G's advantage to be SSI-related. Mr. G is conditionally Medicaid-eligible on the SSI-related case.

Because Mr. G is not receiving SSI, his income must be used to determine eligibility for his child and spouse on the FMAP-related case. Therefore, he is a responsible relative on the FMAP-related case. Mrs. G is conditionally Medicaid-eligible on the FMAP-related case. George is a considered person on the Medically Needy case, as he is MAC eligible.

Mr. G has a medical bill of $250 that occurred in January. (**Note:** The family was not certified for Medically Needy in January.) This bill remains unpaid as of May 1. This bill is applied to the spenddown for Mr. G and is also applied to the spenddown of the FMAP-related case.

Mr. G also has a $1,000 medical bill that occurred in May. $744 of this bill will be applied to meet his spenddown. The remaining amount of the medical bill is Medicaid-payable. Therefore, only $744 of the $1,000 medical bill may be applied to the spenddown of the FMAP-related case.

	SSI-related	**FMAP-related**
Spenddown	$ 994.00	$ 1,868.00
January bill	- 250.00	- 250.00
	$ 744.00	$ 1,618.00
$1,000 May bill	- 744.00	- 744.00
	0.00	$ 874.00
	Spenddown met	Spenddown not met

If Mrs. G has medical bills, she must meet the remaining spenddown amount on the FMAP-related case.

Composite Households With Lump-Sum Income

Legal reference: 441 IAC 75 (Rules in Process)

A lump sum payment received by a person in an SSI-related or FMAP-related composite household is treated according to the person's categorical relationship.

Household composition:

SSI-related:	**FMAP-related:**
Mr. H, SSI-related (disabled)	Mrs. H, FMAP-related specified relative
Mrs. H, responsible relative	Holly, 10, FMAP-related child
	Henry, 18, FMAP-related child
	Mr. H, responsible relative

The application date is July 1 and the date of decision is July 30. On July 10, the household receives a retroactive social security disability lump sum:

Mr. H receives $4,000
Mrs. H receives $666
Holly receives $666
Henry receives $666

The lump sums received by Mr. and Mrs. H are counted in full ($4,666) as July's income for the SSI-related case.

For the FMAP-related case, the lump sums for Mr. H, Mrs. H, Holly, and Henry are totaled and added to any other income received in that month and then divided by the standard of living costs for four to determine the number of months to consider the lump sum.

Lump sum	$ 5,998.00
July net countable income	900.00
Total lump sum & July income	$ 6,898.00

Proration of lump sum & July income $6,898 ÷ 986 = 6.99 months to consider the lump sum income.

	July	and	August
Prorated lump sum and July income	$ 986.00		$ 986.00
August net countable income			900.00
Total for certification period	$ 986.00		$ 1,886.00 = 2,872

NOTE: Holly and Henry are eligible for MAC and are considered persons on the FMAP-related Medically Needy case for the month of July.

Income and Spenddown in the Retroactive Period

Legal reference: 441 IAC 75 (Rules in Process)

Assign a retroactive period of one, two, or three months depending on which month the retroactive period begins. (See Retroactive Eligibility for determining which months to include in the retroactive period.)

Consider all months of the retroactive period in which eligibility under another coverage group does not exist as a "unit." The "unit" for the Medically Needy retroactive period may be one, two, or three months depending on the first month in which Medicaid-covered services were received. Count all income for this unit, even if the household is ineligible in any month (for example, because of excess resources).

Determine the income for the retroactive period by adding the net countable income for each month of the Medically Needy retroactive period to arrive at a total. Do not count income from a month of the retroactive period when eligibility for that month is established under a coverage group other than Medically Needy.

Determine the MNIL for the retroactive certification period by adding the MNIL for each month of the Medically Needy retroactive period to arrive at a total.

Compare the net countable income to the MNIL for the retroactive period. (Use all months of the retroactive period, as previously determined, even if the client was ineligible for a part of it.)

1. The household, a pregnant woman, files an application November 10. The household paid a medical bill in August and has an unpaid medical bill in October. The retroactive period is August, September, and October. The household is over resource limits for September.

   Net countable income:

August	$ 700.00	
September	1,000.00	
October	+ 859.00	
	$ 2,559.00	Total net countable income for the retroactive period

   Income from all three months is totaled and considered in determining spenddown. As September is an ineligible month, retroactive eligibility is coded as first and third prior months only. When the Eligibility Status Turnaround Document is received, the individuals' fund code for the month of September is "9," not eligible.

2. Ms. S, a pregnant woman, files an application November 15 and requests retroactive benefits. She indicates that she has an unpaid bill for Medicaid-covered services received in October. She did not receive any Medicaid-covered services in August or September.

   The retroactive period consists of October. Income from October is used to determine the spenddown for the retroactive period.

3. Mr. and Mrs. T, a pregnant woman, applies for Medicaid April 2. Mrs. T was hospitalized in the month of February and the bills remain unpaid. They did not receive any Medicaid-covered services in January or March.

   The retroactive period includes the months of February and March. The worker uses income from February and March to determine the spenddown for the retroactive period.

4. Ms. G, a pregnant woman, applies for Medicaid April 15. She paid medical bills in January and has unpaid bills in March. These bills were for Medicaid-covered services. She did not receive any Medicaid-covered services (paid or unpaid) in February.

   The retroactive period includes the months of January, February, and March. The worker uses income from all three months to determine the spenddown amount.

Income of an Institutionalized Person

Legal reference: 441 IAC 75 (Rules in Process)

Persons in medical institutions who have income exceeding the 300% Medicaid cap or resources exceeding the SSI resource limit may be conditionally eligible for Medically Needy **if all other eligibility factors are met**. **No payment** is made for nursing facility care by Medicaid under the Medically Needy coverage group. NOTE: The cost of the nursing facility care may be used to meet spenddown.

To determine Medically Needy eligibility for the community spouse of an institutionalized eligible spouse, use the community spouse's income plus any income diverted by the institutionalized spouse to the community spouse.

See 8-I, *Income and Resources of Married Persons*, for the policies on counting income and resources for spouses when one spouse enters a medical institution.

- When the institutionalized spouse is expected to stay in a medical institution less than 30 consecutive days, consider the resources and income of both spouses together in determining Medicaid eligibility.
- When the institutionalized spouse (who entered the institution on or after September 30, 1989) is expected to stay more than 30 consecutive days or has stayed 30 days, use only the institutionalized spouse's income to determine eligibility, both in the initial month and in the succeeding months.

  Complete an attribution of resources for the month that one spouse enters an institution expecting to stay 30 consecutive days when there is a community spouse.

1. Mrs. W, age 66, enters a nursing facility on June 16. Her monthly gross income is $2,000 social security and $870 IPERS. Her countable income of $2,870 exceeds the Medicaid cap for the 300% group. To determine Medically Needy countable income, deduct the $20 general income exclusion.

   Certification period: June - July income

$ 2,870.00	Gross unearned income
- 20.00	General income exclusion
$ 2,850.00	
$ 2,850.00	
+ 2,850.00	
$ 5,700.00	Net countable income for the certification period
- 966.00	MNIL for the certification period ($483 × 2 months)
$ 4,734.00	Spenddown

   Even if spenddown is met, no Medicaid payment will be made to the facility. Mrs. W is responsible for payments to the facility.

2. Mr. Z resides in a nursing facility and is Medicaid eligible. His monthly income is $737.00 social security and $564 IPERS. He is eligible for the 300% group ($737.00 + 564.00 = $1,301.00). Mrs. Z, the community spouse, has $600.00 social security, $200 IPERS, and the Medicare Part B premium of $174.70 is deducted from her social security check.

   Mrs. Z: Determination of unmet maintenance needs.

$ 3,853.50	Monthly maintenance needs allowance
- 800.00	Mrs. Z's monthly gross income
$ 3,053.50	Unmet maintenance needs

   Mr. Z:

$ 1,301.00	Total gross income
- 50.00	Personal needs
$ 1,251.00	Amount that may be diverted to Mrs. Z.

   Mrs. Z's Medically Needy determination:

$ 600.00	Social security income
+ 200.00	IPERS income
+ 1,251.00	Mr. Z's diversion for Mrs. Z's maintenance needs
$ 2,051.00	Total countable income
- 20.00	General income exclusion
$ 2,031.00	Net countable income
× 2	Months
$ 4,062.00	Two months of net countable income
- 966.00	MNIL for one for two months ($483 × 2)
$ 3,096.00	Spenddown
- 349.40	Medicare premium ($174.70 × 2)
$ 2,746.60	Final spenddown

Applying Medical Expenses to Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

"Spenddown" is the process in which a Medically Needy person's excess income is obligated for allowable medical expenses in order to reduce countable income to the household's MNIL. When incurred medical expenses have reduced income to the applicable MNIL, the conditionally eligible person becomes eligible for Medicaid for the certification period.

Health insurance premiums and Medicare premiums are allowable medical expenses to meet spenddown. Deduct these premiums from the client's spenddown on the *Medically Needy Spenddown Computation Worksheet* to determine the **final** spenddown amount before entry of the spenddown amount on the ABC system.

Cases that have a spenddown in either the retroactive or the prospective certification period have information passed to the Medically Needy subsystem. The Medically Needy subsystem builds files for recipients with spenddown amounts and tracks the verified expenses applied to meet the spenddown obligation.

Providers submit claims to the Iowa Medicaid Enterprise (IME) for Medicaid-covered services incurred during the certification period.

The client or the provider submits information on non-Medicaid-payable expenses to you on a claim form. Attach the claim to *Medically Needy Transmittal*, form 470-3630, and submit both forms to the IME Medically Needy Unit by one of the following methods:

- Electronically to: imemedicallyneedy@dhs.state.ia.us
- Fax it to (515) 725-1350, or
- Send it to the IME Medically Needy Unit, Hoover Building, Des Moines.

Data from these claims is entered into the Medically Needy subsystem for processing. The Medically Needy subsystem prioritizes and accepts or rejects medical expenses, and automatically calculates whether spenddown has been met. The subsystem generates a computer-issued *Notice of Spenddown Status*, form 470-1967:

- Biweekly, when the IME Medically Needy Unit has input a claim.
- Biweekly, when changes in circumstances affect the spenddown calculation.
- On the day when a conditionally eligible recipient has met spenddown.

When the spenddown obligation is met, the Medically Needy subsystem notifies IME that the client is eligible for Medicaid and that certain bills are not payable because they were used to meet the spenddown obligation. The subsystem issues an *Eligibility Status Turnaround Document* (ESTD), form 470-1941, to document the case's status for each month of the certification period.

See 14-I(1) for information on ABC system entries for Medically Needy and 14-I for more information on the Medically Needy subsystem. See the following sections for more information on:

- Deducting health insurance premiums
- Deducting Medicare premiums
- Submitting Medical expenses for spenddown
- When medical expenses may be used to meet spenddown
- Allowable expenses for spenddown
- Determining the client's obligation
- Order of deducting expenses

Deducting Health Insurance Premiums

Legal reference: 441 IAC 75 (Rules in Process)

Verify health insurance premiums by bills from the insurance company, pay stubs, or other documentary evidence. MEPD premiums for the responsible relative are an allowable deduction from the spenddown amount. Prorate the premiums over the period they are intended to cover. Use the applicable *Medically Needy Spenddown Computation Worksheet* to deduct these amounts from the spenddown before entering it on the system.

NOTE: Premiums for insurance policies that pay a flat rate to the policyholder may be deducted from spenddown if:

- The policy was purchased to pay for medical care and with regard to anticipated charges, and
- The benefit is payable only if the policy holder actually receives the type of medical care for which the policy was purchased, and
- The benefit is intended to be used to pay for medical care for which the policy was purchased, and
- The benefit is not being counted as income for determining eligibility.

NOTE: Most discount drug plans are not health insurance contracts and thus should not be considered a health insurance premium. Obtain a copy of the plan if you are in doubt.

Do not allow the deduction for a premium that is paid by the Health Insurance Premium Payment (HIPP) program. Allow premiums paid by the AIDS/HIV Health Insurance Premium Payment program. See Medical Expenses Paid by a State Public Program.

When a client's countable income is below the MNIL and the health insurance premium is not used to meet the spenddown, the person may be eligible for the HIPP program. See 8-M, *Who Is Eligible for HIPP*. If the client is covered or could be covered by an employer's group health insurance plan, send a copy of the *Employer's Statement of Earnings*, form 470-2844 or 470-2844(S), to HIPP unit.

Deducting Medicare Premiums

Legal reference: 441 IAC 75 (Rules in Process), 75.52(5)

Medicare premiums are an allowable medical expense. However, do not allow deduction for the Medicare premium if it is paid by Medicaid.

People in the qualified Medicare beneficiary (QMB) coverage group cannot use Medicare premiums, deductibles or coinsurance to meet spenddown, because Medicaid pays these costs. Similarly, people in the specified low-income Medicare beneficiary (SLMB) and expanded specified low-income Medicare beneficiary (E-SLMB) coverage groups cannot use the Medicare Part B premium to meet spenddown.

Iowa "buys in" Medicare premiums for all Medicaid members. The buy-in automatically occurs for people whose social security claim number is correctly coded and who receive Medicare Part B. The buy-in tape is sent two days before the ABC month end. If buy-in is in effect for a Medically Needy member, buy-in will continue if the client has met spenddown before the buy-in tape is sent.

For clients who are not QMB, SLMB, or E-SLMB eligible, determine if Medicare Part B buy-in is in effect. Do **not** allow the Medicare premium as a medical deduction for the current certification period if the buy-in is in effect or if there is time to enter the Medically Needy case on the ABC system before the buy-in tape is sent.

If the buy-in tape will not be updated until **after** the two-month certification period is entered onto the system **or** the client meets spenddown, allow the premium deduction for the entire two-month certification period.

If the buy-in tape will not be updated until after ongoing eligibility is entered onto the system, allow the premium deduction until buy-in occurs. On the applicable *Medically Needy Spenddown Computation Worksheet*, deduct the Medicare premium from the client's spenddown before entering it on the system.

Tell the client to notify you when the buy-in occurs. (You can also determine when buy-in occurs from the SSBI screen, from the Bendex report in WISE, by the change of the Medicare premium coding on the TD03 screen in ABC, or by an alert in WISE.) When the buy-in occurs, recalculate the client's spenddown.

When the client meets spenddown at the end of the certification period or after the certification period, request a manual buy-in. To request a manual buy-in, notify the staff in the IME Policy Unit in writing by e-mail to: medicarebuyin@dhs.state.ia.us. Provide the following information on the people whose Medicaid buy-in needs to be processed:

- Member's name.
- SID number.
- Social security claim number.
- Months of eligibility for buy-in.

1. Ms. Z applies for Medically Needy on December 11 for the first time. She does not want Medicaid in December. Her social security disability income is projected as follows:

January	**February**	
$800.00	$800.00	Her Medicare premium is $174.70 for each month. Her Medicare supplement is $200.00. She is over resources for QMB.

In processing the application on January 3, the IM worker determines that since Ms. Z is not already "bought in," the Medicare premium is allowable as a deduction. The calculation is as follows:

January	+	**February**	=	**Total Period**	
$ 800.00		$ 800.00		$ 1,600.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 780.00		$ 780.00		$ 1,560.00	Net income
- 483.00		- 483.00		- 966.00	MNIL
$ 297.00		$ 297.00		$ 594.00	Spenddown
- 174.70		- 174.70		- 349.40	Medicare premium
- 200.00		- 200.00		- 400.00	Medicare supplement
$ 00.00		$ 00.00		$ 00.00	

Since there is no spenddown in the initial two months, Ms. Z has ongoing eligibility.

When buy-in is reported, the IM worker recalculates the spenddown for the certification period. This causes the ongoing eligibility to be redetermined to a two-month certification period, since the Medicare premium is not allowed as a deduction after buy-in has occurred.

2. Mr. Y is QMB-eligible. He applies for Medically Needy on December 11. He has social security disability income of $850 and the Medicare premium of $174.70 is paid by Medicaid.

The IM worker is processing this application on January 3 and **does not** allow the Medicare premium as a deduction, since Mr. Y is in the buy-in process (He is QMB-eligible). The calculation for spenddown is as follows:

January	+	**February**	=	**Total Period**	
$ 850.00		$ 850.00		$ 1,700.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 830.00		$ 830.00		$ 1,660.00	Net income
$ 483.00		$ 483.00		- 966.00	MNIL
				$ 694.00	Spenddown

3. Mr. Z has $950 gross social security and is over resources for SLMB. Mr. Z met his spenddown for the April-May certification and buy-in for his Medicare premium occurred in May.

   At the end of May, Mr. Z reapplies for Medically Needy for June-July certification. Since buy-in is already in effect and the application is being processed on June 3, no deduction is allowed for the Medicare premium.

June	+	July	=	Total Period	
$ 950.00		$ 950.00		$ 1900.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 930.00		$ 930.00		$ 1860.00	Net income
$ 483.00		$ 483.00		- 966.00	MNIL
				$ 894.00	Spenddown

   Mr. Z is assigned a two-month certification period. If spenddown is never met or is met after the buy-in tape is produced in January, buy-out will occur.

   On the next recertification, if buy-in is not in effect, allow the monthly amount of Mr. Z's Medicare premium (except for Part D) as a deduction. Mr. Z's Part D premium is paid by Extra Help for Medicare Part D.

4. Ms. A is now age 65 and has just enrolled for Medicare. As a new Medicare enrollee her Medicare Part B premium is $174.70. Ms. A applies for Medically Needy and QMB on April 15. Her social security income is $980 and she has the Medicare Part B premium deducted from her social security check.

   The IM worker processes the application on May 5. Ms. A is QMB eligible effective June 1. The IM worker allows the Medicare Part B premium as a deduction for the April - May certification period. The calculation for spenddown is as follows:

April	+	May	=	Total Period	
$ 980.00		$ 980.00		$ 1,960.00	Gross income
- 20.00		- 20.00		- 40.00	Disregard
$ 960.00		$ 960.00		$ 1,920.00	Net income
- 483.00		- 483.00		- 966.00	MNIL
$ 477.00		$ 477.00		$ 954.00	Spenddown
- 174.70		- 174.70		- 349.40	Medicare premium
$ 302.30		$ 302.30		$ 604.60	Final spenddown

   Ms. A sends an application to the IM worker on June 2. The IM worker processes the application for the June - July certification period. Mrs. A is now QMB eligible. The Medicare Part B premium is not allowed as a deduction, as Medicaid is paying for it. Ms. A's spenddown for the June - July certification period is $954.

5. Mr. M applies for Medically Needy and QMB November 2. On November 20, Mr. M is approved for QMB effective December and for a November-December certification for Medically Needy.

   Mr. M is a Medicare enrollee and $174.70 is deducted from his social security check. The Medicare premium of $174.70 is allowed for a deduction for November but is not allowed for December, because the client is eligible for QMB for December.

Submitting Medical Expenses

Legal reference: 441 IAC 75 (Rules in Process)

Send the client a *Notice of Decision for Medically Needy*, form 470-2330, as soon as the certification period is on the ABC system. Tell clients to inform their providers that they are on Medically Needy and that the provider should:

- Send claims for Medicaid-covered services occurring in the certification period to Iowa Medicaid Enterprise (IME).
- Send all other claims to the IM worker.

Conditionally eligible clients inform their providers that they have a spenddown to meet by showing the provider their *Notice of Decision for Medically Needy* when they receive services. If services are received in the certification period before the client gets the notice of decision, the client should inform the provider of the spenddown obligation.

The provider needs either the state ID number or the social security number for the person receiving the services in order to check the Eligibility Verification System (ELVS) for billing information. ELVS notifies the provider if the client is conditionally eligible and the remaining amount of spenddown.

When the conditionally eligible person or the responsible relative receives Medicaid-covered services during the certification period, the provider completes a paper claim, electronic claim, or point-of-sale claim, and sends it to the IME.

When the state ID number is on the SSNI system for the 37-E aid type with a "P" or "S" fund code for the month of service, the IME enters the claim information into the Medically Needy subsystem. The IME notifies the provider that the claim has been denied for payment and that the claim has been submitted for spenddown consideration.

If the client asks a provider to submit a claim to be used to meet spenddown before the certification period is on both the ABC system and the Medically Needy subsystem, the claim will be denied and will not be submitted for spenddown consideration.

Mr. and Mrs. A file an application for Medically Needy. The worker determines that they have a spenddown of $230 for a May-June certification period. Mrs. A calls and states that Mr. A has an unpaid medical bill of $50 at the Wall Clinic that was incurred four months ago. She also states that she has a medical bill of $80 at Pharmacy C for May 2.

The worker advises Mrs. A to show Wall Clinic and Pharmacy C the *Notice of Decision for Medically Needy*. Wall Clinic sends the $50 claim to the worker. Pharmacy C sends an $80 claim to the IME for spenddown consideration.

The worker also advises them to show the *Notice of Decision for Medically Needy* to providers during the certification period until they meet spenddown and get Medicaid cards.

Expenses Submitted Through IM Worker

Legal reference: 441 IAC 75 (Rules in Process)

When the conditionally eligible person or responsible relative has received services before the certification period or receives non-Medicaid-covered services during the certification period, the provider submits a paper claim form to the IM worker.

NOTE: If a provider questions submitting a paper claim instead of filing electronically, refer the provider to the ***Medicaid All Providers Manual***, CHAPTER II. MEMBER ELIGIBILITY: Medically Needy Conditional Eligibility.

Allow applicants 12 months after the end of the certification period to submit medical expenses to be used to meet spenddown. Allow 12 months from the date of the notice of decision when the certification period or the retroactive certification period has ended before the issuance of the notice of decision.

Claims that are received after the 12-month period can be used for later certification periods **only** if spenddown was met for the original certification period and the bill is not Medicaid-payable. EXCEPTION: Bills incurred in the retroactive period can be applied to the certification period immediately following the retroactive period.

When you receive claims, determine:

- Whether the claim is for a period of time that can be allowed for spenddown. (See When Incurred Medical Expenses May Be Used.)
- Whether the expenses are of a type that is allowable for spenddown. (See Allowable Medical Expenses for Spenddown.)
- Whether the client still remains obligated for the expenses. (See Determining the Client's Obligation.)

When the expenses meet these tests, submit the completed claim forms to the IME Medically Needy Unit **within five days of receipt**. Attach the *Medically Needy Transmittal* to the claim form. (If the provider does not send a claim for an old bill, attach the provider's statement to the *Medically Needy Transmittal*.)

Medical transportation costs incurred when the client was not certified for Medically Needy are an allowable deduction for spenddown if the transportation expense remains unpaid. Clients must submit evidence of transportation medical expenses.

When the client submits transportation expenses, determine whether the expenses remain unpaid on the first day of the certification period and whether a third-party payment is anticipated. If the expenses are allowable, transfer the information onto the *Medically Needy Transmittal*, form 470-3630.

When the client verifies residential care personal care services, enter the amount on the *Medically Needy Transmittal* and send it to the IME Medically Needy Unit.

If an alien who is only eligible for emergency services does not have a bill, a statement, or a claim, verify the diagnosis code. Mail form 470-4299, *Verification of Emergency Health Care Services*, to the provider for completion.

The Medically Needy subsystem generates the *Bill Status Turnaround Document* (BSTD), 470-1942, to track the application of the expenses to the spenddown. When the bill is large enough to be applied to more than one certification period, use the BSTD to resubmit it for subsequent periods.

Once spenddown is met, the Medically Needy subsystem will accept changes to:

- Decrease the amount of spenddown. (Use the ESTD.)
- Apply an old bill or noncovered Medicaid payable claim that occurred before the spenddown date. (Submit the claim with the *Transmittal*.) When this type of claim is received after spenddown has been met, the Medicaid covered claim will be backed out of the Medically Needy subsystem and the provider will be paid.

When Incurred Medical Expenses May Be Used

Legal reference: 441 IAC 75 (Rules in Process)

Use paid or unpaid medical services that occurred in the certification period to meet the spenddown obligation for that period.

> The S family has a spenddown of $300 for the certification period of June and July. During June, they pay or incur $200 in medical expenses. In July, they pay or incur $125 in medical expenses. They are eligible for Medicaid as Medically Needy for June and July. Medicaid will not pay the bills used to meet the $300 spenddown.

Paid and unpaid expenses incurred in the retroactive period may be used to meet spenddown in the certification period that immediately follows the retroactive period if they were not used for spenddown in the retroactive period.

Use incurred medical expenses to meet spenddown only if they were not already used in full to meet spenddown in a previous certification period and were not Medicaid-payable. (NOTE: For these expenses to be allowed in the subsequent certification period, the spenddown in the previous certification period must have been met.)

Medical expenses incurred in a certification period where spenddown is not met cannot be used to meet spenddown in any subsequent certification period. If the spenddown was not met in a preceding certification period (other than the retroactive period), do not carry unpaid medical expenses that were incurred in that period forward to the current certification period.

See the following sections for more details on applying these expenses:

- Expenses from months not certified as Medically Needy
- Expenses from the retroactive period
- Expenses from a prior certification period

Expenses From Months Not Certified for Medically Needy

Legal reference: 441 IAC 75 (Rules in Process)

Apply old unpaid bills for services received when the client was not certified for Medically Needy (conditionally eligible or eligible) to any certification period, regardless of whether or not spenddown was met in a certification period.

The unpaid bill must remain unpaid on the first day of the month of the certification period. Only the portion of the bill that was not used to meet a spenddown may be applied to a subsequent certification period. See Old Bills With Remaining Balances.

> Ms. Z is conditionally eligible for the October-November certification period with a $200 spenddown. Ms. Z has a dental bill for $335 that she incurred on May 15. She was not certified for Medically Needy in the month of May.
>
> The dentist submits a claim or bill indicating that Ms. Z still owes the $335. The dental expense is applied to the $200 spenddown for the October-November certification period. The dental bill has a remaining value of $135 that may be applied to the next certification period, if the expense remains unpaid.

Expenses From the Retroactive Period

Legal reference: 441 IAC 75 (Rules in Process)

Use the following guidelines to apply paid or unpaid medical expenses incurred in the retroactive period to meet spenddown for the certification period that immediately follows the retroactive period:

- It does not matter if spenddown was met in the retroactive period.
- Use non-Medicaid-covered expenses that were incurred in the retroactive period to meet spenddown for the certification period that immediately follows it, if they were not used to meet spenddown in retroactive period. This applies whether the expenses are paid or unpaid.
- Use paid bills incurred in the retroactive period to meet spenddown in the certification period that immediately follows the retroactive period, if the expense has not been used to meet spenddown in the retroactive period. Do not use these paid expenses from the retroactive period to meet the spenddown for any subsequent certification period.
- If the bill incurred in the retroactive period is unpaid and is for a service that will be paid by Medicaid, do not use the bill to meet spenddown in the following certification period.

The certification period that "immediately follows" the retroactive period means that there has been no lapse in time between the retroactive certification period and the next certification period.

NOTE: If the retroactive period is not entered on the Medically Needy subsystem, the subsystem will not allow the paid medical bill from the retroactive period to be applied to the following certification period.

Ms. M, a pregnant woman, files an application April 2 and does not request retroactive benefits. The worker contacts Ms. M and asks if she has any unpaid medical bills in the retroactive months. Ms. M states that she did not.

The worker then asks if she had paid any medical bills that she incurred during the retroactive period. Ms. M remembers that in February she went to the dentist for a check-up and paid the dental bill of $65. There were no other medical expenses in the retroactive period.

The worker determines Ms. M has a spenddown of $500 for the retroactive period (February and March). The worker enters a two-month retroactive certification period on the Automated Benefit Calculation (ABC) system.

Ms. M does not have any unpaid medical bills for services received before the retroactive period. The worker determines that Ms. M would not meet the spenddown of $500 for the retroactive period with the $65 dental bill.

Therefore, the February dental bill of $65 is applied to the spenddown for the April-May certification period. Ms. M has a spenddown of $500 for the April-May certification period.

Expenses From a Prior Certification Period

Legal reference: 441 IAC 75 (Rules in Process)

When the spenddown has been met in the previous certification period, move the remaining value of unpaid non-Medicaid covered expenses from that certification period to the following certification period. (This does not apply to unpaid bills in the retroactive certification period being moved to the certification period that immediately follows the retroactive period.)

Medical expenses that occurred in a prior certification period that did not meet spenddown may **not** be used in a following certification period.

1. The M family has a $500 spenddown for the June-July certification period.

   Junior M incurs a medical expense of $800 on June 5 with a non-Medicaid provider. ($500 is applied to the spenddown and the remaining value of $300 may be applied to the next certification period if still obligated.) The M family meets the spenddown for the June-July certification period.

   The M family applies for the August-September certification period. They are approved with a spenddown of $500. Mrs. M still owes the non-Medicaid provider for her son's April bill. The $300 remaining value of the $800 medical expense that was not used before is applied to the spenddown amount.

   The M family does not incur any medical bills in the August-September certification period. Spenddown is not met for the August-September certification period. (NOTE: Spenddown was not met for this certification period, therefore, the $300 cannot be moved to the next certification period.)

2. Same situation as Example 1, except the M family does not apply for the August-September certification period. They wait and apply after Mrs. M is hospitalized in October. They are approved with a spenddown of $400 for the October-November certification period.

   The worker asks Mrs. M if they still owe the non-Medicaid provider the $300 from the $800 bill that was incurred in June. (Because the M family met spenddown for the June-July and this amount is still obligated it may be applied to the spenddown for the next certification period after the June-July certification period.)

   Mrs. M states that they still owe $200. This is verified with a call to the provider and the BSTD is submitted to indicate the payments of $400 on July 20 and $200 on September 10. The $200 is applied to spenddown and Mrs. M's hospital bill is used to meet the remaining spenddown amount.

Allowable Medical Expenses for Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

Apply actual expenses for necessary medical and remedial services and approved transportation expenses incurred by a recipient or conditionally eligible person or responsible relative to the spenddown amount for the certification period. This includes some over-the-counter drugs. See the Medicaid provider's manual for the covered services. Incurred medical expenses are:

- Medical bills paid during the certification period or retroactive certification period by:
  - A recipient or a conditionally eligible person.
  - A responsible relative.
  - A public program of a state or political subdivision (other than Medicaid).
- Unpaid medical expenses for which the recipient or conditionally eligible person or responsible relative remains obligated to pay. See When Incurred Medical Expenses May Be Used and Determining the Client's Obligation.

Bills for a person who is not a responsible relative or a conditionally eligible person cannot be used to meet spenddown. Bills of any person voluntarily excluded from the household cannot be used to meet spenddown.

The family consists of Ms. H, who receives child support, and her two children, ages 15 and 14. The 14-year-old is hospitalized. The 15-year-old, who receives $500 unearned income, is healthy.

When the 15-year-old is included in the Medically Needy household, there is a high spenddown caused by the 15-year-old's income. When the 15-year-old is excluded from the FMAP-related household, there is a much lower spenddown for the Medically Needy household. The family chooses to exclude the 15-year-old.

Only the incurred expenses of the Medically Needy household are used to reduce spenddown. Incurred expenses of the 15-year-old excluded child are not allowable in meeting spenddown.

If a person is conditionally eligible on one case and also a responsible relative or considered person on another case, use the same bills to meet both spenddowns. Do not include any portion of a bill paid by Medicaid. See SSI-Related, FMAP-Related Composite Households for examples.

If the noncustodial parent is legally responsible for medical expenses and does not pay, use these expenses for spenddown when the medical expenses revert to the conditionally eligible or responsible relative to pay.

When medical expenses are used to reduce the period of time a lump sum is considered, also use these same medical expenses to meet the client's spenddown.

The following sections give more detail in these areas:

- Noncovered Medicaid services
- Prepaid medical coverage
- Medical expenses of stepparents
- Medical expenses paid by a state public program
- Personal care services in a residential care facility
- Acupuncture services

Noncovered Medicaid Services

Legal reference: 441 IAC 75 (Rules in Process)

Bills for a service that is not "necessary," as defined by Medicare and Medicaid, cannot be used for spenddown.

Medical expenses that are ordinarily covered by Medicaid but are not payable for the Medically Needy client may be used for spenddown. This includes services that are not payable because:

- The provider is not enrolled in Medicaid.
- The expense is for a responsible relative who is not in the Medically Needy eligible group.
- Services were received before the start of the certification period.
- The service is a nonemergency service provided to aliens who are eligible only for payment of emergency medical expenses.
- The Medically Needy program does not pay for the service, although it is available under other Medicaid coverage groups. These services include:
  - Payment for care in a nursing facility or NF/MI.
  - Payment for care in a Medicare-certified skilled nursing facility.
  - Payment for care in an intermediate care facility for persons with an intellectual disability.
  - Payment for care in an institution for mental disease.
  - Payment for rehabilitative treatment services. These are specified services in the family preservation, family-centered services, family foster care treatment, and group care programs.

Prepaid Medical Coverage

Legal reference: 441 IAC 75 (Rules in Process)

With a prepaid medical package, such as orthodontia or prenatal care, allow the cost of medical services that:

- Were received during the certification period, or
- Remain unpaid as of the first day of the certification period.

EXCEPTION: For orthodontia for children that would be billed under Care for Kids (EPSDT) after spenddown is met, use the prepaid amount to meet spenddown. This is allowable because EPSDT allows Medicaid prepayment at the time of banding to cover active treatment and the retainer for a 30-month period. The client must obtain prior approval for Medicaid to pay any remaining amount. The client should pursue the prior approval immediately (before the spenddown is met).

1. The orthodontist requires a prepayment for braces of $2,000. The orthodontist received prior approval for the braces from the IME. The prepayment is due May 1. Mrs. X, age 28, pays the $2,000 on May 1. Mrs. X receives $200 in dental services for the month of May and $150 for the month of June.

   The worker allows only $350 to meet the spenddown for the May-June certification period. The remaining $1,650 that was paid is not allowed as a deduction in any certification period, as it does not represent an obligation for medical services received. The remaining medical services have been prepaid.

2. Mrs. Z asks the orthodontist if Medicaid would pay for the treatment. He states that for Medicaid to pay, prior approval needs to be requested and granted. Mrs. Z explains that they have a $500 spenddown to meet before they would be eligible.

   The orthodontist submits the request for prior approval January 5. After the dentist receives prior approval, treatment begins on February 20. The claim submitted to IME January 10 indicates the total private-pay charge. Spenddown is met.

   After spenddown is met, the IME pays $2,000. Mrs. Z is responsible for paying $500 of the $2,500 for treatment. (**Note:** If the prior approval is denied, Mrs. Z will be responsible for paying the private pay charges.)

Medical Expenses of Stepparents

Legal reference: 441 IAC 75 (Rules in Process)

Use the medical expenses of stepparents who are included in the FMAP-related Medically Needy household to meet spenddown.

Use the expenses of stepparents who are not included in the FMAP-related Medically Needy household if income from the stepparent was diverted to that household. (The stepparent is considered a responsible relative.)

1. The family consists of Mrs. D, her child, and Mr. D, the stepparent. There are no common children. Mr. D, who is not disabled, is not considered in the Medically Needy group.

   The resources of Mrs. D and her child exceed FMAP limits but are within Medically Needy limits. Mrs. D has net countable income of $600.

   Mr. D has $1,700 earnings. There is stepparent income attributable to the household after applicable deductions and diversions. The income calculation is as follows:

$ 1,700.00	Stepparent's earnings
- 340.00	20% earned income deduction
$ 1,360.00	
- 365.00	Stepparent's needs
$ 995.00	Attributable to Mrs. D and her child
+ 600.00	Mrs. D's net countable income
$ 1,595.00	Is compared to MNIL for a household of two

   Mr. D is not included in the MN household size to determine the MNIL. However, he is entered on ABC as a financially responsible relative, so that his unpaid medical expenses are usable in meeting the Medically Needy household's spenddown.

2. Same situation as above, except that Mr. D has only $450 earnings. He has no income to attribute to the FMAP-related household of Mrs. D and her daughter. Mrs. D has net countable income of $750. His income is calculated as follows:

$ 450.00	Stepparent's earnings
- 90.00	20% earned income deduction
$ 360.00	
- 365.00	Stepparent's needs
$ 0.00	

   There is no income to attribute to Mrs. D and her child. Mr. D is not included in the Medically Needy household size to determine the MNIL. His unpaid medical expenses are not allowed as a deduction in meeting spenddown for Medically Needy group, as his income was not used to determine spenddown.

   NOTE: Ms. D's daughter is eligible for MAC and is a considered person for Medically Needy.

Medical Expenses Paid by a State Public Program

Legal reference: 441 IAC 75 (Rules in Process)

Use incurred medical expenses paid **in a certification period** by a state public program (other than Medicaid) to meet spenddown. If a medical expense was paid **before** the certification period by a public program, do not allow it as a spenddown deduction.

A state public program is a program administered by the state or financed by state appropriations (including a political subdivision). A state public program does not receive any federal funding. Examples of state public programs are:

- Veteran's Assistance (soldier's relief).
- General Relief.
- Renal programs.
- AIDS/HIV health insurance premium payment program.
- State Public Health Nursing Grant.

- County nurses.
- State payment program for MH/ID/DD state cases.

Treat payments made by these programs the same as patient payments. The payment reduces the obligated medical expense when it is made before the certification period. Disregard payments when they are made within the certification period.

> Mr. A's certification period is October 1 through November 30. The spenddown is $50. Mr. A verifies that he incurred a $50 physician bill on September 15. General Relief paid the $50 medical expense for Mr. A on October 1.
>
> The General Relief payment is disregarded because it occurred during the certification period. The entire physician expense is applied towards spenddown. When the spenddown is met on the Medically Needy subsystem, Mr. A is issued a Notice of Spenddown Status (NOSS).

Medical expenses written off by a medical facility as part of its Hill-Burton commitment apply to spenddown when this was done in the certification period. Determine through discussion with the client or provider if Hill-Burton assistance was granted.

Medicare Part D

Medicare Part D is a prescription drug benefit available to Medicare beneficiaries. Enrollees in Part D may be required to:

- Pay a monthly premium.
- Pay a co-payment on each prescription.
- Meet a deductible.

Medically Needy clients who enroll in a prescription drug plan may use prescription drug expenses not covered by the plan to meet their spenddown. NOTE: Prescription drug plans vary, so costs to enrollees will be different.

Do **not** deduct prescriptions paid by Medicare Part D or another party from the spenddown for people who are eligible for Part D.

Deductions to Allow for Spenddown

Deduct the following expenses for spenddown for people who are eligible for Part D:

- Medicare Part D premiums the client paid.
- Prescriptions paid by the client that apply to the Medicare Part D deductible.
- Coinsurance or copayments the client paid for Medicare Part D prescriptions.
- Prescriptions paid by the client that are not paid by Medicare Part D because they are not covered in the Part D plan's formulary when the client has applied for and been denied an exception for the plan to cover the drug.
- Prescriptions paid by the client that are in a class of drugs not covered by Medicare Part D. After spenddown is met, these drugs may be Medicaid payable.

- Prescriptions paid by the client for Part D-covered drugs when the client is eligible for Part D, but has not signed up.

Applying Part D Expenses to the Spenddown

Apply Part D expenses to spenddown in the following order:

1. **Medicare Part D Premiums:** Subtract Part D premiums from the calculated spenddown on the applicable *Medically Needy Spenddown Computation Worksheet* before the spenddown is entered on ABC, along with any other health insurance or Medicare premiums.
2. **All other Medicare Part D related medical expenses:**
   - The client submits the monthly statement from the drug plan and any drug plan exception notices to you, the worker. (Prescription drug plans must issue a statement to the client at least monthly to explain all benefits paid and denied.)
   - You review the drug plan statement and circle in red the prescription expenses that should be applied to the spenddown.
   - Attach form 470-3630, *Medically Needy Transmittal*, to the completed claim form, and submit it to the IME Medically Needy Unit within five working days of receipt. The claim and transmittal can either be:
     - Electronically sent to: imemedicallyneedy@dhs.state.ia.us
     - Faxed to the Medically Needy Unit at: 515-725-1350, or
   - Mailed to: IME Medically Needy Unit, 1305 E. Walnut St., Des Moines, Iowa 50319-0114.

NOTE: Advise applicants and recipients to keep their drug plan monthly statements and exception notices and to submit them to determine whether the denied drugs can be applied to the spenddown.

Personal Care Services in a Residential Care Facility

Legal reference: 441 IAC 75 (Rules in Process)

In addition to food and shelter, residents of residential care facilities may also receive personal care services from the facility. Any resident of a licensed residential care facility qualifies for this medical expense deduction. Verify the client's residence with the facility.

"Personal care services" include assistance with activities of daily living, such as preparation of a special diet, personal hygiene and bathing, dressing, ambulation, toilet use, transferring, eating, and managing medication. For purposes of the Medically Needy coverage group, these personal care services do meet the definition of a necessary medical and remedial service.

The medical expenses deduction for personal care services is based on the average per day health care costs for a member in a residential care facility, which currently is $32.36, or $983.74 per month.

Allow $983.74 per month for the cost of medically necessary personal care services provided in a licensed residential care facility as a medical expense deduction from spenddown. If a client is in the residential care facility for only part of the month, prorate expenses for the medical expense deduction, allowing $32.36 per day.

Do not allow any facility charges for maintenance to meet spenddown, because a residential care facility is not classified as a medical institution.

Acupuncture Services

Legal reference: 441 IAC 75 (Rules in Process)

Allow acupuncture services that are necessary medical and remedial service for spenddown. Medicaid does not cover acupuncture services.

Determining the Client's Obligation

Legal reference: 441 IAC 75 (Rules in Process)

Medical expenses for which the recipient or responsible relative remains obligated to pay are allowable for spenddown. Applying an expense toward a client's spenddown is considered to meet that obligation.

Therefore, the following are **not** allowable for spenddown:

- Bills paid by Medicaid or other insurance.
- Bills used in full for spenddown previously on this case or another case.
- A paid bill incurred and used in full to meet spenddown in the retroactive period.
- A paid bill incurred in the retroactive period that was not used to meet spenddown in the retroactive period or the certification period immediately following the retroactive period.
- Bills incurred in a certification period that did not meet spenddown. These bills cannot be applied to spenddown for a subsequent certification period.

If the recipient paid with a bank loan or credit card, the recipient could be obligated to the credit card company. See Loans to Pay Medical Expenses.

When a person files bankruptcy and later signs a written agreement to pay medical bills, the person is once again obligated and the bill can be applied to spenddown. If a court assigns the person a payment plan, the bill is the person's obligation and is usable for spenddown.

Several situations that require more effort to determine the client's current obligation for medical expenses are addressed in the following sections:

- Old bills with remaining balances
- Loans to pay medical expenses
- Estimating expenses paid by insurance or another third party

Old Bills With Remaining Balances

Legal reference: 441 IAC 75 (Rules in Process)

If a client has bills that have not been paid in full but were incurred before the client was certified for Medically Needy (as conditionally eligible or eligible), apply these charges to spenddown if they were not previously used to meet a spenddown. The client must verify with a statement or bill from the provider any payments made during the certification period and the balance due.

Determine if bills that the provider turns over to a collection agency for collection are still legally obligated to the provider. If the expenses are still legally obligated to the provider, the expenses may be applied towards spenddown. Verify the status of the bill with the provider. Do not use the following for spenddown:

- Late fees or finance charges.
- Any charge no longer owed to the provider. This includes bills that the provider has written off and unpaid bills that a provider sells to a collection agency.

To apply payments made on old medical bills:

1. Total all payments before the certification period.
2. Apply payments against each charge (beginning with the oldest).
3. Determine if the charges exceed payments. If so, enter remaining balance on the *Medically Needy Transmittal* and attach a copy of the claim or the provider's statement. Be sure to enter the total charges on the *Medically Needy Transmittal* for that date of service and, if applicable, any payments that apply to the charge.

Attach the *Medically Needy Transmittal* to the claim for old medical bills (or to the bill, if the provider submits a bill rather than the claim). Enter the total remaining charges on the *Medically Needy Transmittal*. Highlight the remaining charges on the bill. If only a portion of the service is payable, highlight the service and indicate the remaining portion.

If the total payments exceed total charges, bills are considered paid in full and cannot be used to meet spenddown. When a medical expense was determined to be paid in full, send a manual *Notice of Decision*. Include the date of service, provider name, patient name, charge, and the reason an expense was not allowed for spenddown.

Deduct the amount applied against spenddown in the certification period from the balance due at the beginning of that certification period. When medical expenses are allowed for meeting spenddown, only the balance remaining can be applied in subsequent periods.

If a payment is made on an obligation that has been counted toward spenddown in a previous certification period that met spenddown, deduct the amount paid from the amount previously allowed. Only the remaining value can be counted toward spenddown in the next certification period, so that deductions are not allowed once as an obligation and later as payment.

1. The G family has a March-April certification period. They have a doctor bill of $200 incurred in November that they still owe. They were not on Medically Needy when they incurred the bill. The Gs have a spenddown amount of $200 for the certification period. The family meets the March-April spenddown.

   The Gs reapply for the months of May-June. In May they pay the doctor $75 on the November bill. This payment does not count toward the May-June spenddown, because the payment is for an expense that was previously counted for spenddown.

2. The D family has a November and December certification period. They have a hospital bill of $500 from two years ago for which they are legally obligated. They were not on Medically Needy when they incurred the bill.

   The Ds have a spenddown amount of $200 for the certification period. The spenddown of $200 for November and December is deducted from the $500 bill, leaving $300 that can be applied to future certification periods.

   The Ds make a $200 payment on December 26 after spenddown was met. They are recertified for January-February. The worker indicates on the payment section of the BSTD that a payment of $200 was made on December 26.

   The Medically Needy subsystem applies this payment to the amount that was previously used to meet spenddown. The worker resubmits the BSTD to have the remaining value of $300 applied to the January-February certification period.

3. The E family received a bill for a non-Medicaid-covered service of $1,000 in January. The family was certified for January-February with a $400 spenddown. The potential remaining value of the bill is $600.

   The family is recertified for March-April with a $500 spenddown. The family still owes $600 on the non-Medicaid-covered service, which is applied to the spenddown for the March-April certification period. The potential remaining value of the bill to be applied to the next certification period is $100.

   The family is recertified for the May-June certification period with a spenddown of $400. The remaining value of $100 is applied to the spenddown, as it still remains obligated. The family incurs $200 more in medical expenses for May-June, which are also applied to spenddown.

   The family does not meet spenddown for the May and June certification period. Even if the total $300 in bills remains unpaid, these bills **cannot be carried forward** to the next certification period.

Loans to Pay Medical Expenses

Legal reference: 441 IAC 75 (Rules in Process)

The balance of a loan used to pay medical expenses for a member of the Medically Needy group or a responsible relative may be used to meet spenddown. Loans include repayment arrangements with financial institutions, credit card companies, private individuals, etc. Do not allow accrued interest or any portion of the loan obtained and used for purposes other than for medical expenses.

If an incurred medical expense that has been paid by a loan has been previously submitted for meeting spenddown for the retroactive period, apply only the remaining value of the medical expense to the two-month certification period immediately following the retroactive certification period.

If an incurred medical expense paid by a loan has been previously submitted and spenddown was met, apply only the remaining value of the medical expense to the subsequent certification period.

As of the first day of the certification period, consider for meeting spenddown the portion of the loan balance that:

- Remains obligated and
- Was used to pay allowable incurred medical expenses for a member of the medically needy group or a responsible relative.

To consider the loan as a medical expense:

1. Verify that the loan was for medical expenses. Examine the repayment or loan document or obtain a statement from the financial institution.

   If the loan was not made by an institution, obtain a statement signed by both parties describing the obligation to repay. This statement does not necessarily have to have been drawn up when the loan was received. A current statement from both parties is enough to verify that an obligation exists to repay the loan.

2. Verify what payments have been made on the loan before the beginning of the certification period.

   The client may have paid medical expenses by using a credit card. If the client pays a portion of a credit card bill, count the first expense incurred as the first paid off. If expenses were incurred on the same day, apply the payment to the advantage of the client.

   For example, if the client incurred a bill for a medical expense and another non-medical expense on the same day, apply the payment to the non-medical expense. This allows the medical expense to be used for spenddown.

3. Deduct any interest from the payments made on the loan.

4. Gather information regarding the medical expense paid in order to record the incurred medical expense in the comment section of the *Medically Needy Transmittal*.

5. Calculate the balance of the medical expense portion of the loan as of the first day of the certification period.

6. Enter in the comment section of the *Medically Needy Transmittal* any payments made on the loan before the certification period and during the certification period. Enter on the *Medically Needy Transmittal* all payments made directly on the bill (payments other than from the loan).

7. For resubmittal of the medical expenses, record any principal payments made since the last determination on the *Bill Status Turnaround Document* (BSTD).

Record all payments toward the incurred medical expense other than payments made from the loan. Determine what the balance of the loan was as of the first day of the certification period. This may involve requesting verification from the financial institution of what the unpaid balance was on that date.

Deduct the balance as of the first of the certification period from the original loan balance. This reflects the reduction of the principal from the loan date to the beginning of the certification period. Record this difference on the *Medically Needy Transmittal* as a payment made before the certification period.

If the bill is resubmitted for use in meeting a future spenddown, again determine the loan balance for the medical expense as of the first day of the new certification period. Again record the difference between these two balances as a payment before this latest certification period.

1. On November 10, Mrs. M gets a loan to pay off the $3,000 remaining balance of a medical expense. The total charge was $5,000 and was incurred for her hospitalization of October 10 through October 20. Insurance paid $2,000 on November 1.

   On March 1, Mrs. M learns of the Medically Needy program and applies for current Medicaid coverage. The IM worker establishes a March-April certification period with a spenddown of $200.

   Mrs. M brings in verification of the October hospitalization, a copy of the loan agreement, and verification that the hospital bill was paid in full. She reports that she made three $50 payments ($150) on the loan before March 1. The IM worker records the total hospitalization expenses ($5,000) in the comment section of the *Medically Needy Transmittal.*

   The payment that is indicated on *Medically Needy Transmittal* reflects the $2,000 paid on November 1 by insurance. To determine the amount of payment that was incurred to pay medical expenses, the worker views the client's loan payment book. On March 1, the current balance was $2,900. ($3,000 original loan balance minus $2,900 equals $100.)

   The worker records a $100 payment on the *Medically Needy Transmittal* with a date before the start of the certification period (March 1). Even though Mrs. M made $150 in payments on the loan, only $100 was paid on the original medical expense. The remaining $50 was for interest, which is not an allowable deduction.

   The claim is attached to the *Medically Needy Transmittal* and sent to the IME. The comment section includes the following information:

10/10 - 10/20	Total charge	$5,000
11/1	Insurance payment	$2,000
Before 3/1	Client payment	$100
	Loan balance as of March 1	$2,900

2. Mr. D, age 20, is hospitalized from December 1 through December 4 and incurs a medical expense of $2,000. He has no health insurance coverage. He has savings of $500, which he decides to use towards his hospital bill. To pay the balance of the bill, Mr. D goes to his credit union and takes out a loan for $1,500 on December 10. He pays the hospital in full on December 11.

On December 20, Mr. D learns that he may be eligible under the Medically Needy program. On December 24, he applies for Medicaid and explains that he paid for his hospitalization by taking out a loan. He further explains that the hospital has told him that if he becomes Medicaid-eligible, the hospital will reimburse him the payment he has made minus any spenddown obligation that may be established.

The IM worker approves Mr. D as potentially eligible for Medically Needy for a December-January certification period. He has a spenddown of $350.

The hospital submits a claim to the IME for use in meeting Mr. D's spenddown. The payment made to the hospital by the proceeds of the loan is not recorded. (Since this medical expense was incurred within the certification period, the computer disregards client payments.)

Mr. D meets the spenddown and cards are issued. The hospital refunds Mr. D all but $350 of his payments made in December, and then the hospital bills Medicaid.

3. Ms. J, age 20, incurs a medical expense with Dr. N on January 2 for $50. She pays this bill in full with her newly obtained MasterCard. (This is the first bill she paid with her MasterCard.) On June 10, Ms. J applies for Medicaid and is conditionally approved with a $50 spenddown for the June through July certification period.

   Between January 10 and June 10, Ms. J used her MasterCard to pay for $500 in nonmedical expenses. She inquires whether the medical expense she paid by MasterCard is usable toward meeting her spenddown.

   The IM worker verifies that Ms. J made four $20 payments on her MasterCard before June 1. This total payment of $80 exceeds the $50 charge plus interest that was first incurred on MasterCard. The IM worker informs Ms. J that there is no unpaid balance of the $50 charge remaining. Therefore, there is no medical expense to be submitted toward meeting her current spenddown.

Expenses Paid by Insurance or Third Party

Legal reference: 441 IAC 75 (Rules in Process)

When the client has other health insurance coverage and either the provider or the IM worker submits a claim to the IME, the claim must reflect the third-party insurance information and payment, when applicable. The IME will deny payment on claims that do not reflect this information.

It is not your responsibility to make sure the claims carry insurance information. Forward the claim to the IME as submitted. The IME will make a determination regarding third-party insurance involvement.

See the following sections for more information on:

- Clients who have Medicare and QMB
- Estimating Medicare Part A payments
- Estimating Medicare Part B payments
- Changes or corrections to insurance payments

Clients Who Have Medicare and QMB

Legal reference: 441 IAC 75 (Rules in Process)

If the client has Medicare and is also eligible for QMB, do not use Medicare claims to meet the spenddown. QMB pays Medicare premiums, deductibles, and coinsurances. The provider will submit the claim to Medicare for payment. Medicare crosses the claim over to Medicaid for payment.

Medicare Part A Payments

Legal reference: 441 IAC 75 (Rules in Process)

If the client has Medicare coverage and is not eligible for QMB, the client may need to meet the Medicare Part A deductible of $1,632. If the deductible has not been met, the Medicare Part A deductible is used to meet the spenddown.

The provider submits the claim to Medicare for payment. Medicare sends the claim to Medicaid for payment of the deductible amount. This is called "crossover" from Medicare to Medicaid.

Medicare Part A includes the following services:

- Inpatient hospital charges (room and board, general nursing, and miscellaneous hospital services and supplies).
- Care in a skilled nursing facility following a hospital stay.
- Home health care for a homebound person. If the client does not have Medicare Part A, then home health care can be paid under Medicare Part B.
- Hospice care for terminally ill persons.

Medicare Part B Payments

Legal reference: 441 IAC 75 (Rules in Process)

If the client has Medicare Part B and is not eligible for QMB, the client may need to meet the Medicare Part B deductible of $240. If the Medicare Part B deductible has not been met, the deductible is used to meet spenddown.

Use the following services to meet the Medicare Part B deductible:

- Physician services.
- Physician charges for inpatient and outpatient medical and surgical services and supplies.
- Physical and speech therapy.
- Ambulance services.
- Diagnostic tests, such as X-rays.
- Outpatient hospital treatment.

- Blood.
- Durable medical equipment.
- Home health care for the homebound if the client does not have Medicare Part A.
- Clinical laboratory services, such as blood tests, urinalyses, biopsies, etc., provided by a Medicare certified laboratory.

The provider submits the claim to Medicare for payment. Medicare submits the claim to Medicaid for payment of the deductible amount or copayment amount. This is called a "crossover" from Medicare to Medicaid. The IME submits the claim to the Medically Needy subsystem for spenddown consideration if the client has a copayment or deductible to pay.

Changes or Corrections on Payments

Legal reference: 441 IAC 75 (Rules in Process)

Make changes or corrections when there is a change in insurance coverage.

If the client verifies that the client no longer has Medicare, complete form 470-0397, *Request for Special Update*, and send it to Quality Assurance.

If the client no longer has insurance, complete an *Insurance Questionnaire*, form 470-2826 and indicate the date insurance was terminated. Send the *Insurance Questionnaire* to the IME Third Party Liability (TPL) Unit. A special update is not required if the date the insurance terminated is on the *Insurance Questionnaire*.

Do not send the claim and *Medically Needy Transmittal* unless the Insurance Questionnaire has been sent to the IME TPL Unit. Indicate on the *Medically Needy Transmittal* that the client no longer has insurance and that the Insurance Questionnaire has been sent. The address of the IME TPL Unit is P.O. Box 36475, Des Moines, IA 50315. The TPL Unit fax number is (515) 725-1352.

Order of Deducting Expenses for Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

To meet spenddown, deduct medical expenses in the following order:

1. Health insurance premiums. (These are deducted when calculating the spenddown.)
2. Deductibles, coinsurance, or Medicaid copayments, if they remain unpaid.
3. Expenses for necessary medical and remedial services **not covered** under the Medicaid program chronologically by date of submission. (See Noncovered Medicaid Services.)
4. Expenses for necessary medical and remedial services covered by Medicaid. A responsible relative's expenses are deducted before those of a conditionally eligible person chronologically by date of submission.

The chart on this page shows the order of deducting bills in the Medically Needy subsystem, as well as the priority within that order. Try to process bills or claims for old bills immediately at the beginning of the certification period, so that they can be applied before current bills.

Type (in priority order)	**Priority of Consideration**
1. Bills paid in the retroactive period	Apply the balance of the bill that was not used to meet spenddown in the retroactive period to the spenddown of the certification period immediately following the retroactive period.
2. Credits	A credit occurs when a nonpayable bill was used to meet spenddown in previous certification period, but then was deleted from spenddown for that period. Use only if the nonpayable bill remains obligated.
3. Nonpayable bills: Old bills Responsible relative bills Non-Medicaid providers Not payable by Medicaid	A. Apply a bill paid in full by the client or a state public program in or after the certification period. B. Apply the paid portion of a bill partially paid by the client or a state public program other than Medicaid in or after the certification period. C. Apply the unpaid portion of the partially paid bills. D. Apply bills with no payments.
4. Medicaid-payable bills incurred within the certification period	A. Apply a bill paid in full by the client or state public program in the certification period. B. Apply the paid portion of a bill partially paid by the client or state public program in the certification period. C. Apply the unpaid portion of the partially paid bills. D. Apply bills with no payments.

Removing Expenses Previously Deducted

Legal reference: 441 IAC 75 (Rules in Process)

When a provider submits a claim to the IME that would be payable by Medicaid but spenddown has not been met, the claim is used to meet spenddown.

However, if a bill or claim for a service that is not Medicaid-payable is received after spenddown has been met **and** the service on the bill or claim has a higher priority than the Medicaid-payable claim occurring in the certification period (see chart: Priority of Consideration), the Medicaid-payable claim needs to be removed or "backed out" of the Medically Needy subsystem.

To back out a claim, the noncovered service must have occurred **before** the spenddown was met. Do not request to back out a claim for the eligible person when a bill or claim is received for a service that occurred after spenddown is met.

After the Medicaid-covered service is backed out of the Medically Needy subsystem, it is Medicaid-payable. See 14-I, *Special Procedures*, for instructions on backing claims out of the Medically Needy subsystem.

Mrs. B has a spenddown of $75 for the July-August certification period. She indicates to the worker that she has a $500 medical bill that she owes.

The notice of decision is sent July 15. Mrs. B goes to the pharmacy on July 16. Her prescriptions cost $85. The pharmacist submits a point-of-sale claim for $85 on July 16 and is informed that the client has a spenddown to meet. The claim is denied and submitted for spenddown consideration.

Mrs. B meets spenddown on July 17.

On July 20, the worker receives a claim for a service not payable by Medicaid that occurred before Mrs. B was certified for Medically Needy. The worker sends a copy of the claim and *Transmittal* to the IME Medically Needy Unit, requesting that the pharmacy bill be backed out and the older bill be used to meet spenddown.

A *Notice of Spenddown Status* (NOSS) is sent to the worker. The worker sends the NOSS to the client. This notifies the client that the pharmacy bill is now Medicaid-payable. The IME reimburses the pharmacy. The pharmacy reimburses the client.

Acting On Changes

Legal reference: 441 IAC 75 (Rules in Process)

A change reported by the client during the certification period is effective the first day of the next calendar month if timely notice is not required and the certification period has not expired.

If timely notice is required, make the change effective the first day of the month following timely notice if the certification period has not expired.

If a client becomes eligible under another coverage group during the certification period, redetermine eligibility.

1. Certification period November and December

Net income	$600	+	$600	=	$ 1,200
MNIL	$483	+	$483	=	- 966
					$ 234 Spenddown

Change: On November 24, the F family files an application for FIP and FMAP because Mr. F lost his job. A *Notice of Decision* issued December 15 states that eligibility exists for FIP and FMAP effective December 1. (The family is still over income for FMAP in November.)

Certification period	November
Net income	$ 600
MNIL	- 483
	$ 117 Spenddown

If incurred medical expenses equal or exceed $117 in November, the family is eligible as Medically Needy. Since the family is eligible for FIP and FMAP in December because of decreased income, the family is no longer eligible under the Medically Needy program.

2. Same situation as Example 1, except the family had already met spenddown for the November-December certification period. Follow procedures in 14-I, *Special Procedures: Deleting Claims: Decrease In Spenddown For a Frozen Period*.

For Medically Needy households that are also on other programs, act on changes that are reported on that program's report form.

See 8-G, *Reporting Changes* for changes that need to be reported.

Effect On Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

When a change is reported, recalculate spenddown unless the change is reported timely in the last month of a certification period. If the change was not reported timely, do a recoupment if the spenddown increases.

Mr. S	(No income)
Mrs. S	($2,000 earned income)
Child W	
Child X	

Mr. S leaves the home February 18 during the February-March certification period. The change is reported to the local office February 22. By removing Mr. S, the spenddown **increases**, as there is one less person to consider for the MNIL. Timely notice is required to remove Mr. S from the case. There is **no** recoupment for March.

Adding An Excluded Person to the Household

Do not add the excluded person to household for the excluded month. If the household requests, the person may be added the following month, regardless of the date of the request in the excluded month.

If the excluded person is added after timely notice and the spenddown increases, do a recoupment for the additional spenddown amount.

If the excluded person is added before timely notice and the spenddown increases follow the instructions in 14-I, Special Procedures: Increasing Spenddown.

Increase in Spenddown

Legal reference: 441 IAC 75 (Rules in Process)

Changes that are reported or discovered may increase a spenddown amount that has previously been entered in the Medically Needy subsystem. Do not establish eligibility for the succeeding months of the certification period until difference between the original spenddown amount and the new spenddown amount has been met.

If spenddown for the certification period has not been met, changes in the spenddown may be made on the ESTD, provided timely notice can be issued to the household.

If there is a zero spenddown or if spenddown has been met, spenddown cannot be changed on the Medically Needy subsystem. If spenddown has been met:

1. Cancel the original case on the ABC system, using the zero notice reason.
2. Change the fund codes to "9" for people coded with an S or P on the ESTD for the subsequent month.
3. Establish a new FBU to reflect the corrected spenddown amount for the subsequent month. The difference between the new and the original spenddown amount is the amount of spenddown entered on the new FBU.
4. Payable bills from a prior period cannot be used to meet spenddown for the second month of the certification period that has been established on the new FBU.

1. Certification period: November & December

Net income	$540	+	$540	=	$ 1,080
MNIL (1 person)	$483	+	$483	=	- 966
					$ 114 Spenddown

Change: On November 10, the SSI-related conditionally eligible person reports a $50 increase in income. Spenddown for the November-December certification period has not been met. The IM worker recalculates as follows and sends timely notice:

Certification period: November & December

Net income	$540	+	$590	=	$1,130
MNIL (1 person)	$483	+	$483	=	- 966
					$ 164 Spenddown

New spenddown	$164	
Original spenddown	- 114	
	$ 50	Additional spenddown for December

The IM worker changes the spenddown amount to $164 on the ESTD and sends the ESTD to the IME Medically Needy Unit.

2. The SSI-related case has an April-May certification period with a spenddown of $155. On April 10, an increase in income is reported. The new spenddown is $250. The difference is $95. The IM worker checks the Medically Needy subsystem and discovers that spenddown was met on April 9. Therefore, the certification period is frozen.

   The IM worker issues a timely notice of decision effective May 1 informing the client of the new spenddown. As it is before April timely notice, the IM worker cancels the Medically Needy case effective May 1. The IM worker changes the ESTD for May, using a fund code of 9 for persons coded with an S or P.

   Once the case is canceled and the ESTD has been corrected, the IM worker establishes a new FBU for the month of May only with the new spenddown amount of $95 (the difference between the new spenddown amount and the previous spenddown that was met). The IM worker ensures that the bills used previously to meet spenddown are not allowed on the new FBU.

   The IM Worker establishes the June-July certification period using the original FBU.

3. In a May-June certification period, spenddown is met May 5. Due to a reported change, the IM worker establishes a separate FBU for the month of June. The spenddown for June is $55.

   A provider submits a claim showing charges for May 30. Once spenddown was met, the client became eligible for Medicaid in May. These charges are Medicaid-payable and do not represent a legal obligation. Therefore, the May bill cannot be used to meet spenddown for the June-only certification period. Allowable medical bills incurred in June are used to meet spenddown for that month.

If a change results in a **spenddown for a case that did not have a spenddown**, assign a two-month certification period. Provide timely notice of the conditionally eligible status, the amount of spenddown, and the months of the certification period.

If the timely notice deadline has passed and the change cannot be made for the certification period, follow recoupment procedures for those errors made by the worker or due to untimely reporting by the household.

Use old medical bills that are not payable in a prior period and remain legally obligated to meet spenddown. See 14-I, *Resubmittals*, for instructions on when to resubmit bills on the *Bill Status Turnaround Document*.

If the change results in a **decrease in spenddown**, recalculate the spenddown. Enter the change on the ESTD regardless of whether spenddown has been met. Send the ESTD:

- Electronically to: imemedicallyneedy@dhs.state.ia.us,
- Faxed to: Medically Needy Unit at 515-725-1350, or
- Mailed to: IME Medically Needy Unit, 1305 E. Walnut St., Des Moines, IA 50319-0114

If bills payable by the Medicaid program were used to meet spenddown the claims will be deleted from the Medically Needy subsystem and paid.

If a nonpayable bill used to meet spenddown is still unpaid, a credit will be indicated on the *Bill Status Turnaround Document*.

Provide notice to the client of the new spenddown amount.

1. February-March Certification Period

   Mr. M ($2000 earned income)
   Mrs. M ($ 500 UIB)
   Child W
   Child X

   Mr. M leaves the home on February 4. This is reported February 15. The county office is not required to issue timely notice, as the overall program effect is positive. Mrs. M continues to be eligible for March with a reduced spenddown. The children are determined eligible for MAC and are considered persons for Medically Needy.

   The IM worker sends a *Notice of Decision* indicating a decrease in spenddown and changes the spenddown amount on the ESTD. The IM worker also sends a *Notice of Decision* on MAC eligibility for the children.

2. Household composition: Mr. T, age 20, and Mrs. T, age 19.

   Mr. T receives $462 unemployment benefits per month. Mrs. T receives $50 worker's compensation per month. The date of decision is November 1.

Certification period	November	and	December			
Net income	$512	+	$512	=	$ 1,024	
MNIL for two	$483	+	$483	=	$ 966	
				=	$ 58	Spenddown

   Mr. T timely reports on November 21 (the first month of the certification period) that Mrs. T has left the home and has filed for divorce. On November 28, the IM worker acts upon the reported change and recalculates the spenddown as follows:

	November		December			
Net income	$512	+	$462	=	$ 974	
MNIL for two	$483					
MNIL for one		+	$483	=	$ 966	
				=	$ 8	Spenddown

   The reported change has a positive effect on the spenddown (it reduces it). The IM worker sends a notice informing Mr. T that his spenddown has been reduced to $8 and changes the amount on the ESTD.

3. Mr. Q's (SSI-related) spenddown for the November-December certification period was calculated as follows:

Certification period	November	and	December			
Net income	$450	+	$534	=	$ 984	
MNIL	$483	+	$483	=	$ 966	
					$ 18	Spenddown

   On November 20, Mr. Q reports his December income will be only $450. Spenddown is recalculated as follows:

Certification period	November	and	December			
Net income	$450	+	$450	=	$ 900	
MNIL	$483	+	$483	=	$ 966	
					$ 0	Spenddown

   The IM worker sends a *Notice of Decision* informing Mr. Q that there is no longer a spenddown obligation for the November-December certification period and changes the amount on the ESTD.