CHAPTER 1-000 GENERAL DEFINITIONS

Absent Parent: A parent who is not living with his/her child(ren).

Adequate Notice: Notice of case action, which includes a statement of what action(s) are intended, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s).

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, as amended by the Three Percent Withholding Repeal and Job Creation Act.

A-Number: Alien registration number, which is assigned to an alien when s/he enters the United States.

Applicant: An individual who is seeking an eligibility determination through submission of an application or a transfer from another agency or insurance affordability program.

Application: A request for Medicaid benefits submitted by an applicant or his/her authorized representative via a Department-approved format.

Application Date: For new and reopened cases, the date a properly signed application is received.

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

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

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

Assignment: The transfer of a client's right to third-party resources to the Department, which is accomplished by the submission and approval of an Application.

Authorized Representative: A person authorized by an applicant, client, or court of competent jurisdiction to represent the applicant or client in any matter(s) with the Department.

Budget Month(s): The calendar month(s) for which verification of eligibility factors is used to compute eligibility.

Casualty: The legal obligation of a third party to indemnify an injured person for damages caused by the third party or for which the third party is otherwise responsible.

Categorical Assistance: Assistance administered by the Department, including; Assistance to the Aged, Blind, and Disabled (AABD)/MA; and Children's Medical Assistance Program.

Child Support: Money that is

1. Ordered by a court of competent jurisdiction to be paid by a noncustodial parent on behalf of a minor child, or
2. Paid by a noncustodial parent on behalf of a minor child without a court order.

Client: An individual who has been determined eligible for and is currently receiving Medicaid.

Court or Tribal Ward: A child whose custody is committed to a court or other public agency. In order to receive payment from the Department that is otherwise permitted or required, the court or other public agency must be authorized under state law for the placement and supervision of children, and the court or other public agency must have a written agreement with the Department to ensure that Title IV-E requirements are met.

Court Order: A document signed by a judge and entered into the court record in a court of competent jurisdiction.

Creditable Health Insurance Coverage: Any current health insurance coverage, except a plan that is limited to a single condition, such as cancer insurance, dental insurance, or long term care insurance. Insurance to which an individual does not have reasonable geographic access is not creditable coverage.

Current Support: The monthly amount of child support or spousal support ordered by a court of competent jurisdiction.

Deeming: The process of determining the amount of income and resources of a parent or sponsor that must be considered available to meet the client's needs. Deeming does not apply to pregnant women or children.

Denial: A case in which an application was completed, signed, and submitted, but the applicant did not meet eligibility requirements.

Department: The Nebraska Department of Health and Human Services (DHHS), Division of Medicaid and Long-Term Care (MLTC). The Department is the single state agency designated to administer and supervise the administration of the Medicaid program under Title XIX of the federal Social Security Act, as amended.

Dependent Child: A child from birth through seventeen (17) years old; or who is eighteen (18) years old and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining nineteen (19) years of age the child may reasonably be expected to complete school or training.

Director: The director of Medicaid.

Discharged Ward: An individual who has been discharged as a ward of a court or tribe.

Educational Institution: A properly licensed or credentialed school, college, university, or vocational or technical training facility.

Effective Income Level: The income standard applicable under the State Plan for an eligibility group, after taking into consideration any income disregards applied in determining financial eligibility for the group.

Electronic Account: An electronic file consisting of information collected or generated by the Department regarding client Medicaid/ Children's Health Insurance Program (CHIP) eligibility and enrollment.

Eligibility Determination: An approval or denial of eligibility, as well as any renewal or termination of eligibility.

Emancipated Minor: A child eighteen (18) years old or younger who is considered an adult because s/he has

1. Married;
2. Moved away from his/her parent's(s') home and is not receiving support from his/her parent(s); or
3. If a pregnant child, eighteen (18) years old or younger, is denied financial support by her parents, guardians, or custodians due to her refusal to obtain an abortion, the pregnant child shall be deemed emancipated for purposes of eligibility, except that benefits may not be used to obtain an abortion.

Federal Poverty Level (FPL): The current federal poverty level in effect for the applicable budget period used to determine an applicant's eligibility or a client's continued eligibility.

Guardian/Conservator: A person appointed by a court of competent jurisdiction to be in charge of the affairs of another person who cannot effectively manage his/her own affairs because of his/her age or incapacity.

Guardian Ad Litem (GAL): A person appointed by a court of competent jurisdiction to protect the best interests of a minor or vulnerable adult in a specific legal action.

Hearing: An administrative proceeding before the Director or his/her designee. During a hearing, a client, applicant, or his/her authorized representative may present evidence with or without the help of witnesses to show why the action as indicated on the relevant Notice of Action or inaction of the Department should be corrected by the Department.

Incapacity (Physical or Mental): As determined by the Social Security Administration (SSA) or the State Review Team (SRT), any physical or mental illness, impairment, or defect, which is expected to last at least thirty (30) days, that is so severe as to reduce substantially or eliminate a parent's ability to provide support or care for a child(ren). Age itself is not considered incapacity.

Inquiry: Any question received by phone, letter, electronically, or personal contact without any indication that the individual wishes to apply. This may or may not be followed by an application for Medicaid.

Irregular Income: Income, earned or unearned, that varies in amount from month to month or that is received at irregular intervals. See 477-000-009 for budgeting procedures.

Lawfully Residing: Qualified alien pregnant women and children who are lawfully present in the United States and who are residents of Nebraska.

Medicaid: A joint federal and state program under Title XIX of the federal Social Security Act, as amended, that provides medical assistance to eligible low-income individuals.

Medical Need: A condition of eligibility referring to a medical need.

Medical Payment: Payment from any health insurance plan, individual, or group or entity for medical expenses, whether for a client or any other member of his/her household.

Medical Support: The obligation of a noncustodial parent to provide health insurance or pay medical costs.

Minimum Essential Coverage: Coverage under a specified government-sponsored program, an eligible employer-sponsored plan, a health plan offered in the individual market, a grandfathered health plan, or other health benefits coverage that is recognized by the federal government.

Minor Parent: An individual eighteen (18) years old or younger, with a child. For treatment of child support when a noncustodial parent pays support for his/her child who is a minor parent, see 477 NAC 22-003.02C.

Non-Applicant: An individual who is not seeking an eligibility determination for him/herself and is included in an applicant’s or client’s household to determine eligibility for the applicant or client.

Notice of Action (NOA): A statement sent by the Department to an applicant, client, or his/her Authorized Representative that includes a reasonably short, plain statement of the action(s) taken by the Department, the factual reason(s) for the action, and reference to the applicable regulatory law(s) or otherwise that authorizes the action(s).

Parent/Caretaker Relative (P/CR): A relative of a dependent child by blood, adoption, or marriage, with whom the child is living, who assumes primary responsibility for the child’s care, and who is one of the following:

1. The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.
2. The spouse of the parent or relative, even if the marriage is terminated by death or divorce.
3. Another relative of the child based on blood, adoption, or marriage, or an adult with whom the child is living and who has provided sufficient documentation of a court-ordered guardianship/conservatorship of the child.

Pending: A case in which a complete and signed application has been received and eligibility has not yet been determined by the Department.

Post-Partum Period: The period following the end of a pregnancy, which begins on the last day of pregnancy, then extends sixty (60) days, and ends on the last day of the month in which the sixty (60)-day period ends.

Power of Attorney (POA): A written and notarized authorization allowing one person to act for another person. The powers granted may be general or may be limited to specific circumstances. A POA may be durable, in which case the powers continue to exist even if the appointing individual becomes legally incompetent. A POA ceases to be effective upon the death of the appointing individual.

Pregnant Woman: A woman during pregnancy and the post-partum period.

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

Reasonably Compatible: For each eligibility factor (except for SSN, citizenship, and immigration status), reasonable compatibility shall be applied. Electronic data matches shall be used when applicable and compared to an applicant's/client's self-attestation of information. See Appendix 477-000-004 for Verification Plan.

Retroactive Eligibility: The date of eligibility beginning no earlier than the first day of the third month before the month of application. See 477 NAC 4-001.02~~1~~1.

Secure Electronic Interface: An interface which allows for the exchange of data between Medicaid and insurance affordability programs.

Sponsor: A sponsor is an individual who

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

An organization cannot be a sponsor.

Spousal Support: Alimony or maintenance support for a spouse or former spouse.

Standard of Need: The maximum standard according to eligible unit size and living arrangement.

State Plan: The written plan between the Department and the federal government that authorizes and describes how the Department administers Medicaid.

Student: An individual who is eighteen (18) years old or younger and attending a secondary school (or the equivalent level of vocational or technical training).

Third-Party Resources: The legal obligation of a third party (including certain individuals, entities, insurers, and programs) to pay for or provide monies or benefits. Medicaid is the payer of last resort. A client must cooperate with the Department to ensure this. Third-Party Resources include Casualty, Child Support, Medical Payment, Medical Support, and Spousal Support.

Timely Notice: A notice of case action dated and mailed at least ten calendar days before the date the action becomes effective.

Unit: The number of individuals in a household.

Unsubsidized Employment: Employment for which the salary is paid wholly by the employer.

Withdrawal: A voluntary written or verbal retraction of an application.

TITLE 477
MEDICAID ELIGIBILITY

CHAPTER 1-000 DEFINITIONS

AABD/MA: A categorical program consisting of medical assistance only. Two types of cases are included in the medical assistance only category:

1. Medical Assistance With No Share of Cost (MA only): A case in which there is income sufficient to meet daily maintenance needs but insufficient to meet medical needs.

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

Absent Parent: A parent who is not in the home where his/her child(ren) is living.

Adequate Notice: Notice of case action which includes a statement of what action(s) are intended, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s).

Advanced Payments of the Premium Tax Credits (APTC): A payment of the tax credits which are provided on an advance basis to an eligible individual enrolled in a Qualified Health Plan (QHP) through an Exchange.

Affordable Care Act (ACA): The Patient Protection and Affordable Care Act of 2010, as amended by the Health Care and Education Reconciliation Act of 2010, as amended by the Three Percent Withholding Repeal and Job Creation Act.

Aged: A client who is age 65 or older.

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

Annuity Beneficiary: Any individual, or individuals, designated in a trust to receive any disbursal from the corpus of the trust, or from income generated by the trust, which benefits the party receiving it. A payment from a trust may include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.

Annuity Transaction: Purchase of an annuity changing the annuity beneficiary or authorizing the commencement of the pay-out period (annuitizing).

A-Number: Alien registration number. An alien registration number is assigned to an alien when s/he enters the United States.

Applicant: An individual who is seeking an eligibility determination for himself or herself through an application submission or a transfer from another agency or insurance affordability program.

Application: The single streamlined application submitted by or on behalf of an individual via a Department approved format.

Application Date: For new and reopened cases, the date a properly signed application is received. When adding a program to a properly signed application, this is the date that the new program is requested.

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

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

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

Assignment: The legal transfer of an individual's right to benefits to the Nebraska Department of Health and Human Services. This includes child, spousal, and medical support and third party medical.

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

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

Budget Month(s): The calendar month(s) for which verification and information on income, resources, and household composition is used to compute eligibility.

Burial Insurance: Insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured.

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

Categorical Assistance: Assistance administered by the Nebraska Department of Health and Human Services. For the purposes of this definition it includes Child Welfare Medical Services Program/MA; Assistance to the Aged, Blind, and Disabled (AABD)/MA; and Children's Medical Assistance Program.

Child Support: Money that is:

3. Ordered by a court of competent jurisdiction on behalf of a minor child; or
4. Paid by the noncustodial parent without a court order.

Client: An individual who has been determined eligible for and is currently receiving Medicaid.

Contributions/Cash Support: Verified payments which are paid to or for a Medicaid unit.

Court or Tribal Ward: A child becomes a court or tribal ward when his/her custody is committed to a court or other public agency. In order to receive payment from the Department, the agency must have a written agreement with the Department, ensuring that Title IV-E requirements are met. The agreement may be with a court or other public agency authorized under state law for the placement and supervision of children.

Court Order: A document signed by a judge and entered in a court of competent jurisdiction.

Creditable Health Insurance Coverage: Any current health insurance coverage except a plan that is limited to a single condition, such as cancer insurance, dental insurance, long term care insurance, etc. Insurance to which the individual does not have reasonable geographic access is not creditable coverage. The health insurance policy should be submitted to Central Office for consideration when it is questionable that it meets this definition.

Current Support: The monthly amount of child/spousal support ordered by a court.

Deeming: The process of determining the amount of income and resources of a parent or sponsor which must be considered available to meet the client's needs. Deeming does not apply to pregnant women and children.

Department: The Nebraska Department of Health and Human Services (DHHS).

Dependent Child: A child from birth through age 17 or who is age 18 and a full-time student in secondary school (or equivalent vocational or technical training), if before attaining age 19 the child may reasonably be expected to complete such school or training. Is deprived of parental support by reason of the death, absence from the home, physical or mental incapacity, or unemployment/underemployment of both parents (neither parent is employed more than 100 hours in a month).

Disabled: A category of eligibility for clients who are age 64 and younger and who are disabled as determined by Social Security Administration or State Review Team.

Discharged Ward: An individual who has been discharged as a ward of the court.

Educational Institution: A school, college, university or vocational or technical training facility.

Effective Income Level: The income standard applicable under the State plan for an eligibility group, after taking into consideration any disregard of a block of income applied in determining financial eligibility for such group.

Electronic Account: An electronic file that includes all information collected and generated by the State regarding each individual's Medicaid eligibility and enrollment, including all documentation.

Eligibility Determination: An approval or denial of eligibility as well as a renewal or termination of eligibility.

Emancipated Minor: A child age 18 or younger who is considered an adult because s/he has:

4. Married;
5. Moved away from the parent(s)' home and is not receiving support from the parent(s); or
6. If a pregnant child, age 18 or younger, is denied financial support by her parents, guardians, or custodians due to her refusal to obtain an abortion, the pregnant child shall be deemed emancipated for purposes of eligibility for public assistance benefits, except that such benefits may not be used to obtain an abortion.

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

Essential Property: Property or equipment owned solely by the client/client's spouse in their name, or held in a partnership or corporation interest.

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

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

Family Size Using Modified Adjusted Gross Income (MAGI) Methodology: Means the number of persons counted as members of an individual's household. When determining the family size of other individuals who have a pregnant woman in their household, the family size is counted as the pregnant woman plus the number of children she is expected to deliver.

Federal Poverty Level (FPL): The Federal poverty level updated periodically by the Federal Government as in effect for the applicable budget period used to determine an individual's eligibility.

Former Foster Care: An individual upon their 19th birthday up to their 26th birthday who was in foster care in Nebraska and receiving Medicaid when they aged out.

Former Ward: An individual upon their 19th birthday up to their 20th birthday who has been discharged as a ward by DHHS and who is in a continuing educational program.

Fugitive Felon: A person who has been charged with a felony and who has fled from the jurisdiction of the court where the crime was committed.

Grantor of a Trust: Any individual who creates a trust. This includes:

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

Guardian Ad Litem: An adult appointed by a court to protect the best interests of a minor child or adult in a specific legal action.

Hearing: An orderly proceeding before the Director or his/her representative. During the hearing a client, applicant, or his/her representative may present his/her case with or without the help of witnesses to show why an action or inaction should be corrected by the Department.

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

Household Size using Non-MAGI Methodology: The total number of individuals living together. There may be more than one medical assistance unit within a household.

Household Size using MAGI methodology: The group of individuals that will be used to determine family size for a particular applicant and whose income may be counted toward the applicant's total household income for purposes of determining his or her eligibility for Medicaid and CHIP. See 477 NAC 14-001.

Household income using MAGI methodology: The sum of an individual's MAGI plus the MAGI of tax dependents in the family if required to file a tax return. See 477 NAC 15-001.

Incapacity (Physical or Mental): Any physical or mental illness, impairment, or defect which is so severe as to substantially reduce or eliminate the parent's ability to provide support or care for a child(ren). The incapacity must be expected to last at least 30 days. Note: Age itself is not considered incapacity.

Income Using Non-MAGI Methodology: Gain or recurrent benefit received in money or in-kind from employment, business, property, investments, gifts, benefits, or annuities, at regular or irregular intervals of time.

In-Kind Income: The value of food, clothing, shelter, or other items received in lieu of wages.

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

Insurance Affordability Program: Means a program that is one of the following:

1. Medicaid, including CHIP or a State basic health program.
2. Coverage in a qualified health plan (QHP) through the Exchange.
3. Advanced Payments of the Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR).

Irregular Income: Irregular income is income, earned or unearned, which varies in amount from month to month or which is received at irregular intervals. See 477-000-010 for budgeting procedures.

Irrevocable Trust: A trust that cannot in any way be revoked by the grantor of the trust.

Lawfully Residing: Qualified alien pregnant women and children who are lawfully present in the United States and who are residents of the state in which they are applying under Nebraska's residency rules.

Legal Guardian: An individual appointed by a court of competent jurisdiction to be in charge of the affairs of a person who cannot effectively manage his/her own affairs because of his/her age or incapacity.

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

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

Medical Support: Medical support is the obligation of the noncustodial parent to provide health insurance or pay medical costs for anyone in the unit.

Minimum Essential Coverage: Means coverage under a specified government sponsored program, coverage under an eligible employer-sponsored plan, coverage under a health plan offered in the individual market within a State, coverage under a grandfathered health plan, and other health benefits coverage that the Secretary of Health and Human Services recognizes. This includes Medicaid and CHIP.

Minor Parent: An individual age 18 or younger, with a child.
Note: For treatment of child support when a noncustodial parent pays support for his/her child who is a minor parent, see 477 NAC 20-001.11C.

Modified adjusted gross income (MAGI): The methodology used to determine financial eligibility.

Need: A condition of eligibility referring to a medical need.

Needy Individual: One whose income and other resources for maintenance are found under assistance standards to be insufficient for meeting the basic requirements.

Non-Applicant: An individual who is not seeking an eligibility determination for himself or herself and is included in an applicant's or client's household to determine eligibility for such applicant or client.

Non-Filer: Individuals who do not intend either to file taxes or to be claimed as a tax dependent.

Parental Deprivation: Two-parent families must meet the Hundred-Hour rule, disability, or have a physical or mental incapacity in order to be eligible for Medicaid as determined by Social Security or the State Review Team (SRT). A single parent household meets deprivation.

Parent/Caretaker Relative: A relative of a dependent child by blood, adoption, or marriage with whom the child is living, who assumes primary responsibility for the child's care, and who is one of the following:

4. The child's father, mother, grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece.
5. The spouse of such parent or relative, even after the marriage is terminated by death or divorce.
6. Another relative of the child based on blood, adoption, or marriage recognized by the State of Nebraska, or an adult with whom the child is living and who has verified guardianship/conservatorship of the child.

Pending Case: A case in which the application has been taken and eligibility is not yet determined.

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

Post-Partum Period: The period following the end of a pregnancy, which begins on the last day of pregnancy, then extends 60 days, and ends on the last day of the month in which the 60-day period ends.

Power of Attorney: A written statement allowing one person to act for another person. A power of attorney may be authorized generally for the management of a specified business or enterprise or more often specifically for the accomplishment of a particular transaction. There is no court involvement or supervision in the appointment. The statement must be notarized. A standard or non-durable power of attorney automatically becomes null and void when the appointing individual becomes incompetent. A durable power of attorney continues in effect even when the appointing individual becomes incompetent. The power of attorney document should clearly specify if it is a durable power of attorney.

Pregnant Woman: A woman during pregnancy and the post-partum period.

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

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

Quarterly Report Form: A form that is sent quarterly to transitional medical assistance households.

Real Property: Land, houses, or buildings.

Reasonably Compatible: For each eligibility factor (except for SSN, citizenship, and immigration status) reasonable compatibility shall be applied. Electronic data matches shall be used when applicable and compared to an individual's self-attestation of information. See Appendix 477-000-004 for verification plan.

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

Retroactive Eligibility for Medicaid: The date of eligibility beginning no earlier than the first day of the third month before the month of request. See 477 NAC 4-001.02.

Secure Electronic Interface: An interface which allows for the exchange of data between Medicaid and other insurance affordability programs.

State Disability Program/Medicaid: A categorical program consisting of financial assistance and medical assistance or medical assistance only. Two types of cases are included in the medical assistance only category:

1. Medical Assistance with No Share of Cost (MA only): A case in which there is income sufficient to meet daily maintenance needs but insufficient to meet medical needs. The case is opened for medical assistance only with no grant payment; and

2. SDP/Medical Assistance Share of Cost Case: A case in which there is sufficient income to meet daily maintenance needs and a portion but not all of the unit's medical needs. The case is opened for medical assistance with no payment for medical services made until the Share of Cost is obligated toward medical services.

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

Specified Living Arrangement:

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

Sponsor: A sponsor is an individual who:

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

An organization is not considered a sponsor.

Spousal Support: Alimony or maintenance support for a spouse or former spouse.

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

Standard of Need: The maximum standard according to eligible unit size and living arrangement.

Student: An individual who is age 18 or younger and attending a secondary school (or the equivalent level of vocational or technical training). Note: An 18 year old who is attending a college or university is not eligible, as a dependent child.

Tax Dependent: An individual for whom another individual claims a deduction for a personal exemption for a taxable year.

Tax Filer: Individuals who intend to file a federal tax return for the coverage year and who do not intend to be claimed as a tax dependent by another taxpayer.

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

Timely Notice: A notice of case action dated and mailed at least ten calendar days before the date the action becomes effective.

Unit: Eligible individuals considered in determining Medicaid.

Unsubsidized Employment: Employment for which the salary is paid wholly by the employer.

Withdrawal: A voluntary written or verbal retraction of an application.

CHAPTER 2-000 OVERVIEW OF ELIGIBILITY REQUIREMENTS

2-001 PRIMARY ELIGIBILITY REQUIREMENTS: To be eligible for Medicaid, an individual must satisfy the requirements of the following eligibility criteria, as applicable:

1. Application;
2. U.S. citizenship or alien status (see Appendix 477-000-003 and 477-000-004);
3. Nebraska residence;
4. Social Security number;
5. Age (limited to ABD, Former Foster Care, Children, 599 CHIP, Former Ward, Women's Cancer Program);
6. Dependent Child;
7. Relative responsibility;
8. Assignment of Third-Party Resources;
9. Cooperation with the Child Support Enforcement Office (see Appendix 477-000-005);
10. Living arrangement;
11. Resources (for exceptions see 477 NAC 17-001);
12. Income (see Appendix 477-000-012); and
13. Categorical Eligibility Factors.

CHAPTER 2-000 OVERVIEW OF ELIGIBILITY REQUIREMENTS

2-001 PRIMARY ELIGIBILITY REQUIREMENTS: To be eligible for Medicaid, the individual must meet the following basic requirements:

14. Application;
15. U.S. citizenship or alien status (see Appendix 477-000-003 and 477-000-004);
16. Nebraska residence;
17. Social Security number;
18. Age (limited to AABD/MA, Former Foster care Children, Children, 599 CHIP, Former Wards, Woman's Cancer Program);
19. Age requirement for a dependent child;
20. Relative responsibility;
21. Assignment/cooperation of third party medical payments;
22. Cooperation with the Child Support Enforcement Office (see Appendix 477-000-005);
23. Living arrangement;
24. Resources (for exceptions see 477 NAC 16-001);
25. Income (see Appendix 477-000-012); and
26. Categorical factors (e.g., deprivation, institutionalization, and pregnancy).

CHAPTER 3-000 APPLICATION PROCESS

3-001 INTERVIEW: An interview shall not be required for either an application or a renewal.

3-002 APPLICANT/CLIENT RIGHTS: An applicant/client has the following rights:

1. The right to have the Medicaid application process and the Medicaid requirements, responsibilities, and benefits reasonably explained to him/her by the Department, including by written translations, oral interpretation, and taglines for individuals with disabilities or limited English proficiency;
2. The right to have other potential sources of assistance explained to him/her by the Department, including, as applicable: income that may be currently or potentially available such as Retirement, Survivors, and Disability Insurance (RSDI);, Supplemental Security Income (SSI);, or, Veteran's Assistance benefits (VA); social and other financial services available through the Department, such as social services, Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and family planning; and, receive a referral to other agencies, if appropriate.
3. The right to have his/her civil rights upheld. No applicant/client may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, political belief, or any other classification protected by law;
4. The right to be offered the opportunity to register to vote (see Appendix 477-000-061).
5. The right to submit an application for him/herself or have an application submitted by his/her authorized representative;
6. The right to have his/her application and any personal information treated confidentially according to the applicable privacy laws;
7. The right to receive reasonably prompt action on his/her application that is pending. A determination of eligibility must be made by the Department about an application within forty-five (45) days of the date the complete and signed application has been received by the Department; except for applications under the disability category, for which a determination of eligibity must be made within ninety (90) days;
8. The right to receive adequate notice of any action affecting his/her application or benefit; and
9. The right to appeal to the Director for a hearing about any action or inaction regarding his/her application, or failure to act with reasonable promptness. Any appeal must be filed with the Department in writing within ninety (90) days of the decision date.

3-003 APPLICANT/CLIENT RESPONSIBILITIES: Each applicant or client is required to

1. Provide complete and accurate information. State and federal law provides penalties that may include a fine, imprisonment, or both, for persons found guilty of making false statements or failing to report promptly any changes in their circumstances to obtain assistance or services for which they are not eligible;

2. Report a change in circumstances no later than ten (10) days following the change. This may include information regarding
   a. Change or receipt of a resource including cash, stocks, bonds, or a motor vehicle. Changes in resources do not apply to clients whose eligibility is determined using MAGI-based methodology;
   b. Change in unit composition, such as the addition, loss of, or temporary absence of a unit member;
   c. Change in residence;
   d. Living arrangement;
   e. Disability status;
   f. New employment;
   g. Termination of employment; or
   h. Change in the amount of monthly income, including
      (1) All changes in unearned income, and
      (2) Changes in the source of employment, in the wage rate, or in employment status, such as part-time to full-time or full-time to part-time.

   For reporting purposes, full-time employment is considered at least thirty (30) hours per week. The client must report new employment within ten (10) days of receipt of the first paycheck, and a change in wage rate or hours within ten (10) days of the change. To avoid adverse action, a Client must prove good cause for any failure to report a change to the Department within ten (10) days. Unconfirmed statements do not constitute good cause;
3. Present his/her Medicaid card to providers;
4. Inform the medical provider and the Department of any third-party resources that may be liable for his/her medical expenses, in whole or in part, and cooperate in obtaining these third-party resources;
5. Enroll in a health plan and maintain enrollment if
   a. One is available to the client,
   b. The client is able to enroll on his/her own behalf, and
   c. The Department has determined that enrollment in the plan is cost effective;
6. Reimburse to the Department or pay to the provider any third-party resources received directly for services that are payable by Medicaid;
7. Pay any unauthorized medical expenses;
8. Pay any required medical copayment;
9. Meet the requirements of Managed Care, if applicable; and
10. Cooperate with state and federal quality control.

3-004 APPLICATION

3-004.01 Application Submittal: An application may be submitted by an applicant or his/her authorized representative. An application may be signed in writing, by telephonic acknowledgment, or by electronic signature. An application may be submitted in person, by mail, by telephone, by fax, or by electronic submission.

3-004.02 Application Date: An application is considered valid the date it is received by the Department if it contains

1. Applicant's name,
2. Address, and
3. Proper signature of the applicant or authorized representative

An application may be taken on behalf of a deceased person (including a miscarriage or a stillborn). If there is no one to represent a deceased person, the administrator of the estate may sign the application.

3-004.03 Application with a Designated Provider: An applicant or his/her authorized representative may apply for Medicaid with a designated outreach provider or entity that has contracted with the Department to accept Medicaid applications at its location.

3-004.04 Alterations: The application, when completed and signed by the applicant or his/her authorized representative, constitutes the applicant's own statement regarding eligibility. Information may be added to an application up to the decision date.

3-004.05 Withdrawals: An applicant may voluntarily withdraw an application verbally or in writing, which will be confirmed by the Department sending a Notice of Action to the applicant or his/her Authorized Representative documenting this voluntary withdrawal.

3-004.06 New Application: A new application is required after ninety (90) days of ineligibility.

3-005 AUTHORIZATION FOR INVESTIGATION: The Department may request a release of information from the applicant or his/her Authorized Representative when it appears that information is incorrect or inconsistent, when the client is unable to furnish the necessary information, or for sample quality control verification.

3-006 RENEWALS

3-006.01 Renewal of Eligibility: A redetermination of eligibility for continued Medicaid benefits must be completed every twelve (12) months.

A renewal shall be completed on the basis of information available to the Department without requiring information from the individual. Information will only be required from the individual when not available through other sources (see Appendix 477-000-002).

A prepopulated renewal form shall be required every twelve (12) months for non-MAGI based eligibility renewals.

If information is not available to complete a renewal, a prepopulated renewal form shall be sent by the Department to the applicant or his/her authorized representative. The completed renewal form and necessary verifications shall be returned within thirty (30) days of the date the renewal form was sent.

If the renewal form and necessary information are submitted within ninety (90) days after termination, a new application shall not be required.

For the Medically Needy category, a client is ineligible if no medical need exists. The client shall be informed in writing that s/he may reapply if there is a medical need at a later date.

3-006.02 Renewal for SSI Recipients: An application is not required at the time of renewal for clients who are receiving SSI. If SSI is discontinued and

1. The last application was completed more than twelve (12) months from the last month of eligibility for SSI, a complete renewal of eligibility must be done within the next thirty (30) days, including completion of an application; or
2. It has been less than twelve (12) months since completion of the last application, a review of all eligibility requirements that are necessary for continued assistance must be completed.

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

SSI clients who are determined eligible for Medicaid by the Social Security Administration (SSA) under the provisions of 1619(b) are not required to complete an application at renewal, and resources do not need to be verified.

3-006.03 Income Review for ABD Clients: For eligibility purposes, a review of income must be completed every twelve (12) months. An income review is completed by SSA for SSI clients, including those placed in 1619(b) status.

3-006.04 Disability Review for ABD Clients: A review of disability for ABD cases must be completed by the State Review Team.

3-007 CONTINUOUS ELIGIBILITY

3-007.01 Continuous Eligibility for Pregnant Women: Once a pregnant woman is determined Medicaid eligible, she remains continuously eligible through the post-partum period.

Continuous eligibility does not apply to pregnant women covered during a period of presumptive eligibility.

3-007.02 Continuous Eligibility for a Newborn: Children born to Medicaid-eligible mothers are deemed eligible for Medicaid and remain Medicaid eligible for one (1) year after birth. For 599 CHIP, see 477 NAC 19-004.07.

3-007.03 Six Months' Continuous Eligibility for Children: Children from birth through age eighteen (18) are eligible for six (6) months of continuous Medicaid from the date of initial eligibility.

Retroactive months do not count in the six (6) months of continuous eligibility unless there is no prospective eligibility. For 599 CHIP, see 477 NAC 19-004.07.

3-007.04 Exceptions to Continuous Eligibility:

The child turns nineteen (19) years old within the six (6) months,
2. The client moves out of state,
3. It is determined that the original eligibility was based on erroneous or incomplete information,
4. The client dies,
5. The client enters an ineligible living arrangement or
6. The child or child's representative requests voluntary disenrollment

3-007.05 Review After Six Months' Continuous Eligibility for Children: Once a household has received continuous eligibility for six (6) months, a desk review is completed by the Department and any information known to the Department shall be acted on, accordingly.

CHAPTER 3-000 APPLICATION PROCESS

3-001 INTERVIEW: An interview shall not be required for either an initial application or a renewal.

3-002 CLIENT RIGHTS: The client has the right to:

1. Apply. Anyone who wishes to request and/or apply for medical assistance must be given the opportunity to do so. No one may be denied the right to apply for medical assistance;
2. Reasonably prompt action on his/her application for medical assistance;
3. Adequate notice of any action affecting his/her application or assistance case;
4. Appeal to the Director for a hearing on any action or inaction with regard to an application, the amount of the assistance payment, or failure to act with reasonable promptness. The appeal must be filed in writing within 90 days of the action or inaction;
5. Have his/her information treated confidentially. (Additional rules apply for disclosure of information regarding a fugitive felon);
6. Have his/her civil rights upheld. No person may be subjected to discrimination on the grounds of his/her race, color, national origin, sex, age, disability, religion, or political belief;
7. Have the program requirements and benefits fully explained;
8. Have information available in written translations, oral interpretation, and taglines to individuals with disabilities and limited English proficiency;
9. Be assisted in the application process by the person of his/her choice;
10. Referral to other agencies;
11. Have eligibility explained and how changes affect eligibility;
12. Have eligibility and items that require verification explained;
13. Give written consent for the needed verifications;
14. Have income that may be currently or potentially available such as RSDI, SSI, Veteran's Assistance benefits (VA), etc. explored;
15. Have information given about the social and other financial services available through the agency, such as social services and Early Periodic Screening, Diagnosis, and Treatment (EPSDT), and family planning;
16. Be informed of his/her rights and responsibilities;
17. Be informed that he/she must show his/her medical card to all providers and must inform the Department of any health insurance plan, any individual, or any group that may be liable for the client's medical expenses;
18. Have the assignment of third party medical payments explained and refund any payments received directly;
19. Be informed of the requirement to participate in the Nebraska Health Connection, if applicable;
20. Have necessary reports and information forms completed by the Department; and
21. Be offered the opportunity to register to vote when they contact a DHHS office (see Appendix 477-000-061).

3-003 CLIENT RESPONSIBILITIES: Each applicant or client is required to:

1. Provide complete and accurate information. State and federal law provides penalties of a fine, imprisonment, or both for persons found guilty of obtaining assistance or services for which they are not eligible by making false statements or failing to report promptly any changes in their circumstances;
2. Report a change in circumstances no later than ten days following the change. This may include information regarding:

    a. Change or receipt of a resource including cash on hand, stocks, bonds, money in a checking or savings account, or a motor vehicle;
    Note: Changes in resources does not apply to groups whose eligibility is determined using MAGI-based methodology.
    b. Changes in unit composition, such as the addition, loss of or temporary absence of a unit member;
    c. Changes in residence;
    d. Living arrangement;
    e. Disability status;
    f. New employment;
    g. Termination of employment; and
    h. Changes in the amount of monthly income, including:
        (1) All changes in unearned income; and
        (2) Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time.

    For reporting purposes, 30 hours is full-time. The client must report new employment within ten days of receipt of the first paycheck, and a change in wage rate or hours within ten days of the change.

    Good cause must be verified for failing to report a change within ten days. Unconfirmed statements do not constitute good cause.

3. Present his/her medical card to providers;
4. Inform the medical provider and the Department of any health insurance plan, any individual, or any group that may be liable for his/her medical expenses;
5. Cooperate in obtaining any third party medical payments;
6. Enroll in a health plan and maintain enrollment if:
    a. One is available to the client;
    b. The client is able to enroll on his/her own behalf; and
    c. The Department has determined that enrollment in the plan is cost effective.
7. Reimburse to the Department or pay to the provider any third party medical payments received directly for services which are payable by Medicaid;

8. Pay any unauthorized medical expenses;
9. Pay any required medical copayment;
10. Meet the requirements of the Nebraska Health Connection, if applicable; and
11. Cooperate with state and federal quality control.

3-004 DEPARTMENT CONTINUING RESPONSIBILITIES

1. Provide timely or adequate notice of any action affecting the client's assistance case;
2. Treat the client's information confidentially;
3. Uphold the client's civil rights; and
4. Inform the client when his/her case is closed that s/he has the right to reapply.

3-005 APPLICATION

3-005.01 Application Submittal: An application for assistance may be made in person, by letter, telephone, fax, phone, or electronic submission and may be made by the applicant, his/her guardian or conservator, an individual acting under a duly executed power of attorney, or another person authorized to act for the applicant.

3-005.02 Application: An application is considered valid the date it is received by the Department and contains:

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

An application may be signed by an individual for himself/herself or by the applicant's guardian, conservator, or an individual acting under a duly executed power of attorney. The client's relative or another individual acting on the client's behalf may sign the application. An application may be taken on behalf of a deceased person (including a miscarriage or a stillborn). If there is no one to represent the deceased person, the administrator of the estate may sign the application.

3-005.03 Assistance with Application or Renewal: An individual seeking help with the application or renewal process in person, over the telephone, and online, and in a manner that is accessible to individuals with disabilities and those who are limited English proficient shall be provided with assistance by the Medicaid agency.

Note: The Medicaid agency must allow individual(s) of the applicant or client's choice to assist in the application process or during a renewal of eligibility.

3-005.04 Application with a Designated Provider: Any individual may apply for medical assistance with a designated outreach provider or who has contracted with the Department to accept Medicaid applications at their location.

3-005.05 Alterations: The application, when completed and signed by the client or his/her representative, constitutes his/her own statement in regard to eligibility. Information may be added to an application up to the date of approval or completed renewal.

3-005.06 Prompt Action on Applications: Reasonable promptness must be taken on all applications for assistance. A determination of eligibility must be made on an application within 45 days from the date of the application for all applicants with the exception of applicants who are applying under the disability category which allows for 60 days. Notice of Action must be sent every 45 days from the date of application for a pending application for all applicants with the exception of applicants who are applying under the disabled category who receive a notice every 60 days.

3-005.07 Withdrawals: The applicant may voluntarily withdraw an application verbally or in writing. A Notice of Action must be sent to the applicant.

3-005.08 New Application: A new application is required after ninety days of ineligibility.

3-006 AUTHORIZATION FOR INVESTIGATION: Release of Information may be obtained from the client when it appears that information given is incorrect or inconsistent, when the client is unable to furnish the necessary information, or for sample quality control verification.

3-007 RENEWALS

3-007.01 Renewal of Eligibility: A redetermination of eligibility for medical assistance must be completed every 12 months.

Renewal shall be completed on the basis of information available to the agency without requiring information from the individual. Information will only be required from the individual when not available through other sources (See Appendix 477-000-002).

Note: A prepopulated renewal form shall be required every 12 months for non-MAGI based renewals.

If information is not available to complete a renewal, a prepopulated renewal form shall be sent. The completed renewal form and necessary verifications shall be returned within 30 days of the date the renewal form was sent.

If the renewal form and necessary information is submitted within 90 days after termination, a new application shall not be required.

Note: For Medically needy category the client is ineligible if there is no medical need. The client shall be informed in writing that they may reapply if there is a medical need at a later date.

3-007.02 Renewal for SSI Recipients: An application is not required at the time of renewal for clients who are receiving SSI. If SSI is discontinued and:

3. The last application was completed more than 12 months from the last month of eligibility for SSI, a complete renewal of eligibility must be done within the next 30 days, including completion of an application;
4. If it has been less than 12 months since completion of the last application, a review of all eligibility requirements that are necessary for continued assistance must be completed.

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

Note: Clients who are determined eligible for Medicaid by SSI under the provisions of 1619(b) are not required to complete an application at renewal. Resources do not need to be verified.

3-007.03 Income Review for AABD/MA Clients: A review of income eligibility must be completed every 12 months for AABD/MA. An income review is not required for SSI recipients. Income must be reviewed for clients who are placed in 1619(b) status by SSI.

3-007.04 Disability Review for AABD/MA Clients: A review of disability for AABD/MA cases must be completed as required by the State Review Team.

3-008 CONTINUOUS ELIGIBILITY

3-008.01 Continuous Eligibility for Pregnant Women: Once a pregnant woman is determined Medicaid eligible, she remains continuously eligible through the 60-day postpartum period.

Note: Continuous eligibility does not apply to pregnant women covered during a period of presumptive eligibility.

3-008.02 Continued Eligibility for a Newborn: Children born to Medicaid eligible mothers are deemed eligible for Medicaid and remain Medicaid eligible through the month the child turns age one. For 599 CHIP, see 477 NAC 18-004.07.

3-008.03 Six Months' Continuous Eligibility for Children: Children from birth through age 18 are eligible for six months of continuous Medicaid from the date of initial eligibility. Retro months do not count in the six months of continuous eligibility unless there is no prospective eligibility. For 599 CHIP, see 477 NAC 18-004.07.

3-008.04 Exceptions to Continuous Eligibility:

1. The child turns 19 within the six months;
2. The recipient moves out of state;
3. It is determined that the original eligibility was based on erroneous or incomplete information;
4. The recipient dies;
5. The recipient enters an ineligible living arrangement; or
6. The child or child's representative requests voluntary disenrollment.

3-008.05 Review After Six Months' Continuous Eligibility for Children: Once a household has received six months' continuous eligibility, a desk review is completed and any information known to the agency shall be acted upon.

CHAPTER 4-000 EFFECTIVE DATE OF MEDICAID ELIGIBILITY

4-001 EFFECTIVE DATE OF MEDICAID ELIGIBILITY: If an individual is eligible one (1) day of the month, s/he is eligible the entire month.

This provision is not applicable to Emergency Medical Services Assistance (EMSA). See 477 NAC 247-008.02A.

4-001.01 Retroactive Eligibility: Retroactive eligibility is applicable if the following conditions are met:

1. Eligibility is determined and a budget computed separately for each of the three (3) months,
2. A medical need exists, and
3. Elements of eligibility were met at some time during each month.

An applicant may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period. Six (6) months of continuous eligibility may begin in a retroactive month; in that case, no further budgeting is required.

The effective date for an otherwise eligible pregnant woman can be determined up to three (3) months before the application, as long as the pregnancy existed at the beginning of this retroactive period.

CHAPTER 4-000 EFFECTIVE DATE OF MEDICAID ELIGIBILITY

4-001 EFFECTIVE DATE OF MEDICAID ELIGIBILITY: If an individual is eligible one day of the month, s/he is eligible the entire month.

4-001.01 Retroactive Eligibilty: Retroactive eligibility is effective if the following conditions are met:

4. Eligibility is determined and a budget computed separately for each of the three months;
5. A medical need exists; and
6. Elements of eligibility were met at some time during each month.

An applicant may be eligible for the retroactive period (or any single month(s) of the retroactive period) even though ineligible for the prospective period. Six months continuous eligibility may begin in a retroactive month; in that case, no further budgets are required.

Note: The Medicaid effective date for an otherwise eligible pregnant woman can be determined up to three months before the request for Medicaid, as long as the pregnancy existed at the beginning of this retroactive period.

CHAPTER 5-000 CITIZENSHIP/ALIEN STATUS AND IDENTITY

5-001 CITIZENSHIP AND ELIGIBLE ALIENS: In order to be eligible for Medicaid, an applicant/client must be a citizen of the United States or an eligible alien. Citizenship or alien status must be verified through acceptable documentation, as defined by federal regulations (see Appendix 477-000-003 for acceptable documents). The following individuals meet the criteria for citizenship or eligible alien status:

1. Citizens of the United States
   a. A child born in the United States is a U.S. citizen. A newborn who was determined to be eligible for Medicaid in the month of birth meets citizenship and identity requirements without further verification, including newborns whose birth expenses were paid for through Emergency Medicaid Assistance for Aliens;
2. Qualified Aliens as defined in Section 431 of the Immigration and Nationality Act (INA):
   a. An alien who was admitted as a lawful permanent resident (LPR) and has resided in the United States for at least five (5) calendar years from the date of entry or who has worked or can be credited with forty (40) qualifying quarters of work. Medicaid-eligible pregnant women and children are exempt from the five (5)-year bar. For sponsored LPRs, see 477 NAC 16-001.09A;
   b. A refugee admitted to the U.S. under Section 207 of the INA;
   c. An asylee under Section 208 of INA;
   d. Victims of a severe form of trafficking (Victims of Trafficking and Violence Protection Act of 2000);
   e. An alien whose deportation is withheld under Section 243(h) of INA;
   f. An alien from Cuba or Haiti who was admitted under Section 501(e) of the Refugee Education Assistance Act of 1980;
   g. A refugee who entered the U.S. before April 1, 1980, and was granted conditional entry;
   h. An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse's or parent's family who is residing in the same household as the alien, but only after having resided in the United States for at least five (5) calendar years from the date of entry or who has worked or can be credited with forty (40) qualifying quarters of work. The child or children of a battered alien meeting these requirements is/are also eligible. Medicaid-eligible pregnant women and children are exempt from the five (5)-year bar;
3. Iraqi and Afghan aliens granted special immigrant status;
4. An Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, as amended;

5. An alien with past or current military involvement, defined as an alien veteran who is on active duty (other than active duty for training) with any of the U.S. Armed Forces units or who has been honorably discharged (not on account of alienage) and who has fulfilled minimum active-duty service requirements. Minimum active duty is defined as at least twenty-four (24) months or the period for which the person was called to active duty. The spouse or unmarried dependent child of an alien veteran as described in this paragraph is also eligible;
6. Certain American Indian tribe members born in Canada or outside the United States or who are a member of an Indian tribe; or
7. An alien who is paroled into the U.S. under Section 212(d)(5) of INA, but only after having resided in the United States for at least five (5) calendar years from the date of entry or who has worked or can be credited with forty (40) qualifying quarters of work.

Aliens who do not meet these requirements may be eligible for emergency medical services only, including aliens with a status of Deferred Action for Childhood Arrivals (DACA) (see Appendix 477-000-003). A pregnant alien woman or alien child who does not meet these requirements may be eligible as lawfully present.

5-002 MEDICAID FOR CERTAIN CHILDREN AND PREGNANT WOMEN: A child or pregnant women may be eligible if s/he is a Nebraska resident and is lawfully present in the United States. A children or pregnant women shall be considered lawfully present if s/he is:

1. A qualified alien as defined in section 431 of the Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) (8 U.S.C. § 1641). Specific documentation requirements for this category are set forth at Appendix 477-000-003 and 477-000-004;
2. An alien in nonimmigrant status who has not violated the terms of the status under which s/he was admitted or to which he or she has changed after admission;
3. An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than one (1) year, except for an alien paroled for prosecution, for deferred inspection, or pending removal proceedings;
4. An alien who belongs to one of the following classes:
    a. Aliens currently in temporary resident status, pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
    b. Aliens currently under Temporary Protected Status (TPS), pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;
    c. Aliens who have been granted employment authorization under 8 CFR 274 a.12(c)(9), (10), (16), (18), (20), (22), or (24);
    d. Family Unity beneficiaries pursuant to section 301 of Pub.L. 101-649, as amended;
    e. Aliens currently under Deferred Enforced Departure (DED), pursuant to a decision made by the President;
    f. Aliens currently in deferred action status (this does not include DACA); or
    g. Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

5. An alien who has a pending application for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of fourteen (14) who has had an application pending for at least 180 days;
6. An alien who has been granted withholding of removal under the Convention Against Torture;
7. A child who has a pending application for Special Immigrant Juvenile status, as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
8. An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands, under 48 U.S.C. § 1806(e); or
9. An alien who is lawfully present in American Samoa, under the immigration laws of American Samoa.

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

Applicants/Clients who declare themselves to be U.S. citizens and meet all other eligibility requirements must be given a reasonable opportunity to present satisfactory documentation of citizenship or nationality. Medical benefits must not be denied, delayed, reduced, or terminated pending receipt of the requested citizenship verification. If the Department has requested verification, such as an out-of-state birth certificate, benefits will not be denied or terminated while awaiting receipt. Once an individual has declared him/herself a U.S. citizen or national and has provided all other information to determine eligibility, benefits must be provided.

If the applicant/client fails to cooperate in providing documentation, the applicant/client is ineligible.

5-003 VERIFICATION OF CITIZENSHIP AND IMMIGRATION STATUS: The Federal Data Services (hub) shall be used to verify citizenship and immigration status, if available. If the hub is not available to verify citizenship and immigration status, SAVE (Systematic Alien Verification for Entitlements Program System of Records) or receipt of Supplemental Security Income (SSI), Social Security Disability Insurance (SSDI), or Medicare is sufficient proof of citizenship or lawfully admitted alien status.

5-004 REASONABLE OPPORTUNITY PERIOD: A ninety (90)-day timeframe is given to verify an individual's satisfactory immigration status if the Department or applicant/client cannot provide verification. A notice shall be sent to inform the applicant/client of the reasonable opportunity period. The reasonable opportunity period extends ninety (90) days from the date on which the notice is received by the applicant/client, which means five (5) days after the date of the notice unless the applicant/client shows s/he did not receive the notice within the five(5)-day period.

If more time is needed to complete the verification process, or the applicant/client requests more time and is acting in good faith to obtain documentation, the reasonable opportunity period is subject to be extended with Central Office approval.

If citizenship and immigration status has not been verified by the end of the reasonable opportunity period, Medicaid benefits shall be terminated. If the individual appeals the case closure, the Medicaid case is not subject to reinstatement pending the outcome of a fair hearing.

The reasonable opportunity period encompasses all aspects of the process to verify citizenship immigration status, including not only time for an individual to provide documentation but also time for the Department to resolve inconsistencies or conclude the electronic verification process.

5-005 VERIFICATION OF ALIEN STATUS: When an applicant/client states that one or more of the unit members is an alien, the applicant/client is required to present verification for each alien member. If the applicant/client has documentation containing an alien registration number, the alien status must be verified using the Federal Data Services hub or SAVE system. See additional available information at Appendix 477-000-004.

5-006 REPATRIATION PROGRAM: The Repatriation Program provides temporary assistance, care, and treatment for up to ninety (90) days for U.S. citizens or dependents of U.S. citizens who have returned from foreign countries. To qualify for repatriation assistance, the individual must be returned from a foreign country because s/he is destitute or ill (including mentally ill) or because of war, threat of war, or a similar crisis. A request must be made by the State Department to the U.S. Department of Health and Human Services to receive the individual in the United States and to provide the necessary care, treatment, and assistance.

The assistance may include reception service, food, shelter, clothing, and transportation. It may also include payment for special services such as medical and psychiatric care. Any assistance that is provided through General Assistance or Emergency Assistance may be reimbursed through federal funds.

Central Office will contact the appropriate local office on all arriving cases. If it appears that the individual is eligible for another form of assistance, a referral must be made (e.g., to the Social Security Administration, the Veterans Administration, etc.) or an application for categorical assistance must be completed.

5-006.01 Eligibility Period: Assistance may be provided for up to ninety (90) days from the date the individual arrives in the United States. If the individual needs assistance beyond ninety (90) days and is not eligible for Retirement, Survivors, and Disability Insurance (RSDI), SSI, or categorical assistance, the local office shall contact Central Office.

5-006.02 Medical Payments: All payments for medical care must be made at rates no higher than those paid by Medicaid.

5-006.03 Repayment: The individual is required to sign an agreement to repay the cost of the assistance provided.

CHAPTER 5-000 CITIZENSHIP/ALIEN STATUS AND IDENTITY

5-001 CITIZENSHIP AND ELIGIBLE ALIENS: In order to be eligible for Medicaid, an individual's status must be documented as one of the following using acceptable documents, as defined by federal regulations (See Appendix 477-000-003 for acceptable documents).

1. A citizen of the United States;
   Note: A child born in the United States is a U.S. citizen. A newborn who was determined to be eligible for Medicaid in the month of birth meets citizenship and identity requirements without further verification; this includes newborns whose birth expenses were paid through Emergency Medicaid Assistance for Aliens;
2. Qualified Aliens as defined in Section 431 of the Immigration and Nationality Act (INA):
   a. An alien who was admitted as a lawful permanent resident (LPR) and has resided in the United States for at least five calendar years from the date of entry or who has worked or can be credited with 40 qualifying quarters of work. Medicaid eligible pregnant women and children are exempt from the five year bar. For sponsored LPRs, see 477 NAC 17-006.01;
   b. A refugee admitted to the U.S. under Section 207 of the INA;
   c. An asylee under Section 208 of INA;
   d. Victims of a severe form of trafficking (Victims of Trafficking and Violence Protection Act of 2000);
   e. An alien whose deportation is withheld under Section 243(h) of INA;
   f. An alien from Cuba or Haiti who was admitted under Section 501(e) of the Refugee Education Assistance Act of 1980;
   g. A refugee who entered the U.S. before April 1, 1980, and was granted conditional entry;
   h. An alien who has been battered or subjected to extreme cruelty in the U.S. by a spouse or a parent or by a member of the spouse's or parent's family who is residing in the same household as the alien; but only after having resided in the United States for at least five calendar years from the date of entry or who has worked or can be credited with 40 qualifying quarters of work. The child or children of a battered alien meeting these requirements is/are also eligible. Medicaid eligible pregnant women and children are exempt from the five year bar;
3. Iraqi and Afghan aliens granted special immigrant status;
4. An Amerasian immigrant under Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988, as amended;

5. An alien with past or current military involvement defined as an alien veteran who is on active duty (other than active duty for training) with any of the U.S. Armed Forces units or who has been honorable discharge (not on account of alienage) and who has fulfilled minimum active-duty service requirements. Minimum active duty is defined as 24 months or the period for which the person was called to active duty. The spouse or unmarried dependent child of an alien veteran as described in this paragraph is also eligible;
6. For Medical assistance only, certain American Indian tribe members born in Canada or outside the United States or who are a member of an Indian tribe; or
7. An alien who is paroled into the U.S. under Section 212(d)(5) of INA, but only after having resided in the United States for at least five calendar years from the date of entry or who has worked or can be credited with 40 qualifying quarters of work.

Note: Aliens who do not meet the requirements above may be eligible for emergency medical services only including aliens with a status of Deferred Action for Childhood Arrivals (DACA) (see Appendix 477-000-003). A pregnant alien woman or alien child who does not meet the above may be eligible as lawfully present and will need Central Office approval.

5-002 MEDICAL ASSISTANCE FOR CERTAIN CHILDREN AND PREGNANT WOMEN: A child or pregnant women may be eligible if s/he is a Nebraska resident, and is "lawfully present" in the United States. A children or pregnant women shall be considered lawfully present if s/he is:

1. A qualified alien as defined in section 431 of PRWORA (8 U.S.C. § 1641). Specific documentation requirements for this category are set forth at Appendix 477-000-003 and 477-000-004;
2. An alien in nonimmigrant status who has not violated the terms of the status under which s/he was admitted or to which he or she has changed after admission;
3. An alien who has been paroled into the United States pursuant to section 212(d)(5) of the Immigration and Nationality Act (INA) (8 U.S.C. §1182(d)(5)) for less than one year, except for an alien paroled for prosecution, for deferred inspection or pending removal proceedings;
4. An alien who belongs to one of the following classes:

   a. Aliens currently in temporary resident status pursuant to section 210 or 245A of the INA (8 U.S.C. §§1160 or 1255a, respectively);
   b. Aliens currently under Temporary Protected Status (TPS) pursuant to section 244 of the INA (8 U.S.C. §1254a), and pending applicants for TPS who have been granted employment authorization;

c. Aliens who have been granted employment authorization under 8 CFR 274 a.12(c)(9), (10), (16), (18), (20), (22), or (24);
d. Family Unity beneficiaries pursuant to section 301 of Pub.L. 101-649, as amended;
e. Aliens currently under Deferred Enforced Departure (DED) pursuant to a decision made by the President;
f. Aliens currently in deferred action status; or
g. Aliens whose visa petition has been approved and who have a pending application for adjustment of status;

5. An alien who has a pending application for asylum under section 208(a) of the INA (8 U.S.C. § 1158) or for withholding of removal under section 241(b)(3) of the INA (8 U.S.C. § 1231) or under the Convention Against Torture who has been granted employment authorization, and such an applicant under the age of 14 who has had an application pending for at least 180 days;
6. An alien who has been granted withholding of removal under the Convention Against Torture;
7. A child who has a pending application for Special Immigrant Juvenile status as described in section 101(a)(27)(J) of the INA (8 U.S.C. § 1101(a)(27)(J));
8. An alien who is lawfully present in the Commonwealth of the Northern Mariana Islands under 48 U.S.C. § 1806(e); or
9. An alien who is lawfully present in American Samoa under the immigration laws of American Samoa.

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

Individuals who declare to be U.S. citizens and meet all other eligibility requirements must be given a reasonable opportunity to present satisfactory documentation of citizenship or nationality. Medical benefits must not be denied, delayed, reduced, or terminated pending receipt of the requested citizenship verification. If the Department has requested verification, such as an out-of-state birth certificate, benefits will not be denied or terminated while awaiting receipt. Once an individual has declared s/he is a U.S. citizen or national and has provided all other information to determine eligibility, benefits must be provided.

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

5-003 VERIFICATION OF CITIZENSHIP AND IMMIGRATION STATUS: Shall be verified using the Federal Data Services (hub) if available. If the hub is not available to verify citizenship and immigration status, SAVE (Systematic Alien Verification for Entitlements Program System of Records) or receipt of SSI, SSDI, or Medicare is sufficient proof of citizenship or lawfully admitted alien status.

5-004 REASONABLE OPPORTUNITY PERIOD: A 90-day timeframe is given to verify an individual's satisfactory immigration status if the Department or individual cannot provide verification. A notice shall be sent to inform the individual of the reasonable opportunity period. The reasonable opportunity period extends 90 days from the date on which the notice is received by the individual, which means 5 days after the date of the notice unless the individual shows they did not receive the notice within the five day period.

If more time is needed to complete the verification process, or the individual requests more time and is acting in good faith to obtain documentation, the reasonable opportunity period is subject to be extended with Central Office approval.

If citizenship and immigration status has not been verified by the end of the reasonable opportunity period, action shall be taken to terminate benefits. If the individual appeals the termination of benefits, the Medicaid case is not subject to reinstatement pending the outcome of a fair hearing.

Note: The reasonably opportunity period encompasses all aspects of the process to verify citizenship immigration status, including not only time for an individual to provide documentation but also time for the agency to resolve inconsistencies or conclude the electronic verification process.

5-005 VERIFICATION OF ALIEN STATUS: When a client states that one or more of the unit members is an alien, the client is required to present verification for each alien member. If the client has documentation containing an alien registration number, the alien status must be verified using the Federal data services hub or SAVE system. See additional available information at Appendix 477-000-004.

5-006 REPATRIATION PROGRAM: The Repatriation Program provides temporary assistance, care, and treatment for up to 90 days for U.S. citizens or dependents of U.S. citizens who have returned from foreign countries. To qualify for repatriation assistance, the individual must be returned from a foreign country because s/he is destitute or ill (including mentally ill) or because of war, threat of war, or a similar crisis. A request must be made by the State Department to the U.S. Department of Health and Human Services to receive the individual in the United States and to provide the necessary care, treatment, and assistance.

The assistance may include reception service, food, shelter, clothing, and transportation. It may also include payment for special services such as medical and psychiatric care. Any assistance that is provided through General Assistance or Emergency Assistance may be reimbursed through federal funds.

Central Office will contact the appropriate local office on all arriving cases. If it appears that the individual is eligible for another form of assistance, a referral must be made (to Social Security, Veterans Administration, etc.) or complete an application for categorical assistance.

5-006.01 Eligibility Period: Assistance may be provided for up to 90 days from the date the individual arrives in the United States. If the individual needs assistance beyond 90 days and is not eligible for SSA, SSI, or categorical assistance, the local office shall contact Central Office.

5-006.02 Medical Payments: All payments for medical care must be made at rates no higher than those paid by Medicaid.

5-006.03 Repayment: The individual is required to sign an agreement to repay the cost of the assistance provided.

CHAPTER 6-000 STATE RESIDENCY

6-001 RESIDENCE: To be eligible for assistance, an applicant/client must be a Nebraska resident. A resident is an individual living in the state voluntarily with the intent of making Nebraska his/her home. Residence starts with the month the applicant/client moves into the state, even if the applicant/client received categorical assistance in another state.

6-002 RESIDENCE OF APPLICANTS ENTERING THE STATE INTO A LICENSED HOME: The intent of an applicant to establish Nebraska residence must be investigated if the applicant comes into the state and immediately enters a home licensed by the Nebraska Department of Health and Human Services, Division of Public Health (nursing home or alternate care facility).

To determine the applicant's intent to establish residence in Nebraska, the applicant's purpose for entering the state must be considered.

The applicant is a Nebraska resident if his/her purpose for entering the state was because s/he

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

If none of these conditions exist, the applicant's intent to establish residence shall be evaluated by the Department. If the applicant states that s/he plans to establish residence, but the situation seems to indicate otherwise, other factors are reviewed, including when the applicant entered the state, whether the applicant maintains a residence or owns property (including real and/or personal property) in another state, and the place of residence of the applicant's spouse and other immediate family members, if any.

Relevant factors to take into consideration include if the applicant was eligible for Medicaid in the state in which s/he previously resided, how the applicant was referred to the facility in Nebraska, and where the applicant would reside if s/he moved out of the facility in Nebraska, and any other related factors.

6-003 NON-INSTITUTIONALIZED APPLICANTS/CLIENTS

6-003.01 Age 21 and Over: For applicants/clients who are not residing in an institution and who are not capable of indicating intent, the state of residence is the state where the applicant/client is living.

6-003.02 If an applicant/client is under age twenty-one (21), not emancipated or married, and not Title IV-E eligible, the state of residence is the state where the individual resides, including

1. With or without a fixed address; or
2. The state of residency of the parent or caretaker.

6-003.03 Any Age

6-003.03A For an individual who is capable of indicating intent and who is emancipated or married, the state of residence is the state where the individual is living, and

1. Intends to reside, including without a fixed address; or
2. Has entered with a job commitment or seeking employment, whether or not currently employed.

6-003.04 Incapable of Indicating Intent: An applicant/client who is not institutionalized and is incapable of indicating intent is considered a resident of the state in which the individual is living if one of the following is met:

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

6-003.05 Applicants/Clients Receiving a State Supplementary Payment (SSP): For any applicant/client who is receiving an SSP, the state paying the SSP is the state of residence.

6-003.06 Applicants/Clients Receiving Title IV-E Payments: For applicants/clients of any age who are receiving federal payments for foster care and/or adoption assistance under Title IV-E of the Social Security Act, as amended, the state of residence is the state where the applicant/client lives.

6-004 INSTITUTIONALIZED APPLICANTS/CLIENTS

6-004.01 Institutionalized Applicants/Clients: The state where the institution is located is an institutionalized applicant/client's state of residence unless it is determined that the applicant/client is a resident of another state, according to the following: For any institutionalized applicant/client who is twenty (20) years old or younger, or who is twenty-one (21) years old or older and became incapable of indicating intent before reaching twenty-one (21) years old, the state of residence is

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

For any institutionalized applicant/client who became incapable of indicating intent at or after reaching twenty-one (21) years old, the state of residence is the state in which the applicant/client is physically present except where another state makes a placement.

6-004.02 Placement in an Out-of-State Institution: If a state arranges for an applicant/client to be placed in an institution located in another state, the state making the placement is the applicant/client's state of residence, regardless of the applicant/client's indicated intent or ability to indicate intent.

6-004.03 Discharge from an Out-of-State Institution: When an applicant/client leaves the facility in which the applicant/client is placed by a state, that applicant/client's state of residence is the state where the applicant/client is physically located.

6-005 ABSENCE

6-005.01 Absence From the State: The Department may not deny assistance because an individual has not resided in the state for a specified period.

6-005.02 Temporary Absence: The Department may not deny or terminate eligibility due to an applicant/client's temporary absence from the state, if the applicant/client intends to return. A temporary absence is ninety (90) days or less, except in extraordinary circumstances.

6-006 LOSS OF STATE RESIDENCE: Eligibility is terminated if the family unit leaves Nebraska with the intent of establishing its home in another state.

CHAPTER 6-000 STATE RESIDENCY

6-001 RESIDENCE: To be eligible for assistance, a client must be a Nebraska resident. A resident is defined as an individual living in the state voluntarily with the intent of making Nebraska his/her home. Residence starts with the month the client moves into the state, even if the client received categorical assistance in another state.

6-002 RESIDENCE OF INDIVIDUALS ENTERING THE STATE INTO A LICENSED HOME: The intent of an individual to establish Nebraska residence must be investigated in accordance with this regulation if the individual comes into the state and immediately enters a home licensed by the Nebraska Department of Health and Human Services Division of Public Health (nursing home or alternate care facility).

To determine the individual's intent to establish residence in Nebraska, the individual's purpose for entering the state must be considered.

The individual is considered a Nebraska resident if his/her purpose for entering the state was because s/he:

4. Desired to be near to close friends or relatives in the state;
5. Previously resided in the state; or
6. Has other contacts in the state.

If none of the previously mentioned conditions exist, the client's intent to establish residence shall be evaluated by the department. If the client states that s/he plans to establish residence but the situation seems to indicate otherwise, other factors are reviewed such as when the client entered the state, whether the client maintains a residence or owns property (including real and/or personal property) in another state, and place of residence of the client's spouse and other immediate family members.

It shall be taken into consideration if the client was eligible for medical assistance in the state in which s/he previously resided, how the client was referred to the facility in Nebraska (e.g., family member, hospital staff, service worker in the other state, etc.), and where the client would reside if s/he moved out of the facility in Nebraska, and any other related factors.

6-003 NON-INSTITUTIONALIZED INDIVIDUALS

6-003.01 Individuals Age 21 and Over: Individuals who are not residing in an institution, who are not capable of indicating intent, state residence is the state where the individual is living.

6-003.02 If the individual is under age 21, not emancipated or married and a non IV-E client, the state residence is the state where the individual resides, including:

1. With or without a fixed address; or
2. The state of residency of the parent or caretaker.

6-003.03 Individuals Under Age 21 or Age 21 and Over

6-003.03A For an individual who is capable of indicating intent and who is emancipated, or is married, state residence is the State where the individual is living, and:

1. Intends to reside, including without a fixed address; or
2. Has entered the state with a job commitment or seeking employment, whether or not currently employed.

6-003.04 Children Attending School in Another State: Children who are attending school in a state other than where the parent/caretaker relative resides must provide evidence of actual residency.

Note: If there is a discrepancy in Medicaid state residency, the individual is a resident in the state in which the individual is physically located.

6-003.05 Incapable of Indicating Intent: An individual who is not institutionalized and incapable of indicating intent is considered a resident of the state in which the individual is living if one of the following is met:

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

6-003.06 Individuals Receiving a State Supplementary Payment (SSP): For any individual who is receiving an SSP, the state paying the SSP is the state of residence.

6-003.07 Individuals Receiving Title IV-E payments: Individuals of any age who are receiving Federal payments for foster care and adoption assistance under title IV-E of the Social Security Act, the state of residence is the state where the child lives.

6-004 INSTITUTIONALIZED INDIVIDUALS

6-004.01 Institutionalized Individuals: The state where the institution is located is the individual's state of residence unless it is determined that the individual is a resident of another state, according to the following regulations. For any institutionalized individual who is age 20 or younger or who is age 21 or older and became incapable of indicating intent before reaching age 21, the state of residence is:

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

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

6-004.02 Placement in an Out-of-State Institution: If a state arranges for an individual to be placed in an institution located in another state, the state making the placement is the individual's state of residence, regardless of the individual's indicated intent or ability to indicate intent.

6-004.03 Discharge from an Out-of-State Institution: When an individual leaves the facility in which the individual is placed by a State, that individual's State of residence is the State where the individual is physically located.

6-005 ABSENCE

6-005.01 Absence From the State: The agency may not deny assistance because an individual has not resided in the state for a specified period.

6-005.02 Temporary Absence: The agency may not terminate a resident's eligibility due to a person's temporary absence from the state, if the person intends to return. Temporary absence is generally 90 days.

6-006 LOSS OF STATE RESIDENCE: Eligibility for assistance ends if the family unit leaves Nebraska with the intent of establishing its home in another state.

6-007 DISQUALIFICATION FOR MISREPRESENTING RESIDENCE: Any person convicted in federal or state court of having fraudulently misrepresented his/her residence in order to obtain medical assistance in two or more states is ineligible for medical assistance for ten years from the date of conviction. Only the individual convicted of the misrepresentation is ineligible.

CHAPTER 7-000 AGE AND DATE OF BIRTH

7-001 AGE REQUIREMENT/AGE LIMIT: To be eligible for Medicaid or 599 CHIP, an applicant/client must meet the age requirements for the applicable Medicaid category.

1. For age requirements for Children's Medicaid, see 477 NAC 19-003.01 and 477 NAC;
2. For 599 CHIP, see 477 NAC 19-004.04;
3. For Former Ward, see 477 NAC 19-005.02;
4. For Former Foster Care, see 477 NAC 27-007;
5. For Aged, Blind, and Disabled (ABD), see 477 NAC 27-001.01 and 477 NAC 24-001.07A;
6. For Women's Cancer Program, see 477 NAC 27-004.02; and
7. For Medically Needy see 477 NAC 27-005.02 and 477 NAC 27-005.02A.

7-002 EFFECTIVE BIRTH DATE IF INFORMATION IS INCOMPLETE: When birth information is incomplete, see Appendix 477-000-004 for the Verification Plan.

7-003 VERIFICATION OF AGE: If age is a factor for eligibility, an applicant's/client's age must be verified, see Appendix 477-000-004 for the Verification Plan.

CHAPTER 7-000 AGE AND DATE OF BIRTH

7-001 AGE REQUIREMENT/AGE LIMIT: To be eligible for medical assistance, the individual must meet the age requirements set by each applicable Medicaid category.

8. For age requirements for Children's Medicaid see 477 NAC 18-003.01 and 477 NAC 18-003.2A;
9. For 599 CHIP see 477 NAC 18-004.04;
10. For Former Wards see 477 NAC 18-005.02;
11. For Former Foster Care see 477 NAC 24-006.01;
12. For AABD see 477 NAC 24-001.01 and 477 NAC 24-001.07A;
13. For Woman's Cancer Program see 477 NAC 24-004.02; and
14. For Medically Needy see 477 NAC 24-005.03 and 477 NAC 24-005.03A.

7-002 EFFECTIVE BIRTH DATE IF INFORMATION IS INCOMPLETE: When birth information is incomplete, see Appendix 477-000-004 for the verification plan.

7-003 VERIFICATION OF AGE: If age is a factor required for eligibility, the individual's age must be verified, see Appendix 477-000-004 for the verification plan.

CHAPTER 8-000 SOCIAL SECURITY NUMBER

8-001 REQUIREMENT OF A SOCIAL SECURITY NUMBER: Each applicant for or recipient of Medicaid is required, as a condition of eligibility, to

1. Furnish his/her Social Security number (SSN); or
2. Apply for an SSN with the Social Security Administration (SSA), if one has not been issued or is not known.

The SSN, in conjunction with other information, provides evidence of identity of the individual.

8-002 EXCEPTION TO REQUIREMENT OF AN SSN: If an applicant/client refuses to obtain an SSN for a well-established religious objection, the Department may assign the individual a unique Medicaid identification number as an alternative.

8-002.01 Well-Established Religious Objection: An individual

1. Is a member of a recognized religious group or division of the group; and
2. Adheres to the tenets or teachings of the group or division of the group, and for that reason is conscientiously opposed to applying for or using a national identification number.

8-003 APPLICATION FOR AN SSN: An applicant who has not previously applied for an SSN shall be given ninety (90) days from the date of application to verify that he/she has submitted an application with the SSA. An applicant shall not be eligible after the ninety (90)-day period unless verification of the application is received.

8-004 ASSISTANCE PENDING VERIFICATION: After the applicant/client has been referred to SSA, if s/he is otherwise eligible, assistance shall not be delayed, denied, or discontinued pending the verification or assignment of an SSN.

8-005 APPLICATION FOR A NEWBORN: An SSN is not an eligibility requirement through the month a child turns one (1) if Nebraska Medicaid paid for the birth.

8-006 INDIVIDUALS NOT SEEKING MEDICAID: An individual not seeking Medicaid assistance shall not be required to provide or apply for an SSN.

CHAPTER 8-000 SOCIAL SECURITY NUMBER

8-001 REQUIREMENT OF A SOCIAL SECURITY NUMBER: Each applicant for or recipient of Medicaid is required, as a condition of eligibility, to:

3. Furnish DHHS with their Social Security number (SSN); or
4. Apply for an SSN if one has not been issued or is not known.

The SSN, in conjunction with other information, provides evidence of identity of the individual.

8-002 APPLICATION FOR AN SSN: If a client has not applied within 30 days of the date s/he applied for Medicaid, the client must not be included in determining the size of the assistance unit.

8-003 ASSISTANCE PENDING VERIFICATION: An individual who has applied for an SSN shall be provided a Medicaid identification number in lieu of an SSN. After the client has been referred to SSA, if s/he is otherwise eligible, assistance shall not be delayed, denied, or discontinued pending the verification or assignment of an SSN.

8-004 APPLICATION FOR A NEWBORN: An SSN is not an eligibility requirement through the month the child turns one if Nebraska Medicaid paid for the birth.

8-005 INDIVIDUALS NOT SEEKING MEDICAID: An individual not seeking Medicaid assistance shall not be required to provide or apply for an SSN.

CHAPTER 9-000 NOTIFICATION

9-001 TYPES OF NOTICES

9-001.01 Adequate Notice: An adequate notice must include a statement of what action(s) are intended, the reason(s) for the intended action(s), and the specific supporting manual reference(s) or the change in federal or state law that requires the action(s). An adequate notice must be sent no later than the effective date of the action.

9-001.02 Timely Notice: A Notice of Action must be sent by the Department to the applicant, client, or his/her authorized representative at least ten (10) calendar days before the date the action becomes effective, which is always the first day of the month.

9-001.03 Adequate and Timely Notice: In cases of intended adverse action (action to discontinue, terminate, or reduce assistance; to change the manner or form of assistance; or to change service provision to a more restrictive method, i.e., medical lock-in), the client must be given both adequate and timely notice.

9-002 SITUATIONS REQUIRING ADEQUATE NOTICE ONLY: In the following situations, timely notice does not apply; however, adequate notice must be sent no later than the effective date of action.

1. The Department has factual information confirming the death of the client;
2. The Department receives a written and signed statement from the client
   a. Stating that assistance is no longer required; or
   b. Giving information that requires termination or reduction of assistance, and indicating, in writing, that the client understands the consequence of supplying the information;
3. The client has been admitted or committed to an institution and no longer qualifies for Medicaid;
4. The client has been placed in skilled nursing care, intermediate care, long-term hospitalization, or Assisted Living Waiver;
5. The client's whereabouts are unknown, and mail directed to the client has been returned by the post office indicating no known forwarding address;
6. The client has been accepted for assistance in another state and that fact has been established; or
7. A change in the level of medical care.

9-003 WAIVER OF NOTICE: If a client agrees to waive his/her right to a timely notice in situations requiring timely notice, a statement signed by the client must be obtained and filed in the case record.

9-004 FRAUD CASES: At least five (5) days' advance written notice must be given if

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

CHAPTER 9-000 NOTIFICATION

9-001 TYPES OF NOTICES

9-001.01 Adequate Notice: An adequate notice must include a statement of what action(s) are intended, the reason(s) for the intended action(s), and the specific manual reference(s) that supports or the change in federal or state law that requires the action(s). An adequate notice must be sent no later than the effective date of the action.

9-001.02 Timely Notice: A timely notice must be dated and mailed at least ten calendar days before the date that action would become effective, which is always the first day of the month.

9-001.03 Adequate and Timely Notice: In cases of intended adverse action (action to discontinue, terminate, or reduce assistance or to change the manner or form or service to a more restrictive method, i.e., medical lock-in), the client must be given adequate and timely notice.

9-002 SITUATIONS REQUIRING ADEQUATE NOTICE ONLY: In the following situations, timely notice does not apply; however, adequate notice must be sent no later than the effective date of action.

8. The agency has factual information confirming the death of a client;
9. The agency receives a written and signed statement from the client:
   a. Stating that assistance is no longer required; or
   b. Giving information which requires termination or reduction of assistance, and indicating, in writing, that the client understands the consequence of supplying the information;
10. The client has been admitted or committed to an institution, and no longer qualifies for assistance;
11. The client has been placed in skilled nursing care, intermediate care, long-term hospitalization, or Assisted Living Waiver;
12. The client's whereabouts are unknown and agency mail directed to the client has been returned by the post office indicating no known forwarding address;
13. The client has been accepted for assistance in another state and that fact has been established;
14. A change in level of medical care;
15. A child receiving Medical Assistance is removed from the home as a result of a judicial determination or is voluntarily placed in foster care; or
16. A special allowance granted for a specific period is terminated and the client has been informed in writing at the time of initiation that the allowance automatically terminates at the end of the specified period.

9-003 WAIVER OF NOTICE: If a client agrees to waive his/her right to a timely notice in situations requiring timely notice, a statement signed by the client must be obtained to be filed in the case record.

9-004 FRAUD CASES: At least five days' advance written notice must be given if:

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

CHAPTER 10-000 FAIR HEARING PROCESSES

10-001 RIGHT TO APPEAL: Every applicant/client has the right to appeal any action, inaction, or failure to act with reasonable promptness. The applicant/client may appeal because

1. His/her application is denied;
2. His/her application is not acted on with Reasonable promptness;
3. His/her Medicaid is suspended;
4. His/her services are reduced;
5. His/her Medicaid case is closed;
6. His/her services are changed to be more restrictive; or
7. S/he thinks the Department's action was erroneous.

The client is not entitled to a fair hearing when either state or federal law requires automatic case adjustments for classes of clients unless the reason for an individual appeal is an incorrect eligibility determination.

The applicant/client must request a fair hearing within ninety (90) days following the date the Notice of Action is mailed. If an applicant/client wishes to appeal due to inaction, s/he must request a fair hearing within ninety (90) days of the date the complete and properly signed application was submitted to the Department. If an applicant/client submits a request for a hearing within ten (10) days following the date the Notice of Action is mailed, the applicant/client is presumed to have requested the continued receipt of any ongoing assistance pending the appeal decision, unless the applicant/client otherwise indicates.

10-001.01 Filing an Appeal: See 465 NAC 6-004.01.

CHAPTER 10-000 FAIR HEARING PROCESSES

10-001 RIGHT TO APPEAL: Every applicant for or recipient of assistance or services provided through the Nebraska Department of Health and Human Services has the right to appeal any action, inaction, or failure to act with reasonable promptness with regard to the assistance or services. The individual may appeal because:

8. His/her application for financial or medical assistance or services is denied;
9. His/her application for financial or medical assistance or services is not acted upon with reasonable promptness;
10. His/her assistance is suspended;
11. His/her assistance or services are reduced;
12. His/her assistance or services are terminated;
13. His/her form of payment or services is changed to be more restrictive; or
14. S/he thinks the staff's action was erroneous.

Exception: The client is not entitled to a fair hearing when either state or federal law requires automatic case adjustments for classes of clients unless the reason for an individual appeal is incorrect eligibility determination.

The applicant or client must request a fair hearing within 90 days following the date the notice of adverse action is mailed. If an applicant wishes to appeal due to inaction, s/he must request a fair hearing within 90 days of the date the application was signed. If the client submits a request for a hearing within ten days following the date the notice is mailed, the adverse action shall not be taken until a fair hearing decision is rendered. If the client submits a request for a hearing within ten days following the date the notice is mailed, the client must be allowed an opportunity to decline receipt of continued assistance pending the appeal decision.

10-001.01 Filing an Appeal: See 465 NAC 6-004.01.

CHAPTER 11-000 LIVING ARRANGEMENTS

For Long-Term Care see 477 NAC 26-001.

11-001 LIVING ARRANGEMENT: With the exception of the situations listed at 42 CFR 435.1009 (Institutionalized Individuals), an applicant/client is eligible regardless of his/her living arrangement.

This does not apply to infants or young children who reside with their mother at the Nebraska Correctional Center for Women.

11-002 ABSENCE

11-002.01 Absence Because of Schooling: The child's absence from home for the purpose of attending school does not affect eligibility.

11-002.02 Temporary Absence from the Home: A child is still considered part of the household while s/he is out of the home for a visit not to exceed three (3) months. A child is still considered part of the original household while s/he is on summer visitation.

11-002.03 Temporary Absence Due to Emergency Situations: In emergency situations that deprive a child of the care of a parent relative, guardian, or conservator, temporary plans may be made to care for the child in the home of an individual or institution acting in the place of the caretaker. The unit may continue to receive assistance for the period of the emergency or the time actually required to make new arrangements for care, but the assistance must not continue beyond three (3) months.

CHAPTER 11-000 LIVING ARRANGEMENTS

For Long-Term Care see 477 NAC 23-001.

11-001 LIVING ARRANGEMENT: With the exception of the situations listed below, an individual is eligible regardless of the living arrangement.

11-001.01 Ineligible Living Arrangements: An individual is not eligible to receive Medicaid if in a prison, jail, or a veteran's hospital. A child is ineligible if s/he is residing in a detention facility, forestry camp, training school, or any other facility that is operated primarily for the detention of children who are determined to be delinquent. See 479 NAC 3-003.04.

11-002 ABSENCE

11-002.01 Absence Because of Schooling: The child's absence from home for the purpose of attending school does not affect eligibility.

11-002.02 Temporary Absence from the Home: A child is still considered part of the household while s/he is out of the home for a visit not to exceed three months. A child is still considered part of the original household while s/he is on summer visitation.

11-002.03 Temporary Absence Due to Emergency Situations: In emergency situations that deprive the child of a parent's or relative's, or guardian or conservator's care, temporary plans may be made to care for the child in the home of an individual or institution acting in the place of the parent or relative. The unit may continue to receive assistance for the period of the emergency or the time actually required to make new arrangements for care, but the assistance must not continue beyond three months.

CHAPTER 12-000 THIRD-PARTY RESOURCES AND CHILD SUPPORT ENFORCEMENT

12-001 ASSIGNMENT OF THIRD PARTY RESOURCES: See 471 NAC 3-004.

The assignment of third-party resources gives the Department the right to pursue and receive payments from any third party liable to pay for the cost of medical care and services for the client or for any other household member, and which otherwise would be covered by Medicaid. The assignment of the rights to third party medical payments is effective with the date of Medicaid eligibility.

For Medicaid cases with a share of cost, the assignment becomes effective the first day of the month when the case status changes to "Share of Cost Met."

For third party payments received directly see Appendix 477-000-015.

12-001.01 Third-Party Payments Not Assigned: The following third-party payments are not subject to the automatic assignment provision:

1. Medicare benefits; and
2. Payments from income-producing policies that subsidize the client's income while s/he is hospitalized or receiving care, regardless of the type of medical service being provided.

12-002 CLIENT COOPERATION

12-002.01 Client Cooperation Required: As a condition of eligibility, a client must cooperate in obtaining third-party resources unless s/he has good cause for noncooperation. Cooperation includes any or all of the following:

1. Providing complete information regarding the extent of third-party resources that s/he or any other household member has or may have. This includes coverage provided by a person not in the household or by an agency;
2. Providing any additional information or signing claim forms that may be necessary for identification and collection of potential third-party payments;
3. Appearing as a witness in a court or another proceeding, if necessary;
4. Notifying the Department of any action s/he is initiating to recover money from a liable third-party for medical care or services. This includes the identity of the third-party, as well as the entire amount of any settlement, court award, or judgment;
5. Reimbursing the Department or paying to the provider any payments received directly from a third-party for any services payable by Medicaid; and
6. Taking any other reasonable steps to secure payments

Noncooperation by the client is failure or refusal by the client to fulfill these requirements. Pregnant women are not exempt from these requirements.

12-003 OPPORTUNITY TO CLAIM GOOD CAUSE

12-003.01 Notification of Right: The client must be notified of the right to claim good cause for noncooperation at the time of application, renewal, and whenever cooperation becomes an issue.

12-003.02 Good Cause Exemption: See 466 NAC 3-003.

12-003.03 Delay Pending Determination: The Department must not deny, delay, or discontinue Medicaid pending a determination of good cause if the client has complied with the requirements of providing acceptable evidence or other necessary information.

12-003.04 Review of Good Cause: At the time of each eligibility renewal, a good cause claim must be reviewed based on a circumstance that is subject to change. If circumstances remain the same, no action is required. A new determination is necessary if circumstances have changed. If good cause no longer exists, the requirement to cooperate must be enforced.

12-004 SANCTION FOR REFUSAL TO COOPERATE: If the client fails or refuses to cooperate and there is no good cause shown, the appropriate sanction must be applied. If the reason for noncooperation is the client's failure or refusal to provide information about or obtain third-party resources, the client is ineligible. Eligibility of dependent child(ren) is not affected. Ineligibility continues for the client until s/he cooperates or cooperation is no longer an issue.

12-004.01 Pregnant Women and Noncooperation: If a pregnant woman refuses to cooperate in obtaining third-party resources and there is no good cause claim or determination, the appropriate sanction is applied.

12-005 THIRD-PARTY RESOURCES RECEIVED DIRECTLY: If a client receives a third-party resource directly and the medical expense for which the third-party resource is intended is payable by Medicaid, the payment is considered unearned income for Non-MAGI based categories unless reimbursed by the client. If the third-party resource exceeds Medicaid rates, the excess is considered unearned income for Non-MAGI based categories unless paid out on other medical services or supplies. Regardless of the existence of a good cause claim, any third-party resource received directly by the client must be reimbursed. See Appendix 477-000-01

12-006 RECOUPMENT OF THIRD-PARTY RESOURCES:

1. In order to claim reimbursement for benefits paid by Medicaid that should have been paid by a third-party resource, the Department must send a letter informing the client that s/he must reimburse the Department or the provider. The client is allowed ten (10) days from the date of notification to reimburse the medical payment. For an applicant, the Department must not delay determination of eligibility pending the applicant's reimbursement. At the time the application is approved, the client must be notified of the number of days left in which to reimburse the payment;

2. If the client tenders the third-Party Resource within the ten (10) days, no further action is taken; or
3. If the client fails or refuses to refund the third-party resource within the ten (10) days, the entire amount is considered unearned income in the first month possible, taking into account adequate and timely notice. Any balance remaining is considered a resource in the following month.

12-007 WILLFULLY WITHHELD INFORMATION: When evidence reasonably establishes a client willfully withheld information regarding a third-party resource that resulted in an overpayment of Medicaid expenditures, the case must be referred to the Special Investigation Unit (SIU).

Once a case has been referred to SIU, no further action shall be taken with regard to the prosecution of the suspected fraud, except in accordance with instructions or approval by SIU. However, normal case actions must be completed, which include applying the appropriate sanction.

12-008 TERMINATION OF ASSIGNMENT: When a client is removed from the household, the assignment provision is terminated. The client's rights to any further third-party resources are automatically restored effective with the date of ineligibility. However, the assignment remains in effect for the time period during which the client was receiving Medicaid.

12-009 HEALTH INSURANCE

12-009.01 Cooperation in Obtaining Health Insurance: A client shall enroll in an available health plan if the Department has determined that it is cost effective and the client is able to enroll on his/her own behalf. In those circumstances, the Department pays the premiums, deductibles, coinsurance, and other cost-sharing obligations for this insurance. See Appendix 477-000-016.

12-010 COOPERATION WITH CHILD SUPPORT ENFORCEMENT (CSE) UNIT: Child Support Enforcement Services are provided to a child eighteen (18) years old or younger who has a noncustodial parent(s). See Appendix 477-000-005.

CSE services are not provided for

1. An unborn child;
2. A child who is receiving Home and Community-Based Services in the home of both parents; or
3. An emancipated minor.

12-011 DUTIES OF THE CLIENT: The parent/needy caretaker relative, relative payee, guardian, conservator, or the minor parent of the child for whom aid is claimed is required to cooperate with CSE (unless good cause for refusing to do so is shown).

12-012 OPPORTUNITY TO CLAIM GOOD CAUSE

12-012.01 Notification of Right: The client must be notified at the time of application and whenever cooperation becomes an issue of the right to claim good cause as an exception to the cooperation requirement. The client must be given

1. A verbal explanation of good cause, and
2. The opportunity to ask questions.

12-012.02 Good Cause Claimed: If the client claims good cause is present, the Department must

1. Have the client provide the name and address of the noncustodial parent and forward this information to the CSE Unit;
2. Have the client provide child/spousal support information and forward this information to the CSE Unit; and
3. Notify the Title IV-D unit that a good cause claim is pending when the CSE referral is made.

12-012.03 Delay Pending Determination: The Department may not deny, delay, or discontinue Medicaid pending a determination of good cause as an exception to the cooperation requirement if the client has complied with the requirements of providing acceptable evidence or other necessary information.

12-013 SANCTIONS FOR REFUSAL TO COOPERATE: Upon receiving notification from the CSE Unit that an individual refused to cooperate, the individual is no longer eligible for Medicaid. The sanctioned individual remains in the household as financially responsible.

12-013.01 Exceptions for Sanctions for Refusal to Cooperate:

1. If an individual is age 18 or younger, Medicaid cannot be closed until the end of his/her initial six months of continuous eligibility.
2. If a minor parent is in the household of his/her active Medicaid parent(s), the minor's parent is responsible for cooperating in obtaining support for the minor's child. The minor’s active Medicaid parent(s) is sanctioned if s/he or the minor does not cooperate.
3. No sanction is imposed for non-cooperation of a pregnant woman.
4. No sanction is imposed if at the time non-cooperation began, a child was not in the household of the active Medicaid parent(s).

12-014 OTHER RELATED ELIGIBILITY REQUIREMENTS

12-014.01 Receipt of Other Assistance: An individual who receives Medicaid may not at the same time receive a payment of another type of categorical assistance administered by the Department. This does not preclude a Medicaid client from being the payee for a grant made on behalf of a child in the individual's care. Assistance from a source other than the Department may be used to supplement but not duplicate assistance for a particular need.

CHAPTER 12-000 THIRD PARTY LIABILITY AND CHILD SUPPORT ENFORCEMENT

12-001 ASSIGNMENT (GENERAL): As a condition of receiving Medicaid, a recipient of services must assign his/her right to any medical support to the state, to reimburse the state for assistance dollars expended. Application for and acceptance of assistance constitutes an assignment by operation of law.

12-002 THIRD PARTY MEDICAL PAYMENTS

12-002.01 Third Party Medical Payments: The application for assistance constitutes an automatic assignment to the Department of the client's rights to third party medical payments. This assignment includes the rights of the client as well as the rights of any other member of the unit for whom the client may legally make an assignment. As a requirement for assistance the client must cooperate (unless s/he has good cause for noncooperation) in securing any third party medical payments. This includes payments from:

1. The client's own medical coverage for any member of the unit, e.g., the client's health insurance; and
2. An individual not in the unit who has medical coverage for any member of the unit, e.g., health insurance of an absent parent or another individual which covers a child in the unit.

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

For Medicaid cases with a Share of Cost, the assignment becomes effective the first day of the month when the case status changes to 450, "Share of Cost Met."

Note: No sanction is taken if a client who is receiving Transitional Medical Assistance does not cooperate in obtaining third party medical payments.

For third party payments received directly see Appendix 477-000-015.

12-002.02 Third Party Payments Not Assigned: The following third party payments are not subject to the automatic assignment provision:

3. Medicare benefits; and
4. Payments from income-producing policies which subsidize the client's income while s/he is hospitalized or receiving care, regardless of the type of medical service being provided.

12-002.03 Cooperation in Obtaining Third Party Payments: As a condition of eligibility for medical assistance, the client must cooperate in obtaining third party payments unless s/he has good cause for noncooperation. Cooperation includes any or all of the following:

7. Providing complete information regarding the extent of third party coverage which s/he or any other unit member has or may have. This includes coverage provided by a person not in the unit or by an agency;
8. Providing any additional information or signing claim forms which may be necessary for identification and collection of potential third party payments;
9. Appearing as a witness in a court or another proceeding, if necessary;
10. Notifying the Department of any action s/he is initiating to recover money from a liable third party for medical care or services. This includes the identity of the third party as well as the entire amount of any settlement, court award, or judgment;
11. Reimbursing the Department or paying to the provider any payments received directly from a third party for any services payable by Medicaid; and
12. Taking any other reasonable steps to secure medical support payments.

12-002.04 Refusal to Cooperate: Noncooperation by the client is determined based on the client's failure or refusal to fulfill the requirements listed (see 477 NAC 12-002.03).

12-003 OPPORTUNITY TO CLAIM GOOD CAUSE

12-003.01 Notification of Right: The client must be notified of the right to claim good cause for noncooperation at intake, renewal, and whenever cooperation becomes an issue. The client must be given a verbal explanation of good cause and the opportunity to ask questions. A written explanation of good cause is included in the Application for Assistance.

12-003.02 Department Responsibilities if Good Cause Claimed: If the client claims good cause:

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

12-003.03 Acceptable Circumstances for Good Cause: Good cause claims must be substantiated by signed statements. When documentary evidence is not available the client shall furnish sufficient information as to the location of the information. To establish good cause, the evidence must show that cooperation would not be in the best interest of the client or another unit member for whom assignment is sought. Good cause includes the following circumstances, provided proper evidence is obtained.

12-003.04 Physical or Emotional Harm: Good cause exists if the client's cooperation in assigning benefits is reasonably anticipated to result in physical or emotional harm to the client or another unit member. Emotional harm must only be based upon a demonstration of an emotional impairment that substantially reduces the individual's functioning.

12-003.05 Documentary Evidence: Documentary evidence which indicates these circumstances includes:

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

12-003.06 Evidence Not Submitted by Client: When the claim is based on the client's anticipation of physical harm and corroborative evidence is not submitted in support of the claim:

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

12-003.07 Department Considerations: If the determination of good cause is not substantiated by documentary evidence, the following evidence must be considered:

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

12-003.08 Decision on Good Cause: Good cause shall be determined and the client must be notified of the decision on a Notice of Action. If it is determined that good cause does not exist, the client is allowed ten days to respond from the date that the Notice of Action was mailed. If the client does not cooperate, withdraw the application, or request the case closed, a sanction is imposed (for Sanction for Refusal to Cooperate see 477 NAC 12-004).

12-003.09 Delay of Assistance Pending Determination: The agency must not deny, delay, or discontinue assistance pending a determination of good cause if the client has complied with the requirements of providing acceptable evidence or other necessary information. In most instances, a good cause determination must be made within 30 days following the receipt of a claim.

12-003.10 Review of Good Cause: At the time of each redetermination, a good cause claim must be reviewed based on a circumstance that is subject to change. If circumstances remain the same, no action is required. A new determination is necessary if circumstances have changed. If good cause no longer exists, the requirement to cooperate must be enforced.

12-004 SANCTION FOR REFUSAL TO COOPERATE: If the client fails or refuses to cooperate and there is no good cause claim or determination, the appropriate sanction is applied. If the reason for noncooperation is the client's failure or refusal to provide information about or obtain third party medical payments (for Third Party Medical Payments see 477 NAC 12-002), the client is ineligible for Medicaid. Eligibility of the dependent child(ren) is not affected. Ineligibility continues for the client until s/he cooperates or cooperation is no longer an issue.

12-005 CHILDREN'S ELIGIBILITY IF PARENT DOES NOT COOPERATE: If a parent who is applying for medical assistance for his/her child(ren) fails or refuses to cooperate with TPL, eligibility of the child(ren) is not affected.

12-006 THIRD PARTY PAYMENTS RECEIVED DIRECTLY: If the client receives a third party medical payment directly and the medical expense for which the third party medical payment is intended is payable by Medicaid, the payment is considered unearned income for non-MAGI based categories unless reimbursed by the client. If the insurance payment exceeds Medicaid rates, the excess is considered unearned income for non-MAGI based categories unless paid out on other medical services or supplies. Regardless of the existence of a good cause claim, any third party medical payment that is received directly by the client must be reimbursed.

12-007 RECOUPMENT OF THIRD PARTY MEDICAL PAYMENTS:

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

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

12-008 WILLFULLY WITHHELD INFORMATION: When the evidence clearly establishes that a client willfully withheld information regarding a third party medical payment which resulted in an overpayment of Medicaid expenditures, the case must be referred to the Special Investigation Unit.

Once a case has been referred to the Special Investigation Unit, no action shall be taken with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, normal case actions must be completed which include applying the appropriate sanction in this section.

12-009 TERMINATION OF ASSIGNMENT: When a client is removed from the medical unit, the assignment provision is terminated. The client’s rights to any further third party and medical support payments are automatically restored effective with the date of ineligibility. However, the assignment remains in effect for the time period during which the client was on medical assistance.

12-010 HEALTH INSURANCE

12-010.01 Cooperation in Obtaining Health Insurance: A client has the option to enroll in an available health plan if the Department has determined that it is cost effective and the client is able to enroll on his/her own behalf. The Department then pays the premiums, deductibles, coinsurance, and other cost sharing obligations. See Appendix 477-000-016.

12-011 COOPERATION WITH CHILD SUPPORT ENFORCEMENT UNIT (CSEU): Child Support Enforcement Services are provided to a child age 18 or younger who has a noncustodial parent(s). See Appendix 477-000-005.

Exceptions: CSE services are not provided for:

4. An unborn child;
5. A child who is receiving Home and Community Based Services in the home of both parents; or
6. An emancipated minor.

12-012 DUTIES OF THE CLIENT: The parent/needy caretaker relative, relative payee, guardian, conservator, or the minor parent of the child for whom aid is claimed is required to cooperate with Child Support Enforcement (unless good cause for refusing to do so is determined).

12-013 OPPORTUNITY TO CLAIM GOOD CAUSE

12-013.01 Notification of Right: The client must be notified at intake and whenever cooperation becomes an issue of the right to claim good cause as an exception to the cooperation requirement. The client must be given:

3. A verbal explanation of good cause for child/spousal support and third party medical support; and
4. The opportunity to ask questions.

12-013.02 Good Cause Claimed: If the client claims good cause, the Department must:

4. Explain that the client has the burden of establishing the existence of a good cause circumstance;
5. Have the client make a signed statement listing the reason(s) for claiming good cause on Form IM-5. The client has 20 days to present evidence of this claim;
6. Have the client provide the name and address of the noncustodial parent and forward this information to the Child Support Enforcement Unit;
7. Have the client provide child/spousal support information and forward this information to the Child Support Enforcement Unit; and
8. Notify the IV-D unit that a good cause claim is pending when the CSE referral is made.

12-013.03 Delay of Assistance Pending Determination: The agency may not deny, delay, or discontinue assistance pending a determination of good cause as an exception to the cooperation requirement if the client has complied with the requirements of providing acceptable evidence or other necessary information.

In most instances, a good cause determination must be made within 30 days following the receipt of a claim.

12-014 SANCTIONS FOR REFUSAL TO COOPERATE: Upon receiving notification from Child Support Enforcement that the individual refused to cooperate, the individual's needs must be removed from the medical unit.

Note: If the individual is age 18 or younger, medical assistance cannot be closed until the end of his/her initial six months of continuous eligibility. If the minor parent is in the unit of his/her parent, the minor's parent is responsible for cooperating in obtaining support for the minor's child. The payee is sanctioned if s/he or the minor does not cooperate. There is no sanction for non-cooperation of a relative payee or guardian or conservator payee or pregnant women.

12-015 OTHER RELATED ELIGIBILITY REQUIREMENTS

12-015.01 Sanction for Non-cooperation with Quality Control: A client (or an individual applying on behalf of the client) must cooperate with state and federal quality control as a condition of eligibility. If a client fails to cooperate, the whole unit is ineligible for one month only.

Note: This requirement does not apply to a child who is receiving a year of medical eligibility following birth or a child, including a 599 CHIP unborn, in six months continuous eligibility.

12-015.02 Receipt of Other Assistance: An individual who receives Medicaid may not at the same time receive a payment of another type of categorical assistance administered by the Department. This does not preclude a Medicaid client from being the payee for a grant made on behalf of a child in the individual’s care. Assistance from a source other than the Department may be used to supplement but not duplicate assistance for a particular need.

CHAPTER 13-000 MEDICAID BENEFITS PROVIDED IN ERROR

13-001 MEDICAID BENEFITS PROVIDED IN ERROR: If a client has received Medicaid benefits through misrepresentation or fraud, including because of erroneously reported income, changes in income, or changes in private health insurance premiums, the client is required to repay those benefits.

13-001.01 Fraud or Abuse: If there is reason to believe that a client has defrauded or abused the Medicaid program, the Department shall refer the case to the Special Investigation Unit (SIU) to conduct a full investigation of the claim. Once a case has been referred to SIU, no additional action shall be taken with regard to the prosecution of the suspected fraud, except in accordance with instructions or approval by SIU.

13-001.02 Repayment of Medicaid Benefits Provided in Error: A client who has received Medicaid benefits for which s/he was not eligible due to an error by the Department may choose to make restitution to the Department.

CHAPTER 13-000 MEDICAID BENEFITS PROVIDED IN ERROR

13-001 REPAYMENT OF MEDICAID BENEFITS PROVIDED IN ERROR: When an error has occurred in the amount of Medicaid benefits received by the client because of erroneously reported income or changes in income and/or private health insurance premiums (not Medicare), Form IM-64 shall be sent to the client requesting voluntary repayment in the following situations:

1. The client failed to report a change timely and the amount of benefits in error is $76 or more;
2. The client reported a change timely but the Department failed to take action in the first month possible and the amount of benefits in error is $251 or more; or
3. The client failed to report a change timely, the Department failed to take action in the first month possible, and the amount of benefits in error is $251 or more.

In determining if there was an error in Medicaid benefits and the period for which repayment should be requested, it must be noted that the client is allowed ten days to report a change and must be given a ten-day notice of an adverse action.

When repayment is requested, voluntary restitution should be attempted from the client effective with the first month that the budget should have been correctly adjusted.

Note: In cases of suspected fraud, the case shall be referred via Form ASD-63 to the Special Investigation Unit. Once a case has been referred to the Special Investigation Unit, no action shall be taken with regard to the prosecution of the suspected fraud except in accordance with instructions or approval by the Special Investigation Unit. However, normal case actions shall be completed, including closing a case that is found to be ineligible and recovering benefits received in error.

13-001.01 Amount of Benefits in Error: The amount of benefits in error for a client who was Medicaid eligible, but should have been Medicaid with a Share of Cost, or who was Medicaid with a Share of Cost but who should have had a larger Share of Cost, is the smaller of:

1. The amount of Medicaid services received for that month; or
2. The amount of Share of Cost in error.

Chapters 477 NAC 14 through 19 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD/Children and Young Adults Eligible for Non-IV-E Assistance, Pregnant Women, 599 CHIP, Former Wards, and Hospital Presumptive.

CHAPTER 14-000 DEFINITIONS PERTAINING TO MAGI-BASED PROGRAMS

599 CHIP: Health care coverage for eligible unborn children of pregnant women and pregnant minors who are otherwise eligible for Medicaid.

Advanced Payments of the Premium Tax Credits (APTC): A payment of the tax credits that are provided on an advance basis to an eligible individual enrolled in a qualified health plan (QHP) through an Exchange.

Children's Health Insurance Program (CHIP): Health care coverage for eligible children eighteen (18) years old and younger who are without other health insurance and who do not otherwise qualify for Medicaid.

Family Size Using Modified Adjusted Gross Income (MAGI)-Based Methodology: The number of persons counted as members of an applicant's/client's household. When determining the family size of other individuals who have a pregnant woman in their household, the family size is counted as the pregnant woman plus the number of children she is expected to deliver.

Household Size Using MAGI-Based Methodology: The group of individuals who will be included to determine family size for a particular applicant and whose income may be counted toward the applicant's total household income for purposes of determining his/her eligibility for Medicaid or CHIP.

Household Income Using MAGI-Based Methodology: The sum of an applicant's/client's MAGI and the MAGI of tax dependents in the family, if required to file a tax return.

Insurance Affordability Program: A program that is one of the following:

1. Medicaid, including CHIP or a state basic health program;
2. Coverage in a qualified health plan (QHP) through the Exchange; or
3. Advanced Payments of the Premium Tax Credit (APTC) and Cost Sharing Reductions (CSR).

Modified Adjusted Gross Income (MAGI): The methodology used to determine financial eligibility.

Non-Filer: Individuals who do not expect to file a tax return and do not expect to be claimed as a tax dependent for the taxable year.

Tax Dependent: An individual for whom another individual claims a deduction for a personal exemption for a taxable year.

Tax Filer: An individual who intends to file a federal tax return for the coverage year and who is not claimed as a tax dependent by another taxpayer for that tax year.

Chapters 477 NAC 14 through 19 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD/Children and Young Adults Eligible for Non-IV-E Assistance, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 15-000 HOUSEHOLD OR UNIT SIZE FOR MAGI-BASED PROGRAMS

15-001 HOUSEHOLD SIZE FOR A TAX FILER: The individual who expects to file a tax return plus all persons whom the individual expects to claim as a tax dependent. See Appendix 477-000-006 on how to construct a Medicaid household.

If an individual does not intend to file an income tax return and do not expect to be claimed as a dependent for the tax year, non-filer rules apply. If the tax filer cannot reasonably establish that another individual is a tax dependent of the tax filer for the tax year in which Medicaid is sought, the inclusion of the individual in the household of the tax filer is determined by using non-filer rules.

15-002 MARRIED COUPLES: In the case of married couples living together or filing jointly, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

15-003 INDIVIDUAL CLAIMED AS A TAX DEPENDENT: In the case of an individual who expects to be claimed as a tax dependent by a tax filer for the taxable year of an eligibility determination, the household is the household of the tax filer claiming the individual as a tax dependent, except when

1. The individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or step parent;
2. The individual is under nineteen (19) years old, expects to be claimed by one (1) parent as a tax dependent, and is living with both parents, but the parents are not expected to file a joint return.
3. The individual is under nineteen (19) years old and expects to be claimed as a tax dependent by a non-custodial parent.
   a. To be considered a non-custodial parent, a court order, binding separation, divorce, or custody agreement establishing custody must exist.
   b. If no court order exists, or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.
   c. In the event of a joint custody arrangement, the child's household includes the individuals listed at 477 NAC 15-005 that reside in either household.

If a tax dependent meets an exception, see Household Size for a Non-Tax Filer at 477 NAC 15-005.

15-004 CHILDREN WHO EXPECT TO FILE BUT DO NOT EXPECT TO BE CLAIMED: When a child under nineteen (19) years old resides with his/her parent(s) and expects to file a tax return, but does not expect to be claimed as a tax dependent by his/her parents(s), non-filer rules shall be applied when constructing the child's household size.

15-005 HOUSEHOLD SIZE FOR A NON-TAX FILER: The individual and, if living with the individual,

1. The individual's spouse;
2. The individual's natural, adopted, and step children under nineteen (19) years old; and
3. In the case of individuals under nineteen (19) years old, the individual's natural, adopted, and step parents, and natural, adoptive, and step siblings under nineteen (19) years.

15-006 FAMILY SIZE USING MODIFIED ADJUSTED GROSS INCOME METHODOLOGY (MAGI): The number of persons counted as members of an applicant's/client's household. When determining the family size of other individuals who have a pregnant woman in their household, the family size is counted as the pregnant woman plus the number of children she is expected to deliver.

15-007 REASONABLY PREDICTABLE CHANGE IN FAMILY SIZE: See 477 NAC 16-001.03.

Note: Chapters 477 NAC 14 through 18 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 14-000 HOUSEHOLD OR UNIT SIZE

14-001 HOUSEHOLD SIZE FOR A TAX FILER: The individual expected to file a tax return plus all persons whom the individual expects to claim as a tax dependent. See Appendix 477-000-006 on how to construct a Medicaid household.

Note: If an individual does not intend to file an income tax return or intend to be claimed as a dependent, non-filer rules apply. If the tax payer cannot reasonably establish that another individual is a tax dependent of the taxpayer for the tax year in which Medicaid is sought, the inclusion of such individual in the household of the tax payer is determined by using non-filer rules.

14-002 MARRIED COUPLES: In the case of married couples living together or filing jointly, each spouse will be included in the household of the other spouse, regardless of whether they expect to file a joint tax return or whether one spouse expects to be claimed as a tax dependent by the other spouse.

14-003 INDIVIDUAL CLAIMED AS A TAX DEPENDENT: In the case of an individual who expects to be claimed as a tax dependent by a tax filer for the taxable year of an eligibility determination, the household is the household of the tax filer claiming such individual as a tax dependent, except when:

4. The individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or step parent;
5. The individual under the age 19, a full time student in secondary school and will graduate before age 19, who expects to be claimed by one parent as a tax dependent and are living with both parents, but the parents are not expected to file a joint return.
6. Individuals under age 19, a full time student in secondary school and will graduate before age 19, who expect to be claimed as a tax dependent by a non-custodial parent.
    a. To be considered a non-custodial parent, a court order, binding separation, divorce or custody agreement establishing custody must exist.
    b. If no such order exists, or in the event of a shared custody agreement the custodial parent is the parent with whom the child spends most nights.

Note: If a tax dependent meets an exception see household size for a non-tax filer at 477 NAC 14-004.

14-004 HOUSEHOLD SIZE FOR A NON-TAX FILER: The individual and, if living with the individual:

4. The individual's spouse,
5. The individual's natural, adopted and step children under age 19.
6. In the case of individual's under age 19, the individual's natural, adopted and step parents and natural, adoptive and step siblings under age 19.

14-005 FAMILY SIZE USING MODIFIED ADJUSTED GROSS INCOME METHODOLOGY (MAGI): Means the number of persons counted as members of an individual's household. When determining the family size of other individuals, who have a pregnant woman in their household, the family size is counted as the pregnant woman plus the number of children she is expected to deliver.

Chapters 477 NAC 14 through 19 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD/Children and Young Adults Eligible for Non-IV-E Assistance, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 16-000 INCOME FOR MAGI-BASED PROGRAMS

16-001.01 MAGI Income: The sum of MAGI-based income for each member of the applicant's/client's household, with the following exceptions (for examples, see Appendix 477-000-006 and 477-000-011):

1. Income of an individual who is included in the household of his/her natural, adopted, or step parent and is not expected to file a tax return for the taxable year in which eligibility for Medicaid is being determined is not included in household income whether or not the individual files a tax return.
2. Income of a tax dependent, other than a spouse or biological, adopted, or step-child, who expects to be claimed as a tax dependent by another taxpayer included in the household and is not expected to file a tax return is not included.
3. Cash support provided by a tax filer to a claimed tax dependent, other than a spouse or biological/adopted/step-child, is not included.

16-001.01A Income Counted for Children Who Expect to File but Who Do Not Expect to Be Claimed: When a child under nineteen (19) years old resides with his/her parent(s) and expects to file a tax return but does not expect to be claimed as a tax dependent by his/her parents(s), non-filer rules shall be applied when constructing the child's household size. The income of the child's parents and siblings living with him/her counts in the child's budget.

16-001.01B Excluded Income for MAGI:

1. Income exclusions that are allowed under the Internal Revenue Code (see Appendix 477-000-008 for allowable deductions);
2. An amount received as a lump sum is counted only in the month received;
3. Scholarships, awards, or fellowship grants used for education, but not living expenses;
4. Child support;
5. Veterans benefits (this does not include military retirement);
6. Workers' Compensation; and
7. Other excluded income, see Appendix 477-000-007.

16-001.01C Excluded Income for Native American/Alaskan Native applicant/client:

1. Distributions from Alaska Native Corporations and Settlement Trusts;
2. Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;
3. Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from
   a. Rights of ownership or possession in any lands from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior; or
   b. Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

4. Distributions resulting from real property ownership interests and related to natural resources and improvements

   a. Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or
   b. Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

5. Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom; and
6. Student financial assistance provided under the Bureau of Indian Affairs education programs.

16-001.02 Monthly Income: Current monthly household income and family size shall be used for individuals who have been determined financially eligible for Medicaid. For family size see 477 NAC 15-000.

16-001.03 Reasonably Predictable Change in Future Income and Family Size: In determining current monthly or projected annual household income and family size, the Department shall include a prorated portion of reasonably predictable future income, to account for a reasonably predictable increase or decrease in future income, or both, as evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indicia of such future changes in income or family size.

16-001.04 Five Percent Federal Poverty Level Disregard: A disregard of five percent (5%) of the Federal Poverty Level (FPL) shall be applied when determining eligibility of an individual for medical assistance under the eligibility group with the highest income standard under which the individual may be determined eligible using MAGI-based methodologies.

16-001.05 Reasonably Compatible Regarding Income: Information obtained through an electronic data match must be considered reasonably compatible with income information provided by or on behalf of an individual if both are either above, at, or below the applicable income standard. See Verification Plan at Appendix 477-000-004 for the applicable income standard.

16-001.06 Reasonable Explanation: If information obtained from an electronic data source is not reasonably compatible with an applicant's/client's self-attestation, the applicant/client shall be asked for a reasonable explanation. See Verification Plan at Appendix 477-000-004.

16-001.07 Earned Income: Earned income is money received from wages, tips, salary, commissions, and profits from activities in which an individual is engaged as a self-employed person or as an employee. See Appendix 477-000-007 for income chart regarding taxable income.

16-001.07A Contractual Income:

1. Income paid on a contractual basis is prorated over the number of months covered under the contract, even if the client is paid in fewer months than the contract covers.
2. Income received intermittently is prorated over the period it is intended to cover if the income is expected to continue.

16-001.07B Disregards for Self-Employment: All operating expenses related to producing goods or services and without which such goods or services could not be produced are deducted from gross income.

16-001.07C Operating Expenses – Farm Income: All expenses related to farm income are considered operating expenses and are allowable deductions.

16-001.08 Unearned Income: Unearned income is any cash benefit that is not the direct result of labor or services performed by the individual as an employee or a self-employed person. See income chart at Appendix 477-000-007.

16-001.08A Spousal Support: Spousal support (alimony) received is considered unearned income. See Appendix 477-000-006 for budgeting.

16-001.08B Delay in Counting RSDI Increase: After the annual Retirement, Survivors, and Disability Insurance (RSDI) cost of living adjustment (COLA), if a client would go from Medicaid only status to Medicaid excess because his/her income exceeds the Federal Poverty Level, the current RSDI amount shall be used. The month after the month that the new FPL figures are published, the client's eligibility shall be determined by comparing the increased RSDI benefit to the new FPL guidelines. The delayed COLA provision applies only if the RSDI increase would cause the client to have excess income. If there is an increase in other unearned income or the client begins receiving other unearned income in the same month as the COLA in RSDI benefits, the delayed COLA provisions do not apply.

16-001.08C Intercepted, Withheld or Garnished Income: If a client's wages or unearned income is being garnished or intercepted, the gross amount of income before garnishment shall be counted.

16-001.09 Deeming Income for Sponsors of Aliens

16-001.09A Sponsors for Aliens: One hundred percent (100%) of the income of a sponsor (and sponsor's spouse, if living with the sponsor) shall be considered when determining the eligibility of an alien who applies for Medicaid if the sponsor has signed an affidavit of support under Section 213A of the Immigration and Nationality Act. The sponsor's income will be considered available to the alien until one or more of the following circumstances apply:

1. The individual becomes a U.S. citizen;
2. The individuals has worked forty (40) qualifying quarters of coverage as defined under Title II of the Social Security Act, or can be credited with the qualifying quarters as provided under Section 435 and the alien did not receive any federal means tested public benefit during that time period. This provision does not apply to restricted medical assistance;
3. The individual is pregnant (including 60 days post-partum); or
4. The individual is under age 19.

16-001.09B Sponsor of More than One Alien: When an individual is a sponsor for two or more aliens who are living in the same home, the amount of deemed income of the sponsor (and the sponsor's spouse, if living with the sponsor) is divided equally among the aliens. When an individual sponsors several aliens but not all apply for Medicaid, the sponsor's total deemable income is applied to the needs of the aliens who apply for Medicaid.

16-001.09C Deeming Exception: If a sponsored immigrant demonstrates that s/he or his/her child(ren) have been battered or subjected to extreme cruelty by a spouse, a parent, or by a member of the spouse's or parent's family who is residing in the same household as the alien, deeming may be waived if a judge, an administrative law judge, or the U.S. Citizenship and Immigration Services (USCIS) recognizes the battery or cruelty.

16-001.09D Alien Duties: As an eligibility requirement, an alien is responsible for

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

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

16-001.10 Potential Income: As a condition of Medicaid eligibility, the Department shall require clients to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled.

Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions, Social Security benefits, railroad retirement benefits, and unemployment compensation.

A client and/or any responsible relative, such as a spouse or parent, is required to apply for any non-Medicaid benefits for which s/he appears to be entitled within 60 days of the date the client is notified of the requirement.

A responsible relative shall be referred for any potential benefit, but there is no sanction applied to the child(ren)'s Medicaid case if the responsible relative fails or refuses to apply.

Determination of eligibility shall not be delayed pending determination of entitlement for potential benefits, so long as the client/responsible relative has applied for such benefits within the 60-day timeframe.

16-001.10A Refusal to Apply for Potential Income: A client is expected to apply for and accept non-Medicaid benefits promptly after the client's apparent entitlement to such benefits have been discussed.

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

Income of responsible relatives is still considered in determining the Medicaid eligibility of the client.

16-001.11 Verification of Income: For verification of income see the Verification Plan listed at Appendix 477-00-004. If paper documentation is required, verification of income consists of at least the following:

1. The source of the income,
2. The date paid or received,
3. The period covered by the payment or benefit, and
4. The gross amount of payment or benefit.

16-001.12 If Paper Documentation is Required for Income Verification

16-001.12A Income Verification

16-001.12A1 At Initial Application: One month of current income is used to determine initial eligibility. Income is converted for weekly and bi-weekly income.

Note: Once eligibility has been determined, no verification is required during the continuous eligibility period.

16-001.12A2 At Renewal: Income must be verified every 12 months.

1. Regular income must be verified using one month's income at a minimum.
2. Irregular income must be verified using the three most recent months, if available.

16-001.12B Income Conversion: Income is converted for weekly and bi-weekly income. This figure is used to project Medicaid eligibility unless

1. There was a significant change in the income of the previous three months; or
2. A significant change is anticipated during the projected 12-month period.

16-001.12C Self-Employment and Farming Income: If electronic data sources are not available, the most recent 1040 or bookkeeping records shall be used. See Verification Plan at Appendix 477-000-004 to determine when paper documentation is required.

16-001.13 Terminated Income: When an individual engages in different types of self-employment, it is not considered a termination of income if the individual stops one type of work. See Appendix 477-000-004.

16-001.14 Retroactive Medical Eligibility: To determine retroactive medical eligibility, each month's actual income shall be used unless an electronic data source is available and is reasonably compatible with the individual's attested income.

Note: Chapters 477 NAC 14 through 18 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 15-000 INCOME

15-001.01 MAGI Income: The sum of MAGI-based income for each member of the individual's household, with the following exceptions (for examples, see Appendix 477-000-006 and 477-000-011):

4. Income of an individual, who is included in the household of his/her natural, adopted or step parent and is not expected to file a tax return for the taxable year in which eligibility for Medicaid is being determined, is not included in household income whether or not the individual files a tax return.
5. Income of a tax dependent, other than a spouse or biological, adopted, or step-child, who expect to be claimed as a tax dependent by another taxpayer included in the household and is not expected to file a tax return, is not included.
6. Cash support provided by a tax filer, to a claimed tax dependent, other than a spouse or biological/adopted/step-child, is not included.

15-001.01A Excluded Income for MAGI:

8. Income exclusions that are allowed under the Internal Revenue Code (See Appendix 477-000-008 for allowable deductions);
9. An amount received as a lump sum is counted only in the month received;
10. Scholarships, awards, or fellowship grants used for education, but not living expenses;
11. Child support;
12. Veterans benefits (this does not include military retirement);
13. Workers' Compensation;
14. Other excluded income, see Appendix 477-000-007.

15-001.01B Excluded Income for Native American/Alaskan Native Applicant/Client:

1. Distributions from Alaska Native Corporations and Settlement Trusts;
2. Distributions from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior;
3. Distributions and payments from rents, leases, rights of way, royalties, usage rights, or natural resource extraction and harvest from:

    a. Rights of ownership or possession in any lands from any property held in trust, subject to Federal restrictions, located within the most recent boundaries of a prior Federal reservation, or otherwise under the supervision of the Secretary of the Interior; or
    b. Federally protected rights regarding off-reservation hunting, fishing, gathering, or usage of natural resources;

4. Distributions resulting from real property ownership interests and related to natural resources and improvements:

    a. Located on or near a reservation or within the most recent boundaries of a prior Federal reservation; or
    b. Resulting from the exercise of federally-protected rights relating to such real property ownership interests;

5. Payments resulting from ownership interests in or usage rights to items that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal Law or custom; and
6. Student financial assistance provided under the Bureau of Indian Affairs education programs.

15-001.02 Monthly Income: Current monthly household income and family size shall be used for individuals who have been determined financially eligible for Medicaid. For family size see 477 NAC 14.

15-001.03 Annualized Income: Annualized income shall be used when a predictable increase or decrease of future income is evidenced by a signed contract for employment, a clear history of predictable fluctuations in income, or other clear indication of such future changes in income.

15-001.04 Five Percent Disregard: A five percent disregard shall be applied when determining eligibility of an individual for medical assistance under the eligibility group with the highest income standard under which the individual may be determined eligible using MAGI-based methodologies.

15-001.05 Reasonably Compatible Regarding Income: Information obtained through an electronic data match must be considered reasonably compatible with income information provided by or on behalf of the individual if both are either above, at, or below the applicable income standard. See verification plan at Appendix 477-000-004 for the applicable income standard.

15-001.06 Reasonable Explanation: If information obtained from an electronic data source is not reasonably compatible with the individual's self-attestation, the individual would be asked for a reasonable explanation. See verification plan at Appendix 477-000-004.

15-001.07 Earned Income: Earned income is money received from wages, tips, salary, commissions, and profits from activities in which an individual is engaged as a self-employed person or as an employee. See Appendix 477-000-007 for income chart regarding taxable income.

15-001.07A Contractual Income:

1. Income paid on a contractual basis is prorated over the number of months covered under the contract, even if the client is paid in fewer months than the contract covers.
2. Income received intermittently is prorated over the period it is intended to cover if the income is expected to continue.

15-001.07B Disregards for Self-Employment: All operating expenses related to producing the goods or services and without which the goods or services could not be produced are deducted from gross income.

15-001.07C Operating Expenses – Farm Income: All expenses related to farm income are considered operating expenses and are allowable.

15-001.08 Unearned Income: Unearned income is any cash benefit that is not the direct result of labor or services performed by the individual as an employee or a self-employed person. See income chart at Appendix 477-000-007. For sponsor deeming see 477 NAC 17-006.

15-001.08A Spousal Support: Spousal support received is considered unearned income. See Appendix 477-000-006 for budgeting.

15-001.08B Delay in Counting RSDI Increase: After the annual RSDI cost of living increase, if a client would go from Medicaid only status to Medicaid excess because his/her income exceeds the Federal Poverty Level, the current RSDI amount shall be used. The month after the month that the new FPL figures are published, the client's eligibility shall be determined by comparing the increased RSDI benefit to the new FPL guidelines. The delayed COLA provision applies only if the RSDI increase would cause the client to have excess income. If there is an increase in other unearned income or the client starts receiving other unearned income in the same month as the COLA in RSDI benefits, the delayed COLA provisions do not apply.

15-001.09 Potential Income: Potential income is defined as income based on entitlement or need which is usually determined by an administering agency as a result of an application for benefits by the individual.

The client is required to apply for any benefits for which s/he appears to be entitled within 60 days of the date the client is notified of the requirement.

The responsible relative shall be referred for any potential benefit, but there is no sanction to the child(ren) Medicaid case if the responsible relative fails or refuses to apply.

Determination of eligibility for assistance and authorization of payment pending determination of entitlement for benefits shall not be delayed.

15-001.10 Refusal to Apply: A client is expected to make application for and accept benefits promptly after the client's apparent entitlement to the benefits have been discussed.

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

Income of responsible relatives is still considered in determining the eligibility of the client.

15-001.11 Intercepted, Withheld or Garnished Income: If the client's wages or unearned income is being garnished or intercepted, the gross amount of income before garnishment shall be counted.

15-001.12 Verification of Income: For verification of income see the Verification Plan listed at 477-00-004. If paper documentation is required, verification of income consists of at least the following:

5. The source of the income;
6. The date paid or received;
7. The period covered by the payment or benefit; and
8. The gross amount of payment or benefit.

15-001.13 If Paper Documentation is Required for Income Verification

15-001.13A Income Verification

15-001.13A1 At Initial Application: One month of current income is used to determine initial eligibility. Income is converted for weekly and bi-weekly income.

Note: Once eligibility has been determined, no verification is required during the continuous eligibility period.

15-001.13A2 At Renewal: Income must be verified every 12 months.

1. Regular income must be verified using one month's income at a minimum.
2. Irregular income must be verified using the three most recent months, if available.

15-001.13B Income Conversion: Income is converted for weekly and bi-weekly income. This figure is used to project medical eligibility unless:

1. There was a significant change in the income of the previous three months; or
2. A significant change is anticipated during the projected 12-month period.

15-001.13C Self-Employment and Farming Income: If electronic data sources are not available, the most recent 1040 or bookkeeping records shall be used. See verification plan at Appendix 477-000-004 to determine when paper documentation is required.

15-001.14 Changes: The client must report the following changes:

1. Change in unit composition, such as the addition or loss of a unit member;
2. Changes in residence;
3. New employment;
4. Termination of employment;
5. Changes in the amount of monthly income, including:
    a. All changes in unearned income; and
    b. Changes in the source of employment, in the wage rate and in employment status, i.e., part-time to full-time or full-time to part-time. For reporting purposes, 30 hours per week is considered full-time. The client must report new employment within ten days of receipt of the first paycheck, and a change in wage rate or hours within ten days of the change; and
6. Changes in allowable tax deductions. See appendix 477-000-008.

15-001.15 Terminated Income: When an individual engages in different types of self-employment, it is not considered a termination of income if the individual stops one type of work.

15-001.16 Retroactive Medical Eligibility: To determine retroactive medical eligibility, each month's actual income shall be used unless an electronic data source is available and is reasonably compatible with the individual's attested income.

Chapters 477 NAC 14 through 19 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD/Children and Young Adults Eligible for Non-IV-E Assistance, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 17-000 RESOURCES FOR MAGI-BASED PROGRAMS

17-001 RESOURCES USING MAGI-BASED METHODOLOGY: In the case of applicants/clients whose financial eligibility for Medicaid is determined using MAGI-based methodologies, the Department shall not apply any asset or resource test.

Note: Chapters 477 NAC 14 through 18 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 16-000 RESOURCES

16-001 RESOURCES USING MAGI-BASED METHODOLOGY: In the case of individuals whose financial eligibility for Medicaid is determined using MAGI-based methodologies, the agency shall not apply any assets or resource test.

Chapters 477 NAC 14 through 19 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD/Children and Young Adults Eligible for Non-IV-E Assistance, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 18-000 RELATIVE RESPONSIBILITY FOR MAGI-BASED PROGRAMS

18-001 RELATIVE RESPONSIBILITY:

1. Spouse for spouse; and
2. Parent (biological, adoptive, or step) for child if the child is eighteen (18) years old or younger and still considered part of the household.

18-001.01 Child Considered Part of Household

1. If a child is living in the same household with his/her parent(s), the parent(s)' income must be included.
2. If a child is temporarily absent from the home (generally ninety (90) days or fewer) but is still considered part of the household, the parent(s)' income must be included. Temporary absence includes, but is not limited to:
   a. School attendance where the child returns to the home on a regular basis (weekends, vacations, or summers); or
   b. Residence in an institution for a developmental disability or mental illness for 90 days or fewer may be considered temporary absence if the child was living in the parent(s)' household before institutionalization and will return to the parent(s)' household upon discharge.

18-001.02 If a child is permanently out of the home and no longer considered part of the household, the parent(s)' income must not be included. If income is deemed from a parent to a child in an IMD, see 477 NAC 19-003.02A.

18-002 FINANCIAL RESPONSIBILITY

18-002.01 Unmarried Parents: When unmarried parents are living together, the alleged father is not financially responsible unless he has acknowledged paternity or a court has determined that he is the father of the child after the birth.

18-002.02 Children of a Marriage: Married individuals are considered the parents of any children who are conceived or born during a marriage, even if the couple is separated, has filed for divorce or annulment, or states that one individual is not the parent of the child, unless there is a court order that states otherwise.

18-003 DETERMINATION OF PATERNITY: Paternity cannot be established unless an alleged father has signed a written and notarized paternity acknowledgment form or a court has determined him to be the father. Note: Paternity cannot be established for an unborn.

18-004 MILITARY SERVICE

18-004.01 If a parent is absent due to active duty in the uniformed services of the United States, that parent is still considered part of the assistance unit and his/her income is considered available to the unit. Uniformed service is defined as the Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Services Administration, and Public Health Service of the United States. If a client states that separation is due to reasons other than performance in military service, the client must provide proof of bona fide separation.

18-004.02 If a parent in the military is incarcerated, s/he is no longer considered part of the assistance unit.

18-005 SPECIAL PROVISIONS PERTAINING TO MINOR PARENTS

18-005.01 Minor Parent: If a minor parent has a legal guardian, according to Nebraska law, the guardian has no financial responsibility for the minor.

18-005.02 Minor's Parent(s) Receiving Medicaid: If a minor parent is living with his/her parent(s) who is receiving Medicaid for another child, the minor parent must be in his/her parent(s)' unit.

Note: Chapters 477 NAC 14 through 18 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 17-000 RELATIVE RESPONSIBILITY FOR NON-FILING HOUSEHOLDS

17-001 RELATIVE RESPONSIBILITY:

3. Spouse for spouse; and
4. Parent (biological, adoptive, or step) for child if the child is age 18 or younger and is still considered part of the household.

17-001.01 Child Considered Part of Household

3. If the child is living in the same household with parent(s), the parent(s)' income must be included.
4. If the child is temporarily absent from the home (generally 90 days or less) but is still considered part of the household, the parent(s)' income must be included. Temporary absence includes, but is not limited to:
   c. School attendance where the child returns to the home on a regular basis (weekends, vacations, or summers).
   d. Residence in an institution for a developmental disability or mental illness for 90 days or less may be considered temporary absence if the child was living in the parent(s)' household before institutionalization and will return to the parent(s)' household upon discharge.

17-001.02 If the child is permanently out of the home and no longer considered part of the household, the parent(s)' income must not be included. If income is deemed from a parent to a child in an IMD, see 477 NAC 18-003.2A.

17-002 FINANCIAL RESPONSIBILITY

17-002.01 Unmarried Parents: When unmarried parents are living together as a family, the alleged father is not financially responsible unless he has acknowledged paternity or a court has determined that he is the father of the child after the birth.

17-002.02 Children of a Marriage: A woman's spouse is considered the father of any children who are conceived or born during a marriage even if the couple is separated and/or has filed for divorce or annulment unless there is a court order that states otherwise. If a woman states that her spouse is not the father of her child, establishment of paternity must be pursued, unless good cause exists.

17-003 DETERMINATION OF PATERNITY: Paternity cannot be established unless an alleged father has signed a written and notarized paternity acknowledgment form or a court has determined him to be the father. Note: Paternity cannot be established for an unborn.

17-004 MILITARY SERVICE

17-004.01 If a parent is absent due to active duty in the uniformed services of the United States, that parent is still considered part of the assistance unit and his/her income is considered available to the unit. Uniformed service is defined as the Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Services Administration, and Public Health Service of the United States. If the client states that separation is due to reasons other than performance in military service, the client must provide proof of bona fide separation.

17-004.02 If the parent in the military is incarcerated, s/he is no longer considered part of the assistance unit.

17-005 SPECIAL PROVISIONS PERTAINING TO MINOR PARENTS

17-005.01 Minor Parent: If a minor parent has a legal guardian, according to Nebraska law the guardian has no financial responsibility for the minor.

17-005.02 Minor's Parent(s) Receiving Medicaid: If a minor parent is living with his/her parent(s) who is receiving Medicaid for another child, the minor parent must be in his/her parent(s)' unit.

17-006 SPONSORS FOR ALIENS

17-006.01 Sponsors for Aliens: 100 percent of the income of a sponsor (and sponsor's spouse, if they are living together) shall be considered when determining the eligibility of an alien who applies for medical assistance if the sponsor has signed an affidavit of support under Section 213A of the Immigration and Nationality Act. The sponsor's income will be considered available to the alien until the alien:

1. Becomes a U.S. citizen;
2. Has worked 40 qualifying quarters of coverage as defined under Title II of the Social Security Act or can be credited with the qualifying quarters as provided under Section 435 and the alien did not receive any federal means tested public benefit during that time period. This provision does not apply to restricted medical assistance;
3. If the individual is pregnant (including 60 day post-partum);
4. If the individual is under age 19.

17-006.02 Sponsor of More than One Alien: When an individual is a sponsor for two or more aliens who are living in the same home, the amount of deemed income of the sponsor (and the sponsor's spouse, if living with the sponsor) is divided equally among the aliens. When an individual sponsors several aliens but not all apply for assistance, the sponsor's total deemable income is applied to the needs of the aliens who apply for assistance. If a sponsored immigrant demonstrates that s/he or his/her child(ren) have been battered or subjected to extreme cruelty by a spouse or a parent or by a member of the spouse's or parent's family who is residing in the same household as the alien, deeming may be waived if a judge, an administrative law judge, or INS recognize the battery or cruelty.

17-006.03 Deeming Exception: If a sponsored immigrant demonstrates that s/he or his/her children have been battered or subjected to extreme cruelty by a spouse or a parent or by a member of the spouse's or parent's family who is residing in the same household as the alien, deeming may be waived if a judge, an administrative judge, or INS recognize the battery or cruelty.

17-007 ALIEN DUTIES: As an eligibility requirement, the alien is responsible for:

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

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

Chapters 477 NAC 14 through 19 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD/Children and Young Adults Eligible for Non-IV-E Assistance, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 19-000 PREGNANT WOMEN, PARENTS/CARETAKER RELATIVES, CHILDREN, 599 CHIP, FORMER WARDS, AND HOSPITAL PRESUMPTIVE

19-001 PREGNANT WOMEN

19-001.01 Pregnant Women: In order to be eligible as a pregnant woman, an individual must have income equal to or less than 194% of the Federal Poverty Level (FPL)

19-001.02 Pregnancy Verification: Verification of pregnancy shall not be required unless information is not reasonably compatible with an applicant or client's attestation.

19-001.03 Presumptive Eligibility: Under Section 1920 of the Social Security Act, Medicaid covers ambulatory prenatal care for pregnant women on the basis of presumptive eligibility. The qualified provider may authorize a period of presumptive eligibility once per pregnancy. Note: There is no presumptive eligibility for 599 CHIP unborns.

19-001.03A Ambulatory Prenatal Care: See 471 NAC 28-001.

19-001.03B Qualified Provider: Only a qualified provider is allowed to make presumptive eligibility determinations. See 471 NAC 28-001.01 for requirements of a qualified provider.

19-001.03C Qualified Provider Responsibilities: A qualified provider makes a presumptive determination of a woman's eligibility based only on declared income and citizenship/eligible alien status.

1. Income of the woman and spouse (if he is in the home) or the responsible parent(s) of a pregnant minor is counted.
2. The provider does not investigate other eligibility requirements.
3. The provider must forward the presumptive eligibility form to the Department within five (5) working days after the determination of presumptive eligibility.

19-001.03D Effective Date: The date a provider determines presumptive eligibility for assistance.

19-001.03E Presumptive Eligibility Period: Presumptive eligibility begins on the day a qualified provider determines that a woman meets any of the income eligibility levels.

If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the presumptive eligibility ends on the day that the Department makes the determination of Medicaid eligibility based on that application.

If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the presumptive eligibility ends on that last day.

A presumptive application approved in error will be closed by the Department upon discovery of the error.

The Department is not required to notify the woman that her presumptive eligibility case has closed, but the Department is required to send a notice when Medicaid eligibility has been determined.

19-001.03F Failure to Meet Categorical Eligibility: If a woman fails to satisfy any of the eligibility criteria for the Pregnant Women's category, other than income, at any time during her presumptive eligibility period, presumptive eligibility must be discontinued regardless of the woman's submission of an application for Medicaid.

19-002 PARENTS/CARETAKER RELATIVES

19-002.01 Parents/Caretaker Relatives: In order to be eligible as a Parent/Caretaker Relative, an individual must

1. Have a dependent child (See 477 NAC 1-000 for the definition of a dependent child), and
2. Have income equal to or less than 58% of the FPL.

19-002.02 Two-Parent Families: If unmarried parents are living together and the father has acknowledged paternity for their child, eligibility must be considered for the family as a unit.

19-003 CHILDREN/CHILDREN IN AN INSTITUTION FOR MENTAL DISEASE (IMD)/CHILDREN ELIGIBLE FOR NON-IV-E ASSISTANCE

19-003.01 Medicaid for Individuals Under Age 19: Children may receive Medicaid if they meet the eligibility requirements outlined in this material.

1. Newborn child(ren): Newborn child(ren) born to Medicaid eligible pregnant women are eligible at the time of birth for one (1) year.
2. Infants under age one: Children under age one (1) are eligible if their household income is equal to or less than 162% of the FPL.

3. Children age one through age five: Children age one (1) year old through age five (5) years old are eligible if their family income is equal to or less than 145% of the FPL.
4. Children age six through age 18: Children age (6) years old through age (18) years old are eligible if their household income is equal to or less than 133% of the FPL.
5. Children's Health Insurance Program (CHIP): Children age eighteen (18) years old or younger who do not meet income limits for Medicaid are eligible for CHIP if their household income is equal to or less than 213% of the FPL and if the children are not covered by creditable health insurance.
6. Minor pregnant women: Minor pregnant women who do not meet the income limits for children's Medicaid are eligible under the Pregnant Women's category if their household income is at or below the applicable FPL. Ongoing Medicaid eligibility must be reviewed prior to the end of the 60-day postpartum period.

19-003.02 Child in an IMD

19-003.02A Individuals Age 19 and 20: Individuals nineteen (19) and twenty (20) years old may be found eligible for services under this category if they are receiving inpatient care in an IMD. If an individual is an inpatient in an IMD when s/he reaches twenty-one (21) years old, s/he may remain eligible for services either until discharge or until s/he reaches twenty-two (22) years old, whichever comes first.

19-003.03 Children Receiving CHIP Who Move to Medicaid Due to the Increased Federal Poverty Levels under the ACA: Children who move from CHIP to Medicaid as a result of increased FPL effective January 1, 2014 shall qualify for CHIP funding for up to one year if the child was CHIP eligible as of December 31, 2013 and continues to meet Medicaid eligibility requirements.

19-003.04 Children Who are State Wards not Eligible for IV-E Assistance: Children who are state wards not eligible for IV-E assistance must complete an application for Medicaid. Eligibility will be determined using MAGI-based methodologies.

19-003.05 Children Eligible for IV-E Assistance: See 477 NAC 28-000.

19-004 599 CHIP

19-004.01 Eligibility Requirements: A pregnant woman, who is not otherwise eligible for Medicaid or CHIP, may have her unborn child(rens)'s eligibility reviewed under 599 CHIP. Eligibility for Medicaid must first be determined before 599 CHIP eligibility can be reviewed. Eligibility is determined for unborn children from conception through birth, if the pregnant woman and spouse's income is equal to or less than 197% of the FPL.

599 CHIP has no requirement for citizenship or alien status, as the unborn(s)'s status is independent of that of the pregnant woman.

There is no eligibility for the unborn(s) if the pregnant woman has creditable health insurance. Health insurance that does not provide prenatal or maternity care is not considered creditable coverage. For a definition of creditable health insurance, see 477 NAC 1-000.

The pregnant woman will not be eligible for post-partum services under 599 CHIP. If post-partum care is needed for complications following labor and delivery, the woman may apply for Emergency Medical Services Assistance (EMSA).

19-004.02 Nebraska Residence: The residency of the unborn(s) will follow the residency of the pregnant woman.

19-004.03 Relative Responsibility: Relative responsibility for 599 CHIP has the following exception:

For a pregnant minor, the income of her financially responsible parent(s) shall not be used in the unborn child(s)'s 599 CHIP budget.

19-004.04 Age Requirement: For receipt of 599 CHIP benefits, an individual is considered an unborn child from conception to birth.

19-004.05 Unborn 599 CHIP Eligibility if Parent(s) Does Not Cooperate: If an ineligible pregnant woman or her spouse fails or refuses to cooperate with third party liability, the unborn(s) is ineligible for 599 CHIP.

19-004.06 Effective Date of Medical Eligibility: The effective date of eligibility for 599 CHIP is no earlier than the first day of the application month.

Note: There is no retroactive eligibility for 599 CHIP.

19-004.07 Continuous Eligibility: Unborn children are continuously eligible up to six (6) months or through their month of birth, whichever comes first. After the six (6) months of continuous eligibility, a full eligibility review is not required. However, information reported or known to the Department must be acted upon.

Note: An unborn must have at least a thirty (30)-day period of ineligibility before s/he would qualify for another six-month period of continuous eligibility.

Following the birth of the child, eligibility will be determined for medical assistance based on any changes reported or known to the Department.

Note: Following the birth, if the newborn is determined eligible for medical assistance, the newborn is eligible for six months of continuous medical eligibility.

19-005 FORMER WARDS

19-005.01 Eligibility Requirements: In order for a ward to be eligible for the former ward program (see 479 NAC 6-000), s/he must

1. Be within age limits;
2. Have been a ward of the Department immediately before entering the program for former wards;
3. Have been in out-of-home care at the time of discharge and continue to be in out-of-home care while in the program;
4. Be single;
5. Be attending or enrolled in a secondary educational program, college, or vocational program and maintaining a passing average;
6. Have income equal to or less than 51% of the FPL; and
7. Enroll in an available health plan.

19-005.02 Age Requirement: A former ward is eligible for Medicaid if s/he is under the age of twenty-one (21) years old.

19-005.03 Living Arrangement: A former ward must continue to be in an out-of-home situation to remain eligible for the program.

19-006 NON-IV-E SUBSIDIZED ADOPTIONS AND GUARDIANSHIPS FOR YOUNG ADULTS

19-006.01 Eligibility Requirements: In order for a young adult to be eligible for Medicaid in this program, s/he must

1. Be at least nineteen (19) years old and under twenty-one (21) years old;
2. Have entered into a subsidized guardianship agreement or a subsidized adoption agreement after reaching sixteen (16) years old;
3. Meet at least one of the following criteria:
    a. The young adult is completing secondary education or in an educational program leading to an equivalent credential;
    b. The young adult is enrolled in an institution that provides postsecondary or vocational education;
    c. The young adult is employed for at least eighty (80) hours per month;
    d. The young adult is participating in a program or activity designed to promote employment or remove barriers to employment; or
    e. The young adult is incapable of doing any part of these activities due to a medical condition, which incapacity must be supported by regularly updated information in the case plan of the young adult; and
4. Have income equal to or less than 23% of the FPL.

19-007 HOSPITAL PRESUMPTIVE ELIGIBILITY: The Department shall provide Medicaid during a presumptive eligibility period to individuals who are determined eligible by a qualified hospital. To be presumptively eligible in accordance with the policies and procedures established by the Department, a presumptive eligibility determination shall be made on the basis of preliminary information indicating the individual has gross income at or below the income standard established for the applicable group, has attested to being a citizen or national of the United States or is in satisfactory immigration status, and is a resident of Nebraska. Determinations are limited to

1. Children (see 477 NAC 19-003);
2. Pregnant women (see 477 NAC 19-001.02);
3. Parents and caretaker relatives (see 477 NAC 19-002);
4. Former foster care children (see 477 NAC 27-007); and
5. Breast and cervical cancer patients (see Women's Cancer Program at 477 NAC 27-004). Hospitals that may determine presumptive eligibility for such patients are limited to those participating in the National Breast and Cervical Cancer Early Detection Program under authority of the Centers of Disease Control and Prevention.

A presumptive eligibility determination is limited to no more than one (1) period within two (2) calendar years per person.

A pregnant woman is eligible for ambulatory care only. A qualified provider may authorize a period of presumptive eligibility once per pregnancy.

Notice and fair hearing regulations do not apply to determinations of presumptive eligibility.

19-007.01 Failure to Meet Categorical Eligibility: If a client fails to satisfy any of the eligibility criteria for a presumptive eligibility Medicaid category, other than income, at any time during the client's presumptive eligibility period, presumptive eligibility must be discontinued regardless of the client's submission of an application.

19-007.02 Responsibilities of Qualified Entities: An entity qualified to make presumptive eligibility determinations shall

1. Notify the appropriate individual at the time a determination regarding presumptive eligibility is made, in writing or orally if appropriate, of such determination, that

    a. If a Medicaid application on behalf of the eligible individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day;
    b. If a Medicaid application on behalf of the eligible individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and
    c. If the individual is not determined presumptively eligible, the qualified entity shall notify the appropriate individual of the reason for the determination and that he or she may file an application for Medicaid with the Department;

2. Provide the individual with a Department approved application for Nebraska Medicaid;
3. Notify the Department that the individual is presumptively eligible within five working days from the date that the determination is made; and
4. Refrain from delegating the authority to determine presumptive eligibility to another entity.

19-007.03 Qualified Hospital Criteria: A hospital qualified to make presumptive eligibility determinations shall

1. Participate as a Medicaid provider;
2. Notify the Department of its decision to make presumptive determinations;
3. Agree to make determinations consistent with state policy and procedures;
4. Assist individuals in completing and submitting full Medicaid applications;
5. Assist individuals in understanding required documentation requirements; and
6. Not be disqualified by the Department.

Note: Chapters 477 NAC 14 through 18 apply to the following: Parents/Caretaker Relatives, Children/Children in an IMD, Pregnant Women, 599 CHIP, Former Wards, Hospital Presumptive

CHAPTER 18-000 PREGNANT WOMEN, PARENTS/CARETAKER RELATIVES, CHILDREN, 599 CHIP, FORMER WARDS, AND HOSPITAL PRESUMPTIVE

18-001 PREGNANT WOMEN

18-001.01 Pregnancy Verification: Verification of pregnancy shall not be required unless information is not reasonably compatible with the applicant or client's attestation.

18-001.02 Presumptive Eligibility (PE): Under Section 1920 of the Social Security Act, Medicaid covers ambulatory prenatal care for pregnant women on the basis of presumptive eligibility. The qualified provider may authorize a period of presumptive eligibility once per pregnancy. Note: There is no presumptive eligibility for 599 CHIP unborn.

18-001.02A Ambulatory Prenatal Care: See 471 NAC 28-001.

18-001.02B Qualified Provider: Only a qualified provider is allowed to make the presumptive eligibility determinations. See 471 NAC 28-001.01 for requirements of a qualified provider.

18-001.02C Qualified Provider Responsibilities: The qualified provider makes a presumptive determination of the woman's eligibility based only on declared income and citizenship/eligible alien status.

4. Income of the woman and spouse (if he is in the home) or the responsible parent(s) of a pregnant minor is counted.
5. The provider does not investigate other eligibility requirements.
6. The provider must forward the application form, along with the attestation form if applicable to the Department within five (5) working days after the determination of presumptive eligibility.

18-001.02D Effective Date: The date the provider determines presumptive eligibility for assistance.

18-001.02E Presumptive Eligibility Period: Presumptive eligibility begins on the day a qualified provider determines that a woman meets any of the income eligibility levels. Eligibility shall be determined within 45 days.

If the woman files an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination of presumptive eligibility, the presumptive eligibility ends on the day that the State agency makes the determination of Medicaid eligibility based on that application.

If the woman does not file an application for Medicaid by the last day of the month following the month in which the qualified provider made the determination, the presumptive eligibility ends on that last day.

A presumptive application approved in error will be closed by the Department upon discovery of the error.

The Department is not required to notify the woman that her PE case has closed, but the Department is required to send a notice when Medicaid eligibility has been determined.

18-002 PARENTS/CARETAKER RELATIVES

18-002.01 Special Provisions for Two Parent Families

18-002.01A Two-Parent Families: If unmarried parents are living together as a family and the father has acknowledged paternity for their child, eligibility must be considered for the family as a unit.

18-002.01B Deprivation Requirements for Two-Parent Families: Two-parent families must meet the following eligibility requirements:

18-002.01B1 Hundred-Hour Rule: Neither medically needy parent can be working more than 100 hours in a calendar month. The parent(s) must not have worked more than 100 hours in any of the three previous calendar months, or if the parent(s) is scheduled to work more than 100 hours for the month of application. Work study is considered employment when determining the 100 hours.

18-002.01B2 Physical or Mental Incapacity of a Parent: A needy child is considered deprived of parental support or care if either parent has a physical or mental incapacity. If the parent is receiving Aid to the Aged, s/he must be determined incapacitated according to provisions set forth below.

18-002.01B3 Determination of Incapacity: If a parent is receiving RSDI, SSI, AABD, or SDP based on disability or blindness, s/he qualifies as incapacitated. For all others the determination of incapacity is made by the State Review Team (SRT).

18-002.01B4 Requirement to Cooperate: The incapacitated parent is required to cooperate in obtaining treatment or rehabilitative or vocational services that are recommended on Form DM-5R. If the incapacitated parent fails to obtain the treatment or services, the case is ineligible.

18-003 CHILDREN / CHILDREN IN AN INSTITUTION FOR MENTAL DISEASE (IMD)

18-003.01 Medical Assistance for Individuals 18 or Younger: Children may receive Medicaid if they meet the eligibility requirements outlined in this material. See Appendix 477-000-012 for the applicable federal poverty levels.

7. Newborn child(ren): Newborn child(ren) born to Medicaid eligible pregnant women are eligible at the time of birth, if the family income equals the applicable federal poverty level, through the month of the child's first birthday.
8. Children up to age one: Children up to the age of one are eligible if the family income equals the applicable federal poverty level.
9. Children age five or younger: Children age one through five (through the month of their sixth birthday) are eligible if the family income equals the applicable federal poverty level.
10. Children ages six and older: Children ages 6 through 18 are eligible if the family income equals the applicable federal poverty level. Eligibility continues through the month of the child's 19th birthday.
11. Children's Health Insurance Program (CHIP): Children age 18 or younger who do not meet income limits for Medicaid are eligible for CHIP if the family income is at or below the applicable Federal Poverty Level and are not covered by creditable health insurance.
12. Minor pregnant women: Minor pregnant women who do not meet the income limits for children's Medicaid are eligible under the Pregnant Woman category if the family income equals the applicable federal poverty level. Ongoing Medicaid eligibility must be reviewed prior to the end of the 60-day postpartum period.

18-003.02 Child in an IMD

18-003.02A Child in an IMD: If a child who is placed in an IMD is a ward of the Department or another public agency or if the placement is court-ordered, see 477 NAC 25-001. If the child who is placed in an IMD is still considered part of the household, the parent(s)' income is deemed. See Appendix 477-000-009 for calculation procedures.

18-003.02B Individuals Age 19 and 20: May be found eligible for services under this category if they are receiving inpatient care in an Institution for Mental Disease (IMD). If an individual is an inpatient in an IMD when s/he reaches 21 years of age, s/he may remain eligible for services either until discharge or until s/he reaches age 22, whichever comes first.

18-003.03 Children Ineligible Due to MAGI Methodologies: Children who lose Medicaid or CHIP eligibility (with or without health insurance) due to the elimination of disregards as a result of the conversion to MAGI shall have protective Medicaid coverage for one year if the child had Medicaid as of December 31, 2013, unless the following conditions are met previously:

1. Attain age 19;
2. Move out of Nebraska;
3. Request removal from the program; or
4. Deceased.

18-003.03A Exceptions to the protective status:

1. Children who are inmates of a public institution; or
2. Children who are patients in an institution for mental disease (IMD).

This protected group expires December 31, 2015.

18-003.04 Children Receiving CHIP Who Move to Medicaid Due to the Increased Federal Poverty Levels under the ACA: Children who move from CHIP to Medicaid as a result of increased Federal Poverty Levels effective January 1, 2014 shall qualify for CHIP funding for up to one year if the child was CHIP eligible as of December 31, 2013 and continues to meet Medicaid eligibility requirements.

This group expires December 31, 2015.

18-004 599 CHIP PROGRAM

18-004.01 Eligibility Requirements: A pregnant woman, who is not otherwise eligible for Medicaid, may apply to have her unborn child(s) eligibility reviewed under the 599 CHIP program. Eligibility for Medicaid must first be determined before 599 CHIP eligibility can be reviewed. Eligibility is determined for unborn children from conception through birth, if the pregnant woman and spouse's income is at or below the Federal Poverty Level (FPL). See Appendix 477-000-012 for the applicable FPL.

599 CHIP has no requirement for citizenship or alien status due to the unborn(s) status being independent of the pregnant woman.

There is no eligibility for the unborn(s) if the pregnant woman has creditable health insurance. Health insurance that does not provide prenatal or maternity care is not considered creditable coverage. For a definition of creditable health insurance, see 477 NAC 1.

The pregnant woman will not be eligible for post-partum services under 599 CHIP. If post-partum care is needed for complications following labor and delivery, the woman may apply for Emergency Medical Services Assistance (EMSA).

18-004.02 Nebraska Residence: The residency of the unborn(s) will follow the residency of the pregnant woman.

18-004.03 Relative Responsibility: Relative responsibility for 599 CHIP has the following exception:

For a pregnant minor, their financially responsible parent(s) income shall not be used in the unborn child(s) 599 CHIP budget.

18-004.04 Age Requirement: For receipt of 599 CHIP benefits, an individual is considered an unborn child from conception to birth.

18-004.05 Unborn 599 CHIP Eligibility if Parent(s) Does Not Cooperate: If an ineligible pregnant woman or her spouse fails or refuses to cooperate with third party liability, the unborn(s) is ineligible for 599 CHIP.

18-004.06 Effective Date of Medical Eligibility: The effective date of eligibility for 599 CHIP is no earlier than the first day of the application month.

Note: There is no retroactive eligibility for the 599 CHIP Program.

18-004.07 Continuous Eligibility: Unborn children are continuously eligible up to six months or through their month of birth, whichever comes first. After the six months of continuous eligibility, a full eligibility review is not required. However, information reported or known to the Department must be acted upon.

Note: The unborn must have at least a 30 day period of ineligibility before they would qualify for another six month period of continuous eligibility.

Following the birth of the child, eligibility will be determined for medical assistance based on any changes reported or known to the Department.

Note: Following the birth, if the newborn is determined eligible for medical assistance, the newborn is eligible for six months of continuous medical eligibility.

18-005 FORMER WARDS

18-005.01 Eligibility Requirements: If the ward is eligible for the former ward program (see 479 NAC 6-000), the former ward must:

8. Be within age limits;
9. Have been a ward of the Department immediately before entering the program for former wards;
10. Have been in out-of-home care at the time of discharge and continue to be in out of home care while in the program;
11. Be single;
12. Be attending or enrolled in a secondary educational program, college or vocational program and maintaining a passing average;
13. Meet income standards (see Appendix 477-000-012); and
14. Enroll in an available health plan.

18-005.02 Age Requirement: A former ward is eligible for medical assistance from age 18 through the month of his/her 21st birthday.

18-005.03 Living Arrangement: The former ward must continue to be in an out-of-home situation to remain eligible for the program.

18-006 HOSPITAL PRESUMPTIVE ELIGIBILITY: The Department shall provide Medicaid during a presumptive eligibility period to individuals who are determined eligible by a qualified hospital. The determination is on the basis of preliminary information, that the individual has gross income at or below the income standard established for the applicable group, has attested to being a citizen or national of the United States or is in satisfactory immigration status, and is a resident of Nebraska, to be presumptively eligible in accordance with the policies and procedures established by the Department. Determinations are limited to:

6. Children (see 477 NAC 18-003);
7. Pregnant women (see 477 NAC18-001.02);
8. Breast and Cervical Cancer (see Women's Cancer Program at 477 NAC 24-004);
9. Parents and caretaker relatives (see 477 NAC 18-002); and
10. Former foster care children (see 477 NAC 24-006).

A presumptive eligibility determination is limited to no more than one period within two calendar years per person.

A pregnant woman is eligible for ambulatory care only. The qualified provider may authorize a period of presumptive eligibility once per pregnancy.

Notice and fair hearing regulations do not apply to determinations of presumptive eligibility.

18-006.01 Qualified Entities Responsibilities

5. Notify the appropriate individual at the time a determination regarding presumptive eligibility is made, in writing or orally if appropriate, of such determination, that:

   d. If a Medicaid application on behalf of the eligible individual is not filed by the last day of the following month, the individual's presumptive eligibility will end on that last day;
   e. If a Medicaid application on behalf of the eligible individual is filed by the last day of the following month, the individual's presumptive eligibility will end on the day that a decision is made on the Medicaid application; and
   f. If the individual is not determined presumptively eligible, the qualified entity shall notify the appropriate individual of the reason for the determination and that he or she may file an application for Medicaid with the Medicaid agency.

6. Provide the individual with an agency approved application for Nebraska Medicaid;
7. Within five working days after the date that the determination is made, notify the agency that the individual is presumptively eligible; and
8. Shall not delegate the authority to determine presumptive eligibility to another entity.

18-006.02 Qualified Hospital Criteria

7. Participate as a Medicaid provider;
8. Notify the Department of its decision to make presumptive determinations;
9. Agree to make determinations consistent with state policy and procedures;
10. Assist individuals in completing and submitting full applications;
11. Assist individuals in understanding required documentation requirements; and
12. Shall not be disqualified by the Department.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 20-000 DEFINITIONS PERTAINING TO NON-MAGI PROGRAMS

ABD: A categorical program consisting of medical assistance only. Two (2) types of cases are included in the medical assistance only category:

1. ABD with No Share of Cost (ABD only): A case in which an individual's income is less than the applicable standard.

2. ABD Share of Cost Case (ABD with Share of Cost): A case in which there is sufficient income to meet daily maintenance needs and a portion, but not all, of the unit's medical needs. The case is opened for medical assistance with no payment for medical services made until the Share of Cost is obligated toward medical services.

Aged: A client who is sixty-five (65) years old or older.

Annuity: A prepaid investment that pays periodic (usually monthly) payments for a set period of time. Payments may begin immediately or at a future date.

Annuity Transaction: The purchase of an annuity, changing the annuity beneficiary, or authorizing the commencement of the pay-out period (annuitizing).

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

Blind: A category of eligibility for clients who are sixty-four (64) years old and younger and who are blind in accordance with program standards.

Burial Insurance: Insurance policies in which the terms specifically provide that proceeds can be used only to pay the burial expenses of the insured.

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

Contributions/Cash Support: Verified payments that are paid to or for a Medicaid unit.

Disabled: A category of eligibility for clients who are sixty-four (64) years old and younger and who are disabled as determined by the Social Security Administration (SSA) or the State Review Team (SRT). An individual is disabled if s/he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months. See Titles II and XVI of the federal Social Security Act, as amended, for further disability criteria.

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

Essential Property: Property or equipment owned solely by the client/client's spouse in his/her name, or held in a partnership or corporation interest.

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

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

Former Foster Care: A client less than twenty-six (26) years old who was in foster care under Nebraska or the tribe's responsibility and receiving Medicaid when s/he became eighteen (18) or nineteen (19) years old, or such higher age at which federal foster care assistance ends.

Former Ward: An individual between the ages of eighteen (18) and twenty-one (21) who has been discharged as a ward by the Department and who is in a continuing educational program.

Grantor of a Trust: Any individual who creates a trust. This includes:

1. An applicant/client;
2. His/her spouse;
3. A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the applicant/client or his/her spouse (guardian/conservator); or
4. A person, including a court or administrative body, acting at the direction or on the request of the applicant/client or his/her spouse.

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

Household Size: The total number of individuals living together on the basis of relative responsibility.

Income: Gain or recurrent benefit received in money or in-kind from employment, business, property, investments, gifts, benefits, annuities, or trusts at regular or irregular intervals of time.

In-Kind Income: The value of food, clothing, shelter, or other items received in lieu of wages.

Irrevocable Trust: A trust that cannot in any way be revoked by the grantor of the trust.

Medicaid-Qualifying Trust: An irrevocable trust or similar legal device that was established before August 11, 1993, by an applicant/client or his/her spouse under which

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

Medically Needy: A program that extends Medicaid coverage to eligible individuals with high medical expenses whose income exceeds the maximum threshold, but who would otherwise be eligible.

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

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

Real Property: Land, houses, or buildings.

Revocable Trust: A trust that can be revoked by the grantor. Any trust stipulating that it may be modified or terminated only by a court is considered to be a revocable trust, as the grantor (or representative) can petition the court to terminate the trust. A trust designated as irrevocable but that will terminate if certain action is taken by the grantor is considered a revocable trust for purposes of these regulations.

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

Special Needs Trust: An irrevocable trust containing the assets of the client and established solely for the benefit of the client by the client's parent, grandparent, legal guardian, or a court, if the state will receive all amounts remaining in the trust upon the death of the client or on termination of the trust up to the amount of total Medicaid paid on behalf of the client.

SSI Federal Benefit Rate: The maximum Supplemental Security Income (SSI) benefit payable based on an individual's living arrangement (e.g., own home, nursing home, living in another's home).

Standard of Need for Non-MAGI Programs: The consolidation of items necessary for basic subsistence with amounts based on unit size. Included in this standard are shelter and utilities.

Testamentary Trust: A trust established through a will.

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

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

Trust Beneficiary: Any individual, or individuals, designated in a trust to receive any disbursal from the corpus of the trust, or from income generated by the trust, which benefits the party receiving it. A payment from a trust may include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.

Unit: The number of individuals in a household.

Women's Cancer Program: Health care coverage for eligible woman who need treatment for breast and cervical cancer. This program was established by the Breast and Cervical Cancer Prevention and Treatment Act of 2000.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 21-000 HOUSEHOLD OR UNIT SIZE FOR NON-MAGI PROGRAMS

21-001.01 Determination of Unit Size: The unit size shall be based on the number of family members. Except for ABD programs, this number shall include unborn(s). The principles of relative responsibility apply, see 477 NAC 24-001.

Note: Chapters 477 NAC 19 through 25 apply to the following: Aged, Blind and Disabled (AABD/MA), Medically Needy (MN), Medicaid Insurance for Workers with Disabilities (MIWD), Women's Cancer Program, Former Foster Care, Emergency Medical Assistance, Child Welfare

CHAPTER 19-000 HOUSEHOLD/UNIT SIZE

19-001.01 Determination of Unit Size: The unit size shall be based on the number of family members including unborn(s). The principles of relative responsibility apply; see 477 NAC 22-001.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 22-000 INCOME FOR NON-MAGI PROGRAMS

22-001 INCOME

22-001.01 Definition of Income: Income is defined as gain or recurrent benefit received in money or in-kind (see 477 NAC 22-003.01B) from employment, business, property, investments, gifts, benefits, or annuities, at regular or irregular intervals of time (for examples see Appendix 477-000-011).

22-002 VERIFICATION OF INCOME: Verification of income consists of at least the following:

1. The source of the income;
2. The date paid or received;
3. The period covered by the payment or benefit; and
4. The gross amount of payment or benefit.

For income verification procedures, see Appendix 477-000-004.

22-002.01 Income Verification: Income must be verified every 12 months and shall be converted for weekly and bi-weekly income.

1. Regular income must be verified using one month's income as a minimum.
2. Irregular income must be verified using the three (3) most recent months, if available.

Retirement, Survivors, and Disability Insurance (RSDI) and Supplemental Security Income (SSI) benefits shall be verified by viewing direct deposit records or the system interface.

22-002.01A Prospective Budgeting: Electronic data sources, if available, shall be utilized to verify income for budgeting purposes. Paper documentation will be required if electronic data sources are unavailable or a reasonable explanation does not apply.

When income is stable and verification is based on paper documentation, one month of income must be used.

When income fluctuates and verification is based on paper documentation, the three most recent consecutive months of income must be used.

The most recent three months' actual income must be averaged to arrive at the gross income amount for the income period. The amount is converted for weekly and bi-weekly income.

22-003 AVAILABILITY AND TYPES OF INCOME: All income, whether earned or unearned, must be considered.

For a unit that includes a child, all of the child's income and all income of his/her responsible relative(s), whether earned or unearned, must be considered.

The provisions for general relative responsibility at 477 NAC 24-001 and parent for child relative responsibility at 477 NAC 24-001.01 must be applied before any income is considered.

22-003.01 Earned Income: Earned income is money received from wages, tips, salary, commissions, profits from activities in which an individual is engaged as a self-employed person or as an employee, or shelter received at no cost in lieu of wages. For partnership and S-corporation income see Appendix 477-000-051. For shelter in lieu of wages see chart at 477 NAC 22-003.02D2a. Items of need received at no cost in lieu of wages are considered earned income for ABD.

Note: A retired individual who is not working full-time for purposes of earning a livelihood is not considered self-employed for Medicaid, regardless of his/her status as a tax filer.

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

22-003.01A Earned Income Tax Credit: Some low-income wage earners are eligible for a tax credit, which may be paid in one of two forms:

1. Advanced Earned Income Tax Credit (AEITC) - a periodic credit received by an employee in advance of filing his/her federal income tax return; or
2. Earned Income Tax Credit (EITC) - an amount received by an employee as part of his/her federal income tax return.

The letters "EITC" are printed on the tax refund check. Both EITCs and AEITCs are disregarded as income and a resource.

22-003.01B In-Kind Income: For ABD only, in-kind income is the value of food, clothing, shelter, or other items received in lieu of wages.

22-003.01C Contractual Income: Income paid on a contractual basis is prorated over the number of months covered under the contract, even if the client is paid in fewer months than the contract covers.

1. Income received intermittently is prorated over the period it is intended to cover if the income is expected to continue.
2. The client must be notified on a Notice of Action that income is being treated as contractual income and how it is budgeted.

22-003.01D Terminated Earned Income: When an individual engages in different types of self-employment, it is not considered a termination of income if the individual stops one type of work.

22-003.02 Unearned Income: Unearned income is any cash benefit that is not the direct result of labor or services performed by the individual as an employee or a self-employed person. Unearned income includes but is not limited to

1. RSDI benefits;
2. Railroad Retirement;
3. Child, cash, and medical support;
4. Military service benefits;
5. Veterans Affairs (VA) benefits;
6. Civil service benefits;
7. Unemployment compensation;
8. Gifts; inheritance
9. Disability insurance benefits;
10. Workers' compensation;
11. Disability benefits paid by an employer (this does not include sick leave);
12. Returns from securities or investments (i.e., stocks, bonds, annuities, or savings) in which the individual is not actively engaged; and
13. Income from a life estate in real property.

If a client receives a benefit (e.g., RSDI or VA) for an individual who is not in the unit and does not give the benefit to the individual, it is counted as income to the client.

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

22-003.02A Income from a Life Estate in Real Property: Income from a life estate in real property is considered unearned income. Allowable deductions from such income are limited to costs expended for maintaining, repairing, or restoring functionality to an already existing feature, structure, or system that produces income. See Appendix 477-000-030 for examples of treatment of life estate income.

22-003.02B Child/Spousal Support: Child, spousal, and cash medical support received by the individual is considered unearned income.

1. If payment has been irregular or less than the court-ordered amount, support paid for the last three months is averaged (unless there has been a significant change). If there is a payment trend, that amount is used.
2. If the Department is retaining part of the child support payments to satisfy a debt to the state, no more than the court-ordered amount shall be used.
3. If there is no debt to the state, a three-month average of the total amount of support that is being paid is used.

For child support disregards for ABD see 477 NAC 22-005.02E.

22-003.02C Child Support Paid for a Minor Parent: If a noncustodial parent pays support for his or her child and that child is a minor parent who is receiving assistance, child support is treated as follows. If the parent of the minor is not receiving assistance and

1. Gives the child support to the minor parent, the child support is treated as unearned income in the minor's child's budget;
2. Does not give the child support to the minor parent, the child support
    a. Is included in the minor's Medicaid budget if the minor is living with his/her parent; or
    b. Is not counted in the budget if the minor parent is living independently.

22-003.02D Contributions/Cash Support: Contributions are verified payments that are paid to or for the unit.

Contributions received regularly to aid in the support of the client, either in the form of money payments or items of need, are considered unearned income.

Payments by relatives directly to an alternate living arrangement that is not a medical facility (i.e., an assisted living facility) are not counted as a contribution.

22-003.02D1 Contribution from an Individual Not in the Household: If an individual who is not living in the household gives money to the unit, the income must be counted in the budget. In order to determine how to treat the income, it must be determined to whom the contribution is paid. The following are not considered contributions:

1. Energy Assistance;
2. Emergency Assistance;
3. General Assistance; and/or
4. Crisis assistance from a community agency or service agency.

22-003.02D2 Shelter Contributions for Children, Parents and Caretaker Relatives Pertaining to Medically Needy: If an individual who is not in the household is paying the client, the payment is counted as unearned income.

When an individual who is not in the household (including a noncustodial parent) makes shelter payments directly to the vendor on behalf of the client or provides total shelter, the chart below is used. Any other payments (e.g., car payments, payments for utilities) made to a vendor by an individual who is not in the unit are not counted as income toward the client.

The budget is figured according to the following guidelines:

1. If the individual pays the entire obligation or provides the total shelter, the appropriate figure from the chart is used as unearned income in the budget;
2. If the individual pays the entire obligation or provides the total shelter, but the amount is less than the figure allowed in the standard of need, the actual amount paid as unearned income is used; or
3. If the individual makes only partial payments or provides partial shelter, none of the payment is counted in the budget.

22-003.02D2a Shelter Amounts from ADC Payment Standard

Unit Size	1	2	3	4	5	6	7	8	9	10	11	12
Shelter	101	101	103	105	108	109	111	112	113	114	123	133

Shelter includes taxes and insurance. The shelter obligation should be compared to the chart, using the amount shown for the unit size.

22-003.02D3 Contributions Not Counted as Income: A contribution is not counted as income in the following situations:

1. A self-supporting individual who resides in the home pays the client for a portion of the shelter expenses;
2. The client states s/he and a self-supporting individual are sharing expenses. The statement must be documented in the case record;
3. An individual who is not in the unit is making payments to a vendor for certain services or goods not listed at 477 NAC 22-003.02D2 (e.g., car payments);
4. Two or more assistance units are in the same household and share expenses. Income of one unit is not counted toward another unit;
5. In determining initial eligibility only when the applicant
    a. Has no income and has been forced to share a living arrangement with a self-supporting individual because of a crisis situation; and

b. Plans to make other arrangements (either to move or pay a share of the expenses) as soon as s/he has income; and

6. Shelter that is indirectly provided to an eligible child by a non-responsible relative, such as a household consisting of ineligible parents, a minor parent for whom assistance is not being requested, and the minor's child, an eligible infant.

It shall be determined if a contribution needs to be counted on the client's budget as soon as the client begins receiving income.

22-003.02D4 Nursing Facility, Assisted Living Waiver, or Hospital Care: Contributions to or for an applicant/client who is receiving nursing facility, Assisted Living Waiver, or hospital care are considered unearned income in the client's budget if Medicaid is or will be paying any part of the nursing facility, Assisted Living Waiver, or hospital care.

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

Contributions to assist an applicant/client in paying for private care are not considered income in his/her budget. The applicant/client may be determined eligible for payment of other medical services (e.g., medication, coinsurance and deductibles, doctor bills).

22-003.02D5 Insurance Premiums

22-003.02D5a Life Insurance Premiums: Payment of premiums on small protective life insurance policies is not considered a contribution.

22-003.02D5b Health Insurance Premiums: Payment of a health insurance premium by another individual is not considered a contribution as long as the premium is paid directly to the insurance company, not to the applicant/client. The amount of the premium is not allowed as a deduction on the Medicaid budget if the applicant/client does not pay the premium.

22-003.02E Income-Producing Insurance Policies: Income received from an insurance policy that supplements the applicant's/client's income is treated as unearned income. These policies provide income regardless of the type of service being provided or the condition of the applicant/client. If it is verified that the income was applied to medical bills, the income is not counted in the applicant's/client's budget. See Appendix 477-000-026 for examples.

22-003.02F Medical Payments: Income received from a third party that pays the applicant/client directly is

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

22-003.02G Inheritance and Gifts: If the applicant/client receives a gift or inheritance, it is considered unearned income in the month of receipt or report and should be counted in the budget the first month possible, considering timely notice; any unspent remainder is considered a resource in the following month.

22-003.02H Life Estate or Land Contract Income: If an applicant receives periodic life estate or land contract income (e.g., annual, semi-annual or quarterly) and the last periodic payment has been spent before the application, the life estate/land contract income may be considered unavailable and not counted in the budget. If the application is approved, the client must be notified that s/he must report receipt of the next payment within ten (10) days and that the life estate/land contract income must then be counted in the budget.

22-003.02I SSI Benefits: SSI benefits are not used in the Medicaid budget.

22-003.02J RSDI Benefits: For budgeting, the gross amount of RSDI is used; the gross amount is the RSDI benefit with no Medicare premium deducted and rounded down to the nearest whole dollar. See Appendix 477-000-041 for RSDI verification process.

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

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

d. Would continue to be eligible for SSI (including the SSI resource standard) if they were not receiving the Title II disabled adult child's benefits;

3. Section 503/Pickle Amendment Group. The Central Office will notify the eligibility worker of an individual in this group; or
4. Disabled Widow(er)s/Additional Reduction Factor (ARF) Widow(er)s. The Central Office will notify the eligibility worker of an individual in this group.

22-003.02J1 Delay in Counting RSDI Increase: After the annual RSDI cost of living increase, if a client would go from MA only status to MA excess because his/her income exceeds the Federal Poverty Level, the current RSDI amount shall be used. The month after the month that the new FPL figures are published, the client's eligibility shall be determined by comparing the increased RSDI benefit to the new FPL guidelines. The delayed COLA provision applies only if the RSDI increase would cause the client to have excess income. If there is an increase in other unearned income or the client starts receiving other unearned income in the same month as the COLA in RSDI benefits, the delayed COLA provisions do not apply.

22-003.02K Veterans' Benefits: Applicants/Clients who are veterans, their spouses, and the widows of veterans may be eligible for Aid and Attendant services. This service may be available and is to be explored if the individual is in a nursing home, residing in his/her own home, in an Adult Foster Home, or other alternate arrangement when the individual requires aid with daily living activities.

22-003.02L Lump Sum Benefits: If an applicant/client is receiving Medicaid when a lump sum is received, the lump sum is considered income in the first month possible taking into account timely notice provision unless the sum is an accumulated payment of Retirement, Survivors, and Disability Insurance (RSDI), Railroad Retirement, veteran's pension, worker's compensation, or other benefit payment. Any unspent remainder is considered a resource in the following month.

Exception: The unspent portion of an RSDI or SSI retroactive payment is excluded for six months following the month of receipt.

22-003.02M Insurance Settlements: Insurance payments for damage to personal property caused by a disaster are not treated as a lump sum.

When a client is a beneficiary of life insurance, verified payment of debts or obligations of the deceased are subtracted from the settlement.

When an applicant/client receives an insurance settlement or other lump sum (e.g., a tort claim settlement), any bills relating to the cause of the settlement, including attorney's fees, that the client is obligated to pay, are subtracted from the amount.

22-003.02N Intercepted, Withheld, or Garnished Income: If the applicant's/client's wages or unearned income are being garnished or intercepted, the gross amount of income before garnishment shall be counted.

22-003.02O Overpayments: If an applicant/client received both ABD and another benefit at any time during which an overpayment occurred and the overpaid amount was included in the ABD budget, the amount after deduction of an overpayment is used.

22-003.02P Income Taxes Paid: Income taxes that must be paid on unearned income are not deducted from the income for budgeting purposes.

22-003.03 Potential Income: As a condition of Medicaid eligibility, the Department shall require applicants/clients to take all necessary steps to obtain any annuities, pensions, retirement, and disability benefits to which they are entitled.

Annuities, pensions, retirement, and disability benefits include, but are not limited to, veterans' compensation and pensions, Social Security benefits, railroad retirement benefits, and unemployment compensation.

A client and/or any responsible relative, such as a spouse or parent, is required to apply for any non-Medicaid benefits for which s/he appears to be entitled within 60 days of the date the client is notified of the requirement.

If the applicant/client is determined eligible for Medicaid, s/he shall be notified in writing of the requirement to apply for a potential benefit for which the applicant/client appears eligible and shall be informed of the number of days left in which to apply.

Determination of Medicaid eligibility shall not be delayed pending determination of entitlement for potential benefits, so long as the client/responsible relative has applied for such benefits within the 60-day timeframe.

22-003.03A Refusal to Apply for Potential Income:

If an individual fails or refuses to apply for potential benefits within 60 days after notification or refuses to accept benefits for which s/he has been determined eligible, Medicaid eligibility cannot be determined.

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

If a responsible relative (including an ineligible spouse or the parent of a minor child) who is considered in determining the need of a client fails or refuses to apply for or comply with requirements for non-Medicaid benefits for which s/he is apparently eligible, the responsible relative is not considered in determining the client's need. However, income and resources of responsible relatives are still considered in determining the Medicaid eligibility of the client.

22-004 INCOME COUNTED FOR RETROACTIVE MEDICAID ELIGIBILITY: To determine retroactive medical eligibility, each month's actual income must be used. Electronic data sources, if available, shall be utilized to verify income for budgeting purposes. Paper documentation will be required if electronic data sources are unavailable. See Appendix 477-000-004 for Verification Plan.

22-005 INCOME DISREGARDS

22-005.01 Medically Needy Income Disregards Pertaining to Parents, Caretaker Relatives, Pregnant Women, and Children's Medicaid

22-005.01A One Hundred Dollar Disregard: A $100 disregard is deducted from gross earned income of each employed individual in the unit to determine the amount of net earned income used in the budgeting process. Deductions from self-employment income may be made before application of the $100 disregard. See 477 NAC 22-005.04.

22-005.01B Parent in the Home but Not in the Unit: The parent's gross earned income minus the $100 earned income disregard is counted. Unearned income is counted in full toward the unit.

22-005.01C Child Care Disregard: The actual cost of child care as billed or paid is disregarded from earned income.

1. The cost of child care must be verified.
2. A child care disregard is allowed for a parent whose income is used in the budget computation if s/he requires child care in order to participate in education, training, or employment.

22-005.02 Aged, Blind, and Disabled Income Disregards: The amount deducted from adjusted gross earned income (the amount after deduction of the cost of operation if self-employment income and the remainder of the general disregard from wages or self-employment) for each unit:

22-005.02A General $20 Disregard: Every ABD unit receives a $20 income disregard.

1. Married couples living together and budgeted together are considered a unit and receive one $20 disregard.

2. The income disregard is applied to unearned income first; any remainder is subtracted from earned income for clients who are receiving SSI.
3. Clients who are receiving Assisted Living AD Waiver services or Program of All-Inclusive Care for the Elderly (PACE) receive the $20 disregard.

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

22-005.02B Blind or Blind-Aged Clients: Net earned income for blind or blind and aged clients is determined by disregarding the first $85 of gross income plus one-half of the remainder.

22-005.02C Aged or Disabled Clients: Net earned income for aged or disabled clients is determined by disregarding the first $65 of gross income plus one-half of the remainder.

22-005.02D Guardianship/Conservator Fee: The expense of a guardian or conservator fee is allowed as paid, up to a maximum of $10 per month. If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of $120) may also be disregarded.

22-005.02E Child Support Disregards for ABD:

a. One-third of the amount of child support paid on behalf of an ABD child is disregarded.
b. Child support payments received by an ABD parent on behalf of an adult child are disregarded if the support is forwarded to the child. A payment retained by the parent is considered unearned income.

22-005.03 Medical Insurance Disregard: The cost of medical insurance premiums is deducted if the client or his/her responsible relative is responsible for payment. The Medicare Part B premium that the client or responsible relative is accountable for paying is included in this disregard. Exception: The cost of premiums for income-producing policies is not allowed as a medical disregard. See Appendix 477-000-059.

22-005.04 Disregards (i.e., Deductions) for Self-Employment: Operating expenses related to producing goods or services and without which the goods or services could not be produced are deducted from gross income. Operating expenses may include

1. Cost of goods sold;
2. Advertising;
3. Bad debts from sales or services;
4. Bank service charges;
   Car and truck expenses;
5. Commission;
6. Employee benefit programs;

7. Freight/shipping costs;
8. Insurance;
9. Interest on business indebtedness;
10. Laundry and cleaning;
11. Legal and professional services;
12. Office supplies and postage;
13. Rent on business property;
14. Repairs and maintenance;
15. Supplies;
16. Utilities and telephone;
17. Wages; and
18. Transportation other than to and from work and child care. Mileage is allowed at the State of Nebraska employee Mileage rate. See Appendix 477-000-013 for mileage rate.

22-005.04A Disregarded Operating Expenses – Farm Income: The following expenses related to farm income are disregarded as operating expenses:

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

22-005.04B Operating Expenses Not Disregarded: The following expenses are not disregarded as operating expenses:

1. Depreciation;
2. Personal business expenses such as subscriptions, dues to professional organizations and unions, training courses, etc.;
3. Personal transportation;

4. Purchase of capital equipment;
5. Payments on the principal of loans; and
6. Business-related entertainment expenses. If the IRS Form 1040 document is used to verify income, depreciation as a cost of operation is not allowed and capital gains and other gains from lines 13, 14, and 15 of Form 1040 are not counted as income.

22-005.04C Offset of Earnings: If a client has a combination of farm or self-employment income and regular earned income, the regular earnings may be offset with a loss from the self-employment or farm operation.

22-005.05 School District Payment Disregards: If a school-aged child is receiving nursing home care in a facility, including an intermediate care facility (ICF), ICF/developmental disability (DD) facility, skilled nursing facility, or chronic care facility, and the school district is contracting with the facility in providing the child's educational needs, the school district payment is disregarded as income if the payment is designated for educational services only.

If any or all of the school district payment is for residential services, that portion must be shown as Payment on Services. The correct standard of need (SON) must be budgeted based on the child's living arrangement.

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

22-005.06 Other Income Disregards

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
1. Earnings of child age 18 or younger and in school	Disregard.	Earned Income.
2. Earnings of a child age 18 or younger an d not in school	Treat as earned income.	Earned Income.
3. Income of a parent in the home but not in the unit	Count as income in full.	N/A
4. Fuel assistance payments and allowances	Disregard.	Disregard.
5. Energy payments	Disregard.	Disregard.
6. Sale of home produce, livestock, poultry	Consider as earned income.	Consider as earned income.
7. Home produce from garden, livestock and poultry used by the household for their own consumption	Disregard.	Disregard.
8. Indian judgment funds distributed as per capita payments to members of Indian tribes or held in trust by the Secretary of the Interior, interest and investment income accrued on Indian judgment funds while held in trust, and purchases made with the funds	Disregard.	Disregard.
9. Jury duty pay	Disregard.	Disregard.
10. Any student financial assistance to an undergraduate student provided under programs in Title IV of the Higher Education Act or under Bureau of Indian Affairs student assistance programs: This would include: a. Pell Grants (formerly called BEOG's); b. Supplemental Educational Opportunity Grants (SEOG); c. College work study; d. Perkins Loans (formerly National Direct Student Loans); e. Guaranteed student loans (including PLUS loans and Supplemental Loans for Students); f. State Student Incentive Grants (SSIG); and g. Student assistance from the Bureau of Indian Affairs	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
11. Graduate Assistantship	Consider as earned income if must perform work for pay.	Consider as earned income if must perform work for pay.
12. Any portion of grants, scholarships, or graduate assistantships not listed and actually used for items such as tuition, books, fees, equipment, special clothing needs, transportation to and from school, child care services necessary for school attendance, etc. Transportation costs are allowed if the client uses private transportation or the actual cost of public transportation. The client must provide verification of expenses. Money received from the GI Bill, Veterans Administration under the Veterans Education and Employment Assistance Act for education expenses of veteran, or BIA, is treated the same way. This reference applies to undergraduate students, graduate students, and students working for a second undergraduate degree.	Disregard.	Disregard.
13. Any portion of a grant, scholarship, or funds paid out from a Veterans Education and Employment Assistance account not used for items listed above.	Consider as unearned income and prorate over the period for which it is intended to cover.	Consider as unearned income and prorate over the period for which it is intended to cover.
14. Financial assistance for a graduate student or student working for a second undergraduate degree if the student is required to work in order to receive the assistance. This includes work study, stipends, fellowships, and graduate assistantships	Consider as earned income.	Consider as earned income.
15. Payments to a client participating in training or school attendance subsidized by the Division of Vocational Rehabilitation	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
16. Payments for services or reimbursement of expenses to volunteers serving as foster grandparents, senior health aides, or senior companions, Service Corps of Retired Executives (SCORE), Active Corps of Executives (ACE) and any other programs under Titles II and III, (P.L. 93-113)	Disregard.	Disregard.
17. Indian land lease	Disregard.	Disregard.
18. Income from land contracts	Consider as unearned income.	Consider as unearned income.
19. HUD rental and/or utility subsidies under Section 8 of the Housing Act (lump sum or monthly payments	Disregard.	Disregard.
20. Rental income from real property	Consider as earned income. Treat like a small business.	a. Consider as earned income if operated as a small business. b. Treat like unearned income from boarder/renter if not operated as a business. C. Rental property must be considered a resource if not operated like a small business. Note: For both a and b, do not deduct payments on the principal of a loan.
21. Income from life estate in real property	Consider as unearned income; determine the total cost of operation and deduct from gross income.	Consider as unearned income; deduct from gross income any expenses specified as a condition of the life estate.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
22. A bona fide loan from any source	Disregard.	Disregard bona fide loans that must be repaid.
23. Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970	Disregard.	Disregard.
24. Payments provided by a state or local government to assist in relocation	Disregard.	Disregard.
25. Income from boarders, rented rooms and apartments	Consider as earned income. Treat like a small business. Exception: Income received from foster care payments is disregarded.	Consider as unearned income: a. Deduct total monthly cost of operation from the monthly gross income (If 1040 document is used to verify income, the allowance for depreciation is added back in to arrive at the adjusted gross income figure); b. From adjusted gross income, deduct the $20 standard disregard. Exception: Income received from one client/unit for board and room and all foster care payments are disregarded. c. Rental property must be considered a resource if not operated like a small business.
26. Retroactive RSDI benefits	Excluded for six months following the month of receipt.	Excluded for six months following the month of receipt.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
27. Income from Experience Works, Inc. Senior Community Service Employment, and any other income received under Title V of the Older Americans Act	Disregard.	Consider as earned income.
28. Benefits from the Supplemental Nutrition Assistance Program (SNAP)	Disregard.	Disregard.
29. The value of federally donated foods	Disregard.	Disregard.
30. Payments from Nutrition Program for the elderly	Disregard.	Disregard.
31. The value of assistance from a Child Nutrition Act or National School Lunch Program	Disregard.	Disregard.
32. Self-employment income	Consider as earned income: a. Deduct total monthly cost of operation from the monthly gross business income (if 1040 document is used to verify income, do not allow depreciation as a cost of operation and do not count as income capital gains and other gains from lines 13, 14 and 15 of form 1040); b. From adjusted gross income, deduct the appropriate standard disregard for earned income.	Consider as earned income: a. Deduct total monthly cost of operation from the monthly gross business income (if 1040 document is used to verify income, do not allow depreciation as a cost of operation and do not count as income capital gains and other gains from lines 13, 14 and 15 of form 1040); b. From adjusted gross income, deduct the appropriate standard disregard for earned income.
33. Federal and state income tax refunds	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
34. EITCs and AEITCs	Disregard.	
35. Victims' compensation payments, e.g., payments received from a state or local government to aid victims of crime	Disregard.	Disregard.
36. Subsidized adoption or subsidized guardianship payments from Title IV-E or child welfare funds	Disregard.	Disregard.
37. Any child, cash, medical, or spousal support received by the individual	Disregard.	Consider as unearned income.
38. Child, cash, or medical support paid on behalf of an ABD child	Consider as unearned income.	Disregard 1/3 of the amount.
39. Payments to individuals due to their status as victims of Nazi persecution	Disregard.	Disregard.
40. Payments from Title I Workforce Investment Act (WIA) for classroom training	Disregard.	Disregard.
41. Unpredictable gifts of indeterminate value	Disregard.	Disregard.
42. Interest on Series E savings bonds and other bonds that accrue interest	Disregard	Disregard
43. Income from the sale of blood or plasma	Count as earned income from self-employment.	Consider as unearned income.
44. Earnings received from the employer or compensation in lieu of wages under a Title I WIA program	Disregard for a student regardless of age.	For clients age 18 and younger who are full-time students, disregard for six months per calendar year; then consider as earned income. b. For clients age 19 and older, consider as earned income.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
45. On-the-job training (OJT) payments made to adults by an employer	Consider as earned income.	Consider as earned income.
46. Title I WIA program allowance paid to the client or vendor payments made to the provider for supportive services, such as transportation, meals, special tools, and clothing. This includes temporary Welfare-to-Work payments and work experience payments made through Workforce Development	Disregard for all ages.	Disregard for all ages.
47. Earned and unearned income received by a youth age 18 or younger under a Title I WIA program. For a minor parent who is applying for Medicaid for him/herself, see 477 NAC 24-001.01F.	Disregard.	Disregard.
48. Declared cash winnings; interest and dividends (may be prorated on a monthly basis); a gift that marks a special occasion; small and insignificant children's cash allowances	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.
49. Income from securities and investments	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
50. Interest on Series H savings bonds and other bonds which pay dividends or interest	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.	
51. Veterans pension benefits reduced to $90 for nursing home residents	N/A	Disregard.
52. Picket pay or strike pay	Consider as earned income	a. Consider as earned income if the client is required to perform specific duties or participate for a specific number of hours. Allow the earned income disregards. b. If the client is not required to perform specific duties or participate for a specific number of hours, consider as unearned income.
53. Any payment received from the Radiation Exposure Compensation Trust Funds (RECTF)	Disregard.	Disregard. Any interest earned on unspent RECTF payments is counted as unearned interest income.
54. Veterans Assistance benefits received by the spouse of an SSI recipient if the spouse is applying for or receiving ABD	N/A	a. Disregard the amount of VA benefits, if any that are budgeted by SSI to the SSI spouse. b. Consider as unearned income the remainder on the ABD budget of the non-SSI spouse.
55. Agent Orange settlement payments	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	ABD and ABD Medically Needy
56. Benefits under Public Law 104-204 for a child born with spina bifida and whose parent(s) is a Vietnam veteran	Disregard.	Disregard.
57. Payments made from any fund established as a result of the case of Susan Walker v. Bayer Corporation, et al. to hemophilia patients who are infected with HIV	Disregard.	Disregard.
58. Payments to AmeriCorps volunteers	Disregard.	Disregard.
59. The living allowance issued to Job Corps recipients or the readjustment allowance that is issued when Job Corps participants leave the program	Consider as earned income.	Consider as earned income.
60. In-kind income received by Job Corps participants for food, shelter, etc.	Disregard.	Disregard.
61. Insurance payments for damage to personal property	Disregard.	Disregard.
62. Assistance received under the Disaster Relief Act of 1974 or under a federal statute because of catastrophe declared to be a major disaster by the President and any interest earned on the assistance	Disregard.	Disregard.
63. Holiday bonus/work- related bonus	Consider as an earned income lump sum. For children, consider as earned income. Count as an earned income lump sum if received in a separate check.	Earned income.

Note: Chapters 477 NAC 19 through 25 apply to the following: Aged, Blind and Disabled (AABD/MA), Medically Needy (MN), Medicaid Insurance for Workers with Disabilities (MIWD), Women's Cancer Program, Former Foster Care, Emergency Medical Assistance, Child Welfare

CHAPTER 20-000 INCOME

20-001 INCOME

20-001.01 Definition of Income: Income is defined as gain or recurrent benefit received in money or in-kind (see 477 NAC 20-001.06D) from employment, business, property, investments, gifts, benefits, or annuities, at regular or irregular intervals of time (for examples see Appendix 477-000-011).

20-001.02 Medically Needy Children: All income of the client and responsible relative, whether earned or unearned, must be considered.

20-001.03 Income Considered: Any unearned income of a child in the unit is counted. Income of a parent(s) in the home is counted. For earned income of children see chart at 477 NAC 20-010.

20-001.04 Standard of Need: The standard of need is a consolidation of items necessary for basic subsistence with amounts based on unit size. Included in this standard are food, clothing, utilities, and shelter.

20-001.05 SIMP/MA: When there is a client living in a specified living arrangement (see 477 NAC 23-001) and a spouse in the community, income is budgeted according to 477 NAC 23-001.15.

20-001.06 Availability and Types of Income: All income, whether earned or unearned, must be considered if received and currently available for the use of the individual.

20-001.06A Earned Income: Earned income is money received from wages, tips, salary, commissions, profits from activities in which an individual is engaged as a self-employed person or as an employee, or shelter received at no cost in lieu of wages. See Appendix 477-000-051. For shelter in lieu of wages see chart at 477 NAC 20-006.07. Items of need received at no cost in lieu of wages are considered earned income for AABD/MA.

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

20-001.06B Earned Income Credit: Some low income wage earners are eligible for a tax credit which may be paid in one of two forms:

1. Advanced Earned Income Credit (AEIC) - a periodic credit paid with the employee's wages; or
2. Earned Income Credit (EIC) - an amount included with a federal income tax return.

The letters "EIC" are printed on the tax refund check. Both EIC's and AEIC's are disregarded as income and a resource.

20-001.06C Contractual Income: Income paid on a contractual basis is prorated over the number of months covered under the contract, even if the client is paid in fewer months than the contract covers.

1. Income received intermittently is prorated over the period it is intended to cover if the income is expected to continue.
2. The client must be notified on a Notice of Action that income is being treated as contractual income and how it is budgeted.

20-001.06D In-Kind Income: For AABD/MA only, in-kind income is the value of food, clothing, shelter, or other items received in lieu of wages.

20-002 EARNED INCOME DISREGARDS PERTAINING TO MEDICALLY NEEDY PARENTS, CARETAKER RELATIVES, PREGNANT WOMEN, AND CHILDREN'S MEDICAID

20-002.01 One Hundred Dollar Disregard: A $100 disregard is deducted from gross earned income of each employed individual to determine the amount of net earned income used in the budgeting process. Self-employment income is allowed disregards before application of the $100 disregard.

20-002.02 Parent in the Home But Not in the Unit: The parent's gross earned income minus the $100 earned income disregard is counted. Unearned income is counted in full toward the unit.

20-002.03 Child Care Disregard: The actual cost of child care as billed or paid is disregarded from earned income.

1. The cost of child care must be verified.

2. Is allowed for a parent whose income is used in the budget computation if they require child care in order to participate in education, training, or employment.

20-002.04 Medical Insurance Disregard: The cost of medical insurance premiums is deducted if the client or responsible relative is responsible for payment. The Medicare Part B premium which the client or responsible relative is responsible for paying is included in this disregard. Exception: The cost of premiums for income-producing policies is not allowed as a medical deduction. See Appendix 477-000-026.

20-003 EARNED INCOME DISREGARDS PERTAINING TO AGED, BLIND, AND DISABLED: The amount deducted from adjusted gross earned income (the amount after deduction of the cost of operation if self-employment income and the remainder of the general disregard from wages or self-employment) for each unit:

20-003.01 Blind or Blind-Aged Clients: Net income for blind or blind and aged clients is determined by disregarding the first $85 plus one-half of the remainder.

20-003.02 Aged or Disabled Clients: Net income for aged or disabled clients is determined by disregarding the first $65 plus one-half of the remainder.

20-004 DISREGARDS FOR SELF-EMPLOYMENT: Operating expenses related to producing the goods or services and without which the goods or services could not be produced are deducted from gross income. Operating expenses may include:

19. Cost of goods sold;
20. Advertising;
21. Bad debts from sales or services;
22. Bank service charges;
23. Car and truck expenses;
24. Commission;
25. Employee benefit programs;
26. Freight/shipping costs;
27. Insurance;
28. Interest on business indebtedness;
29. Laundry and cleaning;
30. Legal and professional services;
31. Office supplies and postage;
32. Rent on business property;
33. Repairs and maintenance;
34. Supplies;
35. Utilities and telephone;
36. Wages; and
37. Transportation other than to and from work and child care. Mileage is allowed at the State employee Mileage rate. See Appendix 477-000-013 for mileage rate.

20-004.01 Operating Expenses – Farm Income: The following expenses related to farm income are considered operating expenses:

21. Cost of goods sold;
22. Cost of labor;
23. Repairs and maintenance;
24. Interest;
25. Rent of farm, pasture;
26. Feed purchased;
27. Seeds, plants purchased;
28. Fertilizers, lime, and chemicals;
29. Cost of machines leased;
30. Supplies purchased;
31. Breeding fees;
32. Veterinary fees, medicine;
33. Gasoline, fuel, or oil;
34. Storage, warehousing;
35. Insurance;
36. Utilities;
37. Freight, trucking;
38. Conservation expenses;
39. Land clearing expenses; and
40. Employee benefit programs.

20-004.02 The following expenses are not allowed as operating expenses:

7. Depreciation;
8. Personal business expenses such as subscriptions, dues to professional organizations and unions, training courses, etc.;
9. Personal transportation;
10. Purchase of capital equipment;
11. Payments on the principal of loans; and
12. Business-related entertainment expenses. If the 1040 document is used to verify income, depreciation as a cost of operation is not allowed and capital gains and other gains from lines 13, 14, and 15 of Form 1040 are not counted as income.

20-004.03 Offset of Earnings: If a client has a combination of farm or self-employment income and regular earned income, the regular earnings may be offset with a loss from the self-employment or farm operation.

20-005 OTHER INCOME DISREGARDS PERTAINING TO AABD/MA CLIENTS

20-005.01 General $20 Disregard: Every AABD/MA unit receives a $20 income disregard.

4. Married couples who are living together and budgeted together are considered a unit and get one $20 disregard.
5. The income disregard is applied to unearned income first; any remainder is subtracted from earned income for clients who are receiving SSI.
6. Clients who are receiving Assisted Living AD Waiver services or Program of All-Inclusive Care for the Elderly (PACE) receive the $20 disregard.

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

20-005.02 Guardianship/Conservator Fee: The expense of a guardian or conservator fee is allowed as paid, up to a maximum of $10 per month. If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of $120) may also be disregarded.

20-006 UNEARNED INCOME

20-006.01 Unearned Income: Unearned income is any cash benefit that is not the direct result of labor or services performed by the individual as an employee or a self-employed person. Unearned income includes but is not limited to:

14. Retirement, Survivors, and Disability benefits;
15. Railroad Retirement;
16. Child, cash, and medical support;
17. Military service benefits;
18. VA Benefits;
19. Civil service benefits;
20. Unemployment compensation;
21. Gifts; inheritance
22. Disability insurance benefits;
23. Workers' compensation;
24. Disability benefits paid by an employer (this does not include sick leave); and
25. Returns from securities or investments (i.e., stocks, bonds, annuities, or savings) in which the individual is not actively engaged.

If the client receives a benefit (such as RSDI or VA) for an individual who is not in the unit and does not give the benefit to the individual, it is counted as income to the client.

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

20-006.02 Child/Spousal Support: Unassigned child, spousal, and cash medical support is considered unearned income.

4. If payment has been irregular or less than the court-ordered amount, support paid for the last three months is averaged (unless there has been a significant change).
5. If there is a payment trend, that amount is used.
6. If the Department is retaining part of the child support payments to satisfy a debt to the State, no more than the court-ordered amount shall be used.
7. If there is no debt to the State, a three-month average of the total amount of support that is being paid is used.

For AABD/MA, one-third of the unassigned child support is disregarded.

20-006.03 Child Support Paid for a Minor Parent: If a noncustodial parent pays support for his or her child and that child is a minor parent who is receiving assistance, child support is treated as follows. If the parent of the minor is not receiving assistance and:

3. Gives the child support to the minor parent, the child support is treated as unearned income in the minor's child's budget;
4. Does not give the child support to the minor parent, the child support:
   a. Is included in the minor's Medicaid budget if the minor is living with his/her parent; or
   b. Is not counted in the budget if the minor parent is living independently.

20-006.04 Contributions: Contributions are verified payments which are paid to or for the unit.

Contributions received regularly to aid in the support of the client, either in the form of money payments or items of need, are considered unearned income.

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

The standard of need is not reduced due to the presence in the household of a self-supporting household member. However, if the self-supporting member is contributing to the support of the household, only the amount in excess of the proportionate share is counted as unearned income. (The proportionate share is figured by dividing the standard of need plus actual shelter cost by the number of persons in the household.) For treatment of loans, see 477 NAC 21-001.15B18.

20-006.05 Contribution from an Individual not in the Household: If an individual who is not living in the household gives money to the unit, the income must be counted in the budget. In order to determine how to treat the income, it must be determined to whom the contribution is paid. The following are not considered contributions:

5. Energy Assistance;
6. Emergency Assistance;
7. General Assistance; or
8. Crisis assistance from a community agency or service agency.

20-006.06 Shelter Contributions for Children, Parents and Caretaker Relatives Pertaining to Medically Needy: If an individual who is not in the household is paying the client, the payment is counted as unearned income.

When an individual who is not in the household (including a noncustodial parent) makes shelter payments directly to the vendor on behalf of the client or provides total shelter, the chart below is used. Any other payments made to a vendor by an individual who is not in the unit (e.g., car payments, payments for utilities) are not counted as income toward the client.

The budget is figured according to the following guidelines:

1. If the individual pays the entire obligation or provides the total shelter, the appropriate figure from the chart is used as unearned income in the budget;
2. If the individual pays the entire obligation or provides the total shelter, but the amount is less than the figure allowed in the standard of need, the actual amount paid as unearned income is used; or
3. If the individual makes only partial payments or provides partial shelter, none of the payment is counted in the budget.

20-006.07 Shelter Amounts from ADC Payment Standard

Unit Size	1	2	3	4	5	6	7	8	9	10	11	12
Shelter	101	101	103	105	108	109	111	112	113	114	123	133

Shelter includes taxes and insurance. The shelter obligation should be compared to the chart, using the amount shown for the unit size.

20-006.08 Not Counted as Income: A contribution is not counted as income in the following situations:

7. A self-supporting individual who resides in the home pays the client for a portion of the shelter expenses;
8. The client states that s/he and a self-supporting individual are sharing expenses. The statement must be documented in the case record;
9. An individual who is not in the unit is making payments to a vendor for certain services or goods not listed at 477 NAC 20-006.06 such as car payments;
10. Two or more assistance units are in the same household and share expenses. Income of one unit is not counted toward another unit;
11. In determining initial eligibility only when the applicant:
    a. Has no income and has been forced to share a living arrangement with a self-supporting individual because of a crisis situation; and
    b. Plans to make other arrangements (either to move or pay a share of the expenses) as soon as s/he has income; and
12. Shelter that is indirectly provided to an eligible child by a non-responsible relative, such as a household consisting of ineligible parents, a minor parent for whom assistance is not being requested, and the minor's child, an eligible infant.

    Note: It shall be determined if a contribution needs to be counted on the client's budget as soon as the client begins receiving income.

20-006.09 Nursing Facility, Assisted Living Waiver or Hospital Care: Contributions to or for a client who is receiving nursing facility, Assisted Living Waiver, or hospital care are considered unearned income in the client's budget if Medicaid is or will be paying any part of the nursing facility, Assisted Living Waiver, or hospital care.

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

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

20-006.10 Insurance Premiums

20-006.10A Life Insurance Premiums: Payment of premiums on small protective life insurance policies is not considered a contribution.

20-006.10B Health Insurance Premiums: Payment of a health insurance premium by another individual is not considered a contribution as long as the premium is paid to the insurance company, not to the client. The amount of the premium is not allowed as a deduction on the Medicaid budget if the client does not pay the premium.

20-006.11 Third Party Medical Payments: Income received from a third party that pays the client directly is:

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

20-006.12 Income-Producing Policies: Income received from an insurance policy that supplements the client's income is treated as unearned income. These policies provide income regardless of the type of service being provided or the condition of the client. If it is verified that the income was applied to medical bills, the income is not counted in the client's budget. See Appendix 477-000-058 and 477-000-059 for examples.

20-006.13 Inheritance and Gifts: If the client receives a gift or inheritance, it is considered unearned income in the month of receipt or report and should be counted in the budget the first month possible, considering timely notice; any unspent remainder is considered a resource in the following month.

20-006.14 Life Estate or Land Contract Income: If an applicant receives periodic life estate or land contract income, e.g., annual, semi-annual or quarterly, and the last periodic payment has been spent before the application, the life estate/land contract income may be considered unavailable and not counted in the budget. When the application is approved the client must be notified that s/he must report receipt of the next payment within ten days and that the life estate/land contract income must then be counted in the budget.

20-006.15 SSI Benefits: SSI benefits are not used in the Medicaid budgets.

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

1. Disabled Early Widow(er)s/COBRA Widow(er)s who meet all the following requirements:
    a. Lose SSI due to mandatory receipt of Title II widows benefits;
    b. Are not yet eligible for Medicare Part A;
    c. Are at least age 50, but not yet age 65; and
    d. Would continue to be eligible for SSI benefits if they were not receiving the Title II benefits;

2. Disabled Adult Children (DAC)/Childhood Disability Beneficiaries (CDB) who meet all the following requirements:
    a. Lose SSI or 1619(b) after 11/10/1986 (Public Law 99-643) due to mandatory receipt/increase of Title II benefits on a parent's record due to retirement, death, or disability of a parent;
    b. Are over the age of 18;
    c. Whose blindness or disability began before the age of 22; and
    d. Would continue to be eligible for SSI (including the SSI resource standard) if they were not receiving the Title II disabled adult child's benefits;
3. Section 503/Pickle Amendment Group. The Central Office will notify the eligibility worker of an individual in this group; or
4. Disabled Widow(er)s/Additional Reduction Factor (ARF) Widow(er)s. The Central Office will notify the eligibility worker of an individual in this group.

20-006.16 RSDI Benefits: For budgeting, the gross amount of RSDI is used; the gross amount is the RSDI benefit with no Medicare premium deducted and rounded down to the nearest whole dollar. See Appendix 477-000-041 for RSDI verification process.

20-006.16A Delay in Counting RSDI Increase: After the annual RSDI cost of living increase, if a client would go from grant or MA only status to MA excess because his/her income exceeds the Federal Poverty Level, the current RSDI amount shall be used. The month after the month that the new FPL figures are published, the client's eligibility shall be determined by comparing the increased RSDI benefit to the new FPL guidelines. The delayed COLA provision applies only if the RSDI increase would cause the client to have excess income. If there is an increase in other unearned income or the client starts receiving other unearned income in the same month as the COLA in RSDI benefits, the delayed COLA provisions do not apply.

20-006.17 Veteran's Benefits: Clients who are veterans, their spouses, and the widows of veterans may be eligible for "Aid and Attendant" services. This service may be available and is to be explored if the individual is in a nursing home, residing in his/her own home, in an Adult Foster Home, or other alternate arrangement when the individual requires aid with daily living activities.

20-006.18 Lump Sum Benefits: If the client is receiving medical only when a lump sum is received, the lump sum is not considered income. Any unspent remainder is considered a resource in the month following the month of receipt or report taking into account timely notice provision.

Exception: The unspent portion of an RSDI or SSI retroactive payment is excluded for six months following the month of receipt.

20-006.19 Insurance Settlements: Insurance payments for damage to personal property caused by a disaster are not treated as a lump sum.

When a client is a beneficiary of life insurance, verified payment of debts or obligations of the deceased are subtracted from the settlement.

When a client receives an insurance settlement or other lump sum, any bills relating to the cause of the settlement that the client is obligated to pay, are subtracted from the amount.

20-006.20 Intercepted, Withheld or Garnished Income: If the client's wages or unearned income is being garnished or intercepted, the gross amount of income before garnishment shall be counted.

20-007 POTENTIAL INCOME: Potential income is defined as income based on entitlement or need which is usually determined by an administering agency as a result of an application for benefits by the individual.

The client and any responsible relative, such as a spouse or parent, are required to apply for any benefits for which s/he appears to be entitled within 60 days of the date the client is notified of the requirement.

The responsible relative shall be referred for any potential benefit, but there is no sanction to the child(ren) Medicaid case if the responsible relative fails or refuses to apply.

Determination of eligibility for assistance and authorization of payment pending determination of entitlement for benefits shall not be delayed.

The client shall be notified in writing after the client's eligibility for categorical assistance s/he has been made of the requirement to apply for a benefit for which the client appears eligible and shall be informed of the number of days left in which to apply.

20-008 REFUSAL TO APPLY: A client is expected to make application for and accept benefits promptly after the client's apparent entitlement to the benefits have been discussed. The client is notified on a Notice of Action of the number of days left in which to apply. A special review must be set up to see if the client is eligible for or already receiving benefits. If the individual fails or refuses to make application within 60 days after notification or refuses to accept benefits for which s/he has been determined eligible, eligibility cannot be determined.

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

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

20-009 SCHOOL DISTRICT PAYMENTS: If a school-aged child is receiving nursing home care, including ICF, ICF/developmental disability (DD), SNF, or chronic care, and the school district is contracting with the facility in providing the child's educational needs, the school district payment is disregarded as income if the payment is designated for educational services only.

If any or all of the school district payment is for residential services, that portion must be shown as Payment on Services. The correct SON must be budgeted based on the child's living arrangement.

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

20-010 OTHER INCOME DISREGARDS

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
1. Earnings of child age 18 or younger and in school	Disregard.	Earned Income.
2. Earnings of a child age 18 or younger and not in school	Treat as earned income.	Earned Income.
3. Income of a parent in the home but not in the unit	Count as income in full.	N/A
4. Fuel assistance payments and allowances	Disregard.	Disregard.
5. Energy payments	Disregard.	Disregard.
6. Sale of home produce, livestock, poultry	Consider as earned income.	Consider as earned income.
7. Home produce from garden, livestock and poultry used by the household for their own consumption	Disregard.	Disregard.
8. Indian judgment funds distributed as per capita payments to members of Indian tribes or held in trust by the Secretary of the Interior, interest and investment income accrued on Indian judgment funds while held in trust, and purchases made with the funds	Disregard.	Disregard.
9. Jury duty pay	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
10. Any student financial assistance to an undergraduate student provided under programs in Title IV of the Higher Education Act or under Bureau of Indian Affairs student assistance programs: This would include: a. Pell Grants (formerly called BEOG's); b. Supplemental Educational Opportunity Grants (SEOG); c. College work study; d. Perkins Loans (formerly National Direct Student Loans); e. Guaranteed student loans (including PLUS loans and Supplemental Loans for Students); f. State Student Incentive Grants (SSIG); and g. Student assistance from the Bureau of Indian Affairs	Disregard.	Disregard.
11. Graduate Assistantship	Consider as earned income if must perform work for pay.	Consider as earned income if must perform work for pay.
12. Any portion of grants, scholarships, or graduate assistantships not listed and actually used for items such as tuition, books, fees, equipment, special clothing needs, transportation to and from school, child care services necessary for school attendance, etc. Transportation costs are allowed if the client uses private transportation or the actual cost of public transportation. The client must provide verification of expenses. Money received from the GI Bill, Veterans Administration under the Veterans Education and Employment Assistance Act for education expenses of veteran, or BIA, is treated the same way. This reference applies to undergraduate students, graduate students, and students working for a second undergraduate degree.	Disregard.	Disregard.
13. Any portion of a grant, scholarship, or funds paid out from a Veterans Education and Employment Assistance account not used for items listed above.	Consider as unearned income and prorate over the period for which it is intended to cover.	Consider as unearned income and prorate over the period for which it is intended to cover.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
14. Financial assistance for a graduate student or student working for a second undergraduate degree if the student is required to work in order to receive the assistance. This includes work study, stipends, fellowships, and graduate assistantships	Consider as earned income.	Consider as earned income.
15. Payments to a client participating in training or school attendance subsidized by the Division of Vocational Rehabilitation	Disregard.	Disregard.
16. Payments for services or reimbursement of expenses to volunteers serving as foster grandparents, senior health aides, or senior companions, Service Corps of Retired Executives (SCORE), Active Corps of Executives (ACE) and any other programs under Titles II and III, (P.L. 93-113)	Disregard.	Disregard.
17. Indian land lease	Disregard.	Disregard.
18. Income from land contracts	Consider as unearned income.	Consider as unearned income.
19. HUD rental and/or utility subsidies under Section 8 of the Housing Act (lump sum or monthly payments	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
20. Rental income from real property	Consider as earned income. Treat like a small business.	a. Consider as earned income if operated as a small business. b. Treat like unearned income from boarder/renter if not operated as a business. C. Rental property must be considered a resource if not operated like a small business. Note: For both a and b, do not deduct payments on the principal of a loan.
21. Income from life estate in real property	Consider as unearned income; determine the total cost of operation and deduct from gross income.	Consider as unearned income; deduct from gross income any expenses specified as a condition of the life estate.
22. A bona fide loan from any source	Disregard.	Disregard bona fide loans that must be repaid.
23. Any payment received under the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970	Disregard.	Disregard.
24. Payments provided by a state or local government to assist in relocation	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
25. Income from boarders, rented rooms and apartments	Consider as earned income. Treat like a small business. Exception: Income received from foster care payments is disregarded.	Consider as unearned income: a. Deduct total monthly cost of operation from the monthly gross income (If 1040 document is used to verify income, the allowance for depreciation is added back in to arrive at the adjusted gross income figure); b. From adjusted gross income, deduct the $20 standard disregard. Exception: Income received from one client/unit for board and room and all foster care payments are disregarded. c. Rental property must be considered a resource if not operated like a small business.
26. Retroactive RSDI benefits	Excluded for six months following the month of receipt.	Excluded for six months following the month of receipt.
27. Income from Experience Works, Inc. Senior Community Service Employment, and any other income received under Title V of the Older Americans Act	Disregard.	Consider as earned income.
28. Food stamps	Disregard.	Disregard.
29. The value of federally donated foods	Disregard.	Disregard.
30. Payments from Nutrition Program for the elderly	Disregard.	Disregard.
31. The value of assistance from a Child Nutrition Act or National School Lunch Program	Disregard.	Disregard.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
32. Self-employment income	Consider as earned income: a. Deduct total monthly cost of operation from the monthly gross business income (if 1040 document is used to verify income, do not allow depreciation as a cost of operation and do not count as income capital gains and other gains from lines 13, 14 and 15 of form 1040); b. From adjusted gross income, deduct the appropriate standard disregard for earned income.	Consider as earned income: a. Deduct total monthly cost of operation from the monthly gross business income (if 1040 document is used to verify income, do not allow depreciation as a cost of operation and do not count as income capital gains and other gains from lines 13, 14 and 15 of form 1040); b. From adjusted gross income, deduct the appropriate standard disregard for earned income.
33. Federal and state income tax refunds	Disregard.	Disregard.
34. EICs and AEIC	Disregard.	Disregard.
Victims' compensation payments, i.e., payments received from a state or local government to aid victims of crime	Disregard.	Disregard.
35. Subsidized adoption or subsidized guardianship payments from Title IV-E or child welfare funds	Disregard.	Disregard.
36. Any unassigned child, cash, medical, or spousal support	Disregard.	Disregard.
37. Unassigned child, cash, medical support paid on behalf of an AABD/MA child	Unearned income.	Disregard 1/3 of the amount.
38. Payments to individuals due to their status as victims of Nazi persecution	Disregard.	Disregard.
39. Payments from Title I Workforce Investment Act (WIA) for classroom training	Disregard.	Disregard.
40. Unpredictable gifts of indeterminate value	Disregard.	Disregard.
41. Interest on Series E savings bonds and other bonds which accrue interest	Treat as a lump sum.	Consider as unearned income when redeemed.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
42. Income from the sale of blood or plasma	Count as earned income from self-employment.	Consider as unearned income.
43. Earnings received from the employer or compensation in lieu of wages under a Title I WIA program	Disregard for a student regardless of age.	For clients age 18 and younger who are full-time students, disregard for six months per calendar year; then consider as earned income. b. For clients age 19 and older, consider as earned income.
44. OJT payments made to adults by an employer	Consider as earned income.	Consider as earned income.
45. Title I WIA program allowance paid to the client or vendor payments made to the provider for supportive services, such as transportation, meals, special tools, and clothing. This includes temporary Welfare-to-Work payments and work experience payments made through Workforce Development	Disregard for all ages.	Disregard for all ages.
46. Earned and unearned income received by a youth age 18 or younger under a Title I WIA program. For a minor parent who is applying for Medicaid for him/herself, see 477 NAC 22-002.06.	Disregard.	Disregard.
47. Declared cash winnings; interest and dividends (may be prorated on a monthly basis); a gift that marks a special occasion; small and insignificant children's cash allowances	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.
48. Income from securities and investments	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
49. Interest on Series H savings bonds and other bonds which pay dividends or interest	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.	Disregard $10 a month per individual for each income type. If more than $10 a month per individual, count the amount that exceeds $10 as unearned income.
50. Veterans pension benefits reduced to $90 for nursing home residents	N/A	Disregard.
51. Picket pay or strike pay	Consider as earned income	a. Consider as earned income if the client is required to perform specific duties or participate for a specific number of hours. Allow the earned income disregards. b. If the client is not required to perform specific duties or participate for a specific number of hours, consider as unearned income.
52. Any payment received from the Radiation Exposure Compensation Trust Funds	Disregard.	Disregard. Any interest earned on unspent RECTF payments is counted as unearned interest income.
53. Veterans Assistance benefits received by the spouse of an SSI recipient if the spouse is applying for or receiving AABD/MA	N/A	a. Disregard the amount of VA benefits, if any that are budgeted by SSI to the SSI spouse. b. Consider as unearned income the remainder on the AABD/MA budget of the non-SSI spouse.

~~54. Agent Orange settlement payments~~	~~Disregard.~~	~~Disregard.~~
~~55. Benefits under Public Law 104-204 for a child born with spina bifida and whose parent(s) is a Vietnam veteran~~	~~Disregard.~~	~~Disregard.~~

Other Income	Parents/Needy Caretaker Relatives and Children Medically Needy	AABD/MA and AABD Medically Needy
56. Payments made from any fund established as a result of the case of Susan Walker v. Bayer Corporation, et al. to hemophilia patients who are infected with HIV	Disregard.	Disregard.
57. Payments to AmeriCorps volunteers	Disregard.	Disregard.
58. The living allowance issued to Job Corps recipients or the readjustment allowance that is issued when Job Corps participants leave the program	Consider as earned income.	Consider as earned income.
59. In-kind income received by Job Corps participants for food, shelter, etc.	Disregard.	Disregard.
60. Insurance payments for damage to personal property	Disregard.	Disregard.
61. Assistance received under the Disaster Relief Act of 1974 or under a federal statute because of catastrophe declared to be a major disaster by the President and any interest earned on the assistance	Disregard.	Disregard.
62. Christmas bonus/work related bonus	Consider as an earned income lump sum. For children, consider as earned income. Count as an earned income lump sum if received in a separate check.	Earned income.

20-011 VERIFICATION OF INCOME: Verification of income consists of at least the following:

5. The source of the income;
6. The date paid or received;
7. The period covered by the payment or benefit; and
8. The gross amount of payment or benefit.

20-011.01 Income Verification: Income must be verified every 12 months and shall be converted for weekly and bi-weekly income.

3. Regular income must be verified using one month's income as a minimum.
4. Irregular income must be verified using the three most consecutive months, if available.
5. RSDI/SSI benefits shall be verified by viewing the direct deposit records or system interface.

20-012 TERMINATED INCOME: When an individual engages in different types of self-employment, it is not considered a termination of income if the individual stops one type of work.

20-013 RETROACTIVE MEDICAID ELIGIBILITY: To determine retroactive medical eligibility, each month's actual income must be used.

Note: Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 23-000 RESOURCES FOR NON-MAGI PROGRAMS

23-001 RESOURCES

23-001.01 Resources: The total equity value of available non-excluded resources of the client or client and responsible relative (see 477 NAC 24-001) is determined and compared with the established maximum for available resources that the client may own and still be considered eligible. If the total equity value of available non-excluded resources exceeds the established maximum, the client is ineligible. See 477 NAC 23-001.11 for Reduction of Resources.

Note: For ABD, assets of each spouse are considered available to the other (even if they no longer live together) unless there is a divorce or spousal impoverishment provisions apply. For examples of resources, see Appendix 477-000-036 and 477-000-052.

23-001.02 Verification of Resources: As a condition of both retroactive and prospective eligibility, all countable resources shall be verified and documented in the case record. See Appendix 477-000-052 for the Resource Verification Plan Table.

23-001.02A Exceptions:

1. For ABD clients who receive Supplemental Security Income (SSI), including individuals in 1619(b) status, verification of resources is not required.
2. If it is unknown whether or not a resource is countable, verification shall be required.

23-001.02B Necessary Verification: Verification of resources consists of but is not limited to the following information:

1. A description of the type of resource (e.g., account or policy number(s), legal descriptions for property, etc.);
2. The location of the resource (e.g., name and address of the bank, insurance company);
3. Current value of the resource, encumbrances against the resource, and the resulting equity value;

4. Description of current ownership; and
5. Source of verification and the date verification is obtained. See Appendix 477-000-052.

If a client or spouse of the client has a guardian, the guardian's annual report to the court may be used for verification. The guardian's report applies only to the period covered by the report. Regular verification procedures must be followed if there is no guardian's report or the report does not coincide with the date of renewal.

23-001.02C Resource Review: If there is reason to believe at any time there has been an increase in resources that may affect eligibility, all resources must be verified immediately. A resource review is not required for SSI recipients.

23-001.03 Availability of Resources: For the determination of Medicaid eligibility, available resources include cash or other liquid assets or any type of real or personal property or interest in property that the client owns and may convert into cash to be used for support and maintenance.

23-001.03A Unavailability of Resource: Regardless of the terms of ownership, if it can be documented in the case record that a resource is unavailable to the client, the value of that resource is not used in determining eligibility. The feasibility of the client's taking legal action to make the resource available must be taken into consideration. If it is determined that legal action can be taken, the client is allowed sixty (60) days to initiate legal action. After sixty (60) days, if the client has not filed legal action, the case is closed for failure to comply.

If the applicant/recipient has benefit funds, such as funds raised by a benefit dance or auction, you must determine whether those funds are available as a resource. If the client or a financially responsible relative can access the benefit funds to pay for shelter costs, maintenance needs, or medical costs otherwise covered by Medicaid, then the funds are considered available.

An applicant/client must file in county court for the maximum elective share of a deceased spouse's augmented estate as specified in Neb. Rev. Stat. sections 30-2313 and 30-2314. The status of the resource must be monitored.

23-001.03B Value and Equity: Equity is the actual value of property (the price at which it could be sold) less the total of encumbrances against it (mortgages, mechanic's liens, other liens and taxes, and estimated selling expenses). If encumbrances against the property equal or exceed the price for which the property could be sold, the client has no equity and the property is not an available resource.

23-001.03B1 Secured Debts: The total value of unpaid personal taxes and other personal debts secured by mortgages, liens, promissory notes, and judgments (other than those on which the statute of limitations applies) is subtracted from the gross value of the encumbered property to find the equity. The case record

shall include documentation of the type of debt and plan under which payment was made. A service or payment made for free at the time for the benefit of the client, without a written agreement for repayment later, is not a debt.

23-001.03B2 Determination of Value: Public tax records or county assessor records may be used to determine the sale value of a resource. If there is a question as to the accuracy of the sale value determined by these records, verification may be obtained from a real estate agent, car dealer, or other appropriate individual.

23-001.04 Deprivation of Resources

23-001.04A Deprivation of Resources: Any action taken by the applicant/client, or any other person or entity, that reduces or eliminates the applicant's/client's or spouse's recorded ownership or control of the asset for less than fair market value (full value) is a deprivation of resources. The fair market value of a resource at the time the resource was disposed of must be verified and the equity value of the resource must be determined by taking into consideration any encumbrances against the resource. A deprivation of resources includes

1. Recorded transfer of ownership of real property;
2. Not receiving the spousal share of an augmented estate;
3. Purchase of a life estate in another individual's home without meeting the twelve(12)-month requirement to reside there;
4. Promissory notes, loans, mortgages, and contract sales for less than fair market value or that are for at least fair market value and are not enforced;
5. Purchase of an irrevocable, non-assignable annuity, if Medicaid is not the preferred beneficiary and the annuity is issued on or after February 8, 2006;
6. Any transfer above the protected spousal reserved amount to a community spouse;
7. Purchase of any contract or financial instrument, including an endowment or insurance, where the criteria for fair market value are not met; and
8. Resources transferred to a pooled trust established for the benefit of a person sixty-five (65) years old or greater at the time of transfer.

23-001.04B Fair Market Criteria: The criteria for fair market value are not met when

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

23-001.04B1 Exculpatory Provision: If a client living in a nursing home lends money to an individual with a promissory note stating that the obligation to pay any remaining balance ceases upon the client's death, the exculpatory provision forgives or clears the debt and is therefore not a permissible transaction that would avoid a deprivation.

23-001.04B2 Repayment Agreement: Any service agreement must be in writing and reasonably describe the services to be rendered prior to the rendering of services. See 477 NAC 23-001.03B1

23-001.04C Asset Placed in Annuity: When an asset is placed in an annuity on February 8, 2006 or later, see annuity regulations at 477 NAC 23-001.05A6a.

23-001.04D Asset Placed in Trust: Trust regulations at 477 NAC 23-001.05A6b take precedence over deprivation when an asset is placed in a trust.

23-001.04E Sale of Real Property in Life Estate: When real property in which the individual has a life estate is sold, the individual or spouse must receive as a lump sum his/her life estate interest from the net proceeds, or the entire net proceeds invested and the individual(s) who has the life estate receives all the income.

23-001.04F Deprivation of Resources Review: Deprivation of a resource must be reviewed only if an individual or an individual's spouse resides in a specified living arrangement, which is defined as

1. A nursing home;
2. Receiving skilled level of care in a hospital, i.e. swing bed services;
3. Receiving Home and Community-Based Services (HCBS), including an assisted living waiver, Program of All-Inclusive Care for the Elderly (PACE), or requesting and meeting the criteria for such services; or
4. An intermediate care facility for persons with a developmental disability.

23-001.04G Look-Back Period for Disposal/Transfer of Resources on or after February 8, 2006: To determine if a client or his/her spouse deprived himself/herself of a resource to qualify for Medicaid, the Department must look back sixty (60) months before the month of application. The look-back is triggered when the applicant first applies for Medicaid and is in a specified living arrangement or is on Medicaid and enters a specified living arrangement.

When an applicant applies for Medicaid more than once, the look-back period is based on the first date the individual meets both of these requirements.

To determine any countable value disposed of, the Department shall

1. Take the equity the client had in the resource at the time of disposition (equity equals fair market value minus encumbrances), and
2. Subtract any compensation received by the client.

23-001.04G1 Period of Ineligibility: If it is determined that an applicant/client disposed of a resource, the applicant/client is ineligible.

To determine the length of the period of ineligibility the countable value of the resource shall be divided by the actual monthly cost of care in the specified living arrangement at the current private pay rate.

If both spouses are applying and eligible for Medicaid, the period of ineligibility is divided equally between the spouses.

The period of ineligibility begins

1. If the client is receiving Medicaid, with the month of entry into a specified living arrangement, following notice requirements; or
2. If an applicant, the month of application if in a specified living arrangement.

The applicant/client must be Medicaid eligible, except for the deprivation of resources in the month of application, for a deprivation penalty to be imposed.

If the division results in a fraction, the fraction is converted to a dollar amount and that amount is included as unearned income for the applicable month.

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

For periodic disposals within the look-back period, each is determined separately; the periods of ineligibility run consecutively. Multiple fractional month transfers are cumulative and treated as a single transfer.

23-001.04G1A: Spouse for Spouse Ineligibility: If a community spouse enters a specified living arrangement and is Medicaid eligible except for the deprivation, divide the full or any remaining period of ineligibility between the spouses.

23-001.04G2 Deprivation Hardship Waiver: An exception may be made if it is determined that a transfer was made for less than fair market value, but the individual can verify that s/he intended to dispose of the resource for fair market value or for other valuable consideration, that the transfer was not made to qualify for assistance, or that denial of assistance would cause undue hardship.

All requests for deprivation hardship waiver must be submitted in writing to the Department. On receipt of the written request, the Department shall follow the process described at Appendix 477-000-033.

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

The guardian, conservator, or anyone acting on behalf of the applicant/client must attempt to recover transferred assets. Up to thirty (30) days of nursing home services may be provided if the applicant/client is cooperating to the fullest extent in attempting to recover transferred assets. If cooperation ceases, undue hardship no longer exists and eligibility is terminated.

A hardship waiver will be denied if the applicant/client or his/her spouse participated in the transfer. A denial of hardship waiver request may be appealed.

23-001.04H Transfers Not Considered Deprivation: It is not considered a deprivation of a resource if

1. An applicant/client transferred a resource to his/her spouse, to an individual with power of attorney, or to a guardian or conservator for the sole benefit of the applicant's/client's spouse;
2. An applicant's/client's spouse transferred a resource to an individual with power of attorney, or to a guardian or conservator, for the sole benefit of the applicant's/client's spouse;
3. A resource was transferred to a trust established solely for the benefit of the applicant's/client's son or daughter who is blind or disabled (receiving or eligible to receive SSI, RSDI, or ABD);
4. A resource was transferred to the applicant's/client's son or daughter who is blind or disabled (receiving or eligible to receive SSI, RSDI, or ABD); or
5. A resource was transferred to a special needs trust established solely for the benefit of an individual sixty-four (64) years old or younger who is disabled (receiving or eligible to receive SSI, RSDI, or ABD).

23-001.04H1 Transfer of a Home: It is not considered a deprivation of a resource if an applicant/client transfers title to his/her home to his/her

1. Spouse;
2. Son or daughter who
    a. Is age 20 or younger;
    b. Is blind or disabled (receiving or eligible to receive SSI, RSDI, or ABD based on blindness or disability); or
    c. Was residing in the home for at least two (2) years before his/her parent applied for Medicaid or entered long-term care and provided care to his/her parent that permitted the parent to reside at home rather than be institutionalized or receive HCBS Waiver; or
3. Sibling who has an equity interest in the home and who was residing in the home for at least one (1) year immediately before his/her sibling applied for Medicaid or entered a specified living arrangement listed at 477 NAC 23-001.04F.

23-001.05 Types of Resources: Resources can be divided into two (2) categories: liquid and non-liquid.

23-001.05A Liquid Resources: Liquid resources are assets that are in cash or financial instruments that are convertible to cash. See Appendix 477-000-036 for examples of liquid resources.

23-001.05A1 Cash, Savings, Investments, Money Due: Cash on hand, cash in checking and savings accounts, salable stocks or bonds, certificates of deposit, promissory notes and other collectible unpaid notes or loans and other investments are available resources.

23-001.05A2 Land Contracts: A land contract, or real estate contract of sale, is considered a resource to the seller of the property if the contract can be sold. In determining the value of the contract, the salability of the contract and the resulting value shall be determined (see 477 NAC 23-001.03B). The contract is not considered salable unless there is a known buyer.

If the contract is determined to be salable, the net value of the contract becomes the value at which it could be sold, minus encumbrances, etc., against the property.

If it is determined and documented that the contract is not salable, the contract is not considered an available resource to the client. A review of the salability shall be completed at all renewals or more often as deemed necessary.

Any income received from a land contract is considered unearned income to the client. The contract may be considered a deprivation of resources; the contract terms which are not a deprivation of resource are at Appendix 477-000-032. See process at Appendix 477-000-031.

23-001.05A3 Funds Set Aside for Burial: A specified maximum may be disregarded if it is set aside for the purpose of paying burial expenses. The individual may choose to put the money in

1. A pre-need burial trust. If the client has an irrevocable burial trust for more than the specified maximum, the excess is considered an available resource;
2. A policy of burial insurance. If the client has irrevocably assigned more than the specified maximum in burial insurance, the excess is not an available resource but may be a deprivation of resources; or
3. A maximum of $1,500 may be designated for burial. These funds may be in an account or in an insurance policy. This provision is applicable to ABD individuals only.

An individual may transfer funds from an irrevocable burial trust fund into an insurance policy if there is no lapse of time between the withdrawal and the transfer. See below for the treatment of burial spaces and burial space items.

23-001.05A3a Irrevocable Burial Trusts: If money was placed in an irrevocable burial trust on July 16, 1982, or later, it is not considered an available resource.

The value of the irrevocable burial trust is limited by the specified maximum amount identified at Neb. Rev. Stat. Section 68-129. The trust must be created for the purpose of paying prearranged burial expenses. The value up to the specified maximum of an irrevocable burial trust and any accrued interest or dividends on that amount, if irrevocable, are considered unavailable and are disregarded. The mortuary may retain an additional amount not to exceed 15 percent (15%), but this amount must not be included in the burial trust.

An irrevocable burial trust must be deposited by a mortuary with a financial institution. A written copy of the contract may be retained by the client or the funeral home.

In determining whether the value of a burial fund contracted in Nebraska is considered available, the terms of the contract must be verified with the financial institution. If a burial trust is drawn up in another state, the contract terms must be verified and determined whether that state allows irrevocable burial funds or whether the value of the trust is available to the client regardless of the contract terms.

23-001.05A3b Interest and Dividends on Burial Trusts: For irrevocable burial trusts all accrued interest or dividends are also irrevocable.

23-001.05A3c Burial Insurance: Burial insurance is defined as insurance in which the policy's terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured, or a life insurance policy that is irrevocably assigned for the specific purpose of burial. When the proceeds of a life insurance policy are irrevocably assigned for the purpose of burial, the cash value is not available and is disregarded as a resource.

If it is burial insurance that has been irrevocably assigned, it is treated according to the rules in the above paragraph and the specified maximum applies. If a total of more than the specified maximum in burial insurance is irrevocably assigned for services, the amount above the specified maximum may be considered deprivation of a resource (see 477 NAC 23-001.04).

23-001.05A3d Money Designated for Burial: Up to $1,500 may be disregarded for each individual if it is set aside for the purpose of paying burial arrangements for the individual or the individual's spouse. This exclusion is in addition to the burial space exclusion. To qualify for this exclusion, funds must be separated into a designated account. The $1500 is reduced by

1. The face value of any policy of life or burial insurance, and
2. The amount of any irrevocably assigned burial trust, contract, or arrangement

23-001.05A3e Burial Spaces: The value of burial spaces (held for the purpose of providing a place for the burial of the client, his/her spouse, and members of the client's immediate family) is not counted as an available resource. Immediate family includes minor and adult children, including adopted children and stepchildren, brothers, sisters, parents, adoptive parents, and the spouses of these individuals.

A burial space includes a crypt, mausoleum, urn, casket, marker, vault, or other repository for the remains of a deceased person. This exemption also applies to markers, vaults, applicable sales tax, charges for opening and closing the grave, but does not include services, burial fees, etc. These items are exempt only if they are actually purchased.

23-001.05A3f Burial Space Items Held in a Contract: Burial space items may be disregarded when they are held for an individual by way of a contract. To meet the requirement that the item is actually purchased, the contract must state that the individual has purchased a particular item for a specified price. The contract may be revocable or irrevocable as long as the agreement itself represents the individual’s ownership. The contract may be funded by money set aside in a bank account or in a burial insurance policy. Any interest accrued and left to accumulate is not counted as income.

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

23-001.05A4 Life Insurance

23-001.05A4a Insured: The person whose life is insured.

23-001.05A4b Insurer: The company that insures others.

23-001.05A4c Owner: The person who has the right to change the policy.

23-001.05A4d Term Insurance: A form of life insurance that generally furnishes insurance protection for only a specified or limited period of time.

23-001.05A4e Face Value: The basic death benefit of a life insurance policy exclusive of dividend additions or additional amounts payable because of accidental death, or under other special provisions. In determining the face value of a policy, the original face value of the policy is used.

23-001.05A4f Adjustment: When a client adjusts a large insurance policy to a smaller amount providing limited protection and allowing the client to benefit from accumulated savings.

23-001.05A4g Interest and Dividends: Interest and dividends actually paid to a client from all life insurance policies are treated according to the treatment of income chart at 477 NAC 22-005.06.

23-001.05A4h Cash Surrender Value: Amount an insurer will pay (usually to the owner) upon cancellation of a life insurance policy before death of the insured or before maturity of the policy.

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

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

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

See 477 NAC 23-001.05A3c for the treatment of burial insurance.

If the cash surrender value is to be counted toward the resource total of a client, consideration is given to any outstanding loans against the policy in determining net cash surrender value. See 477 NAC 23-001.03B.

23-001.05A5 Long-Term Care (LTC) Partnership Program: Resources equal to the amount of benefits paid out by a qualified LTC Partnership policy are disregarded for an individual applying for Medicaid if the policy was issued on July 1, 2006, or later, and the individual is otherwise Medicaid-eligible. The benefits may be paid as direct reimbursement of long-term care expenses, or paid on a per diem or other periodic basis, for periods during which the individual received long-term care services. The disregard is applied to the amount of benefits paid to or for the individual as of the month of application, even if additional benefits remain available under the terms of the policy. The amount of the resource disregard is also excluded from estate recovery.

23-001.05A5a Qualified LTC Partnership Policy: A long-term care insurance policy that has been approved by the Nebraska Department of Insurance. The Department accepts the Department of Insurance's certification of the policy. If an individual has a long-term care insurance policy that does not meet the requirements for a Qualified LTC Partnership policy because it was issued before July 1, 2006, the individual may exchange the policy for another.

23-001.05A5b Exchange of Non-Partnership Policy for Qualified LTC Partnership Policy: An applicant/client may exchange a policy that does not meet the requirements of a qualified LTC Partnership Policy for one that does meet the requirements. The date of exchange is considered the issue date for the qualified LTC Partnership Policy.

23-001.05A5c Reciprocity with Other States: The Department will accept qualified LTC Partnership Policies issued in other states with LTC Partnership Programs.

23-001.05A6 Annuity, Trust, and Guardianship/Conservatorship Funds: When an annuity, trust, guardianship, or conservatorship has been established on behalf of an applicant/client and the applicant/client who has applied has resources exceeding the total resource limit, it must be verified if the annuity, trust, guardianship, or conservatorship is available to the applicant/client.

23-001.05A6a Annuities

23-001.05A6a(1) Annuity: A prepaid investment that pays periodic (usually monthly) payments for a set period of time. Payments may begin immediately or at a future date.

23-001.05A6a(2) Annuity Transaction: The purchase of an annuity, changing the annuity beneficiary, or authorizing the commencement of the pay-out period (annuitizing).

23-001.05A6a(3) Purchased or Annuitized before February 8, 2006: When an applicant/client cannot assign or change the ownership or payee of an annuity, the annuity is unavailable. A determination must then be made if a deprivation has occurred. If the expected return on the annuity is commensurate with the life expectancy of the applicant/client, the annuity can be deemed actuarially sound and no deprivation has occurred. If the average number of years of expected life remaining for the applicant/client does not coincide with the life of the annuity (i.e., the applicant/client is not reasonably expected to live longer than the guarantee period of the annuity), a deprivation has occurred. The look-back period is the same as for trusts. See Appendix 477-000-039 for Period Life Tables.

23-001.05A6a(4) Annuity Transaction on or after February 8, 2006

23-001.05A6a(4)(i) Countable Resources: Revocable and assignable annuities are countable resources. A saleable annuity that has not been sold is a countable resource for the amount annuitized, less the payment amount(s) already received. A saleable annuity that has been sold for a value consistent with the secondary market is a countable resource in the amount of the proceeds. If a saleable annuity is sold for less than a value consistent with the secondary market, it will be valued at the current secondary market amount and the difference will be subject to the deprivation of resources regulation.

23-001.05A6a(4)(ii) Deprivation of Resources for Annuity Transactions: For long-term care services, an annuity transaction after February 8, 2006, is treated as a disposal of an asset for less than fair market value unless the State of Nebraska is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid, or is named as the remainder beneficiary in the second position after a community spouse and/or minor or disabled child. An annuity is also treated as a disposal of assets for less than fair market value unless it is irrevocable and non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments. This provision also applies to a community spouse.

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

23-001.05A6a(5) Annuities Excluded from Resources: An annuity that has been annuitized will be excluded from countable resources if it meets the following conditions:

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

23-001.05A6b Trusts

23-001.05A6b(1) Trust: For purposes of these regulations, a trust is any arrangement in which an individual (grantor) transfers property to another person(s) (trustee[s]) with the intention that it be held, managed, or administered by the trustee(s) for the benefit of the grantor or certain designated beneficiaries. The trust must be valid under state law and manifested by a valid trust instrument of agreement. A trustee holds a fiduciary responsibility to manage the trust's corpus and income for the benefit of the beneficiaries.

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

23-001.05A6b(2) Grantor of a Trust: Any individual who creates a trust. This includes

1. An applicant/client;
2. The applicant's/client's spouse;
3. A person, including a court or administrative body, with legal authority to act in place of, or on behalf of, the applicant/client or the applicant's/client's spouse (guardian/conservator); or

4. A person, including a court or administrative body, acting at the direction or upon the request of the applicant/client or his/her spouse.

23-001.05A6b(3) Trust Beneficiary: Any individual, or individuals, designated in a trust to receive any disbursal from the corpus of the trust, or from income generated by the trust, which benefits the party receiving it. A payment from a trust may include actual cash, as well as non-cash or property disbursements, such as the right to use and occupy real property.

23-001.05A6b(4) Disclosure of Trust Interest: An applicant or client of ABD or Long-Term Care who has been a grantor, or is a beneficiary, of a trust must report the interest granted to, or held by , the trust. Eligibility cannot be determined until the trust interest has been verified.

23-001.05A6b(5) Revocable Trust: A trust that can be revoked by the grantor. Any trust stipulating that it may be modified or terminated only by a court is considered to be a revocable trust, as the grantor (or representative) can petition the court to terminate the trust. A trust designated as irrevocable but that will terminate if certain action is taken by the grantor is considered a revocable trust for purposes of these regulations.

In the case of a revocable trust:

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

23-001.05A6b(6) Irrevocable Trusts: Trusts that cannot in any way be revoked by the grantor of the trust.

23-001.05A6b(6)(a) Trusts Established before August 11, 1993: For a Medicaid-qualifying trust established before August 11, 1993, the maximum amount that could have been distributed from either the income or principal is considered an available resource. A Medicaid-qualifying trust is a trust or similar legal device that was established by a applicant/client (or his or her spouse) under which

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

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

23-001.05A6b(6)(b) Trusts Established on or after August 11, 1993: In accordance with Sections 1917 (c) and (d) of the Social Security Act, the following regulations apply to all trusts created on or after August 11, 1993. These regulations apply to any applicant/client who establishes a trust or who is a beneficiary of a trust. An applicant/client is considered to have established a trust if his/her assets or assets of his/her spouse were used to form a part or the entire corpus of the trust other than by will. These include trusts established by

1. The applicant/client;
2. His/her spouse;
3. A person, including a court or administrative body, with legal authority to act in place of or on behalf of the applicant/client or his/her spouse; or
4. A person, including any court or administrative body, acting at the direction or upon the request of the applicant/client or his/her spouse.

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

23-001.05A6b(6)(b)(i) Payment Can Be Made from Trust: In the case of an irrevocable trust, where there are any circumstances under which payment can be made to or for the benefit of the applicant/client from all or a portion of the trust, the following rules apply to that portion:

1. Payments from income or from the corpus made to or for the benefit of the applicant/client and/or his/her spouse are treated as income to the applicant/client.
2. Income on the corpus of the trust which could be paid to or for the benefit of the applicant/client and/or his/her spouse must be considered a resource available to the applicant/client.
3. The portion of the corpus that could be paid to or for the benefit of the applicant/client and/or his/her spouse is treated as an available resource.
4. Payments from income or from the corpus that are not made to or for the benefit of the applicant/client and/or his/her spouse are treated as a transfer of assets for less than fair market value.

23-001.05A6b(6)(b)(ii) Exceptions: A trust is not considered available if it is established for a disabled client sixty-four (64) years old or younger (receiving or eligible to receive SSI, RSDI, or ABD) and is a:

1. Special needs trust: A trust containing the assets of the applicant/client and established solely for the benefit of the applicant/client by his/her parent, grandparent, legal guardian, or a court, if the state will receive all amounts remaining in the trust upon the death of the applicant/client or on termination of the trust up to the amount of total Medicaid paid on behalf of the applicant/client; or
2. Pooled trust: A trust containing the assets of the applicant/client and:
    a. Established and managed by a non-profit association;

b. A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of assets, the trust pools these accounts;
c. Accounts in the trust are established solely for the benefit of individuals who are blind or disabled (receiving or eligible to receive SSI, RSDI, or ABD); and
d. The trust provides that to the extent any amounts remaining in the applicant's/client's account on his/her death are not retained by the trust, the trust shall pay to the state the amount remaining up to the amount of total Medicaid paid on behalf of the applicant/client.

Note: See Supplemental Security Income (SSI), Program Operations Manual System (POMS), SI 01120.201F.

23-001.05A6b(6)(b)(iii) Payment Cannot Be Made from Trust: When payments from some portion or all of a trust cannot under any circumstances be made to or for the benefit of an applicant/client, or where there is some portion of the trust from which no payments can be made to or for the benefit of the applicant/client, all of the corpus, or income on the corpus, which cannot be paid to the applicant/client is considered a transfer of assets for less than fair market value. See Deprivation of Resources at 477 NAC 23-001.04.

23-001.05A6b(6)(b)(iv) Hardship Exception: A trust will not be considered available if denial of assistance would cause undue hardship. See 477 NAC 23-001.04F2.

23-001.05A6b(7) Testamentary Trusts: Trusts established through a will. Testamentary trusts may be excluded as resources, depending on the availability of the funds to the applicant/client or his/her spouse, as specified in the terms of the trust.

23-001.05A6c Guardianships/Conservatorships: Nebraska law requires that funds in conservatorships or "blocked" accounts be made available for the care and maintenance of the individual whose funds are in the account (See Neb. Rev. Stat. 30-2654 and 30-2628).

23-001.05A6d ABLE Accounts: The balance of an ABLE account is disregarded as a countable resource. A contribution to an ABLE account is not counted as income for an applicant/client. A distribution from an ABLE account is not considered income, but conversion of a resource. A distribution from an ABLE account for a non-housing Qualified Disability Expense to an applicant/client or his/her financial account is disregarded. A distribution from an ABLE account for a housing Qualified Disability Expense is not counted in the month of receipt. The distribution is counted only if retained in a later month. A distribution from an ABLE account is counted as a resource if it is not spent on a Qualified Disability Expense.

23-001.05B Non-Liquid Resources: Non-liquid resources are tangible properties that must be sold if they are to be used for the maintenance of an applicant/client. They include all properties not classified as liquid resources. See Appendix 477-000-036 for examples of non-liquid resources.

23-001.05B1 Real Property Other Than the Principal Home: In computing the amount of a unit's total available resources, the potential sales value of all real property, other than the allowed exemption for the home, must be determined and used.

23-001.05B2 Joint Ownership of Real Property: Real property that is jointly owned is excluded if sale of the property would cause the other owner(s) undue hardship. However, if undue hardship does not apply or ceases to exist, the property is included in countable resources and handled according to the following regulations.

If an applicant/client owns a property with other persons who are not on Medicaid and the real property is not the principal place of residence for the other owner(s), the other owners shall be contacted to determine if they are willing to liquidate their interest in the property. If all parties are willing to liquidate, the liquidation proceeds. For the time limit for liquidation see 477 NAC 23-001.05B4a.

If one (1) or more of the parties do not wish to liquidate, the process for unavailability of a resource is applied, which requires the applicant/client to take legal action to force a sale of the property. A written statement may be obtained from the other parties and filed in the case record. After a legal determination is made regarding the availability of the applicant’s/client’s interest in the property, appropriate action must be taken.

23-001.05B3 Exemption of the Home: The applicant's/clients home is exempt from consideration as an available resource, subject to the limitations below.

23-001.05B3a Definition of Home: Home is defined as any shelter that an individual owns and uses as his/her principal place of residence. The home includes any land on which the house is located and any related outbuildings necessary to the operation of the home.

23-001.05B43b Home Equity Value: For applications on or after January 1, 2006, an applicant/client is not eligible for any long-term care services if the equity value interest in the home exceeds the specified amount. See Appendix 477-000-014.

23-001.05B3c Trailer Houses and Other Portable Housing Units: If an applicant/client occupies a trailer house or other portable housing unit as his/her home, the property is allowed the resource exemption for a home.

If the applicant/client enters a nursing home, s/he is allowed the exemption of a home for up to six (6) months

1. If the trailer house or other portable housing unit is used for the client's trade or business, or
2. If it is used to produce goods for the client's own consumption or use.

23-001.05B3d Adjacent Lots: A lot adjacent to the home is considered available if it can be sold separately from the home. If it is determined and documented in the case record that a lot adjacent to the home cannot be sold or is not salable due to the location or condition of the property, the adjacent lot is also exempt. See 477 NAC 23-001.05B10 for maximum equity value.

23-001.05B3e Removal from Home: If an applicant/client moves away from the home and does not plan or is unable to return to it, it must be determined when the home becomes an available resource in accordance with the following provisions. The home continues to be exempt as a resource while it is actually occupied by the applicant's/client's spouse or dependent relative. A dependent relative includes the client's

1. Child, stepchild, or grandchild seventeen (17) years old or younger;
2. Child, stepchild, or grandchild eighteen (18) years old or older if aged, blind, or disabled and receiving or eligible to receive SSI, ABD, and/or other categorical assistance; or

3. Brother, sister, stepbrother, stepsister, half-brother, half-sister, parent, stepparent, grandparent, aunt, uncle, niece, nephew, or the spouse of any persons previously named, even after the marriage has been terminated by death or divorce, who is receiving or who would be eligible for categorical assistance except for income and resources and who lived in the home at any time one year before the client moved away from the home.

When it is not possible to determine immediately whether an applicant/client who moves to a nursing home or assisted living facility and is receiving AD waiver services will be able to return to the home, a maximum of six (6) months must be allowed to make this determination.

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

After an applicant/client lives out of the home for a maximum of six (6) months, the home is no longer considered the applicant's/client's principal place of residence and must be considered an available resource. However, the applicant/client is allowed a reasonable amount of time commensurate with then existing conditions to liquidate the property before it affects eligibility.

The six (6) months begin with the first full month following the month of admission to a nursing home or assisted living facility, if receiving HCBS or PACE services. After the applicant/client is admitted, if the home is exempt because it is occupied by one (1) or more of the relatives identified previously, the six (6) months begin with the first full month following the month that the home is no longer allowed the exemption for occupation.

23-001.05B3e(1) Liquidation of Home: As soon as the determination is made that the applicant/client will not be able to return home, the applicant/client must be allowed time to liquidate the property. The applicant/client is also allowed time for liquidation if s/he leaves the home for a reason other than entering a medical institution. For the time limit for liquidation, see 477 NAC 23-001.05B4a.

23-001.05B3f Sale of Home: If an applicant/client sells his/her home, the net proceeds become an available resource unless reinvested immediately in another home. In order to be allowed time to reinvest the proceeds, an applicant/client must be residing in the home at the time of the sale and move directly to his/her new home. Net proceeds are the remainder after payment of the mortgage, realtor's fees, legal fees, etc. Any deductions must be verified.

23-001.05B4 Liquidation of Real Property: When an applicant/client as excess resources because of real property, s/he may receive Medicaid pending liquidation of the resource, according to the following regulations. This reference does not apply if the community spouse under spousal impoverishment regulations will retain any of the proceeds of the sale. For the time limit for liquidation, see 477 NAC 23-001.05B4a.

Note: If an applicant/client has excess resources because of real property other than his or her home during a retroactive period, s/he is ineligible for Medicaid. The applicant/client may be prospectively eligible with excess resources because of real property if an Agreement to Sell Real Property Form is signed.

23-001.05B4a Time Limit for Liquidation: Real property that an applicant/client is making a good faith effort to sell must be excluded. First, it must be determined if the applicant/client has the legal authority to liquidate the property. The applicant/client is allowed sixty (60) days to initiate legal action to obtain liquidation. If the applicant/client owns the property with other persons, see 477 NAC 23-001.05B2.

Once the applicant/client has the legal authority to liquidate the property, the client's signature on the Agreement to Sell Real Property Form must be obtained. The applicant/client is allowed six (6) calendar months to liquidate the real property. If the applicant/client refuses to sign the Agreement to Sell Real Property Form, s/he is immediately ineligible due to excess resources. The six (6)-month period begins with the month following the month in which the Agreement to Sell Real Property Form is signed.

Once the Agreement to Sell Real Property Form is signed, the six (6) calendar months are counted whether or not the applicant/client is receiving Medicaid. If, after the Agreement to Sell Real Property Form is signed, the applicant/client goes into current pay status for SSI, the Agreement to Sell Real Property Form is void.

Note: If the applicant/client later goes into non-pay status for SSI, a new Agreement to Sell Real Property Form is signed and a new six (6)-month liquidation period is established. If the applicant/client moves back to the home and subsequently moves out again during the six (6)-month period, s/he is only allowed the months remaining in the original six (6)-calendar-month period. One (1) liquidation period is allowed for each piece of real property that is determined to cause excess resources, even if the case is closed and subsequently reopened.

23-001.05B4a(1) Extension of Time Limit: If an applicant/client is unable to liquidate a property in six (6) calendar months, the Department may authorize one (1) additional three(3)-calendar-month extension. In determining whether to allow a three (3)-calendar-month extension, the Department shall consider:

1. If the property has been placed on the market with a real estate licensee;
2. If the applicant/client is asking a fair price for the property;
3. If the asking price has been reduced;
4. If the applicant/client understands the requirement for liquidation of the property;
5. If the applicant/client has refused a reasonable offer to purchase (If there is no better offer, a reasonable offer is defined as at least 2/3 of either the estimated current market value or the proven actual value); and
6. The economic conditions in the area and if real estate is selling.

The three (3) calendar months are counted whether or not the applicant/client is receiving Medicaid. If the applicant/client moves back to the home during the three (3)-month period and subsequently moves out again, s/he is allowed the months remaining in the initial three (3)-month extension.

23-001.05B5 Motor Vehicles: One (1) motor vehicle regardless of its value, as long as it is necessary for an applicant/client or a member of his/her household for employment or medical treatment, shall be disregarded. If an applicant/client has more than one (1) motor vehicle, the vehicle with the greatest equity must be excluded. Any other motor vehicles are treated as non-liquid resources and the equity is counted toward the resource limit. An applicant's/client's verbal statement that the motor vehicle is used for employment or medical treatment is sufficient for verification purposes. See Appendix 477-000-052.

23-001. 05B5a Exceptions:

1. The disregard of any motor vehicle is not allowed when it has been determined that a client residing in a nursing home or an assisted living facility and receiving services through HCBS or PACE does not intend, or will not be able to return home if medical transportation is included in the payment to the facility; or
2. The applicant/client designates the disregarded vehicle for Assessment of Resources.

23-001.05B5b Determination of Fair Market Value: For motor vehicles that are counted toward the resource total, fair market value is used. Cars, trucks, SUVs, vans, motorcycles, recreational vehicles, motorboats and watercraft, and planes are included in the category of motor vehicles. See Appendix 477-000-052.

23-001.05B6 Life Estates: The owner of a life estate in real property is generally unable to sell the property. The net income from the life estate must be included in the budget rather than considering the life estate as an available resource. If the owner of a life estate transfers it to another individual, it must be determined whether or not it is deprivation of a resource. If the life estate is sold, the proceeds are counted as resources. See Appendix 477-000-030 for examples of treatment of life estate income.

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

See Appendix 477-000-038 for the Life Estate Interest Table.

23-001.05B7 Essential Property: Resources that are used in an applicant's/client's or responsible relative's trade or business as the primary means of earning a livelihood for self-support are disregarded, regardless of value. This includes:

1. Real property such as land, houses, buildings, business equipment and fixtures, farm machinery, tools, safety equipment, livestock, and crops used for a client's trade or business.
2. Business bank accounts, as long as the funds are separated from other liquid resources.

See Appendix 477-000-050 for examples.

Filing a self-employment tax refund alone is not sufficient to meet the criteria of being engaged in a trade or business as a primary means of earning a livelihood. Land that is leased or rented out to another person or entity or land enrolled in an agricultural development program is not disregarded.

Resources that are excluded under this provision must be in current use in the type of activity described. If not in current use there must be a reasonable expectation that the required use will resume. Resumption of use must be expected within twelve (12) months of last use.

23-001.05B8 Household Goods and Personal Effects: Household goods and personal effects of moderate value used in the home are exempt. Household goods include

1. Household furniture;
2. Furnishings and equipment used in the operation, maintenance, and occupancy of the home or in the functions and activities of the home and family life;
3. Those items that are for comfort and accommodation; and
4. Personal effects (e.g., clothing, jewelry, items of personal care).

23-001.05B9 Non-Business Property for ABD: A maximum of $6,000 in equity value of nonbusiness property (real or personal) that is used to produce goods or services essential to daily activities is excluded from resources. Any equity in excess of $6,000 is counted as a resource. If the excess resource is real property, see 477 NAC 23-001.05B4 for liquidation of real property. See Appendix 477-000-050 for examples.

23-001.05C Inheritance: When an applicant/client receives an inheritance, verified payment of debts or obligations of the deceased are subtracted from the settlement, and the remainder is considered unearned income.

23-001.06 Excluded Resources: Disregarded income is also disregarded as a resource, unless there is a specific regulation stating otherwise (see 477 NAC 22-005.06 for income treatment). In addition, the following resources are excluded in making a determination of eligibility:

1. Real property that the individual owns and occupies as a home;
2. Household goods and personal effects of a moderate value used in the home;
3. Cash surrender value of life insurance policies with combined face values of $1,500 or less per individual (see 477 NAC 23-001.05A4);
4. A specified maximum in proceeds from an insurance policy irrevocably assigned for the purpose of burial of the client (see 477 NAC 23-001.05A3c);
5. Irrevocable burial trusts up to the specified amount per individual and the interest if irrevocable (see 477 NAC 23-001.05A3a);
6. Burial space items or a contract for the purchase of burial space items owned by a client or designated family member (see 477 NAC 23-001.05A3f);
7. Burial spaces (see 477 NAC 23-001.05A3e);
8. Up to $1,500 set aside for burial arrangements (see 477 NAC 23-001.05A3d);
9. One motor vehicle if it is used for employment, or medical transportation. If the client has more than one motor vehicle, s/he may designate the vehicle to be excluded (see 477 NAC 23-001.05B5).
10. Certain trusts (including guardianships). The person(s) in whose behalf the trust is established may be ineligible but this may not affect Medicaid eligibility of the other person(s) in the unit (see 477 NAC 23-001.05A6).
11. Certain life estates in real property (see 477 NAC 23-001.05B6);

12. Income received annually, semi-annually, or quarterly which is prorated on a monthly basis and included in the budget. This income is excluded as a resource over the period of time it is being considered as income;
13. The unspent portion of any RSDI or SSI retroactive payments (excluded for six months following the month of receipt);
14. U.S. savings bonds (excluded for the initial 12 month mandatory retention period);
15. A resource used in the client's trade or business (see 477 NAC 23-001.05B7 and 23-001.05B7);
16. A maximum of $6,000 equity value of nonbusiness property (real or personal) that is used to produce goods or services essential to daily activities for the Aged, Blind, and Disabled categories;
17. The unspent portion of an AABD payment or State Disability Program retroactive payment (excluded for six months following the month of receipt);
18. Victims compensation payments, i.e., payments received from a state or local government to aid victims of crime (excluded for nine months beginning with the first month after receipt);
19. Payments received from a state or local government to assist in relocation (excluded for nine months beginning with the first month after receipt);
20. An unavailable job-related retirement account that is held by the employer; and
21. An Individual Development Account (an account set up for postsecondary education or purchase of a client's first home); and
22. Medicare set-aside accounts that may be used only for payment of medical bills of Medicare beneficiaries.
23. Funds held in an Achieving a Better Life Experience (ABLE) account (See 23-001.05A6d).

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

For any of these resources in the form of monetary funds to be excluded, they must be segregated in a separate account so that they can be identified. If the funds are not in a separate account, an applicant/client shall be allowed thirty (30) days from notification of the requirement to set up a new account. After thirty (30) days, the resource is included in the resource limit if the applicant/client fails to segregate the funds. Several excludable resources may be combined in a single account.

23-001.06A Excluded Resources for American Indians and Alaska Natives~~:~~

23-001.06A1 Legal Basis: As established under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), states are required to exclude certain types of property specific to American Indians and Alaska Natives as resources when determining Medicaid eligibility for an individual who is an American Indian or an Alaska Native.

23-001.06A2 Definition of American Indian or Alaska Native: Anyone who, pursuant to 25 U.S.C. § 1603(c) & (f) and 25 U.S.C §1679(b), or 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, is eligible to receive health care services from Indian health care providers or through referral under Contract Health Services.

The following resources are excluded in making a determination of Medicaid eligibility for an individual who is an American Indian or Alaska Native:

1. Property, including real property and improvements, that is held in trust, subject to federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior;
2. For any federally recognized Tribe not described in paragraph 1, property located within the most recent boundaries of a prior federal reservation; Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights; and
3. Ownership interests in or usage rights to items not covered by paragraphs 1 through 3 that have unique religious, spiritual, traditional, or cultural significance, or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom; and,
4. Historical Accounting Class and Trust Administration Class payments made under the Claims Resolution Act of 2010 (*Cobell v. Salazar*) are excluded as a resource for one year from the date of receipt.

23-001.07 Determination of Ownership of Resources: A resource that appears on record in the name of an applicant/client or responsible relative (see 477 NAC 24-001.01G1 and 477 NAC 24-002.02) must be considered to belong to the applicant/client. Ownership of real estate must be verified through records in the offices of the register of deeds or county clerk.

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

23-001.07A Real Estate: Ownership of real estate shall be verified through records in the offices of the register of deeds or county clerk. The terms on which property is held in cases of joint ownership shall be verified.

Transfer on Death Deed(s) must be revoked for initial and continued eligibility. This includes real property owned by a community spouse. See Appendix 477-000-048 for procedures.

23-001.07B Jointly Owned Resources

23-001.07B1 Resources Owned with Other Clients: If an applicant/client owns a resource with another applicant/client, the value of the resource shall be divided by the number of owners, regardless of the terms of ownership. The appropriate value is counted for each unit. This reference also applies to resources owned with a spouse or child.

23-001.07B2 Resources Owned with Non-Clients: If an applicant/client owns a resource with an individual who is not receiving Medicaid, the following regulations apply:

23-001.07B2a Motor Vehicles: Ownership of a motor vehicle shall be verified by the title. The number of individuals on the title legally determines the percentage of ownership.

23-001.07B2b Bank Accounts: The terms of the account shall be verified with the bank. If any person on the account is able to withdraw the total amount, the full amount of the account belongs to the applicant/client. If all signatures are required to withdraw funds, the proportionate share must be counted toward the applicant/client. If the applicant/client verifies that none of the funds belong to him/her, the applicant/client must be allowed sixty (60) days to remove his/her name from the account. The applicant/client must provide proof of the change.

After the applicant/client removes his/her name from the bank account, eligibility may be determined retrospectively or prospectively, as applicable. If the applicant/client does not remove his/her name within sixty (60) days, the funds are counted as a resource. If a portion of the funds belongs to the applicant/client, the applicant/client must be notified of the requirement to place the funds in a separate account. Verified contributions to the account determine ownership if ownership is disputed.

23-001.07B2c Other Resources: For all other jointly owned resources other than those specified above and real property, the terms of ownership and forfeiture shall be reviewed by the Department.

23-001.08 Resources of Other Individuals Countable in a Client's Budget

23-001.08A Resources of an Ineligible or Sanctioned Parent for Medically Needy: The resources of an ineligible or sanctioned individual/parent are included in the resource total for the eligible unit members. The ineligible or sanctioned individual/parent is allowed Medicaid resource exclusions. After resource exclusions, the remaining resource amount is counted in the resource total of the eligible unit members.

23-001.08B Individual Added to an Existing Unit: The resources of the total unit (the previous unit plus the added individual) are compared to the resource maximums based on the total unit size.

23-001.08C Deeming Resources of a Parent: In considering the resources of a parent(s) counted toward the resource total of a child seventeen (17) years old or younger who is eligible for ABD or a medically needy child eighteen (18) years old or younger who is eligible and living in the parent's household, the following resources are counted for the child whether or not they are actually made available:

1. All resources exceeding $4,000 in the case of one parent; or
2. All resources exceeding $6,000 in the case of:
    a. Two parents;
    b. One parent and the spouse of the parent; or
    c. One parent and one minor sibling; and
3. $25 for each additional minor sibling in the parent(s)'s household.

Resource exclusions listed at 477 NAC 23-001.06 and/or 477 NAC 23-001.06A apply to the parent(s)'s resources. The resources of the eligible child's siblings are not counted toward the child's resource total.

Note: If income of a parent is not deemed according to 477 NAC 24-001.01G2b, resources are also not deemed.

23-001.09 Determination of Value of Total Available Resources: The total value of all available resources is the total value of real and personal property determined according to the preceding guidelines.

23-001.10 Maximum Available Resource Levels: The established maximums for available resources that an applicant/client may own and still be eligible are as follows:

1. One member unit: $4,000;
2. Two member unit or family: $6,000;
3. Three member unit or family: $6,025; or
4. Each additional individual: + $25.

Note: If two or more related ABD clients (other than a married couple), i.e., an eligible ABD parent and his/her eligible ABD minor child or two or more unrelated eligible ABD clients, reside in the same household, each client is entitled to a resource maximum of $4,000.

The treatment of resources of a spouse or a parent is the same as for an applicant/client. See 477 NAC 24-001.01G1 and 477 NAC 24-002.02. If the total equity value of available non-excluded resources exceeds the maximums specified at 477 NAC 23-001.10, the applicant(s)/client(s) is/are ineligible. Resources must be below the maximum resource level for one (1) day in the month in order for the applicant/client to be eligible for that month.

For information regarding SIMP resources, see 477 NAC 26-003.

23-001.11 Reduction of Resources: The applicant/client may reduce available resources to the allowable limit if the case record contains documentation that the resources have been reduced and the unit is within the allowable resource limits. An applicant who has excess resources other than real property may have his/her application held pending until the resources are reduced. See 477 NAC 23-001.05B3e(1) and 23-001.05B4 for treatment of real property that causes an applicant to have excess resources.

An applicant/client may reduce his/her resources by paying any secured or unsecured debts, purchasing personal property, establishing burial funds, or expending the resources in any manner that the applicant/client deems appropriate. If the applicant/client is in a medical institution or receiving waiver services, s/he cannot give away resources in order to establish eligibility, see 477 NAC 23-001.04.

If the applicant/client is not in a medical institution or receiving waiver services, giving away the excess resources is not considered a deprivation of a resource. If the applicant/client reduces resources in any way except paying on outstanding medical bills, eligibility is effective the first day of the month in which the resources are actually expended, if all other eligibility factors are met. The applicant's/client's statement of expenditures is acceptable as verification.

23-001.11A Reduction of Resources to Establish Earlier Medicaid Effective Date: An applicant/client may do a reduction of resources to establish an earlier Medicaid effective date if s/he has outstanding medical bills. However, eligibility may not begin earlier than the third month before the month of application (see 477 NAC 4-000). In order for an applicant/client with excess resources to establish an earlier effective date, s/he must pay all of the excess resources on medical bills incurred no earlier than the third month before the month of application. The medical expense does not have to be a Medicaid-covered service. The applicant/client should pay on the oldest medical bills incurred within the retroactive period and continue paying bills until the amount of the excess resources has been expended. Once it has been determined there are medical expenses in the retroactive period, the applicant/client is given ninety (90) days to complete the reduction of resources on medical expenses.

Medicaid eligibility may begin with the first day of the month in which the last medical bill was paid, which reduced the resources to the allowable limit. Expenditures for medical bills must be verified.

If an applicant has excess resources in the month of application, it is not necessary to verify resources in any of the retroactive months. The spend-down of the excess resources from the month of application is all that is necessary. If the applicant does not have excess resources in the month of application, resources must be verified in the oldest retroactive month in which the applicant has outstanding medical bills. If there are excess resources during this retroactive month, only this amount of excess resources must be used to complete the resource spend-down. See Appendix 477-000-034 for procedures related to documenting a resource spend-down.

23-001.12 Resource Requirements for Medicare Savings Plan (MSP) Clients

23-001.12A Working Disabled Part A Medicare Beneficiaries: Resources are treated according to the Maximum Available Resource Levels at 477 NAC 23-001.10.

23-001.12B Specified Low-Income Medicare Beneficiaries (SLMB) and Qualified Individuals-1 (QI-1): Resource limits are adjusted annually by the Centers for Medicare and Medicaid Services. See Appendix 477-000-012.

23-001.12C MSP/Qualified Medicare Beneficiaries (QMB): Resource limits are adjusted annually by the Centers for Medicare and Medicaid Services. See Appendix 477-000-012.

Note: Chapters 477 NAC 19 through 25 apply to the following: Aged, Blind and Disabled (AABD/MA), Medically Needy (MN), Medicaid Insurance for Workers with Disabilities (MIWD), Women's Cancer Program, Former Foster Care, Emergency Medical Assistance, Child Welfare

CHAPTER 21-000 RESOURCES

21-001 RESOURCES

21-001.01 Resources: The total equity value of available non-excluded resources of the client or client and responsible relative (see 477 NAC 22-001) is determined and compared with the established maximum for available resources which the client may own and still be considered eligible. If the total equity value of available non-excluded resources exceeds the established maximum, the client is ineligible.

Note: For AABD/MA, assets of each spouse are considered available to the other (even if they no longer live together) unless there is a divorce or spousal impoverishment provisions apply. The following are examples of resources:

1. Cash on hand;
2. Cash in savings or checking accounts;
3. Certificates of deposit;
4. Stocks;
5. Bonds;
6. Investments;
7. Collectable unpaid notes or loans;
8. Promissory notes;
9. Mortgages;
10. Land contracts;
11. Land leases;
12. Revocable burial funds;
13. Trust or guardianship funds;
14. Cash value of insurance policies;
15. A home;
16. Additional pieces of property;
17. Trailer houses;
18. Burial spaces;

19. Motor vehicles;
20. Life estates;
21. Farm and business equipment;
22. Livestock;
23. Poultry and crops;
24. Household goods and other personal effects;
25. Contents of a safe deposit box;
26. Tax refunds;
27. Elective share of a spouse's augmented estate; and
28. Revocable, assignable, or saleable annuity.

21-001.02 Verification of Resources: All resources shall be verified and documented in the case record.

21-001.02A Medically Needy: If the total amount of countable resources indicated is $1500 or more it must be verified. Client declaration is accepted when the amount of resources indicated on the application is less than $1500.

21-001.02B AABD/MA

1. For an AABD/MA client who does not receive SSI all resources must be verified and documented.
2. For an AABD/MA client who does receive SSI, including those in 1619(b) status, verification of resources is not required.
3. For any retroactive or prospective month that an AABD/MA client is not in current pay status for SSI, resources must be verified.

21-001.02B1 Verification of resources consists of but is not limited to the following information:

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

If the client or spouse of the client has a guardian, the guardian's report to the court may be used for verification. The guardian's report applies only to the period covered by the report. Regular verification procedures must be followed if there is no guardian's report or the report does not coincide with the date of renewal.

21-001.03 Available Resources: For the determination of eligibility, available resources include cash or other liquid assets or any type of real or personal property or interest in property that the client owns and may convert into cash to be used for support and maintenance.

21-001.04 Unavailability of Resource: Regardless of the terms of ownership, if it can be documented in the case record that the resource is unavailable to the client, the value of that resource is not used in determining eligibility. The feasibility of the client's taking legal action to make the resource available must be taken into consideration. If it is determined that legal action can be taken, the client is allowed 60 days to initiate legal action. After 60 days, if the client has not filed legal action, the case is closed for failure to comply. The resource is not considered available until the legal action is completed.

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

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

21-001.05 Excluded Resources: Disregarded income is also disregarded as a resource unless there is regulation stating otherwise (see 477 NAC 20-010 for income treatment). In addition, the following resources are excluded in making a determination of eligibility:

17. Real property which the individual owns and occupies as a home;
18. Household goods and personal effects of a moderate value used in the home;
19. Cash surrender value of life insurance policies with combined face values of $1,500 or less per individual (see 477 NAC 21-001.15A4);
20. A specified maximum in proceeds from an insurance policy irrevocably assigned for the purpose of burial of the client (see 477 NAC 21-001.15A3c);
21. Irrevocable burial trusts up to the specified amount per individual and the interest if irrevocable (see 477 NAC 21-001.15A3);

22. Burial space items or a contract for the purchase of burial space items owned by a client or designated family member (see 477 NAC 21-001.15A3f);
23. Burial spaces (see 477 NAC 21-001.15A3e);
24. Up to $1,500 set aside for burial arrangements (see 477 NAC 21-001.15A3d);
25. One motor vehicle if it is used for employment, medical transportation, or as the client's home. If the client has more than one motor vehicle, s/he may designate the vehicle to be excluded (see 477 NAC 21-001.15B12).
26. Certain trusts (including guardianships). The person(s) in whose behalf the trust is established may be ineligible but this may not affect eligibility of the other person(s) in the unit (see 477 NAC 21-001.15A6).
27. Certain life estates in real property (see 477 NAC 21-001.15B13);
28. Income received annually, semi-annually, or quarterly which is prorated on a monthly basis and included in the budget. This income is excluded as a resource over the period of time it is being considered as income;
29. The unspent portion of any RSDI or SSI retroactive payments (excluded for six months following the month of receipt);
30. U.S. savings bonds (excluded for the initial six-month mandatory retention period);
31. A resource used in the client's trade or business (see 477 NAC 21-001.15B19);
32. A maximum of $6,000 equity value of nonbusiness property (real or personal) that is used to produce goods or services essential to daily activities for the Aged, Blind, and Disabled categories;
17. The unspent portion of an AABD/MA or SDP retroactive payment (excluded for six months following the month of receipt);
18. Victims compensation payments, i.e., payments received from a state or local government to aid victims of crime (excluded for nine months beginning with the first month after receipt);
19. Payments received from a state or local government to assist in relocation (excluded for nine months beginning with the first month after receipt);
20. An unavailable job-related retirement account that is held by the employer; and
21. An Individual Development Account (an account set up for postsecondary education or purchase of a client’s first home).

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

For any of these funds to be excluded as a resource, they must be segregated in a separate account so that they can be identified. If the funds are not in a separate account, the client shall be allowed 30 days from notification of the requirement to set up a new account. After 30 days, the resource is included in the resource limit if the client fails to segregate the funds. Several excludable resources may be combined in a single account.

21-001.06 Excluded Resources for American Indians and Alaska Natives:

21-001.06A Legal Basis: As established under the American Recovery and Reinvestment Act of 2009 (Public Law 111-5), States are required to exclude certain types of property specific to American Indians and Alaska Natives as resources when determining eligibility for medical assistance for an individual who is an American Indian or an Alaska Native.

21-001.06B Definition of American Indian or Alaska Native: Anyone who, pursuant to 25 U.S.C. § 1603(c) & (f) and 25 U.S.C §1679(b), or 42 C.F.R. 136.12 or Title V of the Indian Health Care Improvement Act, is eligible to receive health care services from Indian health care providers or through referral under Contract Health Services.

The following resources are excluded in making a determination of eligibility for medical assistance for and individual who is an American Indian or Alaska Native:

5. Property, including real property and improvements, that is held in trust, subject to Federal restrictions, or otherwise under the supervision of the Secretary of the Interior, located on a reservation, including any federally recognized Indian Tribe's reservation, pueblo, or colony, including former reservations in Oklahoma, Alaska Native regions established by the Alaska Native Claims Settlement Act, and Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior;
6. For any federally recognized Tribe not described in paragraph 1, property located within the most recent boundaries of a prior Federal reservation;
7. Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally protected rights; and
8. Ownership interests in or usage rights to items not covered by paragraphs 1 through 3 that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable tribal law or custom.

21-001.07 Resources of an Ineligible or Sanctioned Parent for Medically Needy: The resources of an ineligible or sanctioned individual/parent are included in the resource total for the eligible unit members. The ineligible or sanctioned individual/parent is allowed Medicaid resource exclusions. After resource exclusions, the remaining resource amount is counted in the resource total of the eligible unit members.

21-001.08 Individual Added to an Existing Unit: The resources of the total unit (the previous unit plus the added individual) are compared to the resource maximums based on the total unit size.

21-001.09 Spouse for Spouse Responsibility and Designation of Resources

21-001.09A Resources Reserved for the Community Spouse: Resources may be reserved for the community spouse when the alternate care spouse is residing continuously in a specified living arrangement and applies for Medicaid. The amount of resources that a community spouse may reserve is based on the Consumer Price Index. This figure is adjusted annually. See Appendix 477-000-029 for the amount of resources a community spouse may reserve. The reserved amount of resources is calculated from the total resources owned by the couple and verified.

21-001.09B Assessment of Resources: Either spouse may request an assessment of their resources no earlier than the beginning of a period of continuous residence in a specified living arrangement. An assessment of resources may not be finalized and signed until a client has been in a specified living arrangement for 30 consecutive days or would have been except for death. A couple is allowed only one assessment. An Assessment of Resources must be completed by the agency listing all verified countable resources owned jointly or individually by the couple the month the spouse entered the specified living arrangement. If a transfer or sale of resources occurred during the month the spouse entered the specified living arrangement, then the assessment of resources must list all countable resources owned jointly or individually by the couple on the day the spouse entered the specified living arrangement. The couple is allowed resource exclusions listed at 477 NAC 21-001.05 and 477 21-001.06.

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

If the community spouse transfers away any resource for less than fair market value, it is a deprivation of resources. The couple or its representative has the responsibility to verify all resources.

21-001.09C Appeal of Assessment: The Assessment of Resources notifies the couple that they may appeal the assessment of resources. The couple may appeal:

1. The value assigned to the resource(s); and
2. The amount reserved for the community spouse.

If the couple shows that the community spouse requires more than the limit, s/he may be allowed to reserve more. In order to appeal, the alternate care spouse must apply for Medicaid, even if s/he has excess resources.

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

21-001.09D Jointly Owned Resources: If the resources are held jointly with persons other than the spouse, ownership is determined according to procedures at 477 NAC 21-001.10.

21-001.09E Unavailable Resources: If it is determined that the resource is not available after applying 477 NAC 21-001.04 the value of the resource is excluded from the total.

21-001.09F Treatment of Resources Not Included on Assessment: Since the resource assessment is completed only once, the total value of countable resources which are owned by either or both spouse and which are acquired, discovered, or lose their exclusion after completion of the assessment and before the designation are considered available resources and cannot be used to increase the community spouse's resource allowance calculated at the time of the assessment. Examples of resources which may lose their exclusion are the home when the community spouse no longer resides in it or business property in which the community spouse is no longer actively engaged in operating.

21-001.09G Continued Validity of Assessment: The Assessment of Resources remains valid as long as the alternate care spouse does not return to the home without waiver services (even if s/he moves from one specified living arrangement to another). If the alternate care spouse returns home without waiver services, the Assessment of Resources becomes invalid. If the alternate care spouse returns to a specified living arrangement, the original Assessment of Resources is again valid.

21-001.09H Designation of Resources: When the spouse in the specified living arrangement is eligible for Medicaid, a Designation of Resources must be completed. The Designation of Resources lists the amount of resources retained by each spouse. All resources must be re-verified.

21-001.09I Transfer of Ownership: Once it's been determined that the alternate care spouse is otherwise eligible, the case is approved without waiting for completion of the transfer. The client must be advised of the 90-day period. If the couple fails to complete the transfer within 90 days, the case is closed. Transfers of countable resources from the alternate care spouse to the community spouse are not considered a deprivation of resources as long as the amount transferred to the community spouse, when added to his/her own resources, does not exceed the amount the community spouse is allowed to reserve as calculated at the time of assessment.

The alternate care spouse may be eligible in the retroactive months if the couple's resources did not exceed the allowable limit plus the amount reserved for the community spouse, even if the couple has not completed a Designation of Resources or necessary transfers of ownership. Excluded resources transferred solely to the community spouse are not a deprivation of resources. If the community spouse disposes of a resource for less than fair market value, it is considered deprivation of a resource.

21-001.09J Treatment of Resources Not Included on Designation: Resources that are acquired or which lose their exclusion after a Designation of Resources is signed are counted as follows:

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

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

The alternate care spouse may transfer a resource that is in his/her name or his/her share of a jointly owned resource to the community spouse if the amount of resources combined with the community spouse's other resources does not exceed the spousal allowance calculated at the time of assessment. This may occur if the community spouse has had to use some of the assets reserved at the time of the assessment. It allows the alternate care spouse to transfer resources back to the community spouse so that the community spouse may maintain the reserved amount on the Assessment of Resources.

The alternate care spouse must provide a written statement of his/her intent to transfer the resource. The alternate care spouse is allowed 90 days from the date of report of the resource to complete the transfer. The couple must be notified in writing of the 90-day limit.

21-001.09K Assigning Support Rights: If the couple have resources that exceed the allowable amount and refuse to spend down which prevents Medicaid eligibility for the alternate care spouse, the Department has the legal right to bring support proceedings against the community spouse.

21-001.09L Continued Validity of the Designation: The designation of resources remains valid even if either spouse enters a different specified living arrangement. If the couple does live together in the home without eligibility for waiver services, the designation becomes invalid. Spouse for spouse responsibility again applies.

If the alternate care spouse later moves out of the home or becomes eligible for waiver services, the original designation again becomes valid and the alternate care spouse is allowed a resource level for one. If the community spouse applies, s/he must reduce his/her designated resources to the maximum allowable for:

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

21-001.10 Determination of Ownership of Resources: A resource which appears on record in the name of a client or responsible relative (see 477 NAC 22-002.07A and 477 NAC 22-002.08A) must be considered belonging to the client. Ownership of real estate through records in the offices of the register of deeds or county clerk must be verified.

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

21-001.11 Jointly Owned Resources:

21-001.11A Resources Owned with Other Clients: If a client owns a resource with another client who is on categorical assistance, the value of the resource shall be divided by the number of owners, regardless of the terms of ownership. The appropriate value is counted for each unit. This reference also applies to resources owned with a spouse or child.

21-001.11B Resources Owned with Non-Clients: If a client owns a resource with an individual who is not receiving categorical assistance, see the following regulations:

21-001.11B1 Real Estate: Ownership of real estate through records in the offices of the register of deeds or county clerk shall be verified. The terms on which property is held in cases of joint ownership shall be verified. Records of the county court have information in regard to estates which have not been settled or which are in probate. Consult the records of the court if the property has come to the holder as a part of an estate; if by joint purchase, the facts will appear in the record of the deed.

Transfer on Death Deed(s) must be revoked for initial and continued Medicaid eligibility. This includes real property owned by a community spouse. See Appendix 477-000-048 for procedures.

21-001.11B2 Motor Vehicles: Ownership of a motor vehicle shall be verified by the title. The number of individuals on the title legally determines the percentage of ownership.

21-001.11B3 Bank Accounts: The terms of the account with the bank shall be verified. If any person on the account is able to withdraw the total amount, the full amount of the account is considered the client's. If all signatures are required to withdraw the money, the proportionate share must be counted toward the client. If the client verifies that none of the money belongs to him/her, the client must be allowed 60 days to remove his/her name from the account. The client must provide proof of the change.

After the client removes his/her name from the bank account, eligibility may be determined retrospectively and/or prospectively. If the client does not remove his/her name in 60 days, the money is counted as a resource. If a portion is the client's, the client must be notified of the requirement to put the money in a separate account. If ownership is disputed then verified contributions to the account determine the ownership.

21-001.12 Consideration of Relative Responsibility: When the client has relative responsibility for a client in another assistance unit and the responsible relative owns the resource(s), the value must be divided by the number of units to determine the amount to be counted to each. An AABD/MA couple is considered one unit.

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

21-001.13 Inheritance: When a client receives an inheritance, verified payment of debts or obligations of the deceased are subtracted from the settlement.

21-001.14 Value and Equity: Equity is the actual value of property (the price at which it could be sold) less the total of encumbrances against it (mortgages, mechanic's liens, other liens and taxes, and estimated selling expenses). If encumbrances against the property equal or exceed the price for which the property could be sold, the client has no equity and the property is not an available resource.

21-001.14A Secured Debts: The total value of unpaid personal taxes and other personal debts secured by mortgages, liens, promissory notes, and judgments (other than those on which the statute of limitations applies) is subtracted from the gross value of the encumbered property to find the equity. The case record shall include documentation of the type of debt and plan under which payment was made. A service or payment made for free at the time for the benefit of the client, without a written agreement for repayment later, is not a debt.

21-001.14B Determination of Value: The use of public tax records may be used to determine the sale value of a resource. If there is a question as to the accuracy of the sale value determined by tax records, verification may be obtained from a real estate agent, car dealer, or other appropriate individual.

21-001.15 Types of Resources: Resources can be divided into two categories: liquid and non-liquid.

21-001.15A Liquid Resources: Liquid resources are assets that are in cash or financial instruments which are convertible to cash. See Appendix 477-000-036 for examples of liquid resources.

21-001.15A1 Cash, Savings, Investments, Money Due: Cash on hand, cash in checking and savings accounts, salable stocks or bonds, certificates of deposit, promissory notes and other collectible unpaid notes or loans and other investments are available resources.

21-001.15A2 Land Contracts: A land contract, or real estate contract of sale, is considered a resource to the seller of the property if the contract can be sold. In determining the value of the contract, the salability of the contract and the resulting value shall be determined (see 477 NAC 21-001.14). The contract is not considered salable unless there is a known buyer.

If the contract is determined to be salable, the net value of the contract becomes the value at which it could be sold - minus encumbrances, etc., against the property.

If it is determined and documented that the contract is not salable, the contract is not considered an available resource to the client. A review the salability shall be completed at all renewals or more often as deemed necessary.

Any income received from a land contract is considered unearned income to the client. The contract may be considered a deprivation of resources, the contract terms which are not a deprivation of resource are at Appendix 477-000-032. See process at Appendix 477-000-031.

21-001.15A3 Funds Set Aside for Burial: A specified maximum may be disregarded if it is set aside for the purpose of paying burial expenses. The individual may choose to put the money in:

4. A pre-need burial trust. If the client has an irrevocable burial trust for more than the specified maximum, the excess is considered an available resource;
5. A policy of burial insurance. If the client has irrevocably assigned more than the specified maximum in burial insurance, the excess is not an available resource but may be a deprivation of resources; or
6. A maximum of $1500 may be designated for burial. These funds may be in an account or in an insurance policy.

If the client has a combination of an irrevocable burial trust, and/or burial insurance that exceed the specified maximum to determine how to treat the excess. An individual may transfer funds from an irrevocable burial trust fund into an insurance policy if there is no lapse of time between the withdrawal and the transfer. See below for the treatment of burial spaces and burial space items.

21-001.15A3a Irrevocable Burial Trusts: If the money was put in an irrevocable burial trust on July 16, 1982, or later, it is not considered an available resource.

According to Nebraska law, an individual is allowed to deposit funds up to the specified maximum in an irrevocable trust fund created for the purpose of a prearranged funeral plan. Therefore, the value up to the specified maximum of an irrevocable burial trust and any accrued interest or dividends on that amount, if irrevocable, are considered unavailable and are disregarded. The mortuary may retain an additional amount not to exceed 15 percent, but this amount must not be included in the burial trust.

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

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

Questions regarding burial funds contracted out of state should be submitted with a copy of the contract to the Central Office.

21-001.15A3b Interest on Burial Funds: For irrevocable burial trusts contracted on December 31, 1986, or earlier, the individual was allowed to stipulate whether the interest or dividends accruing to the trust fund were irrevocable. If the interest or dividends are irrevocable, they are disregarded. It must be determined if the contract stipulates that the interest or dividends are irrevocable. For irrevocable burial trusts contracted on January 1, 1987, or later, all accrued interest or dividends are also irrevocable.

21-001.15A3c Burial Insurance: Burial insurance is defined as insurance whose terms specifically provide that the proceeds can be used only to pay the burial expenses of the insured, or a life insurance policy that is irrevocably assigned for the specific purpose of burial. When the proceeds of a life insurance policy are irrevocably assigned for the purpose of burial, the cash value is not available and is disregarded as a resource.

21-001.15A3d Money Designated for Burial: Up to $1,500 may be disregarded for each individual if it is set aside, for the purpose of paying burial arrangements for the individual or the individual's spouse.

1. This exclusion is in addition to the burial space exclusion.
2. This exclusion is not in addition to a burial trust or burial insurance that has been irrevocably assigned.

21-001.15A3e Burial Spaces: The value of burial spaces (held for the purpose of providing a place for the burial of the client, his/her spouse, and members of the client's immediate family) is not counted as an available resource. The immediate family includes minor and adult children, including adopted children and stepchildren, brothers, sisters, parents, adoptive parents, and the spouses of these individuals.

A burial space includes a crypt, mausoleum, urn, casket, marker, vault, or other repository for the remains of a deceased person. This exemption also applies to markers, vaults, applicable sales tax, charges for opening and closing the grave, but does not include services, burial fees, etc. These items are exempt only if they are actually purchased. If the client has a life insurance policy for the purchase of burial items, the cash value is included in the specified maximum if the policy is irrevocably assigned.

21-001.15A3f Burial Space Items Held in a Contract: Burial space items may be disregarded when they are held for an individual by way of a contract. To meet the requirement that the item is actually purchased, the contract must state that the individual has purchased a particular item for a specified price. The contract may be revocable or irrevocable as long as the agreement itself represents the individual's ownership. The contract may be funded by money set aside in a bank account or in a burial insurance policy. Any interest accrued and left to accumulate is not counted as income.

If it is burial insurance which has been irrevocably assigned, it is treated according to the "Burial Insurance" rules above (see 477 NAC 21-001.15A3c) and the specified maximum applies. If a total of more than the specified maximum in burial insurance is irrevocably assigned for services and/or burial space items, the amount above the specified maximum may be considered a deprivation of a resource (see 477 NAC 21-001.25A). If the client transfers ownership of a life insurance policy to someone else, e.g., a mortuary or a relative, and there is a contract with a mortuary for purchase of burial space items which the insurance policy will be used to fund, the cash value of the policy is not considered a resource since the client does not own it and this is not considered deprivation of a resource.

21-001.15A4 Life Insurance

21-001.15A4a Cash surrender value: Amount which the insurer will pay (usually to the owner) upon cancellation of the policy before death of the insured or before maturity of the policy.

21-001.15A4b Term Insurance: A form of life insurance that generally furnishes insurance protection for only a specified or limited period of time.

21-001.15A4c Face value: Basic death benefit of the policy exclusive of dividend additions or additional amounts payable because of accidental death or under other special provisions. (In determining the face value of a policy, the original face value of the policy is used.)

21-001.15A4d Insured: The person whose life is insured.

21-001.15A4e Insurer: The company that insures others.

21-001.15A4f Owner: The person who has the right to change the policy.

21-001.15A4g Cash Surrender Value: Using the following criteria, the cash surrender value of life insurance owned by the client is considered a resource. If the combined original face value of all the life insurance policies owned by the client exceeds $1,500, the cash surrender value of all the policies is considered a countable resource. Each person in the unit is allowed the $1,500 exemption for the face value of his/her life insurance.

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

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

See 477 NAC 21-001.15A3c for the treatment of burial insurance.

If the cash surrender value is to be counted towards the total resource of a client, consideration is given to any outstanding loans against the policy in determining net cash surrender value see 477 NAC 21-001.14.

21-001.15A4h Adjustment: The client can usually adjust a large insurance policy to a smaller amount providing limited protection and allowing the client to benefit from accumulated savings.

21-001.15A4i Interest and Dividends: Interest and dividends actually paid to the client from all life insurance policies are treated according to the treatment of income chart at 477 NAC 20-010.

21-001.15A5 Long-Term Care (LTC) Partnership Program: Resources equal to the amount of benefits paid out by a qualified Long-Term Care Partnership policy are disregarded for an individual applying for Medicaid if the policy was issued on July 1, 2006, or later, and the individual is otherwise Medicaid-eligible. The benefits may be paid as direct reimbursement of long term care expenses, or paid on a per diem or other periodic basis, for periods during which the individual received long term care services. The disregard is applied to the amount of benefits paid to or for the individual as of the month of application, even if additional benefits remain available under the terms of the policy. The amount of the resource disregard is also excluded from estate recovery.

21-001.15A5a Definition of a Qualified Long-Term Care Partnership Policy: A Qualified LTC Partnership policy is a long-term care insurance policy that has been approved by the Nebraska Department of Insurance. The Department accepts the Department of Insurance's certification of the policy. If an individual has a long term care insurance policy that does not meet the requirements for a Qualified LTC Partnership policy because it was issued before July 1, 2006, the individual may exchange the policy for another.

21-001.15A5b Exchange of Non-Partnership Policy for Qualified LTC Partnership Policy: An individual may exchange a policy that does not meet the requirements of a qualified LTC Partnership Policy for one that does meet the requirements. The date of exchange is considered the issue date for the qualified LTC Partnership Policy.

21-001.15A5c Reciprocity with Other States: The Department will accept qualified LTC Partnership Policies issued in other states with Long-Term Care Partnership Programs.

21-001.15A6 Trust, Guardianship/Conservatorship and Annuity Funds: When a guardianship, conservatorship, annuity, or trust has been established on behalf of a client and the client(s) who has applied has resources exceeding the total resource limit for medical, it must be verified if the trust, guardianship/conservatorship, or annuity is available to the client.

21-001.15A7 Annuities

21-001.15A7a Purchased or Annuitized before February 8, 2006: Where the client cannot assign or change the ownership or payee, the annuity is unavailable. A determination must then be made if a deprivation has occurred. If the expected return on the annuity is commensurate with the life expectancy of the client, the annuity can be deemed actuarially sound and no deprivation has occurred. If the average number of years of expected life remaining for the client does not coincide with the life of the annuity (i.e., the client is not reasonably expected to live longer than the guarantee period of the annuity),a deprivation has occurred. The look back period is the same for trusts, i.e., 60 months. See Appendix 477-000-039 for Period Life Tables.

21-001.15A7b Annuity Transaction on or after February 8, 2006: Revocable and assignable annuities are a countable resource. A saleable annuity which has not been sold is a countable resource for the amount annuitized, less the payment(s) amount already received. A saleable annuity which has been sold for a value consistent with the secondary market is a countable resource in the amount of the proceeds. If a saleable annuity is sold for less than a value consistent with the secondary market, it will be valued at the current secondary market amount and the difference will be subject to deprivation of resources regulation.

21-001.15A8 Annuities Excluded from Resources: An annuity which has been annuitized will be excluded from countable resources if it meets the following conditions:

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

21-001.15A9 Deprivation of Resources for Annuity Transactions: For long term care services, an annuity transaction after February 8, 2006, is treated as a disposal of an asset for less than fair market value unless the State of

Nebraska is named as the remainder beneficiary in the first position for at least the total amount of Medicaid expenditures paid, or is named as the remainder beneficiary in the second position after the community spouse and/or minor or disabled child. An annuity is also treated as a disposal of assets for less than fair market value unless it is irrevocable and non-assignable, actuarially sound, and provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments. This provision also applies to a community spouse.

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

21-001.15A10 Revocable Trusts: In the case of a revocable trust:

5. The entire corpus of the trust is counted as an available resource to the client;
6. Any payments from the trust made to or for the benefit of the client are counted as income;
7. Any payments from the trust which are not made to, or on behalf of, the client are considered assets disposed of for less than fair market value; and
8. If the client must go to court to access the funds, the client or his/her guardian or conservator is allowed 60 days to initiate court action.
   b. An applicant is allowed 60 days from the approval date; and
   c. A recipient is allowed 60 days from the date of notification of the requirement to file for access.

21-001.15A11 Guardianship/Conservatorships: When a fund is established in the process of the appointment of a guardianship or conservatorship, it must be determined if the funds are available without court approval. The client is ineligible for categorical assistance until the guardian gives the local office written notice of refusal to spend guardianship/conservatorship monies for the care and maintenance of the client. In order to be considered current notice, it must be given within one year of its use in determining eligibility for categorical assistance.

After current notice has been given, the client, if otherwise eligible, may receive benefits if all judicial remedies are pursued to determine the availability of the funds. This may include an appeal to the proper district court and, if necessary, to the Court of Appeals and the Nebraska Supreme Court.

However, certain guardianships/conservatorships are not reasonably available and judicial review may be waived; these include some guardianships/conservatorships where the guardian or conservator's discretion is limited and certain guardianships/conservatorships established from the proceeds of a personal injury case on behalf of a child. The child or his/her guardian/conservator must file a request for access to the funds in a court of competent jurisdiction within:

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

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

21-001.15A12 Testamentary Trusts: Testamentary trusts may be excluded as resources, depending on the availability of the funds to the individual or his/her spouse as specified in the terms of the trust.

21-001.15A13 Irrevocable Trusts

21-001.15A13a Trusts Established before August 11, 1993: For a Medicaid-qualifying trust, established before August 11, 1993, the maximum amount that could have been distributed from either the income or principal is considered an available resource. A Medicaid-qualifying trust is a trust or similar legal device that was established by a client (or his or her spouse) under which:

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

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

21-001.15A13b Trusts Established on or after August 11, 1993: In accordance with Sections 1917 (c) and (d) of the Social Security Act, the following regulations apply to all trusts created on or after August 11, 1993. These regulations apply to any client who establishes a trust, who is a beneficiary of a trust, and who is an applicant or recipient of Medicaid. A client is considered to have established a trust if his or her assets or assets of his or her spouse were used to form a part or the entire corpus of the trust other than by will. These include trusts established by:

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

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

21-001.15A13b(1) Payment Can Be Made from Trust: The following applies when payment may be made to the individual and/or the individual's spouse under the terms of the trust:

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

21-001.15A13b(1)(a) Exceptions: A trust is not considered available if it is established for a disabled client age 64 or younger (receiving or eligible to receive SSI, RSDI, or AABD/MA) and is a:

1. Special needs trust: A trust containing the assets of the client and established solely for the benefit of the client by the client's parent, grandparent, legal guardian, or a court if the State will receive all amounts remaining in the trust upon the death of the client or upon
2. termination of the trust up to the amount of total Medicaid paid on behalf of the client; or
3. Pooled trust: A trust containing the assets of the client and:
    e. Established and managed by a non-profit association;
    f. A separate account is maintained for each beneficiary of the trust, but, for purposes of investment and management of assets, the trust pools these accounts;
    g. Accounts in the trust are established solely for the benefit of individuals who are blind or disabled (receiving or eligible to receive SSI, RSDI, or AABD/MA); and
    h. The trust contains the provision that the State of Nebraska will receive all amounts remaining in the trust for the beneficiary upon the death of the client up to the amount of total Medicaid paid on behalf of the client.

21-001.15A13b(2) Payment Cannot Be Made from Trust: When payments from some portion or all of the trust cannot under any circumstances be made to or for the benefit of the client, or where there is some portion of the trust from which no payments can be made to or for the benefit of the client, all of the corpus, or income on the corpus, which cannot be paid to the client is considered a transfer of assets for less than fair market value.

21-001.15A13b(3) Hardship Procedures: A trust will not be considered available if denial of assistance would cause undue hardship. See 477 NAC 21-001.25D3.

21-001.15B Non-Liquid Resources: Non-liquid resources are tangible properties which need to be sold if they are to be used for the maintenance of the client. They include all properties not classified as liquid resources. See Appendix 477-000-036 for examples of non-liquid resources.

21-001.15B1 Exemption of Home: The client's home is exempt from consideration as an available resource, with the following limitations.

21-001.15B2 Definition of Home: Home is defined as any shelter which the individual owns and uses as his/her principal place of residence. The home includes any land on which the house is located and any related outbuildings necessary to the operation of the home.

21-001.15B3 Adjacent Lots: Lots adjacent to the home are considered available if they can be sold separately from the home. If it is determined and documented in the case record that the lots adjacent to the home cannot be sold or are not salable due to the location or condition of the property, the adjacent lots are also exempt.

21-001.15B4 Home Equity Value: For applications on or after January 1, 2006, or later, the individual is not eligible for any long term care services if the equity value interest in the home exceeds the specified amount. See Appendix 477-000-014.

21-001.15B5 Removal from Home: If the individual moves away from the home and does not plan or is unable to return to it, it must be determined when the home becomes an available resource in accordance with the following provisions. The home continues to be exempt as a resource while it is actually occupied by the client's spouse or dependent relative. A dependent relative includes the client's:

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

When the client moves to a nursing home or to an assisted living facility and is receiving AD waiver services, and it is not possible to determine immediately if the client will be able to return home, a maximum of six months may be allowed to make that determination. Unless the client or the client's representative signs a statement that the individual will not return to the home, or the home is already listed for sale, it is not possible to determine immediately if s/he will return home.

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

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

21-001.15B5a Liquidation of Property: As soon as the determination is made that the client will not be able to return home, the client must be allowed time to liquidate the property. The client is also allowed time for liquidation if s/he leaves the home for a reason other than entering a medical institution.

21-001.15B6 Sale of Home: If the client sells his/her home, the net proceeds become an available resource unless reinvested immediately in another home. In order to be allowed time to reinvest the proceeds, the client must be residing in the home at the time of the sale and move directly to his/her new home.Net proceeds are the remainder after payment of the mortgage, realtor's fees, legal fees, etc. Any deductions must be verified.

21-001.15B7 Liquidation of Real Property: When a client has excess resources because of real property, s/he may receive Medicaid pending liquidation of the resource, according to the following regulations. This reference does not apply if the community spouse under spousal impoverishment regulations will retain any of the proceeds of the sale.

Note: If the client has excess resources because of real property other than his or her home during a retroactive period, s/he is ineligible for Medicaid. The client may be prospectively eligible with excess resources because of real property if an Agreement to Sell Real Property and Repay Assistance is signed.

21-001.15B8 Time Limits for Liquidation: Real property which the client is making a good faith effort to sell must be excluded. First it must be determined if the individual has the legal authority to liquidate the property. If not, the client is allowed 60 days to initiate legal action to obtain authority to liquidate. If the client owns the property with other persons, see 477 NAC 21-001.15B9.

Once the client has the legal authority to liquidate the property, the client's signature on the Agreement to Sell Real Property and Repay Assistance must be obtained. The client is allowed six calendar months to liquidate the real property. If the client refuses to sign the Agreement to Sell Real Property and Repay Assistance, s/he is immediately ineligible because of excess resources. The six-month period begins with the month following the month in which the Agreement to Sell Real Property and Repay Assistance is signed.

Once the Agreement to Sell Real Property and Repay Assistance is signed, the six calendar months are counted, whether or not the client is receiving assistance. If after the Agreement to Sell Real Property and Repay Assistance is signed the client goes into current pay status for SSI, the Agreement to Sell Real Property and Repay Assistance is void.

Note: If the client later goes into non-pay status for SSI, a new Agreement to Sell Real Property and Repay Assistance is signed and a new six-month liquidation period is established. If the client moves back to the home and subsequently moves out again during the six-month period, s/he is only allowed the months remaining in the original six-calendar month period. One liquidation period is allowed for each piece of real property that is determined to cause excess resources, even if the case is closed and subsequently reopened.

21-001.15B8a Extension of Time Limit: If the client is unable to liquidate the property in six calendar months, the supervisor may authorize an additional three calendar months. In determining whether to allow a three-calendar-month extension, the supervisor shall consider:

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

21-001.15B9 Joint Ownership: Real property that is jointly owned is excluded if sale of the property would cause the other owner (whether the other owner is on assistance or not) undue hardship. However, if undue hardship ceases to exist, the property is included in countable resources and handled according to the following regulations.

If the client owns the property with other persons who are not on assistance and the real property is not the principal place of residence of the other owner(s), the other owners shall be contacted to determine if they are willing to liquidate their interest in the property. If all parties are willing to liquidate, the liquidation proceeds.

If one or more of the parties do not wish to liquidate, the process for unavailability of a resource is applied and requires the client to take legal action to force a sale of the property. A written statement may be obtained from the other parties and filed in the case record. After a legal determination is made regarding the availability of the client's interest in the property, appropriate action must be taken.

21-001.15B10 Additional Pieces of Real Property: In computing the amount of the unit's total available resources the potential sales value of all real property, other than the allowed exemption for the home must be determined and used.

21-001.15B11 Trailer Houses and Other Portable Housing Units: If a client occupies a trailer house or other portable housing unit as his/her home, the property is allowed the resource exemption for a home.

If the client enters a nursing home, s/he is allowed the exemption of a home for up to six months:

1. If the trailer house or other portable housing unit is used for the client's trade or business.
2. If it is used to produce goods for the client's own consumption or use.

21-001.15B12 Motor Vehicles: One motor vehicle regardless of its value as long as it is necessary for the client or a member of his/her household for employment or medical treatment must be disregarded. If the client has more than one motor vehicle, the vehicle with the greatest equity must be excluded. Any other motor vehicles are treated as non-liquid resources and the equity is counted in the resource limit. The client's verbal statement that the motor vehicle is used for employment or medical treatment is sufficient.

21-001.15B12a Exceptions:

3. A client in a nursing home or receiving services through an Assisted Living Waiver is not allowed the disregard of any motor vehicles because medical transportation is included in the payment to the facility; or
4. The client designates the disregarded vehicle for Assessment of Resources.

21-001.15B12b Determination of Fair Market Value: For motor vehicles that are counted in the resource total, fair market value is used. Cars, trucks, SUVs, vans, motorcycles, recreational vehicles, motorboats and watercraft, and planes are included in the category of motor vehicles.

21-001.15B13 Life Estates: The owner of a life estate in real property is generally unable to sell the property. The net income from the life estate must be included in the budget rather than considering the life estate as an available resource. If the owner of a life estate transfers it to another individual, it must be determined if it is deprivation of a resource. If the life estate is sold, the proceeds are counted as resources. See Appendix 477-000-038 for the Life Estate Interest Table. It is a disposal of assets to purchase a life estate interest in another individual’s home unless the purchaser resides in the home for at least 12 months after the date of purchase.

21-001.15B14 Farm Equipment: Farm equipment used for the client's trade or business or to produce goods for the client's own consumption or use. See Appendix 477-000-052.

21-001.15B15 Business Equipment, Fixtures, Machinery: Business equipment, etc., is used for the client's trade or business or to produce goods for the client's own consumption or use. See Appendix 477-000-052.

21-001.15B16 Livestock, Poultry, Crops (Growing and On-Hand): Livestock, poultry, and crops grown for the client's trade or business or for the client's own consumption.

21-001.15B17 Household Goods and Personal Effects: Household goods and personal effects of moderate value used in the home are exempt. Household goods are defined as including:

1. Household furniture
2. Furnishings and equipment used in the operation, maintenance, and occupancy of the home or in the functions and activities of the home and family life
3. Those items which are for comfort and accommodation.
4. Personal effects include clothing, jewelry, items of personal care, etc.

21-001.15B18 Loans: A bona fide loan to a client or financially responsible relative is disregarded as a resource. A bona fide loan is defined as one that must be repaid. The agreement for repayment may be verbal or written and the loan may be owed to an individual or to an organization or agency. Using prudent person principle the client's statement is adequate verification that the loan must be repaid.

Note: Real property that is used solely for self-employment is considered a resource.

21-001.15B19 Essential Property: Resources that are used in the client’s trade or business are disregarded, regardless of the value. This includes:

1. Real property such as land, houses, or buildings
2. Personal property such as farm machinery, business equipment, livestock, poultry, crops, tools, safety equipment
3. Business bank accounts as long as the funds are separated from other liquid resources.

The client or a responsible relative (spouse or parent) must be actively involved in the day to day operation of the trade or business as a primary means of earning a livelihood. See Appendix 477-000-050 for examples. If the client or responsible relative is not actively involved in the trade or business, it must be due to circumstances that are beyond the individual's control, e.g., illness, and there must be a reasonable expectation that the use will resume.

21-001.15B20 Non-Business Property: A maximum of $6,000 equity value of nonbusiness property (real or personal) that is used to produce goods or services essential to daily activities is excluded from resources. Any equity in excess of $6,000 is counted as a resource. If the excess resource is real property, see 477 NAC 21-001.15B5a for liquidation of real property.

21-001.16 Maximum Available Resources: The established maximums for available resources which the client may own and still be eligible are as follows:

5. One member unit $4,000;
6. Two member unit or family $6,000;
7. Three member unit or family $6,025;
8. Each additional individual + $25.

Note: If two or more related AABD/MA clients (other than a married couple), i.e., an eligible AABD/MA parent and his/her eligible AABD/MA minor child or two or more unrelated eligible AABD/MA clients, reside in the same household, each client is entitled to resource maximum of $4000. The treatment of resources of a spouse or a parent is the same as for a client. If the total equity value of available non-excluded resources exceeds the maximums specified above, the client(s) is ineligible. Resources must be below the maximum resource level for one day in the month in order for the client to be eligible for that month.

21-001.17 Maximum Available Resource Levels For AABD/MA: The established maximum for available resources which the client, or the client and responsible relative, may own and still be considered eligible for Medicaid, according to unit size, are as follows:

1. One member unit - client only $4000
   If a couple has a valid designation of resources and -
   a. There is an eligible spouse and an ineligible spouse, the resource level for the eligible spouse is $4,000; or
   b. The ineligible spouse later becomes eligible; each spouse is allowed $4,000.

2. Two member unit - $6000
   a. Client and eligible spouse;
   b. Client and ineligible spouse; or
   c. Client and ineligible spouse who have designated resources but the client returns home or no longer is eligible for waiver services.

For procedures on designating resources, see 477 NAC 21-001.09.

If two or more related AABD/MA clients (other than a married couple), i.e., an eligible AABD/MA parent and his/her eligible AABD/MA minor child or two or more unrelated eligible AABD/MA clients, reside in the same household, each client is entitled to a resource maximum of $4000.

The treatment of resources of a spouse or a parent is the same as for a client see 477 NAC 22-002.07A and 477 NAC 22-002.08A. If the total equity value of available non-excluded resources exceeds the maximums specified above, the client(s) is ineligible. Resources must be below the maximum resource level for one day in the month in order for the client to be eligible for that month.

21-001.18 AABD/MA Deeming Resources of a Parent: In considering the resources of a parent(s) who is not considered an EP towards an eligible child age 17 or younger and living in the parent's household, the following resources are considered to the child whether or not they are actually made available:

1. All resources exceeding $4,000 in the case of one parent; or
2. All resources exceeding $6,000 in the case of:
   a. Two parents;
   b. One parent and spouse of the parent; or
   c. One parent and one minor sibling.
3. $25 each additional minor sibling in the parent(s)' household.

Resource exclusions listed at 477 NAC 21-001.05 and/or 477 NAC 21-001.06 apply to the parent's resources. The resources of the eligible child's brothers and sisters are not considered towards the child.

Note: If income of a parent is not deemed according to 477 NAC 22-002.08B2 resources are also not deemed.

21-001.19 AABD/MA Resource Review: The amount of total resources determines how often verification is required. See Appendix 477-000-049 for the verification table.

If there is reason to believe that at any time there has been an increase in resources which may affect eligibility all resources must be verified immediately.

A resource review is not required for SSI recipients.

21-001.20 Resource Requirements for Medicare Savings Plan (MSP) Clients

21-001.20A Working Disabled Part A Medicare Beneficiaries: Resources are treated according to regulations provided above.

21-001.20B SLMB and QI-1: Resource limits are adjusted annually. See Appendix 477-000-012.

21-001.20C MSP/QMB: Resource limits are adjusted annually. See Appendix 477-000-012.

21-001.21 Determination of Value of Total Available Resources: The total value of all available resources is the total value of real and personal property figured in according with the preceding instructions.

21-001.22 Resources of a Spouse, Parent or Other Essential Person: All resources of a client and spouse or other EP who is included in the budget and who share the same home are considered available for the support of both unless one spouse is eligible for or receiving waiver services. Relative responsibility includes eligible spouse for spouse (eligible or ineligible) and parents for children who are age 17 or younger and still considered part of their household.

If the client and spouse are legally separated or divorced, consideration must still be given to jointly owned resources and their availability in determining the individual's eligibility. In the case of an eligible client whose payment standard has been increased because of the inclusion of EP's, the resources of the essential person(s) are considered available to the client.

Resources of an essential person are treated the same as the resources of the eligible client. However, if the resources of the essential person make the client ineligible, unless the essential person is the ineligible spouse or parent of a minor child, the essential person may be removed from the budget. Once the EP is removed from the budget, his/her resources are no longer considered.

When the client (i.e., a spouse or parent) has relative responsibility for a client in another assistance unit and both clients own the resource(s), the resource is divided by the number of owners only. This meets the requirement of relative responsibility.

21-001.23 Deeming of Resources of a Parent: In considering the resources of a parent(s) who is not considered an EP towards an eligible child age 17 or younger and living in the parent's household, the following resources are considered to the child whether or not they are actually made available:

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

Resource exclusions apply to the parent's resources. The resources of the eligible child's brothers and sisters are not considered towards the child.

Note: If income of a parent is not deemed, resources are also not deemed.

21-001.24 Reduction of Resources: The client may reduce available resources to the allowable limit if the case record contains documentation that the resources have been reduced and the unit is within the allowable resource limits. An application for an individual who has excess resources other than real property may be held pending until the resources are reduced. See 477 NAC 21-001.15B5a for treatment of real property which causes the client to have excess resources.

The client may reduce his/her resources by paying any secured or unsecured debts, purchasing personal property, establishing burial funds, or expending the resources in any manner that the client deems appropriate. If the client is in a medical institution or receiving waiver services, s/he cannot give away resources in order to establish Medicaid, see 477 NAC 21-001.25A and 477 NAC 21-001.25C.

If the client is not in a medical institution or receiving waiver services, giving away the excess resources is not considered a deprivation of a resource. If the client reduces resources in any way except paying on outstanding medical bills, eligibility is effective the first day of the month in which the resources are actually expended if all other eligibility factors are met. The client's statement of expenditures is acceptable.

The client may do a resource spend-down to establish an earlier medical effective date if s/he has outstanding medical bills. However, medical eligibility may not begin earlier than the third month before the request for assistance, see 477 NAC 4. In order for a client with excess resources to establish an earlier medical effective date, s/he must pay all of the excess resources on medical bills incurred no earlier than the third month before the month of request. The medical expense does not have to be a Medicaid covered service. The client should pay on the oldest medical bills incurred within the retroactive period and continue paying bills until the amount of the excess resources has been expended.

Medical eligibility may begin with the first day of the month in which the last medical bill was paid which reduced the resources to the allowable limit. Expenditures for medical bills must be verified.

If the client has excess resources in the month of application it is not necessary to verify resources in any of the retroactive months. The resource spend-down of the excess resources from the month of application is all that is necessary. If the client does not have excess resources in the month of application, resources must be verified in the oldest retroactive month in which the client has outstanding medical bills. If there are excess resources during this retroactive month, only this amount of excess resources must be used to complete the resource spend-down. See Appendix 477-000-034 for procedures related to documenting a resource spend-down.

21-001.25 Other Resource Provisions Pertaining to Individuals Requesting Long-Term Care Only

21-001.25A Deprivation of Resources: Any action taken by the individual, or any other person or entity, that reduces or eliminates the individual's or spouse's recorded ownership or control of the asset for less than fair market value (full value) is a deprivation of resources. The fair market value of the resource at the time the resource was disposed of must be verified and determine the equity value of the resource by taking into consideration any encumbrances against the resource. This includes:

9. Recorded transfer of ownership of real property;
10. Not receiving the spousal share of an augmented estate;
11. Purchase of a life estate in another individual's home without meeting the 12-month requirement to reside there;
12. Promissory notes, loans, mortgages, and contract sales for less than fair market value and not enforced;

13. Purchase of an irrevocable, non-assignable annuity if Medicaid is not the preferred beneficiary and the annuity is issued on February 8, 2006, or later;
14. Any transfer above the protected spousal reserved amount to a community spouse; and
15. Purchase of any contract or financial instrument, including an endowment or insurance, where the criteria for fair market value are not met.

21-001.25B Fair Market Criteria: The criteria for fair market value are not met when:

1. The term of the instrument exceeds the life expectancy of the applicable client(s);
2. The instrument does not provide for equal monthly or annual payments commencing immediately during the term of the contract;
3. The instrument does not provide for the recovery of assets in the event of default; or
4. The instrument contains exculpatory or cancellation terms of balance due.
5. A service given for free at the time cannot later be claimed as an amount owed.

When an asset is placed in an annuity on February 8, 2006 or later, see annuity regulations at 477 NAC 21-001.15A7b.

Note: Trust regulations at 477 NAC 21-001.15A take precedence over deprivation when an asset is placed in a trust.

21-001.25C Deprivation of Resources for Medicaid: Deprivation of a resource must be reviewed only if an individual or an individual's spouse resides in a specified living arrangement which is defined as:

1. Residing in a nursing home;
2. Receiving the skilled level of care in a hospital, i.e., swing bed services;
3. Receiving home and community based services including an assisted living waiver, home health care or personal care services; or requesting and meeting the criteria for such services; or
4. Residing in an intermediate care facility for persons with a developmental disability. If a couple chooses to do an assessment, see 477 NAC 21-001.09B.

21-001.25D Disposal/Transfer of Resources on February 8, 2006 or Later

21-001.25D1 Look Back Period: To determine if a client or his/her spouse deprived himself/herself of a resource to qualify for Medicaid, the agency must look back 60 months before the month of application. The look back is triggered when the individual first applies for Medicaid and is in a specified living arrangement or is on Medicaid and enters a specified living arrangement.

When an individual applies for Medicaid more than once, the look back period is based on the first date the individual meets both requirements. To determine the countable value disposed of, the Department:

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

21-001.25D2 Period of Ineligibility: If it is determined that an individual disposed of a resource, the applicant or recipient is ineligible for the number of months determined by dividing the countable value of the resource by the actual monthly cost of care in the specified living arrangement at the current private pay rate.

The period of ineligibility begins:

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

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

If the division results in a fraction, the fraction is converted to a dollar amount and includes that amount as unearned income for the applicable month. In determining the period of ineligibility, the fair market value of the transferred resource only is used. The value of other resources and income are not included in the calculation.

For periodic disposals within the look back period, each are determined separately; the periods of ineligibility run consecutively. Multiple fractional month transfers are cumulative and treated as one transfer. The remaining time of ineligibility is divided by two and shared by the couple if the community spouse enters one of the specified living arrangements during the period of ineligibility of the institutionalized spouse.

21-001.25D3 Availability of Hardship Waiver Process: The individual may request in writing to the agency a hardship waiver exception when imposing a period of ineligibility for transfer of assets would deprive the individual of medical care so that his/her health or his/her life would be endangered. A notice of discharge from the facility is not necessary to demonstrate that health or life would be endangered. Undue hardship also exists when application of the transfer of assets provisions would deprive the individual of food, clothing, shelter, or other necessities of life. See Appendix 477-000-033.

The facility in which the institutionalized individual resides may file the undue hardship waiver request on behalf of the individual with the written consent of the individual or his/her legal representative. The request will be submitted to Central Office for determination, along with information including, but not limited to, spouse's resources, any written demand for return of assets, any legal action taken to recover the asset, documentation of the individual that signed for or requested the transfer of assets, and living arrangement of the individual(s) at time of transfer.

Central Office will make a determination within 30 days from receipt of the hardship waiver request by the Central Office. If circumstances beyond the control of the agency prevent action within the required time, the Central Office will send a notice to the individual who filed the hardship waiver request. The guardian, conservator, or anyone acting on behalf of the client must attempt to recover transferred assets.

Up to 30 days of nursing home services may be provided if the individual is cooperating to the fullest extent in attempting to recover transferred assets. If cooperation ceases, undue hardship no longer exists. A hardship waiver will be denied if the individual or his/her spouse participated in the transfer. A denial of hardship waiver request may be appealed.

21-001.25E Transfers Not Considered Deprivation for Medical: It is not considered a deprivation of a resource if:

1. An applicant or recipient transferred a resource to his/her spouse or to an individual with power of attorney or a guardian or conservator for the sole benefit of the applicant or recipient's spouse;
2. An applicant or a recipient's spouse transferred a resource to an individual with power of attorney or a guardian or conservator for the sole benefit of the applicant or recipient's spouse;

3. A resource was transferred to a trust established solely for the benefit of the individual's son or daughter who is blind or disabled (receiving or eligible to receive SSI, RSDI, AABD/MA, or MA);
4. A resource was transferred to the individual's son or daughter who is blind or disabled (receiving or eligible to receive SSI, RSDI, AABD/MA, or MA); or
5. A resource was transferred to a trust established solely for the benefit of an individual age 64 or younger who is disabled (receiving or eligible to receive SSI, RSDI, AABD/MA, or MA). For transfer of a home, see 477 NAC 21-001.25F.

21-001.25F Transfer of a Home: It is not considered a deprivation of a resource if an applicant or recipient transfers title to his/her home to his/her:

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

21-001.25G Exceptions to Deprivation Policy: An exception may be made if it is determined that a transfer was made for less than fair market value but the individual can verify that s/he intended to dispose of the resource for fair market value or for other valuable consideration, that the transfer was not made to qualify for assistance, or that denial of assistance would cause undue hardship.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 24-000 RELATIVE RESPONSIBILITY AND SPONSOR DEEMING FOR ALIENS FOR NON-MAGI PROGRAMS

24-001 RELATIVE RESPONSIBILITY: In determining eligibility, the Department must consider as available to a client the income and resources of

1. A parent (biological, adoptive, or step) for a child if the child is eighteen (18) years old or younger and is still considered part of the household; and
2. One spouse for another spouse.

24-001.01 Parent for Child Relative Responsibility

24-001.01A Child Considered Part of Household: If a child is living in the same household with his/her parent(s), the parent(s)'s income and resources must be considered available to the child.

24-001.01A1 Exceptions: A parent(s)'s income and resources are not considered available to

i. A pregnant minor who, pursuant to Neb. Rev. Stat. section 71-6903, is denied financial support by her parents, guardians, or custodians due to her refusal to obtain an abortion, and is therefore considered emancipated for purposes of public assistance;
ii. A child receiving Home and Community-Based Waiver;
iii. A child receiving Developmental Disability Waiver; or
iv. A child approved for Katie Beckett Medicaid. See 477 NAC 24-001G2b(1) and 477 NAC 27-009.

24-001.01A2 Temporary Absence: If a child is temporarily absent from the home (ninety (90) days or fewer) but is still considered part of the household, the parent(s)'s income and resources must be considered available to the child. Temporary absence includes, but is not limited to

1. School attendance where the child returns to the home on a regular basis (weekends, vacations, or summers).

2. Residence in an institution for a developmental disability or mental illness for 90 days or fewer may be considered temporary absence if the child was living in his/her parent(s)'s household before institutionalization and will return to the parent(s)'s household upon discharge.

24-001.01B Child No Longer Considered Part of Household: If a child is permanently out of the home and no longer considered part of the household, his/her parent(s)'s income and resources shall not be considered available to the child.

24-001.01C Determination of Paternity: Paternity cannot be established unless an alleged father has signed a birth certificate, written and notarized paternity acknowledgment form or a court has determined him to be the father.

Note: Paternity cannot be established for an unborn.

24-001.01C1 Unmarried Parents: When unmarried parents are living together, the alleged father is not financially responsible unless he has acknowledged paternity or a court has determined that he is the father of the child after the birth.

24-001.01C2 Children of a Marriage: Married individuals are considered the parents of any children who are conceived or born during a marriage, even if the couple is separated, has filed for divorce or annulment, or states that one individual is not the parent of the child, unless there is a court order that states otherwise.

24-001.01D Military Service: If a parent is absent due to active duty in the uniformed services of the United States, that parent is still considered part of the assistance unit and his/her income is considered available to the unit. Uniformed service is defined as the Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Services Administration, and Public Health Service of the United States. If the client states that separation is due to reasons other than performance in military service, the client must provide proof of bona fide separation.

If the parent in the military is incarcerated, s/he is no longer considered part of the assistance unit.

24-001.01E Joint Physical Custody: In a household where both parents are present, though not necessarily continuously, income and resources of each must be used in a child’s eligibility determination and the needs of both parents included in the unit. This includes situations in which the non-custodial parent has sufficiently frequent contact with the child(ren) so that the normal parental roles of providing guidance, physical care, and maintenance have not been interrupted.

This policy applies when there is joint physical (shared) custody in which the physical custody of the child(ren) is split between both parents. This can be either on a scheduled basis as included in a divorce decree or on an informal basis as agreed to

by both parents. The percentage of time spent with each parent is irrelevant in a joint custody arrangement for Non-MAGI cases.

24-001.01F Special Provisions Pertaining to Minor Parents

24-001.01F1 Minor Parent: If a minor parent has a legal guardian, according to Nebraska law, the guardian has no financial responsibility for the minor.

24-001.01F2 Medically Needy Minor's Parent(s): If a minor parent is living with his/her medically needy parent(s) who is receiving Medicaid for another child, the minor parent must be in his/her parent(s)'s unit.

If assistance is received for the minor's child, that child must also be in the parent(s)'s unit.

When a minor parent becomes emancipated, graduates from secondary school at age 18, or reaches age 19, s/he and his/her child become a separate unit.

Note: The family is not required to receive Medicaid for the minor's child.

24-001.01F3 Minor Living in Parent(s)' Home: If a minor is living in his/her parent(s)' home, s/he is considered emancipated if s/he has married. If the minor has married, s/he may be a separate unit with his/her child. If the marriage is annulled, the minor is not considered emancipated.

24-001.01F4 Minor Not Living with Parent(s): If the parent(s) has been contributing to the support of the minor, written verification from the parent(s) of his/her plans to continue or not continue to support is required.

24-001.01F5 Minor Parent Living with Specified Relative, Guardian, or Conservator: A minor parent who is living with a specified relative, guardian, or conservator is considered emancipated unless the minor parent is being supported from his/her parent(s), guardian, or conservator.

Note: See 477 NAC 1-001 for a list of specified relatives.

24-001.01G Deeming Provisions for ABD Children

24-001.01G1 Parent for Child: If an ABD child age 17 or younger is living in the household of his/her parent(s), the income and resources of the parent(s) shall be deemed (i.e., determined available).

See 477 NAC 24-002.03 for exceptions to this deeming requirement.

24-001.01G2 Disabled Child Not Receiving SSI

24-001.01G2a Deeming Income and Resources of Responsible Persons: A parent(s)'s income and resources are considered in determining the eligibility of a child age 17 or younger who is part of the household when the disabled child does not receive SSI.

When there is a self-supporting parent(s) for children in two different program cases, the procedures for deeming found below are followed and the resulting deemed income and resources are divided between the program cases containing the children on ABD. A portion of the income and resources of these individuals is deemed to the child using the following procedures.

24-001.01G2b Neither Parent nor Child is Receiving SSI: If neither a disabled child nor his/her disabled parent(s) is receiving SSI, and the child is living in the same household with his/her parent(s), the parent(s)'s income and resources must be deemed, with the following exceptions.

24-001.01G2b(1) Exceptions:

1. Home and Community-Based Waiver: If a child living in his/her parent(s)'s home is receiving Medicaid services through a Home and Community-Based Service waiver, the parent(s)'s income and resources are not deemed when determining eligibility for Medicaid.

2. Katie Beckett: If a child is not receiving waiver services, the income and resources of a parent are not deemed for Medicaid if the child is severely disabled and would require the level of care provided in a medical institution as well as certain medical services for special needs (a Katie Beckett child; see 477 NAC 27-009).

24-001.01G3 Child Receiving SSI: If a child age 17 or younger leaves a nursing facility or hospital where s/he was receiving an institutional personal needs amount SSI payment and goes home under a waiver, SSI must be notified of the waiver eligibility. Even though income and resources of the parent(s) may make the child ineligible for SSI, if the child is waiver-eligible, SSI continues the institutional personal needs amount payment without deeming income and resources of the parent(s).

Note: If the parent(s) is receiving SSI, none of the parent(s)'s income shall be deemed.

24-001.01G4 Child in an IMD: If a child under age 19 is placed in an IMD and is a ward of the Department or another public agency, or if the placement is court-ordered, see 477 NAC 25-001. If the child who is placed in an IMD is still considered part of the household, the parent(s)' income is deemed. See Appendix 477-000-009 for calculation procedures.

24-001.02 Special Provisions Pertaining to Spouse-for-Spouse Relative Responsibility for ABD

24-001.02A Divorce and Separation: A divorce dissolves the marriage of a couple and there is no longer spouse-for-spouse responsibility. A legal separation does not dissolve the marriage.

24-001.02B Determining Financial Responsibility for a Married Couple:

24-001.02B1 Living Together without Medicaid Waiver or Program of All-Inclusive Care for the Elderly (PACE) Services: The income and resources of spouses living together in the same household shall be considered available to each other. The resource standard for two shall be used to determine eligibility whether one spouse or both are eligible.

Exception: If one spouse is receiving VA benefits, and is eligible for ABD Medicaid, then eligibility shall be determined separately. This only applies if the couple would be ineligible for SSI as a couple. If they would both be eligible for SSI, the non-SSI spouse must apply.

24-001.02B2 Living Together with Medicaid Waiver or PACE Services: If only one spouse is eligible for ABD Medicaid, then use the spousal impoverishment treatment of resources and income. An assessment and designation of resources must be completed. See 477 NAC 26-003.01B and 477 NAC 26-003.01F. If both spouses are eligible for ABD Medicaid, then eligibility shall be determined separately. The resource standard for one shall be used for each spouse. The combined resources must be $8,000 or less.

24-001.02B3 Living Apart and Neither in a Specified Living Arrangement: Eligibility shall be determined separately beginning the first full month the couple ceases to live together. Consider only the income and resources in the applicant spouse's name. The spouse shall be allowed a resource standard for one, and eligibility shall be determined separately. Total countable resources for each spouse must not exceed $4,000. This guideline shall be followed whether one spouse or both are eligible.

24-001.02B4 Living Apart and Both in a Specified Living Arrangement: If both spouses are in a specified living arrangement (see 477 NAC 26-001), eligibility is determined as follows: Consider the income of each spouse separately.

Consider the resources that each spouse has in their own name. Combined resources must be below $8,000. Each spouse shall be allowed a resource standard for one. This guideline shall be followed whether one spouse or both are eligible.

24-001.02B5 Living Apart with One in a Specified Living Arrangement: If only one spouse is eligible for ABD Medicaid, spousal impoverishment rules apply for treatment of income and resources (see 477 NAC 26-004 and 477 NAC 26-003). An assessment and designation of resources must be completed (see 477 NAC 26-003.01B and 477 NAC 26-003.01F). The spouse shall be allowed the resource standard for one. If both spouses are eligible and one enters a specified living arrangement, income and resources shall be considered separately beginning the first full month the couple ceases to live together. Each spouse shall be allowed a resource standard for one. Combined resources must be $8,000 or less.

Note: If one spouse is temporarily absent from the home, the couple's income and resources shall continue to be considered together. An absence of fewer than 90 days is considered temporary. If the spouse will be absent more than 90 days, the spouse's plans or ability to return home shall be evaluated.

24-001.02C Spouse for Spouse Hardship Exemption: A hardship exemption may be granted to enable an eligibility determination using only the applicant's resources in cases where it is noy possible to verify the resources of the non-institutionalized spouse due to inability to obtain complete information. This exemption can only be granted by Central Office.

Note: If the community spouse is assisting the applicant with the application process or was living with the institutionalized spouse just prior to institutionalization, spouse for spouse financial responsibility applies.

24-002 SPONSOR DEEMING FOR ALIENS

24-002.01 Sponsors for Aliens: One hundred (100) percent of the income and resources of a sponsor (and sponsor's spouse, if they are living together) shall be considered when determining the eligibility of an alien who applies for Medicaid if the sponsor has signed an affidavit of support under Section 213A of the Immigration and Nationality Act. Alien status must be verified by electronic data sources. The sponsor's income and resources will be considered available to the alien until one or more of the following circumstances apply:

1. The individual becomes a U.S. citizen;
2. The individual has worked 40 qualifying quarters of coverage as defined under Title II of the Social Security Act or can be credited with the qualifying quarters as provided under Section 435, and the alien did not receive any federal means tested public benefit during that time period. This provision does not apply to restricted Medicaid;
3. The individual is pregnant (including 60 days post-partum); and/or
   The individual is under age 19.

24-002.02 Sponsor of More than One Alien: When an individual is a sponsor for two or more aliens who are living in the same home, the amount of deemed income and resources of the sponsor (and the sponsor's spouse, if living with the sponsor) is divided equally among the aliens. When an individual sponsors several aliens but not all apply for Medicaid, the sponsor's total deemable income and resources is applied to the needs of the aliens who apply for Medicaid.

24-002.03 Deeming Exceptions

24-002.03a Battery or Extreme Cruelty: If a sponsored immigrant demonstrates that s/he or his/her child(ren) have been battered or subjected to extreme cruelty by a spouse, a parent, or by a member of the spouse's or parent's family who is residing in the same household as the alien, deeming may be waived if a judge, an administrative judge, or the U.S. Citizenship and Immigration Services (USCIS) recognize the battery or cruelty.

24-002.03b Categorically Ineligible Spouse: The sponsor's deemed income and resources for a categorically ineligible spouse (e.g., not aged, blind, or disabled) are not deemed to the non-sponsored eligible spouse.

24-002.04 Alien Duties: As an eligibility requirement, the alien is responsible for:

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

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

Note: Chapters 477 NAC 19 through 25 apply to the following: Aged, Blind and Disabled (AABD/MA), Medically Needy (MN), Medicaid Insurance for Workers with Disabilities (MIWD), Women's Cancer Program, Former Foster Care, Emergency Medical Assistance, Child Welfare

CHAPTER 22-000 RELATIVE RESPONSIBILITY

22-001 RELATIVE RESPONSIBILITY

2. Spouse for spouse; and
3. Parent (biological, adoptive, or step) for child if the child is age 18 or younger and is still considered part of the household.

22-001.01 Child Considered Part of Household

22-001.01A If the child is living in the same household with parent(s), the parent(s)' income must be included.

Exceptions: Home and Community Based and Developmental Disability Waiver and Katie Beckett.

22-001.01B Autism Waiver: If a child, living in the parent(s)' home is receiving Medicaid services through Nebraska's Home and Community Based Waiver for Children with Autism Spectrum Disorder, both the parent(s)' income and Autism waiver child's income must be verified solely to determine a premium due amount when the gross income exceeds 185% FPL.

22-001.01C If the child is temporarily absent from the home (generally 90 days or less) but is still considered part of the household, the parent(s)' income must be included. Temporary absence includes, but is not limited to:

3. School attendance where the child returns to the home on a regular basis (weekends, vacations, or summers).
4. Residence in an institution for a developmental disability or mental illness for 90 days or less may be considered temporary absence if the child was living in the parent(s)' household before institutionalization and will return to the parent(s)' household upon discharge.

22-001.02 Child No Longer Considered Part of Household: If the child is permanently out of the home and no longer considered part of the household, the parent(s)' income must not be included.

22-002 FINANCIAL RESPONSIBILITY

22-002.01 Unmarried Parents: When unmarried parents are living together as a family, the alleged father is not financially responsible unless he has acknowledged paternity or a court has determined that he is the father of the child after the birth.

22-002.02 Children of a Marriage: A woman's spouse is considered the father of any children who are conceived or born during a marriage even if the couple is separated and/or has filed for divorce or annulment unless there is a court order that states otherwise. If a woman states that her spouse is not the father of her child, establishment of paternity must be pursued, unless good cause exists.

22-002.03 Determination of Paternity: Paternity cannot be established unless an alleged father has signed a birth certificate, written and notarized paternity acknowledgment form or a court has determined him to be the father.

Note: Paternity cannot be established for an unborn.

22-002.04 Military Service: If a parent is absent due to active duty in the uniformed services of the United States, that parent is still considered part of the assistance unit and his/her income is considered available to the unit. Uniformed service is defined as the Army, Navy, Air Force, Marine Corps, Coast Guard, Environmental Sciences Services Administration, and Public Health Service of the United States. If the client states that separation is due to reasons other than performance in military service, the client must provide proof of bona fide separation.

If the parent in the military is incarcerated, s/he is no longer considered part of the assistance unit.

22-002.05 Joint Physical Custody: In a household where both parents are not continuously present, a determination must be made if both parents are present, if so income and resources of both parents must be used in the eligibility determination and the needs of both included in the unit. This includes when the non-custodial parent has sufficiently frequent contact with the child(ren) so that the normal parental roles of providing guidance, physical care, and maintenance have not been interrupted.

In addition, this policy applies when there is joint physical (shared) custody where the physical custody of the child(ren) is split between both parents. This can be either on a scheduled basis as included in a divorce decree or on an informal basis agreed to by both parents.

22-002.06 Special Provisions Pertaining to Minor Parents

22-002.06A Minor Parent: If a minor parent has a legal guardian, according to Nebraska law the guardian has no financial responsibility for the minor.

22-002.06B Minor's Parent(s) Receiving ADC/MA: If a minor parent is living with his/her parent(s) who is receiving ADC/MA for another child, the minor parent must be in his/her parent(s)' unit.

If assistance is received for the minor's child, that child must also be in the parent(s)' unit.

When a minor parent becomes emancipated, graduates from secondary school at age 18, or reaches age 19, s/he and his/her child become a separate unit.

Note: The family is not required to receive Medicaid for the minor's child.

22-002.06C Minor Parent Living with Specified Relative, Guardian or Conservator: A minor parent who is living with a specified relative, guardian, or conservator is considered emancipated unless the minor parent is receiving support from his/her parent(s), guardian or conservator.

Note: See 477 NAC 1-001 for a list of specified relatives.

22-002.06D Minor Not Living with Parent(s): If the parent(s) has been contributing to the support of the minor, written verification from the parent(s) of his/her plans to continue or not continue to support is required.

22-002.06E Minor Living in Parent(s)' Home: If a minor is living in his/her parent(s)' home, s/he is considered emancipated if s/he has married. If the minor has married, s/he may be a separate unit with his/her child. If the marriage is annulled, the minor is not considered emancipated.

22-002.07 Special Provisions Pertaining to Spouse for Spouse for AABD/MA

22-002.07A Spouse for Spouse: A divorce dissolves the marriage of a couple and there is no longer spouse-for-spouse responsibility. A legal separation does not dissolve the marriage. The following guidelines shall be used in determining financial responsibility for a married couple:

1. Living Together Without Medicaid Waiver or Program of All-Inclusive Care for the Elderly (PACE) Services: Consider income and resources of both spouses living together in the same household as available to each other. Use the resource standard for two for medical. Budget together for medical, whether one or both are eligible.
   Exception: If the spouse receiving VA is eligible for AABD/MA, budget him/her separately for medical. This only applies if they would be ineligible for SSI as a couple. If they would both be eligible for SSI, the non-SSI spouse must apply.
2. Living Together With Medicaid Waiver or PACE Services: For medical eligibility, consider income and resources separately. Use the medical resource standard of one for each and budget separately for medical. If only one spouse is eligible, consider income and resources together for grant eligibility.
3. For medical eligibility, use the spousal impoverishment treatment of resources and income. An assessment and designation of resources must be completed.
4. Living Apart and Neither in a Specified Living Arrangement: Consider income and resources separately beginning in the first full month the couple cease to live together. Allow the client(s) a resource standard for one for medical and budget the client(s) separately. Total countable resources for the couple must not exceed $8,000. Follow this guideline whether one or both are eligible.
   Exception: If either spouse is current pay SSI, follow SSI budgeting rules.
5. Living Apart and Both in a Specified Living Arrangement: If both spouses are in a specified living arrangement, consider income and resources separately. Allow the client(s) a resource standard for one for medical. Budget the client(s) separately for medical. Follow this guideline whether one or both are eligible.
6. Living Apart with One in a Specified Living Arrangement: If only one spouse is eligible, spousal impoverishment rules apply for treatment of income and resources. An assessment and designation of resources must be completed. For medical, allow the client the resource standard for one and budget on Form DA-4M. If both spouses are eligible and one enters a specified living arrangement, consider income and resources separately beginning in the first full month the couple ceases to live together. Allow each a resource standard for one for medical. Budget separately for medical.

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

22-002.08 Deeming Provisions for AABD/MA Children

22-002.08A Parent for Child: For AABD/MA income and resources of a parent(s) to a child age 17 or younger, if living in the same household, shall be deemed.

See 477 NAC 22-002.08B for deeming procedures and 477 NAC 22-001.01 for exceptions to this deeming requirement.

22-002.08B Disabled Child Not Receiving SSI

22-002.08B1 Deeming Income of Responsible Persons: Income of the following individuals is considered in determining a client's eligibility when s/he does not receive SSI:

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

When there is a self-supporting parent(s) for children in two different units, the procedures for deeming found below are followed and the resulting deemed income is divided between the units with the children on AABD/MA. A portion of the income of these individuals is deemed (determined available) to the client using the following procedures.

22-002.08B2 Parent (No SSI): If the client does not receive SSI, the following guidelines must be used to determine if the parent(s') income is deemed:

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

   Exceptions:

   a. Home and Community Based Waiver: If a child, living in the parent(s)' home is receiving Medicaid services through a Home and Community Based Service waiver, the parent(s)' income and resources are not deemed when determining eligibility for medical only.
   b. Katie Beckett: If the child is not receiving waiver services, the income and resources of a parent are not deemed for Medicaid only if the minor is severely disabled and would require the level of care provided in a medical institution (Katie Beckett child) and requires certain medical services for special needs. (See 471 NAC 12-014.) This exception applies only if the cost of care in the home is less expensive than the cost of care in a medical institution. To determine if deeming may be waived, the situation must be explained on, attach a current medical report, and forward it to the Central Office.

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

2. If the minor is temporarily absent from the home but is still considered part of the household, the parent(s)' income must be deemed.

3. If the minor is permanently out of the home and no longer considered part of the household, the parent(s)' income must not be deemed.

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

22-002.08C Client Receiving SSI: If a child age 17 or younger leaves a nursing facility or hospital where s/he was receiving an institutional personal needs amount SSI payment and goes home under a waiver, SSI must be notified of the waiver eligibility. Even though income and resources of the parent(s) may make the child ineligible for SSI, if the child is waiver-eligible, SSI continues the institutional personal needs amount payment without deeming income and resources of the parent(s).

Note: If the parent(s) is receiving SSI, none of the parent(s) income shall be deemed.

22-002.08D Child in an IMD: If a child who is placed in an IMD is a ward of the Department or another public agency or if the placement is court-ordered, see 477 NAC 25-001. If the child who is placed in an IMD is still considered part of the household, the parent(s)' income is deemed. See Appendix 477-000-009 for calculation procedures.

22-002.09 Sponsors for Aliens

22-002.09A Sponsors for Aliens: 100 percent of the income and resources of a sponsor (and sponsor's spouse, if they are living together) shall be considered when determining the eligibility of an alien who applies for Medicaid if the sponsor has signed an affidavit of support under Section 213A of the Immigration and Nationality Act. The sponsor's income and resources will be considered available to the alien until the alien:

4. Becomes a U.S. citizen;
5. Has worked 40 qualifying quarters of coverage as defined under Title II of the Social Security Act or can be credited with the qualifying quarters as provided under Section 435 and the alien did not receive any federal means tested public benefit during that time period. This provision does not apply to restricted Medicaid;
6. If the individual is pregnant (including 60 days post partum);
7. If the individual is under age 19.

22-002.09B Sponsor of More than One Alien: When an individual is a sponsor for two or more aliens who are living in the same home, the amount of deemed income and resources of the sponsor (and the sponsor's spouse, if living with the sponsor) is divided equally among the aliens. When an individual sponsors several aliens but not all apply for assistance, the sponsor's total deemable income and resources are applied to the needs of the aliens who apply for assistance.

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

22-002.09C Deeming Exception: If a sponsored immigrant demonstrates that s/he or his/her children have been battered or subjected to extreme cruelty by a spouse or a parent or by a member of the spouse's or parent's family who is residing in the same household as the alien, deeming may be waived if a judge, an administrative judge, or INS recognize the battery or cruelty.

22-002.10 Alien Duties: As an eligibility requirement, the alien is responsible for:

3. Providing income and resource information from the sponsor; and
4. Obtaining the necessary cooperation from the sponsor. If the alien does not provide the necessary information, s/he is not eligible for assistance.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 25-000 ABD BUDGETING

25-001 ABD BUDGETING

25-001.01 Medical Budget Periods: The medical budget is normally computed on a monthly basis. See Appendix 477-000-009 for procedures.

25-001.02 Alternate Living Arrangements Standard of Need: The standard of need for alternate living arrangements is a consolidated allowance for items necessary for basic subsistence. Included in this standard are

1. Board;
2. Room;
3. Clothing;
4. Personal needs;
5. Laundry;
6. Transportation; and
7. Medical and remedial services. (The consolidated standard of need for board and room [see 477 NAC 25-001.02B] includes items 1 through 6 but does not include remedial services.)

25-001.02A Licensing of Facilities: In determining the appropriate standard to be allowed, the current licensure/certification of the facility shall be verified. If the facility is covered under more than one licensure/ certification, it shall be verified in which section the client is residing and which licensure/certification applies.

Nebraska law directs the Department and other public and private agencies who arrange and supervise living arrangements to report any facility which is not currently licensed and serves more than three individuals. Central Office, Aged and Disabled Services, must be contacted if an unlicensed facility is identified.

25-001.02B Board and Room: Board and room does not include care or supervision and may be with a relative.

In addition to the actual amount of board and room paid, the client is allowed a personal needs allowance. The total allowance must not exceed the standard for Board and Room, see Appendix 477-000-044.

25-001.02C Licensed Assisted Living Facility: An Assisted Living facility provides accommodation and board and care (e.g., personal assistance in feeding, dressing, and other essential daily living activities) for four or more individuals not related to the owner, occupant, manager, or administrator. These individuals are unable to care for themselves sufficiently or properly or manage their own affairs because of illness, disease, injury, deformity, disability, or physical or mental infirmity.

Individuals residing in Assisted Living facilities do not require the daily services of licensed, registered, or practical nurses. However, staff in an assisted living facility may assist the individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication. See Appendix 477-000-043 for procedures.

The monthly standard for an Assisted Living facility includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02D Certified Adult Family Home: An Adult Family Home is a residential living unit that provides full-time residence with minimal supervision and guidance to not more than three individuals age 19 or older. Service includes board and room with meals, standard furnishings, equipment, household supplies, and facilities to ensure client comfort. These individuals are essentially capable of managing their own affairs but are in need of supervision. This may include supervision of nutrition by the facility on a regular, continuing basis, but not necessarily on a consecutive 24-hour basis.

The monthly standard for an Adult Family Home includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02E Residential Child-Caring Agencies: This group care facility provides 24-hour accommodation for minors including care and supervision. The home provides services to two or more individuals who are developmentally disabled.

The monthly standard for a Licensed Group Home for Children or a Child Caring Agency includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02F Licensed Center for the Developmentally Disabled: A center for the developmentally disabled is any facility, place, or building not licensed as a hospital that provides accommodation, board, training, and other services when appropriate, primarily or exclusively, for four or more persons who are developmentally disabled.

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

The term "center" includes:

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

The monthly standard for a Licensed Center for the Developmentally Disabled includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

25-001.02G Long-Term Care (LTC) Facility: The payment to a long-term care facility includes an allowance for personal needs of the client, which is determined by the licensure or certification of the facility where the client resides (see 477 NAC 25-001.02).

This facility may be considered for all alternate care standards. The maximum amount allowed is the Assisted Living standard; see Appendix 477-000-044. For a client living in a long-term care facility, see 477 NAC 26-004.03D.

25-001.02H Assisted Living Waiver: See Appendix 477-000-012, 477-000-028, and 477-000-043 for the standard for an individual receiving Assisted Living Waiver services. The monthly standard includes an allowance for personal needs of the client.

25-001.02I Licensed Mental Health Center: Mental health center means a facility where shelter, food, counseling, diagnosis, treatment, care, or related services are provided for a period of more than 24 consecutive hours to persons residing at the facility who have a mental disease, disorder, or disability.

25-001.03 ABD Continuation for SSI Clients: The standard of need is used for independent living and shelter costs or the consolidated standard for alternate living when the Social Security Administration notifies the Department that a client will continue to receive full Supplemental Security Income (SSI) payments for up to three months because the individual is likely to return to his/her previous living arrangement. The procedures at 477 NAC 26-004.04D are followed for allowing shelter and/or utilities when

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

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the standard of need that most accurately reflects the client's living arrangement must be used.

25-001.04 Budgeting for ABD

25-001.04A ABD Budget: A budget or system must be used to determine eligibility for Medicaid and Medicaid share of cost cases. If at any time factors change that affect the budget, the budget must be re-computed.

For ABD change report procedures, see Appendix 477-000-009.

If a parent(s)' income has been deemed to a child, the medical expenses (including insurance premiums) of the parent(s) and any siblings for whom the parent(s) is responsible for paying medical expenses may be applied to the child's share of cost. See Appendix 477-000-045.

Note: Current share of cost amounts must be applied to current monthly medical expenses, not previous months' medical expenses.

25-001.04B Methodology Used:

1. The treatment of income and resources for medically needy individuals is based on Aid to Families with Dependent Children (AFDC) methodology for parent/caretakers and children.
2. The treatment of income and resources for individuals who are aged, blind, or disabled is based on SSI methodology.

25-001.04C Standard Levels: When computing a Medicaid budget for medically needy children and parent/caretaker relatives, the following individuals shall be considered in determining the unit or family size:

1. Client;
2. Spouse; and
3. The applicant/spouse's minor child(ren) residing in the household.

When computing a Medicaid budget for ABD, only the client and his/her spouse is considered in determining the medically needy or Federal Poverty income level.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the standard of need shall be used that most accurately reflects the client's living arrangement.

When computing a medical budget, the following steps shall be used to determine if the client is eligible for Medicaid only or Medicaid with share of cost:

1. The client's net income shall be compared to the percentage of the Federal Poverty Level (FPL) (see Appendix 477-000-012). If the client's income is equal to or less than the FPL, the client is eligible for MA only. If the client's income is more than the FPL, step 2 determines the amount of share of cost. For clients in long-term care, go directly to step 2.

2. The medically needy income level shall be subtracted from the client's net income to determine the amount of share of cost (see Appendix 477-000-045).

When a client enters long-term care, the standard is not reduced to the long-term care level or Assisted Living Waiver level until the first full month that the client resides in long-term care.

25-001.04D Computation of Net Income:

25-001.04D1 Income Disregarded: Income disregarded for the ABD client is not considered in determining the eligibility of or the amount of assistance for the client or any other individual.

Savings from disregarded income are considered the same as assets accumulated from any other source.

25-001.04E Budget Disregards: In addition to disregards outlined in 477 NAC 22-005, the following disregards are allowed:

25-001.04E1 Clients in a Long-Term Care Facility or Receiving Assisted Living Aged and Disabled Waiver Services: In addition to guardian/conservator fee disregard and the maintenance allowance for long-term care or the standard for Assisted Living, the cost of homeownership or rent expense, including utilities up to six (6) months is deducted. The allowances must not exceed the maximum shelter amount for one (see Appendix 477-000-044) if the client does not have a spouse.

25-001.04E2 Budgeting Individuals in Nursing Home or Acute Care Hospitalization for Three Continuous Months: Non-SSI budgeting procedures shall be used for individuals in nursing home or acute care hospitalization when SSI does not make a change in living arrangement at the end of three full continuous months and income exceeds the Federal Benefit Rate (FBR) for a single individual in an institution (see Appendix 477-000-037).

25-001.04F Buy-In of Part B: A client is eligible for state payment of Medicare Part B premium (buy-in) if his/her income is equal to or less than 100 percent of the FPL. Buy-in begins the month following the month of processing. See Appendix 477-000-012 for the buy-in procedure.

For Medicare beneficiaries, see 477 NAC 27-002.

25-001.05 Client Living in a Long-Term Care Facility: The budget of a client living in a long-term care facility (i.e., a nursing home, Assisted Living Waiver, or an acute care hospital) shows

1. The standard of need; and
2. An amount up to $10 when the client has a guardian or conservator who requests a fee (see 477 NAC 22-005.02D).

The expense of home ownership and/or utilities may be allowed only until it is apparent that the client cannot live there again (not to exceed six months).

The budget may allow for the expense of rent and/or utilities for up to six months. The total time for either allowance shall not exceed six months. The allowances must not exceed the maximum shelter amount for on (see Appendix 477-000-044) if the client does not have a spouse.

Exception: See 477 NAC 25-001.03 for budgeting a client who continues to receive full SSI benefits for up to three months.

Note: If a client in an alternate care facility goes to a long-term care facility, the budget must continue to allow the alternate care standard until it is apparent that the client will not return to the alternate care facility (not to exceed two months). If the client remains in the long-term care facility beyond two months, Central Office approval is required to continue using the alternate care standard.

Note: Chapters 477 NAC 19 through 25 apply to the following: Aged, Blind and Disabled (AABD/MA), Medically Needy (MN), Medicaid Insurance for Workers with Disabilities (MIWD), Women's Cancer Program, Former Foster Care, Emergency Medical Assistance, Child Welfare

CHAPTER 23-000 AABD/MA BUDGETING AND SPOUSAL IMPOVERISHMENT BUDGETING

23-001 AABD/MA BUDGETING AND SPOUSAL IMPOVERISHMENT BUDGETING

23-001.01 Alternate Living Arrangements: The standard of need for alternate living arrangements is a consolidated allowance for items necessary for basic subsistence. Included in this standard are:

8. Board;
9. Room;
10. Clothing;
11. Personal needs;
12. Laundry;
13. Transportation; and
14. Medical and remedial services (The consolidated standard of need for board and room [see 477 NAC 23-001.03] and licensed boarding homes [see 477 NAC 23-001.04] includes items 1 through 6 but does not include remedial services.)

23-001.02 Licensing of Facilities: In determining the appropriate standard to be allowed, the current licensure/certification of the facility shall be verified. If the facility is covered under more than one licensure/ certification, it shall be verified in which section the client is residing and which licensure/certification applies.

Nebraska law directs DHHS and other public and private agencies who arrange and supervise living arrangements to report any facility which is not currently licensed and serves more than three individuals. Central Office, Aged and Disabled Services, must be contacted if an unlicensed facility is identified.

23-001.03 Board and Room: Board and room does not include care or supervision and may be with a relative.

In addition to the actual amount of board and room paid, the client is allowed a personal needs allowance. The total allowance must not exceed the standard for Board and Room, see Appendix 477-000-044.

23-001.04 Licensed Assisted Living Facility: An Assisted Living facility provides accommodation and board and care (e.g., personal assistance in feeding, dressing, and other essential daily living activities) for four or more individuals not related to the owner, occupant, manager, or administrator. These individuals are unable to sufficiently or properly care for themselves or manage their own affairs because of illness, disease, injury, deformity, disability, or physical or mental infirmity.

Individuals residing in Assisted Living facilities do not require the daily services of licensed, registered, or practical nurses. However, staff in an assisted living facility may assist the individuals residing there in taking routine oral or external medication and also provide for storage and handling of the medication. See Appendix 477-000-043 for procedures.

The monthly standard for an Assisted Living Facility includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

23-001.05 Certified Adult Family Home: An Adult Family Home is a residential living unit which provides full-time residence with minimal supervision and guidance to not more than three individuals age 19 or older. Service includes board and room with meals, standard furnishings, equipment, household supplies, and facilities to ensure client comfort. These individuals are essentially capable of managing their own affairs but are in need of supervision. This may include supervision of nutrition by the facility on a regular, continuing basis, but not necessarily on a consecutive 24-hour basis.

The monthly standard for an Adult Family Home includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

23-001.06 Licensed Group Home for Children and/or Child Caring Agency (Formerly Group Homes for the Mentally Retarded): This group care facility provides 24-hour accommodation for minors including care and supervision. The home provides services to two or more individuals who are developmentally disabled.

The monthly standard for a Licensed Group Home for Children or a Child Caring Agency includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

23-001.07 Licensed Center for the Developmentally Disabled: A center for the developmentally disabled is any facility, place, or building not licensed as a hospital which provides accommodation, board, training, and other services when appropriate, primarily or exclusively, for four or more persons who are developmentally disabled.

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

The term "center" includes:

3. Group Residence - Any group of rooms located within a dwelling and forming a single habitable unit with living, sleeping, cooking, and eating facilities for 4 through 15 developmentally disabled persons.
4. Institution for the Developmentally Disabled - Any facility other than a skilled nursing facility or an intermediate care facility I or II where 16 or more developmentally disabled persons reside.
5. The monthly standard for a Licensed Center for the Developmentally Disabled includes an allowance for personal needs of the client. See Appendix 477-000-044 for the payment standard.

23-001.08 Long Term Care Facility: The payment to a long term care facility includes an allowance for personal needs of the client which is determined by the licensure or certification of the facility where the client resides, see 477 NAC 23-001.01.

This facility may be considered for all alternate care standards. The maximum amount allowed is the Assisted Living standard, see Appendix 477-000-044. For a client living in a care facility, see 477 NAC 23-001.15E.

23-001.09 Assisted Living Waiver: See Appendix 477-000-028, 477-000-012, and 477-000-043 for the standard for an individual receiving Assisted Living Waiver services. The monthly standard includes an allowance for personal needs of the client.

23-001.10 Licensed Mental Health Center: Mental health center means a facility where shelter, food, counseling, diagnosis, treatment, care, or related services are provided for a period of more than 24 consecutive hours to persons residing at the facility who have a mental disease, disorder, or disability.

23-001.11 AABD/MA Continuation for SSI Clients: The standard of need is used for independent living and shelter costs or the consolidated standard for alternate living when SSI notifies the agency that the client will continue to receive full SSI payment for up to three months because the individual is likely to return to his/her previous living arrangement. The procedures in 477 NAC 23-001.15E are followed for allowing shelter and/or utilities when:

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

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, standard of need must be used which most accurately reflects the client's living arrangement.

23-001.12 Buy-In of Part B: A client is eligible for state payment of Medicare Part B premium (buy-in) if his/her income is equal to or less than 100% of the federal poverty level.
For Medicare beneficiaries, see 477 NAC 24-002.

Note: If a client in an alternate care facility goes to a care facility, the alternate care standard must continue to be budgeted until it is apparent that the client will not return to the alternate care facility (not to exceed two months). If the client remains in the care facility beyond two months, Central Office approval is required in order to continue using the alternate care standard.

23-001.13 Medical Budgeting for AABD/MA

23-001.13A Medical Budget: A medical budget or system must be used to determine eligibility for Medicaid and Medicaid share of cost cases. If at any time factors change that affect the budget, the budget must be re-computed.

If the parent(s)' income has been deemed to the child, the medical expenses (including insurance premiums) of the parent(s) and any siblings for whom the parent(s) is responsible for paying medical expenses may be applied to the child's share of cost. See Appendix 477-000-045.

23-001.13B Spousal Impoverishment Medical (SIMP) Budget: A SIMP budget is required for an eligible spouse in a specified living arrangement and an ineligible spouse in the community:

1. SIMP budget is used to calculate the amount of income (if any) to be allocated from the eligible spouse to the ineligible spouse and/or family members.
2. SIMP budget is used to calculate eligibility for Medicaid only or Medicaid with share of cost for the eligible spouse

23-001.13C Standard Levels: When computing a medical budget, the following individuals are considered in determining the unit or family size:

4. Client; and
5. Spouse.
6. The applicant/spouses minor child(ren) residing in the household.

When computing a budget, only the client is considered in determining the medically needy or Federal Poverty income level.

If the client is in a hospital (or receiving acute hospital care) or licensed alcohol/drug treatment center, the standard of need shall be used which most accurately reflects the client's living arrangement.

When computing a medical budget, the following steps are used to determine if the client is eligible for MA only or MA with excess:

1. Compare the client's net income to the percent of the Federal Poverty Level (FPL) (see Appendix 477-000-012). If the client's income is equal to or less than the FPL, the client is eligible for MA only. If the client's income is more than the FPL, go to step 2 to determine the amount of Share of Cost. For clients in long term care, go directly to step 2.
2. Subtract the medically needy income level from the client's net income to determine the amount of Share of Cost (see Appendix 477-000-045).

When a client enters long term care, the standard is not reduced to the long term care level or Assisted Living Waiver level until the first full month that the client resides in long term care.

23-001.14 Disregards for Medical Budgets: In addition to disregards outlined in 477 NAC 20-002, the following disregards are allowed:

23-001.14A Medical Insurance Disregards: The cost of medical insurance premiums is deducted if the client or responsible relative is responsible for payment. The Medicare

Part B premium which the client or responsible relative is responsible for paying is included in this disregard. Exception: The cost of premiums for income-producing policies is not allowed as a medical deduction. See Appendix 477-000-026.

23-001.14B Guardianship/Conservator Fee: The expense of a guardian or conservator fee is allowed as paid, up to a maximum of $10 per month. If the guardian/conservator is required by the court to purchase a bond and file an annual report with the court, the amount allowed by the court for expenses (in excess of $120) may also be disregarded.

23-001.14C Clients in LTC Facility or Receiving Assisted Living Aged and Disabled Waiver Services: In addition to the maintenance allowance for long term care or the standard for Assisted Living, the following expenses are deducted:

1. Cost of homeownership or rent expense, including utilities up to six months. The allowances must not exceed the maximum shelter amount for one (see Appendix 477-000-044) if the client does not have a spouse.
2. Guardian or conservator fee as paid, up to a maximum of $10 per month. If the guardian/ conservator is required by the court to purchase a bond and file an annual report with the court.

23-001.14D Budgeting Individuals in Long Term Care for Three Continuous Months: Use non-SSI budgeting procedures for individuals in long term care when SSI does not make a change in living arrangement at the end of three full continuous months and income exceeds the FBR for a single individual in an institution (see Appendix 477-000-037).

23-001.14E Client Living in a Care Facility: The budget of a client living in a care facility shows:

3. The standard of need; and
4. An amount up to $10 when the client has a guardian or conservator who requests a fee (see 477 NAC 23-001.15B).

The expense of home ownership and/or utilities may be allowed only until it is apparent that the client cannot live there again (not to exceed six months).

The budget may allow for the expense of rent and/or utilities for up to six months. The total time for either allowance shall not exceed six months. The allowances must not exceed the maximum shelter amount for on (see Appendix 477-000-044) if the client does not have a spouse.

Exception: See 477 NAC 23-001.12 for budgeting a client who continues to receive full SSI benefits for up to three months.

Note: If a client in an alternate care facility goes to a care facility, the budget must continue to allow the alternate care standard until it is apparent that the client will not return to the alternate care facility (not to exceed two months). If the client remains in the care facility beyond two months, Central approval is required to continue using the alternate care standard.

23-001.15 Income When the Eligible Spouse Is in a Specified Living Arrangement and the Ineligible Spouse and/or Family Member(s) Is in the Community

23-001.15A Definitions

Community Spouse: A spouse who is:

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

Family Members: Minor children residing with a community spouse, or dependent parents or siblings of the community spouse or alternate care spouse who reside with the community spouse and could be claimed as dependents for tax purposes.

Maintenance Allowance: The amount deducted from an alternate care spouse's income to meet the maintenance needs of the community spouse and family members.

Maintenance Need Standard: The income standard to which the community spouse's and other family members' income is compared for the purpose of determining the amount of allowance which may be made from the alternate care spouse's income.

23-001.15B Allocation of Income: When computing the Medicaid budget for an alternate care spouse in a specified living arrangement, only his/her income (SIMP budget) is considered. Income of a community spouse is not considered available to the alternate care spouse. Some of the income of the alternate care spouse may be allocated to the community spouse and/or family members to bring their income up to a minimum monthly amount. The amount which may be allocated is computed on the SIMP budget. If the community spouse does not provide verification of his/her income, SIMP budget is not used. A Medical budget would be used for the client and no allocation of the client's income would be made to the community spouse.

When allocated allowances are not made available to the community spouse, these allowances shall not be deducted from the client's income on side one of the SIMP budget. The allowances for other family members shall be deducted, even if the institutionalized spouse does not make these allowances available to the family members.

The alternate care spouse must be residing in one of the following living arrangements for these special budgeting procedures to apply:

1. A long term care facility;
2. An Adult Family Home;
3. A Licensed Assisted Living Facility;
4. A Center for the Developmentally Disabled; or
5. Receiving services in a Home and Community Based Service Waiver or PACE (see Appendix 477-000-042 for procedure).

If the spouse no longer meets the definition of a community spouse spousal impoverishment budgeting stops the first month possible.

Budgeting procedures apply beginning with the month an eligible spouse enters a specified living arrangement (even if it is a partial month) and cease with the first full month the alternate care spouse is no longer in a specified living arrangement. An assessment and designation of resources shall be completed.

The community spouse or other family member shall not be on assistance if s/he is included in this budgeting procedure. They may be eligible in their own right, but may choose not to apply if this is to their benefit.

23-001.15C Determining Ownership of Income: All income must be verified to determine the amount of the income and the individual in whose name the income is received.

1. If payment is made in the name of both spouses, half is considered available to each spouse.
2. The income shall be divided by the number of payees if payment is made in the name of one or both spouses and a third party.
3. Only the spouse's proportionate share is considered available to him/her.
4. If income is paid to one spouse and a third party but the verification reveals that the income is intended for both spouses, both spouses shall be included in the division to determine the proportionate share.

If income does not specify either spouse, one-half of the amount is considered available to each spouse.

The client may appeal the assumption of ownership of income.

23-001.15D Determining the Family Member's Maintenance Need Standard:

1. Takes the percent of the Federal Poverty Level (see Appendix 477-000-012);
2. Subtracts the family member's gross income; and
   Note: SSI is included as income.
3. Divides the result by 3.

A separate calculation is completed for each family member. This is calculated on the SIMP budget.

23-001.15E Determining the Spousal Maintenance Need Standard:

1. Takes the percent of the Federal Poverty Level (see Appendix 477-000-012); and
2. Adds excess shelter costs, if any.

Excess shelter cost is the amount by which the rent or cost of home ownership (e.g. mortgage, taxes, insurance and cooperative/condominium maintenance fees) plus a utility standard exceed the prescribed shelter limit.

The utility standard shall be allowed even if utilities are included in the rent.

Shelter costs shall not be prorated even if someone lives with the community spouse.

If the community spouse is paying board and room, the food stamp allotment for one is subtracted from the actual board and room paid to determine shelter. See Appendix 477-000-044 for the utility standard and the shelter limit. This is calculated on the SIMP budget.

23-001.15F Determining the Maintenance Allowance: To determine the amount of income from the alternate care spouse that may be allocated to the community spouse and other family members, complete the following:

1. Take the family maintenance need standard;
2. Add the spousal maintenance need standard; and
3. Subtract the gross income of the community spouse. SSI is included. If the community spouse has self-employment income, use the adjusted gross income.

The spousal maintenance allowance must not exceed the maximum in Appendix 477-000-028. If a court has ordered the client to make support payments to the spouse in excess of the maximum, the court order takes precedence over the maximum.

The couple may appeal the maintenance allowance. To support an increase in the maintenance allowance, either spouse must establish that the community spouse needs income above the maintenance allowance because of exceptional circumstances resulting in significant financial duress. If the couple wins their appeal, the community spouse may reserve more than the maximum maintenance allowance.

23-001.15G Income Provisions: All income is included in the calculation, including SSI and income of minors.

If the primary income, RSDI, SSI, earnings, etc., is equal to or exceeds the maintenance need standard, other income does not need to be verified.

If income is $10 or less for anyone, it does not need to be verified.

23-001.15H Budgeting the Alternate Care Spouse: The following is deducting amounts from the alternate care spouse's net earned and unearned income in computing the alternate care spouse's budget:

1. MNIL or FPL level (see Appendix 477-000-012);
2. Guardian/Conservator fee;
3. Amount allocated to the community spouse and/or family member(s);
4. Medicare premium and/or health insurance premium. If the couple has a combined health insurance premium, one-half of the amount is allowed on the client's budget.

This is calculated on the SIMP budget.

23-001.16 Computation of Net Income for AABD/MA:

23-001.16A Income Disregarded: Income disregarded for the AABD/MA client is not considered in determining the eligibility of or the amount of assistance for the client or any other individual.

Savings from disregarded income are considered the same as assets accumulated from any other source.

23-001.16B Income Taxes Paid: Income taxes that must be paid on unearned income are not deducted from the income for budgeting purposes.

23-001.16C Garnishments and Overpayments: See definition at 477 NAC 20-006.20.

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

23-001.16D Offset of Earnings: If a client has a combination of farm, self-employment, and regular earned income, a loss from one source of income may be used to offset a gain from another source.

23-001.16E Prospective Budgeting: The most recent three months' actual income must be averaged to arrive at the gross income amount for the income period. Income is converted for weekly and bi-weekly income.

This figure is used to project medical eligibility for the next 12 months unless:

1. There was a significant change in the income of the previous three months; or
2. A significant change is anticipated during the projected 12-month period. When income fluctuates, an average of income must be used for the three most recent consecutive months.

When income is stable, one month's income must be used.

When income fluctuates, the three most recent consecutive months must be used.

23-001.16F Medical Budget Periods: The medical budget is normally computed on a monthly basis. See Appendix 477-000-009 for procedures.

23-001.16G Procedures for Change: It must be determined if the change(s) affects Medicaid eligibility.

If it does:

1. Compare resources to the resource limit;
2. Compare the income to the medically needy income level;
3. Determine eligibility based on the household composition;
4. Recompute the budget; and
5. Send an adequate and/or timely notice of change.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 26-000 SPOUSAL IMPOVERISHMENT MEDICAID PROGRAM BUDGETING

26-001 SPOUSAL IMPOVERISHMENT MEDICAID PROGRAM (SIMP): The budgeting procedures used when a client is residing in a specified living arrangement and has a spouse who has remained in the community. The client in the specified living arrangement is considered the alternate care spouse.

The alternate care spouse must be residing in one of the following living arrangements for these special budgeting procedures to apply:

1. A long-term care facility, including Assisted Living Waiver;
2. A medical institution or nursing facility;
3. A center for the developmentally disabled;
4. Receiving or eligible for Home and Community-Based Waiver services; or
5. Receiving or eligible to receive Program of All-Inclusive Care for the Elderly (PACE). See Appendix 477-000-042 for procedures.

26-002 DEFINITIONS

26-002.01 Community Spouse: A spouse who is

1. Not applying for or receiving Medicaid, including PACE;
2. Not residing with the alternate care spouse unless the alternate care spouse is in the home and eligible for Home and Community-Based Waiver Services, including PACE; and
3. Not in a hospital, skilled nursing facility, intermediate care facility, or intermediate care facility for persons with a developmental disability.

26-002.02 Family Members: Minor children residing with a community spouse, dependent parents, or siblings of the community spouse or alternate care spouse who reside with the community spouse and could be claimed as dependents for tax purposes.

26-002.03 Allocated Maintenance Allowance: The amount deducted from an alternate care spouse's income to meet the maintenance needs of the community spouse and family members.

26-002.04 Maintenance Need Standard: The income standard to which the community spouse's and other family members' income is compared for the purpose of determining the amount of allowance that may be made from the alternate care spouse's income.

26-003 RESOURCES

26-003.01 Assessment of Resources:

26-003.01A Resources Reserved for the Community Spouse: Resources may be reserved for the community spouse when the alternate care spouse is residing continuously in a specified living arrangement and applies for Medicaid. The amount of resources that a community spouse may reserve is based on the Consumer Price Index. This figure is adjusted annually. See Appendix 477-000-029 for the amount of resources a community spouse may reserve and examples. The reserved amount of resources is calculated from the total resources owned by the couple and must be verified.

26-003.01B Assessment of Resources: Either spouse may request an assessment of resources no earlier than the beginning of a period of continuous residence in a specified living arrangement. If the institutionalized individual has not already met the 30 day continuous stay, then the facility must state that the stay is likely to be at least 30 days, or would have been except for death. The completion of a Home and Community-Based Waiver or PACE assessment meets the criteria for the likely thirty(30)-day period.

A couple is allowed only one assessment. An Assessment of Resources must be completed by the Department, listing all verified countable resources owned jointly or individually by the couple in the month the spouse entered the specified living arrangement. If a transfer or sale of resources occurred during the month the spouse entered the specified living arrangement, then the Assessment of Resources must list all countable resources owned jointly or individually by the couple on the day the spouse entered the specified living arrangement. The couple is allowed resource exclusions listed at 477 NAC 23-001.06 and 477 23-001.06A.

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

If the community spouse transfers away any resource for less than fair market value, it is a deprivation of resources. The couple or its representative has the responsibility to verify all resources.

26-003.01C Appeal of Assessment: The Assessment of Resources notifies the couple that they may appeal the assessment. The couple may appeal:

1. The value assigned to the resource(s); and
2. The amount reserved for the community spouse.

If the couple shows that the community spouse requires more than the limit, s/he may be allowed to reserve more. In order to appeal, the alternate care spouse must apply for Medicaid, even if s/he has excess resources.

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

26-003.01D Treatment of Resources Not Included on Assessment: Because the resource assessment is completed only once, the total value of countable resources that are owned by either or both spouses and that are acquired, discovered, or lose their exclusion after completion of the assessment and before the designation are considered available resources and cannot be used to increase the community spouse's resource allowance calculated at the time of the assessment. Examples of resources that may lose their exclusion are the home if the community spouse no longer resides in it or business property in which the community spouse is no longer actively engaged in operating.

26-003.01E Continued Validity of Assessment: The Assessment of Resources remains valid as long as the alternate care spouse does not return to the home without waiver services (even if s/he moves from one specified living arrangement to another). If the alternate care spouse returns home without waiver services, the Assessment of Resources becomes invalid. If the alternate care spouse returns to a specified living arrangement, the original Assessment of Resources is again valid.

26-003.02 Designation of Resources:

26-003.02A Designation of Resources: When the spouse in the specified living arrangement is eligible for Medicaid, a Designation of Resources must be completed. The Designation of Resources lists the amount of resources retained by each spouse. All resources must be re-verified.

26-003.02B Transfer of Ownership: Once it has been determined that the alternate care spouse is otherwise eligible, the case is approved without waiting for completion of the transfer. The couple must complete the transfer within 90 days, otherwise the case is closed. Transfers of countable resources from the alternate care spouse to the community spouse are not considered a deprivation of resources as long as the amount transferred to the community spouse, when added to his/her own resources, does not exceed the amount the community spouse is allowed to reserve as calculated at the time of assessment.

The alternate care spouse may be eligible in the retroactive months if the couple's resources did not exceed the allowable limit plus the amount reserved for the community spouse, even if the couple has not completed a Designation of Resources or necessary transfers of ownership. Excluded resources transferred solely to the community spouse are not a deprivation of resources. If the community spouse disposes of a resource for less than fair market value, it is considered deprivation of a resource.

26-003.02C Treatment of Resources Not Included on Designation: Resources that are acquired or that lose their exclusion after a Designation of Resources is signed are counted as follows:

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

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

The alternate care spouse may transfer a resource that is in his/her name or his/her share of a jointly owned resource to the community spouse if the amount of resources combined with the community spouse's other resources does not exceed the reserved amount calculated at the time of assessment. This may occur if the community spouse has had to use some of the assets reserved at the time of the assessment. It allows the alternate care spouse to transfer resources back to the community spouse so that the community spouse may maintain the reserved amount on the Assessment of Resources.

The alternate care spouse must provide a written statement of his/her intent to transfer the resource. The alternate care spouse is allowed 90 days from the date of report of the resource to complete the transfer.

26-003.02D Assigning Support Rights: If the couple has resources that exceed the allowable amount and refuse to spend down, which prevents Medicaid eligibility for the alternate care spouse, the Department has the legal right to bring support proceedings against the community spouse.

26-003.02E Continued Validity of the Designation: The Designation of Resources remains valid even if either spouse enters a different specified living arrangement. If the couple lives together in the home without eligibility for waiver services, the designation becomes invalid. Spouse-for-spouse responsibility again applies.

If the alternate care spouse later moves out of the home or becomes eligible for waiver services, the original designation again becomes valid and the alternate care spouse is allowed a resource level for one. If the community spouse applies for Medicaid, s/he must reduce his/her designated resources to the maximum allowable for

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

26-003.03 Maximum Available Resource Levels For SIMP: The established maximum for available resources that a client may own and still be considered eligible for Medicaid, according to unit size, are as follows:

1. One member unit - client only: $4,000 if a couple has a valid Designation of Resources and
   a. There is an eligible spouse and an ineligible spouse, the resource level for the eligible spouse is $4,000; or
   b. If the ineligible spouse later becomes eligible, each spouse is allowed $4,000.
2. Two member unit: $6,000
   a. Client and eligible spouse;
   b. Client and ineligible spouse; or
   c. Client and ineligible spouse who have designated resources but the client returns home or is no longer eligible for waiver services.

26-004 INCOME TREATMENT AND BUDGETING

26-004.01 SIMP Budgeting: A SIMP budget is required for an eligible spouse in a specified living arrangement and an ineligible spouse in the community.

1. The SIMP budget is used to calculate the amount of income (if any) to be allocated from the eligible spouse to the ineligible spouse and/or family members.
2. The SIMP budget is used to calculate eligibility for Medicaid only or Medicaid with a share of cost for the eligible spouse.

The community spouse or other family member shall not be on Medicaid if s/he is included in this budgeting procedure. S/he may be eligible in his/her own right, but may choose not to apply if this is to his/her benefit.

See 25-001.04D for Computation of Net Income.

26-004.02 SIMP Budgeting Effective and End Dates

SIMP budgeting procedures apply beginning with the month an eligible spouse enters a specified living arrangement (even if it is a partial month) and cease with the first full month the alternate care spouse is no longer in a specified living arrangement. An Assessment

and Designation of Resources shall be completed (see 477 NAC 26-003.01B and 26-003.01F).

If the spouse no longer meets the definition of a community spouse, SIMP budgeting ends the first month possible.

26-004.03 Budgeting the Alternate Care Spouse: The following amounts are deducted from the alternate care spouse's net earned and unearned income in computing the alternate care spouse's budget:

1. Medically Needy Income Level or FPL (see Appendix 477-000-012);
2. Guardian/conservator fee up to $10;
3. Amount allocated to the community spouse and/or family member(s); and
4. Medicare premium and/or health insurance premium. If the couple has a combined health insurance premium, one-half of the amount is allowed on the client's budget.

This is calculated on the SIMP budget.

26-004.04 Income When the Eligible Spouse Is in a Specified Living Arrangement and the Ineligible Spouse and/or Family Member(s) Is in the Community

26-004.04A Income Provisions: All income is included in the budget calculation, including Supplemental Security Income (SSI) and income of minors.

All income must be verified.

26-004.04B Allocation of Income: When computing the Medicaid budget for an alternate care spouse in a specified living arrangement, only his/her income (SIMP budget) is considered. Income of a community spouse is not considered available to the alternate care spouse. Some of the income of the alternate care spouse may be allocated to the community spouse and/or family members to bring their income up to a minimum monthly amount. The amount that may be allocated is computed on the SIMP budget.

If the community spouse does not provide verification of his/her income, the SIMP budget is not used. A Medicaid budget would be used for the client and no allocation of the client's income would be made to the community spouse.

When allocated allowances are not made available to the community spouse, these allowances shall not be deducted from the client's income from the SIMP budget. The allowances for other family members shall be deducted, even if the institutionalized spouse does not make these allowances available to the family members.

26-004.04C Determining Ownership of Income: All income must be verified to determine the amount of the income and the individual in whose name the income is received.

1. If payment is made in the name of both spouses, one-half is considered available to each spouse.
2. Income shall be divided by the number of payees if payment is made in the name of one or both spouses and a third party.
3. Only the spouse's proportionate share is considered available to him/her.
4. If income is paid to one spouse and a third party but the verification reveals that the income is intended for both spouses, both spouses shall be included in the division to determine the proportionate share.

If income does not specify either spouse, one-half of the amount is considered available to each spouse.

The client may appeal the assumption of ownership of income.

26-004.04D Determining the Spousal Maintenance Need Standard:

1. The percentage of the Federal Poverty Level (FPL) shall be determined (see Appendix 477-000-012); and
2. Added to excess shelter costs, if any (see Appendix 477-000-012 for the shelter allowance resource limit).

Excess shelter cost is the amount by which the rent or cost of home ownership (e.g., mortgage, taxes, insurance, or cooperative/condominium maintenance fees) plus a utility standard exceed the prescribed shelter limit.

The utility standard shall be allowed even if utilities are included in the rent.

Shelter costs shall not be prorated even if someone lives with the community spouse.

26-004.04E Determining a Family Member's Maintenance Need Standard:

1. The percentage of the FPL shall be determined (see Appendix 477-000-012);
2. The family member's gross income subtracted; and
   Note: SSI is included as income.
3. The result shall be divided by three.

A separate calculation must be completed for each family member. This is calculated on the SIMP budget.

26-004.04F Determining the Allocated Maintenance Allowance: In determining the amount of income from the alternate care spouse that may be allocated to the community spouse and other family members, the following shall be completed:

1. The family maintenance need standard shall be determined;
2. The spousal maintenance need standard shall be added; and
3. The gross income of the community spouse shall be subtracted. SSI is included. If the community spouse has self-employment income, adjusted gross income shall be used.

The spousal maintenance allowance must not exceed the maximum in Appendix 477-000-028. If a court has ordered the client to make support payments to the spouse in excess of the maximum, the court order takes precedence over the maximum.

The couple may appeal the allocated maintenance allowance. To support an increase in the maintenance allowance, either spouse must establish that the community spouse needs income above the maintenance allowance because of exceptional circumstances resulting in significant financial duress. If the couple wins their appeal, the community spouse may reserve more than the maximum maintenance allowance.

This is calculated on the SIMP budget.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 27-000 AGED, BLIND AND DISABLED MEDICAID (ABD); MEDICALLY NEEDY (MN); MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD); WOMEN'S CANCER PROGRAM; EMERGENCY MEDICAL SERVICES ASSISTANCE (EMSA); AND KATIE BECKETT

27-001 ABD

27-001.01 ABD: In order to be eligible in the ABD category, an applicant/client must have income equal to or less than 100% of the FPL.

27-001.02 Age Requirement/Age Limit: To be eligible for Medicaid, an applicant/client must meet the age requirements for the applicable Medicaid category.

For ABD individuals, an individual must meet the following age limits:

1. To qualify as aged, an individual must be sixty-five (65) years old or older;
2. To qualify as blind, an individual must be sixty-four (64) years old or younger; or
3. To qualify as disabled, an individual must be sixty-four (64) years old or younger.

The month a blind or disabled person turns sixty-five (65) years old, s/he becomes eligible for Assistance to the Aged.

27-001.03 Eligibility Categories

27-001.03A Blind or Disabled Recipients Eligible for Medicaid: A blind or disabled client who has earned income is eligible without regard to share of cost if s/he meets specified guidelines. If a blind or disabled client reaches sixty-five (65) years old, the SSA may continue eligibility under section 1619(b) of the Social Security Act, as amended.

27-001.03B Current and Former SSI Recipients: A blind or disabled client who has earned income is eligible without share of cost if s/he

1. Received Medicaid in the month before the month in which this reference applies and continues to receive Supplemental Security Income (SSI) either in the form of regular SSI payments or special SSI payments under section 1619(a) of the federal Social Security Act, as amended; or
2. Received Medicaid and SSI in the month before the month in which this reference applies and whose SSI payment stopped due to the level of earnings and who is determined by SSA to have special Medicaid status under section 1619(b) of the federal Social Security Act, as amended.

The 1619(b) status can be verified from the State Data Exchange (SDX6, Special Medicaid Status field). If SSA reviews the client's disability and determines that s/he is no longer disabled, the case must be closed in the first month possible, considering the ten (10)-day notice requirement.

27-001.04 Blindness or Disability Determination

27-001. 04A Eligibility Requirements Applicable Only to the Blind or Disabled: All applicants for Aid to the Blind or Aid to the Disabled after January 1, 1974, must meet the medical definitions of blindness or disability of the Retirement, Survivors, and Disability Insurance (RSDI)/SSI Programs as administered by SSA. The determination by SSA that an individual is disabled or blind must be accepted for eligibility for ABD. In some cases, the State Review Team (SRT) may make the determination of blindness or disability.

Generally, an individual is disabled if s/he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months. A child through seventeen (17) years old is considered disabled of s/he suffers from any medically determinable physical or mental impairment of comparable severity. See Titles II and XVI of the federal Social Security Act, as amended, for further disability criteria.

SRT shall review medical documentation dated no more than twelve (12) months prior to the request. An individual requesting a determination by SRT must have seen a doctor for condition(s) related to the alleged condition for which they are seeking a determination within three (3) months of the request.

27-001.04B Determination of Eligibility for the Blind or Disabled

27-001. 04B1 Disability Determination: In the determination of eligibility for Aid to the Blind or Disabled, all eligibility requirements except that of the disability determination are the responsibility of the Department.

27-001.04B2 Appeal to SSA: An individual who is determined ineligible for ABD because s/he does not meet SSI disability requirements may appeal the decision to SSA. Upon receiving an affirmative redetermination of disability from SSA, the Department shall use the original date of application in determining eligibility for Medicaid if the applicant

1. Has been determined ineligible for SSI because s/he is not considered disabled due to lack of severity;
2. Appeals SSA's decision; and
3. Wins his/her appeal.

27-001.04B3 Direct Referral to the State Review Team: In the following situations a referral may be submitted directly to SRT for a determination of disability and its probable duration without waiting for an SSI determination if the individual is not eligible for another medical program, and during the initial intake it is apparent that

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

See 477 NAC 27-001.04A regarding disability criteria.

27-001.04B4 Subsequent Referrals to SSA: The Department shall continue to monitor the client's potential eligibility for RSDI and SSI benefits even though SRT has made the determination of disability.

27-001.04B5 SSA Determines that the Client is Not Disabled After SRT Approval: If the SRT has determined disability for the client, SSI later determines that the client is not disabled due to lack of severity or the ability to engage in substantial gainful activity, and the client has filed an appeal with SSA, the client must be considered disabled through the review period established by the SRT.

If no appeal has been filed the Medicaid case must be closed. If the case is closed before the end of the current SRT period, the closing notice must instruct the client to contact the Department immediately if an appeal is filed and the Mediciad case can be opened for the remainder of the SRT period. At the end of the current review period, the Medicaid case is closed without a referral to the SRT.

27-001.05 SSI Program: If a client has not applied for SSI, an application must be filed immediately. A client must be referred to SSA for an SSI determination if

1. The client lives alone and has monthly unearned income less than the referral amount for an individual;
2. An eligible couple is living together and has monthly unearned income less than the referral amount for a couple (Note: both spouses must apply for SSI); or
3. An individual is in a nursing home and has monthly unearned income that is less than the SSI personal needs allowance.

If income is less than these amounts but resources are less than levels for ABD, an SSI referral is not made but eligibility for ABD must be considered.

27-001.05A Suspension of SSI Benefits: If a client's SSI benefits are suspended due to excess income and/or resources, the client is still considered disabled according to SSI standards for a period of twelve (12) consecutive months, as long as all other eligibility factors are met. The twelve (12)-month period is effective the first day of the month in which the client's benefits are suspended. To continue ABD at the end of the twelve (12)-month period, a review of disability by SRT is needed.

27-001.06 Institutionalization: An individual may qualify for ABD while living in an institution only if the institution is subject to the licensing requirements of the Department's Public Health Licensure Unit.

27-001.06A Definitions: The following definitions are used in the administration of Medicaid to individuals who are institutionalized:

27-001.06A1 Institution: An establishment that furnishes (in single or multiple facilities) food and shelter to four or more persons unrelated to the proprietor and, in addition, provides some treatment or services that meet some need beyond the basic provision of food and shelter.

27-001.06A2 Medical Institution: An institution that is organized to provide medical care, including nursing and convalescent care, and has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards. The institution must be authorized under state law to provide medical care.

27-001.06A3 Inpatient: A patient who has been admitted to a medical institution on the recommendation of a physician or dentist and is receiving room, board, and professional services in the institution on a continuous 24-hour-a-day basis.

27-001.06A4 Public Institution: An institution that is the responsibility of a governmental unit, or over which a governmental unit exercises administrative control.

27-001.06A5 Publically Operated Community Residence: A publically operated residence to serve no more than sixteen (16) residents and provide some services beyond food and shelter, such as social services, help with personal living activities, or training in socialization or life skills. Occasional or incidental medical or remedial care may also be provided.

27-001.06A5a Exclusions: The following facilities are not considered publically operated community residences, even if their accommodations are for 16 or fewer residents:

1. Residential facilities adjacent to any large institution or multi-purposes complex;
2. Educational or vocational training institutions;
3. Correctional or holding facilities for individuals whose personal freedom is restricted because of a court sentence, holding, or pending disposition; and
4. Medical treatment facilities such as hospitals and skilled nursing facilities.

27-001.06A6 Inmate of a Public Institution: A person who is living in a public institution and receiving treatment and/or services that are appropriate to the person's requirements. A person is not considered an inmate when s/he is in a public educational or vocational training institution for purposes of securing educational or vocational training, or s/he is in a public institution for a temporary period pending other arrangements appropriate to his/her needs.

27-001.06A7 Institution for Mental Disease: An institution primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases. Such care includes medical attention, nursing care, and related services.

27-001.06A8 Institution for Developmental Disabilities: An institution (or distinct part of an institution) that is primarily for the diagnosis, treatment, or rehabilitation of persons with developmental disabilities. The institution provides, in a protected residential setting, ongoing evaluation, planning twenty-four (24)-hour supervision, and coordination and integration of health and rehabilitative services to help each individual function as his/her greatest ability.

27-001.06B Levels of Care: The previously listed facilities must be licensed by the Department's Public Health Licensure Unit, and certified by Medicaid as one or more of the following types of facilities:

1. Acute hospital;
2. Psychiatric care facility; or
3. Intermediate care facility for the developmentally disabled (ICF/DD).

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

Psychiatric care is provided only to individuals in an Institute for Mental Disease who are twenty-one (21) years old or younger and sixty-five (65) years old or older. If an individual is receiving treatment in a facility on his/her twenty-first (21st) birthday, s/he is eligible until the sooner of

1. Release; or
2. The month of his/her twenty-second (22nd) birthday.

27-001.06C Patients in a Medical Institution: Medicaid may be provided for a client who is a patient in a medical institution (e.g., hospital, nursing home) if all other eligibility factors are met. Psychiatric wards of medical hospitals are considered part of the medical institution and are not subject to the restriction on psychiatric care identified at 477 NAC 27-001.05A5a.

27-001.06D Convalescent Leave: Eligibility for applicants/clients on convalescent leave or visit from public medical institutions is determined in accordance with the applicable program standards. Eligibility is based on an applicant's/client's living situation and needs while on leave.

27-001.06E Responsibility for Determining Nature of Institution: Central Office is responsible for determining the public or private nature of an institution, and whether a public institution is one in which otherwise eligible individuals may receive Medicaid.

27-001.06F Criteria for Determining Public Nature of Institutions: Prisons, jails, etc., are designated in the law as public institutions whose inmates are ineligible to receive Medicaid. Governmental participation in financial support of an institution, in policy formulation, or in the application of policy to specific situations, is evidence of the public control that makes it a public institution. Payment from public funds to, or in support of, individuals in a private institution is not considered governmental participation in support of the institution.

27-001.07 Factors Relating to Eligibility of Clients in Institutions

27-001.07A Private Institution and Home: The private institution in which a client chooses to reside may be a fraternal, benevolent, or charitable institution, or a client may make plans for living in a home that is privately owned and operated and that furnishes shelter, board, and care according to the client's needs. In determining the Medicaid eligibility of a person living in a private institution or home, it is necessary to determine if s/he has entered into any agreement with the institution that s/he is to receive shelter and care in return for a transfer of property, insurance, or other assets.

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

27-001.08 Working Disabled Part A Medicare Beneficiaries: Individuals who were receiving RSDI disability benefits and return to work, but remain disabled, may continue to be entitled to Part A Medicare at no cost for forty-eight (48) months. The Omnibus Budget Reconciliation Act of 1989 allows these individuals, at the end of forty-eight (48) months, to enroll in Part A Medicare and pay a premium. The act also requires state Medicaid programs to purchase Medicare Part A premiums for these individuals.

27-001.08A Age: To be eligible for the payment of the Medicare premium, an individual must be sixty-four (64) years old or younger.

27-001.08B Disability: To be eligible for the payment of the Medicare premium, an individual must continue to have a disabling impairment as determined by SSA. SSA has the responsibility to verify periodically that the disability continues. If SSA determines through a continuing disability review that the client is no longer disabled, SSA notifies the Department and eligibility for ABD ceases. If the client voluntarily withdraws from Medicare Part A premium, eligibility for ABD ceases.

27-001.08C Receipt of Other Assistance: Through the ABD program an individual may choose to receive either payment of the Medicare Part A premium or full Medicaid benefits but not both at the same time. While receiving either form of assistance, the client may request the other; however, the client is not eligible for full Medicaid benefits for any month for which the Department pays the Medicare Part A premium.

If a client who is on ABD with share of cost and is paying his/her own Part A Medicare premium fails to meet his/her share-of-cost obligation, the Department retroactively pays the Medicare Part A premium for the excess cycle. At the end of this excess cycle, the client must decide whether to continue to have the state pay the Part A premium or to begin a new excess cycle and assume payment of the Part A premium him/herself.

27-002 MEDICARE PART B BUY-IN

27-002.01 Medicare Savings Program/ Qualified Medicare Beneficiaries (MSP/QMB): In order to meet eligibility for MSP or QMB, an applicant/client must have

1. Income equal to or less than 100 percent of the Federal Poverty Level (FPL); and
2. Resources in excess of the $4,000 and $6,000 limits.

MSP/QMB individuals who are within specific resource guidelines at 477 NAC 23 are eligible for payment of deductibles and co-pay costs associated with Medicare claims. They are not eligible for additional medical services. An annual review is required to verify income and resources. The resource limit amounts are adjusted annually.

27-002.02 Specified Low Income Beneficiaries (SLMB) and Qualified Individuals (QI-1): In order to meet eligibility as an SLMB or QI-1, an individual must

1. Be a current Medicare beneficiary who meets the required income guidelines:
    a. In order to qualify in the SLMB category, an individual must have income equal to or less than 120% of the FPL
    b. In order to qualify in the QI-1 category, an individual must have income equal to or less than 135% of the FPL; and
2. Fulfill all other eligibility requirements of the ABD program and be eligible for payment of his/her Part B Medicare premium.

These clients are eligible only for payment of the Medicare premium; they are not eligible for any additional medical services.

27-002.03 Income Treatment: In accordance with regulations for ABD. The income limits are based on the FPL.

1. If total net earned and unearned income is equal to or less than the required income limit, the client is eligible for payment of the Medicare premium.
2. If the income is more than the income limit, the client is ineligible for payment of the Medicare premium.

27-002.03A The client may choose to receive ABD with a share of cost and attempt to spend down if there is a medical need.

1. If a client who is on ABD with a share of cost fails to meet any of his/her share of cost by the next case review and a medical need cannot be anticipated, an SLMB or QI-1 budget shall be authorized.

2. If a client has been an SLMB and later wants Medicaid with a share of cost for the same month(s) and up to three months before, a share of cost budget shall be authorized.
3. If a client has been a QI-1 and later wants Medicaid with a share of cost for the same month(s), only the current month's share of cost budget shall be authorized.

27-003 MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD)

27-003.01 Medicaid Insurance for Workers with Disabilities: Working individuals who meet the necessary disability criteria, have income within income guidelines, and are working are eligible for Medicaid. After application of income disregards, individuals with income less than 200 percent of the Federal Poverty Level (FPL) are eligible for Medicaid with no premium; individuals with incomes of 200 through 249 percent of the FPL are eligible for Medicaid with a monthly premium payment. See Appendix 477-000-046 for procedures.

27-003.02 Eligibility Requirements: In order to receive Medicaid, the individual must

1. Qualify for Medicaid except for income;
2. Not be eligible for ABD, but may be eligible with a share of cost;
3. Meet the Social Security Administration (SSA) or State Review Team (SRT) definition of disability;
4. Be working;
5. Using a two-part income test, have income that is equal to or less than 200% of the FPL;
6. Meet Medicaid resource limits; and
7. Pay a premium, if required (If income is above 200% of the FPL and equal to or less than 250% of the FPL).

27-003.03 Disability Determination: Individuals who are not receiving a Social Security Disability payment must be determined disabled by SRT. Receipt of a Social Security Disability Insurance (SSDI) payment meets the disability requirement.

27-003.04 Income Determination: The income calculation for MIWD is a two-step process. The income of the disabled individual and his/her spouse must be considered. See Appendix 477-000-009 for calculation procedures.

27-003.05 Premium Payment: If the individual is determined eligible for Medicaid with a premium, s/he must pay the full premium no later than the 21st day of the month following the month for which the payment is designated.

27-004 WOMEN'S CANCER PROGRAM

27-004.01 Women's Cancer Program: Under the Breast and Cervical Cancer Prevention and Treatment Act of 2000, certain women who need treatment for breast or cervical cancer may be eligible for Medicaid. Neb. Rev. Stat. section 68-1020 authorizes this coverage in Nebraska.

27-004.02 Eligibility Requirements: In order to receive Medicaid, the woman must

1. Be screened for breast and cervical cancer by Every Woman Matters;
2. Be found to need treatment for breast and/or cervical cancer, including a precancerous condition or early stage cancer;
3. Be sixty-four (64) years old or younger;
4. Not be otherwise eligible for Medicaid;
5. Not be covered by creditable health insurance;
6. Be a Nebraska resident; and
7. Be a U.S. citizen or a qualified alien.

27-004.03 Creditable Health Insurance: For purposes of this program, creditable health insurance includes any health insurance coverage except a plan that

1. Provides limited scope coverage such as plans that only cover dental, vision, or long-term care;
2. Provides coverage for only a specified disease or illness;
3. Does not include treatment for breast or cervical cancer (such as a period of exclusion); or
4. Has exhausted the woman's lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer.

27-004.04 Eligibility Period: Eligibility begins the first of the month in which the client signs the application for the Women's Cancer Program. Eligibility continues as long as the client requires treatment for breast or cervical cancer, as determined by her physician, unless she becomes ineligible for some other reason. Eligibility automatically ends the last day of the month of the client's 65th birthday.

For pre-cancerous cervical conditions, eligibility automatically ends the last day of the month following the month treatment begins unless the physician provides the Department with a monthly statement indicating continued treatment is required.

Continued treatment does not include continued surveillance, testing, or screening.

For breast and cervical cancer, a physician's statement verifying the need for treatment must be provided to the Department every six months for the woman to remain eligible for Medicaid coverage.

27-004.05 Presumptive Eligibility: The client may be determined presumptively eligible by a qualified Medicaid provider. Presumptive eligibility begins on the date a qualified provider determines that the client appears to meet eligibility criteria.

For limits on Hospital Presumptive Eligibility see 477 NAC 19-006 #4.

27-005 MEDICALLY NEEDY

27-005.01 Individuals Ineligible for Medicaid Due to Income: Parents/caretaker relatives, children, pregnant women, and ABD individuals with a medical need and high medical expenses whose income exceeds the guidelines for Medicaid eligibility may be eligible for a share of cost if all other eligibility requirements are met. A medically needy individual must incur and obligate a certain amount of medical expenses each month before Medicaid will provide coverage for the rest of the month. These medical expenses must be at least equal to the difference between the individual's income and the applicable income standard. Such share of cost varies depending on the individual's household size and income. Each month is determined separately and continuous eligibility does not apply. See Appendix 477-000-045 for examples. Individuals without a demonstrated medical need are not eligible under this category.

27-005.02 Age: A medically needy child is eligible through eighteen (18) years old if s/he is a U.S. citizen or is a qualified alien.

27-005.02A Exception: A medically needy child may be found eligible under this category if they are receiving inpatient care in an Institution for Mental Disease (IMD). If an individual is an inpatient in an IMD when s/he reaches twenty-one (21) years old, s/he may remain eligible either until discharge or until s/he reaches twenty-two (22) years old, whichever comes first.

27-005.03 Two-Parent Families: If unmarried parents are living together and the father has acknowledged paternity for their child, eligibility must be considered for the family as a unit.

27-006 TRANSITIONAL MEDICAL ASSISTANCE (TMA)

27-006.01 TMA Eligibility: A household may receive up to twelve (12) months of Transitional Medical Assistance without a share of cost if the parent/caretaker relative

1. Is in the household;
2. Has earned income that results in ineligibility for a grant and/or Medicaid; and
3. Is employed.

27-006.01A Prior Eligibility Requirement: The parent/caretaker relative (P/CR) must have received, or met income and resource eligibility to receive, a grant and/or Medicaid for which s/he was eligible in three (3) of the last six (6) months preceding ineligibility.

27-006.01B Fraud Exclusion: The household is ineligible for TMA if it received a grant and/or Medicaid in one or more of the three qualifying months as a result of convicted fraud during the last six (6) months before the beginning of the transitional period.

27-006.02 Resources: There is no resource test while the household is receiving TMA.

27-006.03 Sanctions: A parent who has been sanctioned for noncooperation with child support or TPL is not eligible for TMA until cooperation is resolved.

27-006.04 Changes in Household Composition

27-006.04A New Individual Added to Household: An individual who was not previously part of the household but who is added (e.g., a child who is born or adopted, a spouse) while the family is receiving TMA is also added to the TMA household.

27-006.04B Family Member Returns to Household: If a family member returns to the home, Medicaid eligibility for the whole household must be reviewed.

1. If the returning family member is a responsible relative, his/her income must be used to compare the family's income to the income guideline for the household plus the responsible relative.
2. If the family is ineligible for a grant or Medicaid, the returning family member is added to the TMA household.

27-006.04C Family Member Leaves Household: If a family member leaves the home, Medicaid eligibility for the remaining household members must be reconsidered.

1. If the family is ineligible for a grant and/or Medicaid, the remaining household members may continue to be eligible for TMA.
2. If it is the only dependent child who leaves, the whole household loses eligibility for TMA.
3. If the only child no longer meets the age qualification, the household loses eligibility for TMA.

In order to be eligible for Medicaid, and added or returning household member must have a valid Medicaid application on file (See 477 NAC 3-005).

27-006.05 Changes in Circumstances

1. If the household regains grant or P/CR Medicaid eligibility for one or two months because of a temporary reduction or loss of income, then again loses grant or P/CR Medicaid eligibility because of earnings, the original TMA cycle resumes.
2. If the household receives three or more grants or months of P/CR Medicaid coverage, then again loses grant or P/CR Medicaid eligibility because of earnings, a new TMA cycle begins.
3. Before closing the TMA case, it must first be determined if children in the household are eligible for another Medicaid program.

27-006.06 Effective Date of TMA Eligibility: TMA begins with the month of ineligibility for a grant and/or P/CR Medicaid.

Note: If it is determined that the household was ineligible for a grant, TMA shall be determined beginning with the first month in which the grant was erroneously paid.

27-006.07 TMA Timeline

27-006.07A Months 1 Through 6

27-006.07A1 Report Requirement: The gross monthly earnings and child care costs for employment (as billed or paid) for each of the first three months of the transitional period must be provided. The first report is due no later than the 21st of the fourth month. See Appendix 477-000-047 for the Transitional Medical Timeline.

24-006.07A2 Causes for Closure: The household becomes ineligible for TMA during the first six-month period if

1. The household becomes eligible for P/CR Medicaid;
2. The household moves out of the state; or
3. There is no longer an eligible dependent child in the household.

27-006.07B Months 7 Through 12: If the household has earned income and child care deductions for employment that are equal to or less than 185% of the Federal Poverty Level (FPL), it is eligible for TMA.

27-006.07B1 Report Requirement: The gross monthly earnings and child care costs for employment (as billed or paid) for each three-month period of months 7 through 12 must be provided.

1. The second report is due no later than the 21st of the seventh month.
2. The third report is due no later than the 21st of the tenth month.

27-006.07B2 Income Eligibility: The household's earned income for the three-month report period is averaged to determine income eligibility.

27-006.07B3 Premium Due: Beginning with month 7, the household is subject to payment of a monthly premium if its countable income is between 100% and 185% percent of the FPL. Failure to pay the required premium by the 21st of the following month will result in ineligibility for the month for which the premium was owed.

27-006.07B4 Causes for Closure: The household is ineligible for the remaining months of TMA (months 7 through 12) if it:

1. Fails, without good cause, to submit required verification of earnings and child care costs for employment;
2. No longer includes a dependent child;
3. Has gross monthly earnings and child care deductions for employment in excess of 185% of the FPL during the preceding three-month period; or
4. The household moves out of the state.

Note: A TMA case shall not be closed for failing to provide if the needed information from the applicable months was received.

27-006.07B4a Good Cause for Failing to Submit Required Information:

1. Death of the parent/caretaker relative;
2. Hospitalization of a household member during the scheduled receipt period for required information (the client is responsible for providing verification of hospitalization); or
3. Natural disaster (Central Office will issue instructions when these situations occur).

27-006.07C After Month 12: When a client has exhausted his/her months of TMA, a redetermination of eligibility for another Medicaid program must be completed.

27-007 EMERGENCY MEDICAL SERVICES ASSISTANCE (EMSA)

27-007.01 Emergency Medical Services Assistance for Undocumented and Ineligible Aliens: An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) where the absence of immediate medical attention could reasonably result in

1. Serious jeopardy to the patient's health;
2. Serious impairment to bodily functions; or
3. Serious dysfunction of any bodily organ or part.

27-007.02 Eligibility for EMSA for Undocumented and Ineligible Aliens:

27-007.02A Restricted Medical Assistance: To be considered eligible for EMSA, the State Review Team shall determine that the individual has an emergency medical condition.

The alien shall be determined eligible under the appropriate Medicaid category by meeting all eligibility criteria except citizenship or qualified alien status.

Note: The provision at 477 NAC 4-001 regarding the Effective Date of Medicaid Eligibility does not apply to EMSA.

27-008 KATIE BECKETT

27-008.01 Katie Beckett: Provides Medicaid coverage to children age 18 or younger with severe disabilities who live in their parent(s)'s household, but who otherwise would require hospitalization or institutionalization due to their high level of health care needs.

27-008.01A Eligibility Requirements: In order to receive Katie Beckett Medicaid, a child must

1. Not be eligible for Medicaid based on parental income or an SSI determination;
2. Be age 18 or younger;
3. Reside at home with a parent or legal guardian;
4. Be certified by the Department's Central Office designee as having hospital level of care needs; and
5. Not incur in-home service costs to be funded by Medicaid that would exceed the costs Medicaid would pay if the child were in a hospital setting.

Note: A child who is SSI eligible cannot be approved for Katie Beckett Medicaid.

27-008.01B Income and Resources: Parental income and resources are not deemed for a child determined eligible for Katie Beckett Medicaid. See 477 NAC 24-001.01A1 and 477 NAC 24-001.01G2b(1). Financial eligibility is based solely upon any income or resources belonging to the child.

27-008.01C Referrals: Medicaid accepts referrals for Katie Beckett eligibility determinations in the following situations:

1. It is anticipated that a child will be discharged from a hospital to his/her home and the child is not currently eligible for Medicaid;
2. Notice has been received from SSI that a child's benefits are being discontinued;
3. The medical need of a child currently eligible for Home and Community-Based Waiver has been determined to have increased beyond the level applicable to the waiver program; or
4. A child is not financially eligible for Medicaid based on family income.

27-008.01D Hospital Level of Care: Hospital level of care means that a child requires an extensive array of health care services throughout the day. This level of care may only be provided by highly skilled medical professionals in amounts normally available in a hospital but not in a skilled nursing facility. Lack of these services would be expected to result in hospitalization of the child.

27-008.01D1 Certification of Hospital Level of Care: Department certification for hospital level of care shall be provided based upon the following criteria:

1. A child needs frequent and complex medical care (defined below at 477 NAC 27-009.01D1) that requires the use of equipment to prevent life-threatening situations;
2. A child's complex skilled medical interventions are expected to persist for a specific duration of time (defined below at 477 NAC 27-009.01D3; and
3. A child's overall health condition must require continuous assessment of a medical condition to prevent a life-threatening situation.

27-008.01D2 Frequent and Complex Medical Care: A child shall need frequent and complex skilled medical interventions that require the use of medical equipment to prevent life-threatening situations. The child's health status must require both of the following:

1. Provision of skilled medical assessment and interventions multiple times every 24-hour period; and
2. At least one of the following complex skilled medical interventions:
    a. Tracheostomy care requiring regular bronchial tree suctioning.
    b. Tracheostomy care with a dependency on a ventilator, for which the average use must be equal to or greater than ten hours per day.
    c. Intravenous (IV) therapy involving central lines (including peripherally inserted central catheters [PICCs]) for daily fluids or parenteral nutrition, for which the average use must be equal to or greater than ten hours per day.
    d. Oxygen use that includes only skilled tasks requiring daily continuous oxygen, daily continuous assessments with titrations according to oxygen saturation levels, and daily bronchial tree suctioning.

Note: Tasks that are performed only when necessary (PRN) and are not continuously required do not meet the criteria for frequent and complex medical care. SiteCare is not considered a skilled medical task for the purpose of these requirements.

27-008.01D3 Duration: To meet hospital level of care, a child's qualifying frequent and complex medical care need shall be expected to be required for at least six months.

27-008.01E Disability and Level of Care Review: The Department shall review a child's Katie Beckett Medicaid eligibility on an annual basis.

Note: Chapters 477 NAC 19 through 25 apply to the following: Aged, Blind and Disabled (AABD/MA), Medically Needy (MN), Medicaid Insurance for Workers with Disabilities (MIWD), Women's Cancer Program, Former Foster Care, Emergency Medical Assistance, Child Welfare

CHAPTER 24-000 AGED, BLIND AND DISABLED MEDICAID (AABD/MA), MEDICALLY NEEDY (MN), MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD), WOMEN'S CANCER PROGRAM, FORMER FOSTER CARE, CHILD WELFARE MEDICAID AND EMERGENCY MEDICAL ASSISTANCE

24-001 AABD/MA

24-001.01 Age Requirement/Age Limit: To be eligible for Medicaid, the individual must meet the age requirements set by each applicable Medicaid category.

For AABD/MA individuals, an individual must meet the following age limits:

1. To qualify as aged, an individual must be age 65 or older;
2. To qualify as blind, an individual must be age 64 or younger; and
3. To qualify as disabled, an individual must be age 64 or younger.

The month that a blind or disabled person becomes 65, s/he becomes eligible for assistance to the aged.

24-001.02 Eligibility Categories

24-001.02A Blind or Disabled Recipients Eligible for Medicaid: A blind or disabled recipient who has earned income is eligible for MA without regard to share of cost if s/he meets specified guidelines. If a blind or disabled person reaches the age of 65, the Social Security Administration (SSA) may continue 1619(b) eligibility.

24-001.02B Current and Former SSI Recipients: A blind or disabled recipient who has earned income is eligible for MA without share of cost if s/he:

1. Received Medicaid in the month before the month in which this reference applies and continues to receive SSI (regular SSI payments or special SSI payments under section 1619(a) of the Social Security Act); or
2. Received Medicaid and SSI in the month before the month in which this reference applies and whose SSI payment stopped due to the level of earnings and who is determined by SSA to have special Medicaid status under section 1619(b) of the Social Security Act.

The 1619(b) status can be verified from the State Data Exchange (SDX6, Special Medicaid Status field). If SSA reviews the client's disability and determines that s/he is no longer disabled, the case must be closed in the first month possible considering the ten-day notice requirement.

24-001.02C Former State (1619b) Supplemental Payment Recipients: A blind or disabled recipient who has earned income is eligible for MA without excess income if s/he:

1. Received a state supplemental payment and Medicaid (but not SSI) in the month before the month in which this reference applies;
2. Except for earnings continues to meet all of the eligibility requirements for AABD/MA and has unearned income less than the AABD/MA standard of need;
3. Continues to be blind or have a disabling impairment as determined by the State Review Team (SRT);
4. Would be seriously inhibited from working without Medicaid; and
5. Has earned income in an amount insufficient to provide the same level of benefits available from SSP, MA, and Title XX attendant care.
    a. The income threshold used by SSA for purposes of determining eligibility for 1619(b) status will be used for this determination.
    b. The continuing blindness/disability review in number 3 must be completed before the end of the 12th month after this section applies, and annually thereafter. See "Forms Necessary" at Appendix 477-000-040 to make the referral to the SRT for this review.

24-001.03 Blindness or Disability Determination

24-001.03A Eligibility Requirements Applicable Only to Blind or Disabled: All applicants for Aid to the Blind or Aid to the Disabled after January 1, 1974, must meet the medical definitions of blindness or disability of the RSDI/SSI Programs as administered by the Social Security Administration (SSA). The determination by SSA that an individual is disabled or blind must be accepted for eligibility for AABD/MA. In some cases, the State Review Team (SRT) may make the determination of blindness or disability.

24-001.03B Determination of Eligibility for the Blind or Disabled

24-001.03B1 Disability Determination: In the determination of eligibility for aid to the blind or disabled, all eligibility requirements except that of the disability determination are the responsibilities of the SSA.

24-001.03B2 Direct Referral to the State Review Team: In the following situations a referral may be submitted directly to the SRT for a determination of disability and its probable duration without waiting for an SSI determination if the individual is not eligible for another assistance program, and during the initial intake it is apparent that:

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

24-001.03B3 Subsequent Referrals to SSA: The agency shall continue to monitor the client's potential eligibility for RSDI and SSI benefits even though the SRT has made the determination of disability.

24-001.04 SSI Program: If a client has not applied for SSI, an application must be filed immediately. A client must be referred to SSI if:

1. The client lives alone and has monthly unearned income less than the referral amount for an individual;

2. An eligible couple are living together and have monthly unearned income less than the referral amount for a couple (Note: both must apply for SSI); or
3. An individual is in a nursing home and has unearned income of less than $50 per month.

Exception: If income is less than these amounts but resources are less than levels for MA, an SSI referral is not made but must consider eligibility for Medicaid.

24-001.05 Institutionalization: An individual may qualify for AABD/MA while living in an institution only if the institution is subject to the licensing requirements of the Nebraska Department of Health.

24-001.05A Patients in a Medical Institution and Convalescent Leave: Assistance may be provided for a client who is a patient in a medical institution, i.e., hospital, nursing home, etc., if all other eligibility factors are met. Psychiatric wards of medical hospitals are considered part of the medical institution and are not subject to the restriction on psychiatric care identified previously.

The Central Office is responsible for determining the public or private nature of an institution, and whether a public institution is one in which otherwise eligible individuals may receive assistance.

24-001.05B Criteria for Determining Public Nature of Institutions: Prisons, jails, etc., are designated in the law as public institutions whose inmates are ineligible to receive assistance. Governmental participation in financial support of an institution, in policy formulation, or in the application of policy to specific situations, is evidence of the public control which makes it a public institution. Payment from public funds to, or in support of, individuals in a private institution is not considered governmental participation in support of the institution.

24-001.06 Factors Relating to Eligibility of Clients in Institutions

24-001.06A Private Institution and Home: The private institution in which the client chooses to reside may be a fraternal, benevolent, or charitable institution, or the client may make plans for living in a home which is privately owned and operated and which furnishes shelter, board, and care according to the client's needs. In determining the eligibility of a person living in a private institution or home, it is necessary to determine if s/he has entered into any agreement with the institution that s/he is to receive shelter and care in return for a transfer of property, insurance, or other assets.

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

24-001.07 Working Disabled Part A Medicare Beneficiaries: Individuals who were receiving RSDI disability benefits and return to work but remain disabled may continue to be entitled to Part A Medicare at no cost for 48 months. The Omnibus Budget Reconciliation Act of 1989 allowed these individuals, at the end of 48 months, to enroll in Part A Medicare and pay a premium. It also required state Medicaid programs to purchase Medicare Part A premiums for these individuals.

24-001.07A Age: To be eligible for the payment of the Medicare premium, an individual must be age 64 or younger.

24-001.07B Disability: To be eligible for the payment of the Medicare premium, an individual must continue to have a disabling impairment as determined by SSA. SSA has the responsibility to periodically verify that the disability continues. If SSA determines through a continuing disability review that the client is no longer disabled, SSA notifies the Department and eligibility for AABD/MA cases. If the client voluntarily withdraws from Medicare Part A premium, eligibility for AABD/MA cases.

24-001.07C Receipt of Other Assistance: Through the AABD/MA program an individual may choose to receive either payment of the Medicare Part A premium or full Medicaid benefits but not both at the same time. While receiving either form of assistance, the client may request the other; however, the client is not eligible for full Medicaid benefits for any month for which the Department has paid the Medicare Part A premium.

If a client who is on AABD/MA with excess and is paying his/her own Part A Medicare premium fails to meet his/her excess obligation, the Department retroactively pays the Medicare Part A premium for the excess cycle. At the end of this excess cycle, the client must decide whether to continue with the state paying the Part A premium or to begin a new excess cycle and assume payment of the Part A premium him/herself.

24-002 MEDICARE PART B BUY-IN

24-002.01 Medicare Savings Program/ Qualified Medicare Beneficiaries (MSP/QMB):

3. Income equal to or less than 100% FPL;
4. With resources in excess of the $4,000 and $6,000 limits.

MSP/ QMB individuals who are within specific resource guidelines at 477 NAC 21 are eligible for payment of deductibles and co-pay costs associated with Medicare claims. They are not eligible for additional medical services. An annual review is required to verify income and resources. The resource limit amounts are adjusted annually.

24-002.02 Specified Low Income Beneficiaries (SLMB) and Qualified Individuals (QI-1):

3. Current Medicare beneficiaries who meet the required income guidelines;
4. And all other eligibility requirements of the AABD/MA program are eligible for payment of their Part B Medicare premiums.

These individuals are eligible only for payment of the Medicare premium; they are not eligible for any additional medical services.

SLMBs and QI-1s are determined by income guidelines based on the Federal Poverty Limits. The resource limits are adjusted annually.

24-002.03 Income Treatment: In accordance with regulations for AABD/MA. The income limits are based on the Federal Poverty Level.

3. If total net earned and unearned income is equal to or less than the required income limit, the client is eligible for payment of the Medicare premium.
4. If the income is more than the income limit, the client is ineligible for payment of the Medicare premium.

24-002.03A The client may choose to receive AABD/MA with a share of cost and attempt to spend down if there is a medical need.

4. If a client who is on AABD/MA with a share of cost fails to meet any of his/her share of cost by the next case review and a medical need cannot be anticipated, a SLMB or QI-1 budget should be authorized.
5. If a client has been SLMB and later wants Medicaid share of cost for the same month(s) and up to three months before, a share of cost budget should be authorized.
6. If a client has been QI-1 and later wants Medicaid share of cost for the same month(s), only the current month share of cost budget shall be authorized.

24-003 MEDICAID INSURANCE FOR WORKERS WITH DISABILITIES (MIWD)

24-003.01 Medicaid Insurance for Workers with Disabilities: Working individuals who meet the necessary disability criteria, have income within income guidelines, and are working, are eligible for Medicaid. After application of income disregards, individuals with income less than 200 percent of the Federal Poverty Level (FPL) are eligible for Medicaid with no premium; individuals with income of 200 through 249 percent of the FPL are eligible for Medicaid with a monthly premium payment. See Appendix 477-000-046 for procedures.

24-003.02 Eligibility Requirements: In order to receive Medicaid, the individual(s) must:

8. Qualify for Medicaid except for income;
9. Not be eligible for AABD/MA, but may be a share of cost;
10. Meet Social Security or State Review Team definition of disability;
11. Be working;
12. Using a two-part income test have income within income guidelines;
13. Meet Medicaid resource limits; and
14. Pay a premium, if required.

24-003.03 Disability Determination: Individuals who are not receiving a Social Security Disability payment must be determined disabled by the State Review Team. Receipt of an SSDI payment meets the disability requirement.

24-003.04 Income Determination: The income calculation is a two-step process. The income of the disabled individual and his/her spouse must be considered. See Appendix 477-000-009 for calculation procedures.

24-003.05 Premium Payment: If the individual is determined eligible for Medicaid with a premium, s/he must pay the full premium no later than the 21st day of the month following the month for which the payment is designated.

24-004 WOMEN'S CANCER PROGRAM

24-004.01 Women's Cancer Program: The Breast and Cervical Cancer Prevention and Treatment Act of 2000 allows Medicaid for women who need treatment for breast or cervical cancer. Section 68-1020, Neb. Rev. Stat. authorizes this coverage in Nebraska.

24-004.02 Eligibility Requirements: In order to receive Medicaid, the woman must:

8. Be screened for breast and cervical cancer by Every Woman Matters;
9. Be found to need treatment for breast and/or cervical cancer, including a precancerous condition or early stage cancer;
10. Be age 64 or younger;
11. Not be otherwise eligible for Medicaid;
12. Not be covered by creditable health insurance;
13. Be a Nebraska resident; and
14. Be a U.S. citizen or a qualified alien.

24-004.03 Creditable Health Insurance: For purposes of this program, creditable health insurance includes any health insurance coverage except a plan that:

1. Is limited scope coverage such as those which only cover dental, vision, or long term care;
2. Is coverage for only a specified disease or illness;
3. Does not include treatment for breast or cervical cancer (such as a period of exclusion); or
4. Has exhausted the woman's lifetime limit on all benefits under the plan or coverage, including treatment for breast or cervical cancer.

24-004.04 Eligibility Period: Eligibility begins with the first of the month that the client signs the application for the Women's Cancer Program on the prescribed application see Appendix 477-000-061. Eligibility continues as long as the client requires treatment for breast or cervical cancer, as determined by her physician, unless she becomes ineligible for some other reason. Eligibility automatically ends the last day of the month of the client's 65th birthday.

For pre-cancerous cervical conditions, eligibility automatically ends the last day of the month following the month treatment begins unless the physician provides the agency with a monthly statement that continued treatment is required.

Continued treatment does not include continued surveillance, testing, or screening.

For breast and cervical cancer, a physician's statement verifying the need for treatment must be provided to the agency every six months for the woman to remain eligible for Medicaid coverage.

24-004.05 Presumptive Eligibility: The client may be determined presumptively eligible by a qualified Medicaid provider. Presumptive eligibility begins on the date that the qualified provider determines that the client appears to meet eligibility criteria.

24-005 MEDICALLY NEEDY

24-005.01 Individuals Ineligible for Medicaid Due to Income: Parents/caretaker relatives, children, pregnant women, and AABD/MA individuals with a medical need whose income exceeds the guidelines for Medicaid eligibility may be eligible for a share of cost if all other eligibility requirements are met. Once excess income is met for the month Medicaid eligibility is established for that month. Each month is determined separately and continuous eligibility does not apply. See Appendix 477-000-045 for examples.

24-005.02 Medical Insurance Disregards: The cost of medical insurance premiums is deducted if the client or responsible relative is responsible for payment. The Medicare Part B premium which the client or responsible relative is responsible for paying is included in this disregard. Exception: The cost of premiums for income-producing policies is not allowed as a medical deduction. See Appendix 477-000-026.

24-005.03 Age: Medically needy children are eligible through the month of his/her 19th birthday if s/he is a U.S. Citizen or is a qualified alien.

24-005.03A Exception: A Medically needy child may be found eligible under this category if they are receiving impatient care in an Institution for Mental Disease (IMD). If an individual is an inpatient in an IMD when s/he reaches 21 years of age, s/he may remain eligible either until discharge or until s/he reaches 22, whichever comes first.

24-005.04 Special Provisions for Two-Parent Families

24-005.04A Two-Parent Families: If unmarried parents are living together as a family and the father has acknowledged paternity for their child, eligibility must be considered for the family as a unit.

24-005.04B Deprivation Requirements for Two-Parent Families: Two-parent families must meet the following eligibility requirements:

24-005.04C Hundred-Hour Rule: Neither medically needy parent can be working more than 100 hours in a calendar month. The parent(s) must not have worked more than 100 hours in any of the three previous calendar months, or if the parent(s) is scheduled to work more than 100 hours for the month of application. Work study is considered employment when determining the 100 hours.

24-005.04D Physical or Mental Incapacity of a Parent: A needy child is considered deprived of parental support or care if either parent has a physical or mental incapacity. If the parent is receiving Aid to the Aged, s/he must be determined incapacitated according to provisions set forth below.

24-005.04D1 Determination of Incapacity: If a parent is receiving RSDI, SSI, AABD/MA, or SDP based on disability or blindness, s/he qualifies as incapacitated. For all others the determination of incapacity is made by the State Review Team (SRT).

24-005.04E Requirement to Cooperate: The incapacitated parent is required to cooperate in obtaining treatment or rehabilitative or vocational services that are recommended on Form DM-5R. If the incapacitated parent fails to obtain the treatment or services, the case is ineligible.

24-005.05 Transitional Medicaid Assistance (TMA): A client may receive up to 12 months of Transitional Medicaid without a share of cost if:

1. The case has earned income which results in ineligibility for a grant and/or ADC related Medicaid.
   Note: The parent or needy caretaker relative or guardian or conservator must be in the household.
2. The unit received, or met income and resource eligibility to receive, a grant and/or ADC related Medicaid for which they were eligible in three of the last six months preceding ineligibility;
3. The parent or needy caretaker relative or needy guardian or conservator is employed.

There is no resource test while the unit is in TMA.

TMA begins with the month of ineligibility for a grant and/or ADC related Medicaid.

If it was determined that the unit was ineligible for a grant, TMA shall be determined beginning with the first month in which the grant was erroneously paid.

The unit must submit the required reports in order to continue to receive TMA in the second six months. See Appendix 477-000-047 for the Transitional Timeline.

Note: The unit is ineligible for TMA if it received a grant and/or ADC related Medicaid in one or more of the three qualifying months as a result of convicted fraud during the last six months before the beginning of the transitional period.

If a family member, such as a parent or a child, returns to the home, grant or ADC related Medicaid eligibility for the whole family must be reviewed. If the returning family member is a responsible relative, the relative's income must be used to compare the family's income to the income guideline for the unit plus the responsible relative. If the family is ineligible for a grant or ADC related Medicaid, the returning family member is added to the TMA unit.

A child who is born or adopted while the family is receiving TMA is added to the TMA unit.

A parent who has been sanctioned while on grant for failure to cooperate with Employment First may be included in the TMA unit.

A parent who has been sanctioned for noncooperation with child support or TPL is not eligible until cooperation is resolved.

Note: Once a client is in TMA, s/he is not required to cooperate with program requirements such as Employment First, TPL, and child support.

24-005.05A If a unit member leaves the home, grant eligibility for the remaining unit members must be considered.

1. If the family is ineligible for a grant and/or ADC related Medicaid, the remaining unit members may continue to be eligible for TMA.
2. If it is the only dependent child who leaves, the whole unit loses eligibility for TMA.
3. If the only child no longer meets the age qualification, the unit loses eligibility for TMA.

Before closing the case, it must first be determined if the child is eligible for another Medicaid program.

24-005.06 TMA Months 1 Through 6

24-005.06A Report Requirement: The unit must report the gross monthly earnings and child care costs as billed or paid for each of the first three months of the transitional period. The first report is due by the 21st of the fourth month.

Note: The unit is not required to report unearned income.

24-005.06B Causes of Termination: The unit becomes ineligible for TMA if:

4. The unit becomes eligible for a grant or ADC related Medicaid;
5. The unit moves out of the state; or
6. There no longer is an eligible dependent child in the unit.

Note: If the only child is receiving AABD/MA or SSI, the parent(s) may be eligible for TMA.

24-005.07 Months 7 Through 12: If the unit has earned income (minus the cost of childcare) equal to or less than 185 percent of the Federal Poverty Level, they are eligible for TMA.

24-005.07A Premium Due: Beginning with month 7, the household is subject to payment of a monthly premium if their countable income is between 100 and 185 percent of the Federal Poverty Level. Failure to pay the required premium by the 21st of the following month will result in ineligibility for the month for which the premium was owed.

24-005.07B Report Requirement: The unit must provide a report of gross monthly earnings and child care costs as billed or paid for each three-month period of months 7 through 12.

1. The second report is due by the 21st of the seventh month.
2. The third report is due by the 21st of the tenth month.

Note: The unit is not required to report unearned income.

24-005.07C Causes for Termination: The unit is ineligible for the remaining months of TMA if it:

5. Fails without good cause to submit required verification of earnings and child care costs;
6. No longer includes a dependent child; or
7. Has gross monthly earnings (less child care costs) during the preceding three-month period in excess of 185 percent of the FPL.

24-005.07D Change in Unit

1. If a unit member leaves, income eligibility for the remaining unit members must be re-determined.
2. If a responsible relative returns to the home, the unit size is increased and the responsible relative's income is budgeted to the TMA unit.

24-005.07E Income Eligibility: The unit's earned income for the three-month report period is averaged to determine income eligibility.

24-005.08 Good Cause for Failing to Submit Information Required from the Quarterly Report Form (QRF):

4. Death of the parent or caretaker relative;
5. Hospitalization of a unit member during the due period for the QRF (the client is responsible for providing verification of hospitalization); or
6. Natural disaster (the Central Office will issue instructions when these situations occur).

Note: Eligibility for TMA shall not be terminated for failing to provide the QRF if the needed information from the QRF, for the applicable months, was received.

24-005.09 After Month 12: When a client has exhausted his/her months of TMA, a redetermination of eligibility for another Medicaid program must be completed.

If the unit regains grant or ADC related Medicaid eligibility for one or two months because of a temporary reduction or loss of income, then again loses grant or ADC related Medicaid eligibility because of earnings, the original TMA cycle resumes.

If the unit receives three or more ADC grants or months of ADC related Medicaid, then again loses grant or ADC related Medicaid eligibility because of earnings, a new TMA cycle begins.

If the unit becomes grant or ADC related Medicaid eligible again because of loss of income, the client may refuse the grant or ADC related Medicaid in order to continue receiving TMA.

24-006 FORMER FOSTER CARE CHILDREN

24-006.01 Former Foster Care Children: Individuals under age 26 who were in foster care and receiving Medicaid when the individual attained age 18 or such higher age at which Nebraska's federal foster care assistance ends.

These individuals are exempt from income and resource tests.

24-006.01A Eligibility Requirements: In order to receive Medicaid, the individual must:

1. Be under age 26;
2. Have received Medicaid at the time they aged out;
3. Have been in foster care under Nebraska or a Nebraska tribe's responsibility; and
4. Not be eligible for and enrolled in mandatory Medicaid coverage through Parent/Caretaker relatives, Pregnant Women, Children, or AABD/MA.

For Former Ward, see 477 NAC 18-005.

24-007 EMERGENCY MEDICAL

24-007.01 Emergency Medical Assistance for Undocumented and Ineligible Aliens: An emergency medical condition is defined as a medical condition (including emergency labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) where the absence of immediate medical attention could reasonably result in:

4. Serious jeopardy to the patient's health;
5. Serious impairment to bodily functions; or
6. Serious dysfunction of any bodily organ or part.

24-007.02 Eligibility for Emergency Medical Services for Undocumented and Ineligible Aliens:

24-007.02A Restricted Medical Assistance: To be considered eligible for Emergency Medical Assistance Services, the State Review Team (SRT) shall determine that the individual has an emergency medical condition.

The alien shall be determined eligible under the appropriate Medicaid category by meeting all eligibility criteria except citizenship or qualified alien status.

Chapters 477 NAC 20 through 28 apply to the following: Aged, Blind, and Disabled (ABD); Medically Needy (MN); Medicaid Insurance for Workers with Disabilities (MIWD); Women's Cancer Program; Transitional Medical Assistance (TMA); Former Foster Care; Emergency Medical Services Assistance (EMSA); Children and Young Adults Eligible for IV-E Assistance

CHAPTER 28-000 CHILDREN ELIGIBLE FOR IV-E ASSISTANCE; NON-IV-E ADOPTION SUBSIDY; FORMER FOSTER CARE CHILDREN

28-001 CHILDREN ELIGIBLE FOR IV-E ASSISTANCE: A child eligible for federally funded assistance through the Title IV-E program (this includes subsidized adoption and subsidized guardianship) is Medicaid eligible.

28-001.01 Eligible Children: A child qualifying for IV-E assistance is eligible for Medicaid if

1. The child Is IV-E eligible and is in the custody of the Department or a court of competent jurisdiction;
2. The child is in the custody of another state that made the IV-E determination, but the child lives in Nebraska; or
3. The child has been determined eligible for IV-E subsidized guardianship or adoption assistance by Nebraska, or another state but the child lives in Nebraska.

28-001.02 Age: A child who is IV-E eligible and under nineteen (19) years old shall be eligible for Medicaid.

28-001.02A Exceptions:

1. A child who is in an Institution for Mental Disease (IMD) is eligible through the month of his/her twenty-first (21st) birthday.
2. A young adult who entered into an adoption or guardianship agreement after reaching sixteen (16) years old and is IV-E eligible may be eligible for Medicaid until twenty-one (21) years old.

28-001.03 Income and Resources: A child eligible for IV-E is exempt from income and resource tests.

28-001.04 Effective Date of Medicaid Eligibility: Medicaid eligibility is effective the first day of the month in which custody was first granted if the child was IV-E eligible in that same month.

28-001.05 Continuous Eligibility: Children who are eligible for Medicaid due to their IV-E status shall receive six months of continuous eligibility from the date of initial Medicaid eligibility. See 477 NAC 3-008.

28-001.06 Child Placed in Jail or Detention Facility: Medicaid cannot be used as a funding source for medical care during incarceration.

28-001.06A Exception: When a child placed in jail or detention leaves that setting and goes to an acute medical treatment setting for at least twenty-four (24) hours, medical treatment in the acute setting may be billed to Medicaid if eligibility requirements are otherwise met.

28-002 CHILDREN ELIGIBLE FOR NON-IV-E ADOPTION: A special needs child eligible for non-IV-E subsidized adoption assistance may be Medicaid eligible if s/he meets special needs criteria.

28-002.01 Eligible Children: A child qualifying for non-IV-E subsidized adoption assistance is eligible for Medicaid if

1. An adoption agreement (other than an agreement under Title IV-E) between the state and the adoptive parent(s) is in effect;
2. The Department has determined that the child cannot be placed for adoption without Medicaid coverage because of special needs for medical or rehabilitative care;
3. The child meets either of the following requirements:
    a. S/he would have been eligible for Medicaid before the adoption agreement was entered into; or
    b. S/he would have been eligible for Medicaid before the adoption agreement was entered into, if the eligibility standards and methodologies of the Title IV-E program were used without employing the threshold ADC eligibility determination; and
4. The child is under nineteen (19) years old.

28-002.02 Income and Resources: A child who meets these criteria is exempt from income and resource tests.

28-003 FORMER FOSTER CARE CHILDREN

28-003.01 Former Foster Care Children: Individuals under twenty-six (26) years old who were in foster care under Nebraska's or a Nebraska tribe's responsibility and receiving Medicaid when the individual became eighteen (18) or nineteen (19) years old, or such higher age at which Nebraska's federal foster care assistance ends.

These individuals are exempt from income and resource tests.

28-003.01A Eligibility Requirements: In order to receive Medicaid, the applicant/client must

1. Be under twenty-six (26) years old;
2. Have been a client at eighteen (18) or nineteen (19) years old;
3. Have been in foster care under Nebraska's or a Nebraska tribe's responsibility, at eighteen (18) or nineteen (19) years old; and
4. Not be eligible for and enrolled in mandatory Medicaid coverage through Parent/Caretaker relatives, Pregnant Women, Children, or ABD.

For Former Ward, see 477 NAC 19-005.

Note: Chapters 477 NAC 19 through 25 apply to the following: Aged, Blind and Disabled (AABD/MA), Medically Needy (MN), Medicaid Insurance for Workers with Disabilities (MIWD), Women's Cancer Program, Former Foster Care, Emergency Medical Assistance, Child Welfare

CHAPTER 25-000 CHILD WELFARE, IV-E MEDICAID

25-001 CHILD WELFARE PROGRAM CLIENTS: Title IV-E eligible children (this includes subsidized adoption and subsidized guardianship) are Medicaid eligible and exempt from income and resource requirements.

25-001.01 Age: A ward may be eligible through the month of his/her 19th birthday.

25-001.01A Exception: A ward that is in an Institution of Mental Disease (IMD) is eligible through the month of his/her 21st birthday.

25-001.02 Eligible Children:

1. Wards of the Nebraska Department of Health and Human Services or the court who are determined to be eligible for IV-E assistance;
2. Wards of another state who are determined IV-E eligible by the other state and are living in Nebraska and;
3. Youth who are eligible for the IV-E subsidized adoption program from another state and living in Nebraska.

25-001.03 Effective Date of Medical Eligibility: Medical eligibility is effective the first day of the month in which custody was first granted if the ward was IV-E eligible in that same month. A child may be eligible earlier than the month of custody according to requirements. Six months of continuous eligibility applies. See 477 NAC 4-001 and 477 NAC 3-008.

25-001.04 Review: Eligibility must be reviewed every twelve months.

25-001.05 Absence from the State: Individuals Receiving Foster Care: The Department may not deny assistance because a ward under the jurisdiction of a Nebraska court has not resided in the state for a specified period. It also may not terminate a resident's eligibility because of that ward's absence from the state; unless another state has determined that the ward is a resident there for assistance purposes. A Department ward that is IV-E eligible and is living in another state is eligible for Medicaid coverage from the state in which she or he resides. The protection and safety worker is responsible to determine if it is in the child's best interest to retain Nebraska Medicaid coverage or receive coverage from the resident state. If the decision is that coverage should be from the resident state, the appropriate form must be completed and sent to the Department's designated ICAMA/COBRA Coordinator for processing.

25-001.06 Department Ward in Home of Parent(s): In determining relative financial responsibility, the agency considers the income of parents as available to children living with parents.

If the court order states the extent of the parent(s)' financial responsibility for the child's medical care, the court order is followed.

After 90 days, it must be determined if the child will remain in the home or has been discharged as a ward.

The family's eligibility for other categorical assistance must be reviewed if the child is discharged as a ward, the case is closed, and the family requires financial assistance.

25-001.07 Receipt of Other Assistance: A ward must not receive assistance in two categorical units at the same time. This does not preclude the client of another type of assistance from being the payee for a foster care payment made on behalf of a ward in that client's care. A ward may also be the payee for his/her ADC or AABD/MA child.

If there is a choice of programs, the following order should be followed: IV-E first and non-IV-E second.

25-001.08 Ward Placed in Jail or Detention Facility: Medicaid cannot be used as a funding source for medical care during the placement.

25-001.08A Exception: When a ward placed in jail or detention leaves that setting and goes to an acute medical treatment setting for at least 24 hours, medical treatment in the acute setting may be billed to Medicaid if eligibility requirements are met.