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Employees' Manual  
Title 8  
Chapter C

# **MEDICAID NONFINANCIAL ELIGIBILITY**



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## **Overview**

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

## **Assignment of Medical Support**

**Legal reference:** 441 IAC 75.14(4), 441 IAC 75.2(2), 42 CFR 433.145

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

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

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

Assignment remains effective for the entire period for which assistance is granted. See [Cooperation With Support Recovery](#) for medical support determined through the child support recovery unit.

## **Benefits From Other Sources**

**Legal reference:** 441 IAC 75.3(249A), 75.2(249A)

Medicaid applicants and members are required to apply for and accept benefits from other sources as a condition of eligibility. This section covers application for and acceptance of:

- ◆ [Medical benefits](#)
- ◆ [Income](#)

### **Medical Benefits**

**Legal reference:** 441 IAC 75.2(249A)

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

Such medical resources include:

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

Deny or cancel Medicaid benefits of the individual when a Medicaid applicant or member fails to file a claim or application or to cooperate in the processing of that claim or application without proving good cause. See [Cooperation in Obtaining Medical Resources](#) and [Cooperation With Investigations and Quality Control](#) in this chapter for additional information.

### **Income Benefits**

**Legal reference:** 441 IAC 75.3(249A)

Medicaid applicants and members must apply for and accept any income benefits for which they are eligible, unless they can prove an incapacity that prevents them from doing so. To “apply for and accept” means that the client:

- ◆ Files an application for benefits.
- ◆ Actively tries to obtain them by complying with all requests for information or evidence to establish eligibility.

#### **Exceptions:**

- ◆ A person does not have to apply for SSI benefits. A person who chooses not to apply for SSI benefits may still receive Medicaid under the coverage group for people eligible for SSI benefits but not receiving them. See [8-F, SSI-Related Coverage Groups: People Eligible for SSI Benefits But Not Receiving Them](#).
- ◆ Applicants for or members of QMB or SLMB are also not required to apply for FIP or State Supplementary Assistance.

- ◆ A person does not need to apply for a retirement account if applying for or receiving MAC or FMAP-related medical needy. See [8-F](#), Mothers and Children (MAC) Program, and [8-J](#), RESOURCE POLICIES.
- ◆ A person does not need to apply for or accept any income benefit that would be considered exempt income. See [8-E](#), TYPES OF SSI-RELATED INCOME and TYPES OF FMAP-RELATED INCOME.

The client may be entitled to cash benefits, such as:

- ◆ Social Security benefits.
- ◆ Annuities.
- ◆ Pensions.
- ◆ IPERS.
- ◆ Railroad benefits.
- ◆ Job insurance benefits.
- ◆ Workers' compensation.
- ◆ Union benefits.
- ◆ Veterans' benefits available to:
  - The veteran.
  - The surviving spouse.
  - The veteran's minor child.
  - Some parents of service personnel or veterans who died on or after January 1, 1957.

Veterans Affairs (VA) "improved" pension payments are limited to \$90 per month after a veteran or surviving spouse enters a medical institution unless the person has a spouse or dependent. Unless a person's VA pension is or will be limited to \$90 per month, the person must apply for an improved pension.

However, people who began receiving a veterans' pension before January 1, 1979, and also receive SSI or mandatory state supplementation are not required to **accept** an improved pension. This is because the cash program sets the policy as to whether the client must apply for the improved pension.

If you decide the client may be entitled to other cash benefits, use form 470-0383, *Notice Regarding Acceptance of Other Benefits*, to notify the client of the requirement to apply for the benefits. See [6-Appendix](#). The client indicates intent to apply by completing Part B of the form and returning it to your office.

Allow the client ten calendar days from the date this notice was given or mailed to the client to complete and return the form. If the client gives you a signed refusal to apply or does not return the form, deny or cancel Medicaid for the person who failed or refused.

Deny or cancel Medicaid for the client when the client fails or refuses to:

- ◆ Comply with any income benefit, or
- ◆ Timely apply for any income benefit, or
- ◆ Accept any income benefit.

EXCEPTIONS: Do not deny or cancel Medicaid when good cause exists or when the client is mentally or physically incapable. If the client is incapable, either ask the client's representative to pursue the other benefits or you may help the client apply if the client's representative has authorized you to do so.

## **Citizenship**

**Legal reference:** 42 CFR 435.406; 441 IAC 75.11(2)"a"; P. L. 104-193

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

- ◆ A citizen of the United States,
- ◆ A U.S. national, or
- ◆ A qualified alien. See 8-L, [ALIENS](#), for more information on eligibility criteria.

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

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

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

People who are not citizens or nationals by birth can become citizens through a process called "naturalization." In addition, certain children born abroad who were not U.S. citizens at the time of birth may establish citizenship automatically under the Child Citizenship Act. See [Acceptable Documentation](#) for more information about this Level 2 verification of automatic citizenship.

NOTE: Persons from the Compact of Free Association States (CFAS) are not U.S. citizens or nationals. The CFAS includes the Republic of the Marshall Islands, the Federated States of Micronesia, and the Republic of Palau. Persons from the CFAS retain citizenship in their country of origin because they are allowed to enter and work in the U.S. without obtaining an immigration status.

Adult citizens of the CFAS (age 21 and over) are not eligible for full Medicaid unless they obtain a qualified alien status. They may be eligible for limited Medicaid for emergency services. See [8-L, Limited Eligibility for Certain Aliens](#). NOTE: Children under age 21 who are citizens of the CFAS and are lawfully residing in the U.S. may be eligible for Medicaid. Refer to 8-L, [ALIENS](#), for complete alien requirements.

### **Declaring Citizenship or Alien Status**

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

Medicaid applicants must:

- ◆ Declare their citizenship or alien status as part of the application process.
- ◆ Provide original documentation to verify their status. (See [Verifying Citizenship and Identity](#) for citizenship verification requirements. For information about acceptable forms of verification for aliens, see [8-L](#).)

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

- ◆ On a state-approved Medicaid application,
- ◆ On form 470-2549, *Statement of Citizenship Status*, or
- ◆ For children under age 19 who are eligible under the express-lane process, on a state-approved Food Assistance application or form 470-2881, 470-2881(S), 470-2881(M), or 470-2881(MS), *Review/Recertification Eligibility Document*, completed for Food Assistance reviews. (See [8-F, Express-Lane Eligibility for MAC](#), for more information.)

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

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

When a person whose citizenship or alien status was not previously declared enters an existing FMAP-related Medicaid household, one of the following must attest to the person's citizenship or alien status using the *Statement of Citizenship Status*:

- ◆ An adult member of the family or household, or
- ◆ Someone acting responsibly on the person's behalf.

If the *Statement of Citizenship Status* is not signed, the person for whom the attestation is required is not eligible for Medicaid (except emergency medical assistance). Failure to sign this form does not affect the eligibility of the remaining household members if they are otherwise eligible.

If the signed statement is received at a later date, treat it as an application to add that person to the eligible group.

### **Persons Exempt From Verification**

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

#### **Policy:**

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

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

- ◆ Current recipients of Supplemental Security Income (SSI), including 1619b individuals.
- ◆ Current recipients of Social Security disability income (SSDI) (benefits based on the person's disability).
- ◆ Current Medicare beneficiaries.
- ◆ People who were initially eligible for Medicaid due to deemed "newborn" status. This exemption continues even when "newborn" status ends, because people born in the U.S. to Medicaid-eligible mothers are permanently exempt from proving citizenship and identity.
- ◆ People born in another state who were initially eligible due to having deemed newborn status in that state. This includes people born to CHIP-eligible mothers if the other state's CHIP program covers pregnant women.

NOTE: Children born to Medicaid–eligible or CHIP–eligible mothers in another state do not qualify for deemed newborn status in Iowa because the mother was not receiving Iowa Medicaid at the time of the child’s birth.

- ◆ Children in out-of-home placement (e.g., foster care or relative placement) under the placement and care responsibility of the Department through a court order or voluntary placement agreement, regardless of the placement’s licensing or payment status.
- ◆ Children currently in IV-E-funded subsidized adoption or subsidized guardianship.
- ◆ Applicants for presumptive Medicaid eligibility (but they are no longer exempt when they apply for ongoing Medicaid).

**Comment:**

NOTE: A person claiming to be an alien rather than a U.S. citizen **must** verify alien status as described in 8-L, [ALIENS](#). These exceptions **do not** apply to aliens. Verification of citizenship and identity is also required for the *hawk-i* program. See 5-E, [hawk-i](#), for more information.

All other Medicaid applicants or members claiming to be United States citizens **are** required to verify their citizenship and identity as a condition of eligibility, including those in the Iowa Family Planning Network (IFPN). See [Loss of Exemption](#) for procedures when a member becomes subject to verification after approval.

**Procedure:**

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

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

## **Verifying Citizenship and Identity**

**Legal reference:** 42 CFR 435.406 and 435.407; 441 IAC 75.11(2)“f”; Sections 211(a) and 211(b)(3) of Public Law 111-3

### **Policy:**

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

The documents used to verify citizenship and identity for each person approved for Medicaid must be maintained in the Department’s records. For this purpose, the Department’s records include:

- ◆ The Inquiry Citizenship (ICIT) screen when proof was obtained electronically through the IEVS match with the Social Security Administration, or
- ◆ Copies of original documents maintained in the Medicaid case file (including IFPN) or the *hawk-i* case file.

### **Procedure:**

Use RC-0085, *Guide for Citizenship and Identification*, as a tool to work through the level of documents available. (See [Acceptable Documentation](#).)

When acceptable proof is provided, enter coding in the us and ID fields on each person’s TD03 screen in the Automated Benefit Calculation (ABC) system to document that both citizenship and identity have been verified. Acceptable codes are listed in [14-B-Appendix](#) and in “Easy Help.”

See [Reasonable Opportunity Period](#) and [Documentation Process](#) for instructions on how to proceed when acceptable proof is not provided with the application. When possible, proof of citizenship and identity will be obtained via an automated match through the Income and Eligibility Verification System (IEVS).

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

Unless the person’s citizenship is verified through the automated IEVS match, record the type of verification obtained from each member on form 470-4381, *Documentation of Citizenship and Identity*.

Keep documentation verifying citizenship and identity in the active case file unless citizenship was verified through the automated IEVS match. If a member has more than one case record and the citizenship and identity verification are in only one case file, note in the other case records where the documentation can be found.

**Comment:**

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

Ms. B and her child are Medicaid members who have provided proof of citizenship and identity. In August, Ms. B requests cancellation because she and her child are moving to another state. Iowa Medicaid is canceled effective September 1.

The following June, Ms. B applies for Iowa Medicaid for herself and her child. Proof of citizenship and identity for Ms. B and her child is not requested, since it was already provided and is not questionable.

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

**Reasonable Opportunity Period**

**Legal reference:** 42 CFR 435.407; 441 IAC 75.11(2)“c”

**Policy:**

A person shall be allowed a reasonable opportunity period to obtain and provide proof of citizenship and identity. The reasonable opportunity period begins with the date a written request to provide the information is issued to the person and continues for 90 days.

Medicaid shall be approved during the 90-day reasonable opportunity period for applicants and shall continue for members who have not previously been required to provide proof of citizenship and identity.

Medicaid shall not be approved for an applicant or continued for a member who has already received a reasonable opportunity period until proof of citizenship and identity is provided.

**Procedure:**

Whenever possible, proof of citizenship or identity will be obtained through an automated IEVS match with the Social Security Administration. The system will update eligibility coding if the match is consistent.

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

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

The system tracks the reasonable opportunity period, beginning on the date the form is system-generated. See [14-B\(4\)](#) for instructions for the ABC ICIT screen. This screen will display the status of each person's:

- ◆ IEVS response,
- ◆ Issuance of form 470-4858, 470-4858(S), 470-4909 or 470-4909(S), and
- ◆ 90-day tracking.

Approve Medicaid for new applicants and continue Medicaid for members who have not previously been required to provide proof of citizenship and identity. See [Retroactive Eligibility](#) if an applicant has requested coverage in retroactive months.

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

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

NOTE: When the system cancels an FMAP-related child or adult due to the expiration of the 90-day reasonable opportunity period, the system will convert the canceled individual to "considered person" status to prevent cancellation for the remaining household. Because a child's needs will still be considered, do not determine a diversion for a child ineligible for this reason.

See [Subsequent Applications](#) and [8-E, Ineligible or Voluntarily Excluded Child](#), for instructions on calculating a diversion for a child who later reapplies.

**Comment:**

Once a 90-day reasonable opportunity period begins, it does not change even if Medicaid is canceled for a different reason before the end of the 90-day period. The reasonable opportunity period lasts 90 days even if the person does not receive Medicaid during the entire 90-day period. See [Subsequent Applications](#) if a person reapplies during the reasonable opportunity period.

No extensions are allowed for the 90-day reasonable opportunity period for providing proof of citizenship and identity. However, reinstatement and grace period policies do apply when proof is provided before the effective date of cancellation or within 14 days of cancellation or denial. Refer to [8-B, Grace Period Following the Denial of an Application](#), and [8-G, Grace Period](#), for more information.

Continuous eligibility does not apply to children whose citizenship and identity is not verified within the 90-day reasonable opportunity period or the subsequent reinstatement and grace period. See [8-F, Exceptions to Continuous Eligibility for Children](#).

**Loss of Exemption**

**Policy:**

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

Children losing an exempt status (e.g., foster care or IV-E subsidized adoption) who are already continuously eligible are not required to verify citizenship and identity until the next annual review.

**Procedure:**

Change the coding in the US and ID fields on TD03 to a "?" to reflect that the member is no longer exempt from verifying citizenship and identity.

EXCEPTION: For a child who is continuously eligible but loses an exempt status, do not change the US and ID coding to "?" until the annual review.

If the member's name, date of birth, and social security number are on TD03, the system will automatically initiate the proof of citizenship request via the Income and Eligibility Verification System (IEVS).

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

If acceptable proof is provided, record the documentation in the US and ID fields on the person's TD03 screen.

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

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

NOTE: When the system cancels an FMAP-related child or adult due to the expiration of the 90-day reasonable opportunity period, the system will convert the canceled individual to "considered person" status to prevent cancellation for the remaining household. Because a child's needs will still be considered, do not determine a diversion for a child ineligible for this reason.

See [Subsequent Applications](#) and [8-E, Ineligible or Voluntarily Excluded Child](#), for instructions on calculating a diversion for a child who later reapplies.

### **Retroactive Eligibility**

#### **Policy:**

The retroactive months are outside the reasonable opportunity period. Retroactive Medicaid eligibility shall **not** be approved until proof of citizenship and identity has been provided.

#### **Procedure:**

Pend each individual on TD03 as soon as a Medicaid application is received to begin the automated IEVS match process for verifying citizenship and identity. This will reduce processing delays on the retroactive portion of the Medicaid application.

Enter code "Z" on the TD05 RETRO field when pending the case if retroactive Medicaid has been requested. See [Documentation Process](#) for instructions.

When any member of the eligible group has not verified both citizenship and identity, entries to approve retroactive Medicaid using the RETRO field on TD05 will generate a fatal WAR. Instead, enter code "Z" in the RETRO field on TD05 when retroactive Medicaid has been requested and both citizenship and identity have not yet been verified for all members of the eligible group.

If code "Z" is entered in the TD05 RETRO field, a WIFS will be sent when:

- ◆ A consistent match is received from the Social Security Administration;
- ◆ The individual is canceled at the end of the 90-day reasonable opportunity period after an inconsistent match was received; or
- ◆ An inconsistent match is received and ongoing Medicaid is denied.

The WIFS alerts you a decision may still be needed on the retroactive portion of the application. Issue a manual *Notice of Decision* when eligibility cannot be system-calculated.

**Comment:**

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

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

If the applicant provides proof of citizenship and identity, record the documentation in the person's TD03 us and ID fields. If optional proof is not provided, take no negative action.

Ms. C mails in an application for Medicaid for herself and her daughter. A request for proof of citizenship will be sent to the SSA through IEVS when their information is entered on TD03.

Because Ms. B indicated on her application that retroactive Medicaid coverage is needed for her daughter, the worker mails a letter to Ms. B asking for proof of her daughter's citizenship and identity.

In the letter, the worker explains that this proof is optional unless the response from SSA does not verify her daughter's citizenship (including identity), but that retroactive Medicaid cannot be approved until proof of citizenship and identity is received.

### **Subsequent Applications**

#### **Policy:**

Only one 90-day reasonable opportunity period per person is allowed under either Medicaid (including IFPN) or *hawk-i*.

A person who has already received the 90-day reasonable opportunity period for either Medicaid (including IFPN) or *hawk-i* must provide proof of citizenship and identity before additional benefits can be approved.

EXCEPTION: One additional 90-day reasonable opportunity period is allowed if necessary to protect the confidentiality of a person who received only limited Medicaid benefits provided under IFPN during the first 90-day reasonable opportunity period.

#### **Procedure:**

If the person has received the 90-day reasonable opportunity period for either Medicaid (including IFPN) or *hawk-i*, do not approve a subsequent Medicaid application until proof of citizenship and identity is provided.

Issue a written request for proof of citizenship and identity. See [8-B, Verification](#), for more information about time limits for providing requested verification. Deny the application if proof is not provided by the due date.

Mr. H and his children were previously on Medicaid. Proof of their citizenship and identity was not provided, so Medicaid was canceled at the end of the 90-day reasonable opportunity period.

After a few months, Mr. H applies again for Medicaid for himself and his children. Mr. H states on the application that he and his children are U.S. citizens. A written request is issued to Mr. H asking that he provide proof of income, proof of citizenship, and proof of identity within ten calendar days.

Mr. H sends in acceptable proof of income and acceptable proof of citizenship and identity for himself and for all but one of his children. The IM worker contacts Mr. H and explains other forms of acceptable proof. Mr. H states he misunderstood and he should be able to obtain acceptable proof for the other child.

The IM worker approves the application for Mr. H and the children for whom acceptable proof was provided. The other child will be treated as an ineligible child and therefore is not included in the household size.

If acceptable proof is provided for the other child by the due date or within the grace period following the denial of an application, Medicaid for that child can be approved based on the original application date. If acceptable proof is not provided until after the due date or within the grace period, treat the receipt of acceptable proof as an add-on application.

When a person has already used the 90-day reasonable opportunity period:

- ◆ Entries to **pend** the individual will generate a screen edit alerting you to request proof of citizenship and identity because the 90-day reasonable opportunity period has already been used.
- ◆ Entries to **approve** the individual will generate a fatal WAR preventing Medicaid approval of the individual until proof of citizenship and identity is obtained and coded in the TD03 us and ID fields.

If a person who has been denied or canceled for another reason reapplies, do not deny the reapplication for lack of proof of citizenship or identity for any benefit period that is within the 90-day reasonable opportunity period.

The system will track whether the IFPN confidentiality exception applies. If the person may receive one additional 90-day reasonable opportunity period, the screen edit or fatal WAR indicating that the 90-day reasonable opportunity period has already been used will not be generated.

1. Ms. D applies for Medicaid on June 15. A request for proof of citizenship is sent through IEVS. On July 2, IEVS produces a response that citizenship could not be verified. The system generates form 470-4858, *Request for Verification of Citizenship and Identity*, informing Ms. D she has until September 16 to provide proof.

On July 10, the worker sends a *Notice of Decision* to Ms. D canceling her Medicaid effective July 31 for a reason unrelated to citizenship.

Ms. D reapplies on September 3. Ms. D's reasonable opportunity period ends September 16 even though she did not receive Medicaid benefits in August. She can be approved for September if all other eligibility requirements are met.

Approval entries made on the system before September timely notice day result in approval for September and October, followed by a system-generated cancellation at September timely notice day for failure to provide proof of citizenship and identity.

If action on the application could not be taken until **after** September timely notice day, the worker would:

- ◆ Complete a *Request for Special Update*.
- ◆ Issue a manual *Notice of Decision* approving eligibility for September.
- ◆ Issue a written request for proof of citizenship and identity to Ms. D.
- ◆ Deny the application for October with a manual *Notice of Decision* if proof is not provided by the due date.

2. Same as Example 1, except Ms. D reapplies on September 27.

Even though the reapplication occurs after the 90-day reasonable opportunity period has ended, eligibility exists for September (assuming all other factors are met). The worker completes a *Request for Special Update* and issues a manual *Notice of Decision* approving eligibility for September only.

The worker issues a written request for proof of citizenship and identity. Ms. D does not provide proof by the due date. The worker denies the application for October with a manual *Notice of Decision*.

3. Same as Example 1, except Ms. D does not reapply until October 3. Because her reasonable opportunity period ended September 16, she must provide proof of citizenship and identity before Medicaid can be approved.

### **Documentation Process**

**Legal reference:** Section 211(a) of Public Law 111-3; 441 IAC 75.11(2) "c" and "i"

#### **Policy:**

A person who attests to U.S. citizenship and provides name, social security number, and date of birth meets the citizenship and identity documentation requirements if the response to submission of this information to the Social Security Administration verifies the person's citizenship (and identity).

A written request for verification shall be issued if:

- ◆ The Social Security Administration returns a response that does not verify the person's citizenship (and identity),
- ◆ A response cannot be requested from the Social Security Administration because the person does not have a social security number, or
- ◆ The person has previously had a 90-day reasonable opportunity period to verify citizenship for Medicaid (including IFPN) or ***hawk-i***.

**Procedure:**

The system will automatically send a request for proof of citizenship and identity to the Social Security Administration via IEVS when a person:

- ◆ Is pending or approved on the system, and
- ◆ The us or ID fields are coded "?" or are left blank.

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

Mr. B files an application for Medicaid in person at the local office on June 28. A request for proof of citizenship will be sent to the Social Security Administration through IEVS when his information is entered on the TD03 screen.

Since Mr. B is already in the local office, the IM worker takes a copy of his driver's license as proof of identity and records a 'D' in the ID field on Mr. B's TD03. The worker also has Mr. B fill out form 470-4400, *Request for Iowa Birth Information*, so a BCV match can be used as proof if needed.

- ◆ If a valid BCV response is returned before the IEVS response is produced, the worker records a 'Z' in the us field on Mr. B's TD03.
- ◆ If an invalid BCV response is returned before the IEVS response is received, the worker takes no negative action because proof from Mr. B is not required unless the IEVS response does not verify his citizenship and identity.

Do **not** enter a "?" over an existing code in the us or ID field indicating that citizenship or identity was already verified. Enter a "?" code in the us or ID fields only when pending or approving an individual who:

- ◆ Attests to U.S. citizenship,
- ◆ Has not yet had the 90-day reasonable opportunity period, and
- ◆ Is required to verify citizenship and identity but has not already done so, as indicated by coding in the TD03 us and ID fields.

When an IEVS request will not be generated for a person who is required to verify citizenship and has not done so, follow the procedures under [No Match](#). An IEVS request for proof of citizenship and identity will **not** be sent when:

- ◆ Coding in **both** the TD03 us and ID fields indicates verification is not needed (e.g., person is exempt, verification is already on file, person is an alien),
- ◆ The fund code indicates the individual is a considered or excluded person, or
- ◆ Eligibility is on the PRSM system (ongoing BCCT).

### **Consistent Match**

#### **Policy:**

When the response to an IEVS request for proof of citizenship is a “consistent match,” this verifies the person’s citizenship (and identity). The person has met the citizenship and identity documentation requirements.

#### **Procedure:**

When the IEVS response reports a consistent match, the system will:

- ◆ Show the response on the ICIT screen, and
- ◆ Automatically update the coding in the US and ID fields on the person’s TD03 screen to a “+”.

No further action is needed for that person’s ongoing Medicaid. If code “Z” is entered in the RETRO field on TD05, you will receive a WIFS message to alert you to complete the decision on retroactive eligibility. See [Retroactive Eligibility](#) for additional information.

#### **Comment:**

An IEVS response about an individual’s citizenship (and identity) can be used **only** for the purposes of determining Medicaid (including IFPN) and **hawk-i** eligibility. These citizenship data matches **cannot** be used to determine eligibility for other programs (Food Assistance, FIP, CCA, etc.).

### **Inconsistent Match**

#### **Policy:**

When the Social Security Administration (SSA) response to an IEVS request for proof of citizenship is “inconsistent match,” the person’s citizenship (and identity) are not verified. The system will generate a written request for verification of citizenship and identity to notify the person that:

- ◆ The person has 90 days to provide verification by either:
  - Correcting any errors in the name, social security number, or date of birth given to the Department so that SSA can verify the person’s citizenship;
  - Correcting any errors in the SSA’s records and providing proof of citizenship and identity from SSA when this is done; or
  - Providing proof of citizenship and identity from the list of documents described under [Acceptable Documentation](#).

- ◆ If proof of citizenship and identity is not provided within 90 days:
  - Medicaid eligibility will end,
  - Retroactive Medicaid, if requested, will be denied, and
  - Medicaid (including IFPN) or *hawk-i* will not be approved again in the future until citizenship and identity is verified.

**Procedure:**

When the response is received that SSA cannot verify the person's citizenship (and identity), the system will automatically:

- ◆ Show the response on the ICIT screen.
- ◆ Change the code in the US and ID fields on the person's TD03 screen from "?" to "-" unless there is already a valid code in that field.
- ◆ Generate form 470-4858 or 470-4858(S), *Request for Verification of Citizenship and Identity*, and Comm. 258, *Verifying Citizenship and Identity* (only if ongoing Medicaid is approved on the system).
- ◆ Send a WIFS that forms have been generated due to an inconsistent match and alert you to review the TD03 entries.
- ◆ Begin counting the 90-day reasonable opportunity period. (See the exception for IFPN cases on the next page.)

When you get a WIFS message that an inconsistent match was received and retroactive Medicaid was requested:

- ◆ Manually issue Comm. 258 and a request for proof of citizenship and identity using the language on form 470-4858 or 470-4858(S), *Request for Verification of Citizenship and Identity*, in [6-Appendix](#).
- ◆ **Immediately review** the TD03 screen and **correct** any errors in the person's name, date of birth, social security number, or sex. When corrections are made in any of these fields, the system automatically sends another IEVS request for citizenship verification.

If these corrections produce an IEVS response that verifies the person's citizenship, the system will update the coding in the US and the ID fields. If code "Z" is entered in the TD05 RETRO field, a WIFS will be sent to alert you that retroactive Medicaid coverage was requested and a decision may still be needed on retroactive eligibility.

If the person provides acceptable proof during the 90-day reasonable opportunity period, record the documentation in the US and ID fields on the person's TD03 screen.

- ◆ If the person has corrected errors in the SSA's records and provides proof of citizenship and identity from SSA when this is done, enter code "#" in the US and ID fields.
- ◆ Otherwise, enter the code indicating the corresponding document from the list provided under [Acceptable Documentation](#).

If proof is provided but is questionable or not acceptable:

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

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

- ◆ Cancel the individual with timely notice.
- ◆ Send a WIFS message if code "Z" was previously entered in the TD05 RETRO field, to alert you to deny retroactive eligibility.

EXCEPTION: The procedure is not entirely automated when an inconsistent match is received for Iowa Family Planning Network (IFPN) cases:

- ◆ When the response is received that SSA cannot verify the person's citizenship and identity, the system will automatically generate form 470-4858, *Request for Verification of Citizenship and Identity*, and Comm. 258, *Verifying Citizenship and Identity*.
- ◆ The system will calculate the 90-day reasonable opportunity period and display it at the "Search Result" screen in the FPW system under the field called 90-DAY DATE.
- ◆ The worker must manually track the date that the 90-day reasonable opportunity period ends.
- ◆ The worker must manually cancel the IFPN case at the end of the 90-day period if proof for citizenship and identity is not returned.

See [Retroactive Eligibility](#) for additional information about retroactive Medicaid coverage and citizenship and identity requirements.

NOTE: When the system cancels an FMAP-related child or adult due to the expiration of the 90-day reasonable opportunity period, the system will convert the canceled individual to "considered person" status to prevent cancellation for the remaining household. Because a child's needs will still be considered, do not determine a diversion for a child ineligible for this reason.

### **No Match**

#### **Policy:**

An IEVS request for proof of citizenship will **not** be sent when:

- ◆ A "?" is coded in the US or ID fields for a person who does not have a social security number,
- ◆ A request was already sent and the person's name, date of birth, social security number, or sex has not been changed on TD03, or
- ◆ Eligibility is on the PRSM system (ongoing BCCT).

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

#### **Procedure:**

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

- ◆ Medicaid eligibility will end,
- ◆ Retroactive Medicaid, if requested, will be denied, and
- ◆ Medicaid (including IFPN) or *hawk-i* will not be approved again in the future until citizenship and identity is verified.

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

- ◆ Is approved on the system,
- ◆ Has all 9s or all 0s in the social security number field on TD03, and
- ◆ Has a "?" code in the US or ID fields.

NOTE: If a person with all 9s or all 0s on TD03 later provides a social security number, entry of the social security number will cause a request for proof of citizenship to be sent via IEVS.

However, because only one 90-day reasonable opportunity period is allowed for each individual, form 470-4858 or 470-4858(S) will **not** be generated if form 470-4909 or 470-4909(S), *Request for Proof of Citizenship and Identity*, was already sent to the person.

If acceptable proof is provided during the 90-day reasonable opportunity period, record the documentation in the US and ID fields on the person's TD03 screen. If code "Z" was previously entered in the TD05 RETRO field, you will receive a WIFS message alerting you to make a decision on retroactive eligibility. See [Retroactive Eligibility](#) for additional information.

If proof is provided but is questionable or not acceptable:

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

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

- ◆ Cancel the individual with timely notice.
- ◆ Send a WIFS message to alert you to deny retroactive eligibility.

See [Retroactive Eligibility](#) for additional information about retroactive Medicaid coverage and citizenship and identity requirements.

NOTE: When the system cancels an FMAP-related child or adult due to the expiration of the 90-day reasonable opportunity period, the system will convert the canceled individual to "considered person" status to prevent cancellation for the remaining household. Because a child's needs will still be considered, do not determine a diversion for a child ineligible for this reason.

For an ongoing BCCT applicant whose eligibility is processed on the PRSM system:

- ◆ Manually issue Comm. 258 and a request for proof of citizenship and identity using the language on form 470-4909 or 470-4909(S), *Request for Proof of Citizenship and Identity*, in [6-Appendix](#).
- ◆ Track the 90-day reasonable opportunity period and cancel Medicaid if proof is not provided within 90 days.

### **Acceptable Documentation**

**Legal reference:** 42 CFR 435.407; 441 IAC 75.11(2)“c,” “d,” “e,” and “i”;  
P. L. 111-3

Original documents or copies certified by the issuing agency are required. “Certified” means that the document is stamped, embossed, or otherwise noted in writing by the agency responsible for maintaining the original that it is a true copy of the original. Copies or notarized copies of documents are not acceptable proof.

When a client submits original documents to prove citizenship or identity, **do not** date-stamp the originals. Instead, photocopy the originals and return them to the client. Date stamp the copy and place it in the case file.

NOTE: Copies of original documents are acceptable only when made by:

- ◆ The Department’s employees (including staff outstationed at other locations) or
- ◆ Staff authorized under intergovernmental contract, such as:
  - **hawk-i** staff,
  - Iowa Family Planning Network providers, and
  - Staff at University of Iowa Hospitals and Clinics who are authorized to take initial applications.

Each state must conduct its own verification of citizenship and identity. Iowa cannot accept another state’s copy of an original document. However, Iowa will accept another state’s data match with that state’s vital records if the verification is received from the other state rather than from the client.

Iowa can accept a faxed or electronic copy of an original document issued directly from the other state's vital records office. The fax should:

- ◆ Be on letterhead or otherwise be identified as coming directly from the vital records office; and
- ◆ Include a written statement indicating that the fax or electronic copy is a true copy of the original, which is dated and signed by the certifying official.

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

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

Citizenship documents are arranged in a hierarchy from most reliable (Level 1) to least reliable (Level 4). Level 1 documents are acceptable proof of both citizenship and identity. If Level 2, Level 3, or Level 4 documents are used to verify citizenship, separate proof of identity is also required.

Obtain the most reliable record the person has available. Accept less reliable documents only when more reliable documents do not exist or cannot be obtained within the 90-day reasonable opportunity period.

When a lower-level document is available, you may accept it if a higher-level document cannot be obtained within the normal time limits for processing an application or automatic redetermination. In this situation, the higher-level document is not considered available.

EXCEPTION: Do not accept a lower-level document when a Birth Certificate Verification (BCV) system match can be done, even if waiting for the BCV match requires exceeding normal processing time limits.

There is no hierarchy of documents for identity. However, accept the three or more corroborating documents or an affidavit only as a last resort. An affidavit cannot be used to verify both citizenship and identity for the same person. Affidavits must be signed under penalty of perjury but need not be notarized.

This chart lists documents acceptable as verification of citizenship and identity:

Level 1: Primary Documents	Verifies both citizenship and identity
Confirmation of citizenship via IEVS automated data match	<p>U.S. citizenship and identity has been verified by the Social Security Administration based on a data match through IEVS.</p> <p>Match can be attempted only for individuals who provide a name, date of birth, and social security number.</p>
U.S. passport	<p>The Department of State issues U.S. passports. An expired passport may be accepted as evidence of U.S. citizenship and identity as long as it was originally issued without limitation.</p> <p><b>EXCEPTION:</b> An <b>expired</b> passport issued to a person born in Puerto Rico cannot be accepted for persons whose eligibility for Medicaid is first determined on or after October 1, 2010. Any <b>unexpired</b> passport remains acceptable for all persons.</p> <p>Do <b>not</b> accept any passport as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.</p> <p><b>NOTE:</b> Spouses and children were sometimes included on one passport through 1980. The citizenship and identity of all of the persons included can be established when one of these passports is presented. U.S. passports issued after 1980 show only one person.</p>
Certificate of Naturalization (Department of Homeland Security Form N-550 or N-570)	Issued when a person becomes a naturalized citizen.
Certificate of U.S. Citizenship (Department of Homeland Security Form N-560 or N-561)	Issued to persons whose U.S. citizenship is derived through a parent.

Level 1: Primary Documents	Verifies both citizenship and identity
<p>Documentation issued by a federally recognized Indian Tribe showing membership or enrollment in or affiliation with that Tribe.</p> <p>(Examples include Tribal enrollment or membership cards, a certificate of degree of Indian blood issued by the Bureau of Indian Affairs, or a Tribal census document.)</p>	<p>Until federal regulations are issued on satisfactory documentation for Tribes having an international border whose membership includes non-U.S. citizens, members of cross-border Tribes may use Tribal enrollment or membership documents for purposes of proving both citizenship and identity.</p> <p>The list of federally recognized Indian Tribes is maintained at <a href="http://www.justice.gov/otj/federal-resources">http://www.justice.gov/otj/federal-resources</a></p>
Level 2: Secondary Documents	Verifies citizenship only
<p>U.S. public birth certificate showing birth in:</p> <ul style="list-style-type: none"> <li>◆ One of the 50 states or the District of Columbia</li> <li>◆ American Samoa</li> <li>◆ Swain’s Islands</li> <li>◆ The U.S. Virgin Islands on or after January 17, 1917</li> <li>◆ The Northern Mariana Islands after November 4, 1986</li> <li>◆ Guam on or after April 10, 1899</li> <li>◆ Puerto Rico on or after January 13, 1941*</li> </ul> <p>* Puerto Rican birth certificates issued <b>before</b> July 1, 2010, are acceptable proof of citizenship only for persons whose eligibility for Medicaid was first determined based on an application received before October 1, 2010.</p>	<p>The state, commonwealth, territory, or local jurisdiction may issue the birth record document.</p> <p>This includes a successful match with Iowa birth records through the Birth Certificate Verification (BCV) system.</p> <p>The birth record must have been recorded before the person was 5 years old. Birth certificates recorded after age 5 can be used only as Level 4 documentation.</p> <p>Contact the SPIRS help desk for assistance in:</p> <ul style="list-style-type: none"> <li>◆ Determining whether the person is a collectively naturalized U.S. citizen if the document shows that a person was born in Puerto Rico, Guam, the Virgin Islands, or the Northern Mariana Islands before the dates listed, or</li> <li>◆ Obtaining a new birth certificate issued on or after July 1, 2010, if an applicant born in Puerto Rico provides a birth certificate issued before July 1, 2010, for an application received on or after October 1, 2010.</li> </ul>

Level 2: Secondary Documents	Verifies citizenship only
<i>Certification of Report of Birth</i> (Form DS-1350)	This form is issued by the Department of State to U.S. citizens who were born outside the U.S. and acquired U.S. citizenship at birth.
<i>Consular Report of Birth Abroad of a U.S. Citizen</i> (Form FS-240)	This form is issued by the Department of State via American consular offices overseas to children under the age of 18. Children born to U.S. military personnel usually have such a form.
<i>Certification of Birth Abroad</i> (Form FS-545)	Before November 1, 1990, Department of State consulates also issued this form with the previous version of form FS-240.
<i>U.S. Citizen I.D. Card</i> (Department of Homeland Security Form I-197 or the earlier version Form I-179)	<p>Form I-179 was issued from 1960 to 1973. Then it was renumbered to form I-197 and was issued until April 7, 1983.</p> <p>These forms were issued to naturalized citizens living near the Canadian or Mexican border who needed identification for frequent border crossings. Although not currently issued, they are still valid.</p>
<i>American Indian Card</i> (I-872) with "KIC" classification	Form I-872 is issued by the Department of Homeland Security to identify U.S. citizen members of the Texas band of Kickapoos living near the U.S./Mexico border. The "KIC" classification code and a statement on the back denote U.S. citizenship.
<i>Northern Mariana Identification Card</i> (I-873)	Form I-873 was issued by the former Immigration and Naturalization Service to a collectively naturalized U.S. citizen who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but is still valid.

Level 2: Secondary Documents	Verifies citizenship only
Final adoption decree	<p>The decree must show the child's name and U.S. place of birth.</p> <p>When an adoption is not finalized and the state in which the child was born will not release a birth certificate before final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The agency must state in its certification that the source of the information is an original birth certificate.</p>
Verification of automatic citizenship under section 320 of the Immigration and Nationality Act, also known as Child Citizenship Act	<p>Children born outside the U.S. who were not U.S. citizens at the time of birth (international adoptions and certain children born abroad whose parents become naturalized citizens) may establish citizenship automatically by providing verification that at any time on or after February 27, 2001, the child met the following conditions:</p> <ul style="list-style-type: none"> <li>◆ The child is under age 18.</li> <li>◆ At least one parent is a U.S. citizen by birth or naturalization.</li> <li>◆ The child is residing in the United States in the legal and physical custody of the U.S. citizen parent pursuant to a lawful admission for permanent residence.</li> <li>◆ If adopted, the child was admitted as either having an immigration status of IR-3 (adopted outside the U.S.) or IR-4 (final adoption within the U.S.).</li> </ul> <p>The parent's status must be verified according to citizenship guidelines. The child's status for admission to the U.S. must be verified according to alien guidelines. The adoption must be verified by obtaining a copy of the full, final adoption decree.</p>

<b>Level 2: Secondary Documents</b>	<b>Verifies citizenship only</b>
Official military record of service	The document must show a U.S. place of birth (for example a DD-214).
Evidence of employment by the U.S. government civil service	The document must show employment by the U.S. government before June 1, 1976.
<b>Level 3: Other Documents</b>	<b>Verifies citizenship only</b>
Extract of hospital record on hospital letterhead that shows a U.S. place of birth	<p>For persons aged 16 or over, the record must have been established at the time of the person's birth and the document created at least 5 years before the Medicaid application date.</p> <p>For children under age 16, the document must have been created near the time of birth or 5 years before the Medicaid application date.</p> <p>NOTE: A souvenir "birth certificate" issued by the hospital does not qualify.</p>
Life, health, or other insurance record showing a U.S. place of birth	<p>For persons aged 16 or over, the record must have been created at least 5 years before the Medicaid application date.</p> <p>For children under age 16, the document must have been created near the time of birth or 5 years before the Medicaid application date.</p>
Religious record showing either the date of birth or the person's age when the record was made	<p>The document must be an official record that was recorded with the religious organization in the U.S. within three months of birth.</p> <p>Caution: In questionable cases (e.g., a record recorded near a U.S. international border and the child may have been born outside the U.S.), the state must verify the record or document that the mother was in the U.S. at the time of birth.</p>
Early school record showing a U.S. place of birth	The record must show the child's name, date of admission to the school, date of birth, U.S. place of birth, and the names and places of the person's parents.

NOTE: With the exception of written affidavits, all Level 4 documents must show a U.S. place of birth and must have been created at least five years before the application for Medicaid (or near the time of birth, for children under 16).

Level 4: Other Documents	Verifies citizenship only
<p>For persons born between 1900 and 1950, federal or state census record showing U.S. citizenship or a U.S. place of birth</p>	<p>The record must show the person's age.</p> <p>To obtain a census record, the person must complete form BC-600, <i>Application for Search of Census Records for Proof of Age</i>. The person will need to add in the remarks section of the form, "U.S. citizenship data requested for the purpose of Medicaid eligibility."</p> <p>There is a minimum fee of \$65 for this information. Download the form at: <a href="http://www.census.gov/topics/population/genealogy/agesearch.html">www.census.gov/topics/population/genealogy/agesearch.html</a></p>
<p>Other documents listed that show a U.S. place of birth and were created at least five years before the Medicaid application date</p>	<p>Examples include:</p> <ul style="list-style-type: none"> <li>◆ Seneca Indian tribal census record</li> <li>◆ Bureau of Indian Affairs tribal census records of the Navaho Indians</li> <li>◆ Roll of Alaska Natives maintained by the Bureau of Indian Affairs for persons born before December 18, 1971. (Contact SPIRS for assistance requesting information from the Roll.)</li> <li>◆ Any U.S. state's vital statistics official notification of birth registration</li> <li>◆ A delayed U.S. public birth record that is recorded more than five years after the person's birth</li> </ul> <p>NOTE: A birth certificate recorded five years or less after the person's birth qualifies as a Level 2 document.</p> <ul style="list-style-type: none"> <li>◆ Statement signed by the physician or midwife who was in attendance at the time of birth</li> </ul>

Level 4: Other Documents	Verifies citizenship only
<p>Institutional admission papers</p>	<p>Admission papers from a nursing home, skilled care facility, or other institution generally show biographical information, including the person's place of birth. The record can be used to establish citizenship when it shows a U.S. place of birth.</p>
<p>Medical (clinic, doctor, or hospital) record</p>	<p>Medical records generally show biographical information, including place of birth. The record can be used to establish citizenship when it shows a U.S. place of birth.</p> <p>NOTE: For this purpose, an immunization record maintained by a parent or school is not considered a medical record but an immunization record maintained by a clinic, doctor, or hospital is considered a medical record.</p>
<p>Affidavit signed under penalty of perjury:  <i>Affidavit Concerning Documentation of Citizenship</i>, form 470-4374,  <i>Affidavit of Citizenship</i>, form 470-4373</p>	<p>Form 470-4374 must be completed by the client or by another knowledgeable person (guardian or representative) explaining why the person does not have and cannot get any of the other documents to prove citizenship.</p> <p>Two people with personal knowledge of the events establishing the client's claim of citizenship must complete form 470-4373. Only one of these can be related to the person. They must also verify their own citizenship and identity.</p> <p>NOTE: If an affidavit is used to prove citizenship, an affidavit cannot be used to prove identity.</p> <p>An affidavit is the only Level 4 document that does not have to show a U.S. place of birth or have been created five years before the Medicaid application. It may be used for both U.S. born and naturalized citizens. It may be used only as a last resort when no other documents are available.</p>

NOTE: Documents used to prove identity should be current. Identity documents that have recently expired may be accepted as long as there is no reason to question that they match the individual. Use the “prudent person” concept in deciding whether a document is “current” or “recently expired.”

Identity Documents:	Explanation:
Driver’s license issued by a U.S. state or territory	Acceptable if the license has a photograph of the person or identifying information such as name, age, sex, race, height, weight, or eye color.
ID card issued by a state, federal, or local government	Acceptable if the ID has the same information included on driver’s licenses e.g., a photograph or other identifying information such as name, age, sex, race, height, weight, or eye color.  NOTE: A voter’s registration card or Canadian driver’s license may not be accepted.
U.S. military card or draft record	Self-explanatory.
Cross match with a federal or state governmental, public assistance, law enforcement, or corrections agency’s data system; if the agency establishes and certifies the true identity of the individuals	This includes data matches with Iowa Department of Transportation (DOT) driver’s license information. Remember to print the driver’s license information screen and file it in the case file as proof.
Military dependent’s identification card	Acceptable if it contains the person’s photograph.
School ID card with a photograph	Self-explanatory.
U.S. Coast Guard Merchant Mariner card	Self-explanatory.

Identity Documents:	Explanation:
U.S. passport issued with limitations	Contact the SPIRS help desk for any questions about the document.
For children under age 16: Clinic, doctor, hospital, or school record	School records include day care records and report cards. School records must be verified with the issuing school.
<p>If none of the evidence of identity listed above is available, three or more corroborating documents may be accepted if the same items were not used to document citizenship.</p> <p>This option can be used only if the person submitted 2<sup>nd</sup>-level or 3<sup>rd</sup>-level citizenship documentation.</p>	<p>Documents that together reasonably corroborate a person's identity may be used, such as employer identification cards, high school or college diplomas, marriage certificates, divorce decrees, and property deeds or titles.</p> <p>All documents must contain the person's name and must contain consistent identifying information.</p>
<p>For children under age 16 and disabled persons in residential care facilities (RCF): <i>Affidavit of Identity</i>, form 470-4386</p>	<p>The form may be signed by a child's parent, guardian, or specified relative or by the disabled person's RCF administrator, under penalty of perjury. It must identify the date and place of the person's birth.</p> <p>NOTE: If an affidavit is used to prove identity, an affidavit cannot be used to prove citizenship. An affidavit may be used only as a last resort when no other identity documents are available.</p>

## **Cooperation in Obtaining Medical Resources**

**Legal reference:** 441 IAC 75.2(249A) and 75.21(249A)

All applicants and members are required to cooperate with certain processes related to obtaining medical resources as a condition of eligibility for Medicaid, unless good cause exists for failure to cooperate. This includes pregnant minors living independently.

EXCEPTION: When the only employed household member is an undocumented alien, do not refer the case to the HIPP Unit.

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

This section covers procedures for:

- ◆ [Cooperation with the Health Insurance Premium Payment Unit](#)
- ◆ [Cooperation with the Third-Party Liability Unit](#)
- ◆ [Good cause for failure to cooperate](#)

## **Cooperation With the Health Insurance Premium Payment (HIPP) Unit**

**Legal reference:** 441 IAC 75.21(1)

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

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

How to make a referral to the HIPP Unit:

- ◆ From the TD03 screen on the ABC system, use the PF6 key labeled "REF MENU" (see [14-C, Adding a HIPP Referral](#)); or
- ◆ E-mail form 470-2844, *Employer's Statement of Earnings*, to [hipp@dhs.state.ia.us](mailto:hipp@dhs.state.ia.us).

Contact the HIPP Unit as follows:

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

### **Failure to Cooperate With the HIPP Program**

**Legal reference:** 441 IAC 75.21(249A), 75.2(249A), 75.4(249A)

If you receive form 470-0409, *Medicaid Notice of Sanction*, from the HIPP Unit, apply a sanction to the parent or specified relative who fails to cooperate unless good cause exists. Continue to include the person under sanction in the household size as a “considered” person. See [Sanctions and Appeals](#).

Do not apply a sanction to a child due to the failure of the parent or specified relative to cooperate. Do apply a sanction to a minor parent for failure to cooperate.

Do not apply a sanction to the spouse of the employed person due to the noncooperation of the employed person when the spouse cannot enroll independently of the employed person. NOTE: A “considered” person is not a Medicaid member and cannot have a sanction applied.

If the person is not currently eligible for Medicaid, file form 470-0409, *Medicaid Notice of Sanction*, in the case file. If the person reapplies for Medicaid, contact the HIPP Unit before approving initial or ongoing Medicaid benefits to ascertain whether the previous sanction still applies.

1. Mr. J, an FMAP member, began working on April 3. The IM worker makes a referral to HIPP Unit.

Mr. J's employer indicates that Mr. J and his dependents will be eligible to enroll in the employer's group health plan on July 2 (90 days after employment began). The IM worker gives this information to the HIPP Unit as part of the referral.

The HIPP worker determines it would be cost-effective for Mr. J to enroll in his employer's health plan for himself and his dependents. Therefore, Mr. J is required to enroll in the health plan at the first opportunity. If Mr. J fails to enroll in the health plan when he becomes eligible to do so, the HIPP Unit will notify the IM worker to apply a sanction to Mr. J.

2. The HIPP program is paying Ms. L's group health insurance premium. On July 3, Ms. L reports that she lost her job on June 28. Once this information is verified, the IM worker makes a referral to the HIPP Unit.

The HIPP worker determines that Ms. L's employer health plan is still available to her and her dependents for 18 months after her employment ends. However, Ms. L would have to pay the employer's share of the premium.

The HIPP worker determines that the group coverage is still cost-effective, even with the increased premium amount, and notifies Ms. L of the requirement to apply for the continuation coverage within the specified period.

If Ms. L fails to apply, the HIPP worker will send form 470-0409, *Medicaid Notice of Sanction*, to the IM worker, and Ms. L will be ineligible for Medicaid benefits due to a sanction for noncooperation.

When new employment is reported and health insurance is available, make a new referral to the HIPP Unit even if the employee is under sanction for previous noncooperation with HIPP. When making the referral, notify the HIPP Unit that there is an outstanding noncooperation issue. The HIPP Unit will resolve the initial noncooperation issue and notify the appropriate DHS office when to release the sanction.

### **Referral to the HIPP Program Not Needed**

**Legal reference:** 441 IAC 75.21(5) and (9)

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

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

### **Lifting a HIPP Sanction**

Before a HIPP sanction can be lifted, the member must actually cooperate. An "intention" to cooperate in the future does not cure the original noncooperation. The member is not eligible until the member has cooperated and verification is received from the HIPP Unit that cooperation has occurred.

If the member fails to apply for enrollment in a group health plan that has been determined to be cost effective, the member is ineligible until the member enrolls at the next opportunity for enrollment. The same applies if the member disenrolls from a cost-effective plan and does not enroll in another cost-effective plan.

When notice from the HIPP Unit that the member has cooperated is received, lift the sanction as of the date the member actually cooperated with the HIPP Unit. Medicaid is not available for any retroactive month in which an individual or family was under sanction for noncooperation.

### **Cooperation With the Third-Party Liability Unit**

**Legal reference:** 42 CFR 433.145 and 146, 42 CFR 441.20, 45 CFR 433.184; 441 IAC 75.2(249A), 75.4(3), 80.5(2)

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

A member or a person acting on the member's behalf must cooperate with the Third-Party Liability Unit by providing information and verification about any medical or third-party resources.

EXCEPTION: A woman eligible under the Iowa Family Planning Network coverage group can claim good cause for not cooperating with the Third-Party Liability Unit due to confidentiality if she is fearful of the consequences of a parent or spouse discovering that she is receiving family planning services.

Third-party resources include:

- ◆ Medicare
- ◆ Insurance policies
  - Private health insurance
  - Group health insurance
  - Liability insurance
  - Automobile medical insurance
  - Family health insurance carried by an absent parent
- ◆ Railroad Retirement benefits
- ◆ Worker's compensation
- ◆ Veterans Affairs benefits
- ◆ TRICARE (military health insurance)
- ◆ Liability lawsuits (tort action)
- ◆ Orders for restitution as a result of a criminal conviction

The client or person acting on the client's behalf shall complete form 470-2826, *Insurance Questionnaire*, in a timely manner:

- ◆ At the time of application, and
- ◆ When any change in medical resources occurs:
  - During the application process, or
  - On an ongoing case.

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

- ◆ By interoffice mail to RevCol/IME
- ◆ By fax to 515-725-1352
- ◆ By E-mail to [revcol@dhs.state.ia.us](mailto:revcol@dhs.state.ia.us)

If you become aware that a client has been involved in an accident and there may be a potential third-party payer, report this to the IME Lien Recovery Unit:

- ◆ By interoffice mail to RevCol/IME
- ◆ By fax to 515-725-1352
- ◆ By E-mail to [revcol@dhs.state.ia.us](mailto:revcol@dhs.state.ia.us)
- ◆ By phone to 515-256-4620

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

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

### **Failure to Cooperate With Third-Party Liability Unit**

**Legal reference:** 441 IAC 75.4(249A)

When a person fails to cooperate with the Third-Party Liability Unit, a sanction must be applied to Medicaid eligibility. EXCEPTIONS: See [Good Cause for Failure to Cooperate](#).

- ◆ Apply a sanction to an applicant or member who fails to return form 470-2826, *Insurance Questionnaire*, or does not provide proof of the availability of medical resources in another manner.
- ◆ Apply a sanction to a minor parent who does not cooperate. NOTE: Do not apply a sanction to a child when a parent or specified relative fails to cooperate.

A person under sanction counts in the household size.

### **Good Cause for Failure to Cooperate**

**Legal reference:** 441 IAC 75.21(1), 75.2(1)

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

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

## **Cooperation With Investigations and Quality Control**

**Legal reference:** 441 IAC 76.8(249A)

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

Do not sanction children who are continuously eligible. See [8-F](#), Cooperation with DIA and QC.

Department of Inspection and Appeals (DIA) conducts front-end investigations of applicant and member cases. DIA also conducts fraud investigations.

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

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

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

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

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

## **Cooperation With Support Recovery**

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

### **Policy:**

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

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

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

A referral to CSRU will be made only as listed in [8-B, Referrals to CSRU](#).

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

Cooperation with the Child Support Recovery Unit (CSRU) is **not** required when:

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

Referrals are not required when:

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

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

- ◆ Children are living on their own and no adult specified relative is acting in a parental capacity over them.
- ◆ The person is eligible for Iowa Family Planning Network (IFPN).

The following sections contain more information on:

- ◆ [What the client must do to cooperate](#)
- ◆ [Good cause for failure to cooperate](#)
- ◆ [Failure to cooperate](#)
- ◆ [If sanctioned parent decides to cooperate](#)

### **What the Client Must Do to Cooperate**

**Legal reference:** 441 IAC 75.14(1) "a" and "b"

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

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

Special provisions apply to:

- ◆ [Minors living independently of their parents.](#)
- ◆ [Pregnant women under the MAC coverage group.](#)

### **Minors Living Independently of Parents**

**Legal reference:** 42 CFR 435.604, 441 IAC 75.14(249A)

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

However, if the minor is living with an adult who is acting in a parental capacity, request the adult or specified relative to cooperate with CSRU.

In each of these situations, cooperation is required regardless of the existence of a court order for support. Use the "prudent-person" concept as defined in [8-A, Definitions](#), to determine parental capacity.

For children in foster care, first determine the household composition of the child's home before going into foster care. Make an Iowa Collections and Reporting (ICAR) system referral if the social worker has not already done this. See [8-H, Referral for Support Recovery](#).

1. Norm, age 16, applies for CMAP. He lives with two of his friends. The worker does not make a referral to CSRU on Norm's parents. Also, the worker does not require Norm's friends to cooperate with CSRU in obtaining support from Norm's parent, because his friends are not acting in a parental capacity.
2. The households consist of Ms. J; her daughter, Mary, age 17; and Mary's daughter Ann, age 2. This household receives Medicaid under the FMAP coverage group. The worker requires Mary to cooperate in establishing paternity and obtaining medical support from Ann's father. The worker also requires Ms. J to cooperate with CSRU on Mary's absent father.
3. Tim, age 17, receives CMAP-related Medically Needy. Also in the home is Cindy, age 26, Tim's girlfriend. The worker does not require the household to cooperate with CSRU on Tim's parents, because Cindy is not acting in a parental capacity.
4. Mr. J, age 32, receives Medicaid for Larry, his nephew, age 4. The worker requires Mr. J to cooperate with CSRU in obtaining medical support from Larry's parents, because Mr. J is acting in a parental capacity.

### **Pregnant Women Who Are Exempt From Cooperation**

**Legal reference:** 441 IAC 75.14(6)

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

This policy applies even if a man in the pregnant woman's household could be the father of the born or unborn children. However, the pregnant woman must provide enough information for you to determine if the man with whom she lives is the father or must be considered the father.

If the man is not the father, no additional information is required until the postpartum period ends. If the man is or must be considered the father, his income and resources may be counted in the pregnant woman's eligibility determination. Do not make a referral to CSRU until the 60-day postpartum period expires unless the woman requests that a referral be made.

Pregnant women applying for or receiving Medicaid under the MAC coverage group are automatically exempt from cooperation. However, request information about the absent parent of born children for whom they are applying or receiving Medicaid in the same manner as you request information with any other case.

1. Ms. E, age 28 and pregnant, applies for Medicaid for herself and her ten-year-old child. Ms. E lives with Mr. F and has not provided any information on the application about the absent parent of the ten-year-old or the father of her unborn child.

Since Ms. E will be establishing Medicaid eligibility under the MAC coverage group, the income and resources of the father of the unborn child, if in the home, must be counted. If the father of the ten-year-old is in the home, his income and resources must also be considered.

Ms. E states that she does not want to provide any information about the fathers of either her born or unborn child. However, as a condition of eligibility, Ms. E must provide enough information to determine if Mr. F is the father or must be considered the father.

If she does provide enough information, and Mr. F is not the legal or biological father of the born or unborn children, no further information regarding either father is required until her postpartum period expires. Ms. E is informed that cooperation will be required at that time.

2. Same situation as Example 1, except that Ms. E lives with her sister. Since there is not a person in Ms. E's household who could be the father of either child, Ms. E is not required to provide any information about the children's father. The worker informs Ms. E that she will be required to provide such information when her postpartum period expires.
3. Ms. M, age 35, is pregnant and has applied for Medicaid. Also in the home is Mr. T. Ms. M refuses to provide enough information to determine if Mr. T is the father of her unborn child.

Since the worker cannot establish whether Mr. T's income should be considered in determining Ms. M's eligibility, Ms. M's application is denied.

If the pregnant woman cooperates by providing information about the absent parent of her born children and a referral is made to CSRU, the ABC system will indicate to the ICAR system that the woman is exempt from cooperation, even though the pregnant woman has cooperated and a referral has been made.

If the pregnant woman fails or refuses to provide information on the absent parent, notify her that this failure or refusal may make her ineligible for Medicaid coverage at the end of the 60-day postpartum period. Near the end of the postpartum period, issue a written request for the information the woman previously failed or refused to provide.

Allow the woman ten calendar days to provide the information. Deny or cancel Medicaid as instructed under [Failure to Cooperate in Obtaining Support](#) if she does not provide the information. However, the effective date of cancellation cannot be any earlier than the last day of the month in which the 60-day period expires.

If the child remains eligible for Medicaid, CSRU staff will again request the information from the woman that she previously failed or refused to provide. If she again fails or refuses to cooperate, CSRU will notify you, so you can apply the penalties.

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

1. Ms. C, age 18 and pregnant, applies for Medicaid for herself and her two-year-old child. Ms. C's resources do not exceed \$2,000. Her family income exceeds the FMAP limits for a two-member household, but when the unborn child is considered, it does not exceed the FMAP limits for a three-member household.

Therefore, Ms. C and her child would be eligible for Medicaid under the FMAP coverage group. However, Ms. C states that she does not want to provide information regarding the absent parent of her two-year-old child. Since she is required to cooperate as a condition of her eligibility under FMAP, she is not determined eligible under the FMAP group.

Due to Ms. C's noncooperation, there is not an eligible parent in the FMAP group. So, if all other eligibility factors are met, Ms. C's child is determined to be eligible under the CMAP group.

Eligibility for Ms. C is established under the MAC group. Ms. C is informed that, at the end of her postpartum period, she will be required to provide information about the absent parent of the two-year-old child, as well as information about the absent parent of the newborn child.

2. Ms. D, age 32 and pregnant, receives FMAP for herself and her two children, ages 6 and 8, as a household of four. Ms. D refuses without good cause to cooperate with CSRU. CSRU notifies the IM worker.

Ms. D loses Medicaid eligibility as an FMAP member. Her Medicaid eligibility is automatically redetermined under MAC coverage group as a household of four (Ms. D and the unborn child, with the two children as "considered persons"), since cooperation is not an eligibility factor under MAC for pregnant women.

Ms. D's children will be eligible to receive CMAP as a household of four. Ms. D will remain a part of the household size. Ms. D is informed that she will be required to cooperate when her postpartum period expires.

3. Ms. B, age 23 and pregnant, receives Medicaid for herself and her two children, ages 2 and 4, under MAC coverage group. Ms. B provided all information about the absent parent of her born children at the time of application and a referral to CSRU was made.

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

### **Good Cause for Refusal to Cooperate**

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

#### **Policy:**

Each applicant and member has the opportunity to claim good cause for refusing to cooperate with the CSRU in establishing paternity or securing medical support payments.

#### **Procedure:**

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

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

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

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

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

If an **applicant** claims good cause, do not act on the application until the time frame for providing the evidence has lapsed or until the applicant provides the evidence, whichever is sooner. You have good cause to delay the eligibility determination if the time frame for providing the evidence exceeds the 30-day time frame for processing applications.

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

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

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

**Comment:**

The following sections give more information on:

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

**Determining if Good Cause Exists**

**Legal reference:** 441 IAC 75.14(8) and (10)

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

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

### **Evidence of Physical and Emotional Harm**

**Legal reference:** 441 IAC 75.14(8) "c" and "d"

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

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

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

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

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

### **Client Responsibilities When Filing a Good Cause Claim**

**Legal reference:** 441 IAC 75.14(9)"d" and (11)

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

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

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

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

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

### **Worker Responsibilities When a Good Cause Claim Is Filed**

**Legal reference:** 441 IAC 75.14(11)"b"

Immediately notify the child support recovery office whenever a client files a claim for good cause. Enter all information relating to the claim and determination of good cause into the case record.

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

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

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

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

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

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

### **Making the Decision About Good Cause**

**Legal reference:** 441 IAC 75.14(10)

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

Extend the time frame only if:

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

Document any time extensions in the case record.

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

Notify the child support recovery office within two working days after the final decision to deny or grant good cause has been made. Give the child support recovery office the opportunity to participate in any appeal hearing.

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

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

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

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

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

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

### **Failure to Cooperate in Obtaining Support**

**Legal reference:** 441 IAC 75.14(1)“e” and 75.14(2)

Deny or cancel Medicaid benefits for an applicant or member whom CSRU reports failed to cooperate in obtaining medical support or establishing paternity without good cause. Sanction only the parent or specified relative for failing to cooperate.

The sanctioned person continues to count in the household size as a “considered” person. The sanction, by itself, does not create ineligibility for the children in the household.

If the parent of a child who is receiving SSI fails to cooperate and that parent is receiving Medicaid on another case, cancel the parent’s Medicaid coverage.

1. Mrs. M, age 31, is receiving SSI and Medicaid. Without good cause, she fails to cooperate in obtaining medical support for her two children who are receiving Medicaid under the MAC coverage group. Mrs. M’s Medicaid is canceled. However, the children continue to receive Medicaid under MAC if otherwise eligible.
2. Ms. T receives FMAP for herself and one child. Ms. T refuses without good cause to cooperate in obtaining medical support for the child. Ms. T’s Medicaid is canceled for failure to cooperate. The child continues to be eligible but under the CMAP coverage group. Ms. T remains a part of the household size.
3. Mr. M has a child, age 6, who is an SSI recipient. The child’s mother is absent from the home. Mr. M must cooperate in obtaining medical support unless he claims and establishes good cause for noncooperation. If Mr. M does not cooperate, he is not eligible to receive Medicaid for himself. His failure to cooperate does not affect the child’s eligibility for Medicaid.

### **If the Sanctioned Parent Decides to Cooperate**

**Legal reference:** 441 IAC 76.1(5), 76.5(2)

A client who is not receiving Medicaid due to failure to cooperate may be eligible to receive Medicaid when the client indicates a willingness to cooperate. The date the client expresses a willingness to cooperate is the date of application. The parent may contact you or CSRU to express willingness to cooperate. Contact with either office establishes the date of application.

If the client contacts you to indicate a willingness to cooperate, tell the client to contact CSRU. State in writing that the client has ten calendar days to contact CSRU and report back you the name and phone number of the person contacted in CSRU. Make it clear to the client that the client cannot receive Medicaid benefits until the client has followed through on the action required by CSRU.

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

Do **not** take action to approve the parent until CSRU gives notice that the parent has cooperated. Approve the client's Medicaid beginning with the first day of the month that the client has cooperated with CSRU. If the client is otherwise eligible, approve Medicaid up to three months before the date of application.

When the client reports a contact with CSRU, call or send an electronic mail message to CSRU staff to confirm the client's contact. Obtain from CSRU the date the client is scheduled to take the required action to cure the noncooperation issue (e.g., appear for an interview, provide absent parent information).

Contact CSRU the first working day after the date the client was to take the required action. If CSRU informs you the client failed to comply without any explanation, deny the application. If CSRU informs you the client has cooperated, process the application in the usual manner.

If CSRU informs you that the client has rescheduled, consult with CSRU whether or not the client is continuing to make an effort to cure the noncooperation. If CSRU indicates the client is making an effort, continue pending the application through the next scheduled appointment date. If CSRU indicates a lack of effort by the client, deny the application. Repeat these steps, if necessary, when the client requests additional extensions.

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

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

When the parent expresses a willingness to cooperate before the effective date of the parent's loss of Medicaid, notify CSRU. When CSRU notifies you that the parent has cooperated, reinstate the parent's Medicaid.

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

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

On December 10, Mrs. A calls the IM worker and expresses her willingness to cooperate. On December 26, CSRU notifies the IM worker that Mrs. A has cooperated. The IM worker reinstates Mrs. A's Medicaid effective January 1.

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

## **Residency**

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

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

How these factors affect residency is explained in this section. See [Nonfinancial FMAP-Related Eligibility: Residency](#), for additional policies specific to FMAP.

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

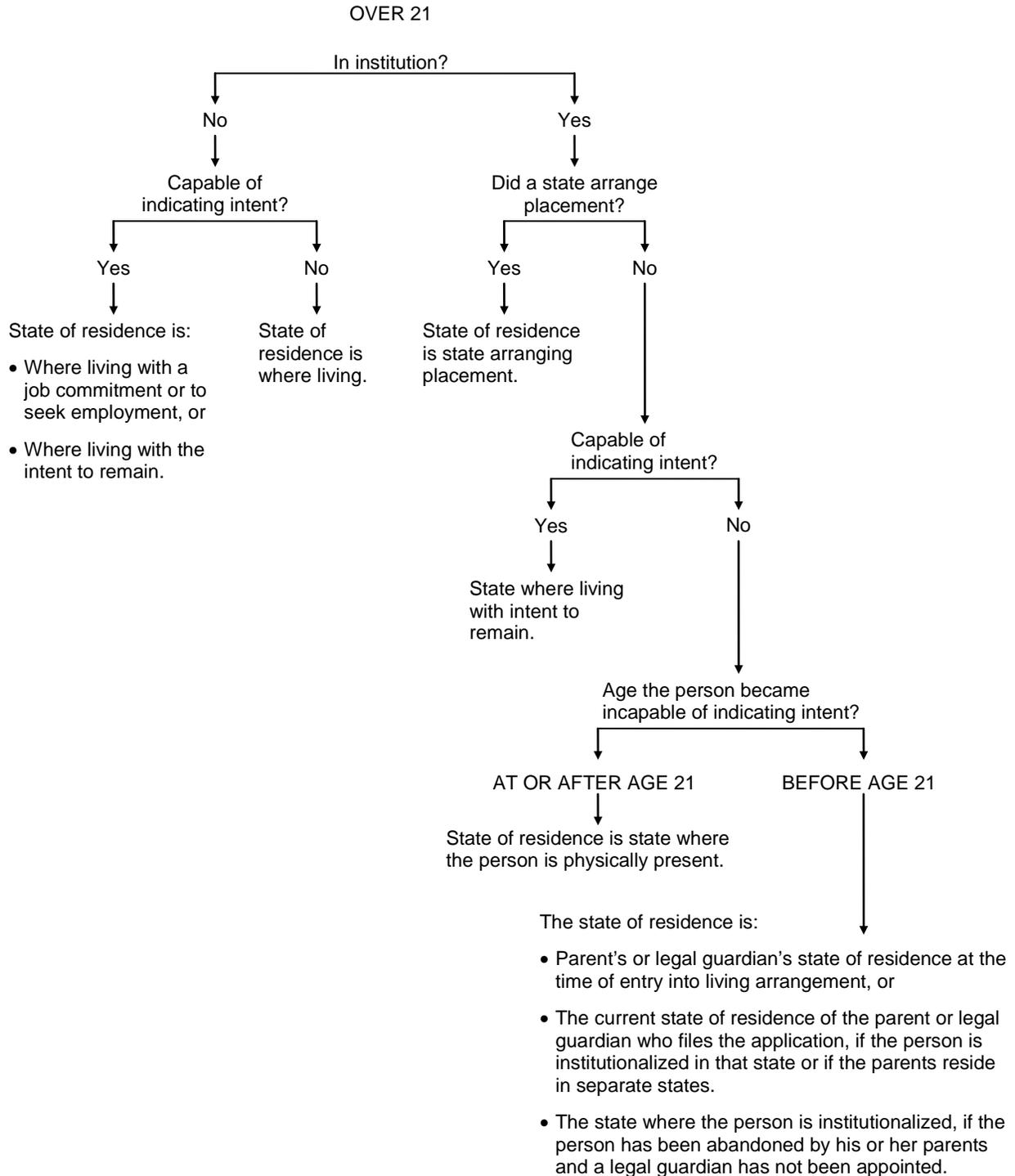
If two or more states cannot resolve a disagreement about which state is a person's state of residence, the state where the person is physically located is the state of residence. Before approval in Iowa, a person receiving care in another state must take all steps available to obtain Medicaid in that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

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

The discussion of residency policies is organized as follows:

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

**Determining Residency for Persons Aged 21 or Over**



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

**Not in an Institution**

**Legal reference:** 441 IAC 75.10(2)"a"(1)

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

Capacity	State of Residence
Capable of expressing intent	State where the person is living: <ul style="list-style-type: none"> <li>◆ With a job commitment or seeking employment. (See <a href="#">Living in Iowa for Employment Purposes.</a>)</li> <li>◆ With intent to remain there permanently or indefinitely. (See <a href="#">Intent to Live in Iowa.</a>)</li> </ul>
Not capable of expressing intent	State where the person is living (i.e., physically present).

**In an Institution**

**Legal reference:** 42 CFR 435.403, 441 IAC 75.10(2)"a"(2)

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

When a state arranged placement, the state of residence is the state making the placement. See [State Placement.](#)

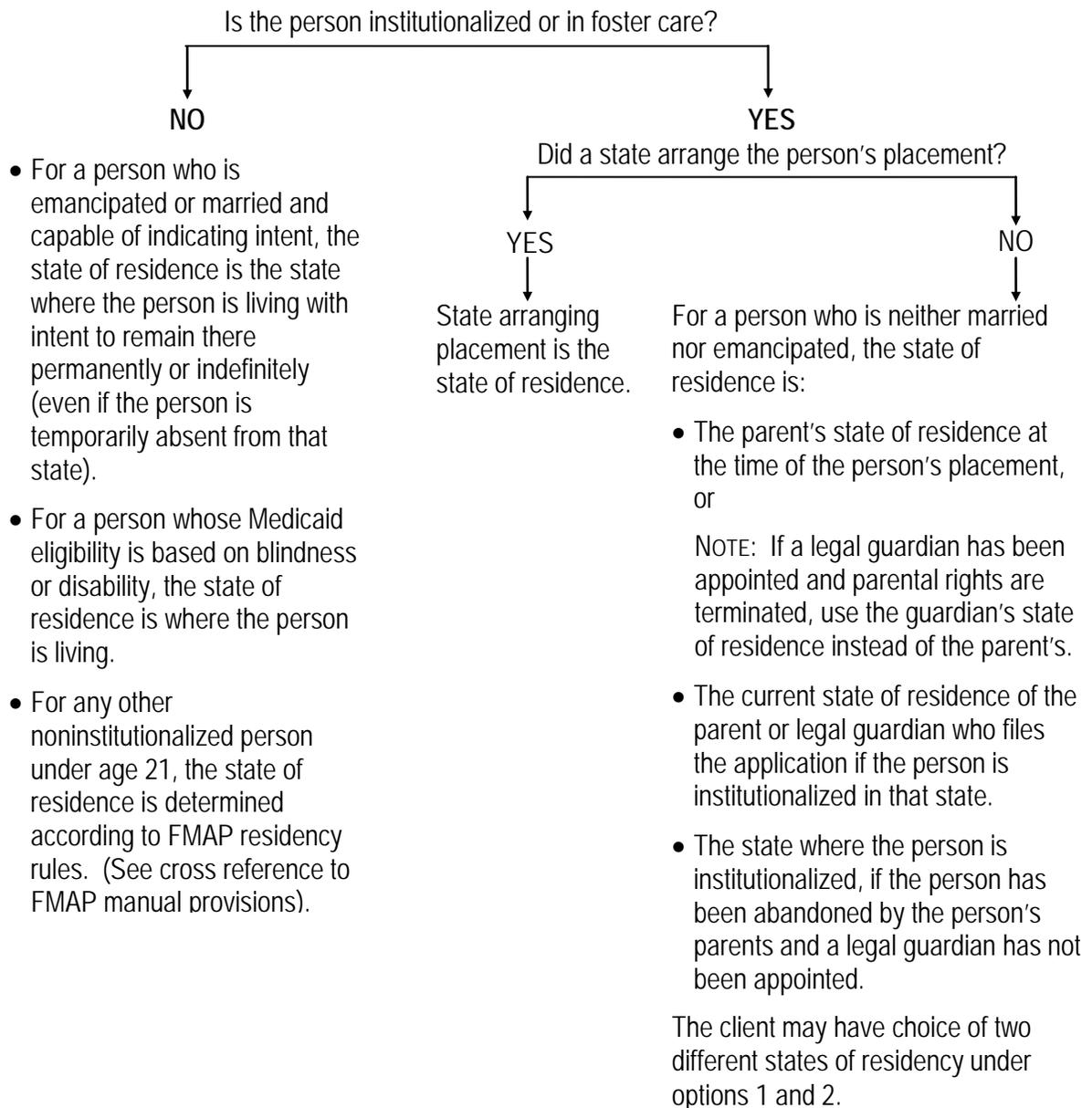
When a state did **not** make the arrangement, state of residence is determined by whether the person is capable of expressing intent as explained in the following chart. See [Incapability of Expressing Intent.](#)

<b>Capacity</b>	<b>State of Residence</b>
Capable of expressing intent	State where the person is living with intent to remain there permanently or indefinitely. See <a href="#">Intent to Live in Iowa</a> . (If the person was a resident of another state before being institutionalized in a second state, and the person intends to return to the first state, the state of residence is the first state.)
Not capable of expressing intent	<ul style="list-style-type: none"> <li>◆ If the person was 21 or older when the person became incapable of expressing intent, state where the person is physically present.</li> <li>◆ If the person was under 21 when the person became incapable of expressing intent:               <ul style="list-style-type: none"> <li>• The parent's or legal guardian's state of residence at the time of placement; or</li> <li>• The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state, or if the parents reside in separate states; or</li> <li>• The state where the person is institutionalized, if the person has been abandoned by the person's parents and a legal guardian has not been appointed.</li> </ul> </li> </ul>

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

## **Determining Residency for Persons Under Age 21**

### UNDER 21



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

### **Not in an Institution or in Foster Care**

**Legal reference:** 441 IAC 75.10(2)"b"

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

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

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

Once adopted, the baby's residency is that of the adoptive parents.

- ◆ For any other noninstitutionalized person, use FMAP residency rules to determine state of residency. See [Nonfinancial FMAP-Related Eligibility: Residency](#).

### **In an Institution or in Foster Care**

**Legal reference:** 441 IAC 75.10(2)"b"(4) and 75.10(2)"c"

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

- ◆ If a state arranged placement, the state of residency is that state. However, a Title IV-E-eligible child placed out of state by DHS is eligible for Medicaid from the other state. A Title IV-E-eligible child placed in Iowa by another state is eligible for Iowa Medicaid.

- ◆ If a state did **not** arrange the placement, the state of residence for an institutionalized person under 21 is:
  - The parent's or legal guardian's state of residence at the time of placement, or
  - The current state of residence of the parent or legal guardian who files the application, if the person is institutionalized in that state, or
  - The state where the person is institutionalized, if the person has been abandoned by the person's parents and a legal guardian has not been appointed.

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

### **Living in Iowa for Employment Purposes**

**Legal reference:** Iowa Code Section 249A.3, 42 CFR 435.403, 441 IAC 75.10(2)"a"(1)

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

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

This provision applies even if:

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

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

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

### **Intent to Live in Iowa**

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

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

Following is a list of factors to consider:

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

### **Temporary Absence**

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

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

### **Incapability of Expressing Intent**

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

A person is considered incapable of expressing intent if:

- ◆ The person has an IQ of 49 or less or has a mental age of 7 or less, or
- ◆ The person has been declared legally incompetent by a court, or
- ◆ Medical documentation from a physician, psychologist, or other person licensed by the state in the field of intellectual disability indicates the person is incapable of expressing intent.

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

### **State Placement**

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

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

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

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

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

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

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

### **Eligibility in Out-of-State Medical Institutions**

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

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

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

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

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

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

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

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

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

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

### **Intent to Return to Iowa From an Out-of-State Facility**

**Legal reference:** 441 IAC 75.10(2)"a"(4)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Guidelines for Discharge Planners**

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

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

The Iowa Foundation for Medical Care (IFMC) can do a nursing facility search for persons who have difficulty finding a facility. If a hospital discharge planner, local DHS worker, or a family is having difficulty finding a nursing facility, the IFMC Clearing House for Individual Placement (CHIP) can be contacted for assistance at 1-(800)-383-2856.

CHIP will send a list of facilities in the area that may be appropriate for the person. If the person needs very specialized care, the list may be for the whole state or if there are several appropriate facilities through the state, the list may be for the area of the state where the person currently lives.

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

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

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

### **Approval for Out-of-State Skilled Care**

**Legal reference:** 441 IAC 81.3(2)“b”

Skilled care in an out-of-state facility requires approval from the Division of Medical Services. Submit requests for payment to the Division of Medical Services, IME, Hoover State Office Building, Des Moines, Iowa 50319-0114. Payment will be approved for out-of-state skilled care when the following criteria are met:

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

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

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

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

### **When a Medicaid-Eligible Person Moves to Iowa**

**Legal reference:** 441 IAC 75.10(2)“d”

#### **Policy:**

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

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

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

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

#### **Procedure:**

The case record must contain:

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

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

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

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

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

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

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

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

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

## **Residents of Institutions**

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

- ◆ [Residents of institutions for mental disease.](#)
- ◆ [Residents of public nonmedical institution.](#)

For policies applicable to residents of medical institutions, see 8-I, [MEDICAL INSTITUTIONS](#).

### **Residents of Institutions for Mental Disease**

**Legal reference:** 42 CFR 435.1008(a)(2), 42 CFR 435.1008(c), 42 CFR 440.160

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

A person who is over age 21 and under age 65 is not eligible for Medicaid when the person lives in an institution for mental disease. EXCEPTION: A person who enters a psychiatric medical institution for children before turning age 22 may receive Medicaid through age 22.

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

When the member is enrolled with the Iowa Plan and enters an MHI as a voluntary admission (not court-ordered), cancel the member's Medicaid, allowing for timely notice.

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

### **Residents of Public Nonmedical Institutions**

**Legal reference:** 20 CFR 416.211, 42 CFR 435.1008-1009; 441 IAC 75.12(249A)

#### **Policy:**

A “public institution” is one that is the responsibility of a government unit or over which a governmental unit exercises administrative control. It includes, but is not limited to, publicly operated penal institutions, jails, work release centers, or wholly tax-supported care facilities, such as some county residential care facilities.

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

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

#### **Procedure:**

The ABC system runs a monthly match with the Social Security Administration to identify clients who are incarcerated. The match includes Medicaid members and people whose income must be considered in determining a household’s eligibility. The *Prisoner Match Report, S470X438-A*, is available on the Mainframe Report Viewer by the 10th of the month.

When a Medicaid member’s name appears on the report, contact the household to verify the information on the report. Do not take any case action based solely on data taken from this match. See [14-G, Prisoner Match Report, S470X438-A](#), for details regarding this report.

Effective January 1, 2012, members who have been incarcerated for 30 days or more and continue to retain their eligibility status while incarcerated are eligible to have their Medicaid benefits suspended for up to 12 months.

Workers will be notified of members who are incarcerated for more than 30 days through the electronic case file process list. See [6-Appendix, RC-0128, \*Suspending Medicaid to Limited Benefits for Incarcerated Individuals Procedure Guide\*](#), for instructions and more information.

An inmate of a public nonmedical institution is not eligible for **SSI-related** Medicaid except as listed under [SSI-Related Eligibility Under Levings Rule](#).

### **Halfway House**

**Legal reference:** 42 CFR 435.1009

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

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

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

### **Inpatient Medical Institutions**

**Legal reference:** 42 CFR 435.1009

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

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

- |
1. Mr. L, an 80-year-old man, entered prison on June 14, 2008, and is serving a ten-year sentence. His Medicaid was canceled when he became incarcerated. Mr. L becomes ill and is transferred to inpatient treatment at a hospital in the community. The hospital is not on the grounds of the prison, and is not owned or operated by the prison.

Mr. L can be eligible for Medicaid for his time as an inpatient of the hospital if he applies and meets all other eligibility requirements. His Medicaid must be canceled again when he returns to the prison.

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

Ms. M is not eligible for Medicaid for her ambulance trip or treatment at the hospital because she was not admitted as an inpatient.

3. Mr. N is a prison inmate. Mr. N was eligible for Medicaid as a disabled person before being incarcerated. Mr. N is injured and must be treated as an inpatient in the prison hospital for several days. Mr. N is not eligible for Medicaid since he was treated in a hospital operated by the penal institution.

### **SSI-Related Eligibility Under Levings Rule**

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

For SSI-related groups, an inmate of a public nonmedical institution is **not** eligible for payment of Medicaid services other than inpatient hospital.

EXCEPTION: Due to a U.S. District Court ruling, *Levings vs. Califano*, residents of public nonmedical institutions can be eligible for SSI (and therefore also SSI-related Medicaid) if they:

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

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

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

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

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

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

## **Sanctions and Appeals**

**Legal reference:** 42 CFR 431.200, 432.220, 433.147, 435.604; 45 CFR 433.184; 441 IAC 7.5(217), 75.2(249A), 75.4(249A), 75.14(249A), 75.21(249A), 76.8(249A), and 80.5(2)

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

- ◆ The Child Support Recovery Unit (CSRU)
- ◆ The Health Insurance Premium Payment (HIPP) Unit
- ◆ The Third-Party Liability (TPL) Unit
- ◆ The Department of Inspections and Appeals (DIA)
- ◆ Quality Control (QC)

When you reinstate or reopen a case that includes a sanctioned person who is “considered,” you will receive a *Notice of Decision* stating why the sanctioned person is not eligible for Medicaid. If you receive an appeal on this *Notice of Decision* due to the sanction that was previously issued, you will need to include the following in your appeal summary:

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

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

Household A consists of Mr. and Mrs. A and their two children, all receiving Medicaid under FMAP. Mr. A begins work, fails to cooperate with the HIPP Unit, and is sanctioned effective January 1. The household size remains four, and Mr. A's income is used in determining Medicaid eligibility for the eligible group. However, Mr. A is not eligible for Medicaid.

In May, the household fails to return the *Review/Recertification Eligibility Document* (RRED), and the case is closed effective June 1. Later in May, the household returns the RRED, and the case is reinstated. Mr. A has not cooperated with HIPP and remains sanctioned. The *Notice of Decision* reinstating Medicaid again mentions that Mr. A is sanctioned for failure to cooperate with HIPP.

The household appeals the *Notice of Decision* reinstating benefits and Mr. A's sanction. When the Appeals Section asks for a copy of the *Notice of Decision*, the local office includes an explanation that the time to appeal the sanction has passed and only the *Notice of Decision* for the Medicaid calculation can be appealed.

In the appeal summary, the worker explains that the original sanction occurred in December and Mr. A's Medicaid eligibility ended effective January 1. The worker includes with the appeal summary a copy of the original *Notice of Decision* sanctioning Mr. A and a copy of the current *Notice of Decision* reinstating the household's Medicaid and leaving Mr. A sanctioned.

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

### **Social Security Number**

**Legal reference:** 441 IAC 75.7(249A) and 9.3(3)

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

- ◆ A child in "newborn" status (see [8-F, Newborn Children of Medicaid-Eligible Mothers](#)), or
- ◆ An unlawful alien, or
- ◆ Any person for whom Medicaid is not being requested or received, such as parents whose children receive Medicaid but who don't receive Medicaid themselves, or
- ◆ A person who is a member of a recognized religious sect who conscientiously opposes applying for or using a social security number.

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

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

The following sections explain:

- ◆ [How clients can apply for a number](#)
- ◆ [Action on an error report](#)

### **How Clients Can Apply for a Social Security Number**

**Legal reference:** 441 IAC 75.7(249A)

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

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

The Social Security Administration will automatically notify the Department when the number has been assigned, if form SS-5 or SS-5-SP is completed as instructed in [14-G, Enumeration](#).

- ◆ The client can apply for a number for a newborn child at the hospital where the child was born, under the "Enumeration at Birth" project.

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

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

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

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

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

### **Acting on an Error Report**

**Legal reference:** 441 IAC 75.7(249A) and 9.3(3)

Social security numbers are verified by the Social Security Administration. When a social security number entered into the ABC system does not match its records, the Social Security Administration generates one of the following reports:

- ◆ Form S470X560, Enumeration Error Report.
- ◆ Form S470X535, Validation Error Report.
- ◆ Form S470X325 B, Bendex Error Report.

If you receive one of these reports, check ABC and the case record to see if the discrepancy is the number, the name, or the date of birth.

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

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

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

## **Nonfinancial SSI-Related Eligibility**

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

- ◆ [Household size.](#)
- ◆ [Presence of age, blindness, or disability.](#)
- ◆ [Department disability determination process.](#)
- ◆ [Disability denial.](#)
- ◆ [Presumptive disability.](#)
- ◆ [Disability determination on reapplications.](#)

### **Household Size**

**Legal reference:** 20 CFR 416.1149, 416.1160, 416.1163, 416.1166, 416.1202;  
441 IAC 75.1(39)“a”(3) and “d”

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

EXCEPTION: For the Medicaid for employed people with disabilities (MEPD) coverage group, determine countable income based on “family size.” Family size is determined as follows:

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

There may be situations where income is deemed to an SSI-related eligible person from an ineligible spouse or parent. Also, in some instances when deeming from an ineligible spouse, an eligible spouse’s income should be compared to the income limits for a couple. See [8-E, Deeming SSI-Related Income](#).

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

1. Child A is disabled and lives with his parents and a sibling, Child B, who is also disabled. To determine Child A's eligibility, his income and resources are compared to the eligibility limits for an individual (although income and resources from his parents may be deemed to him). Child B is also treated as an individual.
2. Mr. L, who is disabled, lives with Child D, who is also disabled. Mr. L's eligibility is determined by comparing his income and resources to limits for an individual. Child D's eligibility is also determined by comparing his income and resources (including any deemed income or resources) to the limits for an individual.
3. Mr. G, who is disabled, lives with Mrs. G, who is not aged, blind, or disabled (an ineligible spouse). Mr. G's worker determines that deeming from Mrs. G to Mr. G is not applicable. Mr. G's eligibility is determined by comparing his income to the limits for an individual. Mr. G's resource eligibility is determined by comparing both spouses' resources to the resource limit for a couple.

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

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

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

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

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

See [8-1, Income and Resources of Married Persons](#), when one or both spouses are in a medical institution.

### **Presence of Age, Blindness, or Disability**

**Legal reference:** 42 CFR 436.540 and 436.541; 20 CFR 416.801 and 416.901; 441 IAC 50.2(1), 50.2(3)"d," 75.1(249A), 75.20(249A), and 76.2(249A); Balanced Budget Act of 1997 (P. L. 105-33)

#### **Policy:**

To be eligible for Medicaid under an SSI-related coverage group, a person must:

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

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

- ◆ The person must be unable to earn income in the amount of "substantial gainful activity" because of a severe physical or mental impairment.  
EXCEPTION: This requirement does not apply to Medicaid for employed people with disabilities.
- ◆ The impairment must be medically documented and must be expected to last continuously for 12 months or result in death.

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

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

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

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

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

**Comment:**

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

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

**Procedure:**

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

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

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

2. If age is verified, process the application. For SSI recipients, determine Medicaid eligibility after checking for:
  - ◆ Medicaid qualifying trusts; and
  - ◆ Transfers of resources; and
  - ◆ Cooperation with Child Support Recovery Unit (CSRU), and
  - ◆ Other health insurance coverage.

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

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

<p>Groups that <b>do</b> require disability determination include:</p> <ul style="list-style-type: none"> <li>◆ Medically Needy (if applying as disabled)</li> <li>◆ Medicaid for Employed People with Disabilities</li> <li>◆ Medicaid for Kids with Special Needs</li> <li>◆ Ill and handicapped waiver</li> <li>◆ Physical disability waiver</li> <li>◆ Persons applying for the following HCBS waivers under <b>SSI-related</b> eligibility                             <ul style="list-style-type: none"> <li>● AIDS/HIV waiver</li> <li>● Brain injury waiver</li> <li>● Children's mental health waiver</li> <li>● Intellectual disabilities waiver</li> </ul> </li> </ul>	<p>Groups that <b>do not</b> require disability determination include persons applying for the following HCBS waivers under <b>FMAP-related</b> eligibility:</p> <ul style="list-style-type: none"> <li>◆ AIDS/HIV waiver</li> <li>◆ Brain injury waiver</li> <li>◆ Children's mental health waiver</li> <li>◆ Intellectual disabilities waiver</li> </ul>
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2. For all applicants claiming disability, determine whether the presence of disability can be verified through receipt of federal benefits by checking SDX and IEVS. For specific situations, see the following chart:

Situation	Action
The applicant is under 65 and gets SSI.	Verify the disability on the SDXD screens.
The applicant is under 65 and gets SSDI.	Verify the disability on the IEVS TPO2 screen.
The applicant is under 65 and gets Social Security survivor benefits.	Verify any disability on the IEVS TPO2 screen. NOTE: A person does not have to be disabled to receive survivor benefits.
The applicant was canceled from SSDI due to losing disability status because of substantial gainful activity (SGA) but remains eligible for extended Medicare benefits.	The only coverage group the applicant can qualify for is MEPD, which skips the SGA requirement. Request a disability determination by the Bureau of Disability Determination Services.

Situation	Action
<p>The applicant qualifies under Railroad Retirement permanent disability benefits.</p>	<p>Send form 470-0461 or 470-0461(S), Authorization for Release of Information, to the Railroad Retirement Board to verify whether the person is getting benefits based on Social Security criteria for disability. Verify the type of RR benefits the person receives. Options include:</p> <ul style="list-style-type: none"> <li>◆ Disabled former railroad worker</li> <li>◆ Disabled adult child</li> <li>◆ Disabled survivor of a railroad worker who is at least age 50</li> </ul> <p>Consider the person disabled for Medicaid if the benefits are received due to permanent disability.</p>
<p>The applicant has a Railroad Retirement benefit due to temporary inability to work.</p>	<p>Disability must be determined, because this person is not considered disabled according to Social Security requirements.</p>
<p>The applicant receives disability income from the Veterans Affairs Department but does not receive disability benefits from Social Security.</p>	<p>Disability may need to be determined, because this person does not automatically qualify as disabled according to Social Security requirements.</p>

3. If age, blindness, or disability is verified, establish the correct Medicaid coverage group and process the application. For SSI recipients, determine Medicaid eligibility after checking for:
  - ◆ Medicaid qualifying trusts; and
  - ◆ Transfers of resources; and
  - ◆ Cooperation with Child Support Recovery Unit (CSRU), and
  - ◆ Other health insurance coverage.
4. If disability is not verified, determine the status of any SSA activity. See [When the Department Follows an SSA Disability Determination](#).
5. If the Department is not required to wait for an SSA disability decision, refer the applicant for a disability determination by the Department. See [When the Department Determines Disability](#).

**Comment:**

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

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

**When the Department Follows an SSA Disability Determination**

**Legal reference:** 20 CFR 416.901-995

**Policy:**

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

- ◆ The Department does not rely on an SSDI denial to deny eligibility for Medically Needy. If the client does not meet the eligibility requirements for any other group except for Medically Needy, then Department must determine disability.
- ◆ The Department will determine disability when the client is claiming that a new disabling condition or a worsening of the original condition has occurred after a final SSA denial.

**Procedure:**

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

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

When SSA-administered disability benefits have been approved, proceed with the Medicaid eligibility determination. Use the following chart to determine what action to take based on the SSA status.

Status	Action
Client receives SSI	Determine Medicaid eligibility after checking for: <ul style="list-style-type: none"> <li>◆ Medicaid qualifying trusts; and</li> <li>◆ Transfers of resources; and</li> <li>◆ Cooperation with Child Support Recovery</li> <li>◆ Other health insurance coverage.</li> </ul>
Client has <b>not</b> applied for SSI but agrees to file an SSI application within ten days.	Notify both SSA and DDS about the concurrent application with form 470-2631, <i>Notice of Pending Medicaid Application</i> , within 15 working days. Possible DDS responses are: <ul style="list-style-type: none"> <li>◆ Have SSA claim and are processing. If so, hold the Medicaid application until the determination has been made.</li> <li>◆ Have SSA claim and recently completed disability determination. If so, check for an SDX message.</li> <li>◆ Do not have a claim. If so, check for an SSI denial for reasons other than disability. If the client has not applied or SSA denies the client for reasons other than disability, proceed with disability determination by the Department. Contact the client to explain that the Department will determine disability.</li> </ul>
Client has never applied for SSI and is <b>not</b> willing to do so.	Proceed with disability determination by the Department if the client meets all other eligibility requirements.
Client <b>has</b> applied for disability benefits.  Initial SSA decision is <b>pending</b> .	Notify both SSA and DDS about the concurrent application with form 470-2631, <i>Notice of Pending Medicaid Application</i> , within 15 working days. Possible responses are: <ul style="list-style-type: none"> <li>◆ Have SSA claim and are processing. If so, hold the Medicaid application until the determination has been made.</li> <li>◆ Have recently completed a disability determination. If so, check for an SDX.</li> <li>◆ Do not have a claim. If so, check for an SSI denial for reasons other than disability. If SSA denies the client for reasons other than disability, proceed with disability determination by the Department. Contact the client to explain that DHS will determine disability.</li> </ul>

Status	Action
<p>Client <b>has</b> applied for disability benefits.</p> <p>SSA denied disability, but decision is <b>not</b> "final."</p>	<p>Deny the Medicaid application based on the SSA denial. Use notice reason 824. See <a href="#">SSA Disability Denial and Appeal Process</a>.</p>
<p>Client <b>has</b> applied for disability benefits.</p> <p>SSA denied disability and decision is "<b>final</b>."</p> <p>Client states there is no new disabling condition and the original has <b>not</b> worsened</p>	<p>Deny the Medicaid application based on the SSA denial. Use notice reason 824. See <a href="#">SSA Disability Denial and Appeal Process</a>.</p> <p>EXCEPTION: For an SSDI denial on a Medically Needy applicant, see <a href="#">8-J, When a Client Has Been Denied Disability Benefits</a>.</p>
<p>Client <b>has</b> applied for disability benefits.</p> <p>SSA denied disability within the last 12 months and decision is "<b>final</b>."</p> <p>Client states the disabling condition has <b>worsened</b> and claims a new 12-month disability period.</p>	<p>Ask the following questions:</p> <ul style="list-style-type: none"> <li>◆ Has the SSA refused to reconsider the claim on the worsening of the condition?</li> <li>◆ Has the client lost eligibility for SSI due to other factors (income, resources, etc.)?</li> </ul> <p>If the answer to both questions is "no," deny the Medicaid application based on the SSA decision and refer the client back to SSA.</p> <p>If the answer to either question is "yes," proceed with disability determination by the Department if the client is otherwise eligible.</p>
<p>Client <b>has</b> applied for disability benefits.</p> <p>SSA denied disability within the last 12 months and decision is "<b>final</b>."</p> <p>Client states there is a <b>new</b> condition that is expected to last 12 months.</p>	<p>Determine whether the client has a different condition than those considered by SSA.</p> <ul style="list-style-type: none"> <li>◆ Request a copy of the denial explanation from the applicant.</li> <li>◆ Compare the information on the denial explanation to the disability information on the Medicaid application.</li> </ul> <p>If there is a new disabling condition, proceed with disability determination by the Department unless the client reapplies at SSA.</p>

**Comment:**

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

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

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

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

**Presumptive Disability**

**Legal reference:** 20 CFR 416.931; 441 IAC 50.2(1) and 75.20(249A)

**Policy:**

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

**Comment:**

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

**Procedure:**

1. The SSA determines presumptive disability for SSI benefits and notifies the Department of this determination.
2. Approve the case under aid type 64-0. Determine eligibility for the retroactive period only **after** the **final** disability determination has been made. Send a *Notice of Decision* to the member using ABC notice reason code 823, which states:

Social Security found \_\_\_\_\_ to be presumptively eligible for disability. Medicaid is approved \*\*/\*\*/\*\* through \*\*/\*\*/\*\*. You will keep getting Medicaid after this date if Social Security finds you are disabled.

Your Medicaid will end if Social Security finds that you are not disabled.

EM 8-C Presumptive Disability; 20 CFR 416.931, 441 Iowa Admin. Code 50.2(1), 75.20(249A), and 75.1(4).

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

If the final decision is that the person was disabled during the retroactive period, issue a manual *Notice of Decision* identifying:

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

4. If SSA determines during the six-month presumptive period that the person is not permanently disabled, or if there is no decision by the end of the six-month period, cancel the case because SSA did not establish permanent disability. Use ABC notice reason code 824, which states:

\_\_\_\_\_ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.

We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.

EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75.1(39)"a"(1), 75.20(2)

### **SSA Disability Denial and Appeal Process**

**Legal reference:** 42 CFR 435.541; 441 IAC 50.1(249), 50.2(1), 75.1(39)"a"(1), 75.20(2), 75.20(249A), and 75.20(2)"a"

#### **Policy:**

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

#### **EXCEPTIONS:**

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

#### **Comment:**

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

Appeal Level	Process
1. Initial determination	The claimant has 65 days from the date the SSA denial is issued to request a reconsideration of the disability determination.
2. Reconsideration	The claimant has 65 days from the date the SSA reconsideration is issued to request an appeal hearing with a SSA administrative law judge (ALJ).
3. Decision by an SSA ALJ	<p>The claimant has 65 days from the date the SSA appeal denial is issued to request a review by the SSA Appeals Council. In some cases the ALJ may not issue a decision, but instead may recommend a decision and send it on to the Appeals Council.</p> <p>Recommended decisions are not considered a new SSI decision for Medicaid purposes until acted on by the Appeals Council.</p>
4. Review by the Appeals Council	<p>The Appeals Council hears cases sent in by the ALJ or upon the request of a claimant. The Appeals Council decides if a request for hearing before the Council will be granted. The Appeals Council can, on its own, take a case from an ALJ before a hearing is conducted.</p> <p>If the Appeals Council denies the request for review, the decision of the ALJ becomes final. A decision on disability by the Appeals Council is the final decision for SSA.</p>

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

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

**Procedure:**

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

Status	Action
SSA decision is not final.	Deny the Medicaid application on the Automated Benefit Calculation (ABC) system using notice reason code 824.
SSA decision on SSDI is final but the applicant could be eligible for <b>Medically Needy</b> coverage	Proceed with Department disability determination. See <a href="#">When the Department Determines Disability</a> .
SSA final decision denies disability based on substantial gainful activity but the applicant could be eligible for <b>MEPD</b> coverage	Check for SDX payment status code N44. Proceed with Department disability determination. See <a href="#">When the Department Determines Disability</a> .
SSA decision is final. The original condition has <b>not</b> worsened and client does not claim a new 12-month period of disability	Deny the Medicaid application on the ABC system using notice reason code 824.
SSA decision is final. Client claims a <b>new</b> disabling condition that will last at least 12 months.	<p>Determine whether the client has a different condition than those considered by SSA.</p> <ul style="list-style-type: none"> <li>◆ Request a copy of the denial explanation from the applicant.</li> <li>◆ Compare the information on the denial explanation to the disability information on the Medicaid application.</li> </ul> <p>If there is a new disabling condition, proceed with disability determination by the Department unless the client reapplies at SSA.</p>
SSA decision has been final for at least 12 months. Client claims a change or deterioration in the disability that is expected to last 12 months.	Proceed with Department disability determination unless the client reapplies with SSA. See <a href="#">When the Department Determines Disability</a> .

Status	Action
<p>SSA decision is final within the last 12 months.</p> <p>Client claims a change or deterioration in the disability that is expected to last 12 months.</p>	<p>Ask the following questions:</p> <ul style="list-style-type: none"> <li>◆ Has the SSA refused to reconsider the claim on the worsening of the condition?</li> <li>◆ Has the client lost eligibility for SSI due to other factors (income, resources, etc.)?</li> </ul> <p>If the answer to both questions is "no," deny the Medicaid application based on the SSA decision and refer the client back to SSA.</p> <p>If the answer to either question is "yes," proceed with disability determination by the Department if the client is otherwise eligible.</p>

**Comment:**

When SSA denies a disability due to substantial gainful activity (SGA), the decision is based on verification that the person has earnings of at least \$1,000 per month from work. The only payment status code on the SDX that means disability was denied due to substantial gainful activity is N44.

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

**When SSA Denies Disability After DDS Disability Approval**

**Legal reference:** 441 IAC 75.20(5)

**Policy:**

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

**Comment:**

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

**Procedure:**

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

<b>Status</b>	<b>Action</b>
DHS receives notification that SSA has denied disability for a person who was approved based on a DDS disability decision.	<ol style="list-style-type: none"><li>1. Continue Medicaid or State Supplementary Assistance for 65 days from the date of the SSA denial.</li><li>2. Enter a system tickler message to track the 65 days.</li><li>3. On the 66<sup>th</sup> day, check to see if an SSA appeal has been filed.</li></ol>
If the member has <b>not</b> filed an appeal with SSA by the end of the 65 days, the SSA decision is a <b>final decision</b> .	Cancel benefits the ABC system with timely notice using reason code 827 (see message below).

Status	Action
<p>If the member appeals the denial within 65 days, the SSA decision is not a final decision.</p>	<p>Continue benefits until there is a final decision from SSA. This could be either:</p> <ul style="list-style-type: none"> <li>◆ A decision issued at the Social Security Administration Review Council level; or</li> <li>◆ The most recent decision that the member does not pursue to the next appeal level by the end of 65 days.</li> </ul>

To cancel the Medicaid case, enter notice reason code 827 into the ABC system:

The Social Security Administration has determined that \_\_\_\_\_ is no longer disabled.

EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75.1(39)“a”(1) and 75.20(2)

**Comment:**

See also:

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

Mr. C is determined eligible for Medicaid in November based on the Department’s disability determination. In April of the following year, Mr. C applies for SSI but on June 5, he is denied SSI as not disabled.

The worker continues Mr. C’s Medicaid eligibility for 65 days until the time to appeal has expired (August 8). As of August 8, Mr. C has not filed an appeal. On August 9, the worker issues a timely notice canceling Medicaid benefits for Mr. C effective September 1.

## **When the Department Determines Disability**

**Legal reference:** 20 CFR 416.202, 416.901, 416.971, 461.972, and 416.973; 441 IAC 75.1(39)“a”(1) and 75.20(249A)

### **Policy:**

The Department must determine an applicant’s disability when the applicant:

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

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

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

### **Procedure:**

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

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

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

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

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

Follow the steps listed below when a DHS determination is required.

Step	Action	Determination	Action
1	IM worker determines if the client engages in substantial gainful activity (SGA). Clients whose current earnings are at or higher than the SGA level are earning too much to meet disability requirements.	Yes, the client engages in SGA	Deny disability.
		No, the client does not engage in SGA	Go to step 2
2	DDS evaluates the client's medical impairments and compares them to a list of qualifying impairments published in federal regulations.	No, severe impairments	Deny Medicaid as not disabled.
		Yes, impairment is listed	Go to step 3
3	DDS staff determines whether the client has an impairment of a severity that meets or equals the severity of impairments listed in the federal regulations.	No, impairment does not meet severity	Deny Medicaid as not disabled.
		Yes, impairment meets severity	Go to step 4
4	DDS staff determines whether the client has the ability to perform past work activities.	Yes, the client can do past work	Deny Medicaid as not disabled
		No, the client cannot perform past work	Go to step 5
5	DDS staff determines whether the client is able to perform other work activities at the SGA level.	Yes, the client can do other work	Deny Medicaid as not disabled
		No, the client cannot perform past work	Approve Medicaid based on disability if client meets all other eligibility requirements

**Comment:**

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

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

The following sections give further instructions on:

- ◆ [Determining substantial gainful activity for an employee](#)
- ◆ [Determining substantial gainful activity for a self-employed person](#)
- ◆ [Submitting medical evidence to DDS](#)

**Substantial Gainful Activity for an Employee**

**Legal reference:** 20 CFR 416.974 and 441 IAC 75.1(39)“a”(1)

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

- ◆ “Significant physical or mental activities” are useful in a job or business and have economic value. Self-care, household tasks, unpaid training, therapy, school attendance, clubs, and social programs **are not** considered SGA.
- ◆ Work may pay either in cash or in kind.
- ◆ The current earnings threshold for determining “substantial” activity is \$1,130.

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

**Comment:**

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

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

**Procedure:**

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

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

Step	Action
Determine average monthly earnings.	Count earnings from employment and self-employment. Determine seasonal income by averaging income over the season to arrive at a monthly countable income. See <a href="#">8-E, INCOME POLICIES FOR SSI-RELATED COVERAGE GROUPS</a> .
Determine excluded earnings.	Do not count: <ul style="list-style-type: none"> <li>• Earnings of volunteers under the Small Business and Domestic Volunteer Acts.</li> <li>• Employer subsidies to an impaired person that are not earned through the person's productivity.</li> </ul> Ask the employer to determine the subsidy. If the employer cannot calculate the subsidy, compare the work to similar work of an unimpaired person, and the value of that work by the prevailing wage scale.
Determine deductions.	Deduct work expenses related to the person's disability. See <a href="#">8-E, Deduction for Impairment-Related Work Expenses</a> .
Compare remainder to \$1,130 per month.	When the countable earnings exceed \$1,130 per month, the applicant does not meet the first requirement of being disabled under SSA standards. Deny Medicaid as not disabled. See <a href="#">When the Department Denies Disability</a> .  When the countable earnings are less than \$300 per month, complete a disability determination, as the client is not engaged in SGA.  When countable earnings are \$300 to \$1,130 per month, proceed to the next tests.

Step	Action
Do the Comparability Test.	Compare the client's work to that of unimpaired people in the area. Look at time, energy, skills, responsibility, pay, and hours. If the work is the same as that done by unimpaired people, the client has SGA and is not disabled.
Do the Worth Test.	<p>Determine if the client's work activity is worth more than \$1,130 per month. If so, the client is engaging in SGA, even if the client's work activity is not comparable to that of an unimpaired person.</p> <p>The value of work in the military must be compared to similar work in a nonmilitary setting. Military wages may continue and the client may be placed on limited duty.</p> <p>Ask your area income maintenance administrator or the DHS SPIRS Help Desk to contact the Bureau of Financial, Health, and Work Supports to determine the actual value of the work.</p>

**Comment:**

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

Mrs. P continues to work at the same job with the same duties (meeting the Comparability Test), but her medical condition has caused her to reduce her work schedule from 40 hours per week to 20 hours per week, which has cut her earnings in half (the Worth Test). Her hourly wage is \$15.00 per hour. Her average monthly pay is \$1,290.00.

The worker determines that Mrs. P does not meet the SGA test for disability for most Medicaid coverage groups because she continues to do the same work and her earnings were over \$1,130.

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

**Substantial Gainful Activity for a Self-Employed Person**

**Legal reference:** 20 CFR 416.975, 441 IAC 75.1(39)“a”(1)

**Policy:**

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

Name of Test:	What this means:
1. Significant services <b>and</b> substantial income  a. Significant services	This test is met if significant services are <b>combined with</b> substantial income.  When a person (with the exception of a farm landlord who rents farmland to another farmer) gives significant services by participating in the following: <ul style="list-style-type: none"> <li>◆ Gets a social security earnings credit on the federal income tax return.</li> <li>◆ Advises or consults with the renter and inspects production periodically.</li> <li>◆ Furnishes a large portion of the machinery and financing.</li> </ul>
b. Substantial income	When a person has: <ul style="list-style-type: none"> <li>◆ Countable income over \$1,130 per month.</li> <li>◆ Countable income that meets the community standard of livelihood for a self-employed person with a similar business.</li> </ul>
2. Comparability of work	If work activities are comparable to that of an unimpaired person in the community engaged in the same or similar business, the person is engaged in SGA.
3. Work activity	If the value of the work is more than \$1,130 per month based on the amount an employer would pay any employee to do the same job, the person engages in SGA.

**Procedure:**

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

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

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

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

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

**Test 1: Significant Services and Substantial Income**

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

### Test 2: Comparability of Work

Evaluate work activity using:

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

### Test 3: Work Activity

Evaluate by determining countable income:

- ◆ A person who earns more than \$1,130 per month meets the criteria for engaging in SGA, which results in not being considered disabled.
- ◆ See the procedures for [Substantial Gainful Activity for an Employee](#).

### Comment:

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

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

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

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

- ◆ Mr. Q is not able to do all the work for his business himself.
- ◆ Mr. Q earns less than \$1,130 per month.
- ◆ Mr. Q's income has dropped significantly from his previous full-time earnings.
- ◆ There is no one else in the local community who builds custom bookcases, so the worker cannot compare Mr. Q's income to the same type of work done by others.

Test 2. Comparability of work:

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

Test 3. Work activity: Mr. Q earns less than \$1,130 per month.

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

**Submitting Medical Evidence to DDS**

**Legal reference:** 441 IAC 75.1(39)"a"(1), 75.20(2)"b"

**Policy:**

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

**Comment:**

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

**Procedure:**

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

<b>Submit to DDS:</b>	<b>Explanation:</b>
Form 470-2465, <i>Disability Report for Adults</i> or Form 470-3912, <i>Disability Report for Children (under 18)</i>	The applicant or the applicant's representative completes the form, which includes a release of information. Check the report to make sure the correct person signed the form, as follows: <ul style="list-style-type: none"> <li>◆ If the release is for mental health information, only an applicant 18 years of age or older or a legal representative can sign the form.</li> <li>◆ If the release is for substance abuse information, only the applicant can sign the form, regardless of age.</li> </ul>

<b>Submit to DDS:</b>	<b>Explanation:</b>
Form 470-2472, <i>Disability Transmittal</i>	<p>This form contains case-related information that helps DDS determine disability.</p> <p>For an MEPD applicant, check the status, "MEPD – SGA not considered" in first step of disability determination.</p>
Form 470-4459 or 470-4459(S) <i>Authorization to Disclose Information to the Iowa Department of Human Services</i>	<p>The release allows DDS to contact sources to get the information needed to determine disability.</p> <p>Send a signed release for each source listed on the applicable <i>Disability Report</i> and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.</p>
Additional records, if available:	<p>This could include:</p> <ul style="list-style-type: none"> <li>◆ Supplemental vocational information.</li> <li>◆ Any information from the Social Security Administration.</li> <li>◆ Copies of medical reports or letters from a provider about the applicant's medical condition from the last 12 months.</li> <li>◆ For an adult applicant, evidence about work activity, even if the work done was not SGA.</li> <li>◆ For a child applicant:             <ul style="list-style-type: none"> <li>• School information</li> <li>• Any work history</li> <li>• Any involvement with vocational rehabilitation or other social services</li> </ul> </li> </ul>
Records about a deceased applicant	<p>Send either:</p> <ul style="list-style-type: none"> <li>◆ Medical records including a note certifying the cause and date of death signed by a medical practitioner, or</li> <li>◆ A death certificate. (When a person dies at home and has no history of medical treatment for the cause of death, a death certificate is required.)</li> </ul>

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

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

**Disability Approved by DDS**

**Legal reference:** 441 IAC 50.1(249), 75.20(2)

**Policy:**

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

**Comment:**

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

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

**Procedure:**

When DDS determines the person is disabled, and all other eligibility requirements are met, approve the Medicaid case in the ABC system with the applicable medical aid type.

### **DHS Responsibility for Disability Review and Redetermination**

**Legal reference:** 42 CFR 435.541; 441 IAC 75.20(4), P. L. 104-193; P. L. 105-33

**Policy:**

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

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

**Comment:**

When disability is established, a date for review of the disability may be established to determine if the person continues to meet the disability or blindness requirements.

Redetermination is required when a disabled child turns 18, since disability must then be determined using adult criteria. This is a separate process from a disability review.

**Procedure:**

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

<b>Member Status</b>	<b>Responsibility for Disability Review</b>
Receiving SSI or SSDI cash benefits	The SSA processes the disability reviews.
Not receiving SSI or SSDI cash benefits	The income maintenance worker must schedule the disability review and initiate the review with DDS.

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

- ◆ [Disability Reviews](#)
- ◆ [Redetermination at Age 18](#)

### **Disability Reviews**

**Legal reference:** 42 CFR 435.541; 441 IAC 75.20(4), P. L. 104-193; P. L. 105-33

#### **Policy:**

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

#### **Comment:**

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

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

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

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

#### **Procedure:**

When the Department is required to complete a disability review, send a request for a disability review by the Bureau of Disability Determination Services (DDS). Schedule the disability review at the Medicaid eligibility review date closest to the review date scheduled by:

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

Use the *Disability Determination Checklist*, RC-0133, as a guide to making the review referral to DDS. Include the following documents in a disability review referral:

<b>Document:</b>	<b>Preparation:</b>
A new form 470-2472, <i>Disability Transmittal</i>	Notify DDS of the need for special review requirements by writing in the "Comment" section of the form: <ul style="list-style-type: none"> <li>◆ For MEPD disregard SGA, or</li> <li>◆ For a child under the standards in effect before enactment of P. L. 104-193.</li> </ul>
The previous form 470-2463, <i>Explanation of Disability Determination</i> , issued by DDS.	If this form is not available, note on the <i>Disability Transmittal</i> the reason it is not included.
<i>Proposed Decision</i> and <i>Final Decision</i>	If disability was approved through an appeal of a Medicaid denial, include a copy of the proposed and final appeal decisions.
A new form 470-2465, <i>Disability Report for Adults</i> , or form 470-3912, <i>Disability Report for Children</i> , if the member is under age 18	Request a new report from the client or the person acting on the client's behalf. Check the report for completeness. Since the form includes a release of information, verify that the correct person signed it: <ul style="list-style-type: none"> <li>◆ If the disability is related to mental health, only a client 18 years of age or older or a legal representative can sign the form.</li> <li>◆ If the disability is related to substance abuse, only the client can sign the form, regardless of age.</li> </ul>
New copies of form 470-4459 or 470-4459(S), <i>Authorization to Disclose Information to the Iowa Department of Human Services</i>	Send a signed release to allow DDS to get information from each source listed on the <i>Disability Report</i> and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.
A complete copy of the previous disability file.	If DHS does not have a copy of the previous disability file because the SSA made the previous disability determination decision, note on the <i>Disability Transmittal</i> the reason the file is not attached.

If DDS notifies you that the member no longer meets disability requirements, follow the procedure under [When the Department Denies Disability](#) to cancel the Medicaid case. (Use ABC notice reason code 817.)

**Redetermination at Age 18**

**Legal reference:** 20 CFR 416.987, IAC 75(20)(249A) and 75.20(4)

**Policy:**

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

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

**Procedure:**

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

<b>Document:</b>	<b>Preparation:</b>
A completed form 470-2472, <i>Disability Transmittal</i>	Note that the SGA step should be skipped, if the redetermination is for the MEPS group.
The previous form 470-2463, <i>Explanation of Disability Determination</i> , issued by DDS.	If this form is not available, note on the <i>Disability Transmittal</i> the reason it is not included.
A completed form 470-2465, <i>Disability Report for Adults</i>	Request the report from the client or the person acting on the client’s behalf. Check the report for completeness. Since the form includes a release of information, verify that the correct person signed it: <ul style="list-style-type: none"> <li>◆ If the disability is related to mental health, only a client 18 years of age or older or a legal representative can sign the form.</li> <li>◆ If the disability is related to substance abuse, only the client can sign the form, regardless of age.</li> </ul>

Document:	Preparation:
New copies of form 470-4459 or 470-4459(S), Authorization to Disclose Information to the Iowa Department of Human Services	Send a signed release to allow DDS to get information from each source listed on the Disability Report and the additional sources of information for children. This includes releases for any doctors who provide care in a hospital.
A complete copy of the previous disability file	If DHS does not have a copy of the previous disability file, note on the Disability Transmittal the reason the file is not attached (such as, the SSA made the previous decision and the file is not available to DHS).

If DDS notifies you that the 18-year-old no longer meets disability requirements, follow the procedure under [When the Department Denies Disability](#) to cancel the Medicaid case. (Use ABC notice reason code 817.)

### **Denial of Medicaid Based on Disability Denial**

**Legal reference:** 441 IAC 75.1(39)“a”(1), and 75.20(2)

**Policy:**

SSI-related Medicaid eligibility can be denied based on a disability determination decision made:

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

**Procedure:**

When the Medicaid denial is based on a denial of disability is from the SSA, deny the application using ABC notice reason code 824, which states:

\_\_\_\_\_ is not blind or disabled. The Social Security Administration denied benefits as you are not disabled at this time.

We are required to follow Social Security's decision. If you are approved for disability benefits at a later date, please tell us within 10 days of the date on your notice from Social Security.

EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75.1(39)"a"(1), 75.20(2)

See the following sections for more procedures:

- ◆ [When the Department Denies Disability](#)
- ◆ [Appeal of a Medicaid Denial Based on a Disability Denial](#)
- ◆ [When SSA Denial Is Reversed in an SSA Appeal](#)

### **When the Department Denies Disability**

**Legal reference:** 441 IAC 50.1(249), 50.2(1), 75.1(35)"a," 75.1(39)"a"(1), 75.20(2), 75.3(249A), and 75.20(249A)

#### **Policy:**

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

#### **Comment:**

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

#### **Procedure:**

Send the client:

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

For an **applicant**, it is important to enter notice reason code 608 into the ABC system, which states:

...you are not blind or disabled. You will get a separate letter that tells you about the disability decision.

EM 6-B SSA Policies Applicable to All Programs; EM 8-C Presence of Age, Blindness, or Disability; EM 8-J SSI-Related Medically Needy; EM 8-J Age Criteria; 8-J Blindness Criteria; EM 8-J Disability Criteria; 441 Iowa Admin. Code 50.1(249), 50.2(1), 75.1(35)"a," 75.3(249A), and 75.20(249A).

If a member's disability is denied due to a **review** of disability or due to a **redetermination** of disability for an 18-year-old using adult criteria, cancel the Medicaid case using ABC notice reason code 817, which states:

The Department has determined that \_\_\_\_\_ is no longer disabled.

EM 8-C Denial Based on Disability; 441 Iowa Admin. Code 75.1(39)"a"(1) and 75.20(2)

**Comment:**

For more information, see:

- ◆ [Appeal of a Medicaid Denial Based on a Disability Denial](#)
- ◆ [When SSA Denies Disability After DHS Disability Approval](#)
- ◆ [When SSA Denial Is Reversed in an SSA Appeal](#)
- ◆ [Disability Reviews](#)
- ◆ [Redetermination at Age 18](#)

**Appeal of a Medicaid Denial Based on a Disability Denial**

**Legal reference:** 441 IAC 7.8(17A)

**Policy:**

An applicant has the right to appeal a denial of Medicaid based on the determination that the applicant is not disabled, according to the policies and procedures in 1-E, [APPEALS AND HEARINGS](#).

**Procedure:**

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

**Step 1:** Send the appeal request along with a copy of the *Notice of Decision* within 24 hours to the DHS Appeals Section at the following address:

DHS Appeals Section Fifth Floor  
1305 E Walnut Street  
Des Moines, IA 50319-0114

**Step 2:** Within ten calendar days, submit a summary of the action taken to the Appeals Section. Include the following information:

- ◆ The SSI-related coverage groups under which the person is eligible.
- ◆ The reason benefits were denied: either
  - A Social Security Administration (SSA) decision or
  - A DDS decision from a DHS referral.

If benefits were denied based on an SSA decision, include:

- ◆ The date of the decision.
- ◆ Proof of the SSA denial of disability

**Step 3:** If the disability determination was done by DDS for DHS, send a complete copy of the disability file to each of the following:

- ◆ DHS Appeals Section
- ◆ The appellant
- ◆ The appellant's representative
- ◆ DDS at the following address:

Disability Determination Services Bureau  
Disability Hearing Unit,  
535 SW 7th Street,  
Des Moines, Iowa 50319

NOTE: Keep the original disability determination file with the case record.

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

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

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

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

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

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

If the Final Decision states that the appellant is disabled, and all other eligibility requirements are met, approve Medicaid under the correct aid type. Under this circumstance, if a date is not given for a continuing disability review (CDR), contact the DHS, SPIRS help desk for guidance.

### **When SSA Denial Is Reversed in an SSA Appeal**

**Legal reference:** 441 IAC 50.2(1) and 75.20(249A)

#### **Policy:**

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

#### **Procedure:**

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

If the SSA reverses an SSI denial, approve Medicaid based on the SSI eligibility if all other Medicaid criteria are met. Determine Medicaid eligibility based on the date of the Medicaid application.

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

- ◆ The IEVS Third-Party Query (TPQY) response lists a specific month, day, and year as the onset date for a SSDI (Title II) disability decision. See the last page of the TPQY.
- ◆ The IEVS BEN2 screen shows the date of the onset of disability in the "DISABILITY" field.
- ◆ For SSI, the onset date is usually shown as the first day of the month that disability is established as shown on the SDX screen.

<b>If SSA disability onset date is ...</b>	<b>Then...</b>
Before the date of the Medicaid application ...	Allow applicable retroactive months of eligibility.
On or before the date of the Medicaid denial ...	Allow applicable retroactive months of eligibility.
After the date of the date of the Medicaid denial notice ...	The person is not entitled to Medicaid based on the denied Medicaid application. The person must file a new Medicaid application.

**Comment:**

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

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

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

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

**Reapplications Based on Disability**

**Legal reference:** 20 CFR 416.913, and 416.920, 441 IAC 50.2(1), 75.1(249A), and 75.20(1)

**Policy:**

The Department must re-evaluate the disability status of an applicant each time a Medicaid application is filed.

**Procedure:**

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

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

**Comment:**

See the following sections:

- ◆ [Reapplying After Disability Is Denied](#)
- ◆ [Reapplying After Cancellation for a Nondisability Reason](#)

### **Reapplying After Disability Is Denied**

**Legal reference:** 20 CFR 416.913, and 416.920; 441 IAC 50.2(1), 75.1(249A), and 75.20(1)

#### **Policy:**

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

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

#### **Procedure:**

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

If the person claims there is no change in condition, deny the application. Make entries into the ABC system to deny the application using notice reason code 825, which states:

\_\_\_\_\_ is not blind or disabled. If your medical condition gets worse or you have a new condition, then you may re-apply for Medicaid.

EM 8-C, Reapplying after Disability is Denied; 441 Iowa Admin. Code 75.20(2); 20 CFR 416.913 and 416.920.

#### **Comment:**

Mr. K applies for Medicaid as a disabled person because of arthritis in May 2008. The worker makes a referral to DDS. In July 2008, DDS determines that Mr. K is not disabled due to the arthritis. The worker issues a *Notice of Decision* in July 2008, denying Medicaid as Mr. K is not disabled.

In January 2009, Mr. K again applies for Medicaid. He does not claim a new disabling condition nor a worsening of his arthritis. The worker denies his Medicaid application by entering denial entries into the ABC system using notice reason code 825.

### **Reapplying After Cancellation for a Nondisability Reason**

#### **Policy:**

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

A disability determination is required when:

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

#### **Procedure:**

Follow procedure under [When the Department Determines Disability](#) to complete a referral for disability determination.

### **Nonfinancial FMAP-Related Eligibility**

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

- ◆ [Absence](#)
- ◆ [Age](#)
- ◆ [Determining the eligible group](#)
- ◆ [Residency](#)
- ◆ [School attendance](#)
- ◆ [Specified relatives](#)
- ◆ [Verification of pregnancy](#)

## **Absence**

**Legal reference:** 441 IAC 75.53(4)

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

- ◆ Consider a parent to be absent from the home when the parent is committed, imprisoned, or admitted to an institution.
- ◆ Consider a parent to be absent from the home when the parent is a convicted offender but is permitted to live at home while serving a court-imposed sentence by performing unpaid public work or unpaid community service during the workday.
- ◆ Consider a parent to be absent from the home when the parent is absent because of the performance of active duty in the uniformed services of the United States. "Uniformed service" means the United States Army, Navy, Air Force, Marine Corps, Coast Guard, National Oceanographic and Atmospheric Administration, or Public Health Service.

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

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

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

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

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

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

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

Verify absence only when questionable. If you have to contact the absent parent, also find out whether:

- ◆ Support payments are being made.
- ◆ Medical resources (such as health insurance) are available for the applicant and children.
- ◆ The absent parent is holding or is aware of any resources belonging to members of the eligible group.

You do not need a signed release from the FMAP-related applicant or member to contact the absent parent. CSRU will make the subsequent contacts with the absent parent to establish and enforce liability for medical support.

### **Questionable Cases**

**Legal reference:** 441 IAC 75.54(3)"a"

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

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

- ◆ The case was recently denied or canceled because the "absent parent's" income or resources were considered.
- ◆ The absent parent moves in and out of the home frequently.
- ◆ Living expenses exceed income.
- ◆ The parent's absence occurs when the parent is on strike or during slack times for a self-employment business, etc.

- ◆ There is no verifiable residence for the absent parent.
- ◆ The verifiable residence for the absent parent is very close to the child's home.

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

### **Temporary Absence**

**Legal reference:** 441 IAC 75.53(4)

#### **Policy:**

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

- ◆ Out of the home to secure education or training.
- ◆ In a medical institution for less than a year.
- ◆ Out of the home for another reason and the payee intends that the person will return to the home within three months.

### **Absence for Education**

**Legal reference:** 441 IAC 75.53(4) "b"

#### **Policy:**

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

#### **Procedure:**

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

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

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

### **Absence in a Medical Institution**

**Legal reference:** 441 IAC 75.53(4) "a"

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There is no FMAP eligibility, because the child did not enter the medical institution from the home.

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

### **Absence for Less than Three Months**

**Legal reference:** 441 IAC 75.53(4), 75.12(249A)

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

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

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

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

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

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

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

Mrs. A is eligible to receive assistance for the three children living in the home. The fourth child is not eligible until he returns to the home because his total length of absence from the home is anticipated to be greater than three months.

3. Mrs. B applies for assistance for herself and one child. The child was living with her grandmother for one month. Before this, the child had been living with Mrs. B. The child will be returning to Mrs. B's home in one month.

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

### **Age of Children**

**Legal reference:** 441 IAC 75.54(1)

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

- ◆ [Child Medical Assistance Program \(CMAP\)](#)
- ◆ [Family Medical Assistance Program \(FMAP\)](#)
- ◆ [Mothers and Children \(MAC\) program](#)

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

The following sections explain the requirements for each group.

### **Child Medical Assistance Program (CMAP)**

**Legal reference:** 441 IAC 75.1(15)

Medicaid coverage under the Child Medical Assistance Program (CMAP) is available to people under age 21 regardless of marital status. Refer to [8-F, Child Medical Assistance Program \(CMAP\)](#).

### **Family Medical Assistance Program (FMAP)**

**Legal reference:** 441 IAC 75.54(1)

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

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

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

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

### **Mothers and Children (MAC) Program**

**Legal reference:** 441 IAC 75.1(28)

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

## **Eligible Group**

**Legal reference:** 441 IAC 75.58(1); 75.59(249A)

### **Policy:**

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

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

See [Absence](#) for more information on who is considered to be in the household. The following sections explain:

- ◆ [Who must be in the FMAP eligible group](#)
- ◆ [Who may be in the FMAP eligible group](#)
- ◆ [Determining the number of eligible groups in a household](#)
- ◆ [Household composition examples](#)

### **Procedure:**

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

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

### **Who Must Be in the FMAP Eligible Group**

**Legal reference:** 441 IAC 75.58(1)"a," 75.58(2)

#### **Policy:**

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

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

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

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

Include the following household members in the eligible group:

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

- ◆ The unborn child, when the pregnant mother is counted in the household. If the only child in the family receives Medicaid as a newborn, the mother cannot establish eligibility under the FMAP coverage group unless she requests that the child be removed from newborn status and added to her eligible group. See [Unborn Children](#).
- ◆ A parent who is not eligible for Medicaid due to a nonfinancial reason. The parent must remain a part of the household size as a “considered” person. The parent’s income and resources are counted toward the eligible group. See [8-D, Whose Resources to Count](#), for instructions on how to treat the resources of an ineligible parent.

**Comment:**

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

Child E is not eligible for Medicaid and is not a “considered” person on his parent’s cases.

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

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

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

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

- ◆ [People who are voluntarily excluded](#)
- ◆ [Unborn children](#)
- ◆ [Siblings](#)
- ◆ [SSI recipients](#)

### **People Voluntarily Excluded from the Eligible Group**

**Legal reference:** 441 IAC 75.59(249A)

**Policy:**

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

- ◆ Self-supporting parents of an unmarried minor who are excluded by the minor parent in order to get Medicaid for the minor parent's child.
- ◆ The minor parent when the minor parent's self-supporting parents are voluntarily excluded. However, consider the minor parent's income and resources (if applicable) when determining eligibility for the minor parent's child.
- ◆ A stepparent.
- ◆ The biological parent and any common children when the stepparent is excluded in order to get Medicaid for a stepchild. Use the biological parent's income and resources when determining eligibility for the biological parent's child.
- ◆ An infant who is receiving Medicaid as a newborn child of a Medicaid-eligible mother.
- ◆ Whole, half, or adoptive siblings of eligible children.
- ◆ A person cannot receive Medicaid if that person is ineligible for a nonfinancial reason, such as no social security number, no verification of citizenship or identity, or a sanction.
  - When a **child** is not eligible for a nonfinancial reason, the child is **not** part of the household size. For example, a child is ineligible when no verification of citizenship or identity has been received after the 90-day period of reasonable opportunity. The child's income and resources are **not** counted toward the eligible group.
  - When a **parent** is not eligible for a nonfinancial reason, the parent must remain a part of the household size as a "considered" person. The parent's income and resources are counted toward the eligible group. See [8-D, Whose Resources to Count](#), for instructions on how to treat the resources of an ineligible parent.

**Comment:**

NOTE: Due to ABC system constraints, a system-generated cancellation of a child due to the expiration of the 90-day reasonable opportunity period for verifying citizenship will convert the child to “considered person” status on the ABC system. See [8-E, Ineligible or Voluntarily Excluded Child](#).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

If Child A is voluntarily excluded, she is not eligible for Medicaid under any coverage group. Baby A would be eligible under CMAP as a one-member eligible group if the income of child A and Baby A is within limits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Unborn Children**

**Legal reference:** 441 IAC 75.1(15)"a"

#### **Policy:**

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

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

Count the unborn child in the household size. (See [Verification of Pregnancy](#).) The pregnant mother may be an eligible, considered, or sanctioned person.

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

### **Siblings**

**Legal reference:** 441 IAC 75.1(15)

#### **Policy:**

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

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

**CMAP exceptions:** The following siblings **may** be separate eligible groups:

- ◆ An unmarried parent under age 21 who cares for a child, regardless of the parent’s school attendance.
- ◆ Household members eligible under FMAP or MAC.

**MAC and FMAP-related Medically Needy exception:** Household members eligible under FMAP may be in a separate eligible group.

#### **Comment:**

See [8-F, FMAP-Related Coverage Groups](#), and [8-J, DETERMINING THE COVERAGE GROUP](#), for more information on determining the eligible group.

### **SSI Recipient**

**Legal reference:** 441 IAC 75.58(1)

#### **Policy:**

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

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

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

### **State Supplementary Assistance Recipient**

**Legal reference:** 441 IAC 50.2(1)

#### **Policy:**

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

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

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

Mr. H receives SSDI income and qualifies to receive State Supplementary Assistance cash support for his dependent wife. The couple has four-year-old twins. The family applies for Medicaid.

Mr. H is not considered to be a part of the FMAP household because he is a State Supplementary Assistance recipient. Mrs. H and the two children are considered together for FMAP-related Medicaid.

### **Who May Be in the FMAP Eligible Group**

**Legal reference:** 441 IAC 75.58(1)

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

- ◆ [Incapacitated stepparents](#)
- ◆ [Stepparents who are not incapacitated](#)
- ◆ [Needy specified nonparental relatives](#)
- ◆ [Needy specified relatives and parents](#)

#### **Incapacitated Stepparent**

**Legal reference:** 441 IAC 75.58(1)“b”(3)

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

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

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

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

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

### **Verifying Incapacity**

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

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

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

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

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

### **Nonincapacitated Stepparent**

**Legal reference:** 441 IAC 75.58(1)“b”(4)

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

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

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

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

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

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

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

### **Needy Nonparental Specified Relative**

**Legal reference:** 441 IAC 75.58(1) "b"(1)

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

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

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

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

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

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

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

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

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

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

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

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

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

### **Needy Specified Relative and Parent**

**Legal reference:** 441 IAC 75.58(1) "b"(2)

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

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

Ms. A and her child are on FMAP. Ms. A is in an auto accident and is hospitalized. She will be unable to care for her child until she has recovered. Ms. A's mother moves into the home to take care of her grandchild in the interim.

Even though Ms. A remains in the eligible group as an FMAP member, Ms. A's mother, if needy, may be added to the eligible group for as long as she acts as the child's caretaker.

### **Defining the Number of Eligible Groups in a Household**

**Legal reference:** 441 IAC 75.55(249A), 75.58(1)

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

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

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

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

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

- ◆ [Parents and married couples](#)
- ◆ [Minor parents](#)
- ◆ [Nonparental specified relatives](#)

### **Parents and Married Couples**

**Legal reference:** 441 IAC 75.55 (249A); 75.58(1)

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

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

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

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

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

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

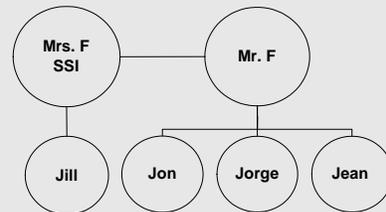
Ms. G has one child and Mr. S has one child. They are living together but are not married. FMAP eligibility is determined for two separate eligible groups.

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

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

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

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



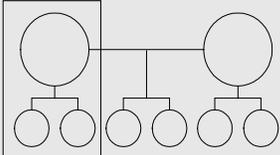
- a. Mrs. F requests Medicaid for Jill only. Because the F's have no common children, the eligible group can be a household of one for Jill. Mr. F is a stepparent and any income he has would first be diverted for his and his children's needs before being used for Jill's eligibility.
- b. Mr. F requests Medicaid for himself, Jon, Jorge, and Jean only. Because the F's have no common children, the eligible group can be a household of four: Mr. F, Jon, Jorge, and Jean. Mrs. F's income is exempt since she's receiving SSI. Jill is not a required household member since she's not a sibling to Mr. F's children.

- c. Mr. and Mrs. F request Medicaid for everyone in the household. Because everyone wants Medicaid and the parents are married, the family has two eligible groups. Mrs. F is a household of one, since she receives SSI. Mr. F, Jill, Jon, Jorge, and Jean are a household of five because they all want Medicaid.
- d. The household size could be reduced if the Fs want to exclude any of Mr. F's children voluntarily. Those children would not be eligible for any other Medicaid coverage group. If the children were voluntarily excluded due to income or resources, they would be referred to **hawk-i**.

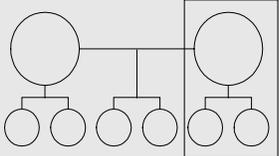
A married couple, their respective own children, and their common children are one eligible group.

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

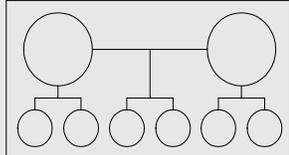
- ◆ The mother could apply for her two children if she excludes the common children.
- ◆ The father could apply for his two children, if he excludes the common children.
- ◆ Both could apply for the entire household.



3-member household  
Option 1



3-member household  
Option 2



8-member household  
Option 3

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

### **Minor Parents**

**Legal reference:** 441 IAC 75.54(2), 75.55(249A), 75.58(249A),  
75.59(249A)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Ann is 16 years old. She has a baby and lives with her mother, Mrs. Z, who receives FMAP for Ann and the baby. In December, Ann fails to cooperate with CSRU.

Ann is sanctioned and canceled from Medicaid. However, the household remains a three-member household.

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

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

See [8-E, Minor Parents and Minor Pregnant Women](#).

### **Nonparental Specified Relative**

**Legal reference:** 441 IAC 75.58(249A)

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

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

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

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

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

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

3. A grandmother who is needy applies for herself and two grandchildren. The IM worker determines that the grandmother is needy based on a household size of one.

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

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

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

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

Do not include children in foster care in the eligible group with the family at home, regardless of the length of the foster child's absence. See 8-H, [FOSTER CARE AND SUBSIDIZED ADOPTION](#), when examining Medicaid eligibility for a foster child.

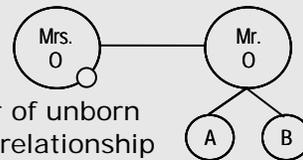
Children in subsidized adoption may be an eligible group of their own or may be included in the adoptive family's eligible group, whichever is most beneficial. See 8-H, [FOSTER CARE AND SUBSIDIZED ADOPTION](#), when examining Medicaid eligibility for a child in subsidized adoption.

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

### Household Composition Examples

1. Household composition:

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



The household applies for Medicaid for everyone.

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

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

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

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

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

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

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

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

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

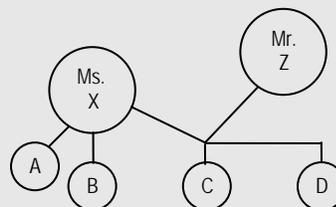
The fact that Mr. O and his children are over income for FMAP has an effect on Mrs. O's eligible group (Mrs. O, the unborn child and Mr. O), but not on Mrs. O's eligibility, because she is continuously eligible.

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

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

3. Household composition:

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



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

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

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

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

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

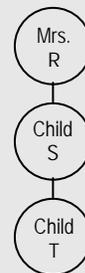
Ms. X and her two children can be eligible under FMAP if countable income is within FMAP limits for a three-member eligible group and all other eligibility factors are met. Mr. Z is a stepparent to this group and his income and resources are considered accordingly.

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

Ms. X's children can be eligible under CMAP if countable income is within the limits for a two-person eligible group (Child A and Child B) and all other eligibility factors are met. Ms. X's income is counted in the eligibility determination. Neither Ms. X nor Mr. Z would be eligible for Medicaid under any other coverage group.

5. Household composition:

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



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

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

6. Household composition:

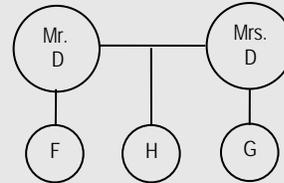
Mr. D

Mrs. D

Child F, age 8, Mr. D's child from a previous relationship

Child G, age 10, Mrs. D's child from a previous relationship

Child H, age 5, common child



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

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

7. Household composition:

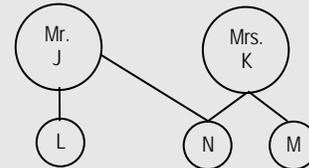
Mr. J

Ms. K

Child L, age 8, Mr. J's child from a previous relationship

Child M, age 10, Ms. K's child from a previous relationship

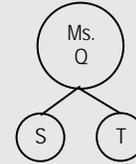
Child N, age 5, common child



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

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

8. Household composition:  
Ms. Q  
Child S, age 16  
Child T, age 19

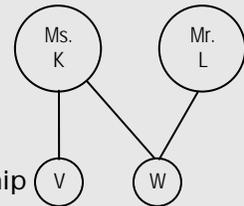


The household applies for Medicaid for everyone.

There are two separate eligible groups. Ms. Q and Child S can be eligible under FMAP if countable income was within limits for a two-person eligible group and all other eligibility factors are met. Child T can be eligible under CMAP as a one-member eligible group.

If the household is over income for FMAP, eligibility is explored under MAC for Child S and under Medically Needy for Ms. Q and Child T. The eligible group size for MAC is two and for Medically Needy is two.

9. Household composition:  
Ms. K  
Mr. L  
Child V, age 13, Ms. K's child from another relationship  
Child W, age 5, common child.



Ms. K and Child V begin receiving Medicaid under FMAP in November. When the application is processed, Mr. L does not want Medicaid. The household chooses to exclude Child W.

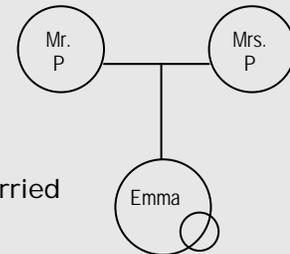
The following April, Mr. L applies for Medicaid and requests retroactive eligibility. Eligibility for the retroactive period can be explored for Mr. L since he was not *excluded* from the eligible group in November. His income and resources were not counted in the eligibility determination due to the voluntary exclusion of Child W.

Mr. L can be eligible during the retroactive period under FMAP if countable income was within limits for a one-person eligible group and all other eligibility factors are met.

If the household chooses to continue to exclude Child W, Mr. L can also be eligible under FMAP for the month of application and ongoing months if countable income is within limits for a one-person eligible group and all eligibility factors are met.

If the household no longer chooses to exclude Child W, the earliest month in which eligibility for Child W can be established is the month following the month of application. At that time, the eligible group size increases to four. However, in determining eligibility for Mr. L for the retroactive period and for the month of application, Mr. L's eligible group size is one.

10. Household composition:  
Mr. P, self supporting  
Mrs. P, self supporting  
Emma, 18 and pregnant



Emma applies for Medicaid. She has never been married and is not in high school.

Mr. and Mrs. P's income exceeds CMAP income limits for a three-person and a four-person household. Since Mr. and Mrs. P are self-supporting, eligibility is examined under MAC. Emma is considered a child under MAC, since she's 18 and has not been married.

However, because Emma is not a minor and she is pregnant, she is eligible for Medicaid under MAC as a two-person household. Her parents' income is not counted when determining her eligibility.

## **Residency**

**Legal reference:** 441 IAC 75.53(1) and 75.53(2)

A person must be a resident of Iowa to be eligible for Medicaid under FMAP-related coverage groups. Generally, a child is considered a resident of the state in which the parent or other person responsible for the child's care, custody, and control resides.

Consider a person a resident of Iowa if the person meets one of the following criteria:

- ◆ The person is living in Iowa voluntarily, intends to make a home in the state, and is not in Iowa for a temporary purpose.
- ◆ The person does not receive assistance from another state and entered Iowa with a job commitment or to seek employment, whether or not the person is currently employed. In this case, the child is a resident of the state in which the caretaker is a resident.

Do not consider a person a resident of Iowa if:

- ◆ The person is in Iowa solely on vacation. (For example, the person lives in another state but spends the summer in Iowa.)
- ◆ The person is living in Iowa on a temporary basis. (For example, the person is a child who lives in Iowa only to attend school but whose parents continue to maintain a home for the child outside the state and claim the child as a dependent for income tax purposes. This may include foreign students.)

Children who meet citizenship requirements are eligible for FMAP-related Medicaid only if all other eligibility requirements (including state residency) are also met.

Mr. and Mrs. G, both age 25, are in the U.S. on currently valid nonimmigrant student visas. Their daughter, age 2, is a U.S. citizen. They apply for Medicaid and the worker determines that Mr. and Mrs. G do not meet Iowa residency requirements. The entire family, including the U.S. citizen child, is ineligible for Medicaid due to not being residents of Iowa.

Residency continues until the client has left the state. When a person temporarily leaves the state but plans to return, do not cancel assistance based on residency requirements.

Continued maintenance of a home in Iowa or the fact that most household goods remain in the state is considered evidence of temporary absence from Iowa. However, the acceptance of employment or the enrollment of the child in school in the other state is an indication that Iowa residency may have been abandoned. Discuss with your supervisor any case in which you find Iowa residency questionable.

### **Strikers**

A "strike" is defined as a concerted stoppage, slowdown, or interruption of operations by employees. This includes a stoppage because a collective bargaining agreement has expired. Being on strike has no effect on FMAP eligibility. When an applicant or member is participating in a strike, do not deny or cancel the case. Continue to process the case as normal.

### **School Attendance**

**Legal reference:** 441 IAC 75.54(1)

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

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

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

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

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

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

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

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

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

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

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

### **Specified Relatives**

**Legal reference:** 441 IAC 75.55(1)

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

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

- ◆ Father, adoptive father
- ◆ Mother, adoptive mother
- ◆ Grandfather, grandfather-in-law (the subsequent husband of the child's natural grandmother, i.e., step grandfather), adoptive grandfather
- ◆ Grandmother, grandmother-in-law (the subsequent wife of the child's natural grandfather, i.e., step grandmother), adoptive grandmother
- ◆ Great-grandfather, great-great-grandfather
- ◆ Great-grandmother, great-great-grandmother
- ◆ Stepfather, but not his parents
- ◆ Stepmother, but not her parents
- ◆ Brother, brother-of-half-blood, stepbrother
- ◆ Brother-in-law, adoptive brother
- ◆ Sister, sister-of-half-blood, stepsister
- ◆ Sister-in-law, adoptive sister

- ◆ Uncle, aunt (of whole or half blood)
- ◆ Uncle-in-law, aunt-in-law (the spouse of the child's natural uncle or aunt)
- ◆ Great uncle, great-great-uncle
- ◆ Great aunt, great-great-aunt
- ◆ First cousins, nephews, nieces

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

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

The following sections give more information on:

- ◆ [Determining who the natural father is.](#)
- ◆ [Determining if a common-law marriage exist.](#)
- ◆ [Determining if a child lives with a specified relative.](#)

### **Determining the Natural Father**

**Legal reference:** 441 IAC 75.55(1)"b"

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

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

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

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

The “biological father” is the male responsible for the conception of the child. The “legal father” is the male considered the father under Iowa law. When the child’s biological father is someone other than the child’s legal father, consider the legal father to be the parent. Do so until the court establishes that the legal father is not the parent of the child. See also [8-B, Referrals to CSRU](#).

Mrs. A, an FMAP member, is separated from Mr. A. She lives with Mr. K and has a child by him. Mr. A is considered the legal father of the child and must be referred to CSRU.

Even though Mr. K is the child’s biological father, he cannot be included in the eligible group until the court declares Mr. A not to be the child’s father. Until such time, Mr. K’s income and resources are not considered (other than any amounts he makes available to the eligible group).

### **Determining if a Common-Law Marriage Exists**

**Legal reference:** Iowa Code Section 252A.3, Subsections 5 and 6

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

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

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

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

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

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

A common-law marriage is a legal and valid marriage. When a common-law marriage exists, treat the adults the same as any other married couple. This means you apply either stepparent or parental policies.

Treat a case as a shared living arrangement when a couple claims not to have a common-law marriage. To initiate the investigation:

- ◆ Make an electronic referral for overpayment recovery. Include an estimated amount the client may owe and the approximate time period involved if the claim of a common-law marriage were substantiated. In agreement with the DIA Division of Investigations, enter a dollar amount of \$1,000 or more so that the referral will receive priority treatment.
- ◆ On form 470-0465, *Overpayment Recovery Supplemental Information*, describe in detail the reason for the referral and the type of evidence that indicates that a common-law marriage exists.

Treat the case as a shared living arrangement until DIA has determined that a common-law marriage exists and has notified you to that effect.

Depending on the findings by the Division of Investigations, you will later revise your copy of the Overpayment Recovery Information Input Summary, either to:

- ◆ Void the claim, if common law **cannot** be substantiated, or
- ◆ Replace the estimated dollar amount and time period with specific entries, if a common-law marriage **is** sustained.

### **Determining if Child Lives With a Specified Relative**

**Legal reference:** 441 IAC 75.55(1), 75.53(4)

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

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

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

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

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

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

The following sections explain this policy in relation to:

- ◆ [Adoption.](#)
- ◆ [Cases where parental rights are terminated.](#)
- ◆ [Cases where parents have joint custody of the children.](#)

### **Adoption**

**Legal reference:** 441 IAC 75.54(2)

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

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

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

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

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

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

### **Parental Rights Terminated**

**Legal reference:** 441 IAC 75.55(1); 75.54(2)

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

### **Joint Custody**

**Legal reference:** 441 IAC 75.54(2)

A child is eligible for FMAP in one home only. When a child spends equal amounts of time in the home of each parent, you must determine with which parent the child is living.

- ◆ If only one parent is interested in applying for FMAP, consider the child as “living with” that parent when determining eligibility.
- ◆ If one parent is receiving FMAP and the other parent applies, advise both parents that FMAP cannot be granted to both parents. The Medicaid application of the parent who applied second cannot be approved, unless the other parent voluntarily agrees to request cancellation of the Medicaid currently received.
- ◆ If both parents apply for FMAP, talk to the parents, together if possible, to determine with which parent the child is “living.” Again, keep in mind, the child can be eligible in one parent’s home only.

If the parents cannot decide who should get FMAP, make the determination yourself. Document the basis for your decision in the case record. Explain the situation in the comment section when referring the absent parent to CSRU.

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

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

### **Verification of Pregnancy**

**Legal reference:** 441 IAC 75.17(249A)

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

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

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

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

Assume that only one unborn child exists unless the woman provides written medical verification to the contrary. If verification is not received, do not cancel Medicaid. Continue to assume that one unborn child exists.

1. Ms. A files an application on July 10. The worker contacts Ms. A she states that she has been pregnant since May and provides medical bills from May and June.

Based on this information, if Ms. A is otherwise eligible, the worker approves Ms. A for Medicaid beginning in May.

2. Ms. Z files an application on December 15. Ms. Z later calls and reports that she is carrying twins. The worker requests medical verification in writing as to how many fetuses Ms. Z is carrying.

Ms. Z does not provide this verification within the time allowed, nor does she request an extension of time. If Ms. Z is otherwise eligible, the worker approves Ms. Z for Medicaid assuming one unborn child.