TABLE OF CONTENTS

These rules (4300s) were repealed effective 1/1/2014 and replaced with Health Benefits Eligibility & Enrollment (HBEE).

Medicaid: Families and Children

4300 Medicaid: Families and Children (07/01/2001, 01-07F)

Individuals under age 21 or pregnant, as well as parents and caretaker relatives of a dependent child, are categorically eligible for ANFC-related Medicaid if they meet the nonfinancial and financial requirements for participation in the Medicaid program. Nonfinancial requirements include general requirements for Medicaid participation (rule 4100), the criteria for one of the coverage groups identified in rules 4312-4320, citizenship (rule 4330), Vermont residency (rule 4331), and living arrangement (rule 4332). Individuals meet the financial requirements (rules 4350–4390) if their resources (rules 4370–4375) and income (rules 4380–4382.4) do not exceed Medicaid limits. Individuals may be able to spenddown excess income or resources and qualify for Medicaid under the ANFC-related medically needy coverage group.

Individuals who meet the criteria in rules 4100 and 4300 are eligible for Medicaid because they meet some or all of the requirements of the Reach Up financial assistance program (formerly Aid to Needy Families with Children), which serves people who are under age 21 or pregnant, as well as parents and caretaker relatives of dependent children. Before terminating Medicaid eligibility of an individual in an ANFC-related coverage group, the department determines the continuing eligibility of individuals under all other applicable Medicaid coverage groups.

Eligibility

4301 Eligibility (07/01/2001, 01-07F)

Section 1931 of the Social Security Act is a part of the federal welfare reform law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), which affected ANFC-related Medicaid. Section 1931 requires states to apply the Aid to Needy Families with Children (ANFC) eligibility criteria in effect July 16, 1996, to individuals currently seeking ANFC-related Medicaid. When the legislature completed its implementation of PRWORA, it renamed the ANFC program Reach Up. The Reach Up eligibility regulations remain the same as those in effect on July 16, 1996, for ANFC-related Medicaid with two exceptions, specified below. In the 4300 rules of ANFC-related Medicaid regulations, wherever the term ANFC is used, it refers to the ANFC criteria in effect July 16, 1996, except where otherwise specifically indicated.

4301.1 Income Maximum (07/01/2001, 01-07F)

The ANFC-related Medicaid income maximum is lower than the Reach Up income maximum. For ANFC-related Medicaid eligibility, the department disregards income equal to the difference between the ANFC payment level in effect on July 16, 1996, and the one currently applied in the Reach Up program. The effect of this income disregard is to bring the countable income of all Reach Up participants to a point at or below the July 16, 1996, payment level. Consequently, families participating in Reach Up will be eligible for Medicaid under rule 4310 A, below.

4301.2 Deprivation Not Required (07/01/2001, 01-07F)

To be eligible for ANFC-related Medicaid, the department no longer requires applicants to establish that a member of the Medicaid group is unemployed, incapacitated or absent.

4310 Categorically Needy Coverage Groups (07/01/2001, 01-07)

To be eligible for ANFC-related Medicaid as categorically needy, individuals must belong to one or more of the following categorically needy coverage groups:

A. Individuals granted Reach Up;

B. Individuals eligible for but not participating in Reach Up; or

C. Members of one of the following groups covered under the conditions specified in rules 4311 through 4320.

4311 Eligible Family Members (07/01/2001, 01-07)

Members of families meet the categorical requirement for ANFC-related criteria when they belong to one or more of the following groups:

A. persons under age 21;

B. pregnant women; or

C. parents or caretaker relatives of dependent children.

A dependent child is either:

- under l8; or
- 18 years old and a full-time student in a secondary school or an equivalent level of vocational or technical training and is expected to complete high school or the equivalent program before reaching his or her 19th birthday.

Children eligible for ANFC-related Medicaid who turn 18 or 19 remain eligible for the full calendar month during which their 18^{th} or 19^{th} birthday occurs.

Family Members Eligible Based on Exceptions

4312 Family Members Eligible Based on Exceptions (07/01/2001, 01-07)

Individuals who would be eligible for ANFC-related Medicaid except for certain conditions, specified below, are also categorically eligible for an ANFC-related Medicaid coverage group.

4312.1 Eligible Except for Earnings (07/01/2001, 01-07)

Medicaid groups who no longer meet the ANFC-related eligibility criteria because a parent or caretaker has new or increased earnings continue to be eligible for transitional Medicaid (TM) for up to 36 months, beginning with the month immediately following the month in which the group becomes ineligible, provided that the Medicaid group:

A. was eligible for and received Medicaid by meeting the ANFC-related Medicaid eligibility criteria in at least three calendar months during the six-month period immediately preceding the month in which the family became ineligible under Reach Up regulations;

B. beginning with the sixth month of TM, has average gross monthly earnings, less actual child care expenses necessary for employment, below 185 percent of the federal poverty level corresponding to the Medicaid group size;

C. continues to include a child, as defined in Reach Up regulations;

D. continues to reside in Vermont;

E. reports earnings and child care expenses quarterly or establishes good cause for failure to report on a timely basis;

F. continues to be eligible under this coverage group without interruption, unless the group becomes ineligible due to failure to meet the quarterly reporting requirement; and

G. includes the parent or caretaker, who remains employed in each month or has good cause for failure to remain employed, as defined in Reach Up regulations.

If the group no longer meets the ANFC-related eligibility criteria solely because of a reason other than new or increased income, the group is not eligible under this coverage group.

If the group fails to meet the quarterly reporting requirement without good cause, as determined by the department, the department shall terminate Medicaid under this TM coverage category. TM shall not be reinstated until the month after the quarterly report is received.

ESD updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds ESD's income maximum, ESD will issue a second increase on April 1.

4312.2 Eligible Except for Child Support (12/01/2003, 03-17)

Medicaid groups who were granted Medicaid but no longer meet the ANFC-related Medicaid eligibility criteria defined above at least partly as a result of collection or increased collection of support on or after August 16, 1984, continue to be eligible for a period of four calendar months if the Medicaid group:

- continues to reside in Vermont; and

- meets the ANFC-related Medicaid criteria in at least three of the six months immediately preceding the month in which such ineligibility begins.

4312.3 Eligible Except for Institutional Status (12/01/2003, 03-17)

Individuals who would meet the ANFC-related eligibility criteria defined above if they were not in a medical institution are eligible for ANFC-related Medicaid.

4312.4 Recipients in August 1972 (12/01/2003, 03-17)

Individuals who would meet the ANFC-related eligibility criteria defined above except for the increase in OASDI benefits under Pub. L. 92-336 (July 1, 1972), were entitled to OASDI in August 1972, and were receiving cash assistance in August 1972 are eligible for ANFC-related Medicaid. This includes persons who would have been eligible in August 1972 but either had not applied for cash assistance or were in a medical institution or intermediate care facility care facility.

4312.5 Eligible Except for Child Care Payments (12/01/2003, 03-17)

Individuals who would meet the ANFC-related eligibility criteria defined above if their work-related child care costs were paid from earnings rather than by a state agency as a service expenditure are eligible for ANFC-related Medicaid.

4312.6 Children Under 18 (Dr. Dynasaur) (07/03/2008, 08-22)

Children under age 18 who would be eligible for ANFC-related Medicaid except that their income or resources exceed the maximums are categorically eligible for Dr. Dynasaur as long as their household income does not exceed 300 percent of the federal poverty level (FPL). There is no resource test under this provision.

Premiums as specified in rules 4160– 4162 are required for the following individuals within this coverage group.

% FPL	**Monthly Dr. Dynasuar Premium Per Household**	
	Family With other Insurance*	Family Without Other Insurance
= 185%	$ 0.00	$ 0.00
> 185% but = 225%	$ 15.00	$ 15.00
> 225% but = 300%	$ 20.00	$ 60.00

* Other insurance must include hospital and physician coverage.

When a single household includes more than one individual eligible for Dr. Dynasaur coverage, the household must pay the highest applicable Dr. Dynasaur premium.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4312.7 Date of this Memo 12/01/2009 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Women fully enrolled in CHAP, Catmount-ESIA or VHAP-ESIA will have their premium assistance continue if they become pregnant and are found eligible for Dr. Dynasaur or Medicaid for pregnant women. The carrier will be the primary insurance and Medicaid will be secondary insurance. The State will pay the ESI and Catamount premiums in full through the post-partum eligibility period. Contact COPS to be sure that the case is set up correctly for continued payments.

Women who are in the process of enrollment when they report a pregnancy will have the process stopped. Medicaid/Dr. Dynasaur will be granted and will be the primary insurance.

Family Members Eligible Based on Exceptions

Children who are members of federally designated American Indian or Alaskan Native tribes, as designated by the federal Bureau of Indian Affairs do not have to pay a premium if their household income is more than 225% but less than or equal to 300% FPL and they have no other insurance. Abenaki is not a federally designated tribe. If other children in the household are beneficiaries but not members of a federally-designated tribe, then the household is still responsible for the premium.

Children qualifying for Medicaid under Dr. Dynasaur and the Disabled Child in Home Care (DCHC/Katie Beckett) coverage group (see rule 4202.3 e) may select which of the two sets of rules that they wish to have determine their eligibility. An applicant applying under the DCHC coverage group who is eligible under Dr. Dynasaur shall receive Dr. Dynasaur coverage while the application is pending.

To assist applicants in making a decision between the two coverage groups, the department will provide the applicant with the requirements specific to the two groups, including the service delivery systems used, the process for determining eligibility, the time for processing applications, and the cost-sharing requirements of beneficiaries in each group.

DCF updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds DCF's income maximum, DCF will issue a second increase on April 1.

4312.7 Pregnant Women (Dr. Dynasaur) (10/01/2007, 07-24)

Pregnant women who would be eligible for ANFC-related Medicaid except that their income or resources exceed the maximums are categorically eligible for Dr. Dynasaur as long as their family income does not exceed 200 percent of the federal poverty level (FPL), without regard to any change in their Medicaid group's income during pregnancy and during the 60-day post-pregnancy period, which ends on the last day of the month during which the 60th day falls. There is no resource test under this provision.

Although a woman may be granted up to three months retroactive coverage if she was pregnant and met all eligibility criteria, she is not eligible for the 60-day post-pregnancy period if she applies after her pregnancy has ended. However, she may be eligible after her pregnancy ends based on another categorical criterion or coverage provision and a different income test.

Pregnant women with income above 185 percent of the FPL but no more than 200 percent are required to pay a monthly premium of $15 for coverage.

When a single household includes more than one individual eligible for Dr. Dynasaur coverage, the household must pay the highest applicable Dr. Dynasaur premium.

DCF updates its income maximums based on the FPL annually on January 1 using a methodology similar to the one employed by the federal government in setting the FPLs. In years when the actual FPL exceeds DCF's income maximum, DCF will issue a second increase on April 1.

4312.8 Other Eligible Family Members (05/01/2010, 10-02)

A. (Newborns) A child born to a woman eligible for and receiving state administered health care assistance, other than premium assistance, on the date of the child's birth is eligible for ANFC-related Medicaid. The child is deemed eligible for twelve months after birth.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4312.8 **Date of this Memo** 07/01/2001 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: What is meant by the term "uninsured" for the breast and cervical cancer treatment group?

ANSWER: Uninsured means the woman has no medical insurance that covers breast or cervical cancer treatment under any conditions. A woman is considered uninsured if she:

- is not covered by Medicare, Medicaid, VHAP, or other medical insurance'
- has exhausted her lifetime limit on benefits for breast and cervical cancer treatment under the plan or coverage, or;
- is in a period of exclusion, such as for preexisting condition or HMO affiliation period.

If a woman will be covered once she meets a deductible, she is considered insured.

(42 U.S.C. §1396a(aa)(4) defines uninsured.)

QUESTION: Must a woman be uninsured for a specific length of time before Medicaid can cover her for breast or cervical cancer treatment?

ANSWER: No.

QUESTION: Can a woman drop her insurance to become eligible for breast or cervical cancer coverage?

ANSWER: Yes. This decision should not be made without legal advice, however. A woman with questions about dropping her current health insurance to establish eligibility for this Medicaid option can receive free legal advice from the Office of Health Care Ombudsman 1-800-917-7787.

B. (Adoption or Foster Care) Children under the age of 21 living in Vermont for whom an adoption assistance agreement is in effect or foster care maintenance payments are being made (by any state) under title IV-E of the Act are automatically eligible for ANFC-related Medicaid. Committed children in the custody of the Family Services Division not IV-E eligible must pass the applicable eligibility tests before their eligibility for Medicaid can be established.

C. (Special Needs Adoption) Children under the age of 21 with special needs for medical or rehabilitative care at the time of adoption who were eligible for Medicaid prior to the adoption assistance agreement other than an agreement under title IV-E are automatically eligible for ANFC-related Medicaid.

D. (Hospice Care) Individuals who would be eligible for Medicaid under the plan if they were in a medical institution (i.e., their income is under the institutional income standard and they meet all other eligibility tests), who are terminally ill, and who receive hospice care in accordance with a voluntary election described in section 1905(o) of the Act.

E. (Breast or Cervical Cancer) Women who have been screened for and found to have breast or cervical cancer, including precancerous conditions, through the National Breast and Cervical Cancer Early Detection Program (NBCCEDP); are under age 65; and are uninsured and otherwise not eligible for SSI-related or ANFC-related Medicaid. Coverage under this category begins following the screening and diagnosis and continues for as long as a treating health professional verifies the woman is in need of cancer treatment services.

Medically Needy Coverage Groups

4320 Medically Needy Coverage Groups (07/01/2001, 01-07)

Individuals who would be members of a categorically needy coverage group except for income or resources that exceed the maximum may be able to qualify for Medicaid under the ANFC-related medically needy coverage group. This program uses the protected income level (PIL) as the income test and the same resource test as the ANFC-related categorically needy Medicaid program. Medical expenses may be used to meet the income test or the resource test according to the spenddown rules specified in rules 4430 – 4454.

Citizenship and Identity

4330 Citizenship and Identity (01/01/2007, 06-48)

The rules for citizenship and identity are in rules 4170 – 4176.

4330.1 Emergency Medical Services (01/01/2007, 06-48)

The rule for emergency medical services is in rule 4177.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4331 **Date of this Memo** 10/18/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Could you summarize the rule regarding state residency?

ANSWER: The only federal regulations regarding state residency which must be followed are in rule which the exception of the following regulation which will be added to rule:

"Where two or more States cannot resolve which State is the State of Residence, the State where the individual is physically located is the State of residence."

The interpretive memos on State Residence have been an attempt to offer guidelines to help you make a decision but should not be rigidly followed. You have latitude to use your judgment regarding state residence in particular situations which are not covered in policy. There are individuals who live in boarder towns, for example, where rigid application of the guidelines could result in hardship for the family. We should be able to work constructively with officials from other states to help families and only rarely depend on the above regulations to establish residency.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4331 **Date of this Memo** 08/02/1994 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: If an individual is eligible for WIC, may we assume he/she meets the state residence requirement for Medicaid?

ANSWER: No. Anyone who is physically present in the state at the time of application is a "resident" for purposes of WIC eligibility. Thus a college student or a Job Corp enrollee who has a home in another state and has no intention of moving to Vermont could be granted WIC but could not be granted Medicaid.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4331 **Date of this Memo** 04/13/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Is there any limit to how long an individual may be absent from the state and still be considered temporarily absent from the state?

ANSWER: No. An individual who has lived in Vermont and intends to return to Vermont and live here either permanently or for an indefinite period of time may be considered a Vermont resident during a temporary absence from the state.

An individual may have an extended temporary absence for many reasons, including obtaining education, obtaining medical treatment, spending the winter in Florida and a sabbatical. As long as the individual has plans to return to Vermont and there is no evidence to the contrary, you may accept his or her statement of intent.

Evidence to the contrary would include such actions as purchase of a home, acceptance of permanent employment and filing income tax forms in the other state.

4331 Residence (10/01/1990, 90-35)

An individual must be a Vermont resident at the time he/she receives a medical service for Vermont Medicaid to pay for that service. The service does not, however, have to be given in Vermont.

Children committed by a Vermont court to the care and custody of the Family Services Division who are not eligible for IV-E are deemed to be residents of Vermont regardless of where they are presently living.

Individuals living in Vermont with the intention of remaining in Vermont permanently or for an indefinite period (including IV-E children found eligible by any state), are considered residents of Vermont with the following possible exceptions:

A. An individual receiving an SSI state supplement is a resident of the state making the payment;

B. An individual who is under age 21, living in an institution, and neither married nor emancipated is a resident of the state where the parent filing the application (or the legal guardian if parental rights have been terminated) lives unless a state agency made the placement (see below);

   NOTE: An individual who is 18, 19 or 20 years of age who files an application on his/her own behalf is considered to be emancipated.

C. An individual who is over 21, living in an institution, and who became incapable of indicating intent before age 21 is a resident of the state where the parent filing the application (or the legal guardian if parental rights have been terminated) lives unless a state agency made the placement (see below);

   NOTE: An individual is considered to be incapable of indicating intent if:

   - The individual has an I. Q. of 49 or less or has a mental age of 7 or less, based on tests acceptable to the mental retardation agency;
   - The individual is judged legally incompetent by a court of law; or
   - Medical documentation obtained only from a physician, psychologist or other person licensed by the state in the field of mental retardation indicates that the individual is incapable of indicating intent.

D. An individual who is not receiving a payment under title IV-E and who is placed in an institution or licensed foster care home by a state agency is a resident of the state making the placement irrespective of the individuals' intent or ability to indicate intent; and

   NOTE: The following actions do not constitute placement by a state agency:

   - providing basic information or
   - providing assistance in locating an institution/foster home if the individual is capable of indicating intent and independently decides to move.

E. An individual who is living in a state under terms of an "interstate agreement" with another state is a resident of the state which agreed to provide Medicaid under the terms of the agreement, i.e. the above rules apply unless two states have an agreement that one state will provide Medicaid to the individual (or group of individuals) for a particular reason.

Residence

Vermont residence is retained until abandoned; i.e., until the person moves outside Vermont with the intent to live permanently or for an indefinite period outside the state.

Temporary absence from Vermont for any of the following purposes does not interrupt or end Vermont residence: visiting, obtaining necessary medical care, or obtaining education or training under a program of Vocational Rehabilitation, JOBS, or higher education.

An individual who is involved in migrant farm work may retain Vermont residence as long as he/she returns every year. An individual who is in the military service may retain Vermont residence as long as Vermont is the residence for payroll and tax purposes.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4332.2 **Date of this Memo** 06/12/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: If an individual is released from a correctional facility to a nursing home for non-emergency care, is he/she still considered to be living in the correctional facility and ineligible for Medicaid?

ANSWER: No. The only time an individual released from a correctional facility is still considered to be living in the facility is when:

- the individual is transferred due to a medical emergency; and
- would otherwise be incarcerated

4332 Living Arrangements (07/01/1992, 92-1)

Individuals or couples living in their own home, in the household of another or living in certain institutions listed in rules 4332.1–4332.3 meet the living arrangement requirement. An institution is an establishment that furnishes food, shelter and some treatment or services to four or more persons unrelated to the proprietor. The financial responsibility of relatives varies depending upon the type of living arrangement. Homeless individuals are deemed to meet the living arrangement requirement. (See section on Financial Responsibility of Relatives.)

4332.1 Public Institution (07/01/1992, 92-1)

A public institution is defined as any institution meeting all of the following conditions:

A. The institution is owned, maintained or operated in whole or in part by public funds; and

B. control is exercised, in whole or in part, by any public agency or an official or employee of that agency; and

C. the institution furnishes shelter and care and can be termed a public institution by reason of its origin, charter, ownership, maintenance or supervision.

Only the following individuals meet the living arrangement requirements if they are living in a public institution:

A. Patients under the age of 21 in the Vermont State Hospital (VSH).

   If a Medicaid recipient is a patient of VSH upon reaching his/her 21st birthday, eligibility may be continued to the date of discharge or his/her 22nd birthday, whichever comes first, upon a finding by the VSH Disability Determination Team that the individual is blind or disabled according to SSI/AABD standards.

B. Patients age 65 or older in the Vermont State Hospital.

C. Residents in an Intermediate Care Facility for the Mentally Retarded.

D. Patients of any age in a facility supported in whole or in part by public funds whose primary purpose is to provide medical care other than the treatment of mental disease, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.

Residence in an institution is determined by the dates of admission and discharge. A person at home in the community on a visiting pass is still a resident of the institution.

4332.2 Private Facility (12/01/1994, 94-42)

A private facility is defined as any home privately owned and operated, or any home or institution supported by private or charitable funds, over which neither the State nor any of its subdivisions has supervision or control even though individuals may be boarded or cared for therein at public expense. Vermont private institutions include boarding homes, fraternal homes, religious homes, community care homes, medical facilities (i.e. general hospitals) and nursing facilities licensed by the State of Vermont.

An individual living in a private facility meets the living arrangement requirement if:

A. the primary purpose of the facility is to provide medical care other than the treatment of mental diseases, including nursing and convalescent care, inpatient care in a hospital, drug and alcohol treatment, etc.; and

B. the facility meets the following criteria:

1. there is no agreement or contract obliging the institution to provide total support to the individual;

2. there has been no transfer of property to the institution by the individual on his/her behalf, unless maintenance by the institution has been of sufficient duration to fully exhaust the individual's equity in the property transferred at a rate equal to the monthly charges to other residents in the institution; and

3. there is no restriction on the individual's freedom to leave the institution.

An individual under the age of 21 or age 65 or older meets the living arrangement requirement if he/she is living at the Brattleboro Retreat. In addition, if an individual is a patient at the facility upon reaching his/her 21st birthday, eligibility continues to the date of discharge (or end of ten day notice period, if later) or his/her 22nd birthday, whichever comes first, as long as the individual continues to meet all other eligibility requirements.

4332.3 Correctional Facility (12/01/1994, 94-42)

Individuals living in a correctional facility, including a juvenile facility are not eligible for Medicaid. Residence in a correctional facility begins on the date of admission and ends when the individual moves out of the correctional facility. An individual transferred from a correctional facility to a medical facility is considered to be still living in a correctional facility.

Individuals who are Medicaid recipients immediately prior to confinement have their Medicaid enrollment terminated as soon as administratively possible, including the provision for advance notice of termination.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4340 **Date of this Memo** 05/15/1988 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: A pregnant woman is eligible for and receiving Medicaid when she miscarries in the fifth month of her pregnancy. Is she eligible for the 60-day post-pregnancy coverage?

ANSWER: Yes. A woman who has been pregnant continues to be eligible for Medicaid for 60 days beginning with the last day of her pregnancy. The circumstances under which the pregnancy ends have no effect on eligibility for the 60-day post-pregnancy coverage.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4340 **Date of this Memo** 08/02/1994 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 01/01/1994

QUESTION: Rule 4343 refers to "caretaker relatives". Now that the caretaker no longer needs to be a relative to be eligible for Reach Up, how does this impact on Medicaid eligibility?

ANSWER: If someone has been granted Reach Up as a needy caretaker, you may grant him or her Medicaid based on Reach Up eligibility and may also find him or her eligible for Transitional Medicaid. However, it is still necessary that an individual be a parent or a caretaker relative to be granted ANFC-related Medicaid.

QUESTION: The rule at 4343 says a parent or caretaker relative is categorically eligible for Medicaid if the child "meets the Reach Up age criteria for a child..." Does this mean that if the only "child" in the household is 18 or older and not in school (or 18 and in school but not expected to complete high school or an equivalent program before reaching his or her nineteenth birthday), the parent or caretaker relative is not eligible for Medicaid?

ANSWER: Yes, unless the parent or caretaker relative is eligible for Medicaid under a different categorical eligibility factor such as pregnancy, blindness, disability or age (65 or older).

4340 ANFC-related Eligibility Factors (12/01/1997, 97-10)

An individual is eligible for ANFC-related Medicaid if he or she is described in one of the groups listed below. The individual must also meet the general eligibility criteria and the financial eligibility criteria. For a listing of Medicaid coverage available under specific situations, refer to the Coverage Groups Section.

Age

4341 Age (12/01/1997, 97-10)

Any person under age 21 is categorically eligible for Medicaid. Categorical eligibility must be reviewed the month prior to the attainment of age 21 so that Medicaid may be closed, with provision for the 10-day notice period, on the anniversary of the date of birth if the individual is no longer eligible.

An applicant's statement of his or her age is acceptable proof of age unless other evidence shows it to be questionable. A birth certificate or baptismal record is the best proof of age, but other records may be submitted if these are not available.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4342 Date of this Memo 01/01/2007 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Applicants/Recipients are no longer required to verify pregnancy unless the pregnancy is questionable.

Pregnancy

4342 Pregnancy (12/01/1997, 97-10)

A pregnant woman is categorically eligible for Medicaid when her pregnancy has been medically verified; she remains categorically eligible for an additional 60 days beginning on the day her pregnancy ends with the following limitation. Although a woman may be granted up to three months retroactive coverage if she was pregnant and met all eligibility criteria, she is not eligible for the 60-day post-pregnancy period if she applies after her pregnancy has ended. She may, however, be eligible after her pregnancy ends based on another categorical criterion or coverage provision and a different income test. Eligibility for the post-pregnancy period ends on the last day of the month during which the 60th day falls.

Parents and Caretaker Relatives

4343 Parents and Caretaker Relatives (12/01/1997, 97-10)

Parents or caretaker relatives are categorically eligible for Medicaid if they live with a child who is under 18 or age 18 and enrolled in a secondary school or an equivalent level of vocational or technical training and expected to complete high school or the equivalent program before reaching his or her nineteenth birthday.

A caretaker relative is defined as a grandfather, grandmother, brother, sister, stepfather, stepmother, stepbrother, stepsister, uncle, aunt, first cousin, nephew, or niece and persons of preceding generations denoted by grand, great or great-great. The term caretaker relative includes blood relations and those of half-blood. It includes adoptive parents, grandparents and siblings, and relatives of adoptive parents. It also includes the spouses of such relatives, even after the marriage is terminated by death or divorce.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4350 **Date of this Memo** 02/01/1993 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 08/11/1989

QUESTION: If a pregnant woman has been found eligible for Medicaid and has an increase in income, do we redetermine her eligibility for Medicaid?

ANSWER: No. A pregnant woman who has been eligible for and receiving Medicaid during her pregnancy remains eligible for Medicaid irrespective of any changes in the countable income of the Medicaid group to which she belongs. She could, however, become ineligible during her pregnancy for some other reason such as moving out of Vermont.

QUESTION: If a woman was eligible for and receiving Medicaid on the day her pregnancy ended, does she have to pass any test in order to remain eligible for Medicaid during the 60-day post-pregnancy period?

ANSWER: No. A woman who was eligible for and receiving Medicaid on the last day of her pregnancy is always eligible for Medicaid during the 60-day post-pregnancy period if she continues to live in Vermont. It does not matter when her pregnancy ended or whether she was eligible under the 200 percent of poverty test or some other income test, there is no test for Medicaid coverage during the 60-day post-pregnancy period.

QUESTION: If a woman applies after her pregnancy ends, may we grant retroactive coverage using the 200 percent of poverty test which applies to pregnant woman?

ANSWER: Yes. However, she is not eligible for the 60-day post-pregnancy period if she applies after her pregnancy has ended. An infant born to a woman granted retroactive coverage must have his/her eligibility for Medicaid determined since the provision at rule 4312.7 applies only if the mother was not only eligible for Medicaid when the child was born but was also receiving Medicaid on the date of the child's birth.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4350 **Date of this Memo** 01/04/1994 **Page** 1 of 2

This Memo: [ ] is New [X] Replaces one dated 04/15/1991

QUESTION: How do we determine a caretaker relative's financial eligibility for Medicaid?

ANSWER: You may include the caretaker relative in the dependent child's (children's) Medicaid group as long as this does not result in the child or children being found ineligible.

If the child or children would be found ineligible, determine the caretaker relative's income and/or resource eligibility for Medicaid as a separate Medicaid group. The caretaker relative has no financial responsibility for the dependent child(ren) so none of his/her income or resources are allocated to the dependent child(ren). If the caretaker relative makes voluntary contributions to the dependent child(ren), these contributions are deducted from the caretaker's income [and treated as unearned income to the child(ren)]. All regular rules (in terms of deductions, exclusions, etc.) apply in determining the caretaker relative's financial eligibility for Medicaid.

QUESTION: What if the caretaker relative has a spouse and/or children of his/her own living in the same household?

ANSWER: The caretaker relative's spouse and/or children constitute a separate Medicaid group.

The caretaker relative has a choice of being included in the dependent child(ren)'s group (unless it makes the child(ren) ineligible) or his/her own family group. All the regular rules of Medicaid, including financial responsibility of relatives, apply to both groups.

Example: Robert and Jane moved to Springfield to live with their aunt and uncle and their two cousins after the death of their parents. Their aunt has been designated the caretaker relative. Robert and Jane each receive $800/mo. from a trust fund. Their uncle is the only other person in the household with income. He works full time and has countable income of $1,000 per month.

Robert and Jane have combined income of $1600 per month which is under the 225% test. The aunt's pro-rata share of the uncle's income is $250 per month. The aunt may not choose to be in Robert and Jane's Medicaid group since her countable income would make Robert and Jane ineligible. Robert and Jane are eligible for Medicaid.

The aunt must be included in the Medicaid group which includes her husband and children as follows:

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4350 **Date of this Memo** 01/04/1994 **Page** 2 of 2

This Memo: [ ] is New [X] Replaces one dated 04/15/1991

Aunt	No Income
Uncle	$1,000 per month
Child 1	No Income
Child 2	No Income
	$1,000 per month which is over the PIL for 4

The aunt is categorically eligible as the caretaker relative and she will be income eligible for Medicaid when she meets a spend-down. Her two children are immediately eligible for Medicaid since total income is under the 225% test. Her husband is not categorically eligible for Medicaid unless he is under age 21, blind or disabled because his children are not deprived of parental care and support and he is not a caretaker relative.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4350 **Date of this Memo** 09/09/1992 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Do we need to complete the steps at E for both income and resources if the individual has already passed one of these tests at C?

ANSWER: No. The steps at E are only completed for a financial test(s) which has been failed at C.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4350 **Date of this Memo** 04/02/1993 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 11/27/1989

QUESTION: What do I do if an individual applies for three (3) months of retroactive coverage and he/she has income under a poverty line income test (which applies to the individual) in one or two of the past months, but not in all three of the months of the retroactive period? May I set up a 3-month accounting period, add together the income received during the 3-month period, and grant Medicaid if the total income did not exceed 3 times the applicable poverty line income test?

ANSWER: No. The only time you may set up an accounting period and add income from different months together is when the individual is not eligible for a poverty line income test or has income which exceeds his/her poverty line income test and you must determine a six-month spend-down using the PIL as the income test.

If you grant Medicaid to the individual in one or more months of the retroactive period and the individual's income exceeds the poverty line income test in subsequent months, the first month that can be used as the beginning of the six-month accounting period for the individual, using the PIL as the income test, is the month following the last month of Medicaid eligibility under the poverty line income test rules.

As an alternative, you may set up a six-month accounting period which includes a retroactive period, the month of application and additional months following the month of application. The total countable income for the six-month period is compared to the PIL for the group size at Step I divided by the group size in order to establish the spend-down. You will need to do both calculations to determine which would be to the advantage of each individual.

REMEMBER: the PIL is the only income test which may be used for an accounting period which exceeds one month. None of the poverty line income tests may be used when you are using a six-month accounting period and adding income from different months together.

QUESTION: What if an individual is found eligible in the month of application using one of the poverty line income tests or using the PIL, but the individual expects to have increased income in some future month?

ANSWER: Instead of granting the individual Medicaid and setting a six-month review as you would normally do if no changes in eligibility will occur (such as an individual reaching age 18 if not in school), grant him/her Medicaid based on current income and schedule a review for the month when the change is expected to occur. Anticipated changes in income do not affect current eligibility for Medicaid. Changes in income are taken into account only after they have actually occurred.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4350 **Date of this Memo** 04/14/1994 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: A few providers refuse to accept Medicaid payment under certain conditions. If a provider refuses to bill Medicaid and bills the recipient instead, may we use this bill to meet the spend-down of financially responsible relatives?

ANSWER: Yes.

Example: John Jones is a Dr. Dynasaur Medicaid recipient. His orthodontist refuses to bill Medicaid for his care. The bills from the orthodontist may be used to meet the spend-down of his parents, who are legally liable for the expense.

4350 Financial Eligibility (07/01/1992, 92-1F)

NOTE

The following policies apply to individuals at the time of application and at time of review of their eligibility for Medicaid.

Each individual who passes the general and categorical test must also pass the resource test (if any, for the individual) and the income test to be found financially eligible for ANFC-related Medicaid. The process for determining if an individual passes these tests is as follows:

A. Constitute a Medicaid group according to ANFC-related Medicaid rules. (See 4360 – 4361.1, ANFC-Related Medicaid group, Medicaid Group Formation, and Exceptions to the Medicaid Group formation rules..)

B. Determine the combined countable income and combined countable resources for the Medicaid group.

C. Compare the result to the resource test, if any, and the highest income test which applies to each individual who passes the general and categorical tests for ANFC-related Medicaid.

D. Grant or continue Medicaid to each otherwise eligible individual in the group who passes his or her resource test, if any, and highest applicable income test.

E. Complete the following steps for each individual in the Medicaid group who has applied for Medicaid and who passed the general and categorical tests but could not be granted at D above.

1. Step 1

Calculate a Medicaid group size for the individual by including either:

a. an individual under the age of 21 and his/her parent(s) and sibling(s); or

b. an individual of any age and his/her spouse and child(ren) under the age of 21; or

c. an emancipated individual under the age of 21 and his/her child(ren), if any.

NOTE: When the group includes one or more pregnant women, the size of the group is increased by one for each expected child.

NOTE: Do not add both an individual's parent(s) and child(ren) in calculating that individual's Medicaid group size. In this "three generation" situation, include only the child(ren) in the individual's group size even though a pro-rata share of the parent(s) income and resources must be counted (see below) when the individual is under the age of 21.

2. Step 2

Determine the income and resources considered available to each individual by:

a. determining his/her own countable income and resources;

b. subtracting a pro-rata share of his/her countable income and resources for each individual for whom he/she is financially responsible; (i.e. spouse and unemancipated children); and

c. adding a pro-rata share of the countable income and resources of financially responsible relatives [i.e. spouse or parent(s) unless the individual is emancipated from his/her parent(s)].

NOTE: a pro-rata share of countable income (or resources) is calculated by dividing the countable income (or resources) by a number equal to the individual plus all individuals for whom he/she is financially responsible (i.e. the individual's spouse and unemancipated children). Unborn children are not included in the calculation of pro-rata shares.

Divide the applicable income test for the group size at Step 1 by the group size at Step 1 and compare to the total countable income of the individual. Divide the resource test for the group size at Step 1 by the group size at Step 1 and compare to the total countable resources of the individual.

3. Step 3

Grant or continue Medicaid to each individual who passes both the resource test, if any, and his/her highest applicable income test at Step 2.

4. Step 4

If any individuals remain after Step 3, calculate his/her spend-down as follows:

a. If the individual has failed the income test:

i. compare the countable income considered available to the individual at Step 2 to the Protected Income Level for the Medicaid group size calculated at Step 1 divided by the group size; and

ii. multiply the result by 6 to obtain the six-month spend-down for the individual.

b. If the individual has failed the resource test:

i. compare the countable resources considered available to the individual at Step 2 to the Resource Maximum for the Medicaid group size calculated at Step 1 divided by the group size; and

ii. the result is the individual's excess resources.

Medical expenses paid or incurred by the individual and members of his or her Medicaid group may be deducted from the excess income and/or excess resources of any member of the group. The medical expenses may be used to meet the spend-down of one or more individuals. The same portion of a medical expense cannot be used to meet more than one individual's spend-down and it cannot be used to meet both an income spend-down requirement and a resource spend-down requirement.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4351 **Date of this Memo** 12/30/1992 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 04/29/91

QUESTION: This rule says that we do not have to consider parent(s) financially responsible for a pregnant minor or minor parent who is making a monthly payment for room and/or board. What is the definition of a "minor" and how do we determine whether or not he or she is making a monthly payment?

ANSWER: A "minor" is an individual under the age of 21. To determine that he/she is making a payment, you would first need to determine that the individual has some form of cash income of his/her own. This income can be earned (from babysitting or some other form of employment) or it can be unearned. Second, you must obtain a statement from the parent(s) verifying the amount of the payment. The Department has not set a minimum payment.

QUESTION: If the income of the individual who is under 21 and pregnant or a parent is from his/her parent, does this count as "income of his/her own"?

ANSWER: No, unless the parent operates a business and the individual is paid as an employee of the business.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4351 **Date of this Memo** 09/13/1994 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: If a child under the age of 21 is living in a private nonmedical institution (PNMI), do we count his or her parent's income and resources in determining the child's eligibility for Medicaid?

ANSWER: Use the same criteria you use in Reach Up rule 2261.3 to determine whether or not the child continues to live in the household of his or her parents. If you determine the child is no longer living in the household of his or her parents, do not count the income and resources of the parents.

For a blind or disabled child who is living in a PNMI, you may use this criteria or the SSI-related rules whichever is to the advantage of the child and his or her family.

4351 Financial Responsibility of Relatives (02/01/1993, 93-2)

In determining the financial eligibility of an individual for ANFC-related Medicaid, the income and resources of financially responsible relatives shall be deemed available to the individual(s) for whom they are financially responsible. Financial responsibility of relatives under ANFC-related Medicaid rules is limited to the following:

A. a spouse for his or her spouse when both spouses are living in the same household; and

B. parent(s), stepparent or adoptive parent(s) for his or her (their) unmarried child(ren) under the age of 21 living in the same household unless the child is pregnant or a parent and she (or he) makes a monthly (or more frequent) room and/or board payment to his/her parent(s).

The income and resources of relatives or non-relatives who are not members of the Medicaid group and who are not financially responsible for any member of the Medicaid group shall be considered available to the Medicaid group only to the extent that such income or resources are actually and voluntarily contributed to one or more members of the Medicaid group.

The income and resources of relatives or non-relatives who are members of the Medicaid group and who are not financially responsible for all of the members of the Medicaid group shall be considered available to those members of the Medicaid group for whom they are not financially responsible only when the deeming of such members' income or resources does not have an adverse effect (denial or termination due to excess income or excess resources) on the financial eligibility of those members of the Medicaid group for whom they are not financially responsible.

4351.1 Spousal Responsibility (12/01/1994, 94-42)

If spouses cease to live with each other, their income and resources must be considered available to each other for the time periods specified below. After the appropriate time periods, only the income and resources actually contributed by one spouse to the other are counted:

When couples cease to live together as a result of:

A. the admission to long-term care of one spouse (treat the couple as having ceased to live together only if he/she is likely to reside in long-term care for at least 30 consecutive days), then:

   1. the income of both spouses ceases to be combined in the month of separation, and

   2. an assessment of resources is made at the time of application for Medicaid.

   NOTE: see Section Special Requirements for Applicants/Recipients Living in Long-Term Care.

B. the death of one spouse or the separation of the couple, then both the income and resources cease to be combined in the first month after the death or separation.

Temporary absence or separation due to illness, employment, school attendance, visits, or other circumstances does not interrupt living in the same household.

4351.2 Parental Responsibility (12/01/1994, 94-42)

Parental financial responsibility ends when a child no longer lives in the same household with his or her parent(s); the circumstances of the absence or separation support a determination that it is not temporary; and the separation has lasted or is expected to last at least 30 days; or the child has attained the age of 21; or the child is pregnant or a parent and is making a monthly payment to the parent(s) for room and/or board.

The child continues to live in his or her parent's(s') household when he or she is a resident of an educational or mental institution as long as he or she returns home for weekends or holidays or both and the parent(s) continues to be responsible for the care and supervision of the child and maintains a home for the child.

Temporary absence or separation due to illness, employment, school attendance, visits, or other circumstances does not interrupt living in the same household.

4360 ANFC-Related Medicaid Group (07/01/1992, 92-1F)

Each ANFC-related Medicaid group must contain at least one individual under age 21 with the following exceptions:

A. A Medicaid group consisting of a pregnant woman with no children living in her household (if the pregnant woman is married and living in the same household with her spouse, her spouse would also be a member of the Medicaid group).

B. A Medicaid group consisting of the parent(s), stepparent, adoptive parent(s) or caretaker relative of a disabled child(ren) recipient of SSI/AABD benefits who meets the Reach Up age criteria for a child and is deprived of parental support or care according to ANFC-related Medicaid rules, when no other children living in the household meet these criteria.

4361 Medicaid Group Formation (07/01/1992, 92-1F)

When an application for ANFC-related Medicaid is made, the Medicaid group shall include all of the children's siblings and half-siblings under the age of 21 eligible and living in the same household. The parents, stepparent or adoptive parents of each and every child included in the Medicaid group (children, siblings and half-siblings) must also be included in the Medicaid group if he or she (they) lives in the home with the children. Children who are not applying (see below), needy caretaker relatives under certain conditions (see below), and unborn children (see rule 4361.1) are included in the Medicaid Group.

The parent or stepparent may choose to apply or not apply for Medicaid for any stepsiblings under the age of 21 living in the same household with the child(ren) for whom Medicaid has been requested but these stepsiblings are counted in determining the Medicaid group size.

The Medicaid group may also include a needy caretaker relative when he or she lives in the same household and requests Medicaid. When the only parent or both parents living in the household are unable to carry out their parental responsibilities, a needy caretaker relative may be included in the Medicaid group in addition to the parent or parents living in the household with the children.

The Medicaid group shall not include any individual living in the household who is eligible for and receiving SSI/AABD benefits. In addition, the income and resources of all SSI/AABD recipients living in the household shall not be considered in determining whether the Medicaid group passes the income and resource tests for ANFC-related Medicaid.

The Medicaid group shall not include any individual who is eligible for and receiving Reach Up benefits. In addition, the income (including the Reach Up assistance payment) and resources of all Reach Up recipients living in the household shall not be considered in determining whether the Medicaid group passes the income and resource tests for ANFC-related Medicaid.

4361.1 Exceptions to the Medicaid Group Formation Rules (07/01/1992, 92-1)

A. When the Medicaid group includes one or more pregnant women, the size of the group shall be increased by one for each expected child associated with the pregnancy(ies). (Example: If it has been medically verified that triplets are expected, the Medicaid group shall be increased by three.)

B. It is not necessary for a child to live with a parent, stepparent, adoptive parent or caretaker relative for him or her to apply and be found eligible for ANFC-related Medicaid.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4362 **Date of this Memo** 01/22/1998 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: I understand that special payments may be made as the result of a settlement in the case of Susan Walker v. Bayer Corporation, et al. This case involved hemophiliacs who contracted the HIV virus from contaminated blood products. Are these payments counted as income or resources in determining eligibility for Medicaid?

ANSWER: No. These payments are excluded as income and resources for Medicaid purposes.

Some SSI recipients who receive these payments may become ineligible for SSI as a result. These closures will be coded on the SDX as excess income or excess resources.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4362 Date of this Memo 02/01/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Any income received from a home equity conversion plan is excluded in the month of receipt. If the income is retained after the month of receipt, count it as a resource beginning the month after receipt.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4362 Date of this Memo 01/01/2010 Page 1 of 1
This Memo: [X] is New [ ] Replaces one dated _____

UPDATE:

Wages paid by the Census Bureau for temporary employment are excluded.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4362 **Date of this Memo** 01/23/1998 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: The Central Vermont Community Action Council (CVCAC) was awarded a grant to develop a Tangible Assets project to help low-income, working families build cash savings from their earned income. The CVCAC Tangible Assets project will operate in Washington, Orange, and Lamoille counties and in Barnard, Bethel, Granville, Hancock, Pittsfield, Royalton, Sharon, and Stockbridge. Earnings deposited into a special savings account by the family and earmarked for first home purchase, postsecondary education expenses, or business capitalization will be matched by the project. How should we treat funds deposited into a Tangible Assets special account?

ANSWER: The savings in these special accounts and any interest earned on those savings are excluded resources, as allowed by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996.

4362 Exclusions from Income and Resources (12/01/1997, 97-10)

The exclusions from income and resources are the same as those which apply to Reach Up applicants (see rules 2276 and 2284) with the following exceptions:

A. No Resource Test Situations:

There is no resource test for a pregnant woman or a child who is found income eligible for Medicaid because the income of the Medicaid group to which she or he belongs does not exceed the pregnant women's or child's applicable poverty line income test (i.e. 200 percent or 225 percent of the federal Poverty Income Guideline).

B. Excluded from resources:

Savings which can be demonstrated are solely from excluded income.

C. Excluded from unearned income:

1. Infrequent or irregular voluntary cash contributions or gifts received from friends or relatives.

2. In-kind income which is unearned.

D. Excluded from earned income:

1. In-kind income which is earned.

2. Depreciation is an allowable business expense in determining the eligibility of a pregnant woman or child under the age of 18 if the resulting income of the pregnant woman's or child's Medicaid group does not exceed her or his applicable poverty line income test. Depreciation is an allowable deduction from the earned income of any of the individuals included in the pregnant woman's or child's Medicaid group when determining the pregnant woman's or child's eligibility for Medicaid. Depreciation is not an allowable deduction in determining Medicaid eligibility for an individual who is not pregnant and is not a child under the age of 18.

E. Excluded from earned or unearned income of Medicaid groups including individuals who qualify for the categorically needy coverage group at rule 4310 by meeting Reach Up eligibility criteria:

An amount equal to the difference between the Reach Up payment level currently in effect and the ANFC payment level in effect on July 16, 1996.

4363 Sponsored Aliens (02/27/2012,11-30)

In determining the financial eligibility of a noncitizen who is admitted to the United States on or after August 22, 1996, based on a sponsorship under section 204 of the Immigration and Nationalization Act (INA), the income and resources of the sponsor and the sponsor's spouse, if living with the sponsor, must be counted as available to the noncitizen when all four of the following conditions are met:

A. the sponsor has signed an affidavit of support on a form developed by the United States Attorney General as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 to conform to the requirements of Section 213A(b) of INA;

B. the noncitizen is lawfully admitted for permanent residence, and a five-year period of ineligibility for Medicaid following entry to the United States has ended;

C. the noncitizen is not battered; and

D. the noncitizen is not indigent, defined as unable to obtain food and shelter without assistance, because his or her sponsor is not providing adequate support.

The above financial responsibility of a sponsor continues until the noncitizen is naturalized or credited with 40 qualifying quarters of coverage by the Social Security Administration (see section on Qualifying Quarters of Coverage).

Children and pregnant women who are exempt from the give-year bar pursuant to rule 4173 C 6 are not subject to the provisions of this rule.

4363.1 Qualifying Quarters of Work (12/01/1997, 97-10)

An alien shall be credited with these qualifying quarters of coverage, as defined under title II of the Social Security Act:

A. all of the qualifying quarters of coverage worked by the alien,

B. all of the qualifying quarters of coverage worked by a parent of such alien while the alien was under age 18, and

C. all of the qualifying quarters worked by a spouse of such alien during their marriage, as long as the alien remains married to such spouse or such spouse is deceased.

No qualifying quarter of coverage for any period beginning after December 31, 1996, may be credited to an alien under (A) or (B) above if the parent or spouse (as the case may be) of such alien received any federal means-tested public benefit during the period for which the qualifying quarter of coverage is credited.

Federal means-tested benefits for this purpose do not include:

- emergency medical assistance;
- short-term, non-cash, in-kind emergency disaster relief;
- assistance under the National School Lunch Act or the Child Nutrition Act of 1966;
- public health assistance for immunizations or testing and treatment of symptoms of communicable diseases not paid by Medicaid;
- payments for foster care and adoption assistance under parts B and E of Title IV of the Social Security Act, under certain conditions;
- programs, services, or assistance specified by the Attorney General;

Sponsored Aliens

- programs of student assistance under titles IV, V, IX, and X of the Higher Education Act of 1965, and titles III, VII and VIII of the Public Health Service Act;
- means-tested programs under the Elementary and Secondary Education Act of 1965;
- benefits under the Head Start Act; or
- benefits under the Job Training Partnership Act.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4370 **Date of this Memo** 04/02/1993 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: I understand some families who live in Section 8 housing will be participating in a Family Self-Sufficiency (FSS) program sponsored by the U.S. Department of Housing and Urban Development (HUD).
Families participating in FSS are required to have a portion of any rent increase resulting from increased earnings placed in an escrow account. These funds and the interest earned thereon could be withdrawn "only after the family is no longer a recipient of any Federal, State, or other public assistance for housing" such as a HUD subsidy.

What is an escrow account and how are the funds in these accounts treated?

ANSWER: An escrow account is an account which is unavailable until certain conditions are fulfilled. In this case, the funds are unavailable to the family as long as it is receiving any Federal, State or other public assistance for housing. Receipt of Reach Up is not considered to be "public assistance for housing."

The money in a FSS family's escrow account would not be considered to be available income or resources in ANFC-related Medicaid since the family lacks the legal ability to use the money for its support and maintenance.

If a client who lives in Section 8 housing reports an increase in earned income but no increase in rent, determine whether or not a reported bank account is an escrow account by calling the local housing authority if it is not clear from the bank statement(s).

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4370 **Date of this Memo** 09/05/1990 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 07/19/1990

QUESTION: The policy says when one or more family members are already enrolled in Medicaid we exclude from consideration the "resources held by the recipient (s)". What if these resources are jointly owned with a member (s) of the applicant group?

ANSWER: The entire value of the resource shall be excluded if it is owned jointly with a family member (s) who is already enrolled in Medicaid with the following exception. It cannot be excluded if it was an excluded resource for the family member (s) already enrolled in Medicaid solely because the joint-owner member(s) of the subsequent applicant group refused to make he resource accessible to the family member(s) already enrolled in Medicaid.

4370 Resources (10/01/1987, 87-33F)

Resources are defined as any assets, other than income, which are owned by a member of the Medicaid group or a financially responsible relative who is not a member of the Medicaid group. Such assets generally take the form of real or personal property owned individually or jointly with other persons. To pass the resource test, the total equity value of all resources as described above, which are not excluded or disregarded, must not exceed the Resource Maximum applicable to a Medicaid group of its given size.

The ANFC-related Medicaid Resource Maximum shall be no less than the higher of the Reach Up or SSI/AABD Resource Maximum for a household of a given size. The Medicaid Resource Maximums, which are the same for both ANFC-related and SSI/AABD-related Medicaid groups, are found in the Medicaid Procedures Manual. All changes to these maximums which result in higher maximums will be made via a procedures change. All changes to these maximums which result in lower maximums will be made via the Administrative Procedures Act.

When the total resources of all members of the Medicaid group and all financially responsible relatives, after exclusions and disregards, are more than the Resource Maximum for the number of persons in the Medicaid group and all other eligibility requirements for Medicaid are met, the group may become eligible for Medicaid by using excess resources to pay for eligible medical expenses and/or maintenance expenses under specific conditions. (See chapter on medical expense spend-down.) All non-excluded resources must be verified where the total is within $200 of the Resource Maximum applicable to the Medicaid group.

The value of each non-excluded resource shall be determined prior to their being added together to determine the total value of the resources. This total value is then compared to the applicable Resource Maximum. The value of a resource is defined to be the applicant's or recipient's equity in that resource. Equity is defined as the fair market value less encumbrances (legal debts).

4371 Jointly Owned and Jointly Held Resources (10/01/1987, 87-33F)

When a resource is jointly held with another person not included in the ANFC-related Medicaid group, at least a pro rata share of this resource shall be considered available to the Medicaid group unless it can be demonstrated by the applicant group that this resource is inaccessible to the group. When the group can demonstrate that it has access to only a portion of any resource, only the value of that portion shall be included in the total value of the group's resources.

The resources shall be considered totally inaccessible to the group if the resource cannot practically be subdivided and the group's access to the value of the resource is dependent upon the agreement of the joint owner whose agreement is not obtained.

The resource shall be considered totally or partially inaccessible to the group if it can be demonstrated by the group that it is a jointly held resource but not a jointly owned resource. An example of this situation would be someone whose name was added to a bank account with the intent that it would be a resource to them upon the death, and only upon the death of, the individual owning the resource. An examination of who made deposits to, and withdrawals from, this account shall be undertaken in making this determination.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4372 **Date of this Memo** 07/01/2001 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Have the rules at 4373.1 changed for counting life insurance as a resource when determining ANFC-related Medicaid eligibility?

ANSWER: Yes. ANFC-related Medicaid excludes the cash value of whole life insurance.

Resource Disregard

4372 Resource Disregard (07/01/1993, 93-19)

Any portion of a bank account, cash on hand, etc., that an individual has set aside for a maintenance expense currently being incurred but for which payment is not yet due; i.e., yearly property taxes, fire insurance premiums, etc., shall be disregarded until the date payment is due.

An amount equivalent to the individual's monthly income can be disregarded from the combined Resource Maximum if it is established that this resource constitutes cash on hand or money in a checking account to be used to meet current monthly expenses.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4373 **Date of this Memo** 02/14/2008 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

UPDATE:

Health Savings Accounts (HSAs) are accounts used to set aside funds to meet medical expenses. A Health Savings Account is counted toward the Medicaid resource limit unless the recipient can demonstrate the funds are not available.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4373.2 **Date of this Memo** 01/05/1994 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 05/08/1992

QUESTION: Is there any situation in which a trust established prior to 1994, might also have to be considered under the Transfer of Assets policy?

ANSWER: Yes. If an applicant (or his/her spouse) has established a trust which limits the maximum distribution to the applicant to less than the full value of the funds put into the trust, the possibility of a transfer of assets exists.

Example: Mrs. Smith has set up a trust with $50,000. The terms of the trust permit the trustee to pay up to $30,000 for medical costs incurred by Mrs. Smith. The trustee is authorized to use the remaining $20,000 to pay the educational expenses of Mrs. Smith's nephew.

This $20,000 reduction in the value of assets available to Mrs. Smith must be considered under the Transfer of Assets policy if Mrs. Smith is admitted to long term care and the $30,000 must be considered under this trust policy.

4373 Liquid Assets (07/01/1993, 93-19)

Liquid assets are defined as cash or assets which can readily be converted to cash. Examples include: bank accounts (savings or checking); postal savings; credit union or building and loan shares; contents of safe deposit boxes; savings bonds; stocks and other securities; promissory notes and mortgages which are payable to the applicant/recipient and negotiable; etc.

Interest on savings accounts shall be considered only at time of initial application and at each regularly scheduled review. In those cases where resources are close to the maximum allowed, up-to-date verification of accrued interest shall be required.

Stocks, bonds (including savings bonds) and other securities shall be evaluated at the current market or redemption value. (See also Non-Liquid Assets.) The principal due on outstanding notes or mortgages payable to a recipient or spouse shall be considered. (See also Non-Liquid Assets.)

Loans and grants (such as scholarships) obtained and used, regardless of source, for a specific purpose which precludes their use for current living costs shall be excluded.

4373.1 Life Insurance (07/01/1993, 93-19)

The cash value of life insurance owned by members of the assistance group shall be counted as a current resource except for any portion of the cash value currently being used as collateral for a loan.

4373.2 Trusts (01/01/1994, 93-60)

Trusts established by persons other than the applicant/recipient or his/her spouse are counted as a resource only if the terms of the trust permit the applicant/recipient to revoke the trust or to have access to the trust without trustee intervention.

Medicaid should not be denied in cases where the counting of such a trust would cause undue hardship. Undue hardship includes situations where the individual would be forced to go without life-sustaining services because the trust funds could not be made available to pay for the services. If an exception has been made because it would cause undue hardship, only amounts actually distributed from the trust are counted as income and/or resources under the regular rules of the Medicaid program.

4373.3 Trusts Established Prior to 1994 (01/01/1994, 93-60)

Grantor trusts (or similar legal devices) which have been established by an individual or his/her spouse with the applicant/recipient as the beneficiary, are counted only to the extent that the trustee could disburse the assets if he/she exercised his/her full discretion under the terms of the trust. The assets are counted whether or not the trustee exercises his/her full discretion. Such grantor trusts are referred to as "Medicaid Qualifying Trusts". Trusts established by the individual or spouse to pay for special needs of the applicant/recipient (e.g., medical, rehabilitative, or educational expenses) may also be considered Medicaid Qualifying Trusts insofar as they meet the criteria mentioned above; such trusts are countable to the extent of the trustee's discretion. However, the following types of trusts are not considered Medicaid Qualifying Trusts:

- a trust established by the will of the individual's deceased spouse;

- a trust established prior to April 7, 1986, for the sole benefit of a mentally retarded individual who resides in an ICF-MR;
- an irrevocable trust which provides only for the burial of the individual - i.e. the trustee has no discretion to disperse any of the funds until the individual is deceased;
- a trust established with benefits received by a disabled child under the Zebley decision.

4373.4 Trusts Established After 1993 (01/01/1994, 93-60)

For purposes of this policy section, the term trust includes any legal instrument or device that is similar to a trust but does not include an annuity.

An individual shall be considered to have established a trust if assets of the individual were used to form all or part of the principal of the trust and if the trust was established through a method other than a will by any of the following individuals: the individual; the individual's spouse; a person, including a court or administrative body, with legal authority to act in place of or on behalf of the individual or the individual's spouse; or a person, including any court or administrative body, acting at the direction or upon the request of the individual or the individual's spouse.

In the case of a trust which includes assets of the individual and assets of any other person(s), this policy applies only to the portion of the trust attributable to the assets of the individual.

With the exception of the excluded trusts listed below, the policy applies without regard to the purposes for which the trust is established, whether the trustees have or exercise any discretion under the trust, any restrictions on when or whether distributions may be made from the trust, or any restrictions on the use of distributions from the trust.

Revocable trusts are treated as follows:

– the principal of the trust shall be counted as a resource,

– payments from the trust to or for the benefit of the individual shall be counted as income, and

– any other payments from the trust shall be considered a transfer of assets.

Irrevocable trusts are treated as follows:

Portion available

- any portion of the trust from which payments could be made to or for the benefit of the individual shall be counted as a resource, and

- any income on the portion of the trust from which payments could be made to or for the benefit of the individual is counted as income if paid to or for the benefit of the individual and is considered a transfer of assets if paid for any other purpose.

Portion unavailable

- any portion from which no payment could under any circumstances be made to the individual shall be considered a transfer of assets as of the date no payments could be made. The amount to be considered transferred includes any payments made after it became unavailable to the individual.

NOTE: An irrevocable trust which provides only for the burial of the individual is considered unavailable.

Excluded trusts include:

- a trust which contains the assets of an individual under age 65 who is disabled; which is established for the benefit of such individual by a parent, grandparent, legal guardian of the individual, or a court; and from which the Department will receive all amounts remaining in the trust upon the death of such individual up to an amount equal to the total Medicaid payments made on behalf of the individual; and

- a trust containing the assets of an individual who is disabled that meets the following conditions:

- the trust is established and managed by a non-profit association; and

- a separate account is maintained for each beneficiary of the trust but, for purposes of investment and management of funds, the trust pools these accounts; and

- accounts in the trust are established solely for the benefit of individuals who are disabled by the parent, grandparent, or legal guardian of such individuals, by such individuals, or by a court, and

- to the extent that amounts remaining in the individual's account upon the death of the individual are not retained by the trust, the trust pays to the Department from such remaining amounts in the account an amount equal to the total Medicaid payments made on behalf of the individual; and

- a trust established by persons other than the applicant/recipient or his/her spouse and a trust established by the will of the spouse unless the terms of the trust permit the applicant/recipient to revoke the trust or have access to the trust without trustee intervention.

4373.5 Burial Plots and Funeral Agreements (07/01/1992, 92-1)

One burial plot for each individual may be excluded as a resource as may be any funeral agreement with equity which does not exceed $1500 per member. The $1500 limit does not apply to an irrevocable burial trust excluded on the basis that counting it as a resource would cause undue hardship.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4374.1 **Date of this Memo** 02/10/1983 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 08/19/1982

QUESTION: In looking at real property (rule 4374.1) and vehicles (rule 4374.2) as a resource we look at equity value – defined as fair market value minus debt owed. What is the debt owed? Is it the principal outstanding or so we consider the projected interest owed as part of the debt?

ANSWER: Federal QC defines debt owed, as debt including principal and interest, including projected interest. We will go along with this definition wherever we are determining the equity value of a resource.

Non-Liquid Assets

4374 Non-Liquid Assets (07/01/1992, 92-1)

Non-liquid assets include real and personal property. Criteria for evaluation of personal property and exclusion of non-liquid assets from combined total resources recognizes the following:

Feasibility of and time required for conversion of non-liquid assets into liquid assets of reasonably equivalent value, including evaluation of ready marketability of assets, legal restrictions on sale or transfer, or other factors affecting practicality of sale or transfer; and

Restricted availability of certain types of personal property (e.g., trust funds, etc.)

Where an asset is deemed "non-liquid", it is understood and agreed that its exclusion is contingent upon the undertaking by the applicant to use his/her best efforts to sell such asset or convert such asset into a liquid asset of reasonably equivalent value.

Assets, such as securities, mortgages, or notes, etc., which cannot readily be converted to cash shall be evaluated considering the immediate and long-range feasibility of conversion to a reasonable cash equivalent. The applicant must agree to sell these assets within a reasonable period of time in order to qualify or continue to receive benefits. A signed agreement will be initiated, defining the assets that must be sold, the expected amount to be received and a date that the transaction shall be completed. At the end of stated period of time an evaluation of the agreement shall be made to see if the conditions have been fulfilled.

Securities, where feasible, shall be converted to cash. If the principal due on a note or mortgage payable to the recipient appears to be a reasonably available resource, the Department may assist the recipient to obtain payment of the full amount.

In cases where payments are being received on notes and mortgages according to a time payment contract and are being considered as income, it is not necessary for the client to agree to convert to liquid assets, although that option is available.

If payments are not being made on a time contract and steps are not being initiated to foreclose, the entire equity remaining in a mortgage shall be considered as a resource. If such resource exceeds the maximum allowable, the case will be closed.

4374.1 Real Property (11/01/1984, 84-54)

Real property is defined as land or property (i/e/, buildings) affixed thereto. All mobile homes shall be considered "real" property. Equity value of all real property owned by assistance group members must be counted except:

Real property, regardless of value, which is owned, used and occupied as a home by the assistance group; and/or

Real property owned, but not used or occupied as a home for a period of up to 6 months provided the family is making a good faith effort to sell, and an additional 3 months with the approval of the District Director.

When an assistance group is temporarily living at a location other than real property owned, and perviously used and occupied as a home but currently not habitable, the owned property is excluded for a maximum of six months. When absence continues beyond six months, exclusion may be continued based on circumstances which preclude immediate return (such as repairs still not completed) and the expected duration of absence from the home.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4374.2 **Date of this Memo** 11/13/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Is a leased vehicle ever counted as a resource?

ANSWER: No. The individual does not own a leased vehicle, so it would never be counted as a resource.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4374.2 **Date of this Memo** 07/01/2001 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: Has the vehicle exclusion for ANFC-related Medicaid changed?

ANSWER: Yes. ANFC-related Medicaid excludes the equity value of one operable motor vehicle per assistance group with one adult and two operable motor vehicles per assistance group with more than one adult.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4374.3 **Date of this Memo** 12/10/1982 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 04/21/1982

QUESTION: Please clarify final regulations regarding counting of resources such as tools and inventory for self-employed and income-producing property?

ANSWER: Interpretation of federal regulations make clear that personal property "used as a means of livelihood" (i.e., income-producing) is excluded from the total value of combined resources. Rule is updated in Bulletin 82-67 proposed, to be effective December 1, 1982. It also states that "stock" and "inventory" need not be considered either as a resource or income. Items or raw materials such as jewelry or antiques being stored to be sold are considered stock and/or inventory. (For rule on real property see 4374.1; for vehicles, 4374.2).

Equity value means fair market value less encumbrances, such as mortgages or other liens. In Vermont, real property is assessed by law at 100% of fair market value.

4374.2 Vehicles (11/01/1984, 84-54)

A vehicle is defined as a passenger car, truck or jeep, motercycle, camper, van, snowmobile, or boat, that is stored, on blocks, or is operable (i.e., includes all major operating parts, such as engine, transmission, wheels, steering mechanism, etc.).

A non-operable vehicle minus operating parts is considered junk and thus does not come within the definition of a vehicle; however, the salvage value of a junked vehicle may represent a substantial resource requiring individual evaluation.

The equity value of up to $1500 for one vehicle used as a primary means of transportation per assistance group is excluded as a resource. (Equity value equals fair market value minus debt owed). In situations where more than one vehicle is owned by the assistance group, the applicant shall identify the vehicle to which the $1500 equity maximum will be applied. the countable value of all remaining vehicles must be individually evaluated for fair market value, in order to determine the equity value to be counted towards the resource limitation.

In situations where the applicant or recipient disagrees with the determined value of the vehicle being considered, a written appraisal submitted by a licensed automobile dealer, as to the value, will be accepted.

4374.3 Income-Producing Property (01/01/1994, 93-60)

Personal property "used as a means of livelihood" (i.e., to produce income is excluded from total value of combined resources.

Income producing property may include tools, livestock, equipment, machinery and similar goods owned, usually in quantities beyond the customary needs of normal living, and in fact, used by members of an assistance group to produce income for support of the group. This may include income producing property owned by a recipient who is currently unemployed, but can reasonably be expected to return to work. However, if there is no expectation that the recipient will return to work, at least in that particular field, then the personal property shall be considered as a resource. (see rules 4374.1, real property; 4374.2, vehicles).

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4375 **Date of this Memo** 10/30/1992 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: If a Medicaid recipient sells real property, used and occupied as the permanent home, are there any circumstances under which we can exclude the proceeds from the sale?

ANSWER: Yes. The rule is the same as Reach Up rule 2281.2. A Medicaid recipient:

A. Shall be permitted to retain the net proceeds from that sale for a period not to exceed 90 days providing:

1. Net proceeds are held in trust; and

2. The plan is to use these proceeds for purchase or construction of another home; and

3. The recipient certifies that the money will be held in trust only for the purpose of obtaining another home.

4. If at the end of the 90 day period there is no agreement to purchase another permanent home (which shall be occupied within 60 days from date of agreement) or to construct a home (which shall be completed and occupied within twelve months from date of agreement), the trust is subject to the Lump Sum Receipts rule.

B. A time payment contract on any real or personal property is treated as income and the balance of equity remaining from the mortgage is not considered a resource.

NOTE: The recipient retains the option of selling the mortgage, or accepting a lump sum settlement (see A. above) which is subject to the Lump Sum Receipts rule.

Lump Sum Receipts

4375 Lump Sum Receipts (01/01/1994, 93-60)

Lump sum benefits which would have been counted as income if received on time, such as Social Security benefits and Unemployment Compensation, shall be added to all other countable income received or expected by an applicant for or recipient of Medicaid during the applicable spend-down period.

Windfall lump sums such as insurance payments and money received from the sale of a resource (including the sale of an excluded resource) are treated as a resource.

An insurance payment or similar third party payment which is received for a specific purpose, for example, the payment of medical bills or funeral costs, and is used for the stated purpose is excluded.

Any balance of a lump sum benefit, irrespective of whether it was counted as income or as a resource in the spend-down period in which is was received, which is still available to the Medicaid group at the beginning of the next spend-down period is treated as a resource. Any balance of a tax refund or rebate which is still available to the Medicaid group at the beginning of the next spend-down period is treated as a resource.

When Medicaid has been denied or closed in an spend-down period because of the receipt of a lump sum and a new person, who would otherwise be required to be included in the Medicaid group, joins the household during the same spend-down period, that person may have his/her eligibility for Medicaid determined as a separate Medicaid group for the balance of that period. In such cases, the income and resources of the original Medicaid group will not be counted in determining the Medicaid eligibility of the person who joined the household.

When Medicaid has been denied or closed and a spend-down amount has been established based on receipt of a lump sum, this spend-down amount must be recalculated if the income received has become unavailable to the family for circumstances beyond its control. Such circumstances are limited to the following unless the Commissioner or his or her designee determines that the recipient's circumstances are substantially similar to those described below:

A. death or incapacity of the principal wage earner

B. loss of shelter due to fire or flood

C. repairs to owner-occupied homes which are essential to the health and safety of the family.

D. repair or replacement of essential, major household appliances.

E. repair or purchase of one motor vehicle per Medicaid group, essential for employment, education, training or other day-to-day living necessities. Expenses may include purchase and use tax, inspection fee, insurance, and registration fees, but not day-to-day operating expenses.

F. payments attributable to current monthly housing expenses (rule 2263) which are in excess of the maximum monthly Reach Up housing allowance. Advance payments (i.e. payments for expenses which will be incurred after the period of ineligibility has ended) toward excess monthly housing expenses are not allowed.

G. payment of expenses which meet the following criteria:

    1. The bills were overdue as of the date the lump sum income was received.

    2. The bills were the legal liability of a member of the Medicaid group.

    3. The client provides documentation that the lump sum income was used to pay the bills.

Lump Sum Receipts

Eligible expenses under "G" above are as follows and are restricted to those of the primary residence and would include any late charges described in payment agreements or allowed by Public Service Board rules.

A. overdue rent (including lot rent)

B. overdue mortgage payments (principal and interest)

C. overdue property taxes

D. overdue homeowner's insurance

E. overdue heating bills

F. overdue utility bills (e.g. electricity, gas, water, or sewage)

G. overdue telephone bills (basic monthly charge, applicable taxes, plus $5 per month in toll charges)

Other eligible expenses:

H. overdue dependent care expenses necessary for a member of the Medicaid group to maintain employment, with the following limitation. If the overdue expenses were incurred when the individual was receiving Medicaid and subsidized dependent care, only the unsubsidized amounts attributable to employment-related dependent care are considered eligible expenses. For those not receiving a dependent care subsidy, only the amounts in excess of the dependent care expense deduction are eligible expenses.

I. overdue expenses for one motor vehicle per Medicaid group, essential for employment, education, training or other day-to-day living necessities. Expenses may include overdue bills for repairs, purchase and use tax, inspection fee, insurance, and registration fees, but not day-to-day operating expenses.

The family incurs and pays for medical expenses which offset the lump sum income.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4380 **Date of this Memo** 11/13/1995 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: What if an individual does not have a resource test but receives income such as interest, dividends or royalties from a resource?

ANSWER: Any cash payment the individual receives or has a right to receive is counted as income, including interest, dividends and royalties.

Income

4380 Income (02/01/1993, 93-2F)

Income is defined as any cash payment which is not considered a resource which is received by a member of the Medicaid group or an individual who is a financially responsible relative of a member of the Medicaid group. Sources of income include, but are not limited to, earnings from employment or self-employment, and unearned income (pensions, benefits, interest, or return on investments, contributions, assistance from other agencies, etc.).

The income test for an individual depends on the coverage group(s) for which he/she is eligible. An individual living in a medical institution, for example, passes the income test if his/her gross income does not exceed the Institutional Income Standard. A child under the age of 18 passes the income test if his/her countable income does not exceed 225 percent of the federal Poverty Income Guideline.

The income tests are in P-2420 B. Any change in an income test which results in an increase will be implemented by a procedures change. Any change in an income test which results in a decrease will be made via the Administrative Procedures Act.

If total countable income exceeds all applicable income tests (including the applicable PIL), the Medicaid group cannot become eligible for Medicaid until eligible paid or incurred medical expenses equal the difference between the Medicaid group's total countable income and the applicable PIL (i.e. the spend-down requirement is met). Verification of all income except that specifically excluded is required.

Transfer or assignment of income for the purpose of qualifying for Medicaid is prohibited. Voluntary transfer of income within two years of the date of application or while in receipt of Medicaid shall result in ineligibility unless the income is reconveyed to the applicant.

Future and potential sources of income shall be identified and developed, when feasible. Medicaid shall continue until such income, in fact, becomes available at which time a change in circumstances shall be processed and eligibility redetermined.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4381 **Date of this Memo** 04/02/1993 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: I understand some families who live in Section 8 housing will be participating in a Family Self-Sufficiency (FSS) program sponsored by the U.S. Department of Housing and Urban Development (HUD).
Families participating in FSS are required to have a portion of any rent increase resulting from increased earnings placed in an escrow account. These funds and the interest earned thereon could be withdrawn "only after the family is no longer a recipient of any Federal, State, or other public assistance for housing" such as a HUD subsidy.

What is an escrow account and how are the funds in these accounts treated?

ANSWER: An escrow account is an account which is unavailable until certain conditions are fulfilled. In this case, the funds are unavailable to the family as long as it is receiving any Federal, State or other public assistance for housing. Receipt of Reach Up is not considered to be "public assistance for housing."

The money in a FSS family's escrow account would not be considered to be available income or resources in ANFC-related Medicaid since the family lacks the legal ability to use the money for its support and maintenance.

If a beneficiary who lives in Section 8 housing reports an increase in earned income but no increase in rent, determine whether or not a reported bank account is an escrow account by calling the local housing authority if it is not clear from the bank statement(s).

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4381 **Date of this Memo** 06/06/1991 **Page** 1 of 1

This Memo: [X**] is New [ ] Replaces one dated** _____

QUESTION: What are military allotments" and how do I count them?

ANSWER: Allotments are payments resulting from deduction (usually voluntary) from the pay check of a member of the uniformed services, for special purposes such as payments to dependents. The uniformed services include the:

- Army;
- Navy;
- Air Force;
- Marine Corps;
- Coast Guard;
- Reserve and National Guard components of above;
- Public Health Service commissioned officer corps; and
- National Oceanic and Atmospheric Administration commissioned officer corps.

If the allotment is for the spouse and children of the individual in the uniformed services (who is absent due solely to active duty in the uniformed services), treat it as unearned income to the entire family.

If the allotment is from a parent who is absent for reasons in addition to active duty (such as divorce or separation), and the allotment includes payment to a child(ren) of the individual in the uniformed services, treat the portion which is for the child(ren) as child support, deduct the first $50.00 of the payment, and allocate a pro-rata share of the remainder to each child for whom the payment is intended.

Unearned Income

4381 Unearned Income (07/01/1993, 93-19)

Unearned income includes the following:

A. Income from pension and benefit programs, such as Social Security, Railroad Retirement, veteran's pension or compensation, Unemployment Compensation, employer or individual private pension plans or annuities, etc; and

B. Income from capital investments in which the individual is not actively engaged in managerial effort; and

C. Time payments on mortgages or notes resulting from a casual sale (i.e., a sale not related to self-employment or real or personal property); and

D. Voluntary contributions from others.

The full amount of available unearned income shall be counted unless specifically excluded (see Exclusions from Income and Resources).

The full amount of Social Security, or Railroad Retirement benefits awarded to members of the assistance group shall be considered. Medicare, Part B premiums withheld are counted as a medical expense (see Health Insurance Expenses under Allowable Medical Expenses in the 4400 rules.)

The Department of Veterans Affairs (VA) allows any guardian appointed by that agency to retain 5 percent of the monthly award handled as reimbursement for guardian services. Income available to the applicant is the amount of the award reduced by the amount retained by the guardian.

Regular and predictable voluntary cash contributions received shall be considered unearned income. Infrequent or irregular voluntary cash contributions or gifts received from friends or relatives shall be disregarded.

Earned Income

4382 Earned Income (10/01/1989, 89-54)

Earned income shall include all wages, salary, commissions or profit from activities in which the individual is engaged as an employee or a self-employed person, including but not limited to active management of capital investments (e.g., rental property).

Earned income is defined as income prior to any deductions for income taxes, FICA, insurance or any other deductions voluntary or involuntary except that, in determining earned income for self-employed individuals, business expenses are deducted first.

Earnings over a period of time, for which settlement is made at one given time, are also included; i.e., sale of farm crops, livestock, poultry, etc.

Payments to individuals under the following federally sponsored programs shall be included as earned income:

A. Economic Opportunity Act

Payment to individuals under any of the following programs, whether as partial and temporary beneficiaries, or as employees, shall be considered "earned income":

1. Work-Training Programs (Title I, Part B)
2. Community Action Programs (Title II)
3. Voluntary Assistance Programs for Needy Children (Title II)

B. Elementary And Secondary Education Act

Income from employment (e.g., as a teacher's aide, lunch room worker, clerical aide, etc.) under a Title I project funded by the Elementary and Secondary Education Act.

C. Job Training Partnership Act - 1982 (JTPA)

Monthly income of any dependent child from any program carried out under the Job Training Partnership Act (JTPA) is disregarded. This applies to earned or unearned income except that in the case of earned income this disregard may not exceed six months per calendar year.

This income cannot be disregarded for adults.

The $10 per day allowance given to individuals in JTPA training is also disregarded as income, and in this case the disregard applies to both dependent children and adults.

4382.1 Income Computation (07/01/1993, 93-19)

The income computation is used to project the amount of income which will be received during the accounting period.

The accounting period is one month for an individual in long-term care and an individual with countable income under his/her poverty line income test and six months for an individual whose eligibility is being determined based on the PIL as the income test.

Countable gross income must be verified and the record should document the method used to project income.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4382.2 **Date of this Memo** 12/21/1993 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 03/08/1991

QUESTION: How are business expenses calculated when the recipient owns a multi-family dwelling and lives in one apartment and rents out the others?

ANSWER: Divide the allowable expenses which are spent on the entire building by the number of apartments (regardless of the size of the apartments). For instance, if the recipient lives in one of three apartments, two-thirds of the expenses would be deducted from the gross receipts.

Allowable expenses include ordinary and necessary expenses such as fire insurance, water/sewer charges, property taxes, minor repairs which do not increase the value of the property, lawn care, snow removal, advertising for tenants and the interest portion of a mortgage payment. The principal portion of a mortgage payment is not an allowable business expense.

The first $50 in child support payments made by a non-custodial parent on behalf of a child within each calendar month is excluded. When more than one non-custodial parent makes child support payments on behalf of a single child in the same calendar month, the maximum amount of child support to be disregarded in determining the child's eligibility is $50.

The following items are deducted from gross earned income in the sequence listed:

A. Business expenses (self-employment only)

B. Standard employment expense deduction

C. Dependent care expenses

Income in the month of application and future months is estimated based on the actual verified income in the month prior to the month of application unless changes have occurred or are expected to occur. If the accounting period includes past months, use the actual verified income received in those months.

If the individual expects to have increased income in some future month, schedule a review for the month when the change is expected to occur. Anticipated changes in income do not affect current eligibility. Changes in income are taken into account only after they have actually occurred.

4382.2 Business Expenses (12/01/1994, 94-42)

Business expenses, which are deducted from gross receipts to determine adjusted gross earned income, are limited to operating costs necessary to produce cash receipts, such as:

A. Office or shop rental; taxes on farm or business property; and

B. Hired help; and

C. Interest on business loans; and

D. Cost of materials, stock, and inventory, livestock for resale required for the production of this income.

However, items such as personal business and entertainment expenses, personal transportation, purchase of capital equipment and payment on the principal of loans for capital assets or durable goods, are not business expenses.

Depreciation is an allowable business expense in determining the eligibility of a pregnant woman or child under the age of 18 if the resulting income of the Medicaid group of the pregnant woman or the Medicaid group of the child does not exceed her or his applicable poverty line income test. Depreciation is an allowable deduction from the earned income of any of the individuals included in the Medicaid group of the pregnant woman or the Medicaid group of the child when determining the eligibility of the pregnant woman or child for Medicaid if the resulting income is below the poverty line income test. Depreciation is not an allowable deduction in determining Medicaid eligibility for an individual who is not pregnant and is not a child under the age of 18.

Tax returns and business records are considered appropriate sources of accurate figures for farm and business receipts and expenses.

INTERPRETIVE MEMO

[X] Medicaid ANFC Rule Interpretation [ ] Medicaid ANFC Procedure Interpretation

This interpretive memo remains effective statewide until it is specifically supersededed–either by a subsequent interpretive memo or by a contradictory rule with a later date.

Reference 4382.4 **Date of this Memo** 08/01/2008 **Page** 1 of 1

This Memo: [ ] is New [X] Replaces one dated 03/19/2008

UPDATE:

Effective immediately, use 58.5 cents per mile to calculate transportation costs.

The income of a household owning or operating a commercial boarding house shall be treated as any other business income. A commercial boarding house is defined as an establishment licensed as a commercial enterprise which offers meals and lodging for compensation. In areas without licensing requirements, a commercial boarding house shall be defined as a commercial establishment which offers meals and lodging with the intention of making a profit.

No computation is required for foster homes furnishing boarding care to children in custody of and placed by the Family Services Division (FSD). Department board rates are established to cover expenses only with no profit available; therefore, no earned income is considered available from this source.

For a household which is not a commercial boarding house, the business expense of furnishing room and board, alone or as part of custodial care, shall be allowed provided that the amount shall not exceed the payment the household receives from the roomer/boarder for lodging/meals. (See the Procedures Manual for the table of standard business expense deductions for homes providing room or board on a non-commercial basis.)

4382.3 Employment Expenses (10/01/1990, 90-35)

The standard employment expense deduction is the first $90.00 earned per month.

The standard employment expense deduction is applied separately to the gross earned income of each individual in the assistance group who is employed or self-employed.

4382.4 Dependent Care Expenses (10/01/1990, 90-35)

Dependent care expenses necessary to enable the individual to retain his or her employment will be deducted up to a maximum of $175.00 per month per incapacitated adult Medicaid group member or child Medicaid group member age two years or older, and up to a maximum of $200 per month per child Medicaid group member under two years of age.

Dependent care expenses will be allowed as paid up to the maximum on the basis of a statement signed by the provider of services. If a recipient's dependent care expenses are below the maximum, transportation to and from the dependent care facility may be deducted as part of the expense.

Payments for dependent care provided by a member of the same Medicaid group, by the child's parent (biological, adoptive, or stepparent) or legal guardian, or by the incapacitated adult's spouse do not qualify as necessary dependent care expenses under this policy.

The provider of care must be at least 16 years of age. A deduction for dependent care expenses for care of a child can be allowed only when neither parent is available and able to provide the necessary care. A deduction for dependent care expenses for care of an incapacitated adult can only be allowed when the incapacitated adult's spouse (where applicable) is either unavailable or available but unable to provide the necessary care.

If dependent care is required for reasons other than employment (e.g., protective services child care or care for training purposes), the client shall be referred to FSD.

Long Term Care and Community Spouses

4390 Long Term Care and Community Spouses (08/01/2003, 02-11)

The treatment of resources held by individuals requesting long-term care who have dependent children and a spouse are the same for ANFC-related Medicaid as for SSI-related Medicaid. The department assesses and allocates resources using the rules at 4264 – 4264.2 for both coverage groups.

Individuals who meet the income rules for Reach Up financial eligibility (rule 4350) meet the income rules for long-term care eligibility, including home-and-community-based waiver services, at rule 4281.7.