STATE OF VERMONT

AGENCY OF HUMAN SERVICES

DCF

Department for Children and Families

B U L L E T I N NO.: 10-04

FROM: Joseph Patrissi, Deputy Commissioner
Economic Services Division

DATE: April 1, 2010

SUBJECT: Citizenship & Identity and Medicaid Procedures
Breast & Cervical Cancer Treatment (BCCT) Medicaid Procedures
Applying for Unemployment as a condition of eligibility

CHANGES ADOPTED EFFECTIVE 4/1/10

INSTRUCTIONS

__X__ **Maintain Manual - See instructions below.**
____ **Proposed Regulation - Retain bulletin and attachments until you receive Manual Maintenance Bulletin: _____**
____ **Information or Instructions - Retain until _____**

MANUAL REFERENCE(S):

TOC P.1 - P.7 (P-2400)	P-2400	P-2421
	P-2405	P-2423

This bulletin adds citizenship and Identity procedures, Breast and Cervical Cancer Treatment procedures, Assistive Community Care Services, Working with Disabilities, and adds a PP&D regarding the mandatory pursuit of Unemployment Compensation.

Manual Maintenance

Medicaid Procedures

Remove		Insert	
TOC p.1	(00-08)	TOC p.1	(10-04)
TOC p.2	(02-42)	TOC p.2	(10-04)
TOC p.3	(06-38)	TOC p.3	(10-04)
TOC p.4	(01-27)	TOC p.4	(10-04)
TOC p.5	(01-27)	TOC p.5	(10-04)
TOC p.6	(01-27)	TOC p.6	(10-04)
TOC p.7	(06-03)	TOC p.7	(10-04)
P-2400 A3	(08-08)	P-2400 A3	(10-04)
P-2400 A4	(08-08)	P-2400 A4	(10-04)

Medicaid Procedures

Remove		Insert	
Nothing		P-2405 (10 pages)	(10-04)
P-2421 D1	(93-26)	P-2421 D1	(10-04)
P-2421 D2	(93-26)	P-2421 D p.2	(10-04)
P-2421 D3	(93-26)	P-2421 D p.3	(10-04)
P-2421 D4	(97-29)	P-2421 D p.4	(10-04)
P-2421 D5	(97-29)	P-2421 D p.5	(10-04)
P-2421 D6	(97-29)	P-2421 D p.6	(10-04)
P-2421 D7	(97-29)	P-2421 D p.7	(10-04)
P-2421 D8	(97-29)	P-2421 D p.8	(10-04)
P-2421 D9	(97-29)	Nothing	
P-2421 D10	(97-29)	Nothing	
P-2421 D11	(97-29)	Nothing	
P-2421 E	(06-38)	P-2421 E	(10-04)
P-2421 E P.2	(06-38)	P-2421 E p.2	(10-04)
P-2421 E P.3	(06-38)	P-2421 E p.3	(10-04)
P-2421 E P.4	(06-38)	P-2421 E p.4	(10-04)
P-2421 E P.5	(06-38)	P-2421 E p.5	(10-04)
P-2421 E P.6	(06-38)	P-2421 E p.6	(10-04)
Nothing		P-2421 E p.7	(10-04)
Nothing		P-2421 E p.8	(10-04)
Nothing		P-2421 F (8 pages)	(10-04)
Nothing		P-2423 J	(10-04)
PP&D P-2127 A-B1	(7-1-08)	Nothing	

P-2421 Documentation of SSI/AABD-Related Eligibility Factors (Continued)

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
1. BCCT Eligibility Screening
2. Medicaid Eligibility Screening
a. Traditional Medicaid Screening
b. Retroactive Eligibility
c. Eligibility for Other Household Members
d. Active District Office Cases
e. BCCT Review
3. Changes
a. Address, Phone Number, Treatment Providers, etc.
b. Age Change – Turning 65
c. BCCT Individual Moves to VT
4. Other Health Insurance
5. BCCT Flow Chart

P-2422 Documentation of ANFC-Related Medicaid Eligibility Factors

A. Medical Factors
1. Incapacity Application
2. Provisional Incapacity
3. Incapacity Review
4. Pregnancy
B. Deprivation Factors
1. Death of Parent
2. Incapacity of Parent
3. Unemployment of Parent
4. Absence
a. Imprisonment
b. Divorce or Legal Separation
c. Desertion or Separation
d. Born Out-of-Wedlock
C. Employment Expense for Dependent Care
D. Computation of Income
E. Basic Financial Eligibility
F. Changes in Financial Eligibility
1. Applicant with Income Change
2. Retroactive Medicaid
3. Spend-Down Changes
4. Household Size

P-2430 Long-Term Care Medicaid (LTC)

P-2430 Long-Term Care Medicaid (LTC) (C0ntinued)

P-2400 A Medicaid Rules and Procedures Index (Continued)

ITEM	SSI-RELATED	ANFC-RELATED	GENERAL
Breast and Cervical Cancer Treatment (BCCT)			4202.4 (A) 4312.8 (E) *4312.8 P-2421 F
Budgeting	4281, P-2421 B	4382.1, P-2422 E	P-2424 A
Burial Funds	4243, P-2421 B#2, 3	4373.5, P-2422 G#2	
Business Expenses (see Income-Business Expenses)			
Buy-In Program	4204.1 – 4204.4		P-2441B
Caretaker Relatives		4343 *4350 *4340	
Case Records			2013, P-2113 B
Catamount Health Premium Assistance Program (CHAP)			4100, P-2420A-B, 4102.4, 4107
Categorical Eligibility	4211, P-2421 A	4341, 4342, 4343, 4300, P-2422 A-B	
Certification Periods (see Review)			
Changes Mass changes		4380, 4382.1, P-2422 D #4, P-2422 F, G	P-2423 F, P-2422 F, 4150 I, P-2411 D9, P-2412 C
Child Care		4382.4, F-2422C	

P-2400 A Medicaid Rules and Procedures Index (Continued)

ITEM	SSI-RELATED	ANFC-RELATED	GENERAL
Child Support:			
Income	4280.2 (S)	4382.1	P-2411 E
Payment	4281.1 (D)		
Choice of Category			4124
Choices for Care (see LTC)			
Citizenship	4216	4330	P-2405 4170
Closures:			
Reach Up		4300,4301 P-2411 C	P-2412 D
Medicaid			4142, P-2423C
SSI/AABD	4202, P-2414 A#3		
Collateral Sources			4136
Committed Children		4312 (B), P-2412	P-2401 #2
Community Care Homes			P-2430 A P-2420 D#12
Confidentiality			All Programs 2000, 4113
Continuing			
Eligibility	4202	4301, P-2411 C	4142, 4153 4140

P-2405 Citizenship & Identity - Acceptable Types of Citizenship & Identity Documentation

Health care rules require most U.S. citizens to provide proof of identity and citizenship. All documents must be originals or certified copies from the issuing agency. We are not allowed to accept photocopies or notarized copies. The documentation needs to be from the highest level possible. (rule M170)

A. Immigrants

Immigrants, otherwise known as "qualified aliens", do not provide proof of citizenship and identity – they must provide proof of their immigration status. When you have received their documentation confirm their current status via the SAVES process. Their MEMB panel needs to have an "N" in the US CITZ field; blank CITZ and ID fields, and their IMMIGRANT STATUS DATA completed.

B. Exempt Individuals

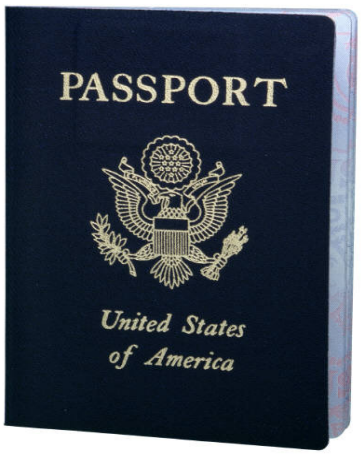
Some individuals are exempt from the citizenship and identity requirement. Both **citizenship and identity** requirements are automatically met for:

• SSI recipients	ES	*These individual retain their exempt status even if their benefit ends.*
• SSDI recipients	ED	
• Medicare recipients	EM	
• IV-E foster care children • IV-E adoption assistance children	EF	*These individuals retain their exempt status even if their adoption benefits end or they leave foster care.*
• Infants Infants born **before 4/1/09** to women who are one of the department's health care programs at the time of birth are exempt for one year so long as the mother remains eligible and the child is a member of her household.	blank	*These individuals will get picked up for C&I at the at the family's next review.* *If they are not yet 1 year old, blank out their CITZ history.*
• Infants Infants born **on or after 4/1/09** to women who are on one of the department's health care programs at the time of birth.	1P	*These individuals permanently retain their exempt status.*

P-2405 A. Citizenship & Identity

C. Proof of both U.S. Citizenship & Identity
(No other documentation is required)

First-Level Citizenship & Identity	1P	▸ U.S. passport. (A passport may be current or expired) ▸ Children born in the U.S. if Mom is on a state health care program at the time of birth (except for HVP).
	1A	▸ Documents from recognized Native American tribes indicating membership, enrollment, or affiliation with a tribe (ie: a tribal enrollment card or certificate of Indian blood).
	1D	▸ Enhanced drivers license
	1N	▸ Certificate of Naturalization (DHS Form N-550 or N-570).
	1C	▸ Certificate of U.S. Citizenship (DHS Form N-560 or N-561).
	Individuals born outside the U.S. who were not U.S. citizens at birth must submit first-level documentation. Adopted children born outside the U.S. may establish citizenship under the Child Citizenship Act. Parents must pursue a Certificate Of U.S. Citizenship on their behalf.	



Expired Passports are acceptable.

Other documents that have RECENTLY expired are also acceptable.

Recent = expired within 1 year

P-2405 A. Citizenship & Identity

D. Proof of U.S. Citizenship
(Proof of Identity is Also Required)

Second-Level Citizenship	2B	▸ U.S. birth certificate issued before the person turned age 5. Includes the 50 states, the District of Columbia, Puerto Rico (on or after January 13, 1941), Guam (on or after April 10, 1899), the U.S. Virgin Islands (on or after January 17, 1917), American Samoa, Swain's Island, or the Northern Mariana Islands (after November 4, 1986).
	2P	▸ Final adoption decree showing the child's name and U.S. place of birth (if adoption is not finalized, a statement from a state-approved adoption agency).
	2F	▸ Certification of Birth Abroad of a U.S. Citizen (Form FS-545)
	2A	▸ Report of Birth Abroad of a U.S. Citizen (Form FS-240, or Form DS-1350).
	2M	▸ An official military record showing a U.S. place of birth.
	2I	▸ U.S. Citizen ID card (INS Form I-197 or I-179).
	2G	▸ Evidence of U.S. civil service employment before June 1, 1976.
	2K	▸ American Indian Card (I-872 with the classification code KlC) issued by the Department of Homeland Security (DHS) to identify U.S. citizen members of the Texas Band of Kickapoos living near the U.S./Mexican border.
	2N	▸ A Northern Mariana Identification Card (I-873) issued by the INS to a collectively naturalized citizen of the United States who was born in the Northern Mariana Islands before November 4, 1986.
	1N	▸ States may verify citizenship of a naturalized citizen through the SAVE program.

P-2405 A. Citizenship & Identity

D. Proof of U.S. Citizenship (Continued)
(Proof of Identity is Also Required)

Third-Level Citizenship	3H	▸ Extract of U.S. hospital record of birth on hospital letterhead that was created at least 5 years before the initial application date. Souvenir birth certificates are not acceptable.
	3I	▸ Life, health, or other insurance record showing a U.S. place of birth that was created at least 5 years before the initial application date.
	3I	▸ Religious records recorded in the U.S. within 3 months of birth. Must show a U.S. place of birth and either the date of birth or the age of the individual at the time the record was made. Must be official records recorded with the religious organization.
	3I	▸ Early school records. Must show the name of the child, the date of admission to the school, the date of birth (or age at the time the record was made), a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

Proof of U.S. Citizenship
(Proof of Identity is Also Required)

Fourth-Level Citizenship	4C	▸ Federal or state census record showing U.S. citizenship or a U.S. place of birth and person's age.
	4L	▸ Admission papers, indicating a U.S. place of birth, from a nursing home or other institution.
	4M	▸ Medical (clinic, doctor, or hospital) record indicating a U.S. place of birth that was created at least 5 years before the initial application date. (For children under 16, the document must have been created near the time of birth or 5 years before the date of application.)

P-2405 A. Citizenship & Identity

D. Proof of U.S. Citizenship (Continued)
(Proof of Identity is Also Required)

Fourth-Level Citizenship (continued)	4O	▸ Other documents created at least 5 years before the initial application for Medicaid: Seneca tribal census records; Bureau of Indian Affairs tribal census records of the Navajo Indians; U.S. State Vital Statistics official notification of birth registration; an amended U.S. public birth record that was amended more than 5 years after the person's birth; or a statement from a physician or midwife who was in attendance at the birth.
	4W	▸ Written declarations, signed under penalty of perjury. ▸ Declarations should be used only in rare circumstances when the individual is unable to provide evidence of U.S. citizenship from any other source listed. ▸ Two declarations must be submitted. One of the two declarations must be from someone who is not related to the individual. Each person providing a declaration must have knowledge of the event(s) establishing the individual's claim of U.S. citizenship; for example, the applicant's birth in the United States, or that they've personally seen a document establishing citizenship – such as a passport that was burned in a fire. ▸ The individuals providing the declarations must also provide proof of both their own U.S. citizenship and identity for the declaration to be accepted. If they know why documentary evidence of the individual's claim of U.S. citizenship cannot be provided, this should be included in the declaration. ▸ The applicant or beneficiary (or other knowledgeable individual) must also provide a separate declaration explaining why this evidence cannot be provided. ▸ Naturalized citizens may use affidavits.
	4O	▸ List of Alaska natives Maintained by BIA.

P-2405 A. Citizenship & Identity

E. Proof of U.S. Identity
(Proof of Citizenship is Also Required)

Ages 16 and older	ID	▸ Current state driver's license containing the individual's photo or other identifying information.
	II	▸ Certificate of Indian Blood or other U.S. tribal document with photo or other identifying information.
	IO	▸ Government-issued identity card containing the individual's photo or other identifying information. ▸ U.S. military card or draft record. ▸ School identity card with photo. ▸ Military dependent's identity card. ▸ U.S. Coast Guard Merchant Mariner card. ▸ Hunting licenses ▸ Firearm Identification cards
	IO	▸ States may accept an identity affidavit signed under penalty of perjury by a residential-care facility director or administrator on behalf of an institutionalized individual.
	IO	▸ A combination of three or more of these documents: ▸ employer ID cards ▸ high school and college diplomas from accredited schools (including GED certificates) ▸ marriage certificates ▸ divorce decrees ▸ property deeds/titles Documents must corroborate one another and must not conflict, and may only be used to verify identity if the individual used secondary or third level evidence of citizenship and the document was not used to verify citizenship.

P-2405 A. Citizenship & Identity

E. Proof of U.S. Identity (Continued)
(Proof of Citizenship is Also Required)

Ages 16 and older	KW	▸ Proof of Identity Form 201ID for 16 and 17-year old children in limited circumstances
	KW	▸ Proof of Identity Form 201ID for disabled individuals living in residential care facilities.
Under age 16	Only use these if one of the documents in the "16 and older" list is not available.	
	KS	▸ School record, including report cards.
	KD	▸ Day-care or nursery school record.
	KM	▸ Clinic, doctor, or hospital records.
	KW	▸ Proof of Identity Form 201ID. (This form may not be used if declarations were used as proof of citizenship)

Expired Passports are acceptable.

Other documents that have RECENTLY expired are also acceptable.

Recent = expired within 1 year

P-2405 A. Citizenship & Identity

F. Alphabetical C&I Code List

?	C or I	Unknown
CM	C or I	Send cross-match request manually
EC	C or I	Exempt – present SCHIP recipient (C2 & C6 cat codes)
ED	C or I	Exempt
EF	C or I	Exempt – presently in foster care
EM	C or I	Exempt – past or present Medicare recipient
ES	C or I	Exempt – past or present SSI/AABD recipient
F	C or I	Failed to verify
ID	I only	Driver's license or other state-issued ID card
II	I only	Certificate of Indian blood or other Native American tribal document
IO	I only	US military or dependent ID, school ID w/ photo, USCG Merchants Mariner or other ID from Immigration and Naturalization Act Sec. 274A (B) (1) (D)
KD	I only	Daycare or nursery school record showing date and place of birth (under age 16)
KM	I only	Clinic, doctor, or hospital record showing date of birth (under age 16)
KS	I only	School record showing date and place of birth and parent's name (under age 16)
KW	I only	Proof of Identity Form 201ID signed by parent/guardian (under age 16) Proof of Identity Form 201ID for 16 and 17-year old children in limited circumstances Proof of Identity Form 201ID for disabled individuals living in residential care facilities.
MB	C only	Citizenship verified using BGS cross-match
MC	I only	Identity verified using OCS-DNA cross-match
MD	I only	Identity verified using DMV cross-match

P-2405 A. Citizenship & Identity

F. Alphabetical C&I Code List (Continued)

MF	I only	Identity verified using Food Stamp cross-match
N	C & I	Not a US citizen; use established procedure for non-citizens (SAVE)
NM	C or I	No BGS/DMV/VDH cross-match
P	C or I	Verification required – starts 202V notice process
SB	C only	Cross-match request sent to BGS (ACCESS generated only)
X	C or I	Extension of deadline for documentation granted
X2	C or I	2nd Extension of deadline for documentation granted
X3	C or I	3rd Extension of deadline for documentation granted
Z	C or I	Administrative extension of deadline for documentation granted
1C	C only	Certificate of Citizenship (DHS Forms N-560 or N-561)
1D	C only	Driver's license issued by state requiring citizenship verification for license issuance
1N	C only	Certificate of Naturalization (DNS forms N-550 or N-570)
1P	C or I	US Passport (current or expired)
2A	C only	Report of birth abroad of a US citizen
2B	C only	US birth certificate issued before person was 5 years old
2F	C only	Certification of birth abroad (Form FS-545)
2G	C only	Evidence of civil service employment by the US Government
2I	C only	US Citizen ID Card (DHS Form I-179 or I-197)

P-2405 A. Citizenship & Identity

F. Alphabetical C&I Code List (Continued)

2K	C only	American Indian Card for members of Texas band of Kickapoos (CHS Form I-872 w/ code "KIC")
2M	C only	Official military record of service
2N	C only	Northern Mariana ID card Documents from recognized Native American tribes indicating membership, enrollment, or affiliation with a tribe (ie: a tribal enrollment card or certificate of Indian blood).
2P	C only	Final adoption decree showing child's name and US birthplace
2S	C only	Certification of birth issued by US Dept of State (form DS-1350)
3H	C only	Hospital record of birth created at birth showing US birthplace
3I	C only	Life, health, or other insurance record showing US birthplace
4C	C only	Federal or state census record showing US citizenship or US birthplace
4L	C only	Admission papers to a LTC facility showing US birthplace
4M	C only	Medical record (not immunization record) showing US birthplace
4O	C only	Other documentation permissible by CMS, including vital statistics
4W	C only	Written affidavit signed by two individuals (last resort)

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

Medicaid individuals who are in Level III and Level IV Residential Care Homes and who do not receive SSI benefits (because these individuals are automatically eligible) may be eligible for a spend-down deduction for the cost of personal care services received.

Residential care homes are state licensed group living arrangements designed to meet the needs of people who can not live independently and usually do not require the type of care provided in a nursing home. Level III homes provide nursing overview, but not full-time nursing care. Level IV homes do not provide nursing overview or nursing care.To determine if he/she is in a Level III or Level IV Residential Care Home (RCH), refer to the list of Level III Residential Care Homes at http://dail.vermont.gov/dail-programs/dail-programs-providers/dail-providers-list-rchiii/dail-rchiii-providers-default-page.

Assisted Living Facilities (ALF) are state licensed residences that combine housing, health and supportive services to support resident independence and aging in place.The ALF list is found at http://dail.vermont.gov/dail-programs/dail-programs-providers/dail-providers-list-alf/dail-alf-providers-default-page.

If an individual lives in a home that is not on either list, contact the home administrator to determine if they are a Level III home or ALF.

ACCS is a more comprehensive bundle of services than Personal Care Services (PCS), but many overlap. The main difference is that ACCS can become a covered Medicaid service, whereas PCS is not a covered service for individuals over age 21.

1. Determining eligibility

a. If the individual is in a level III home, send the Verification of Eligibility for Medicaid payment of Assistive community Care Services (ESD 225A) to the client to complete and return. The purpose of the form is twofold: 1. Since most ACCS providers charge more than the standard ACCS rate at P-2420 D5, you will have the actual private pay rate to use when determining the ACCS start date. 2. once eligibility is processed, returning the 225A will let the client and provider know the ACCS start date. However, if the form is not returned, do not deny or close for non-cooperation. Process the spenddown using the ACCS standard deduction at P-2420 D5.

b. Enter an INST panel in ACCESS with code 23 (Community Care Home/ACCS) in the INST TYPE field.

c. Compute the spenddown per procedures at P-2424 A.

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

d. If the spenddown is met using allowable deductions, other than ACCS, proceed with grant procedures at P-2423 A.

Because the spenddown was met without using ACCS expenses, the individual is eligible for both Medicaid and coverage of Assistive Community Care Services (ACCS). Medicaid eligibility begins on the first day of the application month or retroactive period, if applicable. ACCS eligibility starts the date the individual started receiving services in the Level III or IV RCH or ALF.

- Complete the bottom section of the Verification of Eligibility for Medicaid Payment of Assistive Community Care Services (ESD 225A). If the client did not return this form, you will need to complete this section out and send with the Notice of Decision.
- Send a computer generated Notice of Decision to the individual. Select the "ACCS Initial Approval" Optional Notice Paragraphs text indicating ACCS effective coverage date. If you use the standard ACCS rate because the form was not returned, let the client know you used the standard ACCS rate and thye may submit a completed 225A providing the actual private pay ACCS rate which may result in an earlier spenddown and ACCS start date.
- If the case is a review, select the "Assistive Community Services Review" Optional Notice Paragraphs text to indicating the ACCS coverage and payment dates.
- Include the individual's copy of the 225A with the Notice of Decision to the individual.
- Send the facility's copy of the ESD 225A to the administrator of the home.

Example:
Application date: Aug. 2
ACCS services began: Aug. 16
Notice of Decision gives the Medicaid eligible date of Aug.1
Enter the ACCS eligible dates on the Optional Notice Paragraphs and would read; "You are eligible for ACCS effective Aug. 16."

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

e. If spenddown is not met using allowable deductions:

Compare the spenddown (after all other allowable deductions) to the ACCS deduction over six months (example: $1,110 x 6 = $6,660). Use the actual daily rate for ACCS (care services only) provided by the home on the 225A. If the amount is not listed, or is the same amount as the room and board cost, call the home and request the ACCS services daily rate only. If they refuse to provide the amount, or to separate the ACCS services rate from the room and board rate, use the Medicaid rate, per P-2420 D5.

1. If the individual's spenddown is less than the ACCS deduction over six months, the spenddown has been met. Follow procedure below.

a. Medicaid is granted effective the first day of the month of application or the first day of the retroactive period, if applicable.

b. The ACCS start date is determined as follows:

Divide the spenddown by the daily cost of ACCS per the ESD 225A or the Medicaid rate, per P-2420 D5, whichever is higher. Drop any numbers after the decimal point. The result is the number of days the client must privately pay his or her ACCS costs. Medicaid will pay for ACCS starting the following day through the end of the spenddown period.

CATN the ACCS daily rate of pay, per ESD 225A form, as well as the private pay and department pay dates (i.e. "Individual responsible to pay ACCS from 01/01/09 – 02/16/09. Dept will pay ACCS 02/17/09-06/30/09").

- Complete the bottom section of the Verification of Eligibility for Medicaid Payment of Assistive Community Care Services (ESD 225A). Send a computer generated Notice of Decision to the individual. Be sure to add the "ACCS Initial Approval" Optional Notice Paragraphs text indicating ACCS effective coverage date. Send the individual's copy of the ESD 225A with the notice. Send the facility's copy of the ESD 225A to the administrator of the home.

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

If the case is a review, be sure to select the "Assistive Community Services Review" Optional Notice Paragraphs text indicating ACCS coverage and payment dates.

Example:

Review application date: Sept 5. individual's current period ends Sept 30.
Individual's spenddown after deductions of Medicare premiums, over-the-counter (OTC) items, and old bills: $1500.00
ESD 225A states ACCS rate is $40/day
$1500 ÷ $40 = 37.50 Individual must private pay 37 days.
Medicaid start date: October 1
ACCS private pay dates: October 1 through November 6
Medicaid covers ACCS cost: November 7 through March 31

i. Individuals with both resource and income spenddowns are eligible for Medicaid as of the month they meet both financial and resource requirements. In the month both tests are met, Medicaid is granted as of the first of that month. ACCS eligibility begins the day after they meet their income spenddown.

NOTE: The same medical expense cannot be used to meet both spenddowns. The cost can only be used to meet one or the other.

Example:

An individual completes the July review application. They have a resource spenddown of $400 and an income spenddown of $800.

The individual meets their resource spenddown August 10th by spending down their resources on ACCS services (ACCS daily rate $40 x 10 days = $400). The individual privately paid ACCS services from Aug 1st – Aug 10th.

If they don't have other expenses to meet their income spenddown and need to use ACCS costs, we would begin counting ACCS private pay days from August 11th forward. Using ACCS costs the client would meet their income spenddown on August 30th (ACCS $40 x 20 days = $800).

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

As both income and resource requirements were met in the month of August they are eligible for the following coverage:

Medicaid begins: August 1st
ACCS eligibility begins: August 31st
The individual is responsible for ACCS private pay: August 1st – 30th.
If the individual met their income spenddown on September 5 instead of August 30, their Medicaid start date would be September 1 and their ACCS start date would be September 6.

2. If the spenddown is greater than the ACCS deduction for six months, the individual is ineligible for ACCS services for the spenddown period, but may become Medicaid eligible.

a. From the spenddown, deduct the cost of the ACCS over six months. If the remaining spenddown is met during the period, they may become *Medicaid* eligible during that time, but ACCS will not be covered.

- If the individual incurs unexpected medical expenses, re-calculate the spenddown to find the earliest Medicaid and ACCS start date.

Example:

Application date: Jan 5.
Client's spenddown after deductions of insurance premiums and over-the-counter items: $9,000
ESD 225A states ACCS rate is $45/day.
$45 x 30 days = 1,350 x 6 months = $8,100 (the total ACCS deduction for the six-month period).
Individual's spenddown ($9000) exceeds the total ACCS rate for the six months ($8,100). Therefore, ACCS services will not be covered during this spenddown period and the ACCS rate is used as a non-covered service deduction.
$9000 - $8100 = $900
Individual's spenddown is $900 from Jan – June.
If spenddown is met during the spenddown period, he/she will be granted Medicaid on the day the spenddown was met. (ACCS services will not be covered).

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

b. Send a denial Notice of Decision denying Medicaid for being over income and add the following in Additional Text of the notice:

"Since you are in a Level III or IV Residential Care Home, you may be able to use personal care expenses to meet your spenddown.

Please have your doctor complete the enclosed forms (ESD 288B, Statement of Need for Personal Care Services and ESD 288C, Statement of Cost for Personal Care Services) and return them to our office".

- The completed forms may provide additional deductions to help meet their Medicaid spenddown. The only additional allowable PCS deductions would be for those services not already covered by ACCS (see chart on following page). Calculate the expense by multiplying the number of hours required each month by the state minimum wage (found at http://www.labor.vermont.gov/Portals/0/UI/WH-11%2008%20Minimum%20Wage%20Rate.pdf), multiply the result by six to calculate the expense over the six-month period.

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

Service description	**Service Category**	
	PCS	**ACCS**
Assistance with self-administered medications	X	X
Assistance w/dressing	X	X
Assistance /bathing	X	X
Assistance w/grooming	X	X
Assistance w/eating, drinking, diet	X	X
Assistance w/toileting	X	X
Assistance w/positioning	X	X
Assistance w/transferring	X	X
Assistance w/ambulation	X	X
Assistance w/use of adaptive equipment	X	X
General supervision of physical & mental well-being	X	X
Assistance w/ food prep	**X**	
Assistance w/limited housekeeping services	**X**	
Accompany individual to clinics, physician's office	X	X
Continuation of training programs	**X**	
Management of money	**X**	
Assistance in monitoring vital signs	X	X
Routine skin care	X	X
Assistance w/exercise	X	X
Medication monitoring		X
Medication administration		X
Restorative nursing		X
Nursing assessment		X
Health monitoring		X
Routine nursing tasks		X
24-hr on-site assistive therapy		X
Case management		X

P-2421 Documentation of SSI-Related Eligibility Factors

D. Assistive Community Care Services (ACCS) - Personal Care Deduction
(Rule: 4452.3 and 4452.4)

c. Note: If the ESD 288B and ESD 288C are not returned, no follow-up is required.

- If the ESD 288B is received at a later date, treat it as if it had been returned in a timely manner.

- When the ESD 288B is returned and it indicates that the individual receives medically necessary personal care services, beyond what is covered by ACCS, recalculate the spenddown by deducting the appropriate standard for the level of care (P-2420 D5).

- If the spenddown is met using the standard deduction, grant Medicaid.

- If a physician requests authorization to charge more than $50 to complete the ESD 288B and ESD 288C, you may authorize up to $75. Amounts from $76 to $150 require supervisory approval. Any amount over $150 requires approval by Operations. Give the authorization over the phone to the physician and document it in the case file.

- For specifications on when a new plan of care is needed, see 4452.3.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)

ACCESS has not been programmed to determine eligibility for working disabled individuals.

Follow the steps below to calculate a manual budget.

1. Step One - Determine Traditional SSI-Related Medicaid Eligibility.

   a. Resources - Determine the resources of the individual(s). Resources must not be above $2,000 for an individual or $3,000 for a couple.

   b. Income - Calculate Medicaid assistance group's net income using an ESD 203B1 (SSI/AABD related) worksheet and the rules at 4281.1. Remember to deduct the work expenses for blind individuals (rule 4283.2) and disabled individuals (rule 4283.3).

      - If the net countable income on Line E is below the PIL for 1 or the SSI/AABD payment level for 2, grant traditional Medicaid.

      - If the net countable income on Line E is above the PIL for 1 or the SSI/AABD payment level for 2, go to step 2.

2. Step Two: Determine WPWD Medicaid Eligibility.

   The individual must be disabled and working to qualify for WPWD.

   a. Resources

      1. Determine the resources of the individual(s). Resources must not be above $5,000 for an individual or $6,000 for a couple, and may include excluded resources (4248.8) that are:

         - Liquid assets accumulated from earnings by a working disabled person on or after 1/1/2000 and kept in a separate account from other liquid assets unless a hardship exists.

         - These may include interest on assets from earnings.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)

- A hardship exists when no bank is within a reasonable distance from work or home that permits the person to establish an account without charging a fee.

- Non-liquid assets purchased by a working disabled person on or after 1/1/2000 with savings from earnings or with a combination of savings from earnings and other excluded income or resources.

  Note: If you granted a working disabled person traditional Medicaid because they were under the PIL for one or the SSI/AABD income level for two, they are still considered a working disabled person and have the option to set aside money from their earnings in a separate account.

b. Income

1. Compare the assistance group's net countable income on Line E to the 250% FPL guideline (P-2420 B1). If the net income is higher than the 250% FPL guideline, the person is not eligible for the WPWD program.

   - If the net income on Line E is below 250% FPL, go to section 3.

   - If the net income on Line E is above 250% FPL, and the individual is categorically eligible, calculate a spenddown. After the spenddown is approved, screen for eligibility for VHAP, VHAP-Pharmacy, VScript, VPharm, HVP or Premium Assistance and/or QMB, SLMB, or QI-1 programs.

   Reminder: QI-1 can only be granted to someone who meets the income test (>120%,≤135% FPL) *AND* is not receiving any federally funded health care such as Medicaid, VHAP, VHAP-Pharmacy or VScript. However, QI-1 can be allowed for someone who is also eligible for VPharm.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)

3. Step Three - Verify earnings using the required proof.

Earnings must be documented by evidence of:

- Federal Insurance Contributions Act (FICA) tax payments,
  - Proof of these payments may appear on pay stubs as FICA, OASDI, Social Security Tax or Medicare Tax.
- Self-Employment Contributions Act tax payments, or
- A written business plan approved and supported by a third-party investor or funding source.

a. Employed - If the individual is employed, a copy of a pay stub must be provided upon application and at each review to proof that FICA taxes are being deducted. If the applicant has multiple employers, they only need to verify that FICA tax payments are being made from one employer.

b. Self-Employed - If the individual is self-employed, one of the following tax forms must be provided at application and at each review to proof that Self-Employment Contributions Act tax payments are being made:

- 1040, Line 27 - shows ½ of the self-employment taxes that are paid by the tax payer
- Schedule SE

Types of self-employment that do not require FICA or SECA tax payments, and thus do not meet the criteria for employment for WPWD eligibility purposes are:

- Rental Income (as shown on Schedule E - Page 1)
- S-Corp (as shown on Schedule E - Page 2)

1. Written business plan: Things that might qualify as a written business plan could include (but would not be limited to) a formal business plan reviewed by the Small Business Administration, a Vocational Rehabilitation Individual Plan for Employment, a written self-employment plan created in conjunction with a person's caseworker, or a written contract containing work/business specifications and payment provisions.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)

2. Third-party funding source**:** The required third-party funding source might be a bank, a credit union, a party to a written contract, a nonprofit social service organization, or a State agency such as Vocational Rehabilitation.

If the applicant cannot show that they are making FICA or Self-Employment Contributions Act tax payments, or if they have no written business plan approved and supported by a third-party investor or funding source, then the employment does not meet the requirement for the WPWD program. Process other health care programs.

If the employment meets the verification requirements as stated above, go to section 4.

c. If an individual is active WPWD and begins receiving Workers Compensation (WC) or Unemployment Compensation (UC), and will be returning to the same employer at the end of the WC or UC period, he or she can be considered employed for WPWD purposes (assuming the person had been paying FICA prior to the WC/UC taking effect, and will continue to do so when he or she returns to work). WC and UC are considered unearned income and are not excluded from the calculations for the WPWD program.

4. Step Four – Re-determine income using SSI/AABD related Medicaid rules (4281.1).

The following disregards under the WPWD program only apply to the disabled working individual and not to the spouse unless the spouse also meets the criteria for the program.

a. Disregard all SSDI and/or VA disability benefits for the working/disabled person.
b. Calculate all of the spouse's unearned income and any other countable unearned income of the disabled person (4281.1) and enter on Line A1 of the worksheet.

c. Deduct any allowable unearned income exclusions in section B to arrive at the net countable unearned income, Line C and D11.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)

d. Enter any unused portion of the unearned income exclusions, if any, on Line D 2.

e. Compute Section D by excluding all earned income of the working/disabled person.

f. Enter the spouse's gross earned income, if any, on Line D1.

g. Deduct all allowable income exclusions and disregards per 4281.1 (Lines D2 – D9 and D13). The spouse get $65 plus ½ disregard.

h. Compare the total countable net income on Line E to the appropriate PIL for (1) or the SSI/AABD payment level for (2).

- If the resulting income is below the PIL for (1) or the SSI/AABD income level for (2), grant WPWD Medicaid to the working disabled individual. See section 5.
- If the resulting income is above the PIL for (1) or the SSI/AABD income level for (2), the individual is not eligible for WPWD Medicaid. Process other health care programs without using the special WPWD disregards.

Reminder: Even though you used the spouse's income in the calculations, you cannot grant WPWD Medicaid to the spouse unless he/she is also disabled and working.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)

5. Step Five - Grant WPWD Medicaid and screen for BYIN.

a. Use a BD category code and assign a 12-month review date with a review reason 50.

b. Screen the working disabled person for QMB and SLMB using the usual SSI/AABD Medicaid rules (i.e., net countable income on Line E at Step 1). Remember, if granting WPWD Medicaid, you cannot grant QI-1.

c. Do not use the working disabled disregards for BYIN programs.

d. If you grant QMB or SLMB to a person with a BD code, use the BYIN window in ELIG-C-ME.1 to enter the appropriate code (Y = QMB; S = SLMB) to start BYIN.

6. Granting WPWD Medicaid when eligible for another program.

To change an active VHAP, Premium Assistance, VHAP-Pharmacy, VScript, VScript Expanded, VPharm or HVP recipient to WPWD Medicaid:

- Close active healthcare program with a code 28.
- After the closure goes through background, enter an "X" on the disabled person's ASSIST ASKED field and enter a "1S" in the ASSISTANCE CASE MEMBER field. If there are other household members, keep the 1A so budget remains correct for other household members. Also consider other household members for ANFC-related Medicaid. Remember that by granting a household member under WPWD Program, you can exclude that person's income and resources in the ANFC-related eligibility of the remaining household members.
- Review all other panels to be sure the information is current, particularly all earned and unearned income panels.
- Grant the working disabled person Medicaid using a BD category code and assign a 12-month review with a review reason 50.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)

7. Applications Needing Disability Determination

- If someone applies for Medicaid, who has not yet been determined disabled, screen the individual's financial eligibility. If the individual passes the financial requirements for traditional Medicaid, forward the disability application to DDS and process as you would for traditional Medicaid.

- If the person fails the traditional Medicaid requirements but passes the WPWD Medicaid financial requirements, check the box on the 213D that states "working - disregard substantial gainful activity".

- If the individual fails the WPWD Medicaid rules and based on earnings, are considered to be engaged in substantial gainful activity, per P-2420 B7. DENY Medicaid w/ RSN 32 and screen for VHAP if the person is not eligible for Medicare or screen for VPharm if the person is eligible for Medicare.

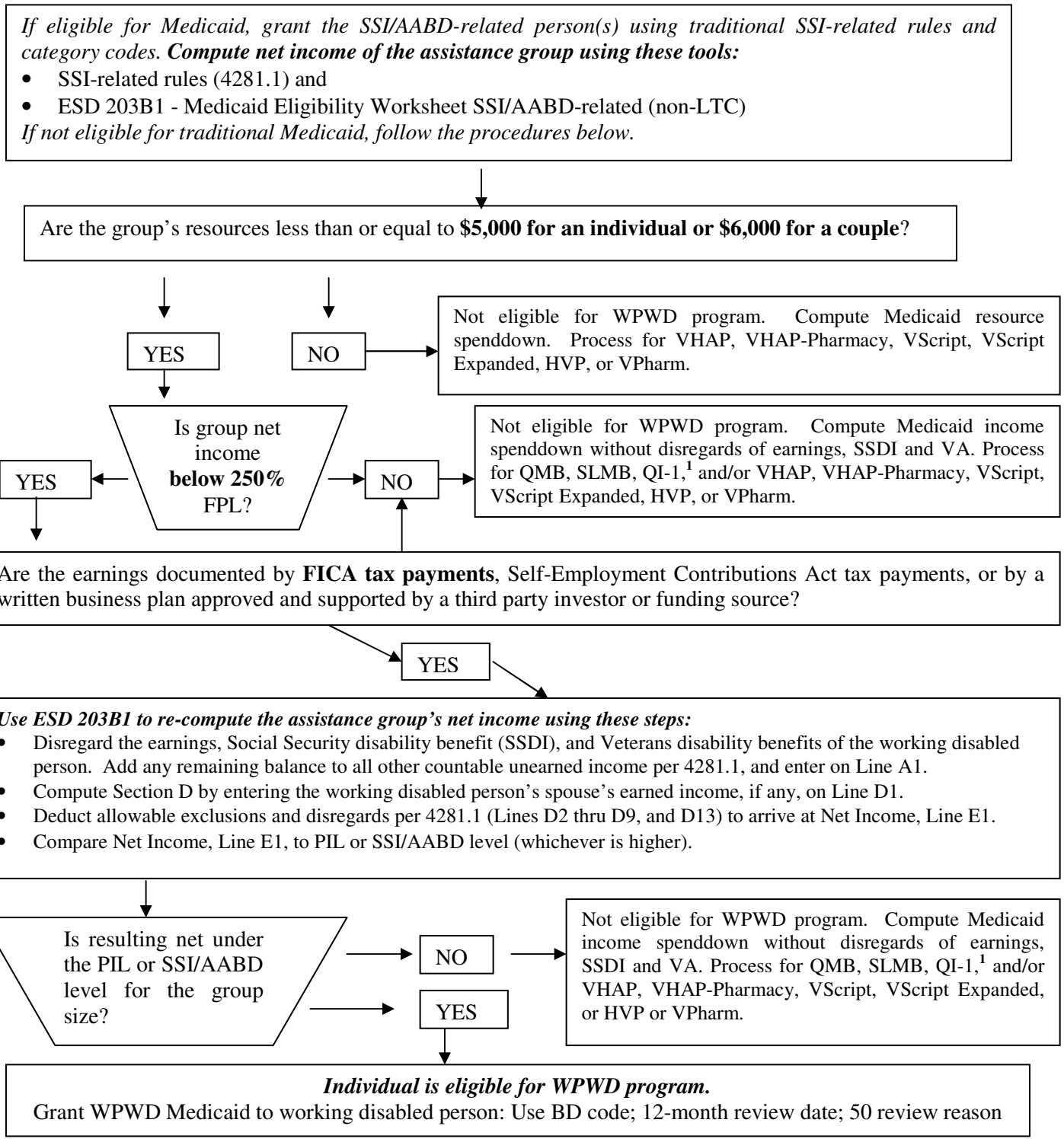
8. Individuals Reaching Full Retirement Age

Individuals may receive WPWD category and disregards until they hit full retirement age, as defined by the Social Security Administration. (To identify an individual's full retirement age, refer to this website: http://www.socialsecurity.gov/retire2/agereduction.htm).

At retirement age, they are no longer eligible for their SSDI income exclusion, as this funding source changes to SSA retirement. However, the working disabled individual's earnings are still excluded and they are still allowed the 250% income test.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

E. Eligibility for Working People with Disabilities (WPWD) Program Rule 4202.4 (B)



[1] **Reminder** – Use traditional SSI-related income rules to process QMB, SLMB, or QI-1. Effective 12/1/05, BYIN programs do not have a resource test.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

1. Step One – BCCT Ladies First Screening for Clinical and Financial Eligibility

If a woman indicates that she is receiving treatment for breast/cervical cancer, or a precancerous condition (i.e. cervical dysplasia), refer her to Ladies First for initial eligibility screening.

Ladies First screens her for eligibility for their program based on the following requirements:

- 18 – 65 years old,
- income below 250% FPL,
- uninsured or underinsured,
- Vermont resident.

Eligible women are then referred for medical screenings. Ladies First verifies if the woman is receiving active treatment for her BCCT related condition.

If eligible for Ladies First AND the medical screening shows a diagnosis of breast cancer, cervical cancer, or a precancerous condition (i.e. cervical dysplasia), Ladies First completes the BCCT application form with the woman. Ladies First then mails the BCCT application to HAEU (or faxes the application and mails the original).

2. Step Two- Determine Medicaid Eligibility

BPS #779 in HAEU is the only BPS who processes eligibility for a BCCT case (applicant and applicant's other family members if applicable). This worker does a preliminary review of the BCCT application for potential eligibility for other traditional Medicaid programs, and determines if she is already covered by another insurance plan. If ACCESS or the BCCT application indicates that she has active health insurance, skip to section 4.

a. Screen for traditional ANFC- or SSI- related Medicaid eligibility

1. If she has category for traditional Medicaid, send her a 202MED application to complete, via 202V letter (and 202V2, if necessary). Explain in the letter that her BCCT application was received, but she must first be screened for traditional Medicaid programs. Request additional information as needed to determine traditional Medicaid eligibility. BCCT applicants must also meet citizenship and identity requirements.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

- If she does not return the 202MED, all coverage must be denied for non-cooperation. Calling her to assist with this process may be effective to avoid denial.

2. Eligible

- Grant traditional Medicaid.
- Enter a WARN: Eligible for traditional Medicaid but if she becomes ineligible before her twelve month review, notify #779 so can grant BCCT for the remainder of the twelve months with a BG category code.
- Enter a CATN stating that she is eligible for traditional Medicaid.
- Notify the Public Health Specialist at Ladies First via email.
- Write the period of eligibility on the bottom of the BCCT application. The 202MED is filed in regular filing, not specified BCCT filing.

3. Ineligible

- If she is not eligible for traditional Medicaid, grant BCCT Medicaid for twelve months, beginning the first day of the month in which the BCCT application was received in HAEU.
- Include explanation in additional text of Notice of Decision that she has been granted coverage through the BCCT Medicaid program and request that she report any changes, including treatment providers, to Member Services.
- Enter a WARN function on all BCCT cases - WARN: BCCT Medicaid Case - Do not make any changes to this case. Contact worker #779 in HAEU.
- If case is active in a district office, worker # 779 will need to be notified if she reports a new treatment provider, as the Breast and Cervical Cancer Treatment Program Manager at OVHA and Ladies First will need to be notified by # 779 of the change.
- If she needs retroactive assistance, see section 2 (b).

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

- Email the Public Health Specialist at Ladies First and the Breast and Cervical Cancer Treatment Program Manager at OVHA contact person with the BCCT eligibility decision, including effective date of coverage, review date and diagnosis.

- Write on the BCCT application the period of coverage granted and make three copies of the application. Forward one to OVHA, one to Ladies First and one is filed in HAEU's regular filing. The original BCCT application is filed in the BCCT filing cabinet kept in HAEU.

- Enter her information on BCCT Tracking Spreadsheet (name, social security number, date coverage began, review date, any case notes, such as retroactive coverage periods granted and diagnosis code). This spreadsheet is used so worker # 779 will know what individuals are scheduled for review each month. Also, OVHA and Ladies First use this spreadsheet to update their records.

Breast and Cervical Treatment Medicaid (BCCT)

New Program -- Effective 7/1/01

Last updated on 7/29/08

Last Name	First Name	Social Security #	Initial Grant	Next Review	DENIAL	**Closed**	(**All cases have WARNs on them.) Notes	Continuing Coverage???	Dx
Simpson	**Marge**	111-11-1111	11/01/03	10/31/04		10/31/04	**No longer receiving treatment**		D
Simpson	**Lisa**	222-22-2222	09/01/05	08/31/08			**Marge Simpson - HH**		B
Boop	**Betty**	333-33-3333	02/01/04	01/31/06		01/31/06	**failure to return review application**		D
Oil	**Olive**	444-44-4444	02/01/07	01/31/08			**has private insu through 1/31/07Active LDO #198**		B
Mouse	**Minny**	555-55-5555	10/01/03	09/30/06		11/30/06	**no longer receiving treatment**		D
Duck	**Daisy**	666-66-6666	09/01/06	08/31/08			**retro 9/06**		D
Poppins	**Mary**	777-77-7777	01/01/04	12/31/06		11/30/06	**no longer receiving treatment**		D
White	**Snow**	888-88-8888	09/01/03	08/31/08			**Retro coverage eff 8/1/03 thru 8/31/03**		B
Fiona	**Princess**	999-99-9999	02/01/04	08/31/05		08/31/05	**HH: Shrek**		C
Shortcake	**Strawberry**	000-00-0000	06/01/07	05/31/08			**retro for 6/07**		D

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

b. Retroactive BCCT Eligibility

Retroactive coverage is available and can be granted up to three months prior to the BCCT application month, but not further back than the date of diagnosis. A Medicaid Request for Retroactive Assistance, ESD 202A, is not needed. If retroactive assistance is being requested, Ladies First will have written it on the BCCT application. If not, email the Public Health Specialist at Ladies First for clarification.

- If retroactive assistance is granted, grant BCCT Medicaid twelve months from the start of the retroactive date, as she is only eligible for twelve months of coverage.

- Enter a CATN with period of retroactive coverage and that Ladies First and OVHA were notified, via email.

- Enter in the "notes" section of the BCCT Tracking Spreadsheet the dates of retroactive coverage granted, if any.

c. Eligibility of Other Household Members

There is no resource or income test for BCCT eligibility, however, if other household members are applying for coverage, her income and resources are counted toward their eligibility.

#779 will determine other household member's eligibility as well. If additional information is needed to determine their eligibility, verification letters will be sent requesting this information. If they fail to respond to the letters, their coverage will be denied/closed for non-cooperation, however the BCCT coverage will not be affected.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

d. ESD District Cases

1. If a BCCT application is received and the case is already pending in a district office and it appears she may have category for Medicaid, request a copy of the 202 or 202MED application from the district. Notify the worker that case will be transferred to # 779 briefly, to determine BCCT eligibility (follow procedures in Step 2), then will be transferred back upon completion.

2. If a district worker transfers an active BCCT case to themselves, # 779 should request that the category code not be changed from BCCT (BG/BH), unless it is a Reach Up Financial Assistance case. RUFA cases will change the BG/BH code to a RUFA code (AR/A8). When RUFA ends, district worker needs to notify #779 of this, and if still BCCT eligible, #779 will change code back to BG/BH.

e. BCCT Review

1. On the first of each month, send separate emails to the Breast and Cervical Cancer Treatment Program Manager at OHVA listing women's names and date of birth who are due for a medical review in the following month. Explain that she is due for review and ask if she is still receiving active treatment for her BCCT related condition. As replies are received from OVHA, print and file the emails and enter a CATN in ACCESS documenting if she is still receiving treatment or if treatment has ended.

2. If she is active in a district case, email the district worker to notify that HAEU needs the case to determine BCCT eligibility and transfer the case to #779. This is done so that the 202MED review form, along with the review letter, will be mailed with HAEU's information instead of the district's, lessening the confusion when the review form comes in. Also put on the WARN function to not send the 202MED to the district office.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

3. Upon receipt of 202MED:

Still in Need of Treatment

- OVHA notifies #779 via email that she is still in need of treatment and to continue BCCT. (Do not screen for traditional Medicaid eligibility at this time).

- Approve BCCT Medicaid for another twelve months.

- Include an explanation in additional text of the Notice of Decision that she continues to receive coverage under the BCCT Medicaid program and request that she notify Member Services if she changes treatment providers.

- Send emails to the Breast and Cervical Cancer Treatment Program Manager at OVHA and Ladies First notifying them that she will continue to receive BCCT Medicaid. Indicate the next review date.

No Longer in Need of, or Complying with, Continued Treatment

- If OVHA notifies #779 that she is no longer in need of, or in compliance with, continued treatment, close BCCT Medicaid with reason code 32, and screen for all other health care programs.

- In additional text of Notice of Decision, explain that she is no longer eligible for BCCT Medicaid, as she is no longer receiving active treatment for her BCCT related condition and that she has been screened for other health care programs.

- Enter a CATN and update WARN in ACCESS explaining this.

- Send an email to Ladies First and OVHA with BCCT closure date, reason for closure and new program she is eligible for, if any.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

4. Update BCCT Tracking Spreadsheet with new review date, if she continues to be eligible for BCCT. If denied/closed, update denial or closure date and include in "notes" section reason for denial/closure.

5. If this case is active in the district, once BCCT eligibility is complete, transfer case back to the district office and note this on BCCT Tracking Spreadsheet.

3. Changes

a. Upon notification of an address, phone number and/or treatment provider changes, # 779 must send an email to the Breast and Cervical Cancer Treatment Program Manager at OVHA and Ladies First with updated information. Enter a CATN to document notification of the change to OVHA and Ladies First.

b. Critical Age changes

1. If she turns 18 or 21 years old, while on Dr. Dynasaur or traditional Medicaid, during the twelve month review period, set her up for a review on the first of the month prior to her birthday month. Her coverage can then be changed to BCCT for the remainder of her twelve month review period, based on the BCCT application date.

2. If she is turning 65:

- Set up for review the month prior to her birthday month and screen for all other health care programs at that time.

- Once review is complete, transfer case to appropriate worker and remove WARN in ACCESS.

- Enter a CATN explaining that she turned 65 and is no longer eligible for BCCT Medicaid.

- Email the Public Health Specialist at Ladies First and the Breast and Cervical Treatment Program Manager at OVHA with closure date and reason and update BCCT Tracking Spreadsheet with closure date and reason in "notes" section.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

F. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

c. BCCT Individual Moves to Vermont

1. VDH and ESD can accept the BCCT determination of the previous state of residence. She does not need to be screened through Ladies First or for traditional Medicaid.

2. Grant BCCT Medicaid with the review date twelve months from the eligibility decision from the previous state of residence.

4. Other health insurance

a. A woman who has health insurance is not eligible for the BCCT program. She may close her private or state health insurance plan and be placed on the BCCT Medicaid program, if eligible. However, you should refer her to the Ombudsman's office before she terminates her current private (non-state sponsored health insurance) coverage.

b. A BCCT recipient under the age of 65 who becomes Medicare eligible is not eligible for BCCT Medicaid. This will be important if she expects to need treatment for an extended period of time and begins receiving Medicare on the basis of disability. You will need to explain this to her in writing, if she indicates that she is contemplating applying for disability and refer her to the Ombudsman's office (1-800-917-7787) for assistance.

★ See Centers for Medicare and Medicaid Services (CMS) website for more information following the link below:

http://www.cms.hhs.gov/MedicaidSpecialCovCond/02_BreastandCervicalCancer_PreventionandTreatment.asp.

P-2421 Documentation of SSI/AABD-Related Eligibility Factors

. Eligibility for Breast and Cervical Cancer Treatment (BCCT) Program
Rule 4202.4 and 4312.8 (E)

5. BCCT Eligibility Flow Chart

* To refer a woman for this program, she must call Ladies First at 1-800-508-2222.

STEP ONE (done by *Ladies First*):

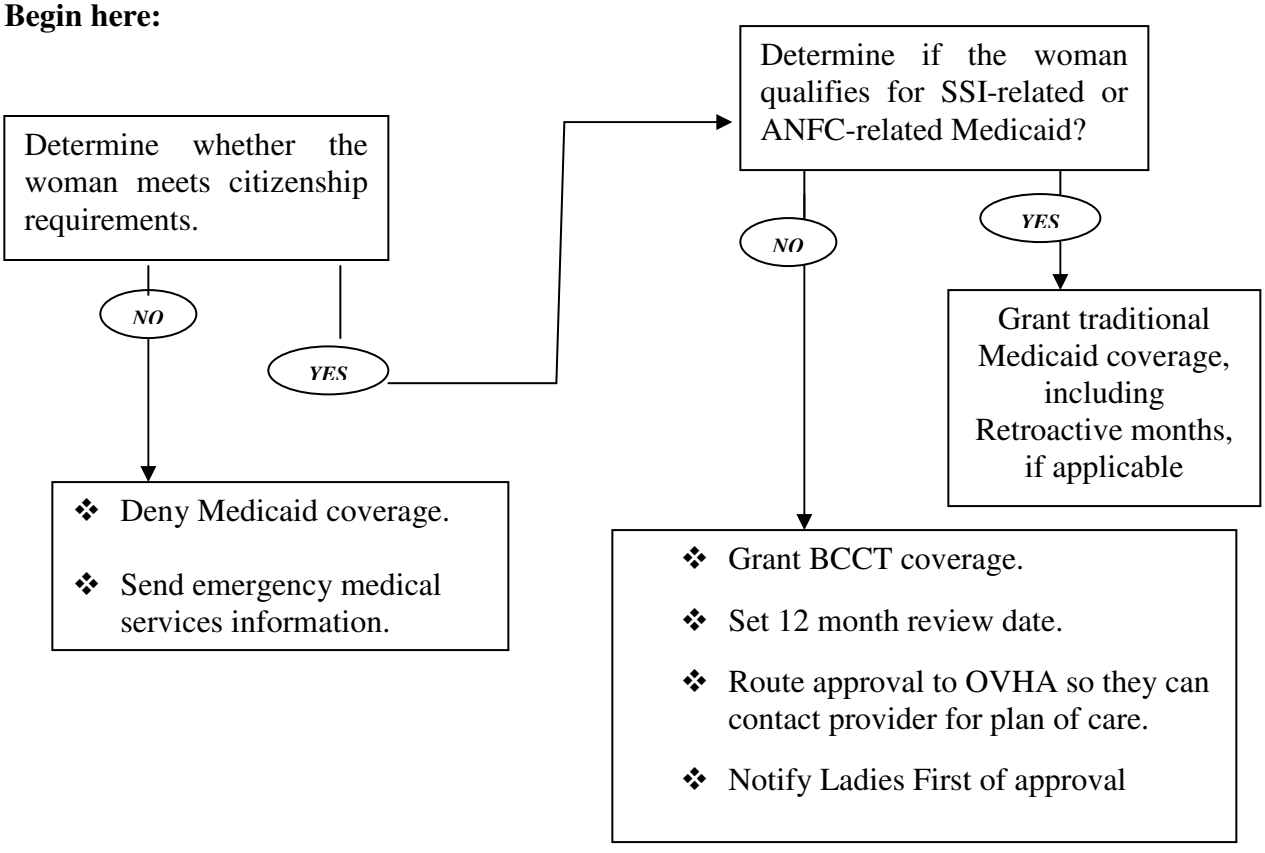
- Initial screening for potential BCCT eligibility.
- Fax /Pink mail completed BCCT application to # 779 in HAEU.

STEP TWO (done by ESD/HAEU):

- PROCESS signed application WHEN IT ARRIVES in the mail/fax.
- Determine from signed application whether woman:
  - might qualify for SSI-related Medicaid
  - might qualify for ANFC-related Medicaid

Eligibility Decision Process

Begin here:



P-2423 Processing Eligibility Decisions (Continued)

J. Pursuing other Types of Income (Rule M128)

As a condition of health care eligibility, applicants and recipients must take all necessary steps to obtain income they may be entitled to – including applying for unemployment compensation.

1) Applications and Reviews

When individuals are applying for health care benefits or are due for review, they must apply for unemployment benefits if:

- their application form does not indicate they are currently working (including self-employment), and
- the loss of private insurance (LOSS) question on the application indicates they lost insurance due to a job loss within the past 12 months.

2) Individuals Who do not Need to Apply for Unemployment Compensation

1. Teachers who will be returning to their job in the next school year.
2. Individuals who are unavailable for work for ANY reason (including stay-at-home parent or for medical reasons).
3. Individuals who are no longer self-employed (ie: their business closed).

3) Reported Job Loss

Individuals receiving health care must apply for unemployment benefits when they report their job has ended, UNLESS they already have another job or meet one of the exception criteria listed above.

4) Referral to Department of Labor

When individuals need to apply for unemployment benefits, please use the following text in your verification request notice:

You must apply for unemployment benefits by calling Department of Labor at 1-877-214-3330. Please let us know when you have done so.

*Reminder: Applicants receive two verification request notices (if needed); active recipients receive only one.