

Par.1. **Material Transmitted and Purpose** – Transmitted with this Manual Letter are changes to Service Chapter 400-29 – Basic Care Program Policy. This also incorporates changes made with:

- IM 5126, Disaster Unemployment Insurance Benefits
- IM 5124, Basic Care Rates and Remedial Expenses – Updated July 2011

Note: IM 5124 will **not** be manualized as the information in the IM is time limited.

Par. 2. **Effective Date** – This manual letter is effective for the benefit month of October 2011.

Items listed in Par. 3 are changes in policy. Items listed in Par. 3. **Policy Changes** This section includes new policy that is effective for the benefit month of October 2011.

Definitions 400-29-15

Added: Words Interest income from liquid assets under #18 after the words "occasional small gifts".

"Gross income" includes any income at the disposal of an applicant, recipient, or responsible relative; any income with respect to which an applicant, recipient, or responsible relative has a legal interest in a liquidated sum and the legal ability to make the sum available for support or maintenance; or any income an applicant, recipient, or responsible relative has the lawful power to make available or to cause to be made available. It includes any income that would be applied in determining eligibility for benefits; any income, except occasional small gifts, **and interest income from liquid assets** that would be disregarded in determining eligibility for benefits; annuities, pensions, retirement, and disability benefits to which an applicant or recipient, or spouse of an applicant or recipient, may be entitled including veteran's compensation and pensions of any type, old-age survivors benefits, and disability insurance benefits; railroad retirement benefits; and unemployment benefits.

Application 400-29-20

Changed: word ~~later~~ to earlier in #6

Deleted: words ~~must be in the case file~~

Added : word for in # 11

6. The date of the application is the date the application is signed by an appropriate person, and is received by the county social service board. The date of eligibility is the date of application or the date the individual became eligible for the program, whichever is ~~later~~ earlier.
10. A completed Personal Care Services Assessment by a county social worker to cover personal care services provided by a basic care facility ~~must be in the case file~~.

NOTE: Approval to cover retroactive eligibility up to 3 prior months requires approval by the State Office Medical Services Rate setting unit.

11. If an individual is private pay and applies for Basic Care Assistance, the individual must apply for Medicaid and a functional assessment and a personal care assessment must be completed. If there is a delay in the completion of the assessment pending determination/approval of Medicaid, the Resident Payment System date for the Functional Assessment may need to be backdated to equal the Basic Care eligibility start date for payment purposes.

Notice of Decision 400-29-25

Deleted: words ~~A 10-day advance notice is required before increasing the next month's recipient responsibility~~ in # 4.

Change: word ~~of~~ to or in #6

4. A 10-day advance notice is required to be sent to a recipient informing them of their next month's recipient responsibility. ~~A 10-day advance notice is required before increasing the next month's recipient responsibility.~~

When reworking a month based on new or changed information, 10-day advance notice or adequate notice does not apply. Basic Care policy states all available income must be counted with no exceptions. If information is received that changes the recipient responsibility, the month must be reworked to account for the new information.

6. A 10-day advance ~~of~~ or adequate notice is not required in the following instances, but the county is still required to inform the recipient of the action taken if:

Eligibility Criteria 400-29-35-05

Added: words "if eligible" in #4.

Changed: missing understanding to misunderstanding in #6 Note.

Added: words, "SFN 21" in # 5 and "SFN 662 and SFN 663" in # 6.

Added: words, An individual that meets the criteria under the functional assessment but not the personal care service assessment may, if they meet all other eligibility criteria, receive assistance for room and board.

4. Must apply for and receive benefits, if eligible, through the Medicare Savings Programs under Qualified Medicare Beneficiaries (OMB), or specified Low-income Medicare Beneficiaries (SLMB). The Medicare Savings Programs are available to assist with Medicare costs for people with limited income and assets.
5. An applicant or recipient must meet functional assessment criteria in accordance with the North Dakota Administrative Code Chapter 75-02-10-10, is not severely impaired in any of the activities of daily living of toileting, transferring to or from a bed or chair, or eating, is in need of a structured or supervised environment, and is impaired in three of the four instrumental activities of daily living. The functional assessment is required before the Department will pay for room and board in a licensed basic care facility. The functional assessment is completed by the Home and Community Based Services Division located at the County Social Service Board.

- A "Transmittal Between Units" form ([SFN 21](#)) is used to request a functional assessment on an applicant or recipient. For a resident of the State Hospital discharged to a Basic Care facility and who is a BCAP applicant, the initial functional assessment done by the State Hospital social worker must be used.
6. An applicant or recipient must receive and meet the criteria established under the personal care service assessment ([SFN 662 and SFN 663](#)) in order for the basic care facility to receive the personal care service payments. The assessment is completed by the Home and Community Based Services or Developmental Disability Services case manager.

Note – At times SSI, SSA and VA benefits are in question because an individual is residing in a basic care facility and there is a ~~missing understanding~~ misunderstanding that the facility is a long term care facility. Basic care facilities are licensed under NDCC 23-09.01 to provide room and board to individuals who have an impaired capacity for independent living but who do not require 24-hour medical or nursing services. Individuals residing in basic care facilities are not receiving care in a nursing facility as described in §1919 of the Social Security Act.

An individual who meets the criteria under the functional assessment but not the personal care service assessment may, if they meet all other eligibility criteria, receive assistance for room and board.

Disqualifying Transfer 400-29-35-15

Added: #10 Section 510-05-80-35, Transfer to Relatives applies to applicants/recipients receiving benefits under this program.

10. Section 510-05-80-35, Transfer to Relatives applies to applicants/recipients receiving benefits under this program.

Temporary Basic Care Assistance 400-29-40-10

Deleted: words " And the 6 months begins the first day of the temporary stay based on that written verification and count 180 days to determine when the home can no longer be excluded."

Added: The words "The six month period begins with the first full calendar month the individual is in the basic care facility."

An applicant or recipient temporarily placed in a licensed basic care facility for a period of less than six (6) months with a goal of returning home must provide written verification from a physician that they will be able to return home within six months;

An individual living in a basic care facility temporarily is allowed the following deductions and exemptions:

1. A deduction of the Medicaid income limit for one person.
2. An exemption on their home for that time period.
3. A deduction for a health insurance premium such as Blue Cross/Blue Shield and or Medicare.
4. A deduction for the amount of the expenses paid of the home the individual will be returning to:
 - a. Rent or mortgage expense
 - b. Mortgage or rental insurance
 - c. Property taxes
 - d. Condo fees
 - e. Utilities and other expenses required to main the home while residing in the basic care facility

Written verification must be obtained to validate that the individual is temporarily placed in the basic care facility (period of less than 6 months). ~~And the 6 months begins the first day of the temporary stay based on that written verification and count 180 days to determine when the home can no longer be excluded. The six month period begins with the first full calendar month the individual is in the basic care facility.~~

Income (BCAP) 400-29-60

Changed: word ~~counts~~ to considers

Deleted: words, "and interest income except IIM interest income" and including interest income from checking or savings accounts. Based on verification of interest income received at the time of application and redetermination from checking or savings account interest income may be annualized or averaged over a 12 month time period.

Deleted: must be considered as income in the month received and assets thereafter.

Changed: paragraph on VA to state that payments are not counted as income:

is not considered as income the month it is received. These payments are considered to be medical payments which must be applied towards the recipient's medical cost.

Basic Care ~~counts~~ considers Individual Indian Monies (IIM) income the same as Medicaid and disregards.

Income is the gain or benefit, earned or unearned, derived from labor, business, capital or property that is received or is available to the individual.

Earned income is defined as income earned through the receipt of wages, salaries, commissions, or profit from activities in which an individual is engaged through employment or self-employment. Earned income must entail personal involvement and effort on the part of the applicant or recipient. The household must verify all income.

Unearned income is income not gained by current labor, service, or skill. The types of unearned income include but are not limited to Social Security benefits (Social Security Income (SSI), Social Security Disability benefits, Social Security Survivors benefits), Veterans benefits, private pensions, Workman's Compensation, rental income, and dividends. ~~and interest income except IIM interest income.~~ Interest income from liquid assets will be disregarded,

All income under the Basic Care Assistance program must be counted. ~~including interest income from checking or savings accounts. Based on verification of interest income received at the time of application and redetermination from checking or savings account interest income may be annualized or averaged over a 12 month time period.~~

VA – Aid and Attendance payment follows Medicaid policy, Section Unearned Income 510-05-85-15, "Veteran's Administration aid and attendance, Veteran's Administration reimbursements for unusual medical expenses, and Veteran's Administration homebound benefits intended for medical expenses, ~~must be considered as income in the month received and assets thereafter.~~" is not considered as income the month it is received. These payments are considered to be medical payments which must be applied towards the recipient's medical cost.

Allowable Gross Income Deductions 400-29-60-05

Changed: word actual to actually

Individuals moving from a basic care facility to another living arrangement such as home, apartment, assisted living, etc., will be allowed the same household expense deduction that they are allowed in the month of entry into a basic care facility as long as the expenses are ~~actual~~ actually paid and not just incurred.

Excluded Income 400-29-60-10

1. **Added:** the sentence Disaster Assistance Unemployment Insurance Benefits are disregarded as income.

The following types of income do not count as income (earned or unearned) and are not used to determine the individual's recipient responsibility towards cost of care in a licensed basic care facility:

1. Occasional small gifts;
Occasional small gifts means cash received for special occasions such as birthdays, Christmas, etc. are considered to be complementary in nature and will be disregarded. The cash gift must be related to a special occasion. If the cash gift is not related to a special occasion, it will be counted as a cash contribution. Occasional means occurring infrequently, done for or connected with a special event such as birthday and Christmas, and it is not essential or necessary to meet an individual's needs. A small amount of money means little in quantity or value. These definitions are provided so that eligibility workers may use prudent judgment regarding occasional gifts received by an individual in a basic care facility.
2. Foster Grandparent Program income if the individual joined the program after entering a licensed basic care facility.
3. Disaster Assistance Unemployment Insurance Benefits are disregarded as income.

Redetermination of Eligibility (BCAP) 400-29-70

Added: Paragraph #3 A redetermination of the recipient's functional status is to be completed at the time of redetermination for Medicaid eligibility. The functional status is reported on SFN 21 under the functional assessment section. New paragraph, Basic Care requires a functional assessment be completed annually. Personal care assessment is required to be updated every six months. If a redetermination and the functional assessment do not coincide, the most recent functional assessment or personal care assessment may be used as long as the assessment is not older than six months.

Redetermination of eligibility for this program must be done at least annually, using SFN 407, "Redetermination of Eligibility for Medicaid." A redetermination of eligibility must be completed within thirty days and the recipient notified in writing of the action taken. A redetermination must be made within thirty days after a county agency has received information indicating a possible change in eligibility status, such as a recipient enters a nursing facility.

A recipient or recipient's guardian has the same responsibility to furnish information during a redetermination as an applicant or an applicant's guardian during an application.

Functional eligibility must be re-established at the time of the annual Medicaid redetermination. A redetermination of the recipient's functional status is to be completed at the time of redetermination for Medicaid eligibility. The Home and Community Based Service case manager will complete the functional status report and inform the Economic Assistance Unit on the transmittal form. The annual functional review is completed by Home and Community Based social worker under the Targeted Case Management provision. The functional status is reported on SFN 21 under the functional assessment section

Basic Care requires a functional assessment be completed annually. Personal care assessment is required to be updated every six months. If a redetermination and the functional assessment do not coincide, the most recent functional assessment or personal care assessment may be used as long as the assessment is not older than six months.

SFN 21, Transmittal Between Units 400-29-85-05

Change: word a to an in first paragraph and moved either to the front of the statement under the paragraph.

Deleted: words ~~TECS~~ and ~~to~~ in the fourth to last paragraph

Added: words in the computer system in Medicaid ID Number and Case Number and ed to the word need in the first bullet under the paragraph.

Changed: word ~~indicate~~ to indicates in the fourth to last paragraph.

PURPOSE: A communication tool between two separate units within the County Social Service Board. This form is used by the HCBS Case Managers to inform eligibility workers that an individual meets functional eligibility criteria for Basic Care Assistance. This form is also used by eligibility workers to inform HCBS Case Managers an individual meets financial eligibility criteria for BCAP.

Medicaid ID Number: This is the Medicaid ID number assigned by TECS the computer system.

Case Number: Enter the Medicaid case number assigned by TECS the computer system.

The remaining boxes on this form are used to indicate why the form is being completed.

- If a functional assessment is needed, the eligibility worker completes the form and checks this box. The form is sent to the HCBS social worker for completion.
- If it is the annual review time, the MA Review and the Functional Assessment Review box is checked by the eligibility worker and sent to the HCBS social worker.
- Either the eligibility worker or the HCBS social worker either completes the Functional/Medicaid Eligibility Criteria.
- The eligibility worker or the HCBS social worker enters the effective date of either the functional assessment or the date of eligibility for Medicaid and Basic Care.
- Either the eligibility worker or the HCBS social worker either completes the closing date. This date is the date the case closed or the date the individual left the basic care facility.

The eligibility worker or the HCBS social worker to indicates that the placement in a basic care facility is temporary. ~~either completes this.~~ If a placement is temporary, the individual is allowed to retain specific assets, such as a home, during the temporary stay. (See 400-29-40-10 Temporary Basic Care Assistance)