Basic Care Assistance Program (BCAP)

Service Chapter 400-29

North Dakota Department of Human Services
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Basic Care Assistance Program (BCAP) 400-29

Authority Reference 400-29-01

(Revised 9/00 ML #2584)

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1. Section 50-24.5, North Dakota Century Code
2. Chapter 75-02-10, North Dakota Administrative Code, Aid to Vulnerable Aged, Blind, and Disabled Persons

General Statement 400-29-05

(Revised 9/00 ML #2584)

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The 1993 Legislature authorized the Department of Human Services to implement a basic care assistance program and to supervise and direct counties in the administration of the program. The Department is further authorized to supplement, within the limits of legislative appropriation, the income of eligible beneficiaries of basic care services to the extent that the eligible beneficiaries lack sufficient income to meet the cost of that care provided at rates determined by the Department.

Purpose 400-29-10

(Revised 9/00 ML #2584)

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This program is intended to assist individuals who are at least age eighteen, who are blind or disabled, or age sixty-five and over, who need the services provided by a licensed basic care facility. This program is a supplement program for individuals residing in participating licensed basic care facilities. The intent of this program is to supplement the income of a person who, after applying all available income to the cost of care at a basic care facility, requires further assistance.

Only those licensed basic care facilities with an audited rate may receive payment from the Department.

Definitions 400-29-15 ML 3269

(Revised 10/1/11 ML #3287)

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(NDAC 75-02-10-01)

1. "Activities of daily living" means bathing, dressing, toileting, transferring, eating, bed mobility, medication management, and individual hygiene.
2. "Aged" means at least sixty-five years of age.
3. "Alzheimers and related dementia facility" means a licensed basic care facility which primarily provides services specifically for individuals with Alzheimer's disease or related dementia.
4. "Applicant" means an individual, or proper person, seeking Basic Care Assistance benefits on behalf of another person, to a county agency.
5. "Assisted living" means an environment where a person lives in an apartment-like unit and receives services on a twenty-four-hour basis to accommodate that person's needs and abilities to maintain as much independence as possible.
6. "Assisted living facility" means any building or structure containing a series of living units operated as one business entity to provide services for five or more individuals who are aged or disabled adults and who are not related by blood or marriage to the owner or manager of the entity and which is kept, used, maintained, advertised, or held out to the public as a place that takes available individualized support services to accommodate an individual's needs and abilities to maintain as much independence as possible. It does not include a facility that is licensed as a basic care facility or a congregate housing facility.

7. "Basic Care Facility" means a residence, not licensed under NDCC § 23-16 by the Department, that provides room and board to five or more individuals who are not related by blood or marriage to the owner or manager of the residence and who, because of impaired capacity for independent living, require health, social, or personal care services, but do not require regular twenty-four hour medical or nursing services and

   a. Makes response staff available at all times to meet the twenty-four hour per day scheduled and unscheduled needs of the individual; or,

   b. Is kept, used, maintained, advertised, or held out to the public as an Alzheimer's, dementia, or special memory care facility.

8. "Blind" has the same meaning as the term used by the Social Security Administration for the Supplemental Security Income Program under Title XVI of the Social Security Act. [42 U.S.C. 1381 et seq.]

9. "Congregate housing" means housing shared by two or more individuals not related to each other and receive services not provided in an institution.

10. "Countable income" means gross income reduced by

    a. The cost of guardianship or conservatorship fees actually charged, but no more than five percent of the monthly gross income;

    b. All health insurance premiums including but not limited to Medicare health insurance supplements, cancer insurance, etc. If the deduction is allowed for Medicaid in TECS, it must be allowed as a deduction for the Basic Care Assistance Program;

    c. Court-ordered child support payments actually paid on behalf of a minor child who is not a member of the person's Medicaid unit; and,

    d. For persons receiving Basic Care Assistance:

i. The month the person enters the basic care facility, the medically needy income level of the size of family in which the person was a member before entering the basic care facility; and

ii. Sixty-five dollars plus one-half of the remaining monthly gross earned income.

e. Medicaid recipient liability.

f. The Personal clothing allowance of $60.00 per month.

11. "County agency" means the county social service board.

12. "Department" means the Department of Human Services.

13. "Disabled" has the same meaning as the term has when used by the Social Security Administration in the supplemental security income program under Title XVI of the Social Security Act [42 U.S.C. 1381 et seq.].

14. "Eligible beneficiary" means a resident of this State who:

a.

i. Is aged; or

ii. Is at least eighteen years of age and is disabled or blind:

b. Has applied for and is eligible to receive benefits under Medicaid provided that an individual who was eligible to receive benefits under Title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] and who was receiving benefits under Title XVI before January 1, 1995, is not ineligible because that individual is not eligible to receive benefits under Title XIX:

c. Based on functional assessment, is not severely impaired in any of the activities of daily living of toileting, transferring to or from a bed or chair, or eating and:

i. Has health, welfare, or safety needs, including a need for supervision or a structured environment, which requires

care in a licensed adult family foster care home or a licensed basic care facility; or

ii. Is impaired in three of the following four instrumental activities of daily living: preparing meals, doing housework, taking medicine, and doing laundry; and

d. Is determined to be eligible pursuant to rules adopted by the Department.

15. "Functional assessment" means an evaluation process based on the person's ability or inability to live independently. The evaluation process is completed by the Home and Community Based Service case manager before entering a basic care facility.

16. "Functionalstatus" means a redetermination of the recipient's functional status at the time of redetermination for Medicaid eligibility.

17. "Functional Status Report" is a report of recipients who may need a review of functional status at the same time as the Medicaid redetermination eligibility. The functional status is reported on SFN 21 under the functional assessment section.

Basic Care policy 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.

18. "Grossincome" 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.

19. "Individualized support services" means services designed to provide assistance to adults who may have physical or cognitive impairments and who require at least a moderate level of assistance with one or more activities of daily living.

20. "Institution" means an establishment that makes available some treatment or services beyond food or shelter to four or more persons who are not related to the proprietor.

21. "Instrumental activities of daily living" means activities to support independent living including housekeeping, shopping, laundry, transportation, and meal preparation.

22. "Livingindependently" includes living in congregate housing. The term does not include living in an institution.

23. "Living unit" means a portion of an assisted living facility occupied as the living quarters of an individual who has entered into a lease agreement with the assisted living facility.

24. "Medical leave day" means a day a resident is not in the basic care facility due to a medical condition.

25. "Necessary benefits" means those benefits:

    a. Provided under this program;

    b. Identified by the department (or a county agency under the direction and supervision of the department) as appropriate to meet the needs of an applicant or recipient; and,

    c. Which, when provided in coordination and conjunction with benefits available from any other source, represent the means

least costly to the department of meeting the needs of the applicant or recipient.

26. "Personal Care Services" means services consisting of a range of human assistance, provided to an individual with disabilities or conditions, that will allow the individual to live as independently as possible while delaying or preventing the need for institutionalization. Assistance may be in the form of hands on assistance or curing so that the individual can perform a task without direct assistance.

27. "Proprietor" means an individual responsible for day-to-day administration and management of a facility.

28. "Proper individual" means any individuals of sufficient maturity and understanding to act responsibly on behalf of the applicant.

29. "Qualified service provider" means a county agency or independent contractor who agrees to meet standards for services and operations established by the department.

30. "Recipient responsibility" means the amount a recipient of the Basic Care Assistance Program is responsible for to the basic care facility. The recipient responsibility cannot be offset by outstanding medical bills.

31. "Related by blood or marriage to the owner or manager" means an individual who is a spouse or former spouse of the owner or manager or is a parent, stepparent, grandparent, stepgrandparent, child, stepchild, grandchild, stepgrandchild, brother, sister, half-brother, half-sister, stepbrother, or stepsister of the owner or manager of the owner or manager's spouse or former spouse.

32. "Related by the proprietor" means an individual who is a proprietor's spouse or former spouse, or a parent, stepparent, grandparent, stepgrandparent, child, stepchild, grandchild, stepgrandchild, brother, sister, half-brother, half-sister, stepbrother, or stepsister, of a proprietor or proprietor's spouse or former spouse.

33. "Remedial care" means services that produce the maximum reduction of an eligible beneficiary's physical or mental disability

and the restoration of an eligible beneficiary to the beneficiary's best possible functional level.

34. "Resident" means an individual who has been admitted to the facility, but not discharged.

35. "Residentday" in a facility means any day for which service is provided or for which payment in any amount is ordinarily sought, including medical care leave and therapeutic leave days. The day of admission and the day of death are resident days. The day of discharge is not a resident day.

36. "Tenant" means an adult individual who has entered into a lease agreement with an assisted living facility.

37. "Therapeuticdayleave" means any day that a resident is not in the facility or in a licensed health care facility other than a medical leave day.

38. "Totalincome" means countable income.

39. "Would be eligible to receive the cash benefits except for income" refers to an individual whose countable income, less the cost of necessary remedial care that may be provided under this chapter, does not exceed an amount equal to the cash benefit under Title XVI of the Social Security Act [42 U.S.C. 1381 et seq.] which the individual would receive if the individual had no income, plus sixty dollars.

Application 400-29-20

(Revised 10/1/11 ML #3287)

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(NDAC 75-02-10-03)

1. All individuals wishing to make application for benefits must have the opportunity to do so. Medicaid recipients may complete a Medicaid Redetermination of Eligibility form to apply for assistance under this program. The application or redetermination must be signed by the applicant, a proper person, or the applicant's court appointed guardian.
2. An application is a request made by a person desiring benefits, or by a proper person seeking such benefits on behalf of another person, to a county agency.

   Note – An applicant for Basic Care Assistance must be eligible for Medicaid to receive benefits under this program.

3. An application consists of an application for Medicaid benefits and an application for services received in a licensed basic care facility, which includes a functional assessment.

   a. An application for the Medicaid and Basic Care Assistance Program on SFN 405, "Application for Assistance," or SFN 958, "Application for Health Care Coverage." A copy of the application is available as an E-form. This application process is completed by the county agency eligibility worker.
   b. An "Application for Services" which includes a completed functional assessment and may require a Personal Care Services Assessment, as described in Service Chapter 670-10 for Expanded SPED Program. This process is completed by the Home and Community Based Service Case Manager or Developmental Disability Services case manager.

Note - When entering information into the Basic Care Resident Payment system, the Effective Date of the Assessment from the Transmittal Form would be entered as the 'First Functional Assessment Date'.

If the BCAP Eligibility Start Date is for a month prior to the month the assessment was completed, the date of the functional assessment must equal that date in order for payment so payment can be made back to the start date.

Example: Individual entered Basic Care September 12th and the Functional Assessment Effective Date is October 12th. The individual was determined eligible from the date of entry. The Functional Assessment was not completed in September due to staffing resource issues. The Functional Assessment Date should be September 12th in the Resident Payment System in this instance or payment will not be made for the month of September.

4. Application forms must be signed by the applicant, a proper person, or the applicant's court appointed guardian if the applicant has been adjudged incompetent by the court.
5. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipients must be furnished to all who require it.
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 earlier.
7. If a person is already receiving Medicaid benefits, a completed redetermination of eligibility is used to determine eligibility for the Basic Care Assistance Program.
8. The applicant or guardian of the applicant must provide information sufficient to establish eligibility for benefits, including a social security number, proof of age, residence, disability, financial

eligibility, and other information as may be required to determine eligibility.

Note - Numident or TPQY may be used as verification for SSN, age and identity, social security benefits received, etc.

9. A copy of Transmittal Between Units (SFN 21) completed by county social worker to cover room and board services provided in a basic care facility must be in the case file.
10. A completed Personal Care Services Assessment by a county social worker to cover personal care services provided by a basic care facility.

    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.

Applicant's or Guardian's Duty to Establish Eligibility 400-29-20-05

(Revised 10/01/01 ML #2738)

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(NDAC 75-02-10-04)

The applicant or guardian of the applicant shall provide information sufficient to establish eligibility for benefits, including a social security number and proof of age, identity, residence, blindness, disability, functional limitation, financial eligibility, and such other information as may be required to determine eligibility.

Notice of Decision 400-29-25

(Revised 10/1/11 ML #3287)

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(NDAC 75-02-10-07)

1. Applications - A decision as to eligibility of an application will be made within forty-five days, or within ninety days in disability cases, from the date of the application, except in unusual circumstances.
2. Redetermination - A decision as to eligibility on a redetermination will be made within thirty days.
3. Immediately upon an eligibility determination, whether eligibility can be found, ineligibility can be found, or eligibility cannot be determined, applicants/recipients must be notified by the county agency. A notice must be sent 10 days in advance of any decision terminating or reducing benefits under this chapter.
4. A 10-day advance notice is required to be sent to a recipient informing them of their 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.

5. A notice must be timely or adequate.
6. A 10-day advance 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:

   a. County has factual information confirming the death of the recipient;

b. The recipient no longer meets the criteria to be in a basic care facility;
c. The county has received in writing the recipient's decision to terminate services;
d. The recipient is placed in a nursing care facility, moved to a different basic care facility, or returns home;
e. State or federal government initiates a mass change which uniformly affects all applicants, recipients, and households;
f. The recipient enters a public institution, occupants of which are not Medicaid eligible;
g. The recipient's whereabouts are unknown and mail directed to the recipient is returned by the post office indicating no known forwarding address; or
h. There is factual information that responsibility for providing assistance has been accepted by another state or jurisdiction.

7. Errors made by public officials and delays caused by the action of public officials do not create eligibility and may not form the basis for the award of any benefit to any adversely affected applicant or recipient who would not otherwise be eligible to receive that benefit.

8. A separate notice must be sent each month unless there is no change in the recipient responsibility.

9. Two notices are sent to the basic care facility address; one for the recipient and one for the facility. The Notice of Action goes to the recipient. The Monthly Budget information goes to the basic care facility which is notification to the facility on how much to collect and for what items.

Appeals 400-29-30

(Revised 10/01 ML #2738)

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1. Applicants or recipients of this program and Medicaid who are dissatisfied with a decision made by the county agency, or who have not had their application acted on with reasonable promptness, may appeal to the North Dakota Department of Human Services. (NDAC Chapter 75-01-03)
2. The claimant must appeal in writing. The appeal need not be on any particular form. The county agency, which issued a decision, shall assist the claimant in filing the claimant's appeal if requested.
3. When a recipient requests an appeal before the effective date of an adverse action and requests continued assistance, the recipient's Medicaid and Basic Care Assistance Program eligibility shall be maintained pending the final administrative resolution of the appeal.
4. The request for a fair hearing by a claimant must be filed within thirty days after the action with which the claimant is dissatisfied.
5. When assistance has continued pending an appeal decision and the county agency's decision to close the case is upheld, the case must be closed the day the decision is received by the county agency.

County Responsibility 400-29-30-01

(Revised 10/01 ML #2738)

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Upon receipt of an appeal and request for a hearing, the county agency is required to complete an "Appeal Background Report," SFN 1784, and send to the Appeals Supervisor. Along with this form include all pertinent documentation such as notices sent to the recipient; the written appeal request and verification provided by the recipient.

Eligibility Determination 400-29-35

(Revised 11/1/10 ML #3238)

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The date of eligibility is the date of application provided the individual is residing in a licensed basic care facility and the individual met the functional assessment criteria, whoever is later. Retroactive eligibility may be established for as many as three calendar months prior to the month in which the signed application was received provided all factors of eligibility are met during each month of retroactive benefits.

Benefits paid on behalf of a recipient are stored in TECS and Vision on Client Profile. Following are the steps to view benefits paid by month:

- Go to ELTM – Eligibility Technician Menu
- Select Option # 10. IEVS INTERFACES
- IEME – IEVS MENU window will display, select option #4 X-SPED AND BASIC CARE BENEFITS PAID
- Enter the individual's social security number. The months paid and the amount paid will display.

Eligibility Criteria 400-29-35-05

(Revised 6/15/15 ML #3448)

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(NDAC 75-02-10-05)

A person may receive necessary benefits under this chapter if the person meets all of the requirements of this section.

1. An applicant or recipient must be a resident of this state;
2. An applicant or recipient must be:

    a. Sixty-five years of age or older;
    b. Eighteen years of age or older and disabled or blind; or
    c. Considered disabled under the Workers with Disabilities program.

3. An applicant or recipient must apply for and receive Supplemental Security Income (SSI) benefits if eligible and been found eligible for Medicaid benefits (Service Chapter 501-05), with the following exceptions:

    a. All income, including SSI income, will be counted.
    b. SSI resource ineligibility - if an applicant or recipient chooses to maintain an asset level that causes that person to be ineligible for SSI benefits, eligibility for BCAP will end and no benefits will be made on behalf of that person until eligibility for SSI benefits is re-established. This exception exists only if the applicant or recipient is able to change the assets to become eligible for SSI benefits.
    c. Disqualifying Transfer of Income and Assets. A person is ineligible for benefits if the person or the spouse of the person disposed of assets or income for less than fair market value during the look-back period of thirty-six months for the purpose

of qualifying for benefits (see section 400-29-35-15, "Disqualifying Transfer ").

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 activates 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 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.

7. In all instances, including determinations of equity, property must be realistically evaluated in accord with current fair market value. The combined equity value of all property of whatever nature, not otherwise excluded, is limited to:

    a. Three thousand dollars for a one-person unit;

    b. Six thousand dollars for a two-person unit; and

    c. An additional amount of twenty-five dollars for each member of the unit in excess of two.

    All other asset limitations under Medicaid Policy Section 510-05-70-15 Asset Limits will apply.

Eligibility Criteria for Nursing Home Residents 400-29-35-10

(Revised 11/1/10 ML #3238)

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An individual may receive benefits under this chapter if the individual:

1. Meets eligibility criteria established under Section 400-29-35-05 of this chapter;
2. Has resided in a nursing facility for at least six months;
    a. Was ineligible for Medicaid upon admittance to the nursing facility; and
    b. Subsequently denied nursing facility level of care; or
    c. Eligible for Medicaid but no longer meets nursing facility level of care criteria.
3. During the first six months in a nursing facility, an individual may be eligible if:
    a. The individual's spouse is admitted to the nursing facility at a nursing level of care; and
    b. There is not a basic care provider in the same city or town as the nursing facility.
4. Meets functional assessment criteria established in the North Dakota Administrative Code Chapter 75-02-10-06. The functional assessment is required before the Department will pay for room and board in a licensed basic care facility.
5. A recipient must receive a personal care service assessment 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 case manager or the Developmental Disability Services case manager.

Disqualifying Transfer 400-29-35-15

(Revised 10/1/11 ML #3287)

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(NDAC 75-02-10-08)

1. A person is ineligible for benefits if the person or the spouse of the person disposes of assets or income for less than fair market value on or after the look-back date of thirty-six months (Example of assets or income: Home, cash, life estates, trust, property, etc.).
2. The look-back date is the date that is thirty-six months before the date of application; or in the case of payments from a trust or portions of a trust, that are treated as income or assets disposed of by a person, sixty months before the date of application.
3. A person is not ineligible for benefits under this program if:

    a. The asset transferred was a home, and title to the home was transferred to:

        i. The person's spouse; and
        ii. The person's son or daughter who is under age twenty-one, blind, or disabled;

    b. The income or assets:

        i. Were transferred to the person's spouse or to another for the sole benefit of the person's spouse; or
        ii. Were transferred from the person's spouse to another for the sole benefit of the person's spouse;

    c. The person makes a satisfactory showing that:

        i. The person intended to dispose of the income or assets at fair market value, and the person had an objectively

reasonable belief that fair market value or its equivalent was received;

ii. The income or assets were transferred exclusively for a purpose other than to qualify for Medicaid or benefits under this program;

iii. For periods after the return, all income or assets transferred for less than fair market value have been returned to the person. If the transferred assets were returned to the client, from the point of return forward, the client is no longer ineligible; or

iv. If all income or assets of a particular transfer are returned at the time of the application, and no periods of eligibility have been established for that transfer after the date of the original transfer, process the application as if the original transfer never occurred.

d. The individual shows that the total cumulative uncompensated value of all income and assets transferred for less than fair market value by the individual or the individual's spouse is less than the actual cost of services of a type provided under this program, provided after the transfer was made, for which payment has not been made and which is not subject to payment by a third party, provided that such a showing may only be made with respect to periods when the person is otherwise eligible for benefits under this program. (Example: Mr. Smith transferred his home to his children two years ago. The fair market value of the home was $20,000. Mr. Smith is ineligible for this program until Mr. Smith incurs $20,000 of expenses during periods in which he was otherwise eligible, for which payment has not been made, and which are not subject to payment by any third party (such as a long term care insurance policy.)

4. There is a presumption that a transfer for less than fair market value was made for purposes of qualifying for benefits under this program when:

a. The person's assets and the assets of the person's spouse that remain after the transfer produce income which, when added to

other income available to the person and to the person's spouse totals an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred by the person and by the person's spouse in the month of transfer and in the thirty-five months, or fifty-nine months in the case of a transfer to a trust, following the month of transfer;

b. The person or the person's spouse was an applicant for or recipient of Medicaid or benefits under this program before the date of transfer;
c. A transfer was made, on behalf of the person or the person's spouse, by a guardian, conservator, or attorney in fact, to:

   i. The guardian, conservator, or attorney in fact; or
   ii. Any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney in fact.

5. An applicant or recipient who claims that income or assets were transferred exclusively for a purpose other than to qualify for Medicaid or benefits under this program before the transfer must show that a desire to receive Medicaid or benefits under this program played no part in the decision to make the transfer and must rebut any presumption under subsection 4. The fact that the person would be eligible for Medicaid or benefits under this program, and the transfer had not been made, is not evidence that the transfer was made exclusively for a purpose other than qualifying for this program.
6. If the transferee of any income or asset is the child, grandchild, brother, sister, niece, nephew, parent, or grandparent of the person or the person's spouse, services or assistance furnished by the transferee to the person or the person's spouse may not be treated as consideration for the transferred income or asset unless the transfer is made pursuant to a valid written contract entered into prior to rendering the service.
7. A transfer is complete when the person, or the person's spouse, who made the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership.

8. For purpose of this section:

   a. Fair market value is received:

      i. In the case of an asset not subject to reasonable dispute concerning its value, such as cash, bank, deposits, stocks, and fungible commodities, when one hundred percent of apparent fair market value is received;
      ii. In the case of an asset subject to reasonable dispute concerning its value, when seventy-five percent of estimated fair market value is received; and
      iii. In the case of income, when one hundred percent of apparent fair market value is received.

   b. "Uncompensated value" means the difference between fair market value and the value of any consideration received.

9. This section is applicable to all transfers whenever made.

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

Hospice Service 400-29-35-20

(Revised 10/01 ML #2738)

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Recipients of the Basic Care Assistance Program may receive Hospice Services while in a basic care facility. Payments to the basic care facility continue while a recipient receives Hospice Services.

Budgeting Process 400-29-40

(Revised 11/1/10 ML #3238)

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The budgeting process for a Basic Care recipient is a two step process:

1. Determine the recipient liability for Medicaid in the TECS System. (See the Medicaid Manual, "Medically needy aged, blind, or disabled recipients, over age eighteen residing in a 'specialized facility' and 'Eligible family unit' with member(s) in a specialized facility.")
2. Determine the recipient responsibility for the room and board expense in a licensed basic care facility for the Basic Care Assistance Program through the Resident Payment System. (See the Resident Payment System document.)

    a. Medicaid "offset" of outstanding medical bills must also be used to determine the recipient responsibility in the Resident Payment System.
    b. The recipient responsibility for married couples living in the same basic care facility, whether sharing a room or not, is determined separately. His income and deductions are used to determine his recipient responsibility and her income and deductions are used to determine her recipient responsibility towards the room and board expense.

Note – Budgets in the Resident Payment System will roll forward month to month unless a redetermination is due. The rollover dates are listed in the TECS/Vision calendar. Cases not processed by that date, will not roll forward into the future month.

Resident Payment System 400-29-40-05

(Revised 11/1/10 ML #3238)

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The county shall determine the recipient's responsibility for payment toward the room and board expense in a licensed basic care facility. This is accomplished by completing the appropriate screens in the Resident Payment System.

The county must use the Resident Payment System screen(s) each time there is a change in the amount the recipient is required to pay toward the room and board costs in a licensed basic care facility. Notification of any change in recipient responsibility is sent to the basic care facility and to the recipient.

BUDGETING EXAMPLE -- MONTH OF ENTRY INTO A BASIC CARE FACILITY

Scenario – Mr. Jones entered the basic care facility on August 13th. For the month of August, he had rent expense of $325.00. The deductions in the month of entry are clothing allowance of $85.00, Medicaid level for one of $750.00, rent expense of $325.00, and the Medicaid Recipient Liability disregard in this case of $128.00. Total deductions for Mr. Jones in the month of entry into the basic care facility equals $1288.00. Mr. Jones has income of $700.00. Following is the example as it would appear in the resident payment system:

GROSS INCOME:		**DEDUCTIONS:**	
SSI:		Clothing/Personal:	85.00
SSA:	700.00		
VA:		MA Level for One:	750.00
OTHER:		Rent:	325.00
		MA RL Deduction:	128.00
TOTAL:	$700.00	Total:	$1,288.00
Resident Payment Amt:			00.00

Computation: $700.00 income minus $1,288.00 deductions equals $0 recipient responsibility towards room and board expense.

In the month of entry, allow the deduction of Medicaid level for one and reasonable living expenses.

BUDGETING EXAMPLE OF AN INDIVIDUAL IN A BASIC CARE FACILITY

Scenario -- Ongoing case for George Dakota who entered the basic care facility August 29, and the benefit month is December. George receives SSA of $1,033.00 monthly. The deduction allowed is $85.00 clothing allowance (zero Medicaid recipient liability). Following is an example of how the system would budget this situation.

GROSS INCOME:		**DEDUCTIONS:**	
SSI:		Clothing/Personal:	85.00
SSA:	1,033.00		
VA:			
OTHER:			
TOTAL:	$1,033.00	Total:	$85.00

Computation: Income is $1,033.00, minus the allowable deduction of $85.00 equals the basic care recipient responsibility of $948.00. The resident is responsible for paying $948 to the basic care facility for room and board.

BUDGETING EXAMPLE – TEMPORARY STAY OF LESS THAN SIX MONTHS

Scenario -- Tom Jones is in a licensed basic care facility recovering from surgery. He will return home within six months. Mr. Jones' stay is temporary; therefore, he is allowed additional deductions such as rent, utilities, and the Medicaid level for one. The additional deductions are allowed in these cases so the individual can maintain their residence while residing temporarily in a basic care facility.

GROSS INCOME:		**DEDUCTIONS:**	
SSI:	129.00	Clothing/Personal:	85.00
SSA:	450.00	MA Level:	750.00
VA:		BC/BS Prc:	319.00
OTHER:			
TOTAL:	579.00	Total:	$1,154.00

Computation: Monthly Income $579.00, a deduction of $1,154.00 leaving a recipient responsibility of $0 for room and board.

Temporary Basic Care Assistance 400-29-40-10

(Revised 10/1/11 ML #3287)

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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 and 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 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). The six month period begins with the first full calendar month the individual is in the basic care facility.

The eligibility worker or the Home and Community Based Service worker may determine temporary stays based on statement from the attending physician. The statement must include the reason for the temporary stay and a projected date of discharge from the basic care facility.

Applies even if there is a community spouse.

Clothing and Personal Needs Allowance 400-29-45

(Revised 11/1/10 ML #3238)

View Archives

(NDCC 50-24.5-01.14)

Each recipient of the Basic Care Assistance Program shall retain $85.00 per month for clothing and personal needs.

County Administration 400-29-50

(Revised 5/1/05 ML #2969)

View Archives

(NDAC 75-02-10-10)

1. The county agency where the applicant or recipient is physically residing must be responsible for the administration of the program with respect to that applicant or recipient.
2. When a recipient moves from one county to another, the county agency in the outgoing county will:

    a. Complete the process of establishing eligibility on new cases prior to shipment. If the case cannot be completed because of a pending functional assessment or personal care service assessment, complete the case as much as possible before forwarding to county social(s) in the receiving county.
    b. Update and process ongoing cases for the month before transferring the case file. The outgoing case file must include a copy of the functional assessment(s) for the case manager in the receiving county. Another functional assessment is not required unless there has been a change in the recipient's functioning abilities.
3. Update the Resident Payment System including the recipient's new address and the receiving county.
4. Send notification to the recipient of the change in the county.
5. The new facility will receive any payment from the resident that was not obligated at the previous basic care facility. The basic care facility may bill for the first day of entry to their facility but not the date of discharge.

Correcting Errors in Payments 400-29-55 (Revised 6/1/11 ML #3269)

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When it is discovered that a recipient failed to report or incorrectly reported income, deductions, assets, or the eligibility worker incorrectly calculated the recipient responsibility resulting in an error in payment resulted, the county currently managing the case shall rework the case in the Basic Care Resident Payment System. When making corrections to a given month, adequate or advance notice does not apply. Send notification to the recipient and provider informing them of the overpayment or underpayment and the reason. Any changes to claims paid to providers will be processed by the Claims Processing Unit in the Medicaid Division based on receipt of form, SFN 639, "Provider Request for an Adjustment," from the provider.

- If the correction to the case is due to the recipient incorrectly reporting income, deductions, or assets, the corrections must be made in the Resident Payment System and notifications sent out from the date of the change forward.
- If the correction to the case is due to an eligibility worker incorrectly calculating the recipient responsibility, the correction is made in the Resident Payment System from the date of discovery forward.

When making corrections to a given month, adequate or advance notice does not apply. Send notification to the recipient and provider informing them of the overpayment or underpayment and the reason. Any changes to claims paid to providers will be processed by the Claims Processing Unit in the Medicaid Division based on receipt of form, SFN 639, "Provider Request for an Adjustment," from the provider.

Income (BCAP) 400-29-60

(Revised 10/19/11 ML #3293)

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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. Interest income from liquid assets will be disregarded.

All income under the Basic Care Assistance program must be counted.

NOTE: This policy differs from Medicaid which states, "The following types of income must be disregarded in determining Medicaid eligibility: Interest or dividend income from liquid assets;" Refer to Medicaid policy – 510-05-85-30, Disregarded Income.

Deemed income actually received is considered countable unearned income.

When there is an SSA or SSI overpayment deducted from the SSI or SSA benefit, follow Medicaid policy Section 510-05-85-05 Income Considerations, "Income that is withheld because of garnishment or to pay a debt or other legal obligation is still considered available. Title II and SSI overpayments being deducted from Title II benefits are normally considered to be available because the applicant or recipient can pursue a waiver of the overpayment. Only if the waiver has been denied after a good faith effort, can the Title II or SSI overpayment deductions be considered unavailable. Occasionally other delinquent debts owed to the federal government may be collected from an individual's Title II benefits. These other reductions of Title II benefits are NOT allowed to reduce the countable benefit amount. The award amount of the Title II benefit is counted as available."

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 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.

VA – Improved Pension, Medicaid allows the individual to keep $90. Basic Care Assistance, the Improved Pension is counted as income but the resident can only retain the maximum of $85 for personal needs per state law.

The policy that Basic Care will follow is below:

Individual Indian Monies (IIM) - Income received from Individual Indian trust or restricted lands will be counted as income. This includes leases on individually owned or restricted Indian lands. The income generally comes from interests in lands allotted to individual Indians many years ago. Income to individual Indians generated by these interests are likely to be small because many of the original interests are allotted lands which have been fractionalized due to the inheritance of multiple heirs over several generations. Incomes

included in the accounts are payments from range unit leasing, farm leases, oil leases, oil rental, gravel pit contract, sales, royalties etc.

The Omnibus Budget Reconciliation Act of 1993 provides that up to $2,000 per year of this income must be disregarded. Funds in the IIM accounts that do not have a specific exclusion must be counted for Basic Care. Other moneys deposited in the accounts, such as inheritances, VA, SSA, SSI, gaming profits, etc. are not part of the $2,000 exclusion.

Beginning January 1, 2003, client statement is an accepted verification of the amount in an IIM account unless one of the following applies:

1. The amount is more than $2000 for the year;
2. The client statement information is questionable; or
3. The IIM account includes countable income such as inheritance, bonuses, and other income that is not derived from leases, trust, or restricted land.

Verification Options

There are three options by which verification may be obtained:

1. Request for verification of IIM account information using form SFN 413, Individual Indian Monies Account. This form will need to be notarized per requirements of the United States Department of the Interior, Office of the Special Trustee for American Indians, Office of Trust Funds Management. These releases are valid for one (1) year and must be renewed annually.
2. Individuals with IIM accounts receive statements from the Office of Trust Funds Management on a quarterly basis. A copy of this form may be requested from the recipient. However, the recipient will not receive the statement if the Office of Trust Funds Management does not have a current address.
3. The individual may obtain a statement of their IIM account directly from the Office of Trust Funds Management through the Bureau of Indian Affairs (BIA) by requesting the information in person or by

making a telephone request. In both cases, the individual will need to know their account number and provide at least two forms of identification.

At the time of application, verification of the deposits into the IIM account for the 12 month period prior to the month of application must be obtained. Deposits such as inheritances, VA, SSA, SSI, gaming profits, etc. must be deducted and the remaining amount divided by 12 to determine the monthly countable income for the next 12 months.

New Source Income

When new source income is deposited into an individual's IIM account, the countable amount for Basic Care will be determined as follows:

Verification of the IIM account must be obtained for the most recent FULL 12 month period through one of the three options identified above. Once verification of the IIM account is received, any deposits that will not be counted as IIM income will be subtracted (inheritances, VA, SSA, SSI, gaming profits, etc.). The most current month's countable new source income (or an average if received for multiple months) will be multiplied by 12 and added to all countable deposits for the 12-month period (excluding the new source income deposited into the IIM account). The $2000 disregard will be subtracted and the remaining balance divided by 12 to determine the monthly countable unearned income.

Example #1: In 02/2009, the Eligibility Worker learns that the individual began receiving a new source income in 02/2009 through their IIM account. The Eligibility Worker will request verification of the IIM account for the period of 02/01/2008 thru 02/28/2009 (the most recent FULL 12 month period, plus the current month of 02/2009) to capture the amount of the new source income.

Reviewing the ledger, the Eligibility Worker would determine which income is countable. The new source income deposited in February was $850. Multiplying $850 by 12 equals $10,200. The countable income, not including the new source income, for the FULL 12 month period (02/01/2008 thru 01/31/2009) totals $1,500. The total of

income to be considered for the 12 month period is $11,700 ($10,200 plus $1,500). After deducting the $2000 disregarded amount from $11,700, $9,700 must be annualized and the monthly amount of $808.33 counted as unearned income.

Example #2: A new application is received in 07/2009 and the Eligibility Worker requests verification of the IIM account for the period of 07/01/2008 thru 06/30/2009, the most recent FULL 12 month period.

Reviewing the ledger, the Eligibility Worker determines a new source income began to be deposited in 04/2009. The Eligibility Worker would first determine which income is countable. The new source income deposited in April was $850, in May was $790 and in June was $825. The three months of the new source income would be totaled and divided by 3 and the average would be projected for a 12 month period ($2,465 divided by 3 equals $821.67). Multiplying $821.67 by 12 equals $9,860.04. The countable, not including the new source income, for the 12 month period totals $87.29. The total of income to be considered for the 12 month period is $9,947.33 ($9860.04 plus $87.29). After deducting the $2000 disregard from $9,947.33, $7,947.33 must be annualized and the monthly amount of $662.28 counted as unearned income.

Once a determination of the countable income has been made, Basic Care must begin counting the income when received and budgeted consistent with the individual's budget methodology.

Allowable Gross Income Deductions 400-29-60-05

(Revised 10/1/11 ML #3287)

View Archives

(NDAC 75-02-10-01.4)

Only specific deductions are allowed for a resident in a basic care facility. Countable income is the remainder of gross income minus any of the following allowable deductions:

1. Personal needs allowance of $85.00;
2. Sixty-five plus one-half of the remaining monthly gross earned income;
3. The cost of guardianship or conservatorship fees actually charged, but not to exceed 5% of gross monthly income;
4. Court-ordered child support payments or alimony payments actually paid on behalf of a minor child or ex-spouse who is not a member of the person's Medicaid unit;
5. The Medicare or health insurance premium will be allowed as a deduction for all individuals residing in a basic care facility if the premium is not paid by another source such as Qualified Medicare Beneficiaries (QMB) or Special Low-Income Beneficiaries (SLMB);
6. Co-payments for Medicaid may be deducted for individuals not eligible for Medicare or if the service is not covered by Medicare;
7. A disregard of recipient liability expense under the Medicaid program; and
8. Income actually deemed to the community spouse from the recipient in a basic care facility.

In the month of entry into a basic care facility, the medically needy income level size of the family in which the person was a member at the beginning of the month (NDAC 75-02-10-01. 4(d)) and

reasonable living expenses. Necessary living expenses are items such as rent, utilities, health insurance premium, etc. Deeming income to the community spouse at the Medicaid level for one is allowed for Medicaid budgeting.

In the second month, following the month of entry, count the income minus applicable disregards to determine the recipient responsibility towards room and board costs.

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 actually paid and not just incurred.

NOTES:

Note - Medicaid transportation to medical appointments is not an allowable expense under this program.

Special Processing for Prescription Drug Co-payment 400-29-60-05-01

(Revised 10/02 ML #2827)

View Archives

Basic Care recipients may have prescriptions for name-brand drugs and be required to pay the co-payment. For clients with a recipient liability such payments will reduce the client's recipient liability in Medicaid. Drug co-payments are to be deducted in the month the expense is incurred. This may require reworking the client's budget in both TECS and in the Resident Payment System for Basic Care in order to show additional co-payments during the month.

Since many Basic Care recipients will have a number of prescriptions that are often of a regular and recurring nature, for these clients the county can reasonably anticipate the ongoing co-payments. In order to reduce the amount of rework, the county should prospectively budget these deductions when the budget is initially created.

When there are occasional co-payments in addition to the regular pattern, the county will need to rework the month the co-payment was incurred in order to deduct those payments from income. If there is a reduction in the co-payment, do not rework the case for a reduction in a prior month.

When the county learns of a change in the regular pattern of name-brand prescriptions, the prospective budget for the next month should be adjusted accordingly.

In cases that do not have a recipient liability for Medicaid and have co-payments for prescription drugs, it is important to use the deduction in the Resident Payment System. When there is no recipient liability the deduction affects the distribution of any client resource to room and board costs.

Excluded Income 400-29-60-10

(Revised 10/1/11 ML #3287)

View Archives

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; and

3. Disaster Assistance Unemployment Insurance Benefits are disregarded as income.

Residency (BCAP) 400-29-65

(Revised 10/02 ML #2827)

View Archives

(NDAC 75-02-10-09)

A person is a resident of this state if:

1. The person is not living in an institution and is living in this state with the intent to remain in this state permanently or for an indefinite period;
2. The person is living in an in-state institution, has lived in that institution for at least thirty days, and was not placed in the institution by another state. A person placed in an institution by another state is a resident of the state making the placement; and,
3. An applicant/recipient is a resident of a county in which he or she is living other than on a temporary basis.

Redetermination of Eligibility (BCAP) 400-29-70

(Revised 10/1/2011 ML #3287)

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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.

Payment to Licensed Basic Care Facilities 400-29-75

(Revised 5/1/05 ML #2969)

View Archives

The Basic Care Assistance Program payment shall be authorized by the county through the Resident Payment System for room and board services received in a licensed basic care facility. The county authorizing the case shall send the "Notice of Action" to the basic care provider and to the recipient.

The Basic Care Assistance Program policy for hospital days is similar to the policy used by the Medicaid Program. A maximum of 15 days per occurrence will be allowed for payment for basic care during a time a recipient requires a level of care higher than basic care, including days in a hospital, swing bed, hospice care, or nursing facility, if the care plan provides that the resident will return to the basic care facility and the facility holds the bed until the resident returns. Payment for therapeutic days, or days when the resident is on personal leave, will be limited to 28 days per year. Basic care facilities will receive payment for room and board for leave days but not the payment for personal care services. A facility may charge to hold a bed for a period in excess of the maximums stated in this paragraph if the resident or a person acting on behalf of the resident has requested the bed be held, the facility informs the person making the request the amount of the charge, and the payment comes from a source other than the recipient's monthly income (75-02-07.1-04).

The basic care provider uses the Medical Management Information System (MMIS) billing codes to record and bill all resident in days and resident leave days, the date of entry into the basic care facility, and the date the individual left the basic care facility. The payment will be made directly to the provider by the Department based on the provider’s billing. The Department will not pay for billings for services from a basic care provider that are over a year old.

The date of entry is billable by the basic care facility, the date of discharge is not.

When a person moves from one basic care facility to another facility, the new facility will receive any payment from the resident that was not obligated at the previous facility. MMIS will identify the new facility name and process payment to both facilities if payment to both is required.

The facility may charge a higher rate for a private room used by a recipient if (NDAC 75-02-07.1-04):

1. The private room is not necessary to meet the recipient's care needs;
2. The recipient, or a person acting on behalf of the recipient, has requested a private room;
3. The facility informs the person making the request of the amount of cost for a private room and that the payment must come from sources other than the recipient's monthly income;
4. The payment does not exceed the amount charged to private pay individuals; and
5. Appropriate semiprivate rooms are available at the time the first charges for a private room apply.

Payment to Licensed Nursing Facilities 400-29-75-01

(Revised 2/02 ML #2785)

View Archives

Participation in the Basic Care Assistance Program is voluntary. The nursing facility must be willing to accept the basic care limit rate established by the Department of Human Services as payment in full. A nursing facility must enroll as a basic care provider to receive basic care payments. Payments to the nursing facility will be for the total daily rate (personal care option and the room and board rate). The personal care option is not available for individual's residing in a nursing facility in a basic care capacity.

If the basic care assistance appropriation is insufficient to pay the estimated supplements for individuals statewide, the rate payable may be reduced in accordance with NDAC § 75-02-07.1-22. A nursing facility providing services to a basic care resident is considered a new facility for purpose of determining a reduced rate. The reduced rate will be determined by the Department of Human Services. The nursing facility will be notified of a rate change 30 days before occurrence.

Basic care payments to a nursing facility will begin from the date of the initiation of the functional assessment or on the first day of the seventh month of residence whichever is later, if applicable. If an individual appeals the level of care determination, basic care payments will not be made until after the appeal decision. The basic care payments will be retroactive to the date of eligibility if the level of care determination is upheld.

Adult Foster Care 400-29-80

(Revised 9/00 ML #2584)

View Archives

Eligibility processing for Adult Foster Care will be processed as prescribed in the "Expanded Service Payments for the Elderly and Disabled Program," Service Chapter 670-10.

Forms (BCAP) 400-29-85

(Revised 9/00 ML #2584)

View Archives

There are two forms for use in this program. The following provides brief instructions and clarity on their intended use.

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

(Revised 10/1/11 ML #3287)

View Archives

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.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (111kb pdf)

1. County Eligibility Worker - The transmittal between units is used by the county eligibility staff to notify the Home and Community Based social worker of an action taken on a basic care applicant or recipient.

    a. Notification of approval, denial, or closure of a Basic Care Assistance Program applicant or recipient.
    b. Initial functional assessment needed or review of functional assessment due.
    c. Review due for Medicaid and Basic Care Assistance Program.
    d. A recipient moves from one basic care facility to another.

2. The Home and Community Based Social Worker - The transmittal between units is used by the Home and Community Based social worker to notify the county eligibility worker of actions taken or the status of a recipient.

    a. Completion date of an initial or review of a functional assessment.
    b. A recipient moves from one basic care facility to another.

INSTRUCTIONS FOR TRANSMITTAL BETWEEN UNITS FORM (SFN 21)

Name: First and last name of individual to receive services. Complete the name as enrolled through Medical Assistance.

Address/City/State/Zip: Address where the individual will be residing and receiving services in a basic care facility.

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

Date of Birth: Enter mm/dd/yyyy for the individual's birth date.

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

Social Security Number: self explanatory

Facility/Facility Provider Number: Enter the name/provider number of the Basic Care Facility the individual will be entering or is currently residing.

Date of Admit: Enter the date (mm/dd/yyyy) the individual entered or will enter the Basic Care facility. It is not necessary to complete this section if this is being used for the annual review or to share information.

Date/To/From –This section is completed by the Home and Community Based Services (HCBS) social worker. It may be used for the initial review and for the annual review.

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 completes the Functional/Medicaid Eligibility Criteria.
- The eligibility worker or the HCBS social worker enter 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 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 indicates that the place in a basic care facility is temporary. 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)

Most often the eligibility worker collects the doctor's statement from the individual in the basic care facility or from the individual's representative.

Assessments and Effective Dates for Payment Eligibility.

A Functional Assessment and Personal Care Plan assessment should be completed by the social worker or DD program manager promptly when the individual applies for MA/Basic Care services. They have to be Medicaid eligible to receive Basic Care services. The county cannot be reimbursed for the assessment unless the individual is Medicaid eligible.

The social worker or DD program manager can only establish retroactive eligibility for 10 working days prior to the date they visited with the client for the assessment. This is the Effective Date of the plan. If the individual entered/needs Basic Care for any time prior to that assessment effective date, the social worker or DD program manager will need to inform Medical Services so the effective date can be established to coincide with the effective date of Medicaid eligibility. Any retroactive eligibility beyond the 10 days approved by the social worker or DD program manager must be approved by the state office – Medical Services, Home and Community Based Services (HCBS) Unit. The request for retroactive eligibility is requested by the eligibility worker based on the application submitted.

Provider Request for An Adjustment, SFN 639
400-29-85-10

(Revised 9/00 ML #2584)

View Archives

This form is generally used by Medicaid service providers and, in fact, will be used by basic care providers. However, when a county discovers that an error has occurred in computing the "Resident Payment Amount" the county currently managing the case file is required to contact the Claims Processing Unit in the Medicaid Division. This form will be used to make corrections.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (100kb pdf)

Basic Care Facilities 400-29-90

Authority Reference 400-29-90-01

(Revised 3/1/05 ML #2958)

View Archives

1. Section 50-24.5 (North Dakota Century Code)
2. 75-02-07 (North Dakota Administrative Code)

Rate-Setting Rules and State Payment 400-29-90-05

General Statement 400-29-90-05-05

(Revised 3/1/05 ML #2958)

View Archives

The 1993 State Legislature required the Department of Human Services to implement a uniform state wide policy for Basic Care Assistance (Service Chapter 400-29) and to develop a uniform state wide payment system. The effective date for these changes was January 1, 1995.

Reasonable Payable Rates 400-29-90-05-10

(Revised 3/1/05 ML #2958)

View Archives

North Dakota Administrative Code 75-02-07.1 requires the Department to establish payable rates for licensed basic care facilities. The Department's Provider Audit Unit conducts an annual review or audit of basic care facility costs. The types of costs are similar to those recognized in nursing facilities.

Each facility's rate is adjusted forward to the beginning of the basic care rate year, July 1. Adjustments include cost of living adjustments to the basic care facility's audited costs. Prior to July 1, the Department establishes the reasonable rate for each facility that chooses to participate in this process.

The payable rate is expressed in terms of a daily rate for personal care and a daily rate for room and board which does not include the provision for a resident's personal needs requirement of $60.00 per month. This allowance from a resident's gross income is determined in the budgeting process as set forth in Service Chapter 400-29.

The Department makes all payments on behalf of eligible residents through the Medicaid Management Information System (MMIS). Only those licensed basic care facilities for whom the Department has determined a payable rate may receive a payment.

Basic Care Assistance Program Payments
400-29-90-05-15

(Revised 3/1/05 ML #2958)

View Archives

North Dakota Century Code, Chapter 50-24.5 Aid to Aged, Blind, and Disabled Persons, authorizes the Department to make payments only if a resident is in a licensed basic care bed. Therefore, if a person is residing in a facility but not in a licensed basic care bed except for nursing facility, no payment will be made.

Rates for Adult Foster Care 400-29-90-05-20

(Revised 3/1/05 ML #2958)

View Archives

Rates for Adult Foster Care are established by the Department. The process for Adult Foster Care is described in the Department's Service Chapter 670-10 for the Expanded SPED Program.

List of Licensed Basic Care Facilities and Rates
400-29-90-10 ML 3269

(Revised 6/1/11 ML #3269)

View Archives

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Appendix 400-29-95

Basic Care Resident Payment System 400-29-95-01

(Revised 11/1/10 ML #3238)

View Archives

A guide to processing cases in the Resident Payment System for room and board.