Par. 1. Material Transmitted and Purpose – Transmitted with this Manual Letter are changes to Service Chapter 510-05 Medicaid Eligibility Factors. References to Service Chapter 449 are updated to Service Chapter 448 throughout this manual/manual letter, as is language changing 'exempt' assets to 'excluded' assets as per manual letter. New language is in red and underlined and removed language has been struck through. This manual letter supersedes IM 5142 "Cooperative Distributions and Healthcare Coverage", IM 5144 "Income from Spirit Lake Nation and Sisseton-Wahpeton Oyate Lake Traverse Reservation", IM 5145 "Electronic Narratives mandated for Medicaid and Healthy Steps", IM 5146 "SFN 162 Request for Hearing", IM 5147 "Releasing Information – Child Protective Service Alerts", IM 5150 "Public Institutions and IMDs" and IM 5152 "Gift Cards and Gift Certificates".

General Statement 510-05-10-05

References to Service Chapter 449 are **updated** to Service Chapter 448.

Following are instructions relating to applications for Medicaid. Additional information concerning administrative procedures, application processing, case maintenance, and appeals are contained in Service Chapter ~~449-05~~ 448-01 through ~~449-55~~ 448-01-60.

Confidentiality 510-05-10-15

References to Service Chapter 449 are **updated** to Service Chapter 448. Items removed from the 449 Chapter have been updated and added to this section. This also **supersedes** IM 5147 "Releasing Information – Child Protective Service Alerts".

All applications, information and records concerning any applicant or recipient of Medicaid shall be confidential and shall not be disclosed or used for any purpose not directly connected with the administration of the Medicaid or Healthy Steps programs. Application, information and records may not be released to elected officials or to any other person not directly connected with the administration of the Medicaid or Healthy Steps programs. Refer to Service Chapter ~~449-05-30~~ 448-01-25 for additional guidelines.

1. Federal law and regulations:

   Federal law and regulations require that the State Plan have protections in place to ensure that the use or disclosure of information concerning applicants and recipients be limited to purposes directly connected with the administration of the plan. Those purposes include establishing eligibility, determining the amount of medical assistance, providing services, and conducting or assisting an investigation, prosecution, or civil or criminal proceeding related to the administration of the plan. (42 U.S.C. § 1396a(a)(7); 42 C.F.R. § 431.300-306).

   NOTE: Information from certain sources may not be released, even with a signed release form. For details see 448-01-25-10-05 "Confidential Information that Must Not be Released".

2. Sharing basic information regarding eligibility with HCBS Case Managers:

   a. Case Managers going out for an initial assessment can be informed if an individual is eligible for Medicaid, the type of coverage (full Medicaid or Medicare Savings Programs), and whether the recipient has a client share.
   b. A county or other waivered service provider is a prospective provider so they can find out if an individual is eligible in order to determine if they can provide Medicaid waivered services, or if they need to pursue other program such as SPED.
   c. An assessment for services under HCBS does not allow for providing eligibility income and asset information or disclosing eligibility to Spousal Impoverishment benefits. A release signed by the recipient, or a verbal release, if documented, is needed if specific information from the eligibility file must be obtained.
   d. Specific information that may be released is a yes/no if the client is eligible on a specific date, any client share amount and the recipient's billing address; which are specific data that can be released to any provider of Medicaid Services. This is like any other potential provider calling the Verify system.

3. Sharing asset, income, household composition, etc. information with social work staff:

   Information cannot be released unless the applicant or recipient has authorized the release of information (form or verbally).

4. Sharing information with Social Workers for investigations of abuse, neglect, or protective services:

   a. Information requests by social workers are not made for the purpose of administration of Medicaid, but are with regard to abuse investigations. The family may not be receptive, but that is not a valid reason to release the information. A signed release is necessary to share specific information about the child/family.

   b. 'Protective Service Alerts' from the North Dakota Department of Human Services, Children and Family Services (CFS) Division and other States are often sent to all county staff. These alerts request information regarding the family's whereabouts. These alerts, do not fall under 'administration of the Medicaid program' so specific information cannot be released. However, it is allowable to disclose the county and state in which the individual is residing and the county social service office that may be contacted for child protective service information, to the requestor as well as to their own county child protective service unit.

      Any additional information, including 'How eligibility staff knows this information' or 'The family has applied or is receiving services' may not be disclosed.

5. Sharing information with Child Support and other specific assistance programs:

   a. Can share information with Child Support as federal regulations specifically require.
   b. Can share information between Healthy Steps and Medicaid per federal requirements to coordinate benefits between the two programs.
   c. Can share information between Medicaid and SSA for Title II and Title XVI benefits as federal regulations specifically require.
   d. Can share information between TANF, SNAP, and the Aid to the Blind Remedial program per federal regulations to coordinate benefits between the programs.

6. Sharing information with Foster Care social workers when an application is received and the child is already on Medicaid:

   a. The county has care, custody, and control, so is acting on behalf of the child. Also, the child is going from one Medicaid case to another for the purpose of establishing eligibility.
   b. Copies of identifying information such as a birth certificate may be made for the Foster Care file so that both files contain the proper documentation.
   c. Only pertinent information needed to determine the child's eligibility should be provided. A social worker needs the parent's income information to determine if the child is IV-E eligible. If that has been established, the social worker should NOT be requesting the information, nor should the eligibility worker be releasing it without a signed release of information.

7. Sharing information with Law Enforcement:

   Medicaid cannot provide information about a specific applicant or recipient to law enforcement unless it has to do with administration of Medicaid.

8. Release of information on application:

   These statements allow county and state staff to obtain information from other sources, but do not give permission to release information to others.

Application and Review 510-05-25-05

Language is added to subsection 1(c) (ix) to **clarify** that a review form will serve as a Medicaid application at the time a Healthy Steps case is reviewed. Language is added to subsection 1(e) to **clarify** that if an online application is submitted after business hours, on a weekend or holiday, the application will be considered received on the next business day.

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1. Application.

   c. An application is a request for assistance on:

      i. SFN 405, "Application for Economic Assistance Programs";

ii. SFN 502, "Application for HealthCare Coverage for Children, Families, and Pregnant Women";

iii. SFN 641, "Title IV-E/Title XIX Application-Foster Care";

iv. SFN 1803, "Subsidized Adoption Agreement";

v. SFN 958, "Health Care Application for the Elderly and Disabled";

vi. The Department's system generated "Statement of Facts";

vii. The Department's online "Application for Economic Assistance Programs";

viii. The Low Income Subsidy file from SSA;

ix. If within one calendar month of when an applicant's Medicaid case was closed, or as part of the Healthy Steps annual review, one of the prescribed review forms (see subsection 2(b);

x. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "HOSPITAL" stamped on the front page; or

xi. ICAMA (Interstate Compact on Adoption and Medical Assistance) form 6.01 "Notice of Medicaid Eligibility/Case Activation" stating North Dakota is responsible for the Medicaid coverage of the specified child.

e. The date of application is the date an application, signed by an appropriate person, is received at a county agency, the Medical Services Division, a disproportionate share hospital, or a federally qualified health center. The date received must be documented. Applications must be registered in the eligibility system as soon as possible upon receipt, but no later than the fifth day following receipt. Applications will be considered received on the day submitted. If an application is submitted after business hours, on a weekend or holiday, the application will be considered received on the next business day.

Eligibility - Current and Retroactive 510-05-25-10

Subsection 7 is added to **clarify** that coverage may be added for a non-covered individual who has been living in the household or for a Specified Low-Income Medicare Beneficiary (SLMB) for up to 12 months in an ongoing case.

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7. For an ongoing medical case, coverage may be added retroactively up to 12 months for a non-covered household member. This provision does not apply to Qualified Medicare Beneficiaries.
    a. The individual must have lived in the household during the months requested.
    b. This includes adding SLMB coverage to an individual's ongoing Medicaid-only case, or adding Medicaid coverage to an individual's ongoing SLMB case.

Electronic Narratives 510-05-25-27

This section is added to mandate the use of electronic narratives on all Medicaid cases. This **supersedes** IM #5145 "Electronic Narratives mandated for Medicaid and Healthy Steps."

All Medicaid cases must include electronic narratives (in Lotus Notes) to support eligibility, ineligibility, and other actions related to the case. The narrative must be detailed to permit a reviewer to determine the reasonableness and accuracy of the determination. Complete and accurate narratives include documenting the action taken; what the action was based on; sources of the information used; or if no action was taken, the reason for no action.

Narratives are also required to document contacts with the applicant, recipient, or other individuals regarding the case, regardless of whether the contact had an impact on the case.

Appeals 510-05-25-30

References to Service Chapter 449 are **updated** to Service Chapter 448. Language is added to subsection 2 to incorporate IM 5146 "SFN 162 Request for Hearing". This **supersedes** IM 5146.

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2. A request to appeal must be in writing and not later than 30 days from the date the notice of action is mailed. When an ~~application~~ applicant or recipient requests a hearing without completing the SFN 162, Request for Hearing, the county must complete an SFN 162, Request for Hearing, based on the information available. When the county is completing the SFN 162, the form is not signed by the county.

6. Refer to Service Chapter ~~449-40~~ 448-01-30 for more information with regard to Hearings and Appeals.

Deprivation 510-05-35-10

Language is added to subsection 4(a) to **clarify** how to determine hours worked for self-employed individuals. New subsection 6 is added to **clarify** deprivation when the only child in-common is an unborn.

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4. A family may also establish deprivation, for the Family Coverage group, if the caretaker who is the primary wage earner is:

   a. Employed less than one hundred hours per month (based on pay stub hours, including holiday and sick pay hours; or if self-employed, in the absence of other credible information, by dividing the gross monthly income by minimum wage); or

   b. Employed more than one hundred hours in the current month, but employed less than one hundred hours in the previous month and is expected to be employed less than one hundred hours in the following month.

6. Deprivation of unemployment, underemployment, incapacity, or disability may be established on an unborn child only when the prospective parents are married and in the same Medicaid unit.

Caretaker Relatives 510-05-35-15

A new paragraph 2 has been added to this section to **clarify** when a caretaker relative may be eligible for Medicaid. The remainder of this section is renumbered.

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2. A caretaker relative may only be eligible for Medicaid when:

   a. A child who is eligible for Medicaid is included in the Medicaid unit; or

   b. When a caretaker relative requests Medical coverage and is otherwise eligible for Medicaid for a month in which all the children in the unit are covered under Healthy Steps, the caretaker relative may be eligible for Medicaid coverage for that month, coverage for future months requires at least one eligible child included in the Medicaid case.

~~2.~~ 3. A child is considered to be living with a caretaker relative when away at school or when otherwise temporarily absent from the home. A child is not considered to be living with a caretaker relative when either the child or the caretaker is residing in a nursing care facility, an intermediate care facility for the mentally retarded, or a specialized facility on other than a temporary basis.

~~3.~~ 4. A child may not be considered to be living with more than one caretaker relative in more than one Medicaid unit for the same time period.

~~4.~~ 5. When the only child in common in a Medicaid unit is unborn and there is deprivation of unemployment/underemployment, incapacity, or disability, the prospective parents must be married, and in the same Medicaid unit, in order for the father to be eligible as a caretaker relative.

~~5.~~ 6. Termination of parental rights removes all relationships and responsibilities between the parent and the child(ren). The parent becomes a "legal stranger" to the child(ren). However, for Medicaid

purposes, the blood relatives of a parent whose parental rights have been terminated continue to be treated as relatives of the child(ren).

~~6.~~ 7. A child other than a natural or adoptive child cannot create eligibility for a caretaker when a natural or adoptive child under age 21, or 18 if blind or disabled, resides in the home of the caretaker.

Age and Identity 510-05-35-40

Subsection 5(d) is **updated** to include the online citizenship/identity verification through TPQY.

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5. Identity must be established and documented as provided in this section.

   d. Primary and preferred verification of identity. Verification documents must be presented in their official and original form as received from the issuing agencies. Photocopies or notarized copies are not acceptable. Once an original document is presented, a photocopy must be made and maintained in the casefile.

Primary Verifications of Identity

(Level One)

These Documents Verify Both Citizenship and Identity:	**Explanatory Information:**
US Passport or US Passport Card Issued since 2007	• Issued by the Department of State • Does not have to be currently valid, as long as it was issued without limitation; (any passport issued with a limitation cannot be used to verify citizenship, but CAN be used to verify identity). • Through 1980, spouses and children were often included on one passport; after that each person is issued his own passport. • The passport card is for frequent travelers by land or sea between the US and Canada, Mexico, the Caribbean and Bermuda.

Certificate of Naturalization (DHS/INS Forms N-550 or N-570)	• Department of Homeland Security or Immigration and Naturalization Service (INS) issues for naturalization.
Certificate of US Citizenship (DHS/INS Forms N-560 or N-561)	• Department of Homeland Security or INS issues certificates of citizenship to individuals who derive citizenship through a parent.
Tribal Enrollment Card Certificate of Degree of Indian Blood Or other documents issued by a federally recognized Indian tribe that evidences membership or enrollment with such tribe	• A Document issued by a federally recognized Indian tribe evidencing membership or enrollment or affiliation with, such tribe. See following table for acceptable verification from ND tribes.
Social Security's TPQY Online Query Response (TPOR)	• Acceptable codes are: ○ "Verified with positive citizenship" or ○ "Verified with positive citizenship; Deceased."

Citizenship and Alienage 510-05-35-45

Subsection 5(a) is **updated** to include the online citizenship/identity verification through TPQY.

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5. Acceptable documentation for US citizens and naturalized citizens.

   a. The~~re are four~~ following documents ~~that~~ may be accepted as proof of both citizenship and identity because ~~each contains a photograph of the individual named in the document and~~ either the US~~, or~~ a state, or Tribal government has established the citizenship and identity of the individual. These ~~four~~ documents are considered to be the primary (Level 1) and preferred verification documents.

Primary Verifications

(Level 1)

These Documents Verify both Citizenship and Identity:	**Explanatory Information:**
US Passport or US Passport Card issued since 2007	• Issued by the Department of State. • Does not have to be currently valid, as long as it was issued without limitation; (any passport issued with a limitation cannot be used to verify citizenship, but CAN be used to verify identity). • Through 1980, spouses and children were often included on one passport; after that each person is issued his own passport. • The passport card is for frequent travelers by land or sea between the US and Canada, Mexico, the Caribbean and Bermuda.
Certificate of Naturalization (DHS/INS Forms N-550 or N-570)	• Department of Homeland Security or Immigration and Naturalization Service (INS) issues for naturalization.

Certificate of US Citizenship (DHS/INS Forms N-560 or N-561)	• Department of Homeland Security or INS issues certificates of citizenship to individuals who derive citizenship through a parent.
Tribal Enrollment Card Certificate of Degree of Indian Blood; or Other documents issued by a federally recognized Indian tribe that evidences membership or enrollment with such tribe	• A document issued by a federally recognized Indian tribe evidencing membership or enrollment or affiliation with, such tribe. See following table for acceptable verifications from ND tribes.
Social Security's TPQY Online Query Response (TPOR)	• Acceptable codes are: ○ "Verified with positive citizenship" or ○ "Verified with positive citizenship; Deceased."

State Residence 510-05-35-85

Subsection 1 has been amended to **clarify** that worker must check with the other state regarding Medicaid coverage prior to authorizing an application.

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1. For individuals entering the state, the earliest date of residency is the date of entry. Residence may not be established for individuals who claim residence in another state.

   An individual's Medicaid case may remain open in the other state for a period of time after the individual moves, however, most states will not cover out-of-state care so eligibility may be determined as of the date the individual entered the state. If ~~it is known that~~ the other state will pay for the care in North Dakota, wait to open the case until the other state stops the coverage. Likewise, when an individual leaves the state, eligibility is ended as soon as, and in accordance with, proper notice. North Dakota Medicaid will no longer extend coverage through the month in which an individual moves out of the state. This information must be documented in the casefile.

~~Inmates of~~ Public Institutions and IMDs 510-05-35-95

This section has been rewritten to clarify policy. This **supersedes** IM 5150 "Public Institutions and IMDs".

~~1. For purposes of this section:~~

1. An "inmate" of a public institution is not eligible for Medicaid unless the eligible individual is a child under the age of 19 who is determined to be continuously eligible. Such child remains eligible for Medicaid; however, no medical services will be covered during the stay in the public institution.

   a. A public institution is an institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control, but does not include a medical institution.

      Examples include (but are not limited to): School for the Blind, School for the Deaf, North Dakota Youth Correctional Center, Women's Correctional Center in New England, North Dakota State Penitentiary, Bismarck Transition Center, and city, county, or tribal jails.

      The Bismarck Transition Center (BTC) is a community-based correctional program designed to help eligible, non-violent offenders transition back into the community, and is a public institution. Individuals entering this facility as "inmates" who are sent to the facility for assessment purposes are committed under the penal system and will be arrested if they leave. Because such individuals are "inmates," they are not eligible for Medicaid. (Individuals entering this facility on a voluntary basis while on probation are not "inmates.")

   While some institutions are owned or controlled by governmental entities, they do not meet the definition of public institutions because they are medical institutions.

      Examples include (but are not limited to): State Hospital, State Developmental Center at Grafton, Veterans Administration Hospitals, and the North Dakota Veteran's Home.

b. An "inmate" of a public institution is a person who has been involuntarily sentenced, placed, committed, admitted, or otherwise required to live in the institution, and who has not been unconditionally released from the institution.

"Unconditionally released" means released, discharged, or otherwise allowed or required to leave the institution under circumstances where a return to the institution cannot be required by the operator of the institution.

Residence in a penal institution is terminated by parole, discharge, release on bond, or whenever the individual is allowed to return and reside in their home. A transfer from a penal facility to the state hospital or another medical institution, for evaluation or treatment does not terminate inmate status.

Example: A release from a penal institution to a hospital for the birth of the inmate's child will not terminate inmate status if the inmate is required to return to the penal institution following discharge from the hospital.

~~a. "Individual on conditional release" means an individual who is away from the institution, for trial placement in another setting or for other approved leave, but who is not discharged. An individual on "definite leave" from the state hospital is an individual on conditional release.~~

~~b. "Inmate of a public institution" means a person who has been sentenced, placed, committed, admitted, or otherwise required or allowed to live in the institution, and who has not subsequently been unconditionally released or discharged from the institution.~~

~~An individual is not considered an inmate if:~~

~~i. The individual is attending school at the North Dakota School for the Blind in Grand Forks, or the North Dakota School for the Deaf in Devils Lake;~~

~~ii. The individual is in a public institution for a temporary period pending other arrangements appropriate to the individual's needs (i.e., Juvenile Detention Center, Fargo); or~~

~~iii. The individual is over age sixty-five and a patient in the state hospital.~~

~~c. "Unconditionally released" means released, discharged, or otherwise allowed or required to leave the institution under circumstances where a return to the institution cannot be required by the operator of the institution.~~

~~Examples of public institutions include but are not limited to: State Hospital, School for the Blind, School for the Deaf, State Developmental Center at Grafton, Veterans Administration Hospitals, North Dakota Veteran's Home, North Dakota Youth Correctional Center, North Dakota State Penitentiary, and city, county, or tribal jails.~~

c. An individual who is voluntarily residing in a public institution or who has not yet been placed in the facility is not an "inmate." An individual is not considered an "inmate" (so can remain or become eligible for Medicaid) if:

i. The individual is attending school at the North Dakota School for the Blind in Grand Forks, or the North Dakota School for the Deaf in Devils Lake;

ii. The individual is in a public institution for a temporary period pending other arrangements appropriate to the individual's needs (i.e., Juvenile Detention Center, Fargo);

iii. The individual has not yet been placed in a public institution. For instance, an individual who is arrested and transported directly to a medical facility is not an inmate until actually placed in the jail. The individual may remain Medicaid eligible until actually placed in jail; or

iv. The individual enters the Bismarck Transitional Center (BTC) on a voluntary basis while on probation.

~~2. An inmate of a public institution is not eligible for Medicaid unless:~~

~~a. The eligible individual is residing in the ICF/ID at the State Developmental Center, or is in long term care in the North Dakota Veteran's Home;~~

~~b. The individual is under age twenty-one, in the state hospital receiving inpatient psychiatric services, and who meets the certificate of need for admission. A person who attains age twenty-one while receiving treatment, and who continues to receive treatment as an inpatient,~~

~~may continue to be eligible through the month the individual attains the age of twenty-two; or~~

~~c. The individual is under the age of 19 and is determined to be continuously eligible for Medicaid. While the individual remains eligible for Medicaid no medical services will be covered during the stay in the public institution.~~

2. An individual under age 65 who is a "patient" in an IMD is not eligible for Medicaid, except as identified in subdivision d, unless the individual is under age 21 and is receiving inpatient psychiatric services and meets the certificate of need for admission. An individual who attains age 21 while receiving treatment, and who continues to receive treatment as an inpatient, may continue to be eligible through the month the individual attains the age of 22.

a. An IMD is a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases. A facility with 16 beds or less is not an IMD. Whether an institution is an IMD is determined by its overall character as that of a facility established and maintained primarily for the care and treatment of mental diseases. An institution for the intellectually disabled (ICF-ID) is not an IMD.

IMDs include the North Dakota State Hospital, facilities determined to be a Psychiatric Residential Treatment Facility (PRTF) by the Medical Services Division, the Prairie at St. John's center, and the Stadter Psychiatric Center. For any other facility, contact the Medical Services Division for a determination of whether the facility is an IMD.

b. An individual on conditional release or convalescent leave from an IMD is not considered to be a "patient" in that institution. However, such an individual who is under age 21 and has been receiving inpatient psychiatric services is considered to be a "patient" in the institution until unconditionally released or, if earlier, the last day of the month in which the individual reaches age 22.

c. An individual on conditional release is an individual who is away from the institution, for trial placement in another setting or for other approved leave, but who is not discharged. An individual on "definite leave" from the state hospital is an individual on conditional release.

d. A child under the age of 19 who is determined to be continuously eligible for Medicaid, but who does not meet the certificate of need,

remains eligible for Medicaid, however, no medical services will be covered during the stay in the IMD.

3. The period of ineligibility under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from a public institution or IMD. A Ten-Day Advance Notice is not needed when terminating benefits due to entry into the public institution or IMD. See Paragraph (4)(c)(iii) of 510-05-25-25, "Decision and Notice," for further information.

~~3. Individuals who are committed under the penal system to a public institution are not eligible for Medicaid even though they may be receiving care in a medical facility. For example, a release from a penal institution to a hospital for the birth of the inmate's child will not terminate inmate status if the inmate is required to return to the penal institution following discharge from the hospital. Inmate status at a penal facility (correctional) begins at the time of confinement.~~

~~Residence in the institution is terminated by parole, discharge, release on bond, or whenever the individual is allowed to return and reside in their home. A transfer from a penal facility to the state hospital or another facility, for evaluation or treatment does not terminate inmate status.~~

~~The Bismarck Transition Center (BTC) is a comprehensive, community-based correctional program designed to help eligible, non-violent offenders transition back into the community.~~

~~a. Individuals entering this facility on a voluntary basis while on probation are not inmates.~~

~~b. Individuals entering this facility as inmates who are sent to the facility for assessment purposes are committed under the penal system and will be arrested if they leave. Such individuals are inmates and not eligible for Medicaid.~~

~~4. An individual on conditional release from the state hospital is not considered to be a patient in that institution. However, such an individual who is under age twenty-two and has been receiving inpatient psychiatric services is considered to be a patient in the institution until unconditionally released or, if earlier, the last day of the month in which the patient reaches age twenty-two.~~

~~5. The period of ineligibility under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from~~

~~such an institution. A Ten-Day Advance Notice is not needed when terminating benefits due to entry into the institution. See Paragraph (4)(c)(iii) of 510-05-25-25, "Decision and Notice," for further information.~~

Blindness and Disability 510-05-35-100

Language is added to subsection (4)(i) to **clarify** that Workforce Safety determinations of disability are also subject to Medical Social review.

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4. The county agency will need to obtain and submit medical and social information to the State Review Team for their evaluation if:
   i. The individual has been found disabled by either the Veteran's Administration (VA), Workforce Safety and Insurance, or the Railroad Retirement Board (RRB) and a determination by the Social Security Administration has not been made.

Incapacity of a Parent 510-05-35-105

Language is added to subsection 1 to **clarify** incapacity determinations when the only child in common is an unborn.

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1. A child, if otherwise eligible for Medicaid benefits, is "deprived of parental support or care" when the child's parent, whether married or unmarried, has a physical or mental defect which is of such a debilitating nature as to reduce substantially or eliminate the parent's capacity either to earn a livelihood (breadwinner) or to discharge the parent's responsibilities as a homemaker and provider of child care (homemaker) for a period of thirty days or more. A parent may establish incapacity by demonstrating that the parent has reached age sixty-five. When the only child is an unborn, the prospective parents must be married, and in the same Medicaid unit to claim incapacity.

Continuously Eligible Individuals Moving Out of the Medicaid Unit 510-05-53-20

Subsection 8 is added to **clarify** the treatment of a continuously eligible individual who enters a public institution or an IMD.

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8. When a continuously eligible individual leaves the household to enter a public institution or IMD, the child remains continuously eligible through the end of their continuous eligibility period. Refer to 510-05-35-95 "Public Institutions and IMD's" for information regarding whether a medical service will be covered by Medicaid.

Asset Limits for the Medicare Savings Program 510-05-60-20

This section is updated for the asset limits effective with the benefit month of January 2013.

No person may be found eligible for the Medicare Savings Programs unless the total value of all non-excluded assets does not exceed the limit established for the Medicare Part D Low Income Subsidy. This amount changes annually. Effective with the benefit month of January 201~~2~~3, the limits are:

1. ~~$6,940~~ $7,080 for a one-person unit (~~$6,680 in 2011~~ $6,940 in 2012); or
2. ~~$10,410~~ $10,620 for a two-person unit (~~$10,160 in 2011~~ $10,410 in 2012).

Assets Which are Excluded for the Medicare Savings Programs 510-05-60-25

This section is updated to recognize the **change** making all exempt and excluded assets excluded assets.

Medically needy ~~exempt and~~ excluded assets are excluded for the Medicare Savings Programs with the following exceptions:

Community Spouse Asset Allowance 510-05-65-20

Subsection 2 is **updated** to reflect the Community Spouse Asset Allowance as of January 1, 2013.

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2. The community spouse asset allowance is determined by first establishing a spousal share. The spousal share is an amount equal to one half of the total value of all countable assets owned (individually or jointly) by the institutionalized, HCBS, or community spouse.

Example:

If the couple's countable assets are:	The community spouse share is:
$25,000	$12,500
$90,000	$45,000
$250,000	$125,000

From the spousal share, the community spouse asset allowance is established, and is an amount that is equal to the community spouse share, but not less than ~~$22,728~~ $23,184, and not more than ~~$113,640~~ $115,920, effective January 2013 ($22,728 ~~$21,912~~ and $113,640 ~~$109,560~~ effective January 201~~209~~).

Example:

If the spousal share is:	The community spouse asset allowance is:
$12,500	~~$22,728~~ $23,184 (at least the minimum)
$45,000	$45,000
$125,000	~~$113,640~~ $115,920 (one-half is more than the maximum allowed, so the community spouse gets the maximum)

The community spouse asset allowance may be adjusted by any additional amount transferred under a court order or established through a fair hearing.

Adjustments in the minimum and maximum allowed for a community spouse may also adjust the community spouse asset allowance.

Assets Which are Excluded for Spousal Impoverishment 510-05-65-25

This section is updated to recognize the **change** making all exempt and excluded assets excluded assets.

The medically needy ~~exempt and~~ excluded assets are excluded with the following exceptions:

Asset Considerations 510-05-70-10

This section is updated to recognize the **change** making all exempt and excluded assets excluded assets. Subsections 1(h) and 1(i) are added to **clarify** the treatment of benefit debit cards, gift cards, other debit cards, pre-paid credit cards and in-store credits. **This supersedes IM 5152.**

Assets, not otherwise ~~exempt or~~ excluded, that are available to an applicant or recipient and that are in excess of the Medicaid asset limits are considered to be available to meet the medical needs of the applicant or recipient and cause ineligibility for Medicaid. An asset is any kind of property interest, whether real, personal, or liquid.

1. All assets which are actually available must be considered in establishing eligibility for Medicaid. Assets are actually available when at the disposal of an applicant, recipient, or responsible relative; when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible relative has the lawful power to make the asset available, or to cause the asset to be made available. Asset availability is also as follows:

   h. Many benefit programs deposit an individual's monthly benefit onto a debit card. Any balance remaining on these debit cards are considered a liquid asset beginning the month following the month it was deposited on the card and counted as income. Examples of these benefit programs are TANF benefits, Unemployment Insurance Benefits (UIB), Child Support benefits, Workforce Safety and Insurance (WSI), Social Security Administration Benefits (SSA), etc.

   i. Individuals may either purchase for themselves or receive as gifts or bonuses items such as gift cards, debit cards, pre-paid credit cards and in-store credits. Regardless of the source, any of these items that an applicant or recipient has in the month following the month of receipt are considered available assets.

Asset Limits 510-05-70-15

This section is updated to recognize the **change** making all exempt and excluded assets excluded assets.

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1. 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 ~~exempted or~~ excluded, is limited to:

Home Equity Limit 510-05-70-27

The 2nd paragraph is updated to recognize the increase in the home equity limit effective January 1, 2013.

The Deficit Reduction Act of 2005 established limits on the home equity an individual may have and still qualify for coverage of nursing care services through Medicaid.

Applicants or recipients who apply for Medicaid coverage on or after January 1, 2006 are not eligible for coverage of nursing care services (which include HCBS) if the individual's equity interest in the individual's home exceeds ~~$525,000~~ $536,000 effective January 1, 201~~23~~ ~~($506,000~~ $525,000 effective January 201~~1~~2). The applicant or recipient may, however, be eligible for other Medicaid benefits.

Excluded Assets 510-05-70-30

The following subsections are updated to recognize the **change** making all exempt and excluded assets excluded assets. Language is added to subsection 1 to **clarify** when a home is considered occupied by the Medicaid unit. Language is added to subsection 7(a) to **clarify** that if a reasonable offer has been received on the property, or the property has sold prior to eligibility determination, the property cannot be determined unsalable "Exempt" has been changed to "Excluded" in subsections 1, 3 and 5.

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1. The home occupied by the Medicaid unit, including trailer homes being used as living quarters.

   The home occupied by the Medicaid unit includes the land on which it is located, provided that the acreage does not exceed one hundred sixty contiguous acres if rural or two acres if located within the established boundaries of a city.

   The home is considered occupied by the Medicaid unit when it is the home the ~~Medicaid unit~~ applicant, or the applicant's spouse or minor or disabled child is living in or, if temporarily absent from, possesses with an intention to return and the capability of returning within a reasonable length of time. Property is not occupied if the right to occupy has been given up through a rental or lease agreement, whether or not that rental or lease agreement is written. Property is not occupied by an individual in long-term care or the state hospital, with no spouse, or son or daughter who is under age twenty-one, or blind or disabled (any age), at home, unless a physician has certified that the individual is likely to return home within six months. (See 510-05-70-27 for home equity limit for ~~exempt~~ excluded home during six-month period and for single HCBS applicants and recipients.)

3. One motor vehicle, if the primary use of the vehicle is to serve the needs of members of the Medicaid unit. If the vehicle is used primarily by someone who is not in the Medicaid unit, it does not meet this exclusion ~~exemption~~.

5. Indian per capita funds and judgment funds awarded by either the Indian claims commission or the court of claims after October 19, 1973, interest and investment income accrued on such Indian per capita or judgment funds while held in trust, and purchases made using interest or investment income accrued on such funds while held in trust. The funds must be identifiable and distinguishable from other funds. Commingling of per capita funds, judgment funds, and interest and investment income earned on those funds, with other funds, results in loss of the exclusion ~~exemption~~.

7. Property that is not saleable without working an undue hardship. Property that is not saleable without working an undue hardship means property which the owner has made a good faith effort to sell which has produced no buyer willing to pay an amount equaling or exceeding seventy-five percent of the property's fair market value, and which is continuously for sale. Property may not be included within this definition at any time earlier than the first day of the first month in which a good faith effort to sell is begun.

   Refer to 05-05 for the definition of "good faith effort to sell" to determine the method and order in which an attempt to sell property must be made.

a. Persons seeking to establish retroactive eligibility must demonstrate that good faith efforts to sell were begun and continued in each of the months for which retroactive eligibility is sought. If a reasonable offer has been received on the property, or the property has sold prior to eligibility determination, the property cannot be determined unsalable.

11. Payments, interest earned on the payments, and in-kind items received for the repair or replacement of lost, damaged, or stolen ~~exempt or~~ excluded assets are excluded for nine months, and can be excluded for an additional twenty-one months if circumstances beyond the person's control prevent the repair or replacement of the lost, damaged, or stolen assets, and keep the person from contracting for such repair or replacement. This asset must be identifiable and not commingled with other assets.

Annuities Purchased Before August 1, 2005 510-05-70-45-20

Subsection 2(c)(v) is **updated** to reflect the change in the spousal maximum monthly needs allowance used to determine the annuity limitations.

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2. An annuity in which a payment option was selected **before August 1,** 2005 is counted as an available asset in the asset test unless:

   a. The annuity must be considered a disqualifying transfer and the penalty period is not finished (if the penalty period is finished and the applicant or recipient still owns the annuity, the annuity may be considered an available asset);

   b. The annuity has been annuitized and constitutes an employee benefit annuity that cannot be surrendered; or

   c. The annuity meets all of the following conditions:

      i. The annuity is irrevocable and cannot be assigned to another person;

      ii. The issuing entity is an insurance company or other commercial company that sells annuities as part of the normal course of business;

iii. The annuity provides for level monthly payments;

iv. The annuity will return the full purchase price and interest within the purchaser's life expectancy; and

v. Unless specifically ordered otherwise by a court of competent jurisdiction acting to increase the amount of spousal support paid on behalf of a community spouse by an institutionalized spouse or a home and community based services (HCBS) spouse, the monthly payments from the annuity do not exceed ~~$2841~~ $2,898 effective January 201~~2~~3 (~~$2739~~ $2841 for ~~2009~~ 2012).

Annuities Purchased from August 1, 2005 Through February 7, 2006 510-05-70-45-25

Subsection 2(c)(v) is **updated** to reflect the change in the spousal maximum monthly needs allowance used to determine the annuity limitations.

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2. The annuity is counted as an available asset in the asset test unless:

a. The annuity must be considered a disqualifying transfer and the penalty period is not finished (if the penalty period is finished and the applicant or recipient still owns the annuity, the annuity may be considered an available asset);

b. The annuity has been annuitized and constitutes an employee benefit annuity that cannot be surrendered; or

c. The annuity meets all of the following conditions:

i. The annuity is irrevocable and cannot be assigned to another person;
ii. The issuing entity is an insurance company or other commercial company that sells annuities as part of the normal course of business;
iii. The annuity provides for level monthly payments;

iv. The annuity will return the full principal and has a guaranteed period that is equal to at least 85% of the annuitant's life expectancy;

v. The monthly payments from all annuities that meet the requirements of this subsection do not exceed ~~$2841~~ $2,898 effective January 201~~2~~3 (~~$2739~~ $2841 for ~~2009~~ 2012) and, when combined with the annuitant's other income at the time of application for Medicaid, does not exceed $4,347 ~~$4261~~ effective January 20~~2~~13 (~~$4109~~ $4261 effective ~~2009~~ 2012); and

vi. If the applicant for Medicaid is age 55 or older, the Department of Human Services is irrevocably named as the primary beneficiary of the annuity following the death of the applicant and the applicant's spouse, not to exceed the amount of benefits paid by Medicaid. If a minor child who resided and was supported financially by the applicant or spouse, or disabled child, survives the applicant and spouse, any payments from the annuity will be provided to those individuals.

Annuities Purchased or Changed on or After February 8, 2006 510-05-70-45-30

Subsection 3(c)(v) is **updated** to reflect the change in the spousal maximum monthly needs allowance used to determine the annuity limitations.

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3. The annuity is counted as an available asset in the asset test unless:

   a. The annuity must be considered a disqualifying transfer and the penalty period is not finished (if the penalty period is finished and the applicant or recipient still owns the annuity, the annuity may be considered an available asset);
   b. The annuity has been annuitized and constitutes an employee benefit annuity that cannot be surrendered; or

c. The annuity meets all of the following conditions:

i. The annuity is irrevocable and cannot be assigned to another person;
ii. The issuing entity is an insurance company or other commercial company that sells annuities as part of the normal course of business;
iii. The annuity provides for level monthly payments;
iv. The annuity will return the full principal and interest within the annuitant's life expectancy and has a guaranteed period that is equal to at least 85% of the annuitant's life expectancy;
v. The monthly payments from all annuities that meet the requirements of this subsection do not exceed ~~$2841~~ $2,898 effective January 201~~2~~3 (~~$2739~~ $2841 for ~~2009~~ 2012) and, when combined with the annuitant's other income at the time of application for Medicaid, does not exceed $4,347 ~~$4261~~ effective January 20~~2~~13 (~~$4109~~ $4261 effective ~~2009~~ 2012); and
vi. The Department of Human Services is irrevocably named as the primary beneficiary of the annuity following the death of the applicant and the applicant's community spouse, not to exceed the amount of benefits paid by Medicaid. If a minor child who resided and was supported financially by the applicant or spouse, or disabled child, survives the applicant and spouse, any payments from the annuity will be provided to those individuals.

Example: Mr. White, who is in LTC, has an annuity that meets the criteria above and names Mrs. White, the community spouse, as the primary beneficiary and the Department as the secondary beneficiary. The annuity is excluded as an asset and is not considered a disqualifying transfer because Mrs. White is a community spouse.

Mrs. White also has an annuity that meets the criteria above and names Mr. White as the primary beneficiary and the Department as the secondary beneficiary. The annuity is not excluded as an asset. It may be considered a disqualifying transfer because Mr. White is not a community spouse. It is necessary to determine whether

Mrs. White's annuity was purchased or changed within Mr. or Mrs. White's look back period. If it was, then her annuity is a disqualifying transfer equal to the annuity value. If the annuity was last changed prior to their look back periods, then it is not a disqualifying transfer.

Valuation of Assets 510-05-70-60

Subsection 3(a) has been amended to **clarify** policy in determining the value of mineral rights.

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3. Real property:

   a. With respect to mineral interests:

      2) If not producing, but mineral rights are leased, two times the lease amount (based on the actual lease and not the yearly lease amount) that was in place at the time of the transfer.

         Example: John Oilslick leased his mineral acres in 2008 for $3000. He transferred his mineral rights to his adult children in January 2010. The children have a new lease on these acres effective January 2011 for $10,000. The disqualifying transfer is equal to two times the $3,000 lease that was in place at the time of the transfer.

      3) If not leased, the greater of two times the estimated lease amount, or the potential sale value of the mineral rights, as determined by a geologist, mineral broker, or mineral appraiser at the time of the transfer, whichever is greater.

         Example: Don Goldmine had his mineral acres valued at $50,000 in 2010 when he transferred them to his children. Today those minerals are valued at $20,000. The amount of the disqualifying transfer would be $50,000, the value at the time of the transfer.

iii. In determining current or previous value, an applicant or recipient may provide persuasive evidence that the value established using the above process is not accurate. Likewise, if an established value is questionable, the Department may require additional evidence be provided to establish estimated fair market value.

Example: Mary Golddigger leased her mineral acres in June 2008 for $5,000 under a 3-year lease. Two months before the lease expired—April 2011, she transferred those acres to her daughter, Nugget Golddigger. Nugget then leased those acres for $20,000. In this situation, at the time of transfer, Mary probably reasonably would be aware of the lease renewal amounts. Even if she didn't know, it is likely that the value was closer to the $20,000 than $5,000. The eligibility worker must get information of the estimated value as of the date of the transfer. The value of the disqualifying transfer at 2 X the newer lease amount of $20,000 equals $40,000.

Communal Colonies 510-05-75-15

Subsection 1 is updated to recognize the **change** making all exempt and excluded assets excluded assets.

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1. Assets. When colonies have a collective ownership in assets, no individual ownership rights remain, and the assets of the colony are not considered available.

   Any personal assets owned by an applicant or recipient that are not owned collectively, and are not otherwise ~~exempt or~~ excluded, are countable, and the medically needy asset limits apply.

Disqualifying Transfer Provisions 510-05-80-10

The N.D.A.C. cite is **updated** to include the section that addresses transfers made on or after February 8, 2006. The example under subsection 5 is **updated** to reflect the 60-month look back.

(N.D.A.C. Section 75-02-02.1-33.1 and 75-02-02.1-33.2)

5. Each individual establishes their own look-back date.

   Example: Mr. and Mrs. Brown make a large disqualifying transfer that causes 70 months of ineligibility. At the same time, Mr. Brown enters LTC and applies for Medicaid. He is ineligible because the disqualifying transfer was made on or after his look-back date. Mrs. Brown enters LTC ~~48~~ 75 months later. The disqualifying transfer was made prior to her look-back date (~~36~~ 60 months). Mrs. Brown can be eligible for Medicaid coverage of her LTC costs while Mr. Brown is still ineligible.

Penalty Periods 510-05-80-15

The N.D.A.C. cite is **updated** to include the section that addresses transfers made on or after February 8, 2006.

(N.D.A.C. Section 75-02-02.1-33.1 and 75-02-02.1-33.2)

Hardship Provision 510-05-80-20

The following subsections are updated to recognize the **change** making all exempt and excluded assets excluded assets.

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4. An undue hardship exists only if the individual shows that all of the following conditions are met:
   e. The individual's remaining available assets, and the remaining assets of the individual's spouse, if any, are less than the asset limit applicable to a Medicaid eligible unit that would include the individual, the individual's spouse, if any, and the individual's minor children, if any, counting the value of all assets except:
      i. The home, but not if the individual, or the individual's spouse, if any, have equity in the home in excess of $125,000;
      ii. ~~Exempt~~ Excluded personal effects, wearing apparel, household goods, and furniture;
      iii. One motor vehicle, if the primary use of the vehicle is to serve the needs of members of the Medicaid unit; and
      iv. Funds for burial of $6,000 or less for the individual and the individual's spouse.

6. A hardship determination approved by the Medicaid eligibility unit, or through the appeal process, may be terminated, or adjusted if;
   a. New information is received that would have affected the original determination;
   b. Circumstances change;
   c. The individual, the individual's spouse, or anyone with authority to transfer income or assets of the individual or the individual's spouse, makes a subsequent transfer of income or assets; or
   d. The individual, the individual's spouse, or anyone with authority to manage the income or assets of the individual or the individual's spouse, converts any income or assets to a form that is ~~exempt or~~ excluded.

Income Considerations 510-05-85-05

This section is updated to recognize the **change** making all exempt and excluded assets excluded assets. Subsection 7 is added to clarify the treatment of items such as gift cards, debit cards, pre-paid credit cards or 'in-store' credits. **This supersedes IM 5152.**

Income is defined as any cash payment, which is considered available to a Medicaid unit for current use. Income must be reasonably evaluated.

1. All income which is actually available must be considered. Income is actually available when it is at the disposal of an applicant, recipient, or responsible relative; when the applicant, recipient, or responsible relative has a legal interest in a liquidated sum and has the legal ability to make the sum available for support, maintenance, or medical care; or when the applicant, recipient, or responsible relative has the lawful power to make the income available or to cause the income to be made available.

   An individual may have rights, authority, or powers that he or she does not wish to exercise. An example includes an individual who allows a relative to use excluded ~~or exempted~~ assets free or at a reduced rental. In such cases, a fair rental amount will be counted as available income whether the applicant or recipient actually receives the income.

7. Many benefit programs deposit an individual's monthly benefit onto a debit card. Examples of these benefit programs are TANF benefits, Unemployment Insurance Benefits (UIB), Child Support benefits, Workforce Safety and Insurance (WSI), Social Security Administration Benefits (SSA), and Supplemental Security benefits. Individuals may also receive as gifts or bonuses such things as gift cards, debit cards, prepaid credit cards or 'in-store credits'. Examples include bonus or commission payments, compensation for work performed, or Tribal Gaming Per Capita Distributions from gaming revenues etc**.** These could be earned or unearned income by applying appropriate policy.

Payments that are normally disregarded as income, such as SNAP or TANF benefits, disregarded Tribal payments (other than per capita payments from gaming revenues), and occasional small gifts, continue to be disregarded as income regardless of the form of payment (510-05-85-25 Post Eligibility

Treatment of Income, 510-05-85-30 Disregarded Income – Medicaid, 510-07-40-30 Disregarded Income – Healthy Steps). All other such payments are counted as income.

Medical Payments 510-05-85-07

Language is added to the first paragraph to **clarify** that Medical Payments only apply to Medicaid and not to the Medicare Savings Programs.

Payments from any source, which are or may be received as a result of a medical expense or increased medical need, are not income, but are considered to be medical payments which must be applied towards the recipient's medical costs. These payments include health or long-term care insurance payments, Veteran's Administration aid and attendance, Veteran's Administration reimbursements for unusual medical expenses, and Veteran's Administration homebound benefits intended for medical expenses. Medical payments from the Veteran's Administration are based on the individual's level of care and may be received regardless of the individual's living arrangement. This section does not apply to the Medicare Savings Programs.

Unearned Income 510-05-85-15

New subsections 5(p) and 5(q) are added to clarify the treatment of Sisseton-Wahpeton Oyate Lake Traverse reservation food distribution casino cash payments to the elderly and the Spirit Lake Nation payments for grades. This **supersedes** IM 5144.

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5. Types of unearned income include but are not limited to:

   p. Sisseton-Wahpeton Oyate Lake Traverse Reservation Food Distribution Program casino cash payments to the elderly is a recurring lump sum payment to be prorated over the period it is intended to cover.

   q. Spirit Lake Nation payments for grades are considered non-recurring lump sums.

Post Eligibility Treatment of Income 510-05-85-25

Language is **changed** in subsection 1 and 3 as the lead-in paragraph already identifies that the Post Eligibility Treatment of Income is used to determine the client's share that is applied to the cost of care. Language is added to subsection 3(c) and **clarify** that what are and are not considered necessary medical expenses can be found in the Income Deductions subsection.

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1. The following types of income may be disregarded ~~in determining~~ ~~Medicaid eligibility~~:

3. ~~In establishing the application of income to the cost of care,~~ The following deductions are allowed in the following order:

   c. Medical expenses for necessary medical or remedial care. (See examples of what are and are not considered necessary medical expenses at 510-05-85-35(2)(e)). Each medical or remedial care expense claimed for deduction must be documented in a manner, which describes the service, the date of the service, the amount of cost incurred, and the name of the service provider. An expense may be deducted only if it is:

Disregarded Income 510-05-85-30

New subsection 47 is added to clarify that food coupons of Sisseton-Wahpeton Oyate Lake Traverse reservation food distributed to the elderly are disregarded income. This **supersedes** IM 5144.

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44. For periods after October 1, 2008, all wages paid by the Census Bureau for temporary employment related to census activities will be disregarded as income; ~~and~~

45. Reimbursements from an employer, training agency, or other organization for past or future training, or volunteer related expenses are disregarded from income. Reimbursements must be specified for an identified expense, other than normal living expenses, and used for the purpose intended. Reimbursements for normal household living expenses or maintenance such as rent or mortgage, clothing or food, are a gain or benefit and are not disregarded~~.~~;

Examples of disregarded reimbursements include:

a. Reimbursements for job or training-related expenses such as travel, per diem, uniforms, and transportation to and from the job or training site;

b. Reimbursements for out-of-pocket expenses of volunteers incurred in the course of their work.

46. The first $2,000 received by an individual age 19 and over as compensation for participation in a clinical trial for rare diseases or conditions meeting the requirements of Section 1612(b)(26) of the Act. This disregard is only allowed if approved by the Medicaid Eligibility Unit and will expire on October 5, 2015~~.~~; and

47. Monthly food coupons distributed to individuals age 55 and over from the Sisseton-Wahpeton Oyate Lake Traverse Reservation Food Distribution program.

Income Deductions 510-05-85-35

A new paragraph "x" is added to the examples of expenses that cannot be used to reduce countable income and affect client share under subsection 2(e) to **clarify** that an expense may not be allowed if it will be reimbursed to the household.

The following income deductions are allowed in determining Medicaid eligibility:

2. Except in determining eligibility for the Medicare Savings Programs, medical expenses for necessary medical or remedial care claimed for deduction must be documented in a manner which describes the service, the date of the service, the amount of cost incurred, and the name of the service provider. A medical expense may be deducted only if it is:

e. Claimed.

Examples of expenses that cannot be used to reduce countable income and affect client share:

i. Extra amounts paid on glasses, such as more expensive frames, tint, etc.;

ii. Expenses that are considered medically necessary, but are applied to client share;

iii. Costs for Lifeline;

iv. Over the counter medications and supplies that Medicaid does not pay for, even if prescribed*;

v. Other medications and services that Medicaid does not pay for, such as DESI drugs, such as Midrin (for Migraines), Tigan (for nausea). (DESI drugs -- Drug Efficacy Study Implementation --are determined by the federal government to be safe but less than effective);

vi. Expenses from visiting a provider who is not the individual's Coordinated Services Program (CSP) "lock-in" provider;

vii. Drugs from Canada prescribed by someone other than a United States physician;

viii. Transportation costs for out of state medical care provided to recipients that have not been prior approved; ~~or~~

ix. Up to 15 bed-hold days in a long term care facility that neither Medicare nor Medicaid will cover~~.~~ ; or

x. Any amount of an expense for which the household will be reimbursed, to the extent of the reimbursement.

Budgeting Procedures for Pregnant Women 510-05-90-25

Language is also added to **clarify** that pregnant women receive extended coverage. .

The Omnibus Budget Reconciliation Act of 1990 provided for ~~continuous~~ extended eligibility for pregnant women effective July 1, 1991.

Budgeting Procedures for Unmarried Parents with Children 510-05-90-40

Subsection 3 is added to **clarify** when to add the father of an unborn to a case.

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3. When the only child in common is an unborn and the prospective parents are unmarried but living together, the unborn's father should be added to the case as of the month in which he joins the household or when paternity is established, whichever is later.

Refugee Medical Assistance Program 510-05-95-20

A row is added to the Refugee Table for Iraqi and Afghan Special Immigrants.

Type of Individual	How to Identify
Alien Granted status as a refugee under Section 207 of the Act	Use of SAVE, **or** obtain Form I-94 annotated with stamp showing admission under section 207 of the INA. Derive the date of admission from the date of inspection on the Form I-94 refugee stamp. Note: If the date is missing, must obtain further verification. (These are the individuals we usually see and deal with in North Dakota.)
Alien Paroled as a Refugee or Asylee* under section 212(d)(5) of the Act	Use of SAVE, **or** obtain a valid I-94 card which will indicate they have been paroled pursuant to section 212(d)(5) of the INA, with an expiration date of at least 1 year from the date issued, or indefinite.
Alien Granted status as an Asylee* under Section 208 of the Act	Use of SAVE, **or** obtain either a Form I-94 annotated with stamp showing grant of asylum under section 208 of the INA, or a grant letter from the Asylum office, or an order of an immigration judge. Derive the date status granted from the date on Form I-94, the grant letter, or the date of the court order. Note: If the date is missing from Form I-94, request the grant letter from the alien. If it is not available, must obtain further verification.
Alien Granted parole status as a Cuban/Haitian Entrant	Use of SAVE, **or** if the individual cannot provide documentation of status, refer him/her to the Department of Homeland Security for evidence of current immigration status.

Certain Amerasians from Vietnam Admitted to the US as immigrants	Use of SAVE, **or** obtain the immigrant's Form I-551 with the code AM1, AM2, or AM3 or passport stamped with an unexpired temporary I-551 showing a code AM6, AM7, or AM8. Derive the date of admission as an Amerasian immigrant from the I-551, or the date of inspection on the stamp on Form I-94. Note: If the date is missing on the I-94, verify status with the Department of Homeland Security.
Individuals Admitted for permanent residence, provided the individual previously held one of the statuses above.	If the individual held one of the previous statuses above, they will more than likely have been in the US more than 8 months and thus cannot be eligible for Refugee Medical Assistance.
Iraqi and Afghan Special Immigrants	Use of SAVE, **or** obtain the immigrant's Form I-551 with the code SQ6, SQ7, SQ9, SI6, SI7, SI9 with "IV" stamp or Afghan or Iraqi passport stamped with an "IV" and showing a code SQ1, SQ2, SQ3, SI1, SI2 or SI3 and DHS stamp or notation on passport showing date of entry; or I-94 with a stamp of "IV" and category SQ1, SQ2, SQ3, SI1, SI2 or SI3 and date of entry. Derive the date of admission as an Iraqi or Afghan Special immigrant from the I-551, or the date of inspection on the stamp on Form I-94. Note: If the date is missing on the I-94, verify status with the Department of Homeland Security.

* For Asylee's, individuals that enter the US and have not been granted Asylum by INS are considered an 'Applicant or Asylum'. Federal Law prohibits 'Applicants for Asylum' from being eligible for Medicaid or Refugee Medical Assistance. Therefore, they must be granted Asylum in order to be eligible for Medicaid or Refugee Medical Assistance under the 'Refugee Category'.

Par. 2. **Effective Date** -- This manual letter is effective for the benefit month of **January 2013 except as indicated.**
