Non-ACA Medicaid

NORTH Dakota Be Legendary.

Health & Human Services

NON-ACA Medicaid Program
510-05

Welcome to the Medicaid Program Policy Manual.

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Eligibility Factors 510-05

Definitions 510-05-05

(Revised 1/1/2025 ML #3916)

(N.D.A.C. Section 75-02-02.1-01)

For the purpose of this chapter:

ACA

Affordable Care Act also known as the Patient Protection and Affordable Care Act of 2010, which was signed into law by President Obama on March 23, 2010.

ACA Individual

An individual required to be budgeted using ACA MAGI-based methodologies as defined in Service Chapter 510-03, Eligibility Factors for ACA (Affordable Care Act) Medicaid. Individuals include:

1. Parents and Caretakers of deprived children and their spouses

2. Parents and Caretaker Relatives of deprived children and their spouses who were eligible under the Parents and Caretaker Relatives and their spouses group in at least three of the six months immediately preceding the month in which the Parents or Caretakers lose coverage under the Parents and Caretaker Relatives and their spouses group due to increased earned income or hours of employment, and their dependent children for up to 12 months (Transitional);

3. Parents and Caretaker Relatives of deprived children and their spouses who were eligible under the Parents and Caretaker Relative and their spouses group in at least three of the six months immediately preceding the month in which the Parents or Caretaker Relatives lose coverage under the Parents and Caretaker Relatives and their spouses group due to increased alimony or spousal support and their dependent children for up to 4 months (Extended)(no budget test);

4. Pregnant Women

5. Pregnant women who applied for and were eligible for Medicaid during pregnancy continue to be eligible for twelve (12) months, beginning on the last day of the pregnancy, and through the last day of the twelfth month;

6. Children born to pregnant women who applied for and were found eligible for Medicaid on or before the day of the child's birth, for one year, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls;

7. Children Ages 0 through 18 (through the month the child turns 19)

8. Single adults ages 19 through 64 not eligible for Medicare (Adult Expansion group)

   Note: This may include SSI recipients who fail eligibility under Non-ACA Medicaid, other disabled individuals who fail the Medicaid asset limits and individuals who are disabled with a large client share.

9. Individuals under age 19 who meet the financial requirements of the Children's group and who are residing in foster homes or private child care institutions licensed or approved by the Department, irrespective of financial arrangements, including children in a "free" foster home placement (Non-IV-E foster care).

10. Individuals who are not eligible as an ACA individual defined in #'s 1 thru 7 above, who were in North Dakota foster care and receiving Medicaid (Title IV-E, state-funded (non-IV-E, tribal or Unaccompanied Refugee Minor) and on ND Medicaid in the month they turned age 18 must be covered through the month in which they turn age 26 with no budget test.

Attorney in Fact

An agent authorized to act on behalf of another person, but not necessarily authorized to practice law, e.g. a person authorized to act by a power of attorney. An attorney in fact is a fiduciary.

Blind

Has the same meaning as the term has when used by the social security administration in determining blindness for Titles II and XVI.

Contiguous

Real property, which is not separated by other real property owned by others. Roads and other public rights-of-way, which run through the property, even if owned by others, do not affect the property's contiguity.

County agency

The county social service board.

Department

The North Dakota Department Health and Human Services.

Disabled

Has the same meaning as the term has when used by the Social Security Administration in determining disability for Titles II and XVI.

Disabled adult child

A disabled or blind person over the age of twenty-one who became blind or disabled before age twenty-two.

Fee for Service

The most common method of Medicaid payments under which Medicaid pays providers directly for their services. It is a specific dollar limit that Medicaid pays for a specific service.

Full calendar month

The period, which begins at midnight on the last day of the previous month and ends at midnight on the last day of the month under consideration.

Good faith effort to sell

An honest effort to sell in a manner which is reasonably calculated to induce a willing buyer to believe that the property offered for sale is actually for sale at a fair price. A good faith effort to sell includes, at a minimum, making the offer at a price based on an appraisal, a market analysis by a realtor, or another method which produces an accurate reflection of fair market value, in the following manner:

1. To any co-owner, joint owner, possessor, or occupier of the property, and, if no buyer is thereby secured;
2. To the regular market for such property, if any regular market exists, or, if no regular market exists (a realtor is considered the regular market for real estate, including mobile homes);
3. By public advertisement for sale in a newspaper of general circulation, the circulation area of which includes the location of any property resource offered

for sale, which advertisement was published successively for two weeks if the newspaper is a weekly publication and for one week if the newspaper is a daily publication, and which includes the selling price, a plain and accurate description of the property and the name, address, and telephone number of a person who will answer inquiries and receive offers.

Home and community based services

Services, provided under a waiver secured from the United States Department of Health and Human Services, that are:

1. Not otherwise available under Medicaid; and
2. Furnished only to individuals who, but for the provision of such services, would require the level of care provided in a hospital, nursing facility, or intermediate care facility for the intellectually disabled (ICF-ID).

Inmate

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

Institutionalized individual

An individual who is an inpatient in a nursing facility, an ICF/ID, the State Hospital, an intermediate care facility for mental disease (IMD), a Psychiatric Residential Treatment Facility (PRTF), or who receives swing bed care in a hospital.

Irrevocable Itemized Funeral Contract

A fully executed document between two or more parties that has been signed and dated. The document must contain an itemized listing of funerary components agreed upon between the parties. Terms and conditions must be irrevocable and cannot be changed, except for the ability to transfer to another licensed funeral establishment or cemetery association.

Living independently

In reference to a single individual who is blind or disabled under age eighteen, a status which arises in any of the following circumstances:

1. The individual has served a tour of active duty with the armed services of the United States and lives separately and apart from the parent.
2. The individual has married, even though that marriage may have ended through divorce or separation. A marriage ended by legal annulment is treated as if the marriage never occurred.
3. The individual has lived separately and apart from both parents for at least three consecutive full calendar months after the date the individual left the parental home, continues to live separately and apart from both parents, and has received no support or assistance from either parent while living separately and apart. Periods in which a child is included in the parent's Medicaid unit are deemed to be periods in which the parents are providing support. Providing health insurance coverage or paying court ordered child support payments for a child is not considered to be providing support or assistance. For purposes of this paragraph, periods when the individual is attending an educational or training facility, receiving care in a specialized facility, or is an institutionalized person are deemed to be periods when the individual was living with a parent, unless the individual had already established that the individual was living independently.
4. The individual has left foster care and established a living arrangement separate and apart from either parent and received no support or assistance from either parent. Providing health insurance coverage or paying court ordered child support payments for a child is not considered to be providing support or assistance.
5. The individual lives separately and apart from both parents due to incest, continues to live separately and apart from both parents, and receives no support or assistance from either parent while living separately and apart. Providing health insurance coverage for a child is not considered to be providing support or assistance.

Long term care, (LTC)/ Nursing Care Services

Refers to care provided in a medical institution, a nursing facility, the State Hospital, an Intermediate Care Facility (IMD), a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the intellectually disabled (ICF-ID), a swing bed, or in a home and community based setting.

MAGI Household

A household required to be budgeted using MAGI methodologies. This includes the Adult Expansion Group, Parents, Caretaker Relatives, and their Spouses, Children, and Pregnant Women.

Medicaid

A program implemented pursuant to North Dakota Century Code chapter 50-24.1 and title XIX of the Act.

Medicare cost sharing

Refers to the following costs:

1. Medicare part A premiums (hospital); and Medicare part B premiums (doctor);
2. Medicare coinsurance (Including coinsurance amounts for certain services and the remaining 20% after Medicare pays 80% on the approved amount of the bill.); and
3. Medicare deductibles.

Medicare Part A Conditional Enrollment

Medicare Part A Conditional Enrollment Medicare Part A conditional enrollment allows an individual to apply for premium-Medicare Part A at Social Security on the condition he/she only wants coverage if the State approves their QMB application. Medicare Part A start date will be the date the State can start paying the Medicare Part A.

No Wrong Door

The federal mandate that allows individuals to apply for Medicaid through any means, may be through the Federal Facilitated Marketplace, the State eligibility portal, by telephone, through the OASYS application, by FAX or in-person.

Non-ACA Individual

Individuals who are required to be budgeted using Non-ACA Medicaid methodologies as defined in Service Chapter 510-05, Eligibility Factors for Non-ACA Medicaid. Such Individuals include:

1. Aged and disabled individuals who choose to be treated as aged or disabled, including individuals eligible for Workers with Disabilities and Children with Disabilities

2. Individuals eligible for:
   a. HCBS or Waivered Services
   b. Workers with Disabilities
   c. Children with Disabilities

3. MEDICARE recipients who choose to be treated as aged or disabled,

4. Individuals who request or are eligible for coverage under the Medicare Savings Programs,

5. Individuals who request eligibility under Spousal Impoverishment,

6. SSI individuals who pass the Medicaid asset test,

7. Individuals who are eligible under the Breast and Cervical Cancer Early Detection.

8. Individuals who are eligible under Refugee Medical Assistance.

9. Individuals who are eligible under Title IV-E and Non IV-E Subsidized Adoption Program

10. Individuals who are eligible under Title IV-E foster care,

11. Individuals who are eligible under Title IV-E Kinship Guardianship Program.

Non-ACA Medicaid

The Medicaid policies and procedures used to determine eligibility for individuals whose eligibility cannot be determined based on methodologies of the Affordable Care Act (ACA).

Optional Children's Group

Coverage for children up to age 19 who do not have other health insurance coverage.

Public institution

An institution that is the responsibility of a governmental unit or over which a governmental unit exercises administrative control. The term “public institution” does not include:

1. A medical institution as defined in 42 CFR §435.1010;
2. An intermediate care facility as defined in 42 CFR §§440.140 and 440.150;
3. A publicly operated community residence that serves no more than 16 residents, as defined in 20 CFR §416.231 (b)(6)(i); or
4. A child-care institution as defined in 42 CFR §435.1010 with respect to:
    a. Children for whom foster care maintenance payments are made under title IV- E of the Act; and
    b. Children receiving AFDC—foster care under title IV-A of the Act.

Remedial services

Those services, provided in specialized facilities, which produce the maximum reduction of physical or mental disability and restoration of the residents to the best possible level of functioning. Remedial services do not include room and board expenses.

Residing in the home

Refers to individuals who are physically present, individuals who are temporarily absent, or individuals attending educational facilities.

Supplemental Nutrition Assistance Program (SNAP)

Previously known as the Food Stamp Program, SNAP is a uniform nationwide program intended to promote the general welfare and safeguard the health and well being of the nation's population by raising the levels of nutrition among low-income households.

Specialized facility

A residential facility, including a basic care facility, a licensed family foster care home for children or adults, a licensed group foster care home for children or adults, a transitional living facility, a facility established to provide quarters to clients of a sheltered workshop, and any other facility determined by the Department to be a provider of remedial services, but does not mean an acute care facility or a nursing facility.

Spouse

A spouse is a person who is legally married to another person.

For a marriage performed in North Dakota to be considered valid in North Dakota, couples are required to obtain a marriage license through the County Recorder’s Office.

Marriages that occur outside of North Dakota are considered valid in North Dakota if:

1. The Marriage was legally performed in another state;
2. The marriage is a common law marriage that occurred in another state and was considered a valid marriage in that state (the couple would be required to provide documentation verifying that the common-law marriage was considered valid by the state in which it took place);

3. The marriage occurred in another country and the marriage was considered valid according to the law of the country were the marriage took place.
4. Polygamous marriages are not recognized in North Dakota. In situations where polygamy has occurred, the first marriage is considered valid in North Dakota if the marriage meets the criteria in #1, 2 or 3 above. Any additional spouse (s) claimed after the first marriage are considered non-relatives.

SSI Buy-In

A program under Section 1843 of the Social Security Act in which Medicaid eligible recipients who are in receipt of Supplemental Security income (SSI) benefits and who are eligible for Medicare Part B, are eligible for the state to pay the monthly Medicare Part B premium.

State agency

The North Dakota Department of Health and Human Services.

Student

An individual who regularly attends and makes satisfactory progress in elementary or secondary school, General Equivalency Diploma (GED) classes, a home-school program recognized or supervised by the student's state or local school district, college, university, or vocational training, including summer vacation periods if the individual intends to return to school in the fall. A full-time student is a person who attends school on a schedule equal to a full curriculum.

(TANF) Temporary Assistance For Needy Families

A program administered under North Dakota Century Code Chapter 50-09 and Title IV-A of the Social Security Act. References to TANF include TANF Kinship Care Assistance, Diversion Assistance, and Transition Assistance.

Title II

Title II of the Social Security Act (Social Security benefits).

Title IV-D

Title IV-D of the Social Security Act (Child Support).

Title IV-E

Title IV-E of the Social Security Act (Foster Care and Adoption Assistance).

Title XVI

Title XVI of the Social Security Act (Supplemental Security Income (SSI)).

Title XIX

Title XIX of the Social Security Act (Medicaid).

Title XXI

For eligibility months prior to January 1, 2020. Title XXI of Social Security Act (Healthy Steps). For eligibility months on or after January 1, 2020. Title XXI of the Social Security Act (Optional Children's Group).

Unconditionally Released

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

General Statement, Purpose, and Objectives 510-05-07

General Statement 510-05-07-05

(Revised 6/01 ML #2590)

View Archives

The Medicaid Program was authorized in 1965 during a special session of the North Dakota Legislature for the purpose of strengthening and extending the provision of medical care and services to certain groups of people whose resources are insufficient to meet such costs. Medicaid began in North Dakota effective January 1, 1966. Corrective, preventive and rehabilitative medical services are provided to help individuals and families retain or attain capability for independence, self-care, and self-support.

Purpose and Objective 510-05-07-10

(Revised 6/02 ML #2590)

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It is known that in addition to imposing financial difficulties, illness and health problems have their effects on personality functioning and interpersonal relationships. Illness can be used as an escape from unpleasant responsibilities and can distort family relationships. Unmet health needs can, therefore, be detrimental to the overall growth and adjustment of individuals and families.

The immediate purpose of the Medicaid Program is to provide an effective base upon which to provide comprehensive and uniform medical services that will enable persons previously limited by their circumstances to receive needed medical care. It is within this broad concept that the Medicaid Program in North Dakota participates with the medical community, to the greatest extent possible, in attempting to strengthen existing medical services in the state.

General Provisions 510-05-10

General Statement 510-05-10-05

(Revised 1/1/13 ML #3358)

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

Nondiscrimination in Federally Assisted Programs 510-05-10-10

(Revised 10/1/13 ML #3390)

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Public Law 88-352, Section 601 (Title VI) of the Civil Rights Act of 1964 states:

No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." (Section 504 of the Rehabilitation Act of 1973, as amended, prohibits discrimination solely on the basis of handicap for those otherwise qualified.)

The Department of Human Services makes available all services and assistance without regard to race, color, religion, national origin, age, sex, political beliefs, disability, or status with respect to marriage or public assistance, in accordance with Title VI of the Civil Rights Act of 1964, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act of 1990, and the North Dakota Human Rights Act of 1983. Persons who contract with or receive funds to provide services for the North Dakota Department of Human Services are obligated to abide by the provisions of these laws. The Department of Human Services makes its programs accessible to persons with disabilities. Persons needing accommodation or who have questions or complaints regarding the provisions of services according to these Acts may contact the Civil Rights Officer, North Dakota Department of Human Services, Judicial Wing, State Capitol, 600 E. Boulevard, Bismarck, ND 58505 or the US Department of Health and Human Services, Office for Civil Rights, Region VIII, 999 18th Street, Suite 417, Denver, Colorado 80202 or call 1-800-368-1019 or 1-800-537-7697 (TTY) or 303-844-2025 (FAX).

Refer to Service Chapter 300-01, Non-discrimination to Clients, for additional guidelines.

Confidentiality 510-05-10-15

(Revised 6/1/22 ML #3675)

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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 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, and SNAP 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.

Assignment of Rights to Recover Medical Costs 510-05-10-20

(Revised 8/1/05 ML #2981)

View Archives

(N.D.A.C. Section 75-02-02.1-09)

1. The assignment of rights to benefits is automatic under North Dakota Century Code sections 50-24.1-02 and 50-24.1-02.1. The assignment is effective to the extent of actual costs of care paid under the North Dakota Medicaid Program. As a condition of eligibility, the applicant or recipient may be required to execute a written assignment whenever appropriate to facilitate establishment of liability of a third party or private insurer. Form SFN 560, "Assignment of Benefits," (05-100-05) may be used for this purpose. If it becomes necessary to secure signatures on additional documents, specific instructions will be provided on a case-by-case basis.
2. The Department and county agency must take reasonable measures to obtain from the applicant or recipient health coverage information to determine the liability of third parties and private insurers.
3. For purposes of this section:

    a. "Private insurer" includes any commercial insurance company offering health or casualty insurance to individuals or groups, including both experience-related insurance contract and indemnity contracts; any profit or nonprofit prepaid plan offering either medical services or full or partial payment for services covered by the Medicaid program; and any organization administering health or casualty insurance plans for professional associations, employer-employee benefit plans, or any similar organization offering these payments or services, including self-insured and self-funded plans.
    b. "Third party" means any individual, entity, or program that is or may be liable to pay all or a part of the expenditures for services furnished under Medicaid, including a parent or other person who owes a duty to provide medical support to or on behalf of a child for whom Medicaid benefits are sought.

Suspected Fraud 510-05-10-25

(Revised 2/15/21 ML #3611)

View Archives

The SFN 20 “SURS Referral Form” must be completed in all instances where there is a suspicion of fraud.

To assist with determining what constitutes a suspicion of fraud the following items should be considered:

- Was information listed on the application(s) on file false? –meaning they were employed or had other assets or household members, ect., were not disclosed at the time of application?
- Were false statement(s) made by the household member? –meaning denying (specifically indicated no) assets or employment on a certain date when there really were assets or employment?
- Recipient admitted they knew they should have reported.
- Other proof or evidence there was false information given in order to receive benefits.

Liens and Recoveries 510-05-10-30

(Revised 1/1/18 ML #3508)

View Archives

1. No lien or encumbrance of any kind shall be required from or be imposed against the individual's property prior to his death, because of Medicaid paid or to be paid in his behalf (except pursuant to the judgment of a court incorrectly paid in behalf of such individual). (42 CFR 433.36)

2. A recovery of Medicaid correctly paid will be made from the estate of an individual who was 55 years of age or older when the recipient received such assistance or who had been permanently institutionalized regardless of age. Recovery is pursued only after the death of the recipient's spouse, if any, and only at a time when the recipient has no surviving child who is under age 21, or who is age 21 or older and who is blind or permanently and totally disabled as defined by the Social Security Administration. The recovery of Medicaid paid for individuals under age 65 is only for assistance paid on or after October 1, 1993. Medicaid benefits incorrectly paid because of a recipient error can be recovered regardless of the individual's age at the time the assistance was received. Overpayments due to recipient errors that are still outstanding are subject to recovery upon the individual's death without regard to whether or not there is a surviving spouse.

   Permanently institutionalized individuals are persons who, before reaching age 55, began residing in a nursing facility, the state hospital, the Prairie at St. John's center, Red River Behavior Health System, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the intellectually disabled (ICF-ID), or receiving swing bed care in hospitals, resided there continuously for at least six months and did not subsequently reside in any other living arrangement for at least 30 consecutive days, and have received written notice that they are consider to be permanently institutionalized. Permanently institutionalized individuals have a right to appeal their permanently institutionalized status.

3. When a qualified beneficiary of an ABLE account dies (or is determined to no longer be disabled) and there are remaining funds in their ABLE account:
   - The funds in the ABLE Account are first distributed to any State Medicaid agency that provided medical assistance to the qualified beneficiary; and

- The amount of any such funds received by the State Medicaid agency cannot exceed the amount paid by the State Medicaid agency AFTER the creation of the ABLE Account.

Third Party Liability 510-05-12

Cooperation - Third Party Liability 510-05-12-05

(Revised 3/1/12 ML #3312)

View Archives

1. States are required to pursue known third parties that may be liable to pay for care or services. The Department and county agency are required to make reasonable efforts to obtain the necessary information needed to pursue third parties. This includes following up on any leads that indicate there may be a third party payer, and assisting applicants and recipients in obtaining necessary information.

2. As a condition of eligibility, legally able applicants or recipients and their spouses must cooperate with the Department and county agency in identifying and providing information to assist Medicaid in pursuing third parties who may be liable to pay for care or services, unless there is good cause not to cooperate.

   This policy is not intended to place an unreasonable burden on applicants or recipients, or to shift the state's responsibility to pursue third parties. If Department and county staff have the ability to obtain the information, it cannot be shown that an applicant or recipient is not cooperating. If the necessary information cannot be obtained without the applicant or recipient's cooperation, and the applicant or recipient has the ability to assist, this provision applies. As part of cooperation, the Department or agency may require an individual to:

   a. Appear at a state or local office designated by the Department or county agency to provide verbal or written information or evidence relevant to the case;
   b. Appear as a witness at a court or other proceeding;
   c. Provide information, or attest to lack of information, under penalty of perjury;
   d. Complete SFN 566, "Medicaid Questionnaire and Assignment," (which is available on eforms).
   e. Pay to the agency any medical payments received that are covered by the assignment of benefits; and

f. Take any other reasonable steps to assist the state in securing third party payments and in identifying information to assist the state in pursuing any liable third party.

3. An exception to cooperation exists when the recipient is receiving Extended or Transitional Medicaid Benefits.

4. It is never a condition of a child's eligibility that a parent or caretaker cooperates. A parent or caretaker who does not cooperate will not be eligible for Medicaid, but the children in the Medicaid unit remain eligible. When a parent or legally responsible caretaker relative is not eligible because they are not cooperating, the earned and unearned income of that individual must still be considered in determining eligibility for the Medicaid unit.

5. The determination of whether an applicant or recipient is cooperating is made by the county agency in conjunction with their Economic Assistance regional representative. The determination may be based on information received from the Third Party Liability unit. The applicant or recipient has the right to appeal the decision.

6. When an applicant initially applies for Medicaid, it can usually be assumed that there will be cooperation. If the recipient then fails to cooperate, without "good cause," eligibility for that recipient is terminated. For applications in which a recipient clearly states that he or she will not cooperate, and there is no "good cause," that recipient is ineligible for Medicaid. Once the individual begins cooperating, eligibility can be restored or established. Eligibility can begin retroactively if the individual cooperates for the period to be covered. If an individual who failed to cooperate, and eligibility was terminated, later reapplies for assistance, the individual will remain ineligible until the individual begins to cooperate.

"Good Cause" -- Third Party Liability 510-05-12-10

(Revised 1/03 ML #2833)

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The requirement to cooperate may be waived when an applicant or recipient has "good cause" not to cooperate.

1. There is no particular form used to claim "good cause"; however, the applicant or recipient will need to provide information and evidence to substantiate the claim. If "good cause" is claimed the applicant or recipient can be eligible for Medicaid while the decision is pending.

2. The determination of whether there is good cause is made by the county agency. The county agency may waive the requirement to cooperate if it determines that cooperation is against the best interests of a child in the unit. Cooperation is against the best interests of a child only if the applicant or recipient's cooperation is reasonably anticipated to result in:

    a. Physical or emotional harm to a child in the Medicaid unit; or
    b. Physical or emotional harm to the parent or caretaker with whom the child is living, of such nature or degree that it reduces such person's capacity to care for the child adequately.

3. There must be evidence to substantiate a claim of "good cause." Exemptions on the basis of physical or emotional harm, either to the child, parent, or caretaker must be of a genuine and serious nature. Mere belief that cooperation might result in harm is not a sufficient basis for finding "good cause." Evidence upon which the county agency bases it's finding must be supported by written statements and contained in the case record.

    It is the applicant or recipient's responsibility to provide the county agency with the evidence needed to establish "good cause." The applicant or recipient is normally given 20 days from the date of claim to collect the evidence. In exceptional cases, the county agency may grant reasonable additional time to allow for difficulty in obtaining proof. Records of law enforcement, social service, or adoption agencies may be readily available to document instances of physical harm, perhaps without requiring further investigation. Documentation

of anticipated emotional harm to the child, parent, or caretaker, however, may be somewhat more elusive. Whenever the claim is based in whole or in part on anticipated emotional harm, the county agency must consider the following:

a. The present emotional state, and the emotional health history, of the individual subject to emotional harm;
b. The intensity and probable duration of the emotional impairment;
c. The degree of cooperation to be required; and
d. The extent of involvement of the child in pursuing third parties who may be liable to pay for care or services.

4. Upon request, the county agency is required to assist the applicant or recipient in obtaining evidence necessary to support a "good cause" claim. This, however, is not intended to place an unreasonable burden on staff, shift the applicant or recipient's basic responsibility to produce evidence to support the claim, or to delay a final determination.

5. The county agency is directly responsible for investigating a "good cause" claim when it believes that the applicant or recipient's claim is authentic, even though confirming evidence may not be available. When the claim is based on a fear of serious physical harm and county agency staff believes the claim, investigation may be conducted without requiring corroborative evidence by the applicant or recipient. It may involve a careful review of the case record, evaluation of the credibility of the applicant or recipient's statements, or a confidential interview with an observer who has good reasons for not giving a written statement. Based on such an investigation, and on professional judgment, the county agency may find that "good cause" exists without the availability of absolute corroborative evidence.

6. Except for extenuating circumstances, the "good cause" issue must be determined with the same degree of promptness as for the determination of other factors of eligibility (45 days). The county agency may not deny, delay, or discontinue assistance pending the resolution of the "good cause" claim.

7. The applicant or recipient and the Third Party Liability unit must be informed of the "good cause" decision. The applicant or recipient must be informed, in writing, of the county agency's final decision that "good cause' does or does not exist and the basis for the findings. A copy of this communication must be maintained in the case record. If "good cause" was determined not to exist, the communication must remind the applicant or recipient of the obligation to cooperate if he or she wishes to be eligible for Medicaid, of the right to appeal the decision, and of the right to withdraw the application or have their eligibility terminated.

8. The county agency must review the "good cause" decision at least every twelve months. If "good cause" continues to exist, the applicant or recipient must again be informed in writing. If circumstances have changed so "good cause" no longer exists, the applicant or recipient must be informed, in writing, and given the opportunity to cooperate, terminate assistance, withdraw the application, or appeal the decision. The Third Party Liability unit must also be informed of whether or not "good cause" continues to exist.

Home and Community Based Services 510-05-15

Home and Community Based Services (HCBS) 510-05-15-05

(Revised 11/1/2025 Release 25.17)

View Archives

The Medicaid program provides home and community based services (HCBS) to eligible individuals who have been screened as requiring nursing care services or ICF/ID (intermediate care facility for individuals with intellectual disabilities) level of care but who choose to receive those services in the community. Eligibility for individuals with an ineligible community spouse may be determined using the Spousal Impoverishment Provision found at 05-65. Services may be provided through one of the following waivers:

1. Traditional Waiver for Individuals with Intellectual and Developmental Disabilities: Home and Community Based Services are provided to individuals who meet the eligibility criteria for early intervention services for infants and toddlers under the age of three; individuals who have an intellectual disability and/or meet the criteria for a related condition prior to the age of 22 and who are screened to the ICF-ID (intermediate care facilities for individuals with intellectual disabilities level of care). These individuals generally meet the disability criteria of the Social Security Administration, however, the few who do not may still be eligible for these waivered services. Waiver services include residential services, day services, employment supports, family support services, parenting supports, extended home health care and financial help with the cost of equipment, supplies and environmental modifications. The waiver covers services provided by licensed providers, qualified service providers, and some services can be directed by the waiver recipient. Fro more information on HCBS Policies and Procedures, refer to 525-05.

2. Medicaid Waiver for Home and Community Based Services: Services are provided to individuals at least 18 years of age, who meet the disability criteria of the Social Security Administration, or are at least 65 years of age who are screened as requiring care in a nursing facility, but choose to receive services in the community. As of April 1, 2007, this waiver merged the Waiver for the Aged or Disabled and the Waiver for the Traumatic Brain Injured.

3. Waiver for Children with Medically Fragile Needs: Services are provided to children ages 3 to 21 who have a serious illness or condition which is anticipated to last at least 12 or more months. Eligible children have medically intensive needs and prolonged dependence on medical care or medical technology. The

waiver is limited to a maximum of 75 per 12-month period. (The increase in available slots in effective November 1, 2025.)

4. PACE (Program of All-Inclusive Care for the Elderly): PACE is a managed care program providing all-inclusive care to include preventive, primary, and acute care, to its participants to maintain them living independently within their home; and when needed long-term care. To qualify, the individual must be 55 years of age or older, needs a level of care required under the State Medicaid plan for coverage of nursing facility services reside in a PACE service area, and be determined safe within a community setting at the time of enrollment.
   A LOC determination is required to initiate waiver services with annual reviews thereafter.

5. Money Follows the Person Grant: This Grant program assists recipients who are residing in a nursing facility or an ICF/ID who want to transition from an institutional care setting to a HCBS setting with 4 or less unrelated individuals. Recipients must have been residing in the institutional setting for a period of 60 consecutive days or more, be screened as requiring care in a nursing facility, hospital or ICF/ID, and be Medicaid eligible for at least the last day of receipt of institutionalized service.

6. Children's Hospice Program: Provides multiple services to children from birth to their 22nd birthday who have been screened as needing Nursing Home level of care and who have less than a year of life expectancy. The services are designed to assist the family in dealing with the diagnosis and emotions a family needs to deal with when preparing for the possible death of their child. This waiver allows a family to continue to explore curative measures at the same time they are utilizing hospice services. The waiver is limited to 30 recipients in a 12-month period. If the child is 6 months to date of death, we need to use state plan services in addition to waiver services.

7. Autism Spectrum Disorder Waiver from Birth through age 20: Provides multiple services to a family with a child from birth to the day prior to the day of their 21st birthday who have a confirmed diagnosis on the Autism Disorder Spectrum, and meet the ICF/ID level of care. These services build on existing services available in North Dakota. Children and families will receive service management, and access to respite services to help provide structured activities that focus on communication, behavior, and other individual needs. The waiver also provides financial help with the cost of assistive technology, community integration, and remote monitoring. The waiver is limited to 345 active recipients at a time with a maximum of 400 in a 12-month period. (the increase in age and slots is effective November 1, 2025).

Cost-Effective Health Insurance Coverage 510-05-20

General Information 510-05-20-05

(Revised 1/03 ML #2833)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

Any recipient of Medicaid benefits who is enrolled in a cost-effective health plan may have the health plans premium paid by Medicaid. (This provision began in North Dakota in June 1993.)

Definitions 510-05-20-10 (Cost Effective Health Ins.)

(Revised 2/04 ML #2900)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

For purposes of the cost-effective health insurance sections:

1. "Cost-effective" means that Medicaid payments for a set of Medicaid-covered services are likely to exceed the cost of paying the health plan premium, coinsurance charges, and deductibles for those services.

2. "Health plan" means any plan under which a third party is obligated by contract to pay for health care provided to an applicant for or recipient of Medicaid.

Applicant's and Recipient's Responsibility 510-05-20-15

(Revised 2/04 ML #2900)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

1. Applicants for and recipients of Medicaid benefits must provide the information necessary to determine if a health plan is cost-effective.

2. Recipients with a health plan the Department has determined is cost-effective must cooperate with all of the conditions or requirements of the health plan. Applicants and recipients must take any optional coverage provided through the plan when it is cost-effective to do so. Failure to cooperate with plan requirements, or to select cost-effective options of the plan, will:

    a. Result in termination of payments for the health plan premiums; and
    b. Result in nonpayment for services, by Medicaid, which the health plan would pay, or would have paid, had the recipient conformed to the requirements of the health plan.

Cost-effectiveness Determination 510-05-20-20

(Revised 4/1/12 ML #3321)

View Archives

(N.D.A.C. Section 75-02-02.1-12.1)

1. Health plans requiring a formal cost-effective determination should be submitted to the Medicaid Eligibility Division on SFN 817, "Health Insurance Cost-Effectiveness Review," (05-100-10) along with any other information the worker feels is pertinent (i.e. a copy of the health plan, available payment reports, information regarding pre-existing conditions . . .). The form asks for information about the policy coverage, the individuals covered, and the premium. The Medicaid Eligibility Division will obtain or request any additional information needed and will make a timely determination (within 15 days) of cost-effectiveness. The county agency will be notified of that determination. An application for assistance should not be held up beyond the standard of promptness pending a cost-effective determination.

2. When an individual has more than one health plan, both plans may be considered cost-effective if they do not provide duplicate coverage.

3. If an individual is eligible for Medicare Part B, but is not enrolled in Part B, enrollment in any other health plan is not considered cost-effective.

4. Premium payments normally are only allowed for eligible Medicaid recipients. A family policy, however, may cover ineligible members. Payment of the full premium amount is allowed when it is determined that the health plan is cost-effective. The needs of the ineligible family members are not taken into consideration when determining cost-effectiveness.

5. The following health plans are usually not considered to be cost-effective.

a. Medicare supplement policies for individuals with routine medical needs (the exceptions are recipients with higher medical needs and the recipient's covered costs exceed the premium);
b. Hospital indemnity policies if the recipient is not currently collecting benefits;
c. Policies where the absent parent is the policy holder;
d. Specific illness policies (i.e. cancer ins.) if the individual covered does not have the illness;
e. Accident insurance policies, if the recipient is not currently collecting benefits; or
f. Policies where all of the members of the Medicaid unit, who are covered by the health plan, have a client share (recipient liability).

If the cost-effectiveness of any of these policies is questionable, the policy should be submitted to the Medicaid Eligibility Division for a formal determination.

6. All cost-effective health plans must be reviewed at least annually.

   Changes in a plan's, premium, coverage or individuals included in the plan must be reported to the Medicaid Eligibility Division.

7. Cost-effective health plan premiums will be paid effective with the month in which the information is sent to the Medicaid Eligibility Division for approval or is required to maintain the health plan.

Application and Decision 510-05-25

Application and Review 510-05-25-05

(Revised 11/1/2025 Release 25.17)

View Archives

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

1. Application.

    a. All individuals wishing to make application for Medicaid must have the opportunity to do so, without delay.
    b. A relative or other interested party may file an application in behalf of a deceased individual to cover medical costs incurred prior to the deceased individual's death.
    c. An application is a request for assistance on a prescribed form designed and approved by the North Dakota Department of Health and Human Services.
    d. There is no wrong door when applying for Medicaid or any of the Healthcare coverages. The experience needs to be as seamless and with as few barriers as possible.
    e. North Dakota Medicaid applications must be maintained electronically in the case file.
    f. A prescribed application form must be signed by the applicant, and authorized representative or, if the applicant is incompetent or incapacitated, someone acting responsible for the applicant.
    g. The date of the application is the date the application, is signed by an appropriate person, is received at a zone office, the Medical Services Division, a disproportionate share hospital, or a federally qualified health center. The date received must be documented.

        - Applications received electronically are considered received based on the time/date stamp

        - Applications received in person must be date stamped as received when the individual delivers it to the zone offices.
        - Applications left in a drop box refer to policy at 448-01-15-10

        Note: 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.

h. An application is required to initially apply for Medicaid, to re-apply after a Medicaid case was closed, or to open a new Medicaid case for a child who has been adopted through the state subsidized adoption program.
i. Zone offices must accommodate any recipient requesting to have a face-to-face or telephone interview when applying for Medicaid. However, an interview is not required to apply for assistance.
j. Information concerning eligibility requirements, available services, and the rights and responsibilities of applicants and recipient must be furnished.

Acceptable forms for applying for Medicaid:

i. The Department's online "Application for Assistance", located at https://applyforhelp.nd.gov
ii. The electronic file received by the state from the Federally Facilitated Marketplace (FFM) containing the single streamlined application; or
iii. The SFN 1909 " Application for Health Coverage and Help Paying Costs"; or
iv. Telephonic applications utilizing any one of the prescribed applications; or
v. SFN 405 " Application for Assistance"; or
vi. SFN 641, "Title IV-E/Title XIX Application- Foster Care"; or
vii. Applications provided by disproportionate share hospitals or federally qualified health centers are SFN 405 with "Hospital" stamped on the front page; or
viii. Interstate Compact on Adoption and Medical Assistance (ICAMA) for 6.01 " Notice of Medicaid Eligibility/Case Activation" stating North Dakota is responsible for the Medicaid coverage for the specific child; or
ix. SFN 958, "Health Care Application for the Elderly and Disabled". However, notification must be sent to the individual requesting information needed to make the ACA eligibility determination; or
x. SFN 1803, " Subsidized Adoption Agreement"; or
xi. The Low-Income Subsidy (LIS) file from SSA

2. Review

A review requires the evaluation of all financial and non-financial requirements affecting eligibility. This will include, but is not limited to, reviewing income, household composition, health insurance coverage, and citizenship status, listed in the case file, reported, and verified on the most recent application or review form, and verifications received from all electronic sources.

Information that is not subject to change, such as US citizenship, date of birth, SSN, etc., does not usually need to be reviewed. However, if questionable, the information needs to be verified.

a. **Passive Reviews:** A Passive review is the annual twelve-month review of eligibility. Information available, the case is processed, and the household must be notified of the eligibility determination and basis of eligibility.

- PASSES Reasonable Compatibility- If able to renew eligibility based on the information available, the case is processed, and the household must be notified of the eligibility determination and basis of eligibility.

    - The individual/household must inform the agency if any of the information contained in the notice is inaccurate. The individual is not required to sign and return such notice if all information in the notice is accurate.

- FAILS Reasonable Compatibility- A Passive review verification notice and pre-populated review form needs to be sent.

    - To complete the review, the pre-populated review form and required verifications must be returned
    - If both are not returned, eligibility will close the last day of the month in which the review is due.
    - The individual has 90 days after the termination to provide the pre-populated review form and verifications. Based on the information received, eligibility must be reconsidered to the termination date.

b. **Ex Parte/ Desk Reviews:** A review completed when a zone office becomes aware of or has received information indicating a change.

Examples: adding a household member, processing a change in level of care, adding Medicare Savings Program coverage, when an ineligible household member is requesting eligibility, when eligibility is lost under a category (e.g., SSI to non-SSI, Expansion to ABD coverage), aligning review dates with SNAP or TANF.

- When the Zone office has all information needed to determine eligibility based on a change in circumstances, a review form does not have to be sent.
- When more information is needed to determine eligibility, a request for verification along with a pre-populated review form must be sent.

Additional information when completing a Review:

- A recipient has the same responsibility to furnish information during a review as an applicant has during an application.
- An online narrative must document the completion of the review
- A review must be completed within thirty days after a county agency has received information indicating a possible change in eligibility status.
- A review, using one of the forms identified, in acceptable review form section, is required to open a new Medicaid case for recipients who move from an existing case to their own case. (e.g. an 18-year-old attains age 19, moves out of the parental home, on other than a temporary basis.)
- Zone offices must accommodate any recipient requesting to have a face-to-face or telephone interview for their review. However, an interview is not required to complete a review.
- Reviews must be completed and processed no later than the last working day of the month in which they are due.
- It is permissible to complete an early review of a child's eligibility for Medicaid and CHIP. However, the household may not be required to provide any information that is needed to specifically determine only the eligibility of the Medicaid and CHIP children who were determined to be continuously eligible. The family may voluntarily provide specific information but must not be required to do so.

If all factors of eligibility are reviewed:

- If the child is found to be eligible for Medicaid (other than Medically Needy), eligibility must be authorized for Medicaid and the child will be given a new twelve-month continuous eligibility period.
- If the child is found to be NOT eligible for Medicaid (other than Medically Needy), the child may not be terminated at the time of the early review unless the child meets one of the state's exceptions to terminate continuous eligibility. They would remain eligible for the reminder of the original continuous eligibility period and a review would be required at that time.

Acceptable forms for completing a review:

i. A review received through the North Dakota Self Service Portal (SSP) for Medicaid
ii. System generated Review or " Monthly/Change Report";
iii. SFN 642, "TitleIV-E/Title XIX Redetermination-Foster Care" for children in Foster Care, or other confirmation from a state IV-E agency (in state or out of state) that verifies continued IV-E foster care eligibility.
iv. One of the previously identified applications; or
v. When completing a review for children eligible for subsidized adoption assistance, receipt of one of the above review forms is required. However, the following two criteria must be verified:
    - The child remains a resident of North Dakota; and
    - The child continues to be eligible for the subsidized adoption program
    - In addition, contact should be made with the household to determine whether the child has obtained or lost other insurance.

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

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-10)

1. Current eligibility may be established from the first day of the month in which the signed application was received, or in the case of an application received through the Low Income Subsidy file of the Medicare Savings Program, the date the Social Security Administration received the Low Income Subsidy application. This provision does not apply to Qualified Medicare Beneficiaries.

2. Retroactive eligibility may be established for as many as three calendar months prior to the month in which the signed application was received. Eligibility can be established if all factors of eligibility are met during each month of retroactive benefits. If a previous application has been taken and denied in the same month, eligibility for that entire month may be established based on the current application. Retroactive eligibility may be established even if there is no eligibility in the month of application. This provision does not apply to Qualified Medicare Beneficiaries.

   All case records shall be documented to reflect eligibility or ineligibility for each individual month assistance is requested prior to and through the month in which the application is processed.

3. An individual determined eligible for part of a month is eligible for the entire calendar month unless a specific factor prevents eligibility during part of that month. Examples of specific factors include:

   a. An individual enters the state, in which case the earliest date of eligibility is the date the individual entered the state unless still receiving Medicaid benefits from another state. Information regarding the date Medicaid benefits from the other state are no longer available should be established in order to determine the beginning date of eligibility in North Dakota; or

b. An individual is discharged from a public institution, in which case the earliest date of eligibility is the date of discharge.

4. Eligibility for Qualified Medicare Beneficiaries begins in the month following the month in which the eligibility determination is made (e.g. the application is received on March 29, eligibility is determined in April, the first month of QMB eligibility is May)

5. An individual cannot be eligible as a Qualifying Individual and be eligible under any other Medicaid coverage for the same period of time

6. A child cannot be eligible for Medicaid for the same period of time the child is covered under the Healthy Steps Program.

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.

Duty to Establish Eligibility 510-05-25-15

(Revised 10/01/13 ML #3390)

View Archives

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

It is the responsibility of the applicant or recipient to provide information sufficient to establish the eligibility of each individual for whom assistance is requested, including, but not limited to, the furnishing of a social security number, and establishing age, identity, residence, citizenship, blindness, disability, and financial eligibility in each of the months in which Medicaid benefits are requested.

Requesting information from an individual or household that is already available to the worker through other sources is prohibited.

No age, residence, citizenship, or other requirement that is prohibited by title XIX of the Social Security Act will be imposed as a condition of eligibility.

Medicaid Brochures 510-05-25-20

(Revised 4/1/06 ML #3021)

View Archives

All applicants for Medicaid must be provided the "Application for Assistance Guidebook" or, in place of the guide book:

1. A brochure entitled "Medicaid" (376kb pdf) (05-100-15) outlining the services available under the Medicaid Program;

2. A brochure entitled "Your Civil Rights" (152kb pdf) (05-100-20);

3. A notice entitled "Notice of Privacy Practices" (18 kb pdf) (DN 900 which is available in E-Forms);

4. All households with individuals of childbearing age must be made aware of the opportunity they have to receive family planning services and must be given a brochure entitled "Family Planning-Choosing Your Family Size," or "Family Planning Program" (05-100-25);

5. All households with individuals under the age of twenty-one must be made aware of the availability of "North Dakota Health Tracks" (early and periodic screening, diagnosis and treatment services) and be given the brochure entitled "ND Health Tracks" (05-100-30); and

6. All households with pregnant, breast feeding or postpartum women, or children under age five, must be made aware of the availability of the WIC (Women, Infants, and Children) Program, and must be provided a "WIC" outreach brochure (05-100-35).

Decision and Notice 510-05-25-25

(Revised 2/21/2025 ML #3907)

View Archives

(N.D.A.C. Section 75-02-02.1-03)

Applicants and recipients may choose the method by which they are notified of their eligibility status. They may choose paper, electronic, or through their portal account.

1. A decision as to eligibility will be made promptly on applications, within forty-five days, or within ninety days for individuals for which disability is pending, except in unusual circumstances. When these time periods are exceeded, the case must contain documentation to substantiate the delay.

   Applications for disability-related Medicaid should be made to both the Social Security Administration and the county agency. When the Social Security Administration denies an application because of lack of disability the application for Medicaid must also be denied. The Social Security Administration's decision with regard to disability is binding. The Medicaid application should not be held pending an appeal of the Social Security decision.

2. Following a determination of eligibility or ineligibility, an applicant must be notified of either approval or denial of Medicaid.

   The notice must address eligibility or ineligibility for each individual month requested including all prior months and through the processing month. In instances where Qualified Medicare Beneficiaries (QMB) or Special Low-Income Medicare Beneficiaries (SLMB) and another coverage is requested, a decision must be made on both types of coverage and the applicant must receive one notice including both determinations.

   If an applicant is denied, or is ineligible for any of the prior months or the processing month, the notice must include the reason(s) for the intended action, the specific administrative code or manual reference supporting the action, the right to a fair hearing, and the circumstances under which assistance is continued if a hearing is requested

Section 1902 of the Social Security Act requires that Medicaid ID Cards and Health Care Coverage notices be made available to an eligible individual who does not reside in a permanent dwelling or does not have a fixed home or mailing address. To meet these federal regulations, when an individual applies for Health Care Coverage and does not have a residential or mailing address, or is unable to utilize a friend or relative's address to receive their mailing, the County Social Service Office address must be used for the individual.

Example: Applicants Name
c/o XXXXX County Social Service Office
123 Main Street
Any town, ND 58111

When an individual applies for Health Care Coverage, and does not have an address to receive his/her mail, the individual must be informed of the following:

- The individual will be required to pick up their mail at the county office on a weekly basis; and
- Failure to pick up their mail for three (3) consecutive weeks may result in their Health Care Coverage being closed.

Since individuals who apply for Health Care Coverage are not required to complete a face to face interview:

- If the individual has a telephone contact number, the requirement to inform the individual will need to be done through a telephone call and this must be documented in the casefile.
- If the individual does not have a telephone contact number, all methods of informing the individual have been exhausted, and the individual does not stop by the county office for three (3) consecutive weeks, the case must be closed.

When an individual fails to pick up their mail for three (3) consecutive weeks and the individual has not contacted the county social service office, the case must be closed for the reason of 'Loss of Contact/ Whereabouts Unknown'. Remember to document this in the casefile narrative.

Note: A ten-day Advance Notice is not required; however, a notice containing the reason(s) for the intended action, the specific administrative code or manual reference supporting the action, the right to a fair hearing, and the circumstances

under which assistance is continued if a hearing is requested, must be mailed no later than the effective date of the action.

3. Once a decision to deny eligibility is made on an application, a new application is needed to re-apply for assistance.

4. As specified below, a notice must be sent in all ongoing cases in which a proposed action adversely affects Medicaid eligibility.
   a. A notice must be mailed (as described in subsection 5) at least ten days in advance of any action to terminate or reduce benefits. The date of action is the date the change becomes effective.

      This "Ten-Day Advance Notice" must include the reason(s) for the intended action, the specific administrative code or manual reference supporting the action, the right to a fair hearing, and the circumstances under which assistance is continued if a hearing is requested. This gives the recipient an opportunity to discuss the situation with the county agency, obtain further explanation or clarification of the proposed action, or present facts to show that the planned action is incorrect. The recipient may appear on his own behalf or be represented by legal counsel, a relative, a friend, or any other spokesperson of their choice.
   b. A "Ten-Day Advance Notice" is not required when information exists confirming the death of a recipient.
   c. Under the following circumstances a "Ten-Day Advance Notice" is not required; however, a notice containing the reason(s) for the intended action, the specific administrative code or manual reference supporting the action, the right to a fair hearing, and the circumstances under which assistance is continued if a hearing is requested, must be mailed (as described in subsection 5) no later than the effective date of action:
      i. The recipient provides a signed, clearly written statement providing information that requires a termination or reduction in benefits, and the recipient indicates that he or she understands that benefits will be reduced or terminated (changes reported on the change report form, the TANF monthly report, the review form, or via an applicant's or recipient's known email address meet this requirement);
      ii. The recipient provides a signed statement requesting termination of assistance (an oral request will also suffice if recorded in the casefile narrative and reflected on the adequate notice to terminate assistance. Termination may be effective as of the current date or a date in the future). Information reported via an applicant's or recipient's known email address is considered a signed statement for Medicaid;

i. The recipient has been admitted to an institution where he or she is ineligible for further services;

iii. The recipient's whereabouts are unknown and mail directed to the client is returned by the post office indicating no known forwarding address;

iv. There is factual information that responsibility for providing assistance has been accepted by another state or jurisdiction; or

v. The recipient has a change in the level of medical care prescribed by the individual's physician, such as the recipient begins or ceases to receive care in a specialized facility, an institution for mental diseases (IMD), a Psychiatric Residential Treatment Facility (PRTF), or nursing care services in a facility (LTC) or in the community (HCBS).

d. A "Ten-Day Advance Notice" is not required when probable fraud exists.

When the county agency obtains facts through objective collateral sources indicating the likely existence of fraud, an advance notice of proposed termination or reduction of benefits must be mailed only five days in advance of the date the action is to be taken. This shorter period allows for more prompt corrective action when probable fraud situations are uncovered.

5. System generated notices are dated and mailed on the next working day after the eligibility is authorized in the eligibility system. Consideration must be given to weekends and holidays to ensure notices are mailed no later than the effective date of the action.

Example: Eligibility is authorized on a Friday. The notice will be dated and mailed on the following Monday. If Monday is a holiday, the notice is dated and mailed on Tuesday. This may mean authorizing the eligibility 1 to 5 days prior to the effective date of the action.

6. Assistance may terminate at any time during the month. If, however, eligibility exists for at least one day of the month, eligibility generally exists for the entire month. Some exceptions to this rule are:
   a. The date of death is the ending day of eligibility;
   b. The last day of eligibility is the date of entry into a public institution.

Reminder: When eligibility is terminated due to death, the eligibility of other individuals in the case cannot be reduced or terminated without appropriate notice.

7. Assistance cannot be terminated as of a past date except in case of death or if another state has assumed responsibility for providing assistance and then only if no assistance has been paid by North Dakota for the period in question.

8. Errors made by public officials and delays caused by the actions of public officials do not create eligibility or additional benefits for an applicant or recipient who is adversely affected.

Electronic Narratives 510-05-25-27

(Revised 3/1/20 ML #3575)

View Archives

All Medicaid cases in Vision or TECS must include electronic narratives in Lotus Notes. All Medicaid cases in SPACES must include an electronic narrative in SPACES. Narratives need 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

(Revised 2/15/21 ML #3611)

View Archives

(N.D.A.C. Chapter 75-01-03)

1. Applicants or recipients of Medicaid who are dissatisfied with a decision made by the county agency or the North Dakota Department of Human Services, or who have not had their application acted on with reasonable promptness, may appeal to the North Dakota Department of Human Services.

2. A request to appeal may be in writing, over the telephone, internet, mail, in person or through other commonly available means. The appeal must be filed no later than 30 days from the mail date on the notice of action. When an applicant or recipient requests a hearing by telephone 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.

3. When a recipient requests an appeal prior to the effective date of an adverse decision, the recipient's Medicaid eligibility may not be reduced or terminated until a decision is rendered after the appeal hearing unless it is determined that the sole issue is one of Federal or state law or policy. In these cases, the recipient must be informed in writing that eligibility will be reduced or terminated pending the final appeal decision. This applies even when a review of eligibility is due before the final appeal decision is made.

4. When assistance has continued pending an appeal decision and the county agency's decision to close the case or reduce benefits is upheld, the case must be closed, or the benefits reduced, immediately upon receipt of the notice of decision.

5. All SSI or SSA denials or terminations based on disability which are reversed on appeal will automatically reverse the Medicaid disability based denial or termination if the person notifies the county agency within six months of the date of the notice informing the person that they won the SSI or SSA appeal.

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

Coverage Groups 510-05-30

Groups Covered Under Medicaid 510-05-30-05

(Revised 03/01/2024 ML #3811)

View Archives

(N.D.A.C. Section 75-02-02.1-05)

Groups Covered Under Medicaid on or after January 1, 2014:

1. Categorically Needy Group:

    a. Children for whom adoption assistance maintenance payments are made under title IV-E or non-IV-E.
    b. Children for whom foster care maintenance payments are made under title IV-E.
    c. Children who are living in North Dakota and are receiving title IV-E adoption assistance payments from another state.
    d. Children in a foster care placement in North Dakota and receiving a title IV-E foster care payment from another state.

        Note: Medicaid eligibility for all regular foster care (non-Title IV_E) children is determined under ACA Medicaid policies.

    e. Children who are living in North Dakota and are receiving title IV-E kinship guardianship assistance payments from another state.
    f. Children who were in foster care at age 18 up through the month they turn 26.
    g. Aged, blind, or disabled individuals who are receiving SSI payments or who appear on ND Verify – Other Benefits as zero payment as a result of SSI's recovery of an overpayment or who are suspended because the individuals do not have a protective payee, provided that the more restrictive Medicaid criteria is met.

        - Individuals under age 21 who have been approved for SSI may be categorically eligible beginning with the month of the SSI application.

- Individuals age 21 or older who have been approved for SSI may be categorically eligible beginning the month following the month of SSI application. (If disabled in the month of SSI application, the individual age 21 or older may be medically needy eligible for that month.) Individuals who qualify under this category who are also eligible for Medicare Part B are also eligible for coverage of their Medicare Part B premium (SSI Buy-In).

h. Individuals who meet the more restrictive requirements of the Medicaid program and qualify for SSI benefits under section 1619(a) or 1619(b) of the Act.

Section 1619 of the Social Security Act provides continued Medicaid eligibility for certain disabled or blind persons who lose SSI benefits because they are performing substantial gainful activity. These benefits may continue beyond the age of sixty-five.

Section 1619a: These individuals continue to receive a special SSI payment, and may continue to be eligible for Medicaid as categorically needy if all other eligibility factors are met. They also will continue to be eligible for coverage of their Medicare Part B premium (SSI Buy-In).

Section 1619b: These are blind and disabled individuals who lose SSI benefits because of their earnings, and whose ability to continue employment or self-employment would be seriously impaired by termination of Medicaid and whose earnings are insufficient to provide the reasonable equivalent of the cash payments and Medicaid benefits (and in the case of determinations made under this law before October 1, 1981, Title XX Social Services) which would be available to them in the absence of such earnings. These individuals will not receive any cash assistance but may continue to be eligible for Medicaid as categorically needy if all other eligibility factors are met. They also will continue to be eligible for coverage of their Medicare Part B premium (SSI Buy-In).

2. Optional Categorically Needy Group:

a. Uninsured individuals under age 65, who have been screened for breast and cervical cancer under the Department of Health Centers for Disease Control and Prevention Breast and Cervical Cancer Early Detection Program and need treatment for breast or cervical cancer, including a pre-cancerous condition of the breast or cervix, and whose family income is at or below 200% of the poverty level. Effective July 1, 2001. (Medicaid Breast and Cervical Cancer Early Detection Program),
b. Workers with Disabilities (Gainfully employed individuals with disabilities) ages sixteen through sixty-four who meet medically needy non-financial criteria, have countable assets within the medically needy asset levels + $10,000, have income at or below 225% of the poverty level, and are not eligible for Medicaid under any other provision other than as a Qualified Medicare Beneficiary or a Special Low-income Medicare Beneficiary. Effective June 1, 2004.
c. Children with Disabilities under age 19 (including the month attaining age 19) who meet medically needy non-financial criteria, have income at or below 250% of the poverty level, and are not eligible for full Medicaid benefits under any other provision. Effective April 2008.

3. Medically Needy Group:

a. Pregnant women who qualify on the basis of financial eligibility.

- Self-attestation of a single-birth or multi-fetus pregnancy is accepted unless it is questionable.
- For determination made after the birth of the baby, the child's birth verification may be used as verification of pregnancy.

b. Eligible pregnant women who applied for Medicaid during pregnancy, and for whom client share (recipient liability) for the month was met no later than on the date each pregnancy ends, continue to be eligible without regard to financial circumstances, for twelve

months, beginning on the last of pregnancy and through the last day of the twelfth month.

c. Children born to eligible pregnant women under age 19 who have applied for and been found eligible for Medicaid on or before the day of the child's birth, for one year, beginning on the day of the child's birth and for the remaining days of the month in which the twelfth month falls.
d. Aged, blind, or disabled individuals who are not in receipt of SSI benefits.
e. Individuals under age twenty-one who have been certified as needing the service, or age sixty-five and over in the state hospital who qualify on the basis of financial eligibility.
f. Individuals who are screened as and receiving Home and Community Based Services at home or in a specialized facility.

4. The poverty level group includes:

a. Qualified Medicare Beneficiaries (QMB), who are entitled to Medicare part A benefits regardless of age or disability status, and who meet the medically needy non-financial criteria, have assets no greater than the limit established for the Medicare part D Low Income Subsidy, and have income at or below one hundred percent of the poverty level. Effective January 1, 1991 (90% of the poverty level from April 1, 1990, through December 31, 1990).
b. Qualified Disabled and Working Individuals (QDWI), who are individuals entitled to enroll in Medicare part A under section 1818a of the Social Security Act, and who have income no greater than two hundred percent of the poverty level, have assets no greater than twice the SSI resource standard, and who are not eligible for Medicaid under any other provision. The SSI program income and asset methodologies must be used and none of the more restrictive 209b criteria may be applied. (The eligibility determination for this group will temporarily be done by the Medicaid Eligibility Division of the North Dakota Department of Human Services.) Coverage for this group began July 1, 1990.

c. Special Low-Income Medicare Beneficiaries (SLMB), who are entitled to Medicare Part A benefits regardless of age or disability status, who meet the medically needy non-financial criteria, have assets no greater than the limit established for the Medicare Part D Low Income Subsidy, and have income above one hundred percent of the poverty level but not in excess of one hundred twenty percent of the poverty level. Effective January 1, 1993.
d. Qualifying Individuals (QI-1), who are entitled to Medicare Part A benefits regardless of age or disability status, who meet the medically needy non-financial criteria, have assets no greater than the limit established for the Medicare Part D Low Income Subsidy, have income above 120% of the poverty level, but not in excess of 135% of the poverty level, and are not eligible for Medicaid under any other provision. Effective January 1, 1998.

Applicant's Choice of Category 510-05-30-10

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-06)

An individual who could establish eligibility under more than one category , such as between Non-ACA categories and ACA categories, may have eligibility determined under the category the individual selects. An individual may establish eligibility under only one category except for QMBs and SLMBs. Individuals eligible as QMBs and SLMBs are eligible as aged, blind or disabled for that coverage but may also establish eligibility under the ACA Categories, (but not the Adult Expansion Group).

SSI recipients must first be tested for eligibility under non-ACA Medicaid methodologies and only if they fail non-ACA methodologies (such as excess assets) may they be tested under one of the ACA categories. This also applies to SSI recipients who may be pregnant women. See also “Blindness and Disability” 510-05-35-100 and "Disability and medically Frail 510-03-35-100", for information as how to treat non-SSI disabled individuals.

Basic Factors of Eligibility 510-05-35

Medicaid Unit 510-05-35-05

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-08)

1. A Medicaid unit may be one individual, a married couple, or a family with children under twenty-one years of age, or if blind or disabled under age eighteen, whose income and assets are considered in determining eligibility for any member of that unit, without regard to whether the members of the unit all physically reside in the same location.

2. An applicant or recipient who is the caretaker of a blind or disabled child under eighteen years of age may select any of their non-blind or disabled children to be included in the Medicaid unit. Anyone whose needs are included in the unit for any month is subject to all Medicaid requirements which may affect the unit. The financial responsibility of relatives must be considered with respect to all members of the assistance unit.

   When a child is included in the Medicaid unit eligibility is pursued for the child unless:

   a. The child is eligible under the Healthy Steps Program;
   b. The child is an ineligible alien or the child's US citizenship has not been verified;
   c. The child is ineligible due to no medical need (client share (recipient liability) exceeds need);
   d. The child is receiving services in a Psychiatric Residential Treatment Facility (PRTF), or the state hospital, the Prairie at St. John's center, the Stadter Psychiatric Center, or any other institution for mental disease (IMD), and has not obtained certification of need for services in that facility; or
   e. The child's identity has not been verified.
   f. The child is eligible under ACA Medicaid

When a caretaker chooses not to include a child in the Medicaid unit, the child is not included in the unit for any other purpose (e.g. in the budget, in the asset test, or to create eligibility for a caretaker).

Caretaker Relatives 510-05-35-15

(Revised 3/1/2024 ML #3811)

View Archives

(N.D.A.C. Section 75-02-02.1-08.1)

1. The following individuals may be considered a caretaker relative of a child seeking eligibility under Non-ACA Medicaid policies:

    a. A natural or adoptive parent;
    b. A grandparent (including a great, great-great, or great-great-great-grandparent);
    c. A sibling, half-sibling, or step-sibling (if age sixteen or older);
    d. An aunt or uncle (including a great or great-great aunt or great or great-great uncle);
    e. A niece or nephew (including a great or great-great niece or great or great-great nephew);
    f. A first cousin (an aunt or uncle's child) or first cousin once removed (an aunt or uncle's grandchild);
    g. A second cousin (a great aunt or great uncle's child);
    h. A stepparent (if natural or adoptive parent is not in the home);
    i. A stepbrother or stepsister; or
    j. A spouse of any of the above individuals even after the marriage is terminated by death or divorce.

2. 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 intellectually disabled, or a specialized facility on other than a temporary basis.

3. 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. 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).

Relative Responsibility 510-05-35-20

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Sections 75-02-02.1-25 and 75-02-02.1-34)

1. As a condition to receiving Medicaid, no support may be required of relatives other than from spouses and from natural or adoptive parents for children, under age 18, who are blind or disabled.

2. Under North Dakota law, a stepparent has no legally enforceable obligation to support stepchildren. Therefore, the stepparent's own personal income and assets cannot be considered available in determining Medicaid eligibility for the stepchildren. The natural parent, however, is legally responsible for supporting the children. The income of the natural parent cannot be first applied to the children if by doing so other members of the family are deprived of basic necessities.

3. If a child resides with a caretaker other than the parent, and the parent’s whereabouts are known, an attempt must be made to obtain the parent’s financial information. If the parent’s income is made available, follow the budgeting procedures outlined in section 05-90-23, Budgeting Procedures for Financially Responsible Absent Parents. If unable to obtain the information, document the efforts made, determine the child’s eligibility without the parental information, and refer the case to the Child Support Enforcement Unit.

Screening for Nursing Care, ICF-ID or HCBS Recipients 510-05-35-25

(Revised 10/1/13 ML #3390)

View Archives

(N.D.A.C. Section 75-02-02.1-04)

1. All applicants or recipients who seek nursing care services in nursing facilities, swing bed facilities, or intermediate care facilities for the intellectually disabled (ICF-ID), or who seek home and community-based services, must be screened to establish the medical necessity for these services.

2. This screening allows payment to providers for eligible recipients from the effective date of the screening. A new screening is required whenever there is a change in provider or a reentry into a facility following a discharge from that facility. A new screening is not required on a reapplication for Medicaid if there has been no change in the living arrangement of the applicant since the initial screening was completed and screening has not since ended. An annual rescreening is required only for recipients requiring care in an ICF-ID or through HCBS.

3. Applicants or recipients who seek nursing care services in the state hospital, the Prairie at St. John's center, the Stadter Psychiatric Center, or any other institution for mental disease (IMD) and who are:
    a. Age 65 or older are not required to be screened.
    b. Age 22 to 65 are not eligible for Medicaid until January 1, 2014, when individuals 19 to 64 will be covered under the adult expansion group. Because this group will have insurance, these individuals will be subject to the requirements of the insurance plan.
    c. Under age 22 who have obtained a certification of need may be eligible as described in 05-35-30.

Certification of Need for Children in a Psychiatric Residential Treatment Facility (PRTF) or an Institution for Mental Diseases (IMD) 510-05-35-30

(Revised 9/1/11 AMENDED ML #3280)

View Archives

(N.D.A.C. Section 75-02-02.1-04.1)

1. Children under age twenty-one who seek services in a Psychiatric Residential Treatment Facility (PRTF), or the state hospital, the Prairie at St. John's center, the Stadter Psychiatric Center, or any other IMD must obtain certification of need in order to be eligible for Medicaid. The certification of need must demonstrate:

    a. Necessity of treatment on an inpatient basis;
    b. That all community resources have been explored prior to admission; and
    c. The treatment to be provided can reasonably be expected to improve the condition.

    For a person who attains age twenty-one while receiving treatment and continues to receive treatment as an inpatient, eligibility may continue through the month the individual attains the age of twenty-two.

2. When a child enters a psychiatric unit in a general hospital or similar facility the child is not in an IMD and the child's living arrangement is not changed. A certification of need may be created for payment purposes only and will indicate what facility the child is in, so the certification of need must be reviewed to determine if the child's eligibility is affected.

3. A child who is residing in an IMD and who is certified as needing that level of care, is only eligible for coverage of the psychiatric services, and is not eligible for services outside of the facility.

Need 510-05-35-35

(Revised 5/1/2025 ML #3918)

View Archives

(N.D.A.C. Section 75-02-02.1-11)

Need is a factor of eligibility. Need in this sense is not to be confused with the necessity for a particular medical service.

1. Need is established for individuals who are determined to be categorically needy, optionally categorically needy, or poverty level eligible.

2. For a medically needy applicant or recipient, need is established when:
   a. The individual has applied for Medicaid; or
   b. There is no client share; or
   c. The individual has incurred or may incur medical expenses which the individual is responsible for after any third-party payments that equal or exceed client share.

3. If an individual does not utilize Medicaid for six months, their eligibility will end the following month.

4. Individuals may request their Medicaid coverage be terminated in writing or verbally. A verbal request must be recorded in the case file narrative and reflected on the closing notice. Follow policy at 510-05-25-25 notice requirements to determine proper closing time frame.

Age and Identity 510-05-35-40

(Revised 1/1/2025 ML #3908)

View Archives

(N.D.A.C. Section 75-02-02.1-12)

1. An eligible categorically or medically needy aged applicant or recipient is eligible for Medicaid for the entire calendar month in which that individual reaches age sixty-five.

2. Eligibility may continue for a person who attains age twenty-one while receiving treatment and continues to receive treatment as an inpatient in a Psychiatric Residential Treatment Facility (PRTF), or the state hospital, the Prairie at St. John's center, or the Stadter Psychiatric Center, through the month the individual attains the age of twenty-two.

3. Blind and disabled individuals are not subject to any age requirements for purposes of Medicaid eligibility.

4. In instances where only the year and not the exact date of birth can be established, use July 1 to designate the date of birth; or if the year and month can be established, use the year and first day of the month for purposes of Medicaid eligibility.

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

    a. The following individuals are exempt from the identity verification requirements:

        i. SSI recipients who claim that they are US Citizens and that claim is not questionable (can prove using the SDX or TPQY SSI match);

ii. Medicare beneficiaries who claim that they are US Citizens and that claim is not questionable (can prove using the TPQY SSA match);
iii. Individuals receiving SSA disability insurance benefits based on their own disability;
iv. Individuals receiving Foster Care maintenance payments;
v. Individuals receiving Subsidized Adoption payments; and
vi. Individuals receiving Subsidized Guardianship payments.

b. Reasonable Opportunity Period. Applicants who claim they are U.S. citizens or qualified aliens are entitled to a reasonable opportunity period to provide verification of citizenship, qualified alien status, and identity. Medicaid is not permitted to deny, delay, reduce, or terminate eligibility while documentation is being gathered during the reasonable opportunity period. A reasonable opportunity period applies when all other information necessary to determine eligibility is available. If an individual is eligible for Medicaid and has met all other criteria except for citizenship or identity verification, that individual's eligibility may not be pended for verification of either citizenship or identity, but must be approved. If the individual does not provide satisfactory documentation of citizenship and identity by the end of the reasonable opportunity period, the individual's eligibility must be terminated with advance (10-day) notice and without regard to continuous eligibility provisions.

A 'reasonable opportunity period' is defined as 90 days from the date the application is submitted and for the remaining days of the month in which the 90th day falls. An extension of an additional 60 days from the 90th day may be granted if the individual has verifiable documented evidence they have been making a good faith effort to obtain the verifications, but still have not received them.

An example of a good faith effort would be a letter from another state's vital statistics office that the documentation was requested timely (no later than 10 days after the latter of the application date or the earliest date the verification was requested by the county or state agency), but there will be a delay in providing the documentation.

Example: Mr. Brown applies for Medicaid on May 11, 2010. He has verification of citizenship; however he has nothing to prove identity. He does not meet any of the exemptions from the verification requirements that are listed in the manual. Mr. Brown is determined to be eligible for Medicaid and the application approved for the prior months of March and April, the application

month of May, and the future month of June. Mr. Brown claims he is a member of a federally-recognized Indian tribe in California. The worker has assisted him in requesting identifying tribal documents from the tribe in California. The worker sets an alert to follow up in early August. The worker does not receive a response by August 20, so sends an advance notice to close. On August 23, Mr. Brown brings in a recent letter from the tribal enrollment office in California, acknowledging receipt of his request for his tribal enrollment verification, and stating that it will take another 6 weeks for them to process it. In this case, an additional 2 month period may be granted. The worker would set an alert for a secondary follow up for October 2010. If not received by October 20, 2010, advance notice to close must be sent.

A reasonable opportunity period is not limited to one.

Example: If granted a reasonable opportunity period but the requested verifications are not received and eligibility is terminated, upon reapplication, if needed, a new reasonable opportunity period will be allowed.

c. Primary and preferred verification of identity. A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as the original document, unless information on the copy submitted is inconsistent with other information available, or there is reason to question the validity of the information in the document. A copy must be maintained in the case file.

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.

Citizenship verification received from using the "Other Benefits" inquiry in the NDVerify system or from the citizenship verification system available through the Federally Facilitated marketplace (FFM)-as automated through the Streamlined application process	• Acceptable codes are:
	  ○ "Citizenship Verified"
	  ○ "Verified with positive citizenship; Deceased."

Documents Issued by Recognized ND Tribes

Tribe:	Documents:

Sisseton-Wahpeton (Wahpeton—SE corner of ND)	• Certificate of Degree of Indian Blood: o Name, DOB, enrollment #, and degree of Indian blood; o Issued to any enrolled member who requests it; o Issued by tribal enrollment office; • Tribal ID cards: o Name, DOB, enrollment #, degree of Indian blood, SSN, photo and individual's signature; o Issued to enrolled members age 16 and older who request it; o Issued by tribal enrollment office;
Spirit Lake (Devils Lake)	• Certificate of Degree of Indian Blood: o Name, DOB, enrollment #, and degree of Indian blood (may have more information); o Issued to any enrolled member who requests it; o Issued by tribal enrollment office; • Tribal Photo ID: o Photo ID including name, DOB, tribal enrollment #, and degree of Indian blood (may have more information); o Issued by tribal motor vehicle office; o Issued to enrolled members;
Standing Rock Sioux Tribe (Fort Yates)	• Certificate of Degree of Indian Blood: o Name, DOB, enrollment #, and degree of Indian blood, (may have more information); o Issued to any enrolled member who requests it; o Issued by tribal enrollment office; • Tribal ID cards:

	○ Name, DOB, enrollment #, and degree of Indian blood, last 4 digits of SSN (may have more information); ○ Issued to enrolled members age 14 and older who request it; ○ Issued by tribal enrollment office;
Three Affiliated Tribes (T. A. T.) (New Town)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing address, physical address, photo); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing address, physical address, photo (plastic card with hologram on back) (will enter SSN (non-verified) at individual's request); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office (Cost = $10; free to seniors); ○ Expire every 4 years;
Turtle Mountain Chippewa (Belcourt, Trenton)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal Enrollment cards: ○ Name, DOB, enrollment #, and degree of Indian blood (may have more information); ○ Issued to enrolled members age 18 and older who request it;

- Issued by tribal enrollment office.

e. Secondary verifications of identity may be accepted if primary verifications are not provided. 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 case file.

Secondary Verifications of Identity

(Level 2)

Acceptable Verifications:	Explanatory Information:
Driver's license issued by a state or territory (DO NOT accept Canadian driver's license)	• Must include a photograph of the applicant or recipient: or • Have other personal identifying information for the individual such as name, age, sex, race, height, weight, or eye color.
Identification card issued by a US Federal, State or local government with the same information as a driver's license.	• DO NOT accept a voter's registration card.
School ID card	• Must include a photograph of the applicant or recipient.
U. S. military ID card or draft record	
Military dependent's identification card	

U. S. Coast Guard Merchant Mariner card	

f. Third level verification of identity. These documents should only be used when documentation from levels one and two are unavailable.

Third Level Verifications of Identity
(Level 3)

Acceptable Verifications:	Explanatory Information:
3 or more documents that together reasonably corroborate the identity of an individual, provided such documents have not been used to establish the individual's citizenship AND the individual has submitted at least second or third level citizenship verification	• Only to be used if no other evidence of identity is available. • Must contain the individual's name plus additional identifying information (employer ID cards, high school and college diplomas from accredited institutions, marriage certificates, death certificates, divorce decrees and property deeds/titles.).

g. Identity verifications for minor children. Exceptions identified in this section are allowed when a child does not have or cannot get any of the identity documents from the first three levels.

Identity Verifications For Children
(Level 4)

Acceptable Verifications:	Explanatory Information:
School record	• Must show child's date and place of birth and parents' name.

Clinic, doctor, or hospital record	• Must show child's date and place of birth and parent's name.
Daycare or nursery school record showing date and place of birth	• Eligibility worker must call and verify with the school that issued the record.
An affidavit, signed under penalty of perjury, by the parent, guardian, or caretaker relative which states the date and place of birth of the child	• Only one affidavit may be used to establish either citizenship or identity. If an affidavit is used to establish citizenship, then identity must be established using a different document from the identity list. • The affidavit is not required to be notarized. • May be used for a child aged 16 to 18 only when school identity cards and driver's licenses are not available to the individual in that area until that age. • SFN 691, "Affidavit of Identity for Children," has been created for convenience.

h. Identity verifications for disabled individuals in institutional care facilities. Exceptions identified in this section are allowed when a disabled individual in an institutional care facility does not have or cannot get any of the identity documents from the first three levels.

Identity Verifications for Disabled Individuals in
Institutional Care Facilities
(Level 4)

Acceptable Verification:	Explanatory Information:

An affidavit signed under penalty of perjury by a residential care facility director or administrator	• Is not required to be notarized. • Should be used only as a last resort. • SFN 690, "Affidavit of Identity for Disabled Individual in Facility," has been created for convenience.

Citizenship and Alienage 510-05-35-45

(Revised 6/3/2024 ML #3823)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

1. As a condition of eligibility, applicants or recipients must be a United States citizen or an alien lawfully admitted for permanent residence. Verification of citizenship, naturalization, or lawful alien status must be documented. This section addresses:

    a. Exceptions to verification of citizenship;
    b. Verification requirements;
    c. Acceptable documentation for US citizens and naturalized citizens; and
    d. Individuals born in Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and Nationals from American Samoa.

    For aliens, apply the appropriate policy identified in sections 510-05-35-50 through 510-05-35-70.

2. Exceptions to verification of citizenship. The following individuals are exempt from the citizenship verification requirements:

    a. SSI recipients who claim that they are US Citizens and that claim is not questionable (can prove using SDX or TPQY SSI match);
    b. Medicare beneficiaries who claim that they are US Citizens and that claim is not questionable (can prove using TPQY SSA match);
    c. Individuals receiving SSA disability insurance benefits based on their own disability;
    d. Individuals receiving Foster Care maintenance payments;
    e. Individuals receiving Subsidized Adoption payments; and
    f. Individuals receiving Subsidized Guardianship payments.

3. Verification Requirements: Applicants must provide satisfactory documentary evidence of citizenship or naturalization.

a. A photocopy, facsimile, scanned or other copy of a document must be accepted to the same extent as the original document, unless information on the copy submitted is inconsistent with other information available, or there is reason to question the validity of the information in the document. A copy must be maintained in the case file.
b. Verifications may be accepted from another state agency that may have already verified citizenship, but a photocopy must be obtained for the case file.
c. Once an individual's citizenship is documented and recorded, subsequent changes in eligibility do not require repeating the documentation unless questionable, or there is no verification in the case file.

> **Example:** John Doe applies for Medicaid and supplies his citizenship verifications and his case closes. If his case file is purged after the three year retention period and he reapplies, he will need to again provide his verifications so that his casefile is complete.

d. If an individual has made a good faith effort to obtain verifications, but cannot obtain them within the processing timeframes , or because the documents are not available, assistance must be provided to the individual in securing evidence of citizenship. Matches with other agencies may be used to assist the individual.
e. Reasonable Opportunity Period. Applicants who claim they are U.S. Citizens or qualified aliens are entitled to a reasonable opportunity period to provide verification of citizenship, qualified alien status, and identity. Medicaid is not permitted to deny, delay, reduce, or terminate eligibility while documentation is being gathered during the reasonable opportunity period. A reasonable opportunity period applies when all other information necessary to determine eligibility is available. If an individual is eligible for Medicaid and has met all other criteria except for citizenship or identity verification, that individual’s eligibility may not be pended for verification of either citizenship or identity, but must be approved. If the individual does not provide satisfactory documentation of citizenship and identity by the end of the reasonable opportunity period, the individual’s eligibility must be terminated with advance (10-day) notice and without regard to continuous eligibility provisions.

A ‘reasonable opportunity period’ is defined as 90 days from the date the application is submitted and for the remaining days of the month in which the 90th day falls. An extension of an additional 60 days from the 90th day may be granted if the individual has verifiable documented evidence

they have been making a good faith effort to obtain the verifications, but still have not received them.

A reasonable opportunity period is not limited to one.

Example:If granted a reasonable opportunity period but the requested verifications are not received and eligibility is terminated; upon reapplication, if needed a new reasonable opportunity period will be allowed.

4. Acceptable documentation for US citizens and naturalized citizens.

   a. The following documents may be accepted as proof of both citizenship and identity because either the US, a state, or Tribal government has established the citizenship and identity of the individual. These 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.
Citizenship verification received from using the “Other Benefits” inquiry in the NDVerify system or from the citizenship verification system available through the Federally Facilitated Marketplace (FFM) – as automated through the Streamlined application process	• Acceptable codes are: ○ “Citizenship Verified” ○ "Verified with positive citizen; Deceased."

Documents Issued by Recognized ND Tribes

Tribe:	Documents:
Sisseton-Wahpeton (Wahpeton—SE corner of ND)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood; ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards:

	○ Name, DOB, enrollment #, degree of Indian blood, SSN, photo and individual's signature; ○ Issued to enrolled members age 16 and older who request it; ○ Issued by tribal enrollment office;
Spirit Lake (Devils Lake)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal Photo ID: ○ Photo ID including name, DOB, tribal enrollment #, and degree of Indian blood (may have more information); ○ Issued by tribal motor vehicle office; ○ Issued to enrolled members;
Standing Rock Sioux Tribe (Fort Yates)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, and degree of Indian blood, last 4 digits of SSN (may have more information); ○ Issued to enrolled members age 14 and older who request it; ○ Issued by tribal enrollment office;
Three Affiliated Tribes (T. A. T.) (New Town)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing address, physical address, photo);

	○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal ID cards: ○ Name, DOB, enrollment #, and degree of Indian blood, mailing address, physical address, photo (plastic card with hologram on back) (will enter SSN (non-verified) at individual's request); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office (Cost = $10; free to seniors); ○ Expire every 4 years;
Turtle Mountain Chippewa (Belcourt, Trenton)	• Certificate of Degree of Indian Blood: ○ Name, DOB, enrollment #, and degree of Indian blood, (may have more information); ○ Issued to any enrolled member who requests it; ○ Issued by tribal enrollment office; • Tribal Enrollment cards: ○ Name, DOB, enrollment #, and degree of Indian blood (may have more information); ○ Issued to enrolled members age 18 and older who request it; ○ Issued by tribal enrollment office.

b. If an individual does not have one of the primary verifications, the individual must supply one document from one of the Citizenship lists (Levels 2, 3, or 4) and one document from the Identity lists (Levels 2, 3, or 4).

The verifications are listed in levels and the levels indicate the degree of reliability of the verifications. Level 1 has the highest reliability and is the

preferred verification. Level 4 has the lowest reliability and those verifications should be used only when documents from levels 1-3 are not available. The verifications in level 1 must be requested prior to requesting those in level 2, those in level 2 must be requested prior to requesting those in level 3, and so on.

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.

Secondary Verification of Citizenship

(Level 2)

Acceptable Verifications:	Explanatory Information:
Certificate of Birth in the United States	• Must have the embossed seal of the issuing agency. • North Dakota only issues certified copies. If it does not have the raised seal, it is not a certified copy - i.e. the old black and white prints. • The original must have been recorded before the person was 5 years of age. (For issuance date, use the "Date received by Local Registrar".) If recorded at or after 5 years of age, it is a 4th level verification. • Must show birth in one of the 50 states, or the District of Columbia. • Persons born to foreign diplomats are not citizens of the United States. • An electronic match with the ND vital statistics agency showing the individual's place of birth will suffice.
Report of Birth Abroad of a Citizen of the United States (FS-240) aka	• Prepared by the Department of State Consular office.

Consular Report of a Birth Abroad of a Citizen of the United States	• Can only be prepared at an American Consular office overseas while the child is under age 18. • Children born outside the US to US military personnel usually have one of these.
Certificate of Birth Abroad (FS-545 or Form DS-1350) aka Certificate of Report of Birth or Certification of Birth Abroad	• For those who were born outside the US and acquired US Citizenship at birth and is based on FS-240. • FS-545 issued prior to November 1, 1990. • DS-1350 issued on and after November 1, 1990. • Is issued only within the US.
United States Citizen Identification Card (I-197 or I-179)	• Issued by the Immigration and Naturalization Service from 1960-1973 as I-179; Issued to naturalized US Citizens living near the Canadian or Mexican border who needed it for frequent border crossings. • Issued as I-197 from 1973-1983. • No longer currently used, but still valid.
American Indian Card (I-872) with the classification code "KIC" and a statement on the back	• Issued by the Department of Homeland Security to identify US citizen members of the Texas Band of Kickapoos living near the US / Mexican border.
Evidence of Civil Service Employment	• Must show employment by the US Government prior to June 1, 1976.
Official Military record of service	• Including a DD-214. • Must show a US place of birth.

A data verification with the Systematic Alien Verification for Entitlements (SAVE) Program for naturalized citizens	• Determines if someone is a naturalized citizen. • May need to provide the individual's alien registration number.
Adopted or biological children born outside the US may establish their automatic citizenship if verification is provided	• Showing at least one parent is a US citizen by either birth or naturalization. • Child is under age 18. • Child is residing in the US in the legal and physical custody of the US citizen parent. • Child was admitted to the US for lawful permanent residence. • If adopted, the child must be a lawful permanent resident as an IR-3 (child adopted outside the US) or as IR-4 (child coming to the US to be adopted); with the final adoption having subsequently occurred.

Third Level Verification of Citizenship

(Level 3)

Acceptable Verifications:	Explanatory Information:
Extract of hospital record on hospital letterhead established at the time of birth and created at least 5 years prior to the Medicaid application	• It must indicate a US place of birth. • A souvenir 'birth certificate' issued by the hospital cannot be accepted. • For children under 16 the document must have been created near the time of birth or 5 years prior to the Medicaid application.
Life or health or other insurance record	• Showing a US place of birth for the individual.

	• Created at least 5 years before the initial application date.
Official religious record (recorded with the religious organization) recorded in the US within 3 months of birth	• Must show a US place of birth. • Must show the individual's date of birth or age at the time the record was made. • In questionable cases, such as where the child's religious record was recorded near a US international border and the child may have been born outside the US, the worker must verify the religious record with the religious organization and verify that the mother was in the US at the time of birth.
Early school record showing a US place of birth	• Must show the name, date of birth, and US place of birth of the child. • Must show the date of school admission. • Must show the name(s) and place(s) of birth of the applicant's parents.

Fourth Level Verification of Citizenship

(Level 4)

Acceptable Verifications:	Explanatory Information:
Federal or state census record showing US citizenship or a US place of birth - (generally for persons born 1900-1950)	• Must also show the applicant's age. • Census records from 1900 through 1950 contain citizenship information. • To obtain this information the applicant or recipient should complete a Form BC-600,

	"Application for Search of Census Records for Proof of Age", adding in the remarks portion, "US Citizenship data requested for Medicaid eligibility." This form can be obtained online at: http://www.census.gov/genealogy/www/bc-600.pdf. • A fee will be charged.
Seneca Indian tribal census record	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Bureau of Indian Affairs tribal census records of the Navajo Indians	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
US State Vital Statistics official notification of birth registration	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Delayed US public birth record that is amended more than 5 years after the person's birth	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Statement signed by the physician or midwife who was in attendance at the time of birth	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.

Institutional admission papers from a nursing home, skilled care facility or other institution	• Must be created at least 5 years prior to initial Medicaid application; and • Must show a US place of birth.
Medical (clinic, doctor or hospital) record (An immunization record is NOT considered a medical record for establishing citizenship)	• Must be created at least 5 years prior to initial Medicaid application (or near the time of birth, if a child under age 16 only); and • Must show a US place of birth.
Written affidavit, made under penalty of perjury, by at least two individuals--one of which is not a relative--showing they have personal knowledge of the event(s) establishing the applicant's claim of citizenship (date and place). These individuals must provide proof of their own citizenship and identity	• It must also state a reasonable basis of personal knowledge that an applicant or recipient who cannot produce documentary evidence of citizenship is a citizen. SFN 707, "Affidavit of Citizenship," has been created for convenience. • A second affidavit from the applicant/recipient or other knowledgeable individual explaining why the information cannot be obtained must also be supplied. SFN 706, "Affidavit of Explanation why Citizenship Cannot be Supplied," has been created for convenience. • Use only in rare circumstances.

6. Individuals born in Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, and Nationals from American Samoa. For purposes of qualifying as a United States citizen, individuals born in Puerto Rico, Guam, the Virgin Island, the Northern Marian Islands and Nationals from American Samoa may qualify as follows:

a. Puerto Rico:

- Certificate of birth in Puerto Rico on or after January 13, 1941 (For applicants whose eligibility is determined for the first time on or after November 1, 2010, the birth certificate must have an issue date of on or after July 1, 2010, to be considered valid.)
- Evidence of birth in Puerto Rico on or after April 11, 1899 and the applicant's statement that he or she was residing in the US, a US possession, or Puerto Rico on January 13, 1941 (For applicants whose eligibility is determined for the first time on or after November 1, 2010, the birth certificate must have an issue date of on or after July 1, 2010, to be considered valid.)
- Evidence that the individual was a Puerto Rican citizen and the applicant's statement that he or she was residing in Puerto Rico on March 1, 1917, and that he or she did not take an oath of allegiance to Spain

b. Guam:

- Evidence of birth in Guam on or after April 10, 1899

c. The US Virgin Islands:

- Certificate of birth in the US Virgin Islands on or after January 17, 1917
- Evidence of birth in the US Virgin Islands and the applicant's statement of residence in the US, a US possession, or the US Virgin Islands on February 25, 1927
- The applicant's statement indicating residence in the US Virgin Islands as a Danish citizen on January 17, 1917 and residence in the US, a US possession, or the US Virgin Islands on February 25, 1927, and that he or she did not make a declaration to maintain Danish citizenship
- Evidence of birth in the US Virgin Islands and the applicant's statement indicating residence in the US, a US possession, or the Canal Zone on June 28, 1932

d. Northern Mariana Islands (NMI) (formerly part of the Trust Territory of the Pacific Islands (TTPI)):

- Certificate of birth in the Northern Mariana Islands after November 4, 1986.

- Evidence of birth in the NMI, TTPI citizenship and residence in the NMI, the US or a US territory or possession on November 3, 1986 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986. These individuals carry the Northern Mariana Identification Care (I-873). This form is no longer issued, but is still valid.
- Evidence of TTPI citizenship, continuous residence in the NMI since before November 3, 1981, voter registration prior to January 1, 1975, and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986.
- Evidence of continuous domicile in the NMI since before January 1, 1974 and the applicant's statement that he or she did not owe allegiance to a foreign state on November 4, 1986.
- If the person entered the NMI as a nonimmigrant and lived in the NMI since January 1, 1974, this does not constitute continuous domicile and the individual is not a US Citizen.

a. Nationals from American Samoa or Swain's Islands:
   - Certificate of birth in American Samoa or Swain's Islands after November 4, 1986
   - Persons born in American Samoa or Swain's Islands are treated as citizens for Medicaid purposes

f. Persons born to foreign diplomats while residing in one of the preceding jurisdictions of the US are not citizens of the United States.

   - The child's citizenship or alien status follows that of the parent.

American Indians Born in Canada 510-05-35-50

(Revised 8/1/10 ML #3227)

View Archives

1. American Indians born in Canada who may freely enter and reside in the United States are considered to be lawfully admitted for permanent residence if at least one-half American Indian blood. This does not include a spouse or child of such an Indian nor a noncitizen whose membership in an Indian tribe or family is created by adoption, unless such person is of at least 50 percent or more Indian blood. These American Indians are qualified aliens and are considered to be lawful permanent residents.

   Article III of the 'Jay Treaty' declared the right of "Indians" ("Native Americans") to trade and travel between the United States and Canada, which was then a territory of Great Britain. As a result of the "Jay Treaty", Native Indians born in Canada are entitled to enter the Unites States for the purpose of employment, study, retirement, investing, and/or immigration.

2. Verification of percentage of American Indian blood may be obtained from INS Form I-551 with the code 513, S1-3, or S-13, or an unexpired temporary I-551 stamp (with the code 513, S1-3, or S-13) in a Canadian passport or on Form I-94. If the individual does not have an INS document, satisfactory evidence of birth in Canada and a document indicating the percentage of American Indian blood must be provided. Documents, indicating the percentage of American Indian blood include a birth certificate issued by the Canadian reservation, or a Blood Quantum Letter, card, or other record issued by the tribe (each tribe provides some type of evidence). The Blood Quantum Letter may use the following verbiage: at least 50% Aboriginal blood, at least 50% Indigenous blood, at least 50% North American Indian blood, or at least 50% American Indian blood. Do not accept a Certificate of Indian Status card ("Band" card) issued by the Canadian Department of Indian Affairs, information from any internet sites, or any other document not directly issued by the individual's tribe.

   Note: The Blood Quantum Letter can be used to show that an individual possesses at least 50% blood of the American Indian Race, but cannot be used to show that an individual does not possess at least 50% blood of the American Indian Race. If the letter does not show an individual

possesses at least 50% blood of the American Indian Race, additional verification may be warranted.

Non-Qualified Aliens 510-05-35-55

(Revised 5/5/2025 ML #3929)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

1. Some non-citizens may be lawfully admitted for a temporary or specified period of time and are not eligible for Medicaid. They have the following types of documentation: Form I-94, Arrival-Departure Record; DSP-150 Border Crossing Card and B-1/B-2 visitor visa; I-586 Mexican Border Crossing Card; Form I-95A, Crewman's Landing Permit. These non-citizens are not eligible for Medicaid because of the temporary nature of their admission status. Ineligible non-citizens are eligible for coverage of emergency services. The following categories of individuals are ineligible non-citizens:

    a. Foreign government representatives on official business and their families and servants;
    b. Visitors for business or pleasure, including exchange visitors;
    c. Non-citizens in travel status while traveling directly through the U.S.;
    d. Crewman on shore leave;
    e. Treaty traders and investors and their families;
    f. Foreign students;
    g. International organization representation and personnel and their families and servants;
    h. Temporary workers including agricultural contract workers; and
    i. Members of foreign press, radio, film, or other information media and their families.

2. Illegal non-citizens who are not lawfully admitted for permanent residence in the United States are not eligible for Medicaid, except for emergency services. Ongoing eligibility does not exist.

Qualified Aliens 510-05-35-58

(Revised 5/5/2025 ML #3929)

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Qualified aliens are aliens that have been legally admitted and may be eligible for Medicaid if they meet all other Medicaid eligibility criteria. Some qualified aliens may be eligible under the Refugee Medical Assistance Program, 510-05-95-20, if they do not meet all other Medicaid eligibility criteria. The following categories of individuals are qualified aliens: (Forms indicated below are USCIS or Immigration and Naturalization Service (INS) forms and the sections refer to the Immigration and Nationality Act (INA):

Individuals with the documents described in subsections 2 through 14 below may be eligible for Medicaid from their date of arrival in North Dakota, without being subject to the five-year ban or required to meet the forty qualifying quarters of social security coverage, as long as they meet all other Medicaid criteria:

1. Aliens who are lawfully admitted for permanent residence (LPR) may be eligible as described in sections 510-05-35-60 and 510-05-35-65.

2. Honorably discharged veterans, aliens on active duty in the United States' armed forces, and the spouse or unmarried dependent child(ren) of such individuals with:

    a. Verification of honorable US military discharge (such as a DD214);
    b. Verification of relationship of family members.

3. Refugees who possess one of the following:

    a. Form I-94 (Arrival Departure Record) showing "207" or "REFUG" or codes RE1, RE2, RE3, RE4; or RE5;
    b. Form I-766 (Employment Authorization Document) with code A3;
    c. Form I-571 (Refugee Travel Document);
    d. Form I-551 or I-151 (Permanent Resident Card) with codes R8-6; RE6, RE7, RE8, RE9.

4. Asylees who have been granted asylum (not applicants for asylum) who possess one of the following:

a. Form I-94 showing “208” or “asylee” and/or codes of AS1, AS2, or AS3);
b. Form I-766 annotated A5;
c. A grant letter from Asylum office of USCIS;
d. An order from immigration judge granting asylum;
e. Form I-571; or
f. Form I-551 or I-151 with codes AS6, AS7, AS8, AS9, GA-6 to GA-8.

5. Cuban and Haitian Entrants who possess one of the following:
   a. Form I-94 showing “Cuban/Haitian Entrant” or “parole” under Section 212(d)(5) or codes CU6, or CU7 or “OOE” or ”outstanding orders of exclusion”, Citation of INA 212(d)(5) or the word “Parole” Automated I-94 Codes CH, CP, HF, HR, HT, HQRAP, PARCIS; codes EQ1, AM2, AM3;
   b. Form I-151 or I-551 with National of Cuba or Haiti and codes CH6,CH7 CNP, CU0, CU-6, CU-7, CU-8, CU-9, CUP, HA-6 to HA-9; HB-6 to HB-9; HD-6 to HD-9; HE-6 to HE-9, or NC-6 to NC-9;
   c. Form I-766 with code A04, A12, C08, C10,C11;
   d. Form I-327- Re-entry Permit;
   e. Form I-797 A and C- USCIS Notice of Action Receipt of Asylum Application;
   f. Form I-862- Notice to Appear;
   g. Form I-220A- Order of Release on Recognizance;
   h. Form I-797A- USCIS Notice of Action;
   i. Form I-589- Date stamped by the Executive Office for Immigration Review (EOIR);
   j. Form I-485- Date stamped by EOIR;
   k. Form Executive Office for Immigration Review (EOIR)-26;
   l. DHS forms: I-221, I-862, I-220A, I-122, I-221S;
   m. Other applications for relief that have been date stamped by EOIR; or
   n. Other documentation pertaining to an applicant's removal, exclusion, or deportation proceedings.

6. Victims of a severe form of trafficking and their families (non-citizens granted non-immigrant status under Section101(a)(15)(T) of the Immigration and Nationality Act (INA)who have a pending application that sets forth a prima facie case for eligibility for that non-immigrant status) who possess on of the following:

   a. Form I-94 showing codes T-1 or T-2;
   b. Form I-94 or passport showing non-immigrant status under Section 101(a)(15)(T) of the INA;
   c. Form I-766 showing 247a.12(a)(16), A16, 274a.12(c)(25) or C25;
   d. Other INS document showing nonimmigrant status under 101(a)(15)(T);
   e. Any verification from the INS or other authoritative documents showing non-immigrant status under Section 101(a)(15)(T) of the INA.

7. Non-citizens whose deportation was withheld under Section 243(h) of the Immigration and Naturalization Act (INA):

    a. Form I-94 or foreign passport showing “243(h)” or “241(b)(3)”;
    b. Form I-766 with code of “274a.12(a)(10) or A10; or
    c. Form I-571.

8. Non-citizens admitted as an Amerasian immigrant who possess one of the following:

    a. Form I-94 showing National of Vietnam and AM1, AM2, or AM3; or
    b. Form I-151 or I-551 showing National of Vietnam and AM-1, AM-2, AM-3, AM-6, AM-7; or AM-8.

9. American Indians born in Canada as described in 510-05-35-50.

10. Non-citizens paroled into the United States under Section 212(d)(5) of the INA for a period of at least 1 year who possess one of the following:

    a. Form I-94 showing “212(d)(5)” or “parolee” or “PIP”;
    b. Form I-766 with code such as 274a.12(a)(4), or A4, or 274a.12(c)(11); or
    c. Cuban-Haitian entrants with parole status.

11. Certain battered aliens; battered alien children; and the parents of such children with a Form I-551 card showing B2-1, B2-3, B2-6, or B2-8.

12. Iraqi and Afghan Special Immigrants and their families who possess:

    a. Form I-94 with a stamp of “IV” and category SQ1, SQ2, SQ3, SQ4, SQ5, SI1, SI2 or SI3 and date of entry. COA of OAR, PAR, or DT;
    b. An Afghan or Iraqi passport with a stamp of “IV” and category SQ1, SQ2, SQ3, SQ6, SQ7, SQ8, SI1, SI2 or SI3 and DHS stamp or notation on passport showing date of entry. COA of OAR, PAR, or DT with CBP PAROLED stamp and/or parole COA notation;
    c. Form I-551 showing national of Afghanistan or Iraq with “IV” code of CQ1, CQ2, CQ3, SQ1, SQ2, SQ3, SQ6, SQ7, SQ8, SQ9, SI6, SI7, SI9; or
    d. Form I-766 with a stamp of ‘IV’ code of SQ4 and SQ5 with C11 Parolee category. COA of OAR, PAR, or DT with C11 Parolee category.

13. Aliens granted conditional entry under section 203(a)(7) of the INA in effect prior to April 1, 1980:

    a. Form I-94 or other document showing “conditional entrant”, “refugee conditional entry”, “seventh preference”; “section 203(a)(7)”; “P7” ;

b. Form I-766 annotated “A3”; or
c. Any verification from the INS or other authoritative document.

14. Individuals from the Federated States of Micronesia, the Marshall Islands and Palau are permanent non-immigrants and must possess one of the following:

a. Form I-94 Arrival/Departure Record created electronically upon arrival to an air or seaport of entry. Paper versions can be obtained by logging on to U.S. Customs and Border Protection (CBP) at CBP’s I-94 website. I-94 will contain an admission stamp, but not an “admit until” date. Form I-94 printed from the CBP website will show an “admitted until” date of D/S (duration of status). D/S indicates that the individual is authorized to remain in the United States as long as they maintain a valid status.
b. A valid, unexpired passport from Federated States of Micronesia (FSM), Republic of Marshall Islands (RMI), or Republic of Palau (PAL).

- Notations on passports will be CFA/PAL (Compact of Free Association/Palau); `CFA/FSM (Compact of Free Association/Micronesia) or CFA/MIS (older version would be RMI) (Compact of Free Association/Marshall Islands).
- Form I-94 will have either an alien registration number (A-number) or an 11 alphanumeric-character admission/departure number.

Aliens Lawfully Admitted for Permanent Residence Before August 22,1996 510-05-35-60

(Revised 8/1/10 ML #3227)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

Aliens who lawfully entered the United States for permanent residence before August 22, 1996, and who meet all other Medicaid criteria may be eligible for Medicaid. These individuals have Forms I-551 or I-151 (Resident Alien Cards) or a Foreign Passport stamped LPR or I-551.

Aliens Lawfully Admitted for Permanent Residence on or After August 22, 1996 510-05-35-65

(Revised 05/02/2024 ML #3824)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

1. Aliens admitted for Lawful Permanent Residence (LPR) on or after August 22, 1996 are banned from Medicaid, for five years from the date they entered the United States. After the five-year ban, aliens who are lawful permanent residents who can be credited with forty qualifying quarters of social security coverage may be eligible for Medicaid.

   Verifications of this status are:

   a. Form I-551 or I-151 (Resident Alien Card) (these are also known as 'green cards' but are not green);
   b. Foreign passport stamped LPR or I-551.

      Note: If a qualified alien's status has changed to LPR, the codes at 510-05-35-58 apply. If the code on the Permanent Resident Card is not in 510-05-35-58, the individual is subject to the 5–yr ban and forty qualifying quarter requirements.

      Example, an asylee entered as an AS1 (which shows on his I-94 card). He has now become a LPR and his code on his I-551 is AS8. He is still an Asylee and a qualified alien. If his LPR code had been issued as an SD6, which is not a qualified alien code instead of the AS8, he is subject to the 5-year ban or the forty-quarter requirements.

2. Qualifying quarters of social security coverage, determined by Social Security Administration, can be obtained using the Verification Interfaces/40 Quarters in the eligibility system.

a. When the interface returns a total of forty quarters or more, no further action is needed.

b. If the interface returns less than forty quarters, but the alien claims to have 40 quarters work history, gather the information regarding the amount of earnings by quarter and contact the Medicaid Eligibility unit for further assistance.

Note: When determining the number of qualifying quarters an individual has, count:

- All qualifying quarters the alien has due to work;
- All qualifying quarters worked by the alien's spouse during their marriage, if the alien remains married to such spouse or the spouse is deceased; and
- All qualifying quarters worked by a natural, adoptive, or stepparent of such alien while the alien was under age 18. Qualifying quarters of an adoptive parent count from the quarter of the adoption. Qualifying quarters of a stepparent count from the quarter of marriage to the alien's parent.
- Earnings of some federal civilian employees hired before 1984, earnings of employees of some states and local governments, and certain agricultural and domestic earnings are not calculated by Social Security.
- Do not count or deem any qualifying quarters for any quarter in which and individual received TANF, SNAP, Medicaid, or SSI benefits (including benefits received in another state), for at least one month in the quarter, or from any parent whose paternal rights have been terminated.

3. Adopted or biological children born outside the US may establish their automatic citizenship if verification is provided as described in the Secondary Verification of Citizenship table at 510-05-35-45.

4. Pregnant women who are lawfully present in the United States and are otherwise eligible for medical assistance are not subject to the 5-year waiting period/40 quarter requirement through the 12 month postpartum period.

Emergency Services for Non-Citizens 510-05-35-70

(Revised 11/1/2025 Release 25.17)

View Archives

(N.D.A.C. Section 75-02-02.1-18)

Ineligible non-citizens (identified in 510-05-35-55) and qualified non-citizens who are not eligible for Medicaid because of the time limitations or forty qualifying quarters of social security coverage requirement, may be eligible to receive emergency services that are not related to an organ transplant procedure, if all of the following conditions are met:

1. The alien has a medical condition (including labor and delivery) manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in:

    a. Placing health in serious jeopardy;
    b. Serious impairment to bodily functions; or
    c. Serious dysfunction of any bodily organ or part.

2. The alien meets all other eligibility requirements for Medicaid except illegal aliens do not have to meet the requirements concerning furnishing social security numbers and verification of alien status; and

3. The alien's need for the emergency service continues. Eligibility for Medicaid ends when the emergency service has been provided, and does not include coverage of follow-up care if the follow-up care is not an emergency service. A pregnant woman may be covered from the date she entered the hospital for labor and delivery through the date she was discharged. A pregnant woman who delivers a child and is covered under this provision is not eligible for the twelve month period of eligibility after pregnancy. Her child, however, is a citizen and may be eligible for twelve months of continuous coverage.

    When a non-qualified alien is requesting coverage for 'Emergency Services' for reasons other than childbirth, a completed SFN 451, Eligibility Report on Disability/Incapacity and medical reports must be submitted to the State Review

Team for a determination of whether the medical condition meets ALL the criteria listed in #1 above.

Note: Remember to check the box in the upper right hand corner titled 'Emergency Services'.

1. Pregnant women who are lawfully present in the United States and are otherwise eligible for medical assistance are not subject to the five-year waiting period/ forty quarter requirement through the 12 month postpartum period.

Social Security Numbers 510-05-35-80

(Revised 9/1/2023 ML 3751)

View Archives

(N.D.A.C. Section 75-02-02.1-13)

1. A valid social security number (SSN), of verification of application for SSN, must be furnished as a condition of eligibility, for each individual requesting coverage.

    - Members of the Medicaid Household who are not seeking coverage may voluntarily provide their SSN; however, they are not required to do so.
    - Individual who do not have a number must be referred to the Social Security Administration to apply for one. The zone may assist the applicant as needed.

    Examples of verification of application for SSN includes but is not limited to:

    - A copy of the Parent Verification document the hospital submitted to Vital Records or written verification from the hospital
    - Refugee Global boarding letter
    - Refugee travel document
    - Any proof from the Social Security Administration

    The following individuals are exempt and do not have to provide an SSN or verification of application for an SSN:

    a. A newborn who is eligible during the birth month, beginning on the date of birth and through the last day of the twelfth month, or if the newborn is continuously eligible, for the remaining days of the newborn's first eligibility period;

        Note: If a newborn is NOT eligible in the birth month, but is eligible for months following the birth month an SSN or Application for SSN is required.

    b. An individual who is currently eligible for Transitional or Extended Medicaid Benefits;

c. An illegal alien seeking emergency services. (see 510-03-35-70 for a description of emergency service.), and
d. An individual who is determined eligible under Hospital Presumptive Eligibility (HPE)

When the exempt period ends, a social security number or verification of application for SSN must be provided to continue Medicaid coverage.

2. The Medicaid household must be informed, at the time of application that the agency will use the SSN in the administration of the Medicaid Program. The SSN will be used to verify income and asset information from the Social Security Administration. Internal Revenue Service, Job Service, Unemployment Compensation, SNAP, TANF Program, Child Support Enforcement, State Motor Vehicle, Department of Vital Statistics and other states.

   The informing requirement is met by the appropriate language found on the Application for Assistance.

3. Social Security numbers are electronically verified through the NDVerify interface in **SPACES** for all individuals. When a number is reported as not valid, the individual must provide their valid SSN to continue to be eligible for Medicaid.

   Refer to the Administrative Manual Section 448-01-50-15-60.

   The eligibility system may be incorrect or the individual's record at SSA has incorrect information. The worker should check the information entered into the system for accuracy. If the worker is unable to determine if the information in the system is accurate, the worker must contact the household (via phone or notice) to determine the correct date of birth or gender and then correct the information in the system.

   If the worker contacts the household by phone, the contact must be thoroughly documented in the narrative. The worker must document the request and give the household 10 days to provide the number.

   - If the household refuses to provide the SSN, or fails to respond to the request, that individual's coverage must be ended or denied.

- If the household requests additional time, another 10 days may be allowed.
- Household members who are not requesting coverage are not required to provide an SSN.

If the individual can only show a request date and not a number, they have until the next review to provide an SSN, or eligibility will end for that individual. Newborns may be eligible until the month of their first birthday with a request date, after that, an SSN must be provided.

4. Except for individuals exempt in Subsection 1, individuals who provided verification of application for an SSN must provide an SSN by the next review. If a child is within a continuous eligibility (CE) period when the case review is being completed, and the SSN is not provided, the child is eligible through the end of the current CE period. However, the child's SSN must be provided for eligibility to continue past the end of the CE period.

State Residence 510-05-35-85

(Revised 10/1/2023 ML#3763)

View Archives

(N.D.A.C. Section 75-02-02.1-16)

An individual must be a resident of North Dakota to be eligible for Medicaid through this state. A resident of the state is an individual who is living in the state voluntarily and not for a temporary purpose. Temporary absences from the state with subsequent returns to the state, or intent to return when the purpose of the absence has been accomplished, do not interrupt continuity of residence. Residence is retained until abandoned or established in another state.

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.

   Note: Individuals in receipt of SSI who have a residence address on SOLQ showing a North Dakota address, will be considered a North Dakota resident. If the residence address on SOLQ indicates an out of state address, the application will need to be pended for verification of residence address. In the pending notice the client must be informed to contact SSA to report their move and update their residence address.

   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. Eligibility may be determined as of the date the individual entered the state. 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 case file.

2. Individuals age twenty-one and under:

   a. For any individual under age twenty-one who is living independently from their parents or who is married and capable of indicating intent, the state of residence is the state where the individual is living with the intention to remain

The state of residence, for Medicaid purposes, of migrants and seasonal farm workers is the state in which they are living due to employment or seeking employment.

b. For any individual who is receiving foster care or adoption assistance payments, under Title IV-E, from another state and is living in North Dakota, North Dakota is the state of residence for Medicaid purposes.

Children receiving non IV-E foster care assistance payments from another state, the state of residence for Medicaid is the state making the payment unless the Interstate Compact on the Placement of Children (ICPC) indicates which state will cover Medicaid.

Children receiving non-IV-E adoption assistance payments from another state are considered residents of North Dakota for Medicaid purposes if there is an Interstate Compact on Adoption and Medical Assistance (ICAMA) agreement with a member state that indicates that the receiving state will cover the Medicaid. Likewise, children from North Dakota receiving non-IV-E adoption assistance payments who move to another member state may no longer be considered North Dakota residents if the ICAMA agreement indicates that the receiving state will cover the Medicaid. The Children and Family Services division provides zone agencies with information on whether a sending or receiving state is a member state and which state is responsible for the medical coverage per the agreement.

c. For any individual under age twenty-one not residing in an institution, whose Medicaid eligibility is based on blindness or disability, the state of residence is the state in which the individual is living.

d. For any other institutionalized individual under age twenty-one, the state of residence is the state in which the child is living with the child's parent or another caretaker relative on other than a temporary basis. A child is normally considered to be living in the state temporary if:
    i. The child comes to North Dakota to receive an education, special training, or services in the Anne Carlsen School, maternity homes, vocational training centers, etc. if the intent

is to return to the child's home state upon completion of the education or service;

ii. The child is placed by an out-of-state court into the home of relatives or foster parents in North Dakota on other than a permanent basis or on other than an indefinite period ; or

iii. The child entered the state to participate in Job Corps or other specialized services if the intent is to return to the child's home state upon completion of the activity or service.

e. For any institutionalized individual under age twenty-one, who is neither married nor living independently, residence is that of the parents or legal guardian at the time of placement or the state of residence of the parent or legal guardian at the time of Medicaid application if the child is institutionalized in the same state. Only if the parental rights have been terminated, and a guardian or custodian appointed, may the residence of the guardian or custodian be used. If the individual has been abandoned by his parents and does not have a guardian, the individual is a resident of the state in which the individual lives.

3. For students entering the state to attend school full time and are between the ages of 18 and 22 (including the month the child attains age 22), who apply for Medicaid on their own behalf, are considered North Dakota residents if the individual intends to remain in North Dakota when their education has been completed. Individuals who do not intend to remain in North Dakota when their education has been completed are considered residing in the state temporarily and are not considered a resident of North Dakota.

4. Individuals age twenty-one and over:

a. For any individual not residing in an institution, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period or is entering the state with a job commitment or seeking employment.

The state of residence, for Medicaid purposes, of migrants and seasonal farm workers is the state in which they are living due to employment or seeking employment.

b. For an institutionalized individual who became incapable of indicating intent before age twenty-one, the state of residence is that of the parent or guardian making application, at the time of placement or, if the individual is institutionalized in that state, at the time of application. If the individual has no guardian, the application is not made by either parent, and the placement was not made by another state, the state of residence is the state in which the individual is physically present.

c. For any other institutionalized individual, the state of residence is the state where the individual is living with the intention to remain there permanently or for an indefinite period.

5. An "individual incapable of indicating intent" means one who:

   a. Has an intelligence quotient of forty-nine or less, or a mental age of seven or less, based upon tests acceptable to the Division of Behavioral Health under the Department of Health and Human Services;
   b. Has been found by a court of competent jurisdiction to be an incapacitated person as defined in subsection 2 of North Dakota Century Code section 30.1-26-01
   c. Has been found by a court of competent jurisdiction to be legally incompetent; or
   d. Is found incapable of indicating intent based on medical documentation obtained from a physician or surgeon, clinical psychologist, or other person licensed by the state in the field of mental retardation.

6. Individuals placed in out-of-state institutions by a state agency retain residence in that state regardless of the individual's indicated intent or ability to indicate intent. State residence ends, however, when the competent individual leaves the facility in which the individual was placed by the state. Providing information about another state's Medicaid program or about the availability of health care services and facilities in another state, or assisting an individual in locating an institution in another state, does not constitute a state placement.

   State agencies include human service centers, the Division of Juvenile Services, special education, zone offices, and the Department Health and Human Services. Tribal entities and hospital social workers or other staff are not state agencies.

7. For any individual receiving a state supplemental payment, the state of residence is the state making the payment.

8. If an interstate reciprocal residency agreement has been entered into between this state and another state pursuant to 42 CFR 435.403(k), the state of residence of residence of the individual is the state determined under that agreement.

   North Dakota has an interstate reciprocal residency agreement with nine states. The agreement provides that individuals of any age institutionalized in one of these states are considered a resident of the state in which they are institutionalized.

   The states with whom we have the agreement are:

California	New Mexico	Tennessee
Kentucky	Ohio	Texas
Wisconsin	Pennsylvania	

   North Dakota also has a specific agreement with the State of Minnesota. The agreement states that individuals who enter a nursing facility in the other state remain a resident of the state they were a resident of prior to admission into the nursing facility for 24 months following admission, and if the individual has a community spouse, they continue to be a resident of the state the community spouse lives in beyond the 24 month time limit. This agreement terminates at the point the individual is discharged from a nursing facility unless the individual is being transferred to a different nursing facility.

9. When two or more states cannot agree which state is the individual's state of residence, the state of residence is the state in which the individual is physically present.

10. North Dakota residents will be provided Medicaid outside the state when:

    a. It is a general practice for residents of a particular locality to use medical resources outside the state;
    b. The availability of medical resources requires an individual to use medical facilities outside the state for short or long periods. Prior approval from the Medical Services Division must be obtained when an individual is being referred for out-of-state medical services.

Transportation for approved out-of-state medical services will be arranged jointly by the individual and the Customer Support Center.

c. Individuals are absent from the state for a limited period of time to receive special services or training;
d. It is an emergency situation; and
e. Services are received during an eligible period but prior to application.

Application for Other Benefits 510-05-35-90

(Revised 1/1/2025 ML 3892)

View Archives

1. Medicaid applicants and beneficiaries are not required to apply for other benefits that they may be entitled to as a condition of Medicaid eligibility, including:
   - Annuities
   - Pensions
   - Retirement benefits
   - Disability benefits
   - Unemployment benefits

   Example: Other benefits include, but are not limited to, Veterans' Compensation and Pensions; Old Age, Survivors, and Disability Insurance Benefits; Railroad Retirement Benefits; and Unemployment Compensation.

2. Applicants and recipients are notified these benefits may be available to them to apply for.

3. Application for needs based payments (e.g. SSI, TANF, etc.) cannot be imposed as a condition of eligibility.

Public Institutions 510-05-35-95

(Revised 1/1/2025 ML #3916)

View Archives

(N.D.A.C. Section 75-02-02.1-19)

1. Incarceration status is not a condition of Medicaid eligibility and does not make an individual ineligible. An individual who is an “inmate” of a “public institution” who meets all eligibility factors for Medicaid is Medicaid eligible. Medicaid eligibility for individuals who are inmates of a public institution will be suspended. No medical services will be covered under the Medicaid program during the individual’s stay in the public institution.

   Public Institutions in North Dakota include (but are not limited to):

   - North Dakota Youth Correctional Center,
   - Dakota Women’s Correctional Center,
   - North Dakota State Penitentiary,
   - Bismarck Transition Center (BTC) Women’s Treatment Program (locked unit which is separate and distinct from the BTC transitional housing and work release unit)
   - James River Correctional Center,
   - Heart River Correctional Center,
   - Missouri River Correctional Center
   - City, County and Tribal Jails

   A transfer from a penal public institution facility to the state a hospital or another medical institution, for evaluation or treatment does not terminate inmate status.

   Example: A release from a public 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 public institution following discharge from the hospital.

2. The period of Medicaid eligibility suspension under this section begins the day after the day the individual enters the public institution and ends the day before the date the individual is discharged from the public institution. A Ten-Day Advance Notice is not needed when suspending benefits due to entry into the public institution. See Paragraph (4)(c)(iii) of 510-05-25-25, "Decision and Notice," for further information.

Institutions 510-05-35-95-05

General Statement (Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions) 510-05-35-95-05-05

(Revised 1/1/2025 ML #3916)

View Archives

An individual's Medicaid coverage is suspended when he or she is incarcerated and is an inmate with the Department of Corrections and Rehabilitation (DOCR) or a county or tribal jail.

Definitions and Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions 510-05-35-95-05-10

(Revised 1/1/2025 ML #3916)

View Archives

For purposes of the Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions section:

1. Inpatient: A patient who has been admitted to a medical institution as an ‘inpatient’ on recommendation of a physician or dentist and:

    a. Receives room, board and professional services in the institution for a 24 hour period or longer, or
    b. Is expected by the institution to receive room, board and professional services in the institution for a 24 hour period or longer even though the patient dies, is discharged or is transferred to another facility and does not actually stay in the institution for 24 hours.

        NOTE: An inmate may be placed in a hospital under an ‘observation’ status, which is an ‘outpatient’ category. These inmates are not considered receiving inpatient medical care and Medicaid would remain in suspended status.

2. Medical Institution means an institution that:

    a. Is organized to provide medical care, including nursing and convalescent care;
    b. Has the necessary professional personnel, equipment, and facilities to manage the medical, nursing, and other health needs of patients on a continuing basis in accordance with accepted standards;
    c. Is authorized under State law to provide medical care; and
    d. Is staffed by professional personnel who are responsible to the institution for professional medical and nursing services. The services must include adequate and continual medical care and supervision by a physician; registered nurse or licensed practical nurse supervision and services and nurses' aid services, sufficient to meet nursing care needs; and a physician's guidance on the professional aspects of operating the institution.

3. Department of Corrections and Rehabilitation includes the ND State Penitentiary and Missouri River Correctional Center in Bismarck, Dakota Women's Correctional and Rehabilitation Center in New England, James River Correctional Center in Jamestown, and the North Dakota Youth Correctional Center in Mandan.

4. County Jail means a place of confinement for persons held in lawful custody under the jurisdiction of a local government. A listing of county jails in North Dakota can be found at: http://www.nd.gov/docr/county/jails.html

   Note: This does not include Tribal run jails.

Individuals Covered (Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions) 510-05-35-95-05-15

(Revised 1/1/2025 ML #3916)

View Archives

Inmates of a public institution for whom Medicaid eligibility is suspended are eligible for payment of their Medicaid-covered services received while an inpatient in one of the following Medical Institutions for a 24-hour period or longer:

- A hospital,
- A nursing facility (nursing home),
- A Psychiatric Residential Treatment Facility (PRTF),
- An Intermediate Care Facility for the Intellectually Disabled (ICF-ID),

The inmate must apply for and meet all other Medicaid factors of eligibility.

Individuals who are aged or disabled will have their eligibility determined based on Non-ACA Medicaid Policy defined in Manual Chapter 510-05.

> **Note #1**: Individuals who become incarcerated will have their Social Security and SSI benefits terminated by the Social Security Administration. However, these individuals continue to be considered disabled for Medicaid purposes.
>
> **Note #2:** Individuals who are under age 65, disabled, and do not have Medicare coverage, who fail the asset limits, can have their eligibility determined under ACA Medicaid.

Eligibility begins on the date the inmate is admitted as an inpatient in a medical institution and ends the day they are discharged from the medical institution. Any services received before the inmate is admitted into a medical institution, or after the inmate is discharged from the medical institution will not be covered by Medicaid.

Individuals who are:

- Aged or disabled will be assigned a COE of M073.

Regardless of the COE assigned individuals eligible under this provision:

- Will have their eligible inpatient care paid through the Traditional Medicaid Fee for Service benefit plan.
- Will receive notification of their Medicaid ID Number from ND Health Enterprise MMIS;
- Will not be issued a Medicaid ID Card;

Asset Considerations (Coverage for Inmates Receiving Inpatient Care in Certain Medical Institutions) 510-05-35-95-05-20

(Revised 1/1/18 ML #3508)

View Archives

The medically needy asset provisions defined in Service Chapter 510-05-70 apply to all aged, blind, and disabled applicants and recipients under this provision.

Income Considerations (Coverage for Inmates who are Inpatients in a Hospital Setting) 510-05-35-95-05-25

(Revised 1/1/18 ML #3508)

View Archives

Income calculations for those eligible under NON-ACA Medicaid are defined at 510-05-85.

Income Levels (Coverage for Inmates who are Inpatients in a Hospital Setting) 510-05-35-95-05-30

(Revised 1/1/18 ML #3508)

View Archives

Income levels for those eligible under ACA Medicaid are defined at 510-05- 85-40.

Budgeting (Coverage for Inmates who are Inpatients in a Hospital Setting) 510-05-35-95-05-35

(Revised 1/1/18 ML #3508)

View Archives

Budgeting provisions for those eligible under ACA Medicaid are defined at 510-03-90.

Refer to Section 510-05-110, Policy Processing Appendix for information on how to process eligibility for these individuals.

Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities 510-05-35-95-10

(Revised 1/1/2025 ML #3916)

View Archives

Inmates residing in state or local corrections-related supervised community residential facilities (whether operated by a governmental entity or a private entity) are eligible for Medicaid unless the inmate does not have the freedom of movement and association while residing at the facility. To meet this requirement, the facility must operate in such a way as to ensure that individuals living there have freedom of movement and association, and the inmate:

1. MUST be able to work outside the facility in employment available to individuals who are not under justice system supervision;
2. MUST be able to use community resources (libraries, grocery stores, recreation, education, etc.) “at will”; and
3. MUST be able to seek health care treatment in the broader community to the same or similar extent as other Medicaid enrollees in the state.

   For this purpose, “at will” includes and is consistent with requirements related to operational “house rules” where, for example the residence may be closed or locked during certain hours or where inmates are required to report during certain times and sign in and out. Similarly, an inmates supervisory requirements may restrict traveling to or frequenting certain locations that may be associated with high criminal activity.

Examples of (not limited to) corrections-related supervised community residential facilities that house inmates include:

- Bismarck Transition Center Transitional Housing and Work Release Program
- Centre Inc. in Mandan
- Centre Inc. in Fargo
- Centre Inc. in Grand Forks
- Lake Region Residential Reentry Center

Note: These facilities also house individuals who are on parole and probation. Individuals on probation or parole are not considered inmates.

Federal inmates residing in supervised community residential facilities are not eligible for Medicaid coverage under this provision as the Department of Justice (DOJ) and/or Bureau of Prisons (BOP) retains responsibility for payment of health care services rendered to individuals in supervised community residential facilities.

If an inmate was incarcerated by another state and was sent to North Dakota for any reason, including the other state not having capacity to house the individual, the other state remains the state of residence. The inmate would retain residency for purposes of Medicaid eligibility in the other state and eligibility in North Dakota would be denied for ‘Not a Resident’.

Likewise, if an inmate was incarcerated by North Dakota and was sent to another State for any reason, including North Dakota not having capacity to house the individual, North Dakota remains the state of residence. The inmate would retain residency for purposes of Medicaid eligibility in North Dakota. When determining the Medicaid Unit for this individual under ACA, the Medicaid Unit of the individual is determined based on their tax filing status. While the individual is considered NOT residing in the home, this may result in a spouse or child(ren) needing to be included in the ACA case.

Many of these individuals are allowed to work in the community. This income must be considered when determining eligibility.

Processing for these individuals can be found in the Processing Appendix at 510-05-110

Institutions for Mental Diseases (IMD) 510-05-35-97

(Revised 10/1/2025 Release 25.16)

View Archives

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. An institution is classified as an IMD if its main purpose is for the care and treatment of mental diseases. An intermediate care facility for individuals with intellectual disabilities (ICF-IID) is not classified as an IMD.

Current listing of IMDs in North Dakota.

Admission at an Institution for Mental Disease (IMD) does not make an individual ineligible for Medicaid. However, Medicaid will not pay for covered services for individuals under age 65 who reside at an IMD unless the individual:

- Is 21 and under AND
- Has a certificate of need AND
- Receives inpatient psychiatric services.

For those who do not meet the criteria for Medicaid to pay for covered services, their Medicaid coverage will be suspended while they are residing at the IMD.

In Medicaid policy, “residing” in an Institution for Mental Disease means that a person is admitted and staying overnight at the facility and is receiving inpatient or residential treatment. Individuals who are present at the IMD only for outpatient services or day treatment are not considered to be residing in the facility. Suspension of Medicaid would not occur if the individual were receiving outpatient or day services at the IMD.

> **Note**: An individual who attains age 21 while receiving treatment, and who continues to receive treatment as an inpatient, may continue to receive Medicaid covered services through the month the individual attains the age of 22.

Note: Individuals eligible under the PACE program will remain eligible for Medicaid covered services regardless of their age while a patient in an IMD.

a. An individual on conditional release or convalescent leave from an IMD is not considered to be a patient residing 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 residing in the institution until unconditionally released or, if earlier, the last day of the month in which the individual reaches age 22.
b. 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.

The period of Medicaid suspension under this section begins the day after the day of entry and ends the day before the day of discharge of the individual from an IMD. A Ten-Day Advance Notice is not needed when terminating benefits due to entry into the IMD. See Paragraph (4)(c)(iii) of 510-03-25-25, "Decision and Notice," for further information.

Blindness and Disability 510-05-35-100

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-14)

1. The definition of blindness in the Social Security Act, Section 1614, for Title II benefits as set forth below, is the definition used in the SSI Program under Title XVI and will be utilized in determining eligibility for applicants for Medicaid who are basing their eligibility on blindness.

   An individual shall be considered to be blind for purpose of this title, if he has central visual acuity of 20/200 or less in the better eye with the use of a correcting lens. An eye which is accompanied by a limitation in the fields of vision such that the widest diameter of the visual field subtends an angle no greater than 20 degrees shall be considered as having central vision acuity of 20/200 or less.

2. The definition of disability in the Social Security Act, Section 1614, for Title II benefits as set forth below, is the definition used in the SSI Program under Title XVI and will be utilized in determining eligibility for applicants for Medicaid who are basing their eligibility on a disability.

   An individual shall be considered to be disabled for purposes of this title if he is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months (or, in the case of a child under the age of 18, if he suffers from any medically determinable physical or mental impairment of comparable severity).

3. SSA and SSI final determinations of blindness and disability are binding (42 CFR 435.541) and serve as evidence of the presence or absence of statutory blindness or of disability. An exception to this provision is if the individual has applied for Workers with Disabilities coverage and Social Security's decision established that the individual is not disabled due to substantial gainful activity. In these situations, the State Review Team may make an independent decision.

Presumptive determinations of blindness and disability are not final determinations for Medicaid purposes. Eligibility for Medicaid cannot be determined until a final determination is made. If a final determination will not be made by the Social Security Administration within 90 days after the date of application for Medicaid, the State Review Team will make a determination.

In Title II benefit approvals, the evidence from the Social Security Administration contains the onset of disability for benefits. The onset of disability month for Title II benefits would be the earliest medical approval month provided all other eligibility factors are met.

In SSI approvals, disability determinations are not made prior to the month of SSI application. If the medical request date is prior to the eligibility month for SSI, medical and social information must be submitted to the State Review Team for a disability determination for the period prior to the SSI approval month.

4. The county agency will need to obtain and submit medical and social information to the State Review Team for their evaluation if:

    a. The applicant is requesting assistance for a month prior to the SSI application and Title II (SSA) has not made a disability determination;
    b. The applicant is not eligible for SSI because of the SSI income and resource levels; or, if a Medicaid recipient and the individual has had a non-pay SSI reason of "N01" or "N04" for one year;

        Note: If the individual is "N01" AND is 1619(b) eligible, the individual is still disabled and no evaluation by the State Review team is required.

    c. The applicant refuses to apply for SSI;
    d. The applicant is not eligible for SSA disability due to not being insured;
    e. The applicant is applying for Workers with Disabilities coverage and is not eligible for SSA disability due to substantial gainful activity;
    f. The applicant has applied for SSA disability and a determination is not made within 45 days of the Medicaid application;
    g. The applicant is within six months of reaching full retirement age;
    h. The applicant is requesting assistance under the Children with Disabilities coverage and has not been determined disabled by SSA; or
    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.

The medical and social information is generally submitted along with SFN 451, "Eligibility Report on Disability/Incapacity" (05-100-40), and if the individual is applying for Workers with Disabilities coverage, SFN 228, "Workers with Disability Report Part II" (05-100-41).

An individual refusing to apply for SSI should be informed of potential eligibility for SSI and that receipt of SSI may yield a larger amount of total income for the family.

The State Review Team shall decline to determine blindness or disability for a period of time that such a determination is made for SSI (Title XVI) or Title II disability benefits by the Social Security Administration, except that the State Review Team shall make a decision in those situations in which the individual has applied for Workers with Disabilities coverage and Social Security's decision established that the individual is not disabled due to substantial gainful activity.

The State Review Team will use the following in determining blindness or disability:

1. DETERMINATION OF BLINDNESS: In any instance in which a determination is to be made whether an individual is blind, the individual shall be examined by a physician skilled in the diseases of the eye, or by an optometrist, whichever the individual may select. The State Review Team shall review and compare that report with the state's definition of blindness and determine:

   (1) Whether the individual meets the definition of blindness; and

   (2) Whether and when reexaminations are necessary for periodic reviews of eligibility.

   Redeterminations of blindness are established at the recommendation of the State Review Team, or at such time that activity or behavior on the part of a blind recipient raises doubts about his visual status. The same procedure is utilized in reviews of blindness as in the original determination.

2. DETERMINATION OF DISABILITY: In any instance in which a determination is to be made as to whether any individual is disabled, each medical report form and social history will be reviewed by a review team consisting of technically competent persons, not less than a physician and an individual qualified by professional training and pertinent experience, acting cooperatively, who shall determine if the applicant meets the appropriate definitions of disability.

5. The state agency may not make an independent determination of disability if the Social Security Administration has made a disability determination or will make a disability determination within ninety days after the date of application for Medicaid.

   - When a Medicaid application, based on disability, is pending for 45 days, the SFN 451 or the SFN 228 must be sent to the State Review Team. The State Review Team will request the medical information from the applicant. A copy of the request will be sent to the county agency. A decision regarding disability will then be made within the 90 day time period if DDS has not made a decision. However, once the Social Security Disability Determination Services Unit (DDS) eventually makes a disability determination, Medicaid must follow that decision.

6. Any medical bills incurred by an applicant upon request of the State Review Team to obtain medical information to determine eligibility will be paid through Medicaid. If the applicant is determined to be ineligible for Medicaid, the medical bills, which are sent to the State Review Team, will be paid through administrative costs.

7. If an applicant or recipient of SSA/SSI disability is determined by the Social Security Administration to not be disabled or no longer continues to meet the disability criteria, the county agency must then deny or send a ten-day advance notice to close the Medicaid case.

   Occasionally, individuals attending school or receiving vocational rehabilitation services will continue to receive a Social Security benefit though they no longer meet the disability criteria. These individuals are not considered disabled and therefore are not eligible for Medicaid.

8. All SSI or SSA denials or terminations based on disability which are reversed on appeal will automatically reverse the Medicaid disability based denial or termination if the person notifies the county agency within six months of the date of the notice informing the person that they won the SSI or SSA appeal.

Child Support Enforcement 510-05-40

Paternity 510-05-40-05

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-09)

1. As a condition of eligibility aged and disabled parents or caretakers must cooperate with the Department and county agency in establishing paternity of any child under age eighteen in the Medicaid unit. An exception to this provision exists when the child is a subsidized adoption child or the aged or disabled parent or caretaker is pregnant, within a continuous eligibility period for Medicaid. It is never a condition of a child's eligibility that the parent or caretaker cooperates.

2. A child for whom "paternity has not been established" means a child who was born out of wedlock and for whom paternity has not been legally established. A child is not considered to be born out-of-wedlock if the child is born within three hundred (300) days after the marriage is terminated by death, annulment, declaration of invalidity, or divorce, or after a decree of separation is entered by a court. Paternity is not considered to be legally established unless adjudicated by a court of law, or the parents completed the process using the "North Dakota Acknowledgment of Paternity" form, SFN 8195, with a revision date of 4/98 or later.

3. An automated referral will be made to Child Support when paternity has not been legally established and a caretaker who is not excluded in subsection 1 is seeking eligibility, or when a child is eligible for foster care.

Medical Support 510-05-40-10

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-09)

1. An assignment of rights to medical support from any absent parent of a child who is under age eighteen and who is deprived of parental support or care is automatic under North Dakota state law. (Refer to Section 05-35-10 for the description of deprivation.)

2. The assignment of rights to medical support from absent parents continues through the month in which the child reaches the age of eighteen or until the child's eligibility for assistance ends, whichever occurs first.

3. An automated referral will be made to Child Support to pursue Medical Support for all children whose deprivation is based on the absence of a parent, except that no referral is made:

    a. For any Subsidized Adoption child;
    b. In any case in which the only eligible individuals are children;
    c. In any case in which the only eligible caretaker is pregnant; or

Cooperation - Child Support
510-05-40-15

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-09)

1. Cooperation with Child Support is required for all legally responsible aged or disabled caretaker relatives for the purpose of establishing paternity and securing medical support. This requirement may be waived for "good cause" as described in 510-40-20.

   The determination of whether a legally responsible caretaker relative is cooperating is made by the Child Support Agency. The caretaker has the right to appeal that decision.

   Legally responsible aged or disabled caretaker relatives who do not cooperate with Child Support will not be eligible for Medicaid. Children in the Medicaid unit, however, remain eligible.

   When a legally responsible aged or disabled caretaker relative is not eligible because of non-cooperation, the earned and unearned income of that ineligible caretaker must be considered in determining eligibility for the child(ren).

   If a previously non-cooperating legally responsible caretaker relative begins cooperating in an open Medicaid case, and the caretaker is otherwise eligible that caretaker's eligibility may be reestablished. The caretaker must demonstrate that they are cooperating with Child Support before Medicaid coverage can be reestablished. When the caretaker previously stopped cooperating, the automated referral to Child Support ended.

   a. If the child Support Enforcement case also closed, the aged or disabled caretaker must apply for Child Support services and fulfill the cooperation requirements as determined by the Child Support program (parents or other legal custodians/guardians can apply online at www.childsupportnd.com or mail a completed application to a Child Support office. Applications can be printed from the web or requested directly from a Child Support office).
   b. If the Child Support Enforcement case did not also close, the caretaker may begin to cooperate with Child Support without application and

confirmation of such can be secured by contacting the Child Support worker.

When child Support has confirmed that the aged or disabled caretaker is cooperating, Medicaid coverage for that caretaker can be reestablished beginning with the first day of the month in which the caretaker began cooperating.

(Confirmation of cooperation must be secured by communicating with the Child Support worker; confirmation of cooperating may not be determined based on the Cooperation indicator on the Fully Automated Child Support Enforcement System (FACSES).) Child Support has 20 days to process an application for services. However, typically, applications are processed more quickly than 20 days, and Child Support can be contacted as soon as an open case can be viewed in FACSES.

If a previously non-cooperating legally responsible aged or disabled caretaker relative reapplies for Medicaid after the Medicaid case closed, the caretaker relative is eligible for Medicaid until it is again determined that the caretaker relative is not cooperating.

"Good Cause" - Child Support 510-05-40-20

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. 75-02-02.1-09)

The requirement to cooperate may be waived when a legally responsible caretaker relative has "good cause" not to cooperate.

1. All legally responsible aged or disabled caretaker relatives must be given the opportunity to claim "good cause". Applicants are notified of their rights to claim good cause in the SFN 405, Application for Assistance, DN 405, the Application for Assistance Guidebook, and the SFN 502, Application for Health Care Coverage for Children, Families and Pregnant Women. Applicants can indicate their request to claim good cause in either application. Recipients who become subject to the cooperation requirements may be notified by providing each legally responsible aged or disabled caretaker with SFN 443, "Notice of Right to Claim 'Good Cause'" (05-100-45). The notice briefly summarizes the legislative intent of child support enforcement, defines the caretaker's responsibility to cooperate in the support enforcement effort, and advises them of their right to claim "good cause". The notice also describes circumstances under which cooperation may be "against the best interests" of the child or caretaker and cites the kinds of evidence needed to substantiate a claim.

   A legally responsible aged or disabled caretaker wishing to claim "good cause" may do so by completing SFN 446, "Request to Claim 'Good Cause'" (05-100-50).

   If "good cause" is claimed, the aged or disabled caretaker relative can be eligible for Medicaid while the decision is pending.

2. The determination of whether there is "good cause" is made by the county agency. The county agency may waive the requirement to cooperate if it determines that cooperation is against the best interests of the child. A county agency may determine that cooperation is against the best interests of the child only if:

a. The aged or disabled applicant's or recipient's cooperation in establishing paternity or securing medical support is reasonably anticipated to result in:

(1) Physical harm to the child for whom support is to be sought;

(2) Emotional harm to the child for whom support is to be sought;

(3) Physical harm to the parent or caretaker relative with whom the child is living which reduces such person's capacity to care for the child adequately; or

(4) Emotional harm to the parent or caretaker relative with whom the child is living, of such nature or degree that it reduces such person's capacity to care for the child adequately; or

b. At least one of the following circumstances exists, and the county agency believes that because of the existence of that circumstance, in the particular case, proceeding to establish paternity or secure medical support would be detrimental to the child for whom support would be sought.

(1) The child for whom support is sought was conceived as a result of incest or forcible rape;

(2) Legal proceedings for the adoption of the child are pending before a court of competent jurisdiction; or

(3) The aged or disabled applicant or recipient is currently being assisted by a public or licensed private social agency to resolve the issue of whether to keep or relinquish the child for adoption, and the discussions have not gone on for more than three months.

3. There must be evidence to substantiate a claim of "good cause." Exemptions on the basis of physical or emotional harm, either to the child or to the aged or disabled caretaker relative must be of a genuine and serious nature. Mere belief that cooperation might result in harm is not a sufficient basis for finding "good cause." Evidence upon which the county agency bases its finding must be supported by written statements and contained in the case record.

It is the aged or disabled caretaker relative's responsibility to provide the county agency with the evidence needed to establish "good cause." The caretaker is normally given twenty days from the date of claim to collect the evidence. In exceptional cases, the county agency may grant reasonable additional time to allow for difficulty in obtaining proof. Records of law enforcement, social

service, or adoption agencies may be readily available to document instances of rape, physical harm, or pending adoption, perhaps without requiring further investigation. Documentation of anticipated emotional harm to the child or caretaker, however, may be somewhat more elusive. Whenever the claim is based in whole or in part on anticipated emotional harm, the county agency must consider the following:

a. The present emotional state of the individual subject to emotional harm;
b. The emotional health history of the individual subject to emotional harm;
c. The intensity and probable duration of the emotional impairment;
d. The degree of cooperation to be required; and
e. The extent of involvement of the child in establishing paternity or health insurance coverage.

4. Upon request, the county agency is required to assist the aged or disabled caretaker in obtaining evidence necessary to support a "good cause" claim. This, however, is not intended to place an unreasonable burden on staff, shift the caretaker's basic responsibility to produce evidence to support the claim, or to delay a final determination. The county agency must promptly notify the caretaker if additional evidence is necessary and actively assist in obtaining evidence when the individual is not reasonably able to obtain it.

5. The county agency is directly responsible for investigating a "good cause" claim when it believes that the aged or disabled caretaker's claim is authentic, even though confirming evidence may not be available. When the claim is based on a fear of serious physical harm and the claim is believed by county agency staff, investigation may be conducted without requiring corroborative evidence by the caretaker. It may involve a careful review of the case record, evaluation of the credibility of the caretaker's statements, or a confidential interview with an observer who has good reasons for not giving a written statement. Based on such an investigation, and on professional judgment, the county agency may find that "good cause" exists without the availability of absolute corroborative evidence.

   While conducting an investigation of a "good cause" claim, care must be taken to ensure that the location of the child is not revealed.

   Except for extenuating circumstances, the "good cause" issue must be determined with the same degree of promptness as for the determination of other factors of eligibility (45 days). The county agency may not deny, delay, or

discontinue assistance pending the resolution of the "good cause" claim. In the process of making a final determination, the county agency is required to give Child Support Enforcement staff the opportunity to review and comment on the findings and basis for the proposed decision. It is emphasized, however, that responsibility for the final determination rests with the county agency.

6. The claimant and the child support agency must be informed of the "good cause" decision.

    a. Claimants – The aged or disabled caretaker must be informed, in writing, of the county agency's final decision that "good cause' does or does not exist and the basis for the findings. A copy of this communication must be maintained in the case record. If "good cause" was determined not to exist, the communication must remind the caretaker of the obligation to cooperate with child support if he or she wishes to be eligible for Medicaid, of the right to appeal the decision, and of the right to withdraw the application or have the case closed. In the event the caretaker relative does appeal, Child Support must be advised to delay its activity until the results of the appeal are known.
    b. Child Support Enforcement – The automated referral process notifies Child Support of the status of all "good cause" claims by:

        (1) Informing them of all aged or disabled caretaker relatives who claim "good cause" exemptions which suspend child support activity pending a determination;

        (2) Informing them of all cases in which it has been determined that there is "good cause" for refusal to cooperate. Once the exemption is established, no child support activity may be pursued unless at a future time it is determined that "good cause" no longer exists; and

        (3) Informing them of all cases in which it has been determined that "good cause" for refusing to cooperate does not exists and that child support enforcement activity can begin or resume.

7. The county agency must review the "good cause" decision at least every twelve months. If "good cause" continues to exist, the aged or disabled caretaker must again be informed in writing. If circumstances have changed so "good cause" no longer exists, the caretaker must be informed, in writing, and given the opportunity to cooperate, terminate the caretaker's assistance, close the case, or appeal the decision. When "good cause" no longer exists Child Support will commence its child support activity.

Continuous Eligibility for Children 510-05-53

General Statement 510-05-53-05

(Revised 6/1/08 ML #3146)

View Archives

Continuous eligibility for children allows recipients under age 19 who have been determined eligible for Medicaid, other than Medically Needy, to be deemed eligible for a total of up to 12 months regardless of changes in circumstances other than attainment of age 19. This has an effective date of June 1, 2008.

Individuals Covered 510-05-53-10

(Revised 7/1/14 ML #3406)

View Archives

1. An individual may be continuously eligible for Medicaid if he or she:

    a. Is under age 19 (including the month the individual turns age 19); and
    b. Is not eligible as medically needy.

2. Individuals under age 19 include children-and caretaker relatives.

3. Individuals eligible for Refugee Medical Assistance (RMA) or Emergency Services are NOT entitled to continuous eligibility.

Continuous Eligibility Periods 510-05-53-15

(Revised 7/1/14 ML #3406)

View Archives

1. Continuous eligibility may be established from the first day of the application month, or if later, the first day that the individual becomes eligible for Medicaid under a coverage group other than medically needy. Continuous eligibility periods cannot be established when re-working a prior month

   Example 1: A child applies for Medicaid on June 8 and is determined to be categorically needy eligible. The child becomes continuously eligible effective June 1.

2. When retroactive eligibility is approved for an applicant, the continuous eligibility period does not begin during any of the retroactive months. An individual may be Medicaid eligible during the retroactive months; however, their eligibility is based on their actual circumstances during those months.

   Example: A family with a disabled child applies for Medicaid on October 9 and requests Medicaid for the three prior months. The application is processed and it is determined that the child is categorically eligible for October, and for the three prior months. The child becomes continuously eligible effective October 1 regardless of their coverage group status during the three prior months.

3. Except as identified in subsection 5, once an individual becomes continuously eligible, they remain eligible for Medicaid without regard to changes in circumstances, until they have been on Medicaid for 12 consecutive months. They do not have to have been continuously eligible for the entire 12 months.

4. When a review of eligibility is completed an eligible individual may be determined to be eligible for a new continuous eligibility period. Reviews must be completed at least annually, but may be scheduled earlier in order to align continuous eligibility periods within a case between children, or to align review dates with other programs.

a. If the individual's previous continuous eligibility period ended, the individual must meet all eligibility criteria to continue eligible for Medicaid.
b. If a review is being completed before the individual's continuous eligibility period has ended, and the individual meets all Medicaid eligibility criteria, the individual begins a new continuous eligibility period.
c. If a review is being completed before the individual's continuous eligibility period has ended, and the individual fails to meet all Medicaid eligibility criteria, the individual remains eligible only until the end of their current continuous eligibility period. A new review of eligibility is required at that time to establish any further eligibility.

5. A continuous eligibility period must be ended earlier than when the review is due for any of the following reasons:

   a. The recipient turns age 19;
   b. The recipient loses state residency;
   c. The recipient requests that their coverage end;
   d. The recipient dies;
   e. The agency has lost contact with the family and the child's whereabouts are unknown; or
   f. The recipient has failed to provide verification of citizenship or identity within their reasonable opportunity period.

   A continuous eligibility period must also be ended if it is determined that the recipient should not have become continuously eligible because the individual was approved in error; approval was based on fraudulent information; an appealed ending is upheld in favor of the agency.

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

(Revised 1/1/13 ML #3358)

View Archives

When an individual who is continuously eligible for Medicaid moves out of the Medicaid unit, that individual's eligibility continues.

1. When a continuously eligible child leaves the Medicaid unit and enters foster care, a new application is processed to determine the child's ongoing eligibility. If the child meets all eligibility criteria, the child begins a new continuous eligibility period. If the child does not meet the eligibility criteria, or would be eligible as medically needy, the child must be approved and remains continuously eligible only until the end of their current continuous eligibility period. A new review of eligibility is required at that time to establish any further eligibility.

2. When a continuously eligible individual enters a long term care facility, the individual is still considered part of the Medicaid unit; however, the post eligibility treatment of income (05-85-25) applies. Even though the individual is continuously eligible and remains eligible as other than medically needy, the individual's income must be considered toward the cost of care, and he or she may have a client share (recipient liability). Once the individual's continuous eligibility period ends, and a review is completed, the individual may become medically needy.

3. When a continuously eligible individual enters a specialized facility other than foster care, the individual is still considered part of the Medicaid unit. The individual remains eligible as other than medically needy. Once the individual's continuous eligibility period ends, and a review is completed, the individual may become medically needy.

4. When a continuously eligible individual elects to receive HCBS, the individual is still considered part of the Medicaid unit. The individual remains eligible as other

than medically needy. Once the individual's continuous eligibility period ends, and a review is completed, the individual may become medically needy.

5. When a continuously eligible individual is away at school or training; is living outside the home to secure medical treatment; or is a child living outside of the parental home and is not living independently, the individual is still considered part of the Medicaid unit.

6. A continuously eligible individual may move from one case to another case. If the individual, through an application or review, meets all eligibility criteria to be continuously eligible in the new case, the individual begins a new continuous eligibility period. If the individual does not meet the eligibility criteria, or would be eligible as medically needy, the individual must be approved and remains eligible only until the end of their current continuous eligibility period. A new review of eligibility is required at that time to establish any further eligibility in the new case.

7. When a continuously eligible individual moves out of a household on other than a temporary basis, and is not being added to another case, the individual remains eligible in the case, but is no longer considered part of the Medicaid unit. Accordingly, the individual's income will no longer affect other members of the Medicaid unit, nor can income be deemed from the Medicaid unit to the individual. Likewise, any caretaker relative remaining in the Medicaid unit can no longer remain eligible if their eligibility is based on being a caretaker relative for the child that left the household. If the caretaker relative remains eligible because of other children still in the case, or because the caretaker relative is eligible in their own right, the caretaker relative is no longer required to cooperate with Child Support for the child that left the household. Once the child's continuous eligibility period ends, the child's eligibility ends in the case.

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.

Foster Care and Related Groups 510-05-55

Foster Care 510-05-55-05

(Revised 6/1/21 ML #3623)

View Archives

For Medicaid purposes, a child is not considered to be in foster care unless the child is an Unaccompanied Refugee Minor (URM) in the custody of Agassiz Valley Human Service Zone Director OR for non-URM youth and all the following requirements are met:

1. There is a current foster care court order;
2. A public agency has care, custody, and control of the child;
3. The child is a foster care child in the state foster care system through the state's Children and Family Services unit, or a Tribal 638 Foster Care child.

Children who are placed on Trial Home Visits, including those who are placed on a Trial Home Visit during the month they attain age 18, will be considered 'in Foster Care'. Therefore, these children will meet the requirements to be eligible under the Former Foster Care Child group through the month they attain age 26, without requiring a budget test, if all other factors of eligibility are met.

Note: If a foster care child was on a trial home visit when the child attained age 18 prior to November 1, 2015, the child should now be considered to have been in ND foster care at that point in time for the purpose of determining current and future Medicaid eligibility for the former foster care eligibility group effective November 1, 2015.

A child who was previously found ineligible for coverage under the Former Foster Care group due to being placed on a Trial Home Visit may meet the requirement for eligibility beginning November 1, 2015. The child's eligibility cannot be changed prior to November 1, 2015, including any THMP months prior to November 1, 2015.

Children who were determined eligible based on the Foster Care eligibility criteria and who no longer meet one of the criteria listed above are no longer considered Foster Care children. Eligibility must be determined based on non-Foster Care criteria.

Children who are removed from the parental home and placed directly into a Psychiatric Residential Treatment facility (PRTF) and meet the three (3) criteria listed above are considered a foster care child.

Foster Care Financial Eligibility Requirements 510-05-55-10

(Revised 7/1/14 ML #3406)

View Archives

1. Children who are receiving a Title IV-E Foster Care Maintenance Payment (including Tribal IV-E payments) are categorically needy eligible for Medicaid and no further financial determination is needed. (Title IV-E foster care eligibility is determined using the Aid to Families with Dependent Children rules in effect on July 16, 1996.)
2. Medicaid eligibility for all regular foster care (non-Title IV-E, tribal or state-funded) children is determined using MAGI methodology.

Former Foster Care Children through Age 26 510-10-05-55-10-05

(Revised 1/11/2023 ML #3695)

View Archives

Individuals who were in foster care (Title IV-E, state-funded (non-IV-E) or tribal) and on Medicaid, in any state, in the month they turned age 18 must be covered through the month in which they turn age 26 with no budget test.

Volunteer Placement Program 510-05-55-15

(Revised 7/1/14 ML #3406)

View Archives

Children in the Volunteer Placement Program are not considered to be in foster care. The parents retain care, custody, and control of the child. When the child is eligible as a disabled individual the income of the child and parents is considered. The child could be placed in a facility that is not in-patient care including PATH and county foster families or facilities, i.e. Manchester House, Dakota Boys Ranch, Prairie learning Center, etc. For a child to qualify under this program, there must not be a delinquency, abuse and/or neglect issue.

> **Note:** If the child is not disabled, MAGI methodology is used in the Medicaid eligibility determination.

The child must be Medicaid eligible to cover medical expenses and the cost of treatment. The Volunteer Placement Program pays the room and board for the child to the county foster home or to the facility. The Administrators of the Volunteer Placement Program, and Mental Health and Substance Abuse must approve any placement in the Volunteer Placement Program.

Subsidized Guardianship Project 510-05-55-20

(Revised 7/1/14 ML #3406)

View Archives

The Subsidized Guardianship Project is designed to serve North Dakota children who are in foster care, but who need a permanency alternative. The program was created in response to the Adoption and Safe Families Act of 1997.

Children in the Subsidized Guardianship Project are no longer foster care children, and the subsidy is not a foster care payment. The guardianship subsidy is paid to help meet the maintenance needs of the child and is considered the child's income.

When the child is eligible as a disabled individual, the child's income is considered, and parental income is not used unless the guardianship court order specifies that the parents are responsible for the child's needs. The assets of the child and parents are also Considered.

> **NOTE:** If the child is not disabled, eligibility is determined under ACA Medicaid policy.

The guardian is not included as part of the case and the guardian's income and assets are not considered in determining the child's Medicaid eligibility. An exception is in cases in which the guardian is a relative, and the relative becomes eligible for Medicaid because of the child. In such cases, the relative chooses to be an eligible caretaker.

> **Note:** The Subsidized Guardianship Project is a North Dakota program. Occasionally, children come to North Dakota from states that have opted to cover children under a Title IV-E program called Kinship Guardianship program. This is not to be confused with either the Subsidized Guardianship Project or TANF's Kinship Program. Children who come from those states under the Title IV-E Kinship Guardianship program are categorically eligible. This is not to be confused with either the Subsidized Guardianship Project or TANF's Kinship Program. Children who come from those states under the Title IV-E Kinship Guardianship program are categorically eligible.

Subsidized Adoption 510-05-55-25

(Revised 7/1/09 ML #3183)

View Archives

Children eligible under the state or Tribal subsidized adoption programs are categorically needy (Title IV-E) or optional categorically needy (non-Title IV-E) eligible for Medicaid and no further financial determination is needed.

Workers with Disabilities 510-05-57

General Information (Workers with Disabilities) 510-05-57-05

(Revised 6/1/04 ML #2925)

View Archives

The Workers with Disabilities coverage allows certain individuals who want to work, or who are working but want to increase their earnings without fear of losing Medicaid coverage, to buy into Medicaid. This coverage became effective in North Dakota on June 1, 2004.

All medically needy technical and financial eligibility factors apply to the Workers with Disabilities coverage except as identified in sections 05-57-10 through 05-57-35.

Individuals Covered (Workers with Disabilities) 510-05-57-10

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-24.2)

1. An individual may be enrolled under the Workers with Disabilities coverage if he or she:

    a. Is gainfully employed;
    b. Is at least sixteen, but less than sixty-five, years of age;
    c. Is disabled;
    d. Is not in receipt of any other Medicaid benefits under Service Chapter 510-03 or 510-05, other than coverage as a QMB or SLMB; and
    e. Pays a one-time, per lifetime, enrollment fee of $100. Indians who are enrolled members of a Federally-recognized Indian tribe are exempt from this requirement.

2. An individual may be eligible under this coverage for the entire month in which the individual turns age sixteen. An individual may not be eligible under this coverage during the month the individual turns age sixty-five.

3. An SSI recipient, or an individual who is eligible as a 1619a or 1619b, is not eligible under this coverage if categorically eligible for Medicaid.

    An individual who loses their SSI or Title II benefits because of employment and receives a Ticket-to-Work from Social Security is considered disabled for Medicaid.

    The Social Security Administration may refuse to determine disability for a new applicant who is gainfully employed. In these situations, the State Review Team will make a medical determination of disability without regard to gainful employment. This disability determination is valid for all Medicaid coverages, however, these individuals will likely remain eligible for Medicaid under the Workers with Disabilities coverage. In the event that an individual stops working, or reduces their hours, and becomes eligible as medically needy, the

individual must be referred back to Social Security to apply for Title II benefits. Because of the decrease in employment, the individual may now be considered disabled by Social Security and may be entitled to a benefit. Per 05-35-90, applicants and recipients must apply for other benefits to which they are entitled.

4. Applicants or recipients who are eligible under this coverage, but who may also be eligible as medically needy, may choose which coverage they want, and will likely be based on which is more cost-effective for them. Once a recipient has been authorized as eligible for a current or past benefit month under one coverage, and the eligibility cannot be unauthorized, the recipient cannot switch coverages for that benefit month. A recipient can switch between coverages prospectively.

5. The $100 enrollment fee must be collected prior to authorizing coverage under this provision. If coverage is denied, the applicant is not responsible for the fee, and any fee collected for the application must be returned to the applicant. If coverage is initially approved for a future month, but coverage doesn't begin because the Medicaid case closes or coverage is changed to a different Medicaid coverage, the applicant is not responsible for the fee, and any fee collected must be returned to the applicant. Enrollment fees for eligible recipients must be submitted to the Department's Fiscal Administration unit using the Medicaid credit form, SFN 828.

   If an enrollment fee is paid by check, and the check is returned due to non-sufficient funds, the enrollment fee is considered unpaid, and eligibility for Workers with Disabilities coverage must end until the fee is paid.

Gainful Employment 510-05-57-15

(Revised 10/1/2025 Release 25.16)

View Archives

(N.D.A.C. 75-02-02.1-24.2)

An individual is considered gainfully employed if all the following conditions are met:

- The employed individual provides a service or product that would require employment and there is a clear employer-employee relationship.
- The individual is paid for their work and withholding taxes or FICA are withheld from their paycheck;
- If the individual is self-employed, they must provide a service or product that results in payment for the service or product; and
- The individual demonstrates the necessary skills to perform essential job functions, including physical or technical knowledge, or they have the ability to direct the activities of others.

Other considerations around gainful employment:

- Gainful employment can include self-employment
- Gainful employment cannot be measured by the number of hours worked or the amount of earnings but is based on the activity involved.
- The work activities of applicants and recipients who receive employment related Extended Services from licensed Extended Services providers meet gainful employment criteria.

Examples of Jobs that meet gainful employment conditions:

- An individual is trained and employed as an electronics technician but does not have the manual dexterity to complete testing and repair procedures due to physical disability. The technician directs an assistant on the testing and repair procedures using the technician’s knowledge of procedures and specifications necessary for production and job completion. The technician is considered gainfully employed as the individual has the skills and knowledge to supervise or direct the activity of others who perform the physical labor.

- Individuals in receipt of Extended Services indicate the individual is not in an evaluative or experimental activity but is participating in supported employment on a long-term basis. Receipt of the Extended Services can be identified in the provider's Individual Service Plan for the applicant or recipient.

Jobs are not considered gainful employment when:

- The individual is not paid for the work they do.
- The employer creates a job for an individual to perform a work activity but there is normally no position required for that work activity. The job could be done by existing personnel, and the individual would not be replaced if they left the job.
- An individual is engaged in an activity sorting objects such as nuts and bolts but when the task is completed, they are dumped together and mixed up again. While there may be some therapeutic value involved for the individual, it does not produce a product that anyone would pay for and is not considered gainful employment even if the individual is paid.
- The employment setting is primarily an evaluative or experimental activity.

  Note: Vocational Rehabilitation, Developmental Disabilities programs and Special Education often use situational assessments in actual business settings to evaluate vocational potential or to provide the individual with experiences in various employment settings to assist in making career decisions. There may be actual work activity in the workplace but there is no commitment to hire, or one expected as an outcome.

When an individual who is considered gainfully employed stops working, and is no longer on the payroll, the individual is no longer considered gainfully employed.

- If an individual quits one job to begin another, the individual is considered gainfully employed if the individual will not be unemployed for more than one calendar month.
- If the individual quits their job and does not have another job, a desk review must be completed to determine if they are asset eligible for traditional Medicaid. If the client does not verify their assets or they are over the medically needy asset limit, the case must be closed. Advance notice rules must apply.

When a recipient of WWD is unable to work due to illness or injury, the individual will continue to be considered gainfully employed if the individual intends to and can return to work.

- A statement from the individual's physician or employer will be needed to indicate when the individual can reasonably be expected to return to work. The individual can remain open on WWD coverage for up to three months while on medical leave. However, if the individual has not returned after the third month, WWD must close, and asset eligibility must be determined for traditional Medicaid. Advance notice rules apply.

Asset Limits for Workers with Disabilities

510-05-57-19

(Revised 8/1/05 ML2981)

View Archives

The medically needy asset limits apply except that each Workers with Disabilities recipient in the Medicaid unit is allowed an additional $10,000 in assets.

Income Considerations for Workers with Disabilities 510-05-57-25

(Revised 6/1/04 ML #2925)

View Archives

(N.D.A.C. Section 75-02-02.1-24.2)

Income calculations must consider income in the manner provided for in the medically needy income considerations; ownership of income; unearned income; earned income; disregarded income; and income deductions; except:

1. Income disregards in 05-85-30 and income deductions in 05-85-35 are allowed regardless of the individuals living arrangement; and

2. The cost of any Workers with Disabilities enrollment fee or premium is not allowed as a deduction in the Workers with Disabilities budget calculation.

Income Levels for Workers with Disabilities 510-05-57-30

(Revised 6/1/04 ML #2925)

View Archives

(N.D.A.C. Section 75-02-02.1-24.2)

Refer to Section 05-85-40 for the Workers with Disabilities income levels.

Premiums for Workers with Disabilities 510-05-57-35

(Revised 5/1/2023 ML #3725)

View Archives

(N.D.A.C. Section 75-02-02.1-24.2)

1. Individuals eligible under the Workers with Disabilities coverage are required to pay a monthly premium amount equal to 5% of the individual's gross countable income. Premiums are computed on a monthly basis and are rounded to the nearest dollar. Indians who are enrolled members of a Federally-recognized Indian tribe are exempt from this requirement.

2. Prior to authorizing initial eligibility for any month(s) prior to the future benefit month, the individual must pay the premium due. Premium payments received by the county must be submitted to the department's Fiscal Administration unit using the Medicaid credit form, SFN 828. Premiums for future benefit months are due on the fifteenth day of the future month and do not need to be paid prior to authorization.

3. When re-budgeting an eligible month of Workers with Disabilities coverage, and the individual remains eligible, a previously established premium is not changed unless it can be changed prospectively with a ten-day advance notice, or if the original premium notice has not been mailed.

4. Monthly premium notifications will be sent informing eligible individuals of any premium amount(s) due.

   Any excess monies received by the Fiscal Administration unit will not be immediately refunded, but will be held as credit, and will be applied to future premiums due. When an individual becomes ineligible for Workers with Disabilities coverage for a period of more than 30 days, Fiscal Administration will return any credit balance to the individual in the form of a refund.

If a premium payment by check is returned due to non-sufficient funds, the premium will be considered unpaid.

5. Any individual who fails to pay the premium established under this section for three consecutive months shall be disenrolled and may not be reenrolled thereafter without first reestablishing eligibility under this section and paying all outstanding enrollment fees and premiums. Any month in which no premium is due shall not be counted as a month in which the individual failed to pay a premium.

   An individual who is under age 19 and is continuously eligible for Medicaid who fails to pay the premium for 3 consecutive months cannot be disenrolled prior to the end of their continuous eligibility period. They may not be re-enrolled thereafter without first reestablishing eligibility under this section and paying all outstanding enrollment fees and premiums.

   Payments received by the Department from an individual claiming eligibility under this section shall be credited first to unpaid enrollment fees and then to the oldest unpaid premium. The Department shall credit payments on the day received, provided that credit for any payment made by an instrument that is not honored shall be reversed. The Department may require any individual who has attempted payment by a dishonored instrument to make subsequent payments in a specified manner.

Children with Disabilities 510-05-58

General Information 510-05-58-05

(Revised 4/1/12 ML #3321)

View Archives

The Children with Disabilities coverage allows options to families of children with disabilities under age 19, who are not eligible for Medicaid or who are eligible for Medicaid and have a client share (recipient liability), to buy into Medicaid. This coverage became effective in North Dakota on April 1, 2008.

All medically needy technical and financial eligibility factors apply to the Children with Disabilities coverage except as identified in sections 05-58-10 through 05-58-35.

Individuals Covered (Children with Disabilities) 510-05-58-10

(Revised 7/1/14 ML #3206)

View Archives

1. An individual may be enrolled under the Children with Disabilities coverage if he or she:

    a. Is under age 19 (including month individual turns age 19);
    b. Is disabled; and
    c. Except for Qualified Medicare Beneficiary or Special Low-income Medicare Beneficiary coverage, is not in receipt of any other Medicaid benefits under Service Chapter 510-03 or 510-05.

2. The Social Security Administration may refuse to determine disability for a new applicant when the family has excess assets or income. In these situations, the State Review Team will make a medical determination of disability. This disability determination is valid for all Medicaid coverages; however, these individuals will likely remain eligible for Medicaid under the Children with Disabilities coverage.

3. Applicants or recipients who are eligible under this coverage, but who may also be eligible as medically needy, may choose which coverage they want, and will likely be based on which is more cost-effective for them. Once a recipient has been authorized as eligible for a current or past benefit month under one coverage, and the eligibility cannot be unauthorized, the recipient cannot switch coverages for that benefit month. A recipient can switch between coverages prospectively.

4. A SSI recipient, or an individual who is eligible as a 1619a or 1619b, is not eligible under this coverage if categorically eligible for Medicaid.

Employer Based Insurance 510-05-58-15

(Revised 3/1/08 ML #3127)

View Archives

As a condition of eligibility for Children with Disabilities coverage, a child must be enrolled in a health insurance policy if:

1. The family has an employer based health insurance available to them; and

2. The employer pays at least 50% of the premium (excluding separate dental and vision coverage).

Income and Asset Considerations for Children with Disabilities 510-05-58-20

(Revised 6/1/2024 ML #3839)

View Archives

Income calculations must consider income in the manner provided for in the Medically Needy income considerations; ownership of income; unearned income; earned income; disregarded income; and income deductions; except:

1. Income disregards in 05-85-30 and income deductions in 05-85-35 are allowed regardless of the individuals living arrangement; and

2. The cost of any Children with Disabilities premium is not allowed as a deduction in the Children with Disabilities budget calculation.

There is no asset test for applicants and recipients who are applying for, or are eligible under the Children with Disabilities coverage.

Income Levels for Children with Disabilities 510-05-58-25

(Revised 3/1/08 ML #3127)

View Archives

Refer to Section 05-85-40 for the Children with Disabilities income levels.

Premium Calculation for Children with Disabilities 510-05-58-30

(Revised 5/1/2023 ML 3725)

View Archives

1. Individuals eligible under the Children with Disabilities coverage are required to pay a monthly premium amount equal to 5% of the family's gross countable income. Premiums are computed on a monthly basis and are rounded to the nearest dollar. Indians who are enrolled members of a Federally-recognized Indian tribe are exempt from this requirement.

   Note: When there is more than one child in the Medicaid Unit covered under Children with Disabilities, the total premiums cannot exceed 5% of the family's gross countable income.

   Premiums are computed on a monthly basis and are rounded to the nearest dollar. Indians who are enrolled members of a Federally-recognized Indian tribe are exempt from this requirement.

2. The Children with Disabilities premium is offset by any premium amount the family pays toward a family health insurance policy in which the disabled child is covered.

3. Prior to authorizing initial eligibility for any month(s) prior to the future benefit month, the individual is required to pay any premiums due for those benefit months. Premium payments received by the county must be submitted to the department's Fiscal Administration unit using the Medicaid credit form, SFN 828. Premiums for future benefit months are due on the fifteenth day of the future month.

4. When re-budgeting an eligible month of Children with Disabilities coverage, and the individual remains eligible, a previously established premium is not changed unless it can be changed prospectively with a ten-day advance notice, or if the original premium notice has not been mailed.

5. Monthly premium notifications will be sent informing eligible individuals of any premium amount(s) due. The notice will include a self-addressed envelope for

the individual to send the premium payment directly to the Fiscal Administration unit.

Any excess monies received by the Fiscal Administration unit will not be immediately refunded, but will be held as credit, and will be applied to future premiums due. When an individual becomes ineligible for Children with Disabilities coverage for a period of more than 30 days, Fiscal Administration will return any credit balance to the individual in the form of a refund.

If a premium payment by check is returned due to non-sufficient funds, the premium will be considered unpaid.

6. Any individual who fails to pay the premium established under this section for three consecutive months shall be disenrolled and may not be re-enrolled thereafter without first reestablishing eligibility under this section and paying all outstanding premiums. Any month in which no premium is due shall not be counted as a month in which the individual failed to pay a premium.

   An individual who is under age 19 and is continuously eligible for Medicaid who fails to pay the premium for 3 consecutive months cannot be disenrolled prior to the end of their continuous eligibility period. They may not be reenrolled thereafter without first reestablishing eligibility under this section and paying all outstanding premiums.

   Payments received by the Department from an individual claiming eligibility under this section shall be credited to the oldest unpaid premium. The Department shall credit payments on the day received, provided that credit for any payment made by an instrument that is not honored shall be reversed. The Department may require any individual who has attempted payment by a dishonored instrument to make subsequent payments in a specified manner.

Medicare Premium Assistance Program 510-05-60

General Information (Medicare Premium Assistance Program) 510-05-60-05

(Revised 8/1/2023 ML #3745)

Individuals entitled to enroll in Medicare need to apply for Medicare through Social Security if they have not done so. The following are individuals who need to apply for Medicare with Social Security.

- Individuals turning 65
- Individuals who have been disabled for 24 months
- Individuals with End Stage Renal Disease (ESRD)
- Individuals with Lou Gehrig's Disease (ALS)

All individuals eligible for Medicare should be tested to determine if Medicaid can pay the Medicare Premium.

Note: Medicare is not an earned right benefit. A Medicaid application or coverage cannot be denied for failure to apply for Medicare.

If the individual has applied for Medicare and has either Medicare Part A, Conditional Medicare Part A or Medicare Part B, they do not need to go to Social Security to apply again.

- A Medicare coverage start date will need to be added as of the date North Dakota can pay the Medicare premium for Medicare Part A or Part B. See job aid for Medicare details screen.

There are two ways an individual can receive assistance with their Medicare premiums and Medicare costs.

1. Medicare Savings Program (MSP)

- Is the primary coverage for individuals with free Medicare Part A or premium Medicare Part A.
- MSP is available to assist with Medicare premiums and cost sharing for people with Limited income and assets

- The program includes coverage of Qualified Medicare Beneficiaries (QMB), Specified Low-income Medicare Beneficiaries (SLMB), Qualifying Individuals (QI), Qualified Disabled Working Individuals (QDWI) and Medicare Part B-ID.
- Individuals eligible for MSP should not have their coverage closed unless:
  - They are over income; or
  - They are over assets; or
  - They are QI and requesting Medicaid coverage; or
  - They become eligible for Medicaid and have coverage as Part B-ID. The Part B-ID coverage needs to be close.

Note: An individual cannot voluntarily terminate from the Premium Assistance Program

Note: Medicaid should not be automatically closed when an individual becomes eligible for QMB or SLMB. They may have services not covered under Medicare that can be paid by Medicaid.

2. The SSI Buy-in Program

- SSI income eligible individuals who are eligible for Medicare Part B only

Note: An individual cannot be covered under SSI Buy-in and Medicare Savings Programs for the same time period.

Individuals Covered and Benefits 510-05-60-10

(Revised 11/1/2025 Release 25.17)

(N.D.A.C. Sections 75-02-02.1-22(1) and 75-02-02.1-10)

SSI Buy-in

- This coverage is for individuals who have SSI income and Medicare Part B only.

Medicare Savings Program (MSP)

1. **Qualified Medicare Beneficiaries (QMB)**- Eligible individuals must have Medicare Part A and meet the following conditions:

- Are entitled to payment of Medicare Part B, and/or
- Payment of premium Part A for individuals who:
    1. Are over 65 eligible for SSI income (with no Medicare Part A); or
    2. Lose SSI income and are no longer eligible for SSI buy-in; or
    3. Have requested North Dakota Medicaid to pay the Medicare Part A premium; or
    4. Have Medicare Part A coverage because another state was paying the premium for Part A and the individual is now a resident of North Dakota; or
    5. Are over 65 not eligible for SSI buy-in (no SSI income), do not have free Medicare Part A or have any means to pay (no income or very low income) for Medicare Part A or Part B premiums.
        a. Will need to apply for "Conditional Medicare Part A" through Social Security if they have not already done so.
- Are entitled to Medicare cost sharing benefits beginning the month following the month the individual is determined eligible.
    - Example 1- Application received March 29th. Eligibility processed in the system on May 1st. Individual is determined eligible for the month of March with QMB coverage starting April 1st (the month after the month the individual is determined eligible).

- Example 2- Application received February 15th. Individual is requesting three prior months. The application is processed March 1st. The individual is eligible for QMB in February, with QMB coverage starting March 1st (the month after the month the individual is determined eligible). The individual is within the income level for QMB in the three prior months however, eligibility for QMB cannot be established for the three prior months.

- Individuals ongoing eligible for Medicaid, who become eligible for Medicare, QMB can start the month Medicare starts if the individual is eligible for QMB in the month prior to the month Medicare starts.

2. **Specified Low-Income Medicare Beneficiaries (SLMB)** - Eligible individuals must have Medicare Part A and meet the following conditions:

- Are entitled only to the payment of their Medicare Part B premium
- Eligibility may be established for as many as three calendar months prior to the month in which the application was received or the date SSA received the Low-income Subsidy application.
  - If the individual only has Medicare Part A, Part B can be added with a coverage start date of when ND can pay the Part B premium.

3. **Qualifying Individuals (QI)**- Eligible individuals must have Medicare Part A and meet the following conditions

- Are entitled to only payment of their Medicare Part B premium
- Eligibility may be established for as many as three calendar months prior to the month in which the application was received or the date that SSA received the Low-income Subsidy application.
- Cannot be in receipt of any other Medicaid coverages for the same time period
  - A QI individual can request coverage for the other Medicaid benefits, and eligibility can be established, only if the QI individual repays the Medicare premium(s) payment received for the month(s) the other Medicaid benefits are needed. Medicaid benefits can only be authorized after the Medicare premium(s) payment have been repaid.
  -

When a recipient needs to reply Medicare premiums, a check or money order can be made payable to the "Dept of Health & Human Services" and collected by the Zone. The Zone office must forward the check or money order to the Finance Division of the ND Dept of Health and Human Services with a completed Medicaid credit form, SFN 828. A copy of the form can be found at 05-100-05

Note: Each year the federal government allocates a set amount of funds that can be used to provide coverage for QI individuals. In the event the allocation for North Dakota is exhausted in any given year, current recipients remain eligible, but additional person(s) cannot be added.

4. **Qualified Disabled Working Individuals (QDWI)**- Eligible individuals must meet the following conditions:

- Are entitled to payment of Medicare Part A premium only.
- Individuals who are:
  - Under 65 years old,
  - Working,
  - Lost their premium-free Medicare Part A due to returning to work
  - Are receiving medical assistance and meet the income and resource limits.

Eligibility may be established for as many as three calendar months prior to the month in which the application was received.

Note: SPACES is not set up to accommodate this coverage in the system. Any inquiries for this coverage, send request to DHHS Medicaid Policy hccpolicy@nd.gov with QDWI in the subject line.

5. **Part B-ID**- Eligible individuals must meet the following conditions:

- Are entitled to coverage for Medicare Part B-ID premium only.
- Have been in receipt of Medicare coverage under Medicare End Stage Renal Disease (ESRD) entitlement which is ending 36 months after a successful transplant
- Cannot have any other coverage under Medicaid

Retroactive months do not apply to this coverage group.

Note: Social Security determines if an individual is eligible for Medicare Part B-ID

Note: SPACES is not set up to accommodate this coverage in the system. Any inquiries for this coverage, sent requests to DHHS Medicaid Policy unit at hccpolicy@nd.gov with Part B-ID in the subject line.

Asset Considerations for the Medicare Premium Assistance Savings Program 510-05-60-15

(Revised 12/1/19 ML #3569)

View Archives

(N.D.A.C. Section 75-02-02.1-22(4))

Medically needy asset considerations, valuation of assets, and forms of asset ownership apply to SSI Buy-In and Medicare Savings Programs. The Medicare Savings Programs eligibility determinations has three exceptions:

1. Half of a liquid asset held in common with another QMB, SLMB, or QI is presumed available;

2. Assets owned by a child, under age twenty-one, in the unit are not considered available in determining eligibility for the child's parent, except that all liquid assets held in common by the child and the parent are considered available to the parent; and

3. Assets owned by a parent or spouse who is not residing with an applicant or recipient for a part of a month are not considered available for that month unless the assets are liquid assets held in common. This provision does not apply to situations where either the parent, spouse, or child is away from the home for a full calendar month for the purposes of work or school.

Asset Limits for the Medicare Premium Assistance Program 510-05-60-20

(Revised 1/1/2025 ML 3891)

View Archives

(N.D.A.C. Section 75-02-02.1-26 and N.D.A.C. Section 75-02-02.1-22(5))

No person may be found eligible for the SSI Buy-In unless the total value of all non-excluded assets does not exceed the limit at Section 05-70-15.

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 2025, the limits are:

1. $9,660 for a one-person unit ($9,430 in 2024); or
2. $14,470 for a two-person unit ($14,130 in 2024).

Assets Which are Excluded for the Medicare Premium Assistance Program 510-05-60-25

(Revised 12/1/19 ML #3571)

View Archives

IM 5410

(N.D.A.C. Section 75-02-02.1-28.1)

Medically needy excluded assets are excluded for SSI Buy-In base on the policy section 05-70-30. Medically needy excluded assets are also excluded for the Medicare Savings Programs with the following exceptions:

1. Instead of the home, a residence occupied by the person, the person's spouse, or the person's dependent relative is excluded.

   The residence includes all contiguous lands, including mineral interests, upon which it is located. The residence may include a mobile home suitable for use, and being used, as a principle place of residence. The residence remains excluded during temporary absence of the individual from the residence, so long as the individual intends to return. Renting or leasing part of the residence to a third party does not affect this definition. Terms used in this subsection have the following meaning:

   a. "Relative" means a child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, first cousin, or in-law.
   b. "Dependent" means an individual who relies on another for financial, medical, and other forms of support, provided that an individual is financially dependent only when another individual may lawfully claim the financially dependent individual as a dependent for federal income tax purposes.

2. Before August 1, 2019 - The applicant or recipient may choose either the North Dakota Medicaid burial provision or the SSI burial provision. After August 1, 2019 - The applicant or recipient may choose either the North Dakota Medicaid irrevocable itemized burial contract provision or the SSI burial provision.

   The SSI burial provision provides for:

a. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded burial funds held for the individual and the individual's spouse are excluded from the date of application. Burial funds may consist of revocable burial accounts, revocable burial trusts, other revocable burial arrangements including the value of installment sales contracts for burial spaces, cash, financial accounts such as savings or checking accounts, or other financial instruments with definite cash value, such as stocks, bonds, the cash surrender value of life insurance not excluded under subsection 3a below, or certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or by the applicant or recipient's statement.

   The value of any irrevocable burial must be designated toward the burial fund exclusion.

   Life or burial insurance excluded under subsection 3a below, (total face value is $1,500 or less), must be considered at face value toward meeting the burial fund exclusion.

   Example 1: Mr. Smith has two life insurance policies each having a face value of $500. Because the total combined face value is less than $1500, the life insurance is excluded as an asset, but the $1000 in face value must be applied to the burial exclusion.

   Example 2: Mrs. Jones has two life insurance policies each having a face value of $1000. Because the total combined face value is more than $1500, the face value is ignored and the cash surrender value is considered as an asset which may be applied towards either the burial exclusion or the asset limit.

   Example 3: Mrs. Smith has two life insurance policies each having a face value of $500. Mrs. Smith also has a $1500 burial fund. Because the total face value of the two policies is less than $1500, the life insurance is excluded as an asset, but the $1000 in face value must be applied to the burial exclusion. Only $500 of the burial fund may be excluded, and the remaining $1000 would be counted towards the asset limit.

   Example 4: Mr. Jones has a life insurance policy with a face value of $1000 and an irrevocable burial with a face value of $1000. The face value of the irrevocable burial must be considered toward the $1500 burial provision leaving $500 that could still be excluded for the burial fund. The life insurance passes the $1500 face value test and is excluded as an asset, but since there is still $500 that

could be excluded for burial, the life insurance must be applied. No other assets can be excluded towards the burial fund.

b. A burial space or agreement which represents the purchase of a burial space, paid for in full, for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this paragraph:

   i. "Burial space" means a burial plot, gravesite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.
   ii. "Other member of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth, adoption, or marriage, except that a relationship established by marriage ends when the marriage ends.

3. The following additional assets are excluded:

   a. Life or burial insurance that generates a cash surrender value is excluded if the face value of all such life or burial insurance policies of that individual total one thousand five hundred dollars or less. This exclusion is not allowed for applicants or recipients who select the North Dakota Medicaid burial provision.
   b. Property essential to self-support is property that a member of the Medicaid unit owns, but which the Medicaid unit is not actively engaged in using to earn income. It is non-business property that may or may not produce unearned income.

      i. Up to six thousand dollars of the equity value of nonbusiness income producing property which produces annual net income at least equal to six percent of the excluded amount is excluded. Up to six thousand dollars of the combined equity of two or more properties may be excluded, however, each property must produce at least a six percent annual return to be excluded.

         The chart at 05-100-60 illustrates how the $6,000 equity/six percent annual return limits apply.

ii. Up to six thousand dollars of the equity value of nonbusiness property used to produce goods or services essential to daily activities is excluded. It is used to produce goods or services essential to daily activities, when, for instance, it is used to grow produce or livestock solely for consumption in the individual's household.

iii. To be excluded, property essential to self-support must be in current use or, if not in current use, the asset must have been in such use and there must be a reasonable expectation that the use will resume:

A. Within twelve months of the last use; or

B. If the nonuse is due to the disabling condition of a member of the Medicaid unit, within twenty-four months of the last use; or

C. With respect to property of the type described in (1) above, if the property produces less than a six percent return for reasons beyond the control of the applicant or recipient and there is a reasonable expectation that the property will again produce a six percent return, within twenty-four months of the tax year in which the return dropped below six percent.

D. Liquid assets are not property essential to self-support.

c. Lump sum payments of Title II or SSI benefits are excluded for nine consecutive months following the month of receipt.

d. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act. This asset must be identifiable and not commingled with other assets.

Income Considerations for the Medicare Premium Assistance Program 510-05-60-30

(Revised 12/1/19 ML #3569)

View Archives

(N.D.A.C. Section 75-02-02.1-22(7))

Income calculations must consider income in the manner provided for in the medically needy income considerations; unearned income; earned income; disregarded income; and income deductions; with the following exceptions for the Medicare Savings Program:

1. Married individuals living separate and apart from a spouse (for the full calendar month) are treated as single individuals;

2. The income disregards in 05-85-30 are allowed regardless of the individuals living arrangement;

3. The earned income of any blind or disabled student under age 22 is disregarded;

4. The $20 income deduction (described in 05-85-35(9) and the $65 plus one-half income deduction (described in 05-85-35(11)(e)) are allowed regardless of the individual's living arrangement; and

5. The following income deductions are not allowed:

    a. The cost of premiums for health insurance;
    b. Medical expenses for necessary medical or remedial care incurred by a member of a Medicaid unit;
    c. The cost of premiums for long term care insurance;
    d. Transportation expenses necessary to secure medical care;

e. The cost of remedial care for an individual residing in a specialized facility; or
f. The mandatory payroll deductions withheld from earned income for aged, blind, or disabled applicants or recipients.

Income Levels for the Medicare Premium Assistance Program 510-05-60-35

(Revised 12/1/19 ML #3569)

View Archives

Refer to Section 05-85-40 for the SSI Buy-In under the Categorically Needy income level and the Medicare Savings Programs income levels.

> **Note:** Annual Title II cost of living allowances effective in January shall be disregarded when determining eligibility for Medicare Savings Programs for January, February, and March. This disregard prevents applicants and recipients from becoming ineligible pending issuance of the new poverty levels which are effective April 1 of each year.

Eligibility Under Spousal Impoverishment 510-05-65

General Information 510-05-65-05

(Revised 1/02 ML #2762)

View Archives

Spousal Impoverishment provisions were enacted by Congress, through the Medicare Catastrophic Coverage Act of 1988, to protect married couples when one spouse requires extended care, in a medical institution, a nursing facility, or through home and community-based services, by ensuring that the spouse living in the community, who does not need Medicaid, has sufficient income and assets to live with independence and dignity. This provision became effective October 1, 1989.

All medically needy technical and financial eligibility policies apply to couples covered under the spousal impoverishment provisions except as identified in sections 05-65-10 through 05-65-40.

Definitions for Spousal Impoverishment 510-05-65-10

(Revised 3/1/20 ML #3575)

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(N.D.A.C. Section 75-02-02.1-24(1))

For purposes of the spousal impoverishment sections:

1. "Community spouse," means the spouse of an institutionalized spouse or the spouse of a Home and Community Based Services (HCBS) spouse who is:
    a. Not in receipt of Medicaid other than coverage under the Medicare Savings Programs; and
    b. Not requiring care in a medical institution, a nursing facility, a swing bed, or in the state hospital, unless the total length of the stay is anticipated to be less than a full calendar month.
2. "Family member" means only minor or dependent children, dependent parents, or dependent siblings of the institutionalized or HCBS or community spouse who are residing with the community spouse. For purposes of applying this definition, a family member is dependent only if that family member is, and may properly be, claimed as a dependent on the federal income tax return filed by the institutionalized, HCBS, or community spouse.
3. "Institutionalized spouse" means an individual who:
    a. Requires care in a medical institution, a nursing facility, a swing bed, or the state hospital and, at the beginning of his or her institutionalization, was likely to be in the facility for at least thirty consecutive days even if the individual does not actually remain in the facility for thirty consecutive days; and
    b. Is married to a spouse who resides in the community at least one day of the month.
4. "Home and Community Based Services (HCBS) Spouse" means an individual who:
    a. Requires care of the type provided in a nursing facility, but chooses to receive HCBS in the community; and

b. Is married to a spouse who resides in the community at least one day of the month.

5. "First continuous period" means the first period in which:

a. An institutionalized spouse requires care in, and enters a medical institution, a nursing facility, or a swing bed, or when a HCBS spouse begins receiving HCBS, and the institutionalized or HCBS spouse is expected to continue to receive that level of care for at least 30 consecutive days; or
b. The date on which a medical doctor, a physician's assistant, a nurse practitioner, or Dual Diagnosis Management has determined that a spouse requires nursing care services for at least 30 consecutive days and the community spouse or a private HCBS agency provides those services.

Institutionalized Spouse or Home and Community Based Services (HCBS) Spouse Asset Limit 510-05-65-15

(Revised 4/1/12 ML #3321)

View Archives

(N.D.A.C. Section 75-02-02.1-24(2))

1. An institutionalized or HCBS spouse is allowed the medically needy asset limit of three thousand dollars. The value of any assets owned jointly with the community spouse are considered in full.
2. An institutionalized or HCBS spouse is asset eligible if the total value of all countable assets owned by both spouses, is less than the total of the community spouse asset allowance and the institutionalized or HCBS spouse asset limit.
3. After eligibility has been established, the institutionalized or HCBS spouse must reduce his or her countable assets (solely or jointly owned) to be within the medically needy asset limit ($3,000) not later than the next regularly scheduled review.

   If the assets are not reduced to the asset limit by the next regularly scheduled review, the individual's case must be closed. Verification of the reduction in assets must be provided.

   When an eligible institutionalized or HCBS spouse exceeds the asset limit due to an increase in the value of, a change in the exclusion of, or the receipt of assets, a new period, until the next regularly scheduled review, may be allowed in order to transfer the excess assets to the community spouse. The amount of assets to which this new period applies is an amount equal to the difference between the current community spouse's asset allowance and the value of assets owned by the community spouse at the time eligibility was established, less the value of assets transferred to the community spouse.

   Example: The community spouse has an asset allowance of $70,000. At the time eligibility was established, the community spouse owned $30,000 and the institutionalized spouse transferred $25,000 to the community spouse by the first review. If the institutionalized spouse received new assets in excess of the $3,000 asset limit, the institutionalized spouse is allowed until the next regularly scheduled review to transfer up to $15,000 to the

community spouse ($70,000 less $30,000 owned by community spouse less $25,000 previously transferred to community spouse equals $15,000 that can still be transferred).

This new period is not allowed if:

a. The community spouse had assets equal to the community spouse asset allowance at the time the institutionalized or HCBS spouse became eligible; or
b. The community spouse has since received assets from the institutionalized or HCBS spouse up to the community spouse asset allowance.

The following examples illustrate:

Example 1: The community spouse had an asset allowance of $90,000. At the time of eligibility, the community spouse owned all $90,000 in countable assets. No new period is allowed to transfer additional assets to the community spouse.

Example 2: The community spouse had an asset allowance of $80,000. At the time of eligibility the community spouse owned $50,000 in countable assets. The institutionalized spouse has since transferred an additional $30,000 to the community spouse. The community spouse has received assets up to the community spouse asset allowance so no new period is allowed to transfer additional assets to the community spouse.

Example 3: The community spouse had an asset allowance of $25,000. At application, the couple has $12,000 in countable assets and they have until the next review to transfer at least $9,000 to the community spouse, which they do. Several months later, the institutionalized spouse inherits $12,000. Because the community spouse still may receive an additional $16,000 and the institutionalized spouse has only $12,000 over his $3,000 asset limit, the institutionalized spouse can have until the next review to transfer at least $12,000 to the community spouse. The transfer is made, bringing the community spouse's total countable/received assets up to $21,000. The institutionalized spouse inherits another $10,000. The community spouse has already received $21,000 of the $25,000 asset allowance. Because the amount that the institutionalized spouse's asset limit is exceeded is greater than the amount that would allow for another transfer period, no new transfer period is allowed. Unless the institutionalized spouse transfers the

excess amount to the community spouse in the month it was received, his case must be closed for excess assets.

4. During the continuous period in which the spouse is in an institution or receives HCBS and after the month in which the spouse is determined to be eligible for benefits under this chapter, no countable assets of the community spouse may be deemed available to the institutionalized or HCBS spouse. Assets owned by the community spouse are not considered available to the institutionalized or HCBS spouse during the continuous period; however, a disqualifying transfer of those assets (or of income) by the community spouse will affect the institutionalized or HCBS spouse's continued eligibility for coverage of nursing care services. See Section 05-80 for more information about the disqualifying transfer provision.
5. If a spousal impoverishment case closes, or otherwise ceases to include an institutionalized or HCBS spouse and a community spouse, spousal impoverishment provisions no longer apply. If the couple again pursues coverage under the spousal impoverishment provisions, they must meet the current asset limits within the appropriate time frames.

Community Spouse Asset Allowance 510-05-65-20

(Revised 1/1/2025 ML 3891)

View Archives

(N.D.A.C. Section 75-02-02.1-24(2)(3) and (7))

1. The community spouse asset allowance is computed considering the assets as of the first continuous period of institutionalization of the institutionalized spouse, or as of the beginning of the first continuous period of receipt of HCBS by a HCBS spouse.
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:
$31,584	$15,792
$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 $31,584 and not more than $157,920, effective January 2025 ($30,828 and $154,140 effective January 2024).

Example:

If the Spousal share is:	The community spouse asset allowance is:
$12,500	$31,584 (at least the minimum)

$45,000	$45,000
$180,000	$157,920 (one-half is more than the maximum allowed, so the community spouse gets the maximum)

The community spouse asset allowance and adjustments in the minimum and maximum amounts may be adjusted by:

a. any additional amount transferred under a court order; or

b. any additional amount established through a fair hearing.

3. After the institutionalized or HCBS spouse has been determined eligible, the community spouse is no longer subjected to the community spouse asset allowance. Assets of the community spouse are subject to the disqualifying transfer provisions and may not be given away or transferred for less than fair market value without causing ineligibility for the institutionalized spouse.

4. Should the Community Spouse require care in a medical institution, nursing facility, swing bed, or in the state hospital, the Spousal Impoverishment Provision no longer apply UNLESS the total length of the Community Spouses stay is anticipated to be less than a full calendar month.

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

(Revised 2/15/21 ML #3611)

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(N.D.A.C. Section 75-02-02.1-28.1)

The medically needy excluded assets are excluded with the following exceptions:

1. Instead of the home, a residence occupied by the community spouse or the person's dependent relative may be excluded. The residence may be owned by either spouse or jointly.

   The residence includes all contiguous lands, including mineral interests, upon which it is located. The residence may include a mobile home suitable for use, and being used, as a principle place of residence. The residence remains excluded during temporary absence of the individual from the residence, so long as the individual intends to return. Renting or leasing part of the residence to a third party does not affect this definition. Terms used in this subsection have the following meaning:

   a. "Relative" means a child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half brother, half sister, first cousin, or in-law.
   b. "Dependent" means an individual who relies on another for financial, medical, and other forms of support, provided that an individual is financially dependent only when another individual may lawfully claim the financially dependent individual as a dependent for federal income tax purposes.

2. The institutionalized or HCBS spouse may choose either the North Dakota Medicaid burial provision or the SSI burial provision. The community spouse is allowed the SSI burial provision or the Irrevocable Itemized Burial Contract.

   The SSI burial provision provides for:

   a. Burial funds of up to one thousand five hundred dollars each, plus earnings on excluded burial funds held for the individual and the

individual's spouse are excluded from the date of application. Burial funds may consist of revocable burial accounts, revocable burial trusts, other revocable burial arrangements including the value of installment sales contracts for burial spaces, cash, financial accounts such as savings or checking accounts, or other financial instruments with definite cash value, such as stocks, bonds, the cash surrender value of life insurance not excluded under subsection 3a below, or certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or by the applicant or recipient's statement.

The value of any irrevocable burial must be designated toward the burial fund exclusion.

Life or burial insurance excluded under subsection 3a below, (total face value is $1,500 or less), must be considered at face value toward meeting the burial fund exclusion.

Example 1: Mr. Smith has two life insurance policies each having a face value of $500. Because the total combined face value is less than $1500, the life insurance is excluded as an asset, but the $1000 in face value must be applied to the burial exclusion.

Example 2: Mrs. Jones has two life insurance policies each having a face value of $1000. Because the total combined face value is more than $1500, the face value is ignored and the cash surrender value is considered as an asset which may be applied towards either the burial exclusion or the asset limit.

Example 3: Mrs. Smith has two life insurance policies each having a face value of $500. Mrs. Smith also has a $1500 burial fund. Because the total face value of the two policies is less than $1500, the life insurance is excluded as an asset, but the $1000 in face value must be applied to the burial exclusion. Only $500 of the burial fund may be excluded, and the remaining $1000 would be counted towards the asset limit.

Example 4: Mr. Jones has a life insurance policy with a face value of $1000 and an irrevocable burial with a face value of $1000. The face value of the irrevocable burial must be considered toward the $1500 burial provision leaving $500 that could still be excluded for the burial fund. The life insurance passes the $1500 face value test and is excluded as an asset, but since there is still $500 that could be excluded for burial, the life insurance must be applied. No other assets can be excluded towards the burial fund.

b. A burial space or agreement which represents the purchase of a burial space paid for in full for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion. Only one item intended to serve a particular burial purpose, per individual, may be excluded. For purposes of this paragraph:

    i. "Burial space" means a burial plot, gravesite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.
    ii. "Other member of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth, adoption, or marriage, except that a relationship established by marriage ends when the marriage ends.

3. The following additional assets are excluded:

    a. Life or burial insurance that generates a cash surrender value is excluded if the face value of all such life or burial insurance policies of that individual total one thousand five hundred dollars or less. (This exclusion is not allowed for an individual who has an Itemized Irrevocable Funeral Contract which includes $1500 for funeral expenses.)
    b. Property essential to self-support is property that a member of the Medicaid unit owns, but which the Medicaid unit is not actively engaged in using to earn income. It is non-business property that may or may not produce unearned income.

        i. Up to six thousand dollars of the equity value of nonbusiness income producing property which produces annual net income at least equal to six percent of the excluded amount is excluded. Up to six thousand dollars of the combined equity of two or more properties may be excluded, however, each property must produce at least a six percent annual net return to be excluded.

            The chart at 05-100-60 illustrates how the $6,000 equity/six percent annual return limits apply.

        ii. Up to six thousand dollars of the equity value of nonbusiness property used to produce goods or services essential to daily

activities is excluded. It is used to produce goods or services essential to daily activities, when, for instance, it is used to grow produce or livestock solely for consumption in the community spouse's household.

iii. To be excluded, property essential to self-support must be in current use or, if not in current use, the asset must have been in such use and there must be a reasonable expectation that the use will resume:

A. Within twelve months of the last use; or
B. If the nonuse is due to the disabling condition of either spouse, within twenty-four months of the last use; or
C. With respect to property of the type described in (1) above, if the property produces less than a six percent return for reasons beyond the control of the applicant or recipient and there is a reasonable expectation that the property will again produce a six percent return, within twenty-four months of the tax year in which the return dropped below six percent.
D. Liquid assets are not property essential to self-support.

c. Lump sum payments of Title II or SSI benefits for nine consecutive months following the month of receipt.
d. Payments to certain United States citizens of Japanese ancestry, resident Japanese aliens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act. This asset must be identifiable and not commingled with other assets.

Income Considerations for Spousal Impoverishment 510-05-65-30

(Revised 2/04 ML #2900)

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(N.D.A.C. Section 75-02-02.1-24(5))

All of the medically needy income provisions apply except no income of the community spouse may be deemed available to the institutionalized or HCBS spouse during any month (including partial months) in which an institutionalized spouse is in the institution or in which a HCBS spouse is in receipt of HCBS.

Income Levels for Spousal Impoverishment 510-05-65-35

(Revised 4/1/2025 ML #3896)

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Refer to Section 05-85-40 for the spousal impoverishment income levels.

Eligibility for Community Spouse 510-05-65-40

(Revised 2/04 ML #2900)

View Archives

A community spouse who needs assistance with medical costs for a past month, in which he or she was a community spouse, can request Medicaid. Eligibility can be determined for the month(s) for which assistance is needed. Current ongoing eligibility for the spouse in the community, however, does not allow that person to be considered a community spouse for purposes of the spousal impoverishment provisions.

For any month for which the community spouse requests eligibility, the couple must be within the medically needy asset limit, must meet all other eligibility criteria, and income deemed from the institutionalized or HCBS spouse is considered to be the community spouse's income.

Asset Assessment Requirement 510-05-65-45

(Revised 6/1/21 ML #3623)

View Archives

(N.D.A.C. Section 75-02-02.1-24(2))

At the beginning of the first continuous period of institutionalization, or receipt of HCBS, an institutionalized spouse, a HCBS spouse, or a community spouse may request an assessment of their assets.

The asset assessment establishes the spousal share, the community spouse asset allowance, and the amount of assets that must be spent down before Medicaid eligibility can begin.

1. When completing an Asset Assessment:

    a. All electronic sources of asset verifications must be checked for potential countable assets (e.g. AVS, NDRIN and Motor Vehicle interface).
    b. If the asset assessment is completed for a date prior to August 1, 2019, the old rules for excluded asset burial provisions will apply in determining the spousal share, the community spouse asset allowance, and the amount of assets that must be spent down before Medicaid eligibility can begin.
    c. If the asset assessment is completed for a date on or after August 1, 2019 the new rules for excluded asset burial provisions will apply in determining the spousal share, the community spouse asset allowance and the amount of assets that must be spent down before Medicaid eligibility can begin.

        NOTE: Individuals have 15 days to provide verification of assets to complete the Assessment. Individuals can have 45 days to complete the process, which includes setting current assets aside for burial into an irrevocable burial fund, thereby excluding the amount set up in the irrevocable burial from the asset assessment.

    d. Enter the physical or legal address of the home on the Asset Assessment. If there is a TRANSFER ON DEATH Deed (TOD) enter TOD in front of the address.

        Example: TOD 123 Main St, Bismarck, ND 58505

A copy of the TOD deed must be attached to the Asset Assessment when scanning the Asset Assessments into File Net.

2. Complete Assessments:

    - Send to Policy & System Support (PaSS) dhseahelpdesk@nd.gov for review.
    - When sending in the Asset Assessment to the soeaprp@nd.gov, please include the completed form and attach all verifications used to calculate the countable assets listed on the Asset Assessment.
    - Once the assessment has been approved, send one copy to the community spouse and one copy to the institutionalized spouse.
    - Asset assessments that are approved by policy are stored in FileNet using the client's social security number.

3. Upon approval of a case, the SFN 52, Spousal Asset Log MUST be completed and sent to the State Medicaid Policy Unit. Retain a copy for your case file.

4. All assets, including those that are excluded must be listed on the asset assessment, but the value of these would be excluded in the 'Total Assets' Amount. Refer to Manual Section 510-05-70-30 for a complete listing of excluded assets.

5. Reminder, applicants and recipients should not be provided financial advice. They must pursue financial advice from individuals who work in that field.

If an asset assessment is not completed at the time of the first continuous period of stay by the institutionalized or HCBS spouse, the couple may later provide verification of the assets they had at that time. Only consider those countable assets that the couple can verify as owning at that time to establish the community spouse asset allowance.

Distribution of the asset assessment form requires that one copy be sent to each spouse, one copy be sent to the Economic Assistance division, and one copy is retained at the county. Economic Assistance can be contacted for a copy of the asset assessment if the institutionalized, or HCBS, spouse applies in the future and the county in which the application is filed does not have a copy.

The assessment of assets is completed using Form SFN 200, "Asset Assessment" (05-100-65). The asset assessment must include all of the couple's assets owned jointly or individually.

Part II of SFN 200, "Asset Assessment," must be completed within thirty days of receipt of the completed Part 1. The file must include documentation of all assets.

Asset Ownership Log 510-05-65-50

(Revised 8/1/05 ML #2981)

View Archives

Approval of any spousal impoverishment application, which includes an institutionalized spouse who is age 55 or older, or is likely to reach age 55 while on assistance, should include the completion of SFN 52, "Spousal Assets" (05-100-70). This spousal assets log should include all of the couple's assets, owned jointly or individually, and must indicate who owns the property and whether the institutionalized spouse ever had ownership in the property. The institutionalized spouse is considered to have had ownership if any of the institutionalized spouse's income or assets were ever put into the asset or used to purchase the asset.

The purpose of this log is for clarification of asset ownership for estate collection purposes. The signed form must be sent to the Economic Assistance Policy Division.

Long-Term Care Partnership Program 510-05-66

General Information 510-05-66-05

(Revised 7/1/09 ML #3183)

View Archives

Under the Long Term Care Partnership Program, individuals who purchase long-term care insurance policies that meet certain requirements (“Partnership Policy”) can apply for Medicaid under special rules for determining financial eligibility. These special rules generally allow the individual to protect assets equal to the insurance benefits received from a Partnership Policy so that such assets will not be taken into account in determining financial eligibility for Medicaid and will not subsequently be subject to Medicaid estate recoveries. The North Dakota Long Term Care Partnership Program became effective on January 1, 2007.

Asset Protection 510-05-66-10

(Revised 7/1/09 ML #3183)

View Archives

1. A Partnership Policy provides asset protection by allowing individuals to protect additional assets if assistance under Medicaid is ever needed. Specifically, Medicaid disregards an additional amount of assets equal to the amount of insurance benefits received from the Partnership Policy.

   Example: If an individual receives $200,000 of insurance benefits from a Partnership Policy, the individual generally will be able to retain $200,000 of assets above the amount of assets normally permitted for Medicaid eligibility. (An equal amount of assets are also protected from Medicaid estate recovery.)

2. The asset disregard applies to all insurance benefits received from a Partnership Policy, regardless of whether the insurance benefits are for long-term care related costs that would not be covered by Medicaid (i.e. benefits paid for assisted living). The asset disregard as of any date equals the insurance benefits that have been received to that date, or are due but not yet paid from a Partnership Policy, even if additional insurance benefits may be received in the future from the Partnership Policy. (The asset disregard, however, does not include return of premium payments made upon the termination of a Partnership Policy (due to cancellation or death) since such payments do not represent insurance benefits.)
3. With regard to married individuals, the asset disregard applies to both spouses, regardless of which spouse actually received the insurance benefits.

   Example: Mr. and Mrs. Smith have a joint Partnership Policy that will pay up to $200,000 in benefits for either of them. Mrs. Smith enters long-term care and uses up $180,000 in benefits before she passes away. Eventually, Mr. Smith enters long-term care. His care is covered by the Partnership Policy for another $20,000. The policy then ends because it has paid a total of $200,000 in benefits. When Mr. Smith applies for Medicaid, he is allowed a disregard of $200,000 in assets in addition to his $3,000 asset level.

   In the above example, if the Partnership Policy only covered Mrs. Smith (Mr. Smith was not covered under the policy), the disregard would still be

allowed for Mr. Smith, but the disregard would only be $180,000 as that was all that was paid by the policy.

Example: Mr. and Mrs. Brown each have their own Partnership Policy that will pay up to $200,000 in benefits. Mrs. Brown enters long-term care and uses up $150,000 in benefits from her Partnership Policy before she passes away. Eventually, Mr. Brown enters long-term care. His care is covered by his own Partnership Policy up to the maximum $200,000 his policy provides. The policy then ends and Mr. Brown applies for Medicaid. He is allowed a total disregard of $350,000 in assets in addition to his $3,000 asset level ($200,000 from his policy and $150,000 for Mrs. Brown's policy).

Application of Other Medicaid Provisions 510-05-66-15

(Revised 7/1/09 ML #3183)

View Archives

1. Eligibility for Medicaid is subject to all other eligibility provisions, such as the disqualifying transfer provision and home equity limitation. For instance, the individual can become Medicaid eligible while retaining the assets, but if the assets are given away without receiving adequate compensation, it may be considered a disqualifying transfer and the individual may be ineligible for coverage of long-term care costs.

   Example: Mr. White had a Partnership Policy that paid $180,000 in benefits before it ended. He is still in the nursing home so applies for Medicaid to further assist with his expenses. He had farmland worth $120,000 and $62,000 in liquid assets, for total countable assets of $182,000. During the application process he transferred ownership of his farmland to his children without receiving adequate compensation. This was a disqualifying transfer that causes him to be ineligible for coverage of nursing care services. If he had not made the transfer, he would have been eligible for Medicaid as $180,000 was protected, and the remaining $2000 in countable assets was within the $3000 asset limit. His penalty period begins in the month of the transfer because he was otherwise eligible for Medicaid at that time.

2. With regard to annuities or special needs trusts, the requirement to name the Department as a primary beneficiary still applies.

Partnership Policy 510-05-66-20

(Revised 7/1/09 ML #3183)

View Archives

1. In order for a long-term care insurance policy to be considered a Partnership Policy (including a certificate issued under a group insurance contract) the policy must satisfy all of the following requirements:

    a. The policy must be a qualified long-term care insurance contract, as defined in the Internal Revenue Code of 1986. The majority of all long-term care policies legally sold in North Dakota already meet this requirement.
    b. The policy must be issued on or after January 1, 2007 which is the effective date of the North Dakota Long Term Care Partnership Program. A policy issued prior to January 1, 2007 is treated as newly issued and eligible for Partnership Policy status only if it is reissued or exchanged on or after January 1, 2007. The addition of a rider, endorsement, or change in the schedule page to policies issued prior to January 1, 2007, may be treated as an exchange for the purpose of meeting the Long Term Care Partnership requirements.
    c. The policy must cover an insured individual who was a resident of the state when coverage first became effective under the policy.
    d. The Federal consumer protection requirements of the Social Security Act must be met with respect to the policy. The majority of all long-term care policies legally sold in North Dakota already meet this requirement.
    e. The policy must include the proper inflation protection based on the insured individual's age at the time the coverage became effective.

        i. If the policy was sold to an individual who was under age 61 on the date of purchase, the policy must provide compound annual inflation protection. There is no set minimum percentage level. Compound inflation protection must continue on the policy and may only end when the policy doubles, or when the insured individual reaches age 76, whichever occurs first;
        ii. If the policy was sold to an individual who was age 61 but had not attained age 76 as of the date of purchase, the policy must provide some level of inflation protection. There is no set minimum percentage level. Inflation protection, which can include simple interest inflation protection, must continue on the policy and may

only end when the policy doubles, or when the insured individual reaches age 76, whichever occurs first; and

iii. If the policy was sold to an individual who had attained age 76 as of the date of purchase, no inflation protection is required.

2. A partnership Policy issued in North Dakota will be identified by a notice to the policy holder (from the insurer) that certifies it as a Partnership Policy at the time the policy is issued. The notice will be issued if the policy meets all of the above criteria, including the inflation protection requirements. Because policies may be changed after they are issued, when an individual applies for Medicaid, they will need to obtain and provide a current notice from the insurer indicating whether the policy continues to meet the Partnership Policy requirements, and if so, to identify the amount of benefits paid while meeting those requirements.

Reciprocity 510-05-66-25

(Revised 7/1/09 ML #3183)

View Archives

The North Dakota Long Term Care Partnership Program will provide reciprocity with respect to long-term care insurance policies covered under other state long-term care insurance partnerships. This will allow individuals who purchase a Partnership Policy in one state to move to another state with a Long Term Care Partnership program without losing the asset protection. This protection is only available between states that offer reciprocity. A federal database is being developed to identify states that agree to reciprocity, and to identify Partnership Policies from those states.

Breast and Cervical Cancer Early Detection Program 510-050-67

General Information 510-05-67-05

(Revised 6/1/22 ML #3675)

View Archives

(N.D.A.C. Section 75-02-02.1-24.1)

The breast and cervical cancer early detection group consists of individuals under age sixty-five who:

1. Are uninsured. (If otherwise eligible for Medicaid with a client share (recipient liability), the individual can choose coverage as Medically Needy with a client share or through the Medicaid Breast and Cervical Cancer Early Detection Program.

   Note: Effective with applications received starting October 1, 2013 for benefits to start January 1, 2014 and reviews starting January 1, 2014, individuals will be first tested under the MAGI methodologies. If an individual is referred by the Department of Health, the individual may be eligible under the Medicaid Breast and Cervical Cancer Early Detection Program up to two hundred percent of the poverty level. If income is above 200 percent of the poverty level, the individual will be referred to the Federally Facilitated Marketplace to choose a health insurance plan.

2. Have been screened for breast or cervical cancer through the Women's Way Screening Program under the Department of Health Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection Program and have been found to require treatment for breast cancer, cervical cancer, or a precancerous condition relating to breast cancer or cervical cancer;
3. Have family income below 200% of the poverty level; and
4. Meet the residence, citizenship, social security number, and inmates of public institutions requirements.

The earliest date of eligibility is the month of diagnosis, but not more than three months prior to the month of application. Eligibility can continue until the woman

reaches age 65, is no longer a state resident, is admitted to a public institution, is eligible for Medicaid through a different category, becomes insured, or no longer needs treatment for breast or cervical cancer.

Eligibility for this group is determined by the Women's Way Screening Program of the North Dakota Department of Health and the Medicaid Eligibility unit of the Department. Coverage for this group began July 1, 2001.

Assets 510-05-70

General Information 510-05-70-05

(Revised 7/1/14 ML #3406)

View Archives

These medically needy asset provisions apply to all aged, blind, and disabled applicants and recipients of Medicaid unless otherwise specified in this chapter.

There is no asset test for applicants and recipients who are applying, or are eligible under the Children with Disabilities coverage.

Asset Considerations 510-05-70-10

(Revised 4/1/2024 ML #3818)

View Archives

(N.D.A.C. Section 75-02-02.1-25)

Assets, not otherwise 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 anyone acting on behalf of an applicant or recipient; when the applicant, recipient, or anyone acting on behalf of an applicant or recipient, 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 anyone acting on behalf of an applicant or recipient, has the lawful power to make the asset available, or to cause the asset to be made available. Asset availability is also as follows:

    a. An individual may have rights, authority, or powers, which he or she does not wish to exercise. Examples include individuals who choose not to collect a secured debt or individuals who believe family disharmony would result from the sale of the individual's interest. It is important to distinguish the individual's desire to avoid a sale from an absence of any right, authority, or power to sell. In such cases, the value of the property will be counted as an available asset whether or not the applicant or recipient pursues selling the asset. Likewise, Medicaid does not require an individual to begin foreclosure against a note in default. However, because the individual has the authority to do so, the current value of the note will be counted as an available asset.
    b. When an applicant or recipient files bankruptcy, it is necessary to consider the terms of the bankruptcy and to determine which assets are included in the bankruptcy. Any assets that are exempt from the bankruptcy are considered available assets for Medicaid purposes.
    c. When an applicant or recipient is a creditor to someone else who files bankruptcy, determine if the applicant or recipient has any security on the debt. If there is security (e.g. the debt is a contract for deed or promissory note on real property), the asset is considered to be available. If there is no security, the asset is not considered to be available.

d. Occasionally, some children receive money through the Uniform Gift to Minors Act. These funds are considered available to the child for Medicaid purposes. A minor, or if under age 14, someone acting on their behalf, can request that the funds be made available to meet the needs of the child.
e. Funds from a loan that must be repaid, including a reverse mortgage, and that the applicant or recipient demonstrates are for a purpose unrelated to achieving Medicaid eligibility, are not considered to be available assets if identifiable as a loan and if not commingled with other assets.
f. The surrender or equity value of any money, insurance, or other property given to another person or entity to be held for the use of a member of the Medicaid unit is considered to be held in trust and is available to the extent provided in 510-05-70-50 (Trusts).
g. When an applicant or recipient has paid an entrance fee or deposit to a continuous care retirement community or a lifecare community, the entrance fee or deposit is considered an available asset to the extent that:

    i. The individual has the ability to use the funds, or the contract provides that the funds may be used, to pay for care;
    ii. The individual is eligible for a refund of any remaining funds when the individual dies or leaves the community; or
    iii. The payment or deposit does not confer an ownership interest in the community.

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.
j. Payments made to a provider for an individual's client share when the client share has not as yet been applied to the individual's bill are not considered available assets once the individual is eligible and the client share has been determined.

Example 1: Ida Maypole applied for Medicaid and was approved with a $500 client share starting in January. She is in a Basic Care facility and knows her monthly bill will exceed her client share. She pays her client share every month on the first. In July, the eligibility worker gets an alert that Ida has not incurred her client share. To date, the facility has not billed Medicaid. Because Ida was informed of her client share, what she paid at this time is not a countable asset for Ida because she was informed of her client share and paid it for services received.

NOTE: If it is later determined that Ida did not actually incur her client share due to a 3rd-party payor such as Medicare paying all or part of the bill, at the time this is discovered, the unapplied client share IS counted as an available asset.

Example 2: Donald Duck applied for Medicaid and was approved with a client share of $785 per month. Donald is in receipt of HCBS services at home, however, the wrong living arrangement was entered, and his HCBS claims are not being applied to his client share. Donald knows his client share and has been paying it to his HCBS provider monthly. His credit balance with his provider is not an available asset because once the living arrangement is corrected, claims will be adjusted and his client share will be incurred.

2. The financial responsibility of any individual for any applicant or recipient of Medicaid is limited to the responsibility of spouse for spouse and parents for a disabled child under age eighteen. Such responsibility is imposed as a condition of eligibility for Medicaid. Except as otherwise provided in this section, the assets of the spouse and parents are considered available even if those assets are not actually contributed. For purposes of this paragraph, biological and adoptive parents, but not stepparents, are treated as parents.

3. All spousal assets are considered actually available unless:

    a. A court order, entered following a contested case, determines the amounts of support that a spouse must pay to the applicant or recipient;
    b. The spouse from whom support could ordinarily be sought, and the property of such spouse, is outside the jurisdiction of the courts of the United States;

c. The applicant or recipient has been subject to marital separation, with or without court order, the parties have not separated for the purpose of securing Medicaid benefits; or
d. In cases where spousal impoverishment applies, the assets are those properly treated as belonging to the community spouse.

Pre-nuptial, or post-nuptial, agreements have no affect and do not allow spousal assets to be considered unavailable.

4. All parental assets are considered actually available to a disabled child under age eighteen unless the child is living:

   a. Independently; or
   b. With a parent who is separated from the child's other parent, with or without court order, if the parents did not separate for the purpose of securing Medicaid benefits. Only the assets of the parent the child is residing with must be considered.

5. Assets received from the estate of a spouse, or a parent who was providing support, are available as of the date of the person's death.

6. Assets received from any other estate are available at the earlier of:
   a. The day on which the assets are received from the estate; or
   b. Six months after the person's death.

Asset Limits 510-05-70-15

(Revised 7/1/2025 ML #3935)

View Archives

(N.D.A.C. Section 75-02-02.1-26)

1. In all instances, including determinations of equity, property must be realistically evaluated in accordance 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.

    Eligibility may exist in a month when countable assets are within the asset limits for at least one day of the month.

2. There is no provision for the Asset Limit to be exceeded.

3. Assets can be accumulated up to the allowable limit at any time and may be accumulated out of disregarded income during periods of eligibility.

Asset Compatibility 510-05-70-17

(New 4/1/2023 ML #3712)

Below are the available electronic verification sources for asset compatibility

- AVS
- Motor vehicle (ND Verify-Motor Vehicle)
- Game and Fish (ND Verify-Game and Fish)

The total combined countable assets must be used to determine reasonable compatibility. If no asset information is returned from a data source and there are no known assets, asset compatibility can be determined.

1. If reported assets and information obtained electronically through a data source are $500 or more below the asset limit for the Medicaid unit, it is asset compatible.

    a. Example - Individual with $3000 asset limit. The individual reports assets of $1500 in a checking account. Data source returns information indicating a checking account with $1000. Since both the reported assets and the data source returned are more than $500 below the asset limit, this would be considered asset compatible.
    b. Example - Individual with $3000 asset limit reports assets of $2700 in a checking account. Data source returns information indicating a checking account with $2800. Since the assets are within $500 of the limit the asset is not reasonably compatible.

2. If reported data assets and information obtained electronically through a data source are more than the asset limit for the Medicaid unit, it is not asset compatible

Example- Couple with an asset limit of $6000 have reported assets of $7000. Data source returns assets of $8000. Both sources are over the asset limit. This would not be considered reasonably compatible. A review form and request for asset information will need to be sent out.

Forms of Asset Ownership 510-05-70-20

(Revised 7/1/09 ML #3183)

View Archives

(N.D.A.C. Section 75-02-02.1-29 and 75-02-02.1-32)

1. Ownership of real or personal property or accounts can take various forms. The first basic consideration is the distinction between real and personal property. Real property relates to land and those things, such as houses, barns, and office buildings, which are more or less permanently attached to it. Personal property describes all other things which are subject to individual rights. Personal property includes liquid assets, but liquid assets are distinguished from other personal property because liquid assets have a market at a price that may not ordinarily be negotiated between buyer and seller. Liquid assets include cash, accounts, publicly traded stocks, bonds, and other securities, and commodities for which there is an established market.

2. Since the various types of property ownership may affect the valuation of the applicant's or recipient's assets, it is important to carefully record information relating to such property.

    a. "Fee" or "fee simple" ownership is a term applied to real property in which the "owner" has the sole ownership interest. A fee simple interest will, in theory, last as long as the land. Even though one owner dies, that owner has the power to sell or to "will" the property. The resulting series of owners each has a fee simple. A fee simple ownership interest is not changed when the property is mortgaged. The mortgage merely secures the owner's promise to repay a debt. If the debt is not paid, the owner may be obliged to forfeit the property. Fee simple ownership may be individual or may be shared.
    b. Shared ownership means that the ownership interest in the property is vested in more than one person. Shared ownership may be by "joint tenancy" or by "tenancy in common". Shared ownership occurs both with real property and with valuable personal property such as accounts, motor vehicles, and mobile homes.

i. In joint tenancy, each of two or more joint tenants has an equal interest in the whole property. On the death of one of two joint tenants, the survivor becomes the sole owner. On the death of one of three or more joint tenants, the survivors remain joint tenants in the entire interest. Any joint tenant, acting independently, may convert the joint tenancy to a tenancy in common by selling that person's interest.

ii. In tenancy in common, two or more persons have an undivided fractional interest in the whole property. There is no "right of survivorship" in a tenancy in common. On the death of one of the tenants in a tenancy in common, the surviving tenants gain nothing, and the estate of the deceased tenant thereafter owns the deceased tenant's share.

c. Life estate and remainder interests.

i. Real property interests may be divided in terms of the time when the owner of the interest is entitled to possession of the property. The owner of a life estate (life tenant) is entitled to possession of the real property for a period measured by the lifetime of a specific person or persons. A life tenant has the right to use the property and is entitled to any rents or profits from the property. A life tenant may sell the life estate, but such a sale does not change the identity of the person or persons whose lifetimes measure the duration of the life estate. A life estate may be referred to as a "life lease".

ii. When a life estate is created, a right to possess the property, after the death of the life tenant, must also be created. That right is called a "remainder interest," and the owner of that right is called a "remainderman." Upon the death of the life tenant, the remainderman owns the property. The remainderman is not entitled to possess or use the property until the death of the life tenant. The remainderman does have the right to sell the remainder interest.

iii. A life estate may be created where the right to possess the property returns, upon the death of the life tenant, to the person or entity which created the life estate. This rare form of ownership may arise when a legal entity which does not die a natural death (i.e., a trust or corporation) creates a life estate. The right to have possession of property returned after the end of a life estate is properly called a "reversion", but is treated as a remainder interest for purposes of valuation.

3. Liquid assets in shared ownership are available in total to the Medicaid unit, unless the liquid asset is held jointly with an individual who is in a different open Medicaid case. In that instance, the liquid asset is considered to be owned in equal shares by each Medicaid unit so that the assets are not counted more than once.

   Occasionally a liquid asset may be held jointly with individuals who are not members of the Medicaid unit. Such accounts may be established for convenience of the parties involved, and the Medicaid unit may not have contributed to the account and may or may not have knowledge of its existence. Regardless of the source of funds, whenever an applicant or recipient is a joint account holder and can legally withdraw funds from the account, the account is presumed to be available. If it is clearly established, however, that despite having access to the account, the applicant or recipient has neither contributed to nor withdrawn funds from the account, and the account was not intended for the applicant or recipient's use, the applicant or recipient should be given the opportunity to have his or her name removed from the account. For applicants, such action must be taken before a decision is made on the application. For recipients, the action must be taken within 30 days of discovery by the county agency.

4. Real property and nonliquid personal property, in shared ownership, is presumed available in the proportion equal to the number of shared owners (i.e., half is available where there are two joint owners, and only one is in the Medicaid unit; one-third is available where there are three joint owners, and only one is in the Medicaid unit; two-thirds is available where there are three joint owners, and two are in the Medicaid unit).

5. When an applicant or recipient is a trustee, guardian or conservator, or has a power of attorney responsibility, the applicant or recipient may have legal access or ownership to real or personal property (liquid or nonliquid) that is intended for the benefit of someone else. Likewise, an applicant or recipient may be named on a bank signature card and have the right to sign checks or withdrawal slips on that account without being a joint owner of the account. In these situations, the trustee, guardian or conservator, the power of attorney, or the individual on the bank signature card is not considered to be the owner of the property for Medicaid eligibility purposes

Home Equity Limit 510-05-70-27

(Revised 1/1/2025 ML 3891)

View Archivesl

(N.D.A.C. Section 75-02-02.1-27)

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, 2025 are not eligible for coverage of nursing care services (which include HCBS) if the individual's equity interest in the individual's home exceeds $730,000. The applicant or recipient may, however, be eligible for other Medicaid benefits.

This provision does not apply if one of the following individuals lives in the home:

1. A spouse;
2. A son or daughter who is under age twenty-one; or
3. A son or daughter of any age who is blind or disabled.

Excluded Assets 510-05-70-30

(Revised 10/1/2025 Release 25.16)

View Archives

(N.D.A.C. Section 75-02-02.1-28)

20 CFR 416.1210

The following types of property interests will be excluded in determining if the available assets of an applicant or recipient exceed asset limits:

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

   The home is considered occupied by the Medicaid unit when it is the home the 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.

   The home occupied by the Medicaid unit includes the land on which it is located, provided that the acreage does not exceed 160 contiguous acres if rural or two acres if located within the established boundaries of a city.

   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 Manual Section 510-05-70-27, Home Equity Limit for home equity limit for excluded home during six-month period and for single HCBS applicants and recipients.)

   When determining whether an individual is likely to return home within six months, the physician's statement must include the date admitted to the facility, the date of the statement, wording showing that the individual is reasonably expected to return home within the six months, and it must be signed by the

physician. Statement language that indicates that an individual “may” return home, or “wants to” return home, is not sufficient. The following are examples of acceptable and non-acceptable physician statements regarding an individual’s stay in a long-term care facility.

Example:A statement is prepared within 30 days of admittance to facility.

(Date Written)

(Recipient Name) entered the (Facility Name) on (Admit date). She is reasonably expected to return home within six months.

(Signed by Physician)

This statement is acceptable as it includes all of the required information.

Example: A statement is prepared at the time the individual was admitted to facility.

(Date Written)

(Recipient Name) was admitted to the (Facility Name) on (Admit Date). It is anticipated that she may be able to return home within six months.

(Signed by Physician)

This statement is not acceptable as “may” is indefinite. It would be acceptable if it said she was expected (or likely) to return home within six months.

Example:A statement is prepared at an unspecified time.

(Date Written)

(Recipient Name) is anticipated to return home in less than six months. Patient will receive physical therapy for strengthening and to recover from pneumonia.

(Signed by Physician)

This statement is not acceptable as there is no admit date to determine the total length of stay is within six months.

2. Personal effects, wearing apparel, household goods, and furniture.

3. One motor vehicle.

4. Indian trust of restricted lands.

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.

   The Bureau of Indian Affairs should be consulted, if necessary, to determine if the payment is the result of an award by either the Indian Claims Commission or the Court of Claims.

6. Property that is essential to earning a livelihood.

   This is defined as property that a member of a Medicaid unit owns, is actively engaged in using to earn income, and where the total benefit of such income is derived for the Medicaid unit's needs.

   A member of a Medicaid unit is actively engaged in using the property if a member of the unit contributes significant current personal labor in using the property for income-producing purposes. The payment of social security taxes on the income from such current personal labor is an indicator of the active use of the property. Except for property enrolled in the Conservation Reserve Program (CRP) which is considered essential to earning a livelihood, other property is not essential to earning a livelihood if the Medicaid unit is merely receiving rental or lease income.

   a. Operating funds in self-employment business accounts may be excluded as follows:
      i. For self-employment in which income is received other than monthly, the current year's self-employment income, and the previous years self-employment income that has been prorated and not yet counted as income; and
      ii. For all other self-employment, two times the monthly gross earnings
   b. Grain or other produce retained for seed or feed is property essential to earning a livelihood. All other grain and produce are property essential to earning a livelihood in the year it is harvested. It is not excluded as property essential to earning a livelihood in the following year. For purposes of this provision, the year in which grain or other produce is harvested is the twelve-month period used by the farmer for tax purposes.

Example: If a farmer's tax year is March through February, grain and other produce harvested beginning in March of each year is excluded as property essential to earning a livelihood until March of the following year.

c. Livestock held for business purposes is property essential to earning a livelihood if a member of the Medicaid unit is actively engaged in raising the livestock to produce income. Livestock held for business purposes is not excluded under this provision if no one in the Medicaid unit is actively engaged in raising the livestock, meaning significant current personal labor is not contributed. The value of such livestock is a countable asset. Livestock raised only for personal use or pleasure is not considered business property and is excluded as an asset.

d. Such property may be excluded only during months in which a member of the Medicaid unit is actively engaged in using the asset to earn a livelihood or if not in current use, the property must have been in such use and there must be a reasonable expectation that the use will resume:
   i. Within 12 months of the last use; or
   ii. If the nonuse is due to the disabling condition of a member of the Medicaid unit, within 24 months of the last use.This exception allows the assets to be excluded but it does not affect income.

7. Property that is not saleable without working an undue hardship.

Property that is not saleable without working an undue hardship means property the owner has made a good faith effort to sell but it has produced no buyer willing to pay an amount equaling or exceeding 75% of the property's fair market value, and which is continuously for sale. **Property must be offered for sale at 100% of the value** and if no offer is received at 100%, an offer at or exceeding 75% may be accepted. 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 Manual Section 510-05-05, Definitions, 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 began 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.
b. Good faith efforts to sell, other than for an annuity, must be repeated at least annually.
c. When making a good faith effort to sell real property or a mobile home, wait to determine that it is non-saleable until the third month after the month in which the good faith effort began. This provides a reasonable amount of time for offers to be received without loss of potential months of eligibility for an applicant. If the property is determined to be non-saleable without working an undue hardship, the property must remain continuously for sale, and any offers received must be reported. The three calendar months must include a good faith effort to sell through the regular market for the three calendar months. For purposes of this provision, an offer to the regular market for real estate is made by listing the property with a professional real estate agent when the property is located in an area serviced by a professional real estate agent.
d. When making a good faith effort to sell property other than real property, a mobile home, or an annuity, wait to determine eligibility until at least 30 days after the good faith effort has been made to determine if any offers are received. If the property is determined to be non-saleable without working an undue hardship, the property must remain continuously for sale, and any offers received must be reported.
e. When making a good faith effort to sell an annuity, there is a specific market, known as the factors market, to which the good faith effort must be made. Eligibility may be determined after the good faith effort has been made and responses received from the factors that were contacted.
f. If a Medicaid unit claims that property should be excluded because it is not saleable without working an undue hardship, verification of the way in which the fair market value was established, the established value, and the good faith effort to sell must be made a part of the file. If the efforts to sell have produced no offers, the written statement of the applicant, recipient, or sales agent, stating that fact, must be made a part of the file. The county agency reviewing the efforts to sell should be alert for actions which reflect an applicant's or recipient's effort to comply with the technical requirements for exclusion without making a genuine and serious attempt to sell the excess asset.
g. To demonstrate that property is not saleable without working an undue hardship, an applicant or recipient must engage in sales efforts which are reasonably calculated to produce a sale. An applicant or recipient is not

obliged to make a sale if a reasonable offer is received, but the property will not thereafter be excluded.

h. When offering property for sale by public advertisements, those containing substantially the following content are acceptable as a means of demonstrating a good faith effort to sell:

Example: Offered at 100% of value.

For Sale: An undivided ½ interest in W½ of Sec. 65, Township 130, Range 102, East of the 5th P.M., located 2 miles west of the junction of U.S. Hwy. 90 and Iron County Rd. 4. This land has a true and full value of $100,000. This undivided ½ interest is offered for $50,000, payable upon sale. Call (701) 555-9999, or write Chaos Realty, Box 1, Tampa, ND 58990.

i. It is expected that a "good faith effort to sell" will normally generate a sale. If no offer for at least 75% of the established fair market value has been received on the property as of the annual review, the county agency must review the previous efforts and determine if they truly reflect a good faith effort to sell, and may require a re-evaluation of the property value, or other appropriate action likely to produce a sale.

8. A burial plot for each family member (eligible or ineligible) is excluded. A burial plot is defined to include a grave site, crypt or mausoleum.

9. Along with the burial plot an individual is allowed either the SSI burial or ND burial provision.

The **SSI Burial Provision** provides for:

a. Burial funds of up to $1,500, plus earnings on excluded burial funds held for the individual and the individual's spouse are excluded from the date of application. Burial funds may consist of revocable burial accounts, revocable burial trusts, other revocable burial arrangements including the value of installment sales contracts for burial spaces, cash, financial accounts such as savings or checking accounts, or other financial instruments with definite cash value, such as stocks, bonds, the cash surrender value of life insurance not excluded under subsection 3a below, or certificates of deposit. The fund must be unencumbered and available for conversion to cash on very short notice. The fund may not be commingled with nonburial-related assets and must be identified as a burial fund by title of account or by the applicant or recipient's statement.

The value of any irrevocable burial must be designated toward the burial fund exclusion.

Life or burial insurance excluded under this subsection (total face value is $1,500 or less), must be considered at face value toward meeting the burial fund exclusion.

Example 1: Mr. Smith has two life insurance policies, each having a face value of $500. Because the total combined face value is less than $1,500, the life insurance is excluded as an asset, but the $1,000 in face value must be applied to the burial exclusion.

Example 2: Mrs. Jones has two life insurance policies, each having a face value of $1,000. Because the total combined face value is more than $1,500, the face value is ignored, and the cash surrender value is considered as an asset which may be applied towards either the burial exclusion or the asset limit.

Example 3: Mrs. Smith has two life insurance policies, each having a face value of $500. Mrs. Smith also has a $1,500 burial fund. Because the total face value of the two policies is less than $1,500, the life insurance is excluded as an asset, but the $1,000 in face value must be applied to the burial exclusion. Only $500 of the burial fund may be excluded, and the remaining $1000 would be counted towards the asset limit.

Example 4: Mr. Jones has a life insurance policy with a face value of $1,000 and an irrevocable burial with a face value of $1,000. The face value of the irrevocable burial must be considered toward the $1,500 burial provision leaving $500 that could still be excluded for the burial fund. The life insurance passes the $1,500 face value test and is excluded as an asset, but since there is still $500 that could be excluded for burial, the life insurance must be applied. No other assets can be excluded towards the burial fund.

b. A burial space or agreement which represents the purchase of a burial space paid for in full for the individual, the individual's spouse, or any other member of the individual's immediate family is excluded. The burial space exclusion is in addition to the burial fund exclusion. Only one item intended

to serve a particular burial purpose, per individual, may be excluded. For purposes of this paragraph:

i. "Burial space" means a burial plot, gravesite, crypt, or mausoleum; a casket, urn, niche, or other repository customarily and traditionally used for a deceased's bodily remains; a vault or burial container; a headstone, marker, or plaque; and prepaid arrangements for the opening and closing of the gravesite or for care and maintenance of the gravesite.

ii. "Other member of the individual's immediate family" means the individual's parents, minor or adult children, siblings, and the spouses of those persons, whether the relationship is established by birth, adoption, or marriage, except that a relationship established by marriage ends when the marriage ends.

North Dakota Burial Provision - Any pre-need funeral service contracts, prepayments or deposits to a fund which are placed in an irrevocable itemized funeral contract designated by an applicant or recipient for the applicant's or recipient's burial. An applicant or recipient designates a prepayment of deposit for his or her burial by providing funds that must be used for that purpose. Only those prepayments paid by members of the Medicaid unit are considered as burial prepayments.

a. Amounts that may be designated as irrevocable vary from State to State. When an individual moves to North Dakota from another state, North Dakota Medicaid will honor the burial plan set up in the other state based on the other state’s burial provision.
b. Earnings accrued on the total amount of the irrevocable itemized burial contract are excluded.
c. A burial plot for each family member (eligible or ineligible) will also be excluded. A burial plot is defined to include a grave site, crypt, or mausoleum. (Effective July 1, 1996).
d. Markers, monuments, and vaults that have been pre-purchased separately from an irrevocable itemized funeral contract are not considered part of a burial plot and are not exempt. These items are countable assets for Medicaid, based on their current market value. A marker or monument that has already been engraved with some of the individual’s information will likely have a reduced value. It may still have a market value; however, the value will be reduced by the cost to resurface the marker or monument. When a double marker has been purchased and one spouse has already passed away, it can be determined that there is no resale value for the marker.
e. Individuals with burial funds set up based on the ND Burial exclusion prior to August 1, 2019 will need to change their funds designated for burial to an

Irrevocable Itemized Burial, or SSI burial provision. Once the burial is changed to an irrevocable itemized burial contract it will be excluded in its entirety. If the funds are not changed to an Irrevocable Itemized Funeral Contract, any amount over the $1500 SSI burial allowable amount will become a countable asset.

- **Example:** Individual has a $4,000 CD set aside for burial. The individual will need to contact the funeral home of their choosing and establish an Irrevocable Itemized Funeral Contract. The CD will need to be transferred into an irrevocable trust designating the interest and payout upon maturity into the trust. Also, the trust must name the funeral home as the beneficiary.
- **Example:** Individual has a $4,000 savings account set aside for burial. The individual will need to contact the funeral home of their choosing and establish an Irrevocable Itemized Funeral Contract. The savings account will need to be transferred into an irrevocable trust with the funeral home named as the beneficiary.

f. Normally a life insurance policy is countable asset valued at its cash surrender value, however, when a whole life insurance policy is used to pay for an irrevocable itemized burial contract, the whole life insurance policy is exempt. Life insurance that is designated for burial must cover the life of the person for whom it is designated. The following are the steps the individual will need to take for their life insurance to be considered excluded for burial:
   - The individual will need to contact the funeral home of their choosing.
   - Change the beneficiary of the life insurance to the funeral home.
   - Execute a contract between the individual and the funeral home to indicate the beneficiary of the life insurance cannot be changed, except for the ability to transfer to another licensed funeral establishment or cemetery association.

g. Information regarding the burial fund of a deceased recipient must be released to the funeral home personnel upon request.

h. A burial fund, which is established at the time of application, can apply retroactively to the three-month prior period and the period in which the application is pending, if the value of all assets are within the Medicaid limits for each of the prior months. Future earnings on the newly established burial fund will be excluded.

10. Home replacement funds, derived from the sale of an excluded home, and if intended for the purchase of another excluded home, until the last day of the third month following the month in which the proceeds from the sale are received. This asset must be identifiable and not commingled with other assets.

11. Unspent assistance and interest earned on unspent assistance, received under the Disaster Relief and Emergency Assistance Act of 1974 or some other federal statute, or because of a presidentially declared major disaster. Comparable assistance received from a state or local government, or from a disaster assistance organization is also excluded. These assets must be identifiable and not commingled with other assets.

12. Payments, interest earned on the payments, and in-kind items received for the repair or replacement of lost, damaged, or stolen 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.

13. For nine months beginning after the month of receipt, unspent assistance received from a fund established by a state to aid victims of crime. This is to the extent that the applicant or recipient demonstrates that such an amount was paid in compensation for expenses incurred or losses suffered as a result of a crime. This asset must be identifiable and not commingled with other assets.

14. Payments made pursuant to the Confederate Tribes of the Colville Reservation Grand Coulee Dam Settlement Act, Public Law 103-436. This asset must be identifiable and not commingled with other assets.

15. Stock in regional or village corporations held by natives of Alaska pursuant to the Alaska Native Claims Settlement Act.

16. For nine months beginning after the month of receipt, any educational scholarship, grant, or award; and any fellowship or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational institution. This asset must be identifiable and not commingled with other assets.

17. For 12 months beginning after the month of receipt, any federal income tax refund, any earned income tax credit refund or any advance payments of earned income tax credit. State income tax refunds are excluded for nine months beginning the month after the month of receipt. This asset must be identifiable and not commingled with other assets.

18. Assets set aside, by a blind or disabled (but not an aged) SSI recipient, as a part of a plan to achieve self-support (PASS) which has been approved by the Social Security Administration.

19. The value of a life estate.

20. Allowances paid to children of Vietnam veterans who are born with spina bifida, or to children of women Vietnam veterans who are born with certain covered birth defects. This asset must be identifiable and not commingled with other assets.

21. The value of mineral acres.

22. An annuity that is excluded per annuity Manual Sections 510-05-70-45-20, Annuities Purchased Before February 8, 510-05-70-45-25, Annuities Purchased or Changed on or After February 8, or 510-05-70-45-30, Annuities Purchased or Changed on or After February 8, 2006.

23. Funds held in retirement plans that are considered qualified retirement plans and meet the qualified retirement criteria established by the Internal Revenue Service (IRS); 26 U.S.C. These include:
    - SEP-IRA (Simplified employee pension) plans
    - Employer or employee association retirement accounts
    - Employer simple retirement accounts
    - 401(k) retirement plans (which include independent (sole proprietorship) plans)
    - 403(b) retirement plans
    - 457 retirement plans
    - 401 (a) Employer-sponsored money-purchased retirement plan

    When accessing their retirement accounts, individuals will have three options:

    - **Option #1:**Purchase an annuity. If the individual chooses this option, policy at Manual Section 510-05-70-45-30, Annuities Purchased or Changed on or After February 8, 2006 applies.
    - **Option #2:**Withdraw the funds without purchasing an annuity. When drawing the funds out without purchasing an annuity, the individual must:
        - Receive level monthly payments AND receive the full principal and interest during or prior to the individual's life expectancy time period; or

- Withdraw the entire amount in a lump sum payment
- **Option #3:**Do nothing and continue to have the money held in the retirement account.

When individuals have begun drawing their retirement benefits prior to applying, Eligibility Workers will need to assess these to determine whether the individual chose Option 1 or Option 2 above, and based on the option they selected, ensure that the individual meets the policy requirements.

24. Property connected to the political relationship between Indian Tribes and the Federal government:
    a. Any Indian trust or restricted land, or any other property under the supervision of the Secretary of the Interior located on a federally-recognized Indian reservation, including any federally-recognized Indian Tribe's, pueblo, or colony, and including Indian allotments on or near a reservation as designated and approved by the Bureau of Indian Affairs of the Department of the Interior. This exclusion includes Individual Indian Monies (IIM) accounts, which are under the supervision of the Secretary of the Interior.
    b. Property located within the most recent boundaries of a prior Federal reservation, including former reservations in Oklahoma and Alaska Native regions established by the Alaska Native Claims Settlement Act. The Tribe, through the Department of the Interior, can provide verification to identify such property.
    c. Ownership interests in rents, leases, royalties, or usage rights related to natural resources (including extraction of natural resources or harvesting of timber, other plants and plant products, animals, fish, and shellfish) resulting from the exercise of federally-protected rights. Monies received from the lease or sale of these natural resources remain excluded while in an IIM account, however, if taken out of the account, they are considered as a countable asset.
    d. Property with unique Indian significance such as ownership interests in or usage rights to items not covered by paragraphs (a) through (c) that have unique religious, spiritual, traditional, or cultural significance or rights that support subsistence or a traditional lifestyle according to applicable Tribal law or custom.

25. **Achieving a Better Life Experience (ABLE) Accounts** - An individual with significant disabilities that meets established criteria is eligible for one ABLE account. The account may be opened at any age but the disability must have an age of onset before the age of 26 and the disability must still exist at the time the ABLE account is opened.

- If the individual is receiving SSI and/or SSDI and meets the age criteria, that individual qualifies.
- If the individual is not receiving SSI and/or SSDI, the individual must meet Social Security's definition and criteria regarding significant functional limitations and may be asked to provide certification from a licensed physician.

The total annual contributions for a single tax year, regardless of the number of contributors, are $16,000, effective January 2022. For individuals with disabilities who are recipients of SSI, the ABLE Act sets some further limitations. When the total account balance meets a Plan's maximum balance limit, additional contributions into an ABLE account will not be accepted. Each state sets its own maximum balance limit.

The funds in an ABLE account can be withdrawn to be used for a 'qualified disability expense.' A 'qualified disability expense' is any expense that results from living a life with disabilities to include education, housing, transportation, employment training and support, assistive technology, personal support services, health care expenses, financial management and administrative services and other expenses which help improve health, independence and/or quality of life.

Originally, the ABLE Act required each state to create their own ABLE plans. Since the passage, changes were made to allow individuals to open an account anywhere in the United States. With this new option, Bank of North Dakota (BND) determined that the residents would have lower expenses if they accessed other states' plans. BND is available as a resource to answer questions about the ABLE Act and will provide a list of resources and state plans. Go to Bank of North Dakota's website at bnd.nd.gov/able/ for more information.

The ABLE Act requires amounts in ABLE accounts be disregarded in determining eligibility for means-tested federal and state programs including Medicaid. This includes the exclusion of any contributions to the ABLE account of the individual and any distributions for qualified disability expenses. However, a transfer of funds into an ABLE Account is subject to the Disqualifying Transfer policy for Medicaid.

Exception: For Medicaid, an individual is allowed to transfer their own funds into an ABLE Account for themselves or their spouse and this would not be treated as a Disqualifying Transfer. If they want to set aside funds for a child who is blind or disabled, money placed into an ABLE Account would be considered a Disqualifying Transfer. However policy at Manual Section 510-05-80-25 #3, Exceptions to Disqualifying Transfer Provisions does allow them to create a Trust.

Since the funds in an ABLE account can only be withdrawn to be used for a 'qualified disability expense,' funds withdrawn from the account are also disregarded.

An individual who would be receiving payment of SSI benefits but for the application of housing expenses paid by the ABLE account or due to having more than $100,000 in the ABLE account" will continue to be treated as a SSI recipient for Medicaid purposes."

Refer to Manual Section 510-05-10-30, Liens and Recoveries for information regarding recovery of remaining funds in an ABLE account when the qualified beneficiary of an ABLE account dies (or is determined to no longer be disabled).

While the above identified assets are excluded in determining eligibility, if the assets are converted to a non-excluded asset, they become countable. For instance, money in an IIM account is excluded, however, once the money is removed from the IIM account it becomes a countable asset. As a general rule, workers may not request IIM information.

26. Lump sum payments of Title II or SSI benefits are excluded for nine consecutive months following the month of receipt.

In determining the resources of an eligible individual (and spouse, if any), we will exclude, for 9 months following the month of receipt, the unspent portion of any title II or title XVI retroactive payment received on or after March 2, 2004.

Converting Assets 510-05-70-35

(Revised 1/03 ML #2833)

View Archives

A Medicaid unit may convert an asset of one type to another. The asset acquired after such a sale or conversion continues to be treated as an asset. However, it is subject to the asset limits, exemptions, and exclusions applicable to the type of asset into which it has been converted.

Contractual Rights to Receive Money Payments 510-05-70-40

(Revised 1/1/18 ML #3508)

View Archives

(N.D.A.C. Sections 75-02-02.1-30 and 75-02-02.1-32(5))

1. For various reasons, but usually because an applicant or recipient has sold property with a contract to receive a series of payments, rather than one payment, an applicant or recipient may own contractual rights to receive money payments. If the applicant or recipient has sold property, and received in return a promise of payments of money at a later date, usually to be made periodically, and an attendant promise to return the property if the payments are not made, the arrangement is usually called a "contract for deed". The essential feature of the contract for deed is the right to receive future payments, usually coupled with a right to get the property back if the payments are not made. Contractual rights to receive money payments also arise out of other types of transactions. The valuable contract document may be called a note, accounts receivable, mortgage, or by some other name.

   Some contractual rights may be written so the lender has the right to demand payment at any time. If so, the note is considered a demand note and can be called in at any time. If a note is written so the lender does not have the right to demand payment but the note is in default, it also becomes a demand note. Contractual rights may or may not have collateral or security to guarantee payment.

2. A contractual right to receive money payments is considered an available asset, subject to the asset limits, unless the Medicaid unit is requesting coverage of nursing care services and the contract itself must be considered a disqualifying transfer (see subsection 4). When the penalty period is finished, and the applicant or recipient still owns the contractual right to receive the money payments, the contractual right is considered an available asset.

3. Contract values.

a. The value of a contract in which payments are current is equal to the total of all outstanding payments of principal required to be made by the contract, unless evidence is furnished that establishes a lower value.
b. The value of a contract in which payments are not current is an amount equal to the current fair market value of the property subject to the contract. If the contract is not secured by property, the value of the contract is the total of all outstanding payments of principal and past due interest required to be made by the contract.
c. In situations where the contractual right to receive money payments is not collectable and is not secured and the debtor does not have any assets such as money in a bank account or real property, is not working or has a very low paying job or the only other source(s) of income are exempt from seizure by judgment creditors, the debt has no collectable value, and thus no countable asset value. An applicant or recipient can establish that a note has no collectable value if:

    i. The debtor is judgment proof. A debtor is judgment proof when money judgments have been secured, an execution has been served against the debtor which has been returned as wholly unsatisfied, and the debtors affidavit and claims for exemptions exempt all of the debtors property or as determined by the department including but not limited to:

        - Has no legal rights to pursue payment of debts by garnishing wages or other sources of income that are not exempt from garnishment;
        - Cannot place a levy on bank accounts, and/or
        - Cannot place a lien against any real estate that the individual owns.

    ii. The applicant or recipient verifies the debt is uncollectible due to a statute of limitations. A satisfactory verification includes an attorney's letter identifying the statute and facts that make a debt uncollectible due to a statute of limitations.

        Applicants and recipients should be encouraged not to forgive debts that have been determined to be uncollectible. Such debts could have a future value if the debtor ever accrues assets. At each annual review, determine whether the judgments are still on file or whether the debtor has any change in assets.

4. The purchase or establishment of a contract may be a disqualifying transfer if the owner, or the owner's spouse, is requesting coverage for nursing care services and the contract was purchased or established on or after the look-back date (as defined in 05-80-10).

    a. A disqualifying transfer will be determined to have occurred if the value of the contract at the time it was purchased or established, plus any compensation received at that time, was less than the value of the property exchanged for the contract. The difference is the amount of the transfer.

        Example: Mr. Green sells land to his children on a contract for deed. The land has a fair market value of $100,000. The contract required a $5,000 down payment and the value of the remaining payments adds up to $60,000. $100,000 less $60,000 (value of contract), and less $5,000 (down payment), leaves a difference of $35,000. Mr. Green made a $35,000 disqualifying transfer when he established the contract.

    b. Except for annuities (see 05-70-45), a contractual right to receive money payments that consists of a promissory note, loan, or mortgage is a disqualifying transfer unless:

        i. All payments due on the contract are expected to be made within the owners life expectancy as established using the tables at 05-100-75;
        ii. The contract provides for equal payments and does not provide for a balloon or deferred payment; and
        iii. The contract cannot be cancelled, or the payments diminished, upon the lender's death.

        The uncompensated value of a contract that is considered a disqualifying transfer is an amount equal to the remaining payments due from the contract.

        Example: When Mr. Green sold his land to his children on a contract for deed, the contract included a clause that no further payments would be due on the contract when he passed away. Because of this clause, the contract is considered a disqualifying transfer. $55,000 is still due on the contract, so the amount of the transfer is $55,000.

As is shown in the above two examples, Mr. Green made two transfers. The first transfer was because he did not receive fair market value for the property, thus he made a $35,000 transfer. The second transfer was because of the cancellation clause, which results in a $55,000 transfer. These two transfers are combined for a total transfer of $90,000.

If the entire contract itself is considered a disqualifying transfer that results in a penalty period, the contract is not also considered an available asset.

5. There is a presumption that the holder's interest in contractual rights to receive money payments is saleable without working an undue hardship. This presumption may be rebutted by evidence demonstrating that the contractual rights are not saleable without working an undue hardship, or in the case of an annuity, by establishing its countable value for Medicaid purposes (see 05-70-45-15 for valuation of annuities) (see 05-70-30(2) for more information regarding property that is not saleable without working an undue hardship).

   When offering contractual rights for sale, they must first be offered to co-owners, joint owners, or occupiers. If no buyer is secured, the contract must be offered for sale by public advertisement. The following content is acceptable as a means of demonstrating a good faith effort to sell a contract for deed:

   Example 1: Offered at 75% of value.

   For Sale: Seller's interest in contract for deed. Secured by W ½ of Sec. 65-13-120. Remaining payments of $18,000 are due in annual installments on Nov. 1, 2006 through 2010. Will consider offers which exceed $13,500. Call 555-3333 or write Box 12, Tampa Gazette, Tampa, ND 58990.

   Example 2: Offered at 100% of value.

   For Sale: Seller's interest in contract for deed. Secured by W ½ of Sec. 65-13-120. Remaining payments of $18,000 are due in annual installments on Nov. 1, 2006 through 2010. Call 555-3333 or write Box 12, Tampa Gazette, Tampa, ND 58990.

6. If an asset is sold in exchange for a contractual right to receive money payments, the principal payments received constitute a converted asset. (The interest portion of the payments is considered unearned income.)

Annuities 510-05-70-45

General Information 510-05-70-45-05

(Revised 5/1/2023 ML 3725)

View Archives

1. An annuity is a financial instrument, identified as such, that is established to provide periodic income payments over a defined period of time (see "annuity"). Most annuities are sold by organizations such as insurance companies (see "issuing entity"), though individuals sometimes assume the responsibility to pay annuity contracts. An annuity may be purchased with a single lump sum payment or through periodic payments. Annuities have long been used as a means of creating retirement income, and many established retirement plans involve the use of annuities. Annuities are also used in an attempt to convert countable assets into income so as to avoid consideration of those assets in eligibility determinations.

2. The following annuity sections describe the effect of any annuity on any application for Medicaid benefits. These sections identify annuities that are not countable assets; annuities that are countable assets, how to establish the value of an annuity; and how to determine if the purchase, annuitization, or change to an annuity is a disqualifying transfer, and if so, how to determine the amount of the disqualifying transfer. These sections take into consideration asset considerations (510-05-70-10), valuation of assets (510-05-70-60), and federal and state (N.D.C.C. 50-24.1-02.8) annuity provisions, which govern transfers and purchases of annuities. These sections recognize the extent to which annuities may be returned to the issuing entity for a cash settlement, transferred to another individual as payee, or have the payee's rights to income sold to another without the permission, or even the knowledge, of the issuing entity.

3. Annuities may be submitted to the Medicaid Eligibility unit for assistance in determining whether the annuity is countable as an asset or whether a disqualifying transfer occurred. A copy of the entire annuity policy, the date of birth of the annuitant, and verification of the annuity purchase price and, if applicable, date of annuitization must be secured and submitted with the inquiry.

A review cover sheet is available on the DHS County Intranet web site under the "Medicaid-Healthy Steps/Hard Cards/Annuity Information" folder for those wishing to submit an annuity to the Medicaid Eligibility Unit. Annuity checklists are also available in that folder for those workers wishing to make the determinations on their own. There is a separate checklist depending on when the annuity was last purchased or changed.

Definitions for Annuities 510-05-70-45-10

(Revised 1/1/08 ML #3120)

View Archives

For purposes of the annuity sections:

1. "Annuitant" means the individual whose life is considered in determining the price and payment schedule of an annuity, and who is usually the payee of the annuity;
2. "Annuitized annuity" means an annuity subject to a contractually established schedule of payments to be made by the issuing entity, other than an immediate lump sum payment of all of the annuity's value;
3. "Annuity" means a policy, certificate, contract, or other arrangement between two or more parties whereby one party pays money or other valuable consideration to the other party in return for the right to receive payments in the future for a fixed period of time;
4. "Employee benefit annuity" means:

    a. An annuity that was purchased with the proceeds from an individual retirement account (IRA), a Roth IRA, a simplified employee pension, an employer or employee association retirement account, or an employer simple retirement account, as described in section 408 of the Internal Revenue code of 1986 (IRC);
    b. An individual retirement annuity under Section 408(b) of the IRC (not to be confused with an individual retirement account); or
    c. An annuity described in any of the following IRC Sections:

        i. Employer plan under 401(a);
        ii. Trust under 501(a);
        iii. Annuity plan under 403(a) or 403 (b); or
        iv. Deferred compensation plan under 457(b).

    (These annuities are considered "qualified" annuities.);

5. "Issuing entity" means the individual or entity that issues and undertakes a promise to make payments provided in an annuity;
6. "Level monthly payments" means substantially equal monthly payments such that the total annual payment in any year varies by five percent or less from the total annual payment of the previous year and does not provide for a balloon or deferred payment of principal or interest;

7. "Life expectancy" means the anticipated lifetimes of individuals of a given age and sex according to the appropriate life expectancy table at 05-100-75.
8. "Third party annuity" means an annuity that is purchased and owned by a third party, but in which a Medicaid applicant, recipient, or their spouse, is the annuitant (i.e. an accident settlement annuity).

Valuation of Annuities 510-05-70-45-15

(Revised 12/1/19 ML #3569)

View Archives

1. The value of a countable annuity is:

    a. If the annuity may be surrendered to its issuing entity for a refund or payment of a specified amount or provides an available lump-sum settlement option, an amount equal to the total available proceeds from that refund, surrender, or settlement; and
    b. For any other annuity, an amount equal to either:

        i. Its value as a contractual right to receive money payments (value of outstanding payments due); or
        ii. Following a good faith effort to sell the annuity, an amount equal to the highest amount offered by a buyer ready and able to complete the purchase of the annuity or the right to receive a stream of income consisting of the payments yet to come due under the terms of the annuity.

2. The owner of an annuity may demonstrate a good faith effort to sell the annuity or the right to receive the payments from the annuity by making an offer to sell to the regular market for such property.

    a. "Receivables" are the legal right to be paid money due under the terms of a contract. The income stream produced by an annuity is such a receivable. Any person may purchase the right to this income stream.
    b. A "factor" is someone who buys receivables at a discount.
    c. The "factors' market" is one place that an annuity's income stream may be sold. Companies and individuals nationwide will pay a lump sum in return for the right to receive the remaining annuity payments. This income stream may be sold regardless of whether the annuity is irrevocable or not assignable. Several offers must be sought in order to establish the fair market value of the annuity.

3. A good faith effort to sell must include an honest effort to sell the annuity that is reasonably calculated to induce a willing buyer to believe the annuity or income stream offered for sale is actually for sale. An offer to sell an annuity or its payments includes making an offer to potential purchasers. The offer must include, at a minimum:

a. That the annuity owner is willing to take all necessary steps to sell the annuity or relinquish the payments under it in exchange for a lump sum payment including but not limited to providing an irrevocable power of attorney, change of beneficiary, payee, or address;
b. The amount of payments;
c. A description of the term of the payments (how long they will last); and
d. The name, address, and telephone number of a person who will answer inquiries and receive offers.

4. An annuity may not be excluded from consideration as an asset on the basis that it is not saleable without working an undue hardship.

Annuities Purchased Before February 8, 2006 510-05-70-45-20

(Revised 12/1/19 ML #3569)

View Archives

1. Any payment received from the annuity is income.

2. Annuities are not considered disqualifying transfers.

3. Annuities are not a countable asset unless the individual is able to liquidate the annuity, or the annuity is revocable.

Annuities Purchased or Changed on or After February 8, 2006 510-05-70-45-25

(Revised 12/1/19 ML #3569)

View Archives

1. Any payment received from the annuity is income, regardless whether the annuity itself is countable as an asset or is considered a disqualifying transfer.

2. An annuity is considered changed on or after February 8, 2006 if any action is taken on or after that date that changes the course of payments or the treatment of the income or principal of the annuity. These actions include additions of principal to the annuity, elective withdrawals, requests to change the distribution of the annuity, elections to annuitize the contract, or similar actions.

3. The annuity is counted as an available asset in the asset test if the individual has the power to liquidate the annuity, the annuity is revocable, or able to be assigned to another person.

4. The annuity is considered a disqualifying transfer unless:

    a. The payment option was selected, or the latest change to the annuity was made, prior to the individual's, or the individual's spouse's look back date;
    b. The annuity is a qualified employee benefit annuity, **and** the Department is named as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of the annuitant or the annuitant's spouse. The Department may be named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or child disposes of any such remainder for less than fair market value;
    c. The annuity:

        i. Provides substantially equal payments, no less frequently than annually, such that the total annual payment is any year varies by five percent or less from the total annual payment of the previous year and does not provide for a balloon or deferred payment of principal or interest;
        ii. The annuity will return the full principal and interest within the annuitant's life expectancy; **and**
        iii. The Department is named as the remainder beneficiary in the first position for at least the total amount of Medicaid paid on behalf of the annuitant or the annuitant's spouse. The Department may be

named as the remainder beneficiary in the second position after the community spouse or minor or disabled child and is named in the first position if such spouse or child disposes of any such remainder for less than fair market value; or

d. The annuity is a third party annuity.

5. The uncompensated value of an annuity that is considered a disqualifying transfer is an amount equal to the remaining payments due from the annuity (or the applicant or recipient can show the outstanding principal amounts due, if that information can be attained).

6. The date of the disqualifying transfer is the date the payment option was selected on the annuity, or if later, the date the annuity was changed so the annuity could no longer be surrendered.

7. When the Department is entitled to be the remainder beneficiary of an annuity purchased or changed on or after February 8, 2006, the “Notice to Insurer of Annuity” (SFN 1186) (05-100-96) must be sent to the company that issued the annuity. The notice must be sent and verification received back from the company, prior to approving the Medicaid application, or if an ongoing case, when the annuity is reported.

Trusts 510-05-70-50

(Revised 1/1/18 ML #3508)

View Archives

(N.D.A.C. Sections 75-02-02.1-31 and 75-02-02.1-31.1)

1. A trust is an arrangement whereby a person known as the "grantor" or "trustor" gives assets to another person known as the "trustee" with instructions to use the assets for the benefit of a third person known as the "beneficiary". The positions of grantor, trustee, and beneficiary occur in all trusts, but it is not uncommon for a single trust to involve more than one grantor, trustee, or beneficiary. It is also not uncommon for a grantor to establish a trust in which the grantor is also a beneficiary or the trustee is also a beneficiary. The assets placed in trust are called the "principal" or "corpus".
2. A trust includes any legal instrument or device, whether or not written, which is similar to a trust. An unwritten trust may arise anytime someone gives property to another with instructions to use the property in a particular way, or anytime someone keeps for his own use property that belongs to another. When this happens, the individual who owned the property is both the grantor and the beneficiary of an unwritten express or implied trust.
3. Trusts may, or may not, make income or assets available to an applicant or recipient. Also, when an applicant or recipient creates a trust, assets put into the trust may be a disqualifying transfer. A thorough review of each trust is necessary to determine its effect, if any, on eligibility. Send trusts to the Legal Advisory Unit for review. When trusts are submitted for review, include all appropriate information so the trust may be reviewed in a timely manner. When requesting a review of a trust document:

    a. Send the **complete** trust agreement (signed, dated, and notarized) and all pages and attachments;
    b. If the trust is unwritten, describe the circumstances that you believe created the trust in a letter;
    c. Provide verification of the value of each asset owned by the trust, when each asset was transferred to the trust, and who transferred the assets to the trust;
    d. Identify **who** is applying for **which** benefits (e.g. Medicaid nursing care, Medicaid no-nursing care, etc.);
    e. Provide any other documents or information you think may be relevant (like schedules, powers of attorney, financial statements, etc.); and

f. Complete and include SFN 1947, "Request for Trust Review" available at http://www.nd.gov/eforms.

4. Applicant as trustee.

An applicant or recipient who is a trustee has the legal ownership of trust property and the legal powers to distribute income or trust assets which are described in the trust. However, those powers may be exercised only on behalf of trust beneficiaries. If the trustee or other members of the Medicaid unit are not also beneficiaries or grantors to whom trust income or assets are treated as available, trust assets are not available to the trustee.

Valuation of Assets 510-05-70-60

(Revised 7/1/2025 Release 25.14)

View Archives

(N.D.A.C. Section 75-02-02.1-32)

Determining the exact value of assets can be challenging, but establishing a value is necessary for eligibility purposes. The applicant or recipient must provide a reliable valuation for each asset needed to determine eligibility. Since they may not know asset values or may have a strong interest in a specific value, these amounts must be verified. If the provided valuation differs significantly from common sources, the reason for the difference must be explained. Without reliable asset value information, eligibility cannot be determined. Useful verification sources include:

1. With respect to liquid assets: reliable account records.
    a. Accounts maintained by banking facilities
        i. When establishing eligibility, the value of liquid assets is determined using the account records provided. If the verification includes more than one balance for the month for which eligibility is being determined, the lowest balance is used. If the applicant or recipient has excess assets, subtract any monthly income that was deposited into the account. Income subtracted from the account, however, cannot be deducted from a balance prior to the date the income was deposited.

            Example: The low balance in an account is on May 2. The monthly income is deposited on May 7. The next low balance is on May 30. The monthly income cannot be subtracted from May 2 low balance, but it can be subtracted from the May 30 balance.

        ii. If an applicant or recipient provides verification of checks that were recently written, but that have not cleared the account by the end of the month, those expenditures can be used to further reduce the value of the account.
    b. Publicly traded stocks, bonds, and securities: Stockbrokers.

2. With respect to personal property other than liquid assets:

a. Motor vehicles, mobile homes, boats, or any other property listed in published valuation guides accepted in the trade: Kelly Blue Book, NADA, etc.
    i. Use the "average trade-in" value for the vehicle without using any add- ons or deductions. The applicant or recipient may also provide verification of the true value from a reliable source if the vehicle is no longer listed in the valuation guide or if the applicant or recipient has reason to believe that the estimate is inaccurate.
b. Harvested grains or produce: grain buyers, grain elevator operators, produce buyers; and, for crops grown on contract: the contract.
c. Stock in corporations not publicly traded: appraisers, accountants.
d. Contractual rights to receive money payments: If payments are current, the contract, and if payments are not current, see 05-70-40.
e. Other personal property: dealers and buyers of that property.
f. Life insurance policies: the insurance company.

3. Real property:

    a. With respect to mineral interests:

        i. If determining current value (for sale or pending transfer):

        (1) Fair market value is the value established by good faith effort to sell. The best offer received establishes the value.

        (2) A good faith effort to sell means offering the mineral interests to at least three companies purchasing mineral rights in the area, or by offering for bids through public advertisement.

        ii. If determining a previous value for mineral rights sold or transferred in the past, fair market value is:

        (1) If producing, the value is an amount equal to any lease income received after the transfer plus three times the annual royalty income.

            (a) Based on actual royalty income from the 60 months following the transfer; or

            (b) If 60 months have not yet passed, based on actual royalty income for the months that have already passed, and an estimate for the remainder of the 60 month period.

(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.

b. With respect to agricultural lands: appraisers, real estate agents dealing in the area, loan officers in local agricultural lending institutions, and other persons known to be knowledgeable of land sales in the area in which the lands are located, but not the "true and full" value from tax records.
c. With respect to real property other than mineral interests and agricultural lands: market value or "true and full" value from tax records, whichever represents a reasonable approximation of market value; real estate agents dealing in the area; and loan officers in local lending institutions. If a valuation from a source offered by the applicant or recipient is greatly different from the true and full value established by tax records, an explanation for the difference must be made, particularly if the applicant or recipient may be able to influence the person furnishing the valuation.

4. Divided or partial interests. Divided or partial interests include assets held by the applicant or recipients, jointly or in common with persons who are not in the Medicaid unit; assets where the applicant or recipient or other persons within the Medicaid unit own only a partial share of what is usually regarded as the entire asset; and interests where the applicant or recipient owns only a life estate or remainder interest in the asset.

a. Liquid assets. The value of a partial or shared interest in a liquid asset is equal to the total value of that asset.
b. Personal property other than liquid assets and real property other than life estates and remainder interests. The value of a partial or shared interest is a proportionate share of the total value of the asset equal to the proportionate share of the asset owned by the applicant or recipient.
c. Life estates and remainder interests.

i. The life estate and remainder interest table must be used to determine the value of a life estate or remainder interest. In order to use the table, it is necessary to first know the age of the life tenant or, if there is more than one life tenant, the age of the youngest life tenant; and the market value of the property which is subject to the life estate or remainder interest. The value of a life estate is found by selecting the appropriate age in the table and multiplying the corresponding life estate decimal fraction times the market value of the property. The value of a remainder interest is found by selecting the appropriate age of the life tenant in the table and multiplying the corresponding remainder interest decimal

fraction times the fair market value of the property. Refer to 05-100-80 for the Life Estate table.

ii. The life estate and remainder interest tables are based on the anticipated lifetimes of individuals of a given age according to statistical tables of probability. If the life tenant suffers from a condition likely to cause death at an unusually early age, the value of the life estate decreases and the value of the remainder interest increases. An individual who requires long-term care, who suffers from a condition that is anticipated to require long-term care within twelve months, or who has been diagnosed with a disease or condition likely to reduce the individual's life expectancy is presumed to suffer from a condition likely to cause death at an unusually early age, and may not rely upon statistical tables of probability applicable to the general population to establish the value of a life estate or remainder interest. If an individual is presumed to suffer from a condition likely to cause death at an unusually early age, an applicant or recipient whose eligibility depends upon establishing the value of a life estate or remainder interest must provide a reliable medical statement that estimates the remaining duration of life in years. The estimated remaining duration of life may be used, in conjunction with a life expectancy table, to determine the comparable age for application of the life estate and remainder interest table. Refer to 05-100-75 for the life expectancy table.

iii. In most situations, the act of establishing a life estate interest in property is transferring a partial interest, a remainder interest, in property to someone else, while retaining (or giving another) the life estate interest. When transferring a remainder interest, part of the value of the property is also transferred. The value transferred is established by multiplying the value of the property at the time of transfer by the appropriate value in the remainder interest column of the life estate and remainder interest table. Equity in the property must also be considered when determining the amount of the transfer. If there is a loan against the property that is assumed by the remaindermen as part of the transfer, then the amount of the loan is considered compensation received. If the life tenant retains the loan obligation, the full value of the remainder interest is the amount transferred.

> **Example**: A 75-year-old individual transfers a remainder interest in property, valued at $80,000, to his children and keeps a life estate interest. Using the table, the value of the remainder interest is $38,280.80 ($80,000 x .47851 =

$38,280.80). That is the amount he gave to his children and is the amount of the disqualifying transfer. He still owns the life estate interest, which has a value of $41,719.20.

Equity in the property must also be considered when determining the amount of the transfer. If there is a loan against the property that is assumed by the remaindermen as part of the transfer, then the amount of the loan is considered compensation received. If the life tenant retains the loan obligation, the full value of the remainder interest is the amount transferred.

Example: A 75-year-old transfers a remainder interest in property, valued at $80,000, to his children and keeps a life estate interest. He has a $20,000 mortgage on the property, which he is still obligated to pay. Using the table, the value of the remainder interest is $38,280.80 ($80,000 x .47851 = $38,280.80) and is the value of what he transferred away. He still owns the life estate interest, which has a value of $41,719.20, but he only has $21,719.20 in equity ($41,719.20 - $20,000 loan). If the children who received the remainder interest also assumed the mortgage, the children actually are giving compensation, so the uncompensated amount of the transfer is only $18,280.80 ($38,280.80- $20,000 loan = $18,280.80).

Income and Asset Considerations in Certain Circumstances 510-05-75

Ownership in a Business Entity 510-05-75-05

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Sections 75-02-02.1 - 28(1) and 75-02-02.1-34(8))

1. Assets. Property consisting of an ownership interest in a business entity (e.g. a corporation or partnership) that employs anyone whose assets are used to determine eligibility may be excluded as property essential to earning a livelihood if:

    a. That individual's employment is contingent upon ownership of the property; or
    b. There is no ready market for the property. A ready market exists if the interest in the business entity (e.g. the corporation stock or partnership interest) may be publicly traded through a broker. A ready market does not exist when there are unreasonable limitations on the sale of the business interest, such as a requirement that the interest be sold at a price substantially below its actual value or a requirement that effectively precludes competition among potential buyers.

        Example 1: An applicant works at a firm that has publicly traded stock. Employment at the firm requires ownership of some of the firm's stock. Even though there is a ready market for the stock, it is excluded because the applicant is employed at the firm and that employment is contingent upon stock ownership.

        Example 2: An applicant works on a private farm that has been incorporated. He owns some of the family farm stock, however, ownership of the stock is not required in order for him to be employed on the farm. Even though stock ownership is not an employment requirement, the stock is excluded because the applicant is employed on the farm and there is no ready market for the farm stock.

        Example 3: An applicant is actively engaged in a partnership. There is no ready market for buying or selling a share in the partnership and the applicant must own part of the partnership in

order to be employed by it. Accordingly, the applicant's share in the partnership is excluded as an asset.

2. Income: Countable income from a business entity (e.g. a corporation or partnership) that employs anyone whose income is used to determine eligibility is established as follows:

    a. If the applicant or recipient and other members of the Medicaid unit own the controlling interest in the business entity, calculate income using the medically needy self-employment rules described in 05-85-20; or
    b. If the applicant or recipient and other members of the Medicaid unit own less than a controlling interest, but more than a nominal interest in the business:

        i. From the business entity's gross income, subtract any cost of goods for resale, repair, or replacement, CRP payments and patronage or cooperative dividends, and subtract any wages, salaries, or guarantees (but not draws), paid to actively engaged owners to arrive at the business entity's adjusted gross income; and
        ii. From the adjusted gross income, establish the applicant or recipient's income share based on the Medicaid unit's proportionate share of ownership in the business entity; and
        iii. Add any wages, salary, or guarantee paid to the applicant or recipient to the applicant or recipient's income share; and
        iv. Apply the medically needy self-employment income disregards described in 05-85-20; and
        v. Based on the applicant's or recipient's proportionate share of ownership in the business entity, establish the individual's share of the CRP payments and patronage or cooperative dividends as unearned income; or

    c. If the applicant or recipient and other members of the Medicaid unit, in combination, own a nominal interest in the business entity, and are not able to influence the nature or extent of employment by that business entity, the individual's earned income as an employee of that business entity, plus any unearned income gained from ownership of the interest in the business entity.

Treatment of Conservation Reserve Program Property and Payments 510-05-75-10

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Sections 75-02-02.1-28(1) and 75-02-02.1-37(3))

1. Assets: Property enrolled in the Conservation Reserve Program (CRP) is considered property essential to earning a livelihood and is excluded as an asset.
2. Income.

   CRP payments are considered unearned income.

   When a CRP contract is set up, the full payment may be received by the landlord or operator, or a portion of the payment may be paid to a tenant of the farm. A portion of the payment is allowed to be paid to a tenant if the tenant was farming the land, or had an interest in the property (e.g. was on the previous contract), in the year before the contract was signed. The CRP contract specifies the amount of the payment and to whom the payment is made.

   For purposes of determining eligibility, only count the share the applicant or recipient receives per the CRP contract.

3. Expenses.

   Actual maintenance expenses, up to $5 per acre per year, which are not reimbursed (e.g. by ASCS), may be deducted from the gross CRP payments. Actual maintenance expenses are those expenses necessary to maintain the property according to the CRP contract, such as seed, spray, etc. Allowable maintenance expenses do not include property taxes or insurance.

   When the CRP contract requires more extensive maintenance or preparation, the $5 per acre can be exceeded by actual verified expenses up to the NDSU Extension rate established for the area.

When the applicant or recipient receives 100% of the payment, the allowable expenses that are not reimbursed are allowed. When the applicant or recipient only receives a percentage of the payment, that same percentage of the allowable expenses is allowed. For example, if 90% of the payment is received by the applicant, then only 90% of the allowable expenses can be allowed as a deduction.

4. Disqualifying transfer of CRP income.

    a. When a landlord/operator who is applying for Medicaid for nursing care services is not receiving 100% of the CRP payment, a determination needs to be made whether there was a disqualifying transfer of income. Follow these steps to determine if a disqualifying transfer occurred:

        i. Determine whether the contract was set up or renewed within the look back period. If not within the look back period, there is no disqualifying transfer.
        ii. If within the look back period, determine if the tenant was farming the property, or had an interest in the property, in the year before the contract was signed. If the tenant was not farming the property, or did not have an interest in the property, the amount of the payment going to the tenant is a disqualifying transfer of income.
        iii. If within the look back period and the tenant was farming, or had an interest in the property, determine if the landlord receives at least 90% of the payment. If not, a disqualifying transfer is considered to have occurred unless the landlord can show that fair value was received for the excess payment (i.e. the cost for the regular maintenance of the property equals the higher percentage).

    b. If it is determined that a disqualifying transfer of income did occur, the amount of the disqualifying transfer is calculated by establishing the value of the payments transferred. Following is an example showing how a disqualifying transfer would be applied.

        Example: Property was put into a CRP contract within the look back period. A tenant was farming the property in the year before the contract was signed. The contract pays $10,000 per year and the tenant receives 50% of the payment. There is nothing showing that the tenant should receive more than 10% of the payment and the landlord is applying for Medicaid. The tenant receives $5000 of the payment each year, but should only receive $1000. The amount of the disqualifying transfer, which occurred when the

contract was signed is $4000 multiplied by the number of years (10) in the contract, for a total of $40,000.

Communal Colonies 510-05-75-15

(Revised 1/1/13 ML #3358)

View Archives

Individuals who live communally (i.e. Hutterites, Mennonites, Amish, etc.) may or may not have a collective ownership of property and income. In determining eligibility, it will first be necessary to determine whether collective ownership of assets and income exists. If it does not, medically needy policy applies to individuals and families, as it does for any other individual or family.

If the commune has collective ownership, also determine whether the commune is self-employed. Most communal colonies are self-employed in agricultural or manufacturing and are incorporated, or set up as a large partnership. Occasionally, some colonies are not self-employed, but may be working under contract for wages.

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 excluded, are countable, and the medically needy asset limits apply.

2. Income. Most colonies have collective ownership of income, which is often generated from their self-employment venture. When colonies have a collective ownership in income, a share attributable to each individual or family must be determined. Countable income is established as follows:

   a. If the colony is self-employed, from the colony's corporate or partnership tax return:

      i. From the total gross income, subtract any cost of goods for resale, repair, or replacement, to arrive at the colony's adjusted gross income; and
      ii. Divide the total amount of adjusted gross income by the number of members in the colony to establish each individual's share of income. Multiply this amount by the number of individuals in the Medicaid unit to determine the unit's share. If the tax return represents an entire year of the business operation, one twelfth of the unit's share is the monthly income; and

iii. Apply the medically needy self-employment income disregards described in 05-85-20; and

> **Example:** There are 124 members in a colony that is engaged in farming. A family of six in the colony applies for Medicaid. The corporate tax return indicates $4,922,603 in adjusted gross earnings. Divide $4,922,603 by 124 members to arrive at each individual's share of $39,698.41. Multiply $39,698.41 by six to arrive at the unit's share of $238,190.46. The self-employment disregard for farming is 75%, which gives the family $59,547.62 in countable annual income. Divide by 12 to determine the Medicaid unit's monthly income of $4,962.30.

iv. Identify the income as belonging only to the adults in the Medicaid unit, or older children who are actively engaged in the operation and are not students, and allow the appropriate earned income deductions for those individuals who are actively engaged in the operation. If no individuals in the Medicaid unit are actively engaged in the business, such as an aged or disabled individual, the income is considered to be unearned income; or

> **Example:** An aged individual from a colony engaged in farming applies for Medicaid. The corporate tax return indicates $4,922,603 in adjusted gross earnings, which is divided by the 124 members in the colony to arrive at each individual's share of $39,698.41. Because there is only one individual in the unit, the unit's share is $39,698.41. The self-employment disregard for farming is 75%, which gives the individual $9,924.60 in countable annual income. Divide by 12 to determine the Medicaid unit's monthly income of $827.05. The income is shown as unearned income because the aged person is no longer actively engaged in the business.

b. If the colony is not self-employed, but is working under contract for wages:

i. Divide the total contract income by the number of members in the colony to establish each individual's share of income. Multiply this amount by the number in the Medicaid unit to determine the unit's share; and

ii. Identify the income as belonging only to the adults in the Medicaid unit, or older children who are actively engaged in the operation and are not students, and allow the appropriate earned income deductions for those individuals who are actively engaged in the operation. If no individuals in the Medicaid unit are actually engaged in the business, such as an aged or disabled individual, the income is considered to be unearned income; and

c. For members who have other earned or unearned income, the income counts as income of the individual who receives it and the medically needy policies apply to the income. Income is counted for the individual, even if the income has been given to the colony.

3. Adding or deleting individuals.

a. Changes in the unit's share of income must be changed when adding or deleting members to the unit and is based on the number of individuals in the unit. The share is not changed when adding an unborn child until the child is born.

Example: The individual share of income established for a colony, based on the colony's self-employment, is $350 per individual per month. A family within the colony consists of 5 individuals so the Medicaid unit's total monthly income is $1,750 (5 x $350). A child is born and added to the unit, so now the unit consists of 6 individuals, and monthly income is $2,100 (6 x $350). If the unit had instead lost a member and reduced in size to 4, the income would have decreased to $1,400 (4 x $350).

b. The individual's share of income, which is based on the number of members in the colony, is normally determined when calculating annual income from self-employment for self-employed colonies, or for a new contract period for colonies working under a contract for wages. The number of members in the colony does not need to be changed in between these calculations, or when adding or deleting a member from the household. However, if the colony reports a change in the number of members, the individual share must be recalculated based on the new information.

Example 1: The individual share of income has been established for a colony at $350 per individual per month. This amount was originally calculated based on the number of members in the colony and the colony's self-employment income. A child is born

to a family. A new calculation does not have to be made because there may now be more members in the colony, but the $350 per person per month continues to be used as the individual share of income.

Example 2: The individual share of income has been established for a colony at $350 per individual per month, and was based on 124 members. A child is born to a family and reported. At the same time, new information is provided that the colony now has 118 members because a different family left the colony, and one member died. A new calculation must be made because a change in the actual membership number has been confirmed by the colony. The new individual share has now increased to $367.80 per person per month.

Disqualifying Transfers 510-05-80

Definitions 510-05-80-05

(Revised 1/1/2025 ML 3891)

View Archives

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

For purposes of this section:

1. Assets or income an individual disposes of means assets or income to which the individual is entitled, or would be entitled if action, or inaction, causes the individual to not receive the asset or income. Examples of actions which would cause assets or income not to be received are:

    a. Irrevocably waiving pension income;
    b. Waiving an inheritance; or
    c. Not accepting or accessing injury settlements.

2. Fair Market value means:

    a. In the case of a liquid asset that is not subject to reasonable dispute concerning its value, such as cash, bank deposits, stocks, and commodities, one hundred percent of apparent fair market value;
    b. In the case of real or personal property that is subject to reasonable dispute concerning its value 75% of estimated fair market value and;

    c. In the case of income, one hundred percent of apparent fair market value.

3. "Relative" means child, stepchild, grandchild, parent, stepparent, grandparent, aunt, uncle, niece, nephew, brother, sister, stepbrother, stepsister, half-brother, half-sister, first cousin, or in-law.

4. "Uncompensated value" means the difference between fair market value as of the date of transfer and the value of any consideration received.

    When the party that receives the transferred property also assumes any outstanding loan(s) on the property, the amount of the outstanding loan(s) is consideration received.

Example: Mr. Green owns property with an estimated value of $80,000. He has a mortgage for $50,000 on the property. If Mr. Green sells the property for $30,000 and the purchaser assumes the mortgage, Mr. Green is actually receiving $80,000 in compensation, and there is no disqualifying transfer. If the purchaser does not assume the mortgage, the uncompensated value is $50,000 (the difference between $30,000 and the estimated market value of $80,000).

5. "Community spouse" has the same meaning as in 05-65-10, Definitions for Spousal Impoverishment.
6. "Home and Community Based Services spouse" has the same meaning as in 05-65-10, Definitions for Spousal Impoverishment.
7. "Institutionalized spouse" has the same meaning as in 05-65-10, Definitions for Spousal Impoverishment.
8. The average cost of nursing facility care is:

Year	Daily Rate	Monthly Rate
2025	401.74	12,219.59
2024	404.19	12,263.70
2023	366.68	11,153.18
2022	352.42	10,719
2021	313.08	9522.85
2020	302.95	9214.73
2019	280.4	8530.05
2018	270.71	8234.10
July - Dec 2017	265.35	8071.06
Jan 2017	257.90	7844.46
2016	258.78	7871.23
2015	249.79	7595.04
2014	238.94	7268
July-Dec 2013	231.39	7038
Jan-2013	223.30	6792
2012	213.82	6504

2011	205.07	6238
2010	195.55	5948
2009	179.27	5453
2008	165.59	5037
2007	159.96	4865
2006	152.33	4633
2005	144.48	4395
2004	137.59	4185
2003	129.71	3945
2002	127.05	3864
July-Dec2001	120.08	3652
Jan-June 2001	109.98	3345
2000	104.94	3192
1999	97.68	2971
1998	94.31	2869
1997	89.00	2713
1996	85.00	2562
1995	80.00	2419
1994	74.00	2339

Disqualifying Transfer Provisions 510-05-80-10

(Revised 1/1/13 ML #3358)

View Archives

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

1. An individual is ineligible for nursing care services if the individual or the spouse of the individual disposes of assets or income for less than fair market value on or after the look-back date. (Transfers by a parent of the parent's assets do not affect a child's coverage of nursing facility services and transfers by a child of the child's assets do not affect the parent's coverage.)
2. The look-back date for income or asset transfers made before February 8, 2006 (other than for transfers to or from a trust) is a date that is thirty-six months before the date on which the individual is both receiving nursing care services and has applied for benefits under this chapter, without regard to the action taken on the application.
3. The look-back date for income or assets transferred on or after February 8, 2006, or transferred to an irrevocable trust, or from a revocable or irrevocable trust, established by an applicant, a recipient, their spouse, or any one acting on their behalf, other than by will, is a date that is 60 months before the date on which the individual is both receiving nursing care services and has applied for benefits under this chapter, without regard to the action taken on the application.
4. Once a look-back date is established for an individual, it will always be the look-back date for that individual.

   Example: Mr. Green entered LTC and applied for Medicaid in January 2000. Since he is both receiving nursing care and has applied for Medicaid, his look-back date is established as January 1997. Mr. Green left LTC in March 2001, closed his Medicaid case, and made a large transfer. In May 2004, he enters LTC again and reapplies for Medicaid. The March 2001 transfer (38 months ago) was made on or after the look-back date (January 1997), so is considered.

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

75 months later. The disqualifying transfer was made prior to her look-back date (60 months). Mrs. Brown can be eligible for Medicaid coverage of her LTC costs while Mr. Brown is still ineligible.

6. A transfer is complete when the individual (or the individual's spouse) making the transfer has no lawful means of undoing the transfer or requiring a restoration of ownership. A transfer takes effect upon delivery, and unless proven otherwise, delivery is presumed to occur at the date the deed was signed. The deed does not have to be physically delivered or registered at the county office to be delivered.
7. The provisions of this section do not apply in determining eligibility for Medicare Savings Programs.

Penalty Periods 510-05-80-15

(Revised 12/1/2023 ML #3804)

View Archives

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

1. The number of months and days of ineligibility for an individual shall be equal to the total uncompensated value of all income and assets transferred by the individual, or individual's spouse, on or after the look-back date, divided by the average monthly cost, or daily cost as appropriate, of nursing facility care in North Dakota at the time of the individual's application during which the disqualifying transfer was determined.

   The following example demonstrates how the monthly and daily period of ineligibility is calculated:

   Example: Mr. Brown applied for Medicaid December 10, 2011 and it was determined Mr. Brown made a disqualifying transfer of $70,000 in November 2010. The December 2011 application was denied.

   Mr. Brown re- applied for Medicaid on July 18, 2013. The average cost of nursing facility care at the time the disqualifying transfer was determined (12-2011) is $6,238 per month and $205.07 per day. $70,000 divided by $6,238 is 11.22 months. Eleven months at $6,238 per month is $68,618, leaving $1,382 to which the daily rate is applied. $1,382 divided by $205.07 is 6.73 days. Mr. Brown's penalty period is 11 months and 7 days (partial days are rounded up).

2. Transfers-Period of Ineligibility:
   a. The period of ineligibility begins on the latest of:
      i. The first day of the month in which the income or assets were transferred for less than fair market value;
      ii. The first day on which the individual is receiving nursing care services and is "otherwise eligible" for Medicaid (per subsection 4);
      iii. The first day thereafter which is not in such a period of ineligibility; or

iv. The first day of the month following the notice of adverse action for ongoing eligible individuals.

b. Separate transfers for which a penalty period has not yet been created, regardless of whether made in separate months, may be combined into on larger transfer for processing purposes.

3. When determining if an individual is "otherwise eligible" for Medicaid:
   a. The individual must have applied for Medicaid and must meet all non-financial eligibility criteria;
   b. Countable assets must be within appropriate Medicaid asset levels; and
   c. The monthly cost of nursing care and other medical care the individual is responsible for must be equal or greater than the individual's client share (recipient liability).

This "otherwise eligible" determination is used to establish whether an individual would be eligible for Medicaid if they were not subject to a penalty period. If so, the "otherwise eligible" determination is used to establish the penalty period start.

An applicant who is determined to be “otherwise eligible” does not mean that the applicant is actually eligible for Medicaid. Since Medicaid is prohibited from paying any nursing care services during a penalty period, these nursing care expenses are not allowed as a deduction in the Post Eligibility Treatment of Income (510-05-85-25(3)). As a result, an individual who made a disqualifying transfer may be “otherwise eligible” for penalty period start purposes, but the individual is not approved for Medicaid because there is no medical need per 510-05-35-35.

Example 1: Mr. Brown made a disqualifying transfer in March 2023 that results in a 6-month penalty period. He entered the nursing home in May 2023 and used his remaining assets to cover his cost of care. In September 2023 his assets were under $3000 and he applied for Medicaid. In determining when Mr. Brown’s penalty period begins it is necessary to establish when he is “otherwise eligible” for Medicaid. First, he meets all non-financial criteria. Second, his assets are within the appropriate level beginning September 2023. Third, he has income of $1900.00 per month; he is allowed the $100 income level; and he pays a Medicare premium of $164.90 per month. This leaves him with a client share of $1635.10 per month. He has actual nursing care costs of $10,000 per month and other medical expenses of $150 per month for total medical costs of $10,150 per month. These medical costs exceed

his client share. He meets all of the criteria to be “otherwise eligible” so his penalty period starts September 1, 2023.

His application for Medicaid is still denied because in determining medical need, his other medical expenses of $150, excluding the nursing care costs, do not exceed his client share.

Example 2: Mr. White made a disqualifying transfer in March 2023, entered the nursing home in May 2023, and used his remaining assets to cover his cost of care. In September 2023 his assets were under $3000 and he applied for Medicaid. In determining whether Mr. White is “otherwise eligible” for Medicaid, it is first established that he meets all non-financial criteria. Second, his assets are within the appropriate level beginning September 2023. Third, he has income of $2500 per month; he is allowed the $100 income level; and he pays a Medicare premium of $164.90 per month. This leaves him with a client share of $2235.10 per month. He has actual nursing care costs of $9500 per month, and he has nursing home insurance that pays $250 per day ($7500 in a 30-day month). As a result, the nursing care costs that he is responsible for ($2000) does NOT exceed his client share, and he is not “otherwise eligible.” His penalty period would not start and his application for Medicaid is denied for no medical need.

If at a later date his nursing care costs increase, or his insurance ends, causing his nursing care costs to exceed his client share, he would become “otherwise eligible,” and his penalty period would only start at that time.

4. If a transfer results in a period of ineligibility for an individual receiving nursing care services, and the individual’s spouse begins receiving nursing care services and is "otherwise eligible" (per subsection 4) for Medicaid, the remaining period of ineligibility shall be apportioned equally between the spouses if the transfer was made on or after the individual's spouse's look-back date. Any months remaining in the period of ineligibility must be assigned or reassigned to the spouse who continues to receive the nursing care services if one spouse dies or stops receiving nursing care services.

   Example: Mr. and Mrs. White make a disqualifying transfer in January 2023. Mrs. White enters LTC in February 2023 and is informed that the transfer in January will cause her to be ineligible for Medicaid coverage

of her nursing care services until June 30, 2025. On March 1, 2004, Mr. White also enters LTC and is otherwise eligible for Medicaid. There are still 16 months of the penalty period remaining, which is divided between them. They will both be ineligible for eight months, or through October 2024.

If Mr. White left LTC on June 20, 2024, his remaining four months and ten days from his ineligibility period must be given back to Mrs. White, extending her period of ineligibility through February 10, 2025.

Example: Mr. and Mrs. Brown make a large disqualifying transfer that causes 70 months of ineligibility. At the same time, Mr. Brown enters LTC, applies for Medicaid, and is ineligible because the disqualifying transfer was made on or after his look-back date. Mrs. Brown enters LTC 62 months later and applies for Medicaid. The disqualifying transfer was made prior to her look-back date (60 months) so none of Mr. Brown's remaining 8 months of penalty period is assigned to Mrs. Brown.

5. As with any adverse action, proper notice is required before the adverse action can be taken. On an application, proper notice is given in the approval or denial notice. In an ongoing case, even though the penalty period should have already begun, it cannot be imposed until an advance notice is provided to the recipient. The penalty period will begin the first of the month following the proper notice of adverse action.

   Example: Ms. Green is a current Medicaid recipient receiving HCBS. On November 2 she made a disqualifying transfer of her home and reported it to the zone office on December 5. The zone worker processes the penalty in the system December 7th. The penalty period will begin January 1, the first month following the advance notice to decrease benefits.

   Example: Mr. Brown is a current Medicaid recipient in a long-term care facility. On March 28 of last year he made a disqualifying transfer of an inheritance, but did not report it until January 15th of this year. The zone office processes the case, entering the disqualifying transfer information on January 27th. Since there is not enough time to provide an advance notice of decrease for February, the penalty period will begin March 1st.

Hardship Provision 510-05-80-20

(Revised 12/1/19 ML #3569)

View Archives

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

1. A disqualifying transfer penalty period is not imposed on an individual to the extent the individual makes a satisfactory showing that an undue hardship exists for the individual.
2. Upon imposition of a penalty period because of a transfer of assets or income, an individual must be provided notification of the right to request an undue hardship exception. An individual may apply for an exception to the transfer of asset penalty if the individual claims that the penalty period will cause an undue hardship to the individual and provides sufficient documentation to support that claim within 90 days of notification of the transfer penalty, or within 90 days after the circumstances upon which the claim of hardship is made known, or reasonably should have been known, to the affected individual or the person acting on behalf of the individual if incompetent.

   The facility in which the person resides may apply for an exception to the transfer penalty on behalf of the individual if they have the individual's, or the individual's personal representative's, consent.

3. Requests for undue hardship exceptions must be submitted to the Medicaid Eligibility Unit. Upon receipt of a request for a hardship exception, the Medicaid Eligibility Unit will determine whether an undue hardship exists. The determination of the hardship made by the Medicaid Eligibility Unit will state the date upon which the hardship exception begins, and, if applicable, when it ends.
4. An undue hardship exists only if the individual shows that all of the following conditions are met:

   a. Application of the penalty period would deprive the individual of food, clothing, shelter, or other necessities of life, or medical care such that the individual's health or life would be endangered;
   b. The individual, the individual's spouse, or anyone acting on behalf of either, has not made the transfer after a previous request for a hardship exception;
   c. The individual who transferred the assets or income, or on whose behalf the assets or income were transferred, has exhausted all lawful means to

recover the transferred assets or income, or the value of the transferred assets or income, from the transferee, a fiduciary, or any insurer;

d. A person who would otherwise provide care would have no cause of action, or has exhausted all causes of action, against the transferee of the assets or income of the individual or the individual's spouse under North Dakota Century Code chapter 13-02.1, the Uniform Fraudulent Transfers Act, or any substantially similar law of another jurisdiction; and
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. 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. Before August 1, 2019 - Funds for burial of $6,000 or less for the individual and the individual's spouse. After August 1, 2019 - Funds are irrevocable itemized burial contract for the individual and the individual's spouse.

5. If a request for an undue hardship exception is denied, the applicant or recipient may request an appeal to the North Dakota Department of Human Services.
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 excluded.

Exceptions to Disqualifying Transfer Provision 510-05-80-25

(Revised 12/1/19 ML #3569)

View Archives

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

1. A transfer is not disqualifying to the extent the asset transferred was the individual's home or residence, and it was transferred to:

    a. The individual's spouse;
    b. The individual's son or daughter who is under age twenty-one, or blind, or disabled;
    c. The individual's brother or sister who has an equity interest in the individual's home and who was residing in the individual's home for a period of at least one year immediately before the date the individual began receiving nursing care services; or
    d. The individual's son or daughter (other than a child described in subdivision b) who was residing in the individual's home for a period of at least two years immediately before the date the individual began receiving nursing care services, and who provided care to the individual which permitted the individual to avoid receiving nursing care services.

2. A transfer is not disqualifying to the extent that the asset transferred was any Medicaid excluded asset other than:

    a. The home or residence;
    b. Property which is not saleable without working an undue hardship;
    c. Excluded home replacement funds;
    d. Excluded payments, excluded interest earned on the payments, and excluded in-kind items received for the repair or replacement of lost, damaged, or stolen exempt or excluded assets;
    e. Life estate interests;
    f. Mineral acres;
    g. Inheritances, during the six months in which they are excluded; or
    h. Annuities.

    Note: This exception to the disqualifying transfer provision does not allow transfers of assets that are protected under the Long Term Care Partnership Program. If assets protected under the Long Term Care Partnership Program are transferred, the disqualifying transfer provisions in 05-80-10 apply.

3. A transfer is not disqualifying to the extent the income or assets were transferred:

    a. To the individual's spouse or to another for the sole benefit of the individual's spouse;
    b. From the individual's spouse to another for the sole benefit of the individual's spouse;
    c. To, or to a trust established solely for the benefit of, the individual's child who is blind or disabled; or
    d. To a trust established solely for the benefit of an individual under sixty-five years of age who is disabled.

    An institutionalized spouse is allowed to transfer ownership of an excluded IRA to the community spouse without resulting in a Disqualifying Transfer. Once the Medicaid Unit makes application and prior to determination of eligibility, the IRA must be converted to an annuity, annuitized, and monthly income counted, if good cause does not exist. The amount of monthly income that must be counted may affect the client share as well as amount deemed to the community spouse.

        NOTE: An Individual Retirement Account (IRA) can only be owned by one person and cannot be jointly owned with a spouse. The owner cannot transfer their IRA to a spouse or another person except under two circumstances:

            1. In a divorce settlement; or
            2. Through an inheritance.

        Money can be withdrawn from the IRA which can be given to the spouse, but that involves transferring cash rather than the IRA itself.

4. A transfer is not disqualifying to the extent the individual makes a satisfactory showing that:

    a. The individual intended to dispose of the income or assets, either at fair market value or other valuable consideration, and the individual had an objectively reasonable belief that fair market value or its equivalent was received;
    b. The income or assets were transferred exclusively for a purpose other than to qualify for Medicaid;
    c. The assets transferred by or on behalf of the individual, or individual's spouse, when added to the value of the individual's other countable assets would not exceed the asset limits of $3,000 for one person or $6,000 for two persons (including spousal impoverishment cases); or

d. All income or assets transferred for less than market value have been returned to the individual. If all of the income or assets of a particular transfer are returned at the time of 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. If all of the income and assets of a particular transfer are returned after Medicaid eligibility has already been established (for a period after the date of the original transfer), the period of ineligibility for that transfer ends as of the date the income or assets are returned, but only if the returned assets do not cause the community spouse to have total countable assets in excess of the community spouse countable asset allowance allowed at the time the institutionalized or HCBS spouse became eligible. In establishing whether all of the income or assets have been returned, the income or assets transferred, or their equivalent value, must be returned.

   A partial return of the income or assets transferred does not end or shorten the period of the ineligibility. The returned income or assets may cause ineligibility for Medicaid, and in any case, can be used to cover the individual's medical needs for the remainder of the penalty period.

5. A transfer is not disqualifying to the extent that the asset was used to acquire an annuity if the annuity meets the requirements in annuity sections 05-70-45-20 or 05-70-45-30.
6. A transfer to meet the burial needs of an individual is not disqualifying to the extent the asset transferred meets the burial exclusion and to the extent the asset is considered available to the individual.

Transfer of Income 510-05-80-30

(Revised 1/1/08 ML #3120)

View Archives

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

When an individual's income is given or assigned in some manner to another person, and adequate compensation is not received, such a gift or assignment is considered a transfer of income for less than fair market value.

In determining whether income has been transferred, do not attempt to ascertain in detail the individual's spending habits during the 36 or 60 month look back period. Absent some reason to believe otherwise, assume that ordinary household income was legitimately spent on the normal costs of daily living.

However, attempt to determine whether the individual has transferred lump sum payments actually received in a month. Non-recurring lump sum payments, while counted as income in the month received for eligibility purposes, would be counted as assets in the following month if they were retained. Recurring lump sum payments would be counted as income over a prorated period. Disposal of such lump sum payments before they can be counted as income or assets constitutes an uncompensated transfer of income. Also, attempt to determine whether amounts of regularly scheduled income or lump sum payments, which the individual would otherwise have received, have been transferred. Normally, such a transfer takes the form of a transfer of the right to receive income. For example, a private pension may be diverted to a trust and no longer be paid to the individual.

When income or the right to income has been transferred, a penalty for that transfer must be imposed.

When a single lump sum is transferred (e.g., a stock dividend check is given to another person in the month in which it is received by the individual), the penalty period is calculated on the basis of the uncompensated value of the lump sum payment.

When a stream of income, (e.g., income received on a regular basis, such as a pension) or the right to a stream of income is transferred, determine the total amount of income expected to be transferred during the individual's life, based on an actuarial projection of the individual's life expectancy, and calculate the penalty on the basis of the projected total income. (The Life Expectancy Table can be found at Appendix O.)

Transfers to Relatives for Services Received 510-05-80-35

(Revised 12/1/19 ML #3569)

View Archives

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

Where any income or asset is transferred to a relative for services or assistance furnished by the relative, the services or assistance furnished may not be treated as consideration for the transferred income or asset unless:

1. The transfer is made pursuant to a valid written contract entered into prior to rendering the services or in the absence of a valid written contract, evidence is provided the services were required and provided;
2. The contract was executed by the individual or the individual's fiduciary who is not a provider of services or assistance under the contract;

   Example: It is acceptable for a Medicaid recipient's fiduciary to sign the contract to have a third party provide the services.

   Example: It is not acceptable for a Medicaid recipient's fiduciary to sign the contract to have the fiduciary provide the services.

   Example: It is acceptable for a competent Medicaid recipient to sign the contract to have the fiduciary provide the services.

3. Compensation is consistent with rates paid in the open market for the services actually provided; and
4. The parties' course of dealing included paying compensation upon rendering services or assistance, or within 30 days thereafter.

Payment for Services to an Attorney-in-Fact 510-05-80-37

(New 10/1/14 ML #3420)

View Archives

(N.D.A.C. Sections 75-02-02.1-43)

When an individual makes a payment to their Attorney-in-Fact for services or assistance furnished to the individual by the Attorney in Fact, the services or assistance furnished may not be treated as consideration for transferred income or assets, unless:

1. There is a valid written contract:
   a. Entered between the individual and the Attorney in Fact prior to the Attorney in Fact rendering the services, and payment is made pursuant to the valid written contract; and
   b. The contract was executed by the individual or the individual's Attorney in Fact who is not a provider of services or assistance under the contract; and

      Example: It is acceptable for a Medicaid recipient's Attorney in Fact to sign the contract to have a third party provide the services.

      Example: It is not acceptable for a Medicaid recipient's Attorney in Fact to sign the contract to have the Attorney in Fact provide the services.

      Example: It is acceptable for a competent Medicaid recipient to sign the contract to have the Attorney in Fact provide the services.

   c. Compensation is reasonable and consistent with rates paid in the open market for the services actually provided; and

   d. The services are necessary and reasonable, or

      Example: Mary has had Power of Attorney for both her parents for the past 3 years. Her parents' health has been steadily deteriorating over the past two years. Mary's Mother has always told her children she never wants to go to a nursing facility, so Mary, as outlined in the Power of Attorney agreement, provides round the clock nursing care for her parents for $2000 per month including her room and board. The worker has verified that both parents need a nursing home level of care and has needed it for at least the past year. Now, Mary's

Father has fallen and it is just too much for Mary to care for both parents, so they are applying for nursing care for Mary's Father. We would consider the $2000 per month plus room and board payments to be reasonable. If the parents had gone directly to long term care, it would have cost them in excess of $14,000 per month. If they'd have hired a private nurse, it would have cost approximately $9,000 month.

Reasonableness is dependent upon the type of service provided, whether the service is necessary, the size and scope of the services and what the going rate is in the community for such services.

Example: John has held a Power of Attorney for his father for the past 3 years. John's Dad lost his eyesight and the largest part of his Power of Attorney duties was to pay bills once per month. The agreement had a stated value for these services of $500 per month. John's Dad at this time had minimal assets, and expenses. Most bills were set up as automatic withdrawals from his bank account. John usually spends 1 hour per month paying his Dad's bills. $500 per hour for writing checks is not reasonable. If Dad, for example would have several pieces of property in which he had a life estate interest, and was collecting rents, and John was spending 30 – 50 hours per month doing this, it would be reasonable.

2. If there is not a written contract, the prior course of dealings between the individual and Attorney in Fact included the individual paying compensation upon rendering services or assistance, or within 30 days thereafter.

Example: Deb is a 'snowbird' who winters in New Mexico 5 months of the year. There is a history of Deb paying Tim to manage her properties while she is in New Mexico during those months. Deb has been fully capable, so Tim does not conduct everything for her, just intermittently. In such a case, a written contract would not be required as there is an established history of payments made for services. We would require verification of past payments made and for which services.

Reasonable payments are allowed as a spend down of assets but not as a deduction from income.

Presumption of Reason for Transfer 510-05-80-40

(Revised 8/1/13 ML #3373)

View Archives

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

1. There is a presumption that a transfer for less than market value was made for purposes which include the purpose of qualifying for Medicaid:

    a. In any case in which the individual's assets (and the assets of the individual's spouse) remaining after the transfer produce income which, when added to other income available to the individual (and to the individual's spouse) totals an amount insufficient to meet all living expenses and medical costs reasonably anticipated to be incurred by the individual (and by the individual's spouse) in the month of transfer and in the (fifty-nine months) following the month of transfer;
    b. In any case in which a transfer is made by or on behalf of the individual or the individual's spouse, if the value of the transferred income or asset, when added to the value of the individual's other countable assets, would exceed the asset limits of $3000 for one person or $6000 for two persons (including spousal impoverishment cases); or
    c. In any case where the transfer was made, on behalf of the individual or the individual’s spouse, by a guardian, conservator, or attorney in fact, to the individual's relative, or to the guardian, conservator, or attorney in fact or to any spouse, child, grandchild, brother, sister, niece, nephew, parent, or grandparent, by birth, adoption, or marriage, of the guardian, conservator, or attorney in fact.

2. An applicant or recipient who claims that income or assets were transferred exclusively for a purpose other than to qualify for Medicaid must show that a desire to receive Medicaid benefits played no part in the decision to make the transfer and must rebut any presumption as described above. The fact, if it is a fact, that the individual would be eligible for Medicaid benefits had the individual or the individual's spouse not transferred income or assets for less than market value, is not evidence that the income or assets were transferred exclusively for a purpose other than to qualify for Medicaid.

Income 510-05-85

Income Considerations 510-05-85-05

(Revised 1/1/2025 ML 3892)

View Archives

(N.D.A.C. Section 75-02-02.1-34)

The following discusses income situations to consider:

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 anyone acting on behalf of an applicant or recipient; or
- The applicant, recipient, or anyone acting on behalf of an applicant or recipient 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
- The applicant, recipient, or anyone acting on behalf of an applicant or recipient has the lawful power to make the income available or to cause the income to be made available.

Medicaid applicants and beneficiaries are not required to apply for other benefits as a condition of Medicaid eligibility (as described in Manual Section 510-05-35-90, Application for Other Benefits).

An individual may have rights, authority, or powers that he or she does not wish to exercise.

Example: An individual who allows a relative to use excluded assets for 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.

a. If an applicant requests coverage for the three prior months and the applicant or another Medicaid Unit member has an excluded retirement account (as defined in #22 under Manual Section 510-05-70-30, Excluded Assets) eligibility can be determined for the three prior

months as those retirement accounts are excluded assets. In addition, if the retirement account is not yet paying out any benefits, we would not consider any income for any of the three prior months. Any payments would be counted when they are actually received.

Example: An IRA was annuitized in June and will begin receiving monthly payments in July. The 1st month the payments would begin to be counted as income is July.

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 federal payment benefit (i.e. Title II, Civil Service, and Railroad Retirement). These other reductions of federal benefits are not allowed to reduce the countable benefit amount. The award amount of the federal payment benefit is counted as available except to the extent an undue hardship is approved for the individual.

Requests for undue hardship exceptions must be submitted to the Medicaid Eligibility Unit where a determination will be made whether an undue hardship exists. An undue hardship may be determined to exist for all or a portion of the debt owed, or all or a portion of the reduction from the monthly income.

An undue hardship will be determined to exist only if the individual shows all of the following conditions are met:

a. The debt is a debt owed to the Federal government;
b. The deduction from the individual's federal payment benefit was non-voluntary;
c. The amount of the deduction exceeds the Medicaid income level(s) to which the individual and the individual's spouse is subject;

d. The individual has exhausted all lawful avenues to get the reduction waived, forgiven, or deferred; and
e. The individual or their spouse does not own assets that can be used to pay for the debt.

2. The financial responsibility of any individual for any applicant or recipient of Medicaid will be limited to the responsibility of spouse for spouse and parents for children under age 21.

Such responsibility is imposed as a condition of eligibility for Medicaid. Except as otherwise provided in this section, the income of the spouse and parents is considered available even if that income is not actually contributed. Natural and adoptive parents, but not stepparents, are treated as parents (exceptions to counting a stepparent's income applies when the stepparent is the only eligible caretaker and is eligible for Medicaid because of the child, as described in Manual Section 510-05-35-20(2), Relative Responsibility.

3. All spousal income is considered actually available unless:

a. A court order, entered following a contested case, determines the amounts of support that a spouse must pay to the applicant or recipient;
b. The spouse from whom support could ordinarily be sought, and the property of such spouse, is outside the jurisdiction of the courts of the United States; or
c. The applicant or recipient is subject to marital separation, with or without court order, and there has been no collusion between the applicant or recipient and his or her spouse, to render the applicant or family member eligible for Medicaid.

4. All parental income is considered actually available to a child unless:

a. The child is disabled and at least age eighteen18;
b. The child is living independently; or
c. The child is living with a parent who is separated from the child's other parent, with or without court order, if the parents did not separate for the purpose of securing Medicaid benefits.

5. Monthly income is considered available when determining eligibility for Medicaid, however, an individual may die before their income is actually received for the month.

An income payment received after death is not considered income, but instead an asset to the individual's estate. In circumstances where the Department will pursue estate recovery, Medicaid eligibility can be re-determined counting only that income which was received prior to the individual's death; resulting in the elimination or reduction of the client share/recipient liability.

When a Medicaid provider reports that a recipient's current month recipient liability was not paid as of the date of death, determine whether the following conditions are met:

a. There is no surviving spouse;
b. There is no surviving minor or disabled child; and
c. Countable monthly income was not received prior to death.

If all conditions are met, refer the case to the Medicaid Eligibility Unit and provide the date of death and the dates of the month in which each source of income is received. The Medicaid Eligibility Unit will determine whether Medicaid estate recovery is being pursued and an adjustment to recipient liability can be approved. If approved, the Medicaid Eligibility unit will process the adjustment.

6. Income may be received weekly, biweekly, monthly, intermittently, or annually.Regardless of the frequency income is received, a monthly income amount must be computed.

7. Income deposited on a debit card could be considered earned or unearned income by applying the appropriate policy.

Example: Unemployment Insurance Benefits (UIB), Child Support benefits, Workforce Safety and Insurance (WSI), Social Security Administration (SSA) benefits, and Supplemental Security Income (SSI) benefits.

Example: Gifts or bonuses in the form of gift cards, debit cards, prepaid credit cards or 'in-store credits'. Others may be bonus or commission payments, compensation for work performed, or Tribal Gaming Per Capita Distributions from gaming revenues etc.

8. Payments that are normally disregarded as income, such as SNAP or TANF benefits, disregarded Tribal payments (other than per capita payments from gaming

revenues), Supplemental Security Income (SSI) and occasional small gifts, continue to be disregarded as income regardless of the form of payment (Refer to Manual Sections 510-05-85-25, Post Eligibility Treatment of Income, 510-05-85-30, Disregarded Income – Medicaid, 510-07-40-30, Disregarded Income – Healthy Steps).

9. Distributions to the beneficiary of a Special Needs Trust are NOT considered to be a 'cash or cash equivalent' distribution and are not income to the beneficiary.

All other such payments are counted as income.

Medical Payments 510-05-85-07

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. Section 75-02-02.1-34(6))

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.

1. Health or long-term care insurance payments must be considered as payments received in the months the benefit was intended to cover and must be applied to medical expenses incurred in those months;
2. Veteran's Administration aid and attendance benefits must be considered as payments received in the months the benefit was intended to cover and must be applied to the medical expense incurred in those months.
3. Veteran's Administration reimbursements for unusual medical expenses must be considered as payments received in the months in which the increased medical expense occurred and must be applied to the medical expense incurred in those months.
4. Veteran's Administration homebound benefits intended for medical expenses must be considered as payments received in the months the benefit was intended to cover and must be applied to the medical expense incurred in those months. This does not apply to homebound benefits which are not intended for medical expenses.

Determining Ownership of Income 510-05-85-10

(Revised 6/01 ML #2590)

View Archives

(N.D.A.C. Section 75-02-02.1-34(7)

1. In determining ownership of income from a document (e.g. a tax return for a self employment business, or a rental agreement for rental property . . .), income must be considered available to each individual as provided in the document, or, in the absence of a specific provision in the document:

    a. If payment of income is made solely to one individual, the income shall be considered available only to that individual; and
    b. If payment of income is made to more than one individual, the income shall be considered available to each individual in proportion to their interest.

2. In the case of income available to a couple in which there is no document establishing ownership, one-half of the income shall be considered to be available to each spouse.
3. Except in the case of income from a trust, the rules for determining ownership of income are superseded to the extent that the applicant or recipient can establish that ownership interests are otherwise than as provided in those rules.

Unearned Income 510-05-85-15

(Revised 7/1/2025 ML #3935)

View Archives

(N.D.A.C. Section 75-02-02.1-37)

Unearned income is income that is not earned. Unearned income which is received in a fixed amount each month shall be applied in the month in which it is normally received. For example, Social Security benefits received in January will be applied against January need.

Child Support payments made via Direct Deposit or Electronic Payment Card are considered received on the third (3rd) working day from the 'Check Date' field on the FACSES ledger, unless the applicant or recipient verifies that the payment is received otherwise. The 'Check Date' will be considered the first day when determining the three (3) working days. Any fees deducted from child support received by the State Disbursement Unit are not counted as child support income (nor may it be subtracted from the child support paid amount when determining the allowable child support deduction).

1. Recurring unearned lump sum payments received after application for Medicaid are prorated over the number of months the payment is intended to cover. When a payment is received and prorated in an ongoing case, or after a period of Medicaid or Healthy Steps eligibility, and the case closes and then reopens during the prorated period, or within the following proration period, the lump sum payment must continue to be used. This prevents cases from being closed temporarily to avoid using the lump sum income. All other recurring unearned lump sum payments received before application for Medicaid or Healthy Steps are considered income in the month received and are not prorated.
2. All nonrecurring unearned lump sum payments, except medical payments of 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, must be considered as income in the month received and assets thereafter.

   Lump sum retroactive adjustment payments from the SSA due to changes in the individual’s earning record are considered nonrecurring lump sums.

3. If an individual has a life insurance policy that allows him or her to receive the death benefit while living and the individual meets the insurance company's requirements for receiving such proceeds, the individual will not be required to file for such proceeds. If, however, the individual does file for and receive the benefits, the payment will be considered income in the month it is received and available as an asset if held into following months.
4. Income only becomes an asset in the month following the month it is counted as income.

   Example 1: An annual recurring lump sum payment of $6000 is received in January and is prorated at $500 per month. In January, none of the $6000 is considered an asset. In February, if any portion of the $500 of January income is retained, it becomes an asset, but the remaining $5500 is not. In March, only $5000 is not an asset, and so on.

   Example 2: A nonrecurring lump sum payment of $5000 is received in May, and is considered May income. Any amount of the $5000 that remains in June is an asset because it has already been counted as income.

5. Types of unearned income include but are not limited to:
   a. Income from pension and benefit programs, such as Social Security, Railroad Retirement, veteran's pension or compensation, veteran's vocational rehabilitation subsistence payments, unemployment compensation, employee or individual pension plans and annuities, union compensation during strikes, Workforce Safety & Insurance, public or private disability payments for an individual, etc.

      These benefits are to be considered in the full amount awarded within the Medicaid unit. However, when a mandatory deduction for taxes is withheld, the benefit is reduced by those deductions (see 05-85-05(1) for policy on how to treat Social Security overpayments);

   b. Voluntary cash contributions from others;

   c. The net amount of court ordered or voluntary support payments and alimony. The net amount of the payment is the amount after fees are deducted from child support payments received by the State Disbursement Unit;

   d. Income from a life estate;

e. Income from rental of rooms, apartments, or other property except that income from room rentals is considered "earned" if the recipient is actively engaged in the venture by such means as making the bed, changing linens, cleaning the room, etc. The first $25 of income from each roomer is exempt to defray any associated expenses;

f. Student income received from the Veterans Administration through the GI Bill or Reserve Education Assistance Program (REAP), except that verified out of pocket school expenses (tuition, books and fees) may be deducted. Such expenses may not be deducted from benefits specifically earmarked for housing or personal needs or from Veteran's vocational rehabilitation subsistence payments;

g. Money received by the Medicaid unit as a result of a benefit or fundraiser. (Money that is received and disbursed by a third party for the benefit of the Medicaid Unit is considered an in-kind contribution);

h. Mineral lease income (If a lump sum, count as income in the month received. If recurring, prorate over the period it is to cover);

i. Royalty income less mandatory production taxes withheld prior to distribution (income taxes withheld are not allowed to reduce the royalty payment);

j. Conservation Reserve Program (CRP) program payments, less expenses, such as seeding and spraying necessary to maintain the CRP land in accordance with the CRP contract;

k. Cooperative payments;

l. Interest payments received as a result of converting an asset (i.e. contractual right to receive money payments);

m. Stipends received to attend an educational facility or training (other than those stipends specifically excluded for victims of domestic violence in 05-85-30, subsection 30);

n. Payment of proceeds or profits to enrolled tribal members from tribal gaming/gambling establishments (the payments are to be annualized and prorated over 12 months).

Exception: MHA (TAT) does not pay out monies from casino gambling. See Disregarded Income 510-05-85-30.

o. Clothing allowance payments received by a volunteer in the AmeriCorps program;

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; and

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

Earned Income 510-05-85-20

(Revised 7/1/14 ML #3406)

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(N.D.A.C. Section 75-02-02.1-38)

Earned income is income which is currently received as wages, salaries, commissions, or profits from activities in which an individual or family is engaged through either employment or self-employment. There must be an appreciable amount of personal involvement and effort, on the part of the individual or family, for income to be considered "earned." Earned income will be applied in the month in which it is normally received.

1. If earnings from more than one month are received in a lump sum payment, the payment must be divided by the number of months in which the income was earned, and the resulting monthly amounts are attributed to each of the months with respect to which the earnings were received.

   Similarly, earnings paid under a contract must be prorated over the period the contract covers.

   Example: A teacher receives paychecks in August through May, however the contract covers 12 months and the contracted salary is $30,000. The annual salary is prorated over 12 months for $2500 per month. The paystubs show that from the August through May monthly checks, $350 per month is withheld. To annualize the withholdings, take the 10 months of withholdings, (10 X $350 = $3500) and divide by 12 ($3500/12) = $291.67 to establish the monthly allowable withholdings.

   Occasionally, migrants may receive an advance lump sum payment to reimburse or cover travel expenses. Such reimbursement is normally received prior to their arrival and is not considered earned income. An advance for wages, however, is counted as earned income and is prorated over the months it is intended to cover.

   Example: Don is a migrant worker who received a reimbursement from his grower for traveling to North Dakota to work. This reimbursement is disregarded from income as a reimbursement. Don’s grower also gave him a wage advance of $900 in May for the months of June, July and

August. The wage advance would be prorated over the months of June, July, and August as earned income.

Bonuses, profit sharing, and other similar payments are not considered lump sum earnings or wages received other than monthly, but an extra payment of earned income based on a productive period, and are considered income in the month received.

2. Income only becomes an asset in the month following the month it is counted as income.

   For Example: A recipient has countable self employment income of $12,000 for the year. The income is prorated at $1000 per month. In January, none of the $12,000 is considered an asset. In February, if any portion of the $1000 of January income is retained, it becomes an asset, but the remaining $11,000 does not. In March, only $10,000 is not an asset, and so on.

3. Types of earned income include:

   a. Wages, salaries, commissions, bonuses, severance pay, or profit received as a result of holding a job or being self-employed.

      Bonuses, profit sharing, and other similar payments are not considered lump sum earnings or wages received other than monthly, but an extra payment of earned income based on a productive period, and are considered income in the month received.

   b. Earnings from on-the-job training as provided by Title II Young and Adult Programs;
   c. Wages received as the result of participation in the Mainstream and Experience Works (formerly Green Thumb) Programs, both funded by the U.S. Department of Labor, or the Senior Community Service Employment Program (SCSEP);
   d. Earnings of recipients employed by school as teachers' aides, etc., under Title I of the Elementary and Secondary Education Act;
   e. Wages received from sheltered workshop employment;
   f. Sick leave pay or loss of time private insurance paid for the loss of employment due to illness (but does not include public or private disability payments);
   g. Compensation for jury duty;
   h. Wages from the Economic Opportunity Act programs under Title I and Title II;

i. Tips. Recipient's statement as to average amount of tips received each month is adequate if consistent with place and kind of employment and number of hours worked;
j. Income in-kind in lieu of wages;
k. Wages received for on-the-job training placement under the Workforce Investment Act (WIA);
l. Stipends and the "living allowance" portion of earnings from AmeriCorps (not to be confused with AmeriCorps*VISTA); and
m. The Family Subsistence Supplemental Allowance (FSSA) paid to members of the Armed Services.

4. Calculating "self-employment" income:

a. Self-employed individuals whose business does not require the purchase of goods for resale. Examples of this type of business include persons who provide childcare services in their own home, or qualified service providers (QSP's) (who are not employees of a home health agency) who provide HCBS. For example, those QSP's who receive payments from the Department. Such income may be accounted for on a monthly basis, or the income tax return from the previous year may be used if it reflects a full year's operation. When the tax return is used, one-twelfth of the annual gross income is monthly earnings. The first 25% of the gross monthly earnings shall be disregarded to offset the cost of producing the income and will cover such things as additional food, utilities, supplies, etc. The remaining 75% of gross monthly earnings is the figure to which the appropriate earned income deductions are applied to arrive at monthly net income.

QSP rates change each July, and per policy at 510-05-85-05(1), all income which is available to a unit must be considered. The annual increase in the rate paid is a known increase, so must be taken into consideration when determining income. The daily rate the QSP is paid should be used. It is important also to note that income tax returns filed by QSPs who are providing services to a family member may only include the income they are paid by the Department, and not the client share (recipient liability) amount that is applied toward the QSP bill (because they did not collect the client share from their family member). The client share due the QSP is income they are paid in addition to that from the Department. The available income to the QSP must include the higher rate and any client share amounts due them. The self-employment percentage disregard and earned income deductions can then be allowed from this total amount. As a result, all available income will be correctly counted. Following is an example:

Example: Mr. Brown receives HCBS services. Mrs. Brown is the QSP and she is entitled to receive the current rate of $36.51 per day. Prior to July she was paid only $26.84 per day. Instead of using last year's tax return, the current rate should be used beginning in July. $36.51 x 365 divided by 12 provides a monthly estimate of earnings, to which the 25% self-employment disregard can be applied. This amount can be used until there is a rate change, at which time a new calculation is needed.

New rate increase information can be obtained from the QSP, or from the HCBS case manager, as rates will vary by case, depending on the type and amount of services received.

b. Self-employed persons whose business requires the purchase of goods for resale. Examples of this type of business enterprise include Avon, Tupperware, Amway, Mary Kay Cosmetics, etc. Such income may be accounted for on a monthly basis, or the income tax return from the previous year may be used if it reflects a full year's operation. In these instances, subtract the cost of the goods (if cost of goods sold includes any labor or wage amounts, those amounts must be deducted from the cost of goods sold amount before subtracting the cost of goods sold from the gross receipts) from the gross monthly or annual receipts to arrive at the adjusted gross income. When the tax return is used, one twelfth of the annual adjusted gross income is monthly earnings. The first 25% of the adjusted gross income shall be disregarded to offset the costs of producing the income and will cover such things as sample kits, demonstrations, supplies, etc. Seventy-five percent of the adjusted gross income will be the monthly income to which the appropriate earned income deductions are applied to arrive at monthly net income.
c. Self-employment income from a room-and-board arrangement. The first $100 per month received from each individual will be disregarded to defray the associated expenses. The remaining amount(s) will be the monthly income to which the appropriate earned income deductions are applied to arrive at the monthly net income.
d. Self-employed persons in a service business requiring purchase of goods or parts for repair or replacement. These include mechanics, TV repairmen, beauty salons, restaurants, etc. Such income may be accounted for on a monthly basis, or the income tax return from the previous year may be used if it reflects a full year's operation. In this instance, subtract the cost of goods or parts (if cost of goods sold includes any labor or wage amounts, those amounts must be deducted from the cost of goods sold amount before subtracting the cost of goods sold from the gross receipts) from the gross monthly or annual receipts to arrive at the adjusted gross income. When the tax return is used, one-

twelfth of the annual adjusted gross income is monthly earnings. The first 75% of the adjusted gross monthly income shall be disregarded to offset the cost of expenses such as heat, lights, phone, rent, or building, etc. The remaining 25% of the adjusted gross income will be the monthly income to which the appropriate earned income deductions are applied to arrive at monthly net income.

e. Income of self-employed individuals received other than monthly. In such cases, income must be established on the basis of the past year's total income to arrive at the amount of income to be anticipated for the current year and reduced to monthly increments. This is the preferred method of considering income arising from self-employment such as farming or other business enterprises. It is first necessary to establish the amount of total annual gross income. For purposes of Medicaid, annual net income is normally defined as one-fourth of the annual gross income shown on Schedule F, Part I, of IRS Form 1040, "Individual Income Tax Return," if the business is farming, or annual gross income shown on Schedule C, Part I, of Form 1040, if the business is other than farming.
f. CRP payments and cooperative distributions, which are considered unearned income, should be deducted from the total income figure on Form 1040, Schedule F, and prorated over a twelve month period.
g. Disaster agricultural payments and other disaster payments made to a self-employment entity due to a disaster must be deducted from the gross income on the tax schedules as this is disregarded income.
h. After the appropriate percentage disregard is applied to self-employment, income, Capital gains and losses are considered.

Income resulting from the sale of capital items or ordinary gains may be offset by a loss from the sale of capital items. The net result, but not less than zero, must be added to the other annual net income to arrive at total net annual income.

The following example demonstrates this process:

Example: Gross annual income (from federal income tax return)	$16,500.00
Net annual income	4,125.00

(25% of $16,500)	
Capital and other gains	1,200.00
Yearly income	5,325.00
Monthly income (yearly income divided by 12)	443.75

The monthly income is the figure to which the appropriate earned income disregards are applied to arrive at monthly net income.

Capital and other gains and losses are always counted when considering actual income for a prior period. When using the prior income to estimate income for a prospective period, however, use capital gains and losses that are reasonably expected to occur in the prospective period.

Capital gains, short term and long term, and other gains are found on the federal tax form as follows:

i. Capital gains - Schedule D; and
ii. Other gains - form 4797.

i. The pro-rata method of determining and deducting monthly income is not practical in instances where the business has been recently established, because the business has been terminated or subject to a severe change, such as a decrease or increase in the size of the operation, or an uninsured loss. In these situations, net income from self-employment is an amount determined by the county agency to represent the best estimate of monthly net income from self-employment. A self-employed individual may be required to provide, on a monthly basis, the best information available on income and cost of goods. The county agency and self-employed individual may use the best information available to estimate the effect of the change on the annual income if the business is a type in which income is received other than monthly. The income must be prorated over a twelve-month period.

   No income from any other source may be used to offset a self-employment loss.

j. When determining income based on income tax forms, attention should be paid to other sources of income listed on page one of Form 1040.

Other types of income that may be reflected on page one of Form 1040 are interest income, dividend income, rental income, royalty income, etc. Interest, dividend, rental and royalty income are to be considered separately from the self-employment income.

k. Once self-employment income is calculated, it is divided by the number of individuals listed on the self-employment schedules.

Income Compatibility 510-05-85-23

(Revised 05/03/2024 ML #3825)

Background

Provisions in the Patient Protection and Affordable Care Act of 2010 (PPACA or ACA) require states to rely as much as possible on electronic data sources when verifying information provided by applicants or recipients. Federal regulations restrict states from requesting verification from applicants or recipients unless the verification cannot be obtained through an electronic data source, or information from the data source is not "reasonably compatible" with what the applicant or recipient has reported.

Available Electronic Verification Sources

The Centers for Medicare and Medicaid (CMS) have identified electronic verifications received from the following data sources to be valid when determining reasonable income compatibility for health care coverage (HCC) programs. Below is the list of electronic data sources in hierarchy order:

- Federal Data Services Hub (FDSH) TALX or The Work Number
  - Can only be used to determine HCC program eligibility
  - FDHS (TALX or the Work Number)
    - Employers are not required to provide payroll information
- Equifax
  - Can only be used for combination cases (HCC and other programs such as SNAP, TANF etc.)
- SDX and BENDEX
- ND Job Service Unemployment Insurance Benefits
- ND State Directory of New Hires
- ND Job Service Wage Information, Quarterly Wage Verification
- ND Child Support (FACSES)
- PARIS Interface

Reasonable Compatibility

Income Compatibility is a comparison of the income in SPACES with electronic data sources against the income limit for the applicable HCC program.

Reasonable Compatibility exists when income information reported by an individual and available electronic data sources are compatible. When reasonable compatibility is determined no further verification is requested from the individual.

The combined income of all types must be used to determine reasonable compatibility.

- Earned income
- Unearned income

Note: When determining "reasonable compatibility" of income, the most recent verification of the income from the electronic sources must be used unless the household has provided more current information.

Verification of income CANNOT be requested from an applicant or recipient unless the information cannot be obtained through an electronic data source, or information from the data source is not "reasonably compatible" with what the applicant or recipient has reported.

Exception: " Reasonable compatibility' does not apply to THMP months.

At the time of initial application or review for Medicaid and the individual also applies for or submits a review for another program, check all data sources and compare the data received against the information received for the other programs to determine reasonable compatibility.

Scenarios for Reasonable Compatibility

If reported income and information obtained electronically through a data source are both above, at or below the applicable HCC program income standard, they are considered reasonably compatible.

1. When determining 'reasonable compatibility' for income other than self-employment

    a. If both the electronic data sources and the member-reported information results in the individual's total countable income being below the individual's budget unit income level, the two data sources are "reasonably compatible" and further verification may not be requested or required. Utilize the most current information available. The calculation used to determine 'reasonable compatibility' MUST be narrated in the case file.

Example #1: Joe is age 25 and single with an income limit of $1, 353.00 per month. At review, Joe reports that his earnings are $500 per month. ND Job Service Wage Match reports that his quarterly earnings are $2,659.72.

To determine his monthly amount from the Job Service wage electronic data verification source, divide $2659.73 by 13 and multiply by 4.3. This results in verification of his monthly income of $818.37.

Since both his reported income and the ND Job Service Wage Match electronic data source verified income are below his budget unit income level, his income is "reasonably compatible" and Joe is re-determined eligible for HCC. The Job Service Wage electronic data verification source will be used since it is the most current and additional verification cannot be requested.

Example #2: A new application is received for Barb, who is age 31 and single with an income limit of $1353.00 per month. Barb reports she is employed and earns $1,250 per month. Since Barb is a new applicant, a search of the electronic data sources did not return a response. Therefore, 'reasonable compatibility' cannot be determined and verification of wages must be requested from Barb.

b. If both the electronic data source and the member-reported information results in the individual's total countable income being above the individual's budget unit income level, the two data sources are "reasonably compatible" and further verification may not be requested or required.

Example #1: Melanie is age 27 and single with an income of $1,353.00 per month. At review, she reports that her earnings are $1,500 per month. The ND Job Service Wage Match reports that her quarterly earnings for the most recent quarter are $4,500.

To Determine her monthly amount from the Job Service wage electronic data verification source, divide $4,500 by 13 and multiply by 4. This results in a verification of her monthly income of $1,384.61. Melanie is determined not eligible for Medicaid and her case would be closed without requesting any further verification.

Example #2: A new application is received for Brady, who is age 40 and single. Brady reports he is employed and earns $1,925 per month. Since Brady is a new applicant, a search of the Federal Data Services Hub (FDSH) does not provide any response. Therefore, 'reasonable compatibility' cannot be determined, and verification of wages must be requested from Brady.

c. If verification from the electronic data source puts the individual's total countable income above the individual's budge unit income level, but the member-reported information puts the individual's total countable income below that level (or vice versa), the two sources are not "reasonably compatible" and further verification is required to determine eligibility.

- The calculation used to determine 'reasonable compatibility' MUST be narrated in the case file.

Example 1: Lynn is age 34 and single with an income limit of $1,353.00 per month. At review, the member - reported information indicates his earnings are $1,100 per month. The Federal Data Services Hub (FDSH) reports that his earnings are $2,066.95. Since there is a difference in the eligibility outcome, between the member-reported earnings and the FDSH data source, Lynn's reported information is not considered to be "reasonably compatible", and the agency must request additional verification from Lynn to determine eligibility.

Example 2: Michelle applies for herself and her two children. She reports that she started a job last month and is earning $1,400 per month. Since this is a new

application, the quarterly Job Service wage verification is not available, and the reasonable compatibility test cannot be performed. Michelle will be required to verify her earnings.

- If the electronic source of Equifax received through the Federal Data Services Hub(FDSH) provided verification of Michelle's wages from Walmart, 'reasonable compatibility' must be used to determined Michelle's eligibility.

2. When determining 'reasonably compatibility' for unearned income:

   - If the source of the income reported matches the source verified through the available electronic sources and the amounts are considered "reasonably compatible", further verification cannot be requested from the applicant or recipient. If verification cannot be obtained through the electronic source, the individual must provide documentation of the unearned income.

     The calculation used to determine 'reasonable compatibility' MUST be narrated in the case file.

3. When determining 'reasonable compatibility' for self-employment income, the income must be verified based on current policy. See Policy at 510-05-85-20 or 510-03-85-13 (ACA).

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

(Revised 10/1/2025 Release 25.16)

View Archives

(N.D.A.C. Sections 75-02-02.1-34(6) and 75-02-02.1-38.1)

This section prescribes specific financial requirements for determining the treatment of income and application of income to the cost of care for individuals with a certification of need or who are screened as requiring nursing care services, and who are residing in nursing facilities, the state hospital, the Anne Carlsen facility, the Prairie at St. John's center, the Stadter Psychiatric Center, a Psychiatric Residential Treatment Facility (PRTF), intermediate care facilities for the intellectually disabled (ICF-ID), and individuals receiving swing bed care in hospitals.

1. The following types of income may be disregarded :
   a. Occasional small gifts;
   b. For so long as 38 U.S.C. 5503 remains effective, ninety dollars ofVeteran's Administration improved pensions paid to a veteran, or asurviving spouse of a veteran, who has neither spouse nor child, and who resides in a Medicaid-approved nursing facility;
   c. Payments to certain United States citizens of Japanese ancestry,resident Japanese aliens, and eligible Aleuts made under theWartime Relocation of Civilians Reparations Act;
   d. Agent Orange payments;
   e. German Reparation payments made to survivors of the holocaust, andreparation payments made under sections 500 through 506 of theAustrian General Social Insurance Act;
   f. Netherlands Reparation payments based on Nazi, but not Japanese,persecution during World War II, Public Law 103-286;
   g. Radiation Exposure Compensation, Public Law 101-426;
   h. Interest or dividend income from liquid assets; and
   i. From annual countable gross CRP and rental income, an amount equal to the real estate taxes for CRP and rental property that the recipient is responsible for paying on that property.

      Example 1: Ed is in the nursing home. He receives rental income on farmland in the amount of $24,000. Ed is responsible to pay the property taxes. The most current tax statement verifies that Ed is responsible for property taxes of $3600. $24,000 - $3600 is his annualized adjusted

rental income of $20,400; divided by 12 equals $1700 per month unearned income to Ed.

Example 2: Ralph and Edna are married. Edna is in the nursing home and Ralph is in the community. Their farmstead is leased out in both of their names. They receive annual gross rent of $30,000 and the property taxes for which both are responsible is $6,000. Since they both own and are entitled to the income, it is divided, so each has gross rental income of $15,000. Likewise, the property tax is split between them. When determining Edna's income, the $15,000 - $3,000, or $12,000 is prorated over the year for $1000 per month. When determining Ralph's income, the $15,000 is prorated over the year, giving him countable income of $1250 per month. Because only Edna is in a long-term care facility, only she is allowed the property tax disregard.

Example 3: Pete is in the nursing home. He receives land rental income of $12,000 in April and $12,000 in October. His most recent tax statement verifies his responsibility of $4,000 in property taxes. Taking his annual rental income of $24,000 minus his property tax liability of $4000 equals $20,000 countable annual rental income. Dividing this by 12 months gives us a prorated countable monthly unearned rental income of $1,666.67. This would be reviewed in March of the following year to determine if the income or the liability has changed. If they apply after the April payment was received, but prior to receipt of the October payment, only the $12,000 October payment minus half of the allowed property tax liability would be prorated up to the next payment the following April.

j. Income tax refunds are excluded in the month received (they may be a countable asset, see 510-05-70-30(16) for treatment as an asset).
k. Money received by Native Americans from the lease or sale of natural resources, and rent or lease income, resulting from the exercise of federally-protected rights on excluded Indian property, is considered an asset conversion and is therefore not considered as income (even if the money is taken out of the IIM account in the same month it was deposited into the account). This includes distributions of per capita judgment funds or property earnings held in trust for a tribe. This does not Include local Tribal funds that a Tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of Interior (e.g., tribally managed gaming revenues - which is countable income).

l. Disbursements from The People's Fund and General Disbursements to members of the Mandan, Hidatsa, Arikara (MHA) Nation also known as Three Affiliated Tribes (TAT) come from natural resources (oil and gas royalties), therefore are disregarded income.

Note: Income received by Native Americans from the sale or lease of natural resources cannot be requested.

2. The mandatory payroll deductions under FICA and Medicare are allowed from earned income. (This does not include federal or state income tax withholding).
3. The following deductions are allowed in the following order:

   a. The appropriate nursing care or ICF-ID income level;
   b. Amounts provided to a spouse or family member for maintenance needs (this is the appropriate Medicaid income level for the spouse or family member, NOT alimony or child support);
   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)(3)). 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:

      i. Incurred in the month for which eligibility is being determined, or was incurred in a prior month but was actually paid in the month for which eligibility is being determined and was not a previous month's client share (recipient liability) or was not previously allowed as a deduction or offset of client share;
      ii. Provided by a medical practitioner licensed to furnish the care;
      iii. Not subject to payment by any third party, including Medicaid and Medicare;
      iv. Not incurred for nursing facility services, swing bed services, or **HCBS** during a period of ineligibility because of a **disqualifying transfer;** and
      v. Claimed.

   d. The cost of Medicare and health insurance premiums. A health insurance premium may be deducted from income in the month the premium is paid or may be prorated and deducted from income in the months for which the premium affords coverage. For purposes of this deduction, premiums for health insurance include payments made for insurance, health care

plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:

i. Limited to disability or income protection coverage;
ii. Automobile medical payment coverage;
iii. Supplemental to liability insurance;
iv. Designed solely to provide payments on a per diem basis, daily indemnity, or nonexpense-incurred basis; or
v. Credit accident and health insurance.

e. The cost of long term care insurance premiums, for insurance carried by the recipient or the recipient's spouse. The premium may be deducted from income in the month the premium is paid or prorated and deducted from income in the months for which the premium affords coverage.
f. A deduction of payments made for services of a guardian or conservator may be made, up to a maximum deduction equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.

4. Payments from any source, which are or may be received as a result of a medical expense or increased medical need, such as health or long-term care insurance payments, VA Aid and Attendance, VA homebound benefits intended for medical expenses, or VA reimbursements for unusual medical expenses, must be added to the remaining income to determine client share.

Disregarded Income 510-05-85-30

(Revised 10/1/2025 Release 25.16)

View Archives

(N.D.A.C. Section 75-02-02.1-38.2)

This section applies to the following:

- Individuals residing in their own home;
- Individuals in a specialized facility;
- Individuals on Medicare Premium Assistance Program 510-05-60;
- Individuals on Workers with Disabilities 510-05-57 or Children with Disabilities 510-05-58 coverages.

This section does not apply to the following:

- Individuals receiving psychiatric or nursing care services in a nursing facility, the state hospital, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the intellectually disabled (ICF-ID), or receiving swing-bed care in a hospital. Refer to the Post Eligibility Treatment of Income section 510-05-85-25 when determining eligibility for these members.

1. Money payments made by the Department, another state, or tribal entities in connection with the State LTC Subsidy program, foster care, subsidized guardianship, or the subsidized adoption program (does not include Casey Family, or other private foster care payments);
2. Court Ordered Child Support payments and Social Security Survivor income for a child under age eighteen years and enrolled in a Medicaid waiver under section 1915c of the Social Security Act.
3. County general assistance that may be issued on an intermittent basis to cover emergency type situations;
4. Income received as a housing allowance by programs sponsored by the United States Department of Housing and Urban Development and rent supplements or utility payments provided through the Housing Assistance Program;
5. Income of an individual living in the parental home if the individual is not included in the Medicaid unit.
6. Educational loans, scholarships, grants, awards, Workforce Safety & Insurance vocational rehabilitation payments, and work study received by a

student. See 510-05-85-15 (Unearned income) for treatment of student income received from the Veteran's Administration; or any fellowship or gift (or portion of a gift) used to pay the cost of tuition and fees at any educational institution;

7. In-kind contributions, except in-kind contributions received in lieu of wages.
8. Per capita judgment funds paid to members of the Blackfeet Tribe and the Gross Ventre Tribe under Pub. L. 92-254, to any tribe to pay a judgment of the Indian claims commission or the court of claims under Pub. L. 93-134, or to the Turtle Mountain Band of Chippewa Indians, the Chippewa Cree Tribe of Rocky Boy's Reservation, the Minnesota Chippewa Tribe, or the Little Shell Tribe of Chippewa Indians of Montana under Pub. L. 97-403;
9. Compensation received by volunteers participating in the ACTION program as stipulated in the Domestic Volunteer Service Act of 1973, including the National Senior Volunteer Corps, including Retired Senior Volunteer Program (RSVP), Foster Grandparents, and Senior Companion Program; National Volunteer Programs to Assist Small Businesses and Promote Volunteer Services by Persons with Business Experience; Volunteers in Service to America (VISTA) (now AmeriCorps*VISTA, not to be confused with AmeriCorps, a separate program), VISTA Literary Corps;
10. Benefits received through the Low Income Home Energy Assistance Program;
11. Training funds received from Vocational Rehabilitation;
12. Training allowances of up to thirty dollars per week provided through a tribal native employment works program, or the Job Opportunities and Basic Skills Training program;
13. Income tax refunds and earned income credits;
14. Needs-based payments, support services, and relocation expenses provided through programs established under the Workforce Innovation and Opportunity Act (WIOA), and through the Job Opportunities and Basic Skills program;
15. Income derived from submarginal lands, conveyed to Indian tribes and held in trust by the United States, as required by Pub. L. 94-114;
16. Income earned by an eligible child (not a caretaker, spouse, or pregnant woman) who is a full-time student, or a part-time student who is not employed one hundred hours or more per month. The earnings of an eligible child are counted if the child is a part time student who is employed full time;
17. Payments from the family subsidy program;
18. Fifty dollars per month of current child support, received on behalf of children in the Medicaid unit, from each budget unit that is budgeted with a separate income level;
19. Payments made to recipients under title II of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970;

20. Tax-exempt portions of payments made as a result of the Alaska Native Claims Settlement Act;
21. Payments to certain United States citizens of Japanese ancestry, resident Japanese noncitizens, and eligible Aleuts made under the Wartime Relocation of Civilians Reparations Act;
22. Agent Orange payments;
23. A loan from any source that is subject to a written agreement requiring repayment by the recipient (which includes a reverse mortgage payment);
24. The Medicare part B premium refunded by the Social Security Administration;
25. Crime Victims Reparation payments;
26. Temporary Assistance for Needy Families (TANF) benefit and support services payments made by the Department or another state;
27. Lump sum SSI benefits in the month in which the benefit is received (subject to the asset limits in the months thereafter);
28. German reparation payments made to survivors of the holocaust, and reparation payments made under sections 500 through 506 of the Austrian General Social Insurance Act;
29. Assistance received under the Disaster Relief and Emergency Assistance Act of 1974 or some other federal statute, because of a presidentially declared major disaster (including disaster assistance unemployment compensation), and interest earned on that assistance. Comparable assistance received from a state or local government, or from a disaster assistance organization is also excluded;
30. Refugee cash assistance or grant payments;
31. Payments from the Child and Adult Food Program for meals and snacks to licensed families who provide day care in their home;
32. Extra checks received by individuals who are paid weekly or bi-weekly. The check may be from earned (but not self-employment) or unearned income. The last check received in the month is always considered the extra check. For individuals paid weekly, it is the fifth check and for individuals paid bi-weekly, it is the third check. Bonus checks, or checks for any other reason, are not considered extra checks;
33. All income, allowances, and bonuses received as a result of participation in the Job Corps Program;
34. Payments received for the repair or replacement of lost, damaged or stolen assets;
35. Homestead tax credits;
36. Training stipends provided to victims of domestic violence by private, charitable organizations, such as the Seeds of Hope Gift Shop, or the Abused Adult Resource Center, for attending their educational programs;

37. Allowances paid to children of Vietnam veterans who are born with Spina Bifida, or to children of women Vietnam veterans who are born with certain covered birth defects;
38. Netherlands Reparation payments based on Nazi, but not Japanese, persecution during World War II, Public Law 103-286;
39. Radiation Exposure Compensation, Public Law 101-426;
40. Interest or dividend income from liquid assets;
41. Additional pay received by military personnel as a result of deployment to a combat zone;
42. Occasional small gifts;
43. Money received by Indians from the lease or sale of natural resources, and rent or lease income, resulting from the exercise of federally-protected rights on excluded Indian property, is considered an asset conversion and is therefore not considered as income (even if the money is taken out of the IIM account in the same month it was deposited into the account). This includes distributions of per capita judgment funds or property earnings held in trust for a tribe. This does not include local Tribal funds that a Tribe distributes to individuals on a per capita basis, but which have not been held in trust by the Secretary of Interior (e.g., tribally managed gaming revenues - which is countable income);
44. Medicare Part D premiums, co-payments, and deductibles refunded by prescription drug plans;
45. 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;
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.
47. Monthly food coupons distributed to individuals age 55 and over from the Sisseton-Wahpeton Oyate Lake Traverse Reservation Food Distribution program.
48. Payments distributed by the Emergency Rent Assistance Program (ERAP).
49. 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.

    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.

50. Disbursements from The People's Fund and General Disbursements to members of the Mandan, Hidatsa, Arikara (MHA) Nation also known as Three Affiliated Tribes (TAT) come from natural resources (oil and gas royalties), therefore are disregarded income.
51. SSI income is not counted in the QMB, SLMB or QI-1 budget.

Note: Income received by Native Americans from the sale or lease of natural resources cannot be requested.

Income Deductions 510-05-85-35

(Revised 8/1/2025 Release 25.15)

View Archives

(N.D.A.C. Section 75-02-02.1-39)

This section applies to the following:

- Individuals residing in their own home;
- Individuals on Medicare Premium Assistance Program 510-05-60;
- Individuals on Workers with Disabilities 510-05-57 or Children with Disabilities 510-05-58 coverages;
  - **Note**: Refer to the Post Eligibility Treatment of Income section 05-85-25 when determining eligibility for the members below:
- Individuals in a specialized facility, and those receiving psychiatric or nursing care services in a nursing facility, the state hospital, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the intellectually disabled (ICF-ID), or receiving swing-bed care in a hospital.

This section does not apply to the following:

- Individuals receiving psychiatric or nursing care services in a nursing facility, the state hospital, a Psychiatric Residential Treatment Facility (PRTF), an intermediate care facility for the intellectually disabled (ICF-ID), or receiving swing-bed care in a hospital. Refer to the Post Eligibility Treatment of Income section 510-05-85-25 when determining eligibility for these members

1. The cost of premiums for health insurance may be deducted from income in the month the premium is both paid (or prorated) and affords coverage. For purposes of this deduction, premiums for health insurance include payments made for insurance, health care plans, or nonprofit health service plan contracts which provide benefits for hospital, surgical, and medical care, but do not include payments made for coverage which is:
   a. Limited to disability or income protection coverage;
   b. Automobile medical payment coverage;
   c. Supplemental to automobile liability insurance;
   d. Designed solely to provide payments on a per diem basis, daily indemnity, or non-expense- incurred basis; or
   e. Credit accident and health insurance.

(If questionable, contact the Third-Party Liability unit for assistance in determining whether a policy fits into one of the above categories.)

2. 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:
   a. Incurred:
      i. By a member of a Medicaid unit in a month for which eligibility is being determined; or
      ii. By a member of the Medicaid unit (or a spouse or child they were legally responsible for) in a prior month, but was actually paid in the month for which eligibility is being determined, and was not a previous month's client share (recipient liability), or was not previously allowed as a deduction or offset of client share.
   b. Provided by a medical practitioner licensed to furnish the care;
   c. Not subject to payment by any third party, including Medicaid and Medicare;
   d. Not incurred for nursing facility services, swing bed services, or HCBS during a period of ineligibility because of a disqualifying transfer;
   e. Claimed

      Examples of expenses that **can** be used to reduce countable income:

      i. Medications and services Medicaid does not pay for only because the provider is not enrolled.
      ii. Over-the-counter medications that Medicaid covers, such as Antacids (for stomach acid), analgesics (for pain), iron supplements (for anemia), and artificial tears (for severe dry eye diseases). Also, medications payable because of rebate, such as Maalox and Advil. (Non-payable are Mylanta and CVS generics). Medicaid covers drugs with a NDC code on the bottom of the bottle label.

         Note:https://mmis.nd.gov/osplusext/X2I/X2IExt/ExternalDrug/ExternalDrugSearch.do is a website that workers may use to inquire whether ND Medicaid covers a specified drug.

      iii. Other over-the-counter supplies that Medicaid covers, such as diabetic supplies.
      iv. Nicotine patches.
      v. Drugs from Canada when prescribed by a United States physician.
      vi. Transportation costs:

a. Lodging up to the per-diem limit. Hotels can bill the difference to the client if they stay at a hotel that charges more. (As with meals, we pay per diem and clients can eat where they want).
b. Allow the difference to reduce client share if reasonable. (If they choose to stay in a penthouse suite when other less costly rooms are available, that is not reasonable).
c. Transportation costs are not paid or allowed as a deduction if the medical services are available locally but the client travels elsewhere, even if referred by a physician.

Examples of expenses that **cannot** be used to reduce countable income:

i. Extra amounts paid for glasses, such as more expensive frames, tints, etc.
ii. Medical expenses that 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 (Drug Efficacy Study Implementation). Examples of DESI drugs include, Midrin (for migraines) and Tigan (for nausea) DESI drugs 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.
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 Medicaid unit will be reimbursed, to the extent of the reimbursement.

3. Reasonable expenses, such as food and veterinarian expenses, necessary to maintain a dog that is trained to detect seizures for a member of the Medicaid unit.

4. Costs of premiums for long-term care insurance carried by an individual or the individuals spouse may be deducted from the income in the month the premium is both paid (or prorated) and affords coverage.

5. Cost of remedial care that may be deducted for an individual residing in a specialized facility is limited to the difference between the recipient's cost of care at the facility (e.g. remedial rate in a basic care facility) and the regular medically needy income level.

   Example:

Recipient's remedial rate at the facility	$1,536
Less the medically needy income level for one	- 1,174
Remedial Care Deduction	$362

6. Transportation expenses may be deducted if necessary to secure medical care for a member of the Medicaid unit. Transportation expenses are not allowed for recipients in a facility that provides nursing care services, or to the extent the transportation cost is paid by any third party. The amount to allow cannot exceed 2025-7-1 NEMT Fee Schedule.xlsx.

7. Non-voluntary child and spousal support payments (including surcharges and arrearages) may be deducted if actually paid by a member of the Medicaid unit. If the support payment is withheld from an extra check that is disregarded, the support payment withheld from that check is not allowed as a deduction.

8. Reasonable childcare expenses, not otherwise reimbursed, that the Medicaid unit is responsible for paying, may be deducted if necessary to engage in employment or training. Reasonable childcare expenses do not include payments to parents to care for their own children. The child must be a member of the Medicaid unit for the deduction to be allowed. This expense may only be allowed as a deduction from the income of the child or those individuals who are responsible for the child, such as a parent or caretaker.

9. Reasonable adult dependent care expenses may be deducted. These are costs for care of an incapacitated or disabled adult who is living in the home so a caretaker or a spouse can work or attend training. The incapacitated or disabled adult must be a member of the Medicaid unit for the deduction to be allowed.

10. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available. This deduction is not allowed if any third party, including TANF, pays the cost.

11. A disregard of $20 per month is deducted from any income, except income which is based on need such as SSI, and need-based veteran's pensions. This deduction applies to all aged, blind and disabled applicants or recipients provided that:
    a. When more than one aged, blind, or disabled persons live together, no more than one $20 disregard may be deducted;
    b. When both earned and unearned income is available, apply the $20 disregard to the unearned income; and
    c. When only earned income is available, the $20 disregard must be applied before the deduction of sixty-five dollars plus one-half of the remaining monthly gross income.

12. A deduction may be made for the cost of services of an applicant's or recipient's guardian or conservator, up to a maximum equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.

13. With respect to each individual in the Medicaid unit who is employed or in training, but who is not aged, blind, or disabled, $30 may be deducted as a work or training allowance, but only if the individual's income is counted in the eligibility determination.

14. The deductions described in this subsection may be allowed only on earned income:
    a. For all individuals, except for aged, blind, or disabled applicants or recipients:
        i. Mandatory payroll deductions and union due withheld, or $90 whichever is greater.
        ii. Mandatory retirement plan deductions.
        iii. Union dues actually paid; and
        iv. Expenses of non-disabled blind person, reasonably attributable to earning income.
    b. For all aged, blind, or disabled applicants or recipients, $65 plus one-half of the remaining monthly gross earned income; provided that, when more than one aged, blind, or disabled person lives together, no more than $65 plus one-half of the remaining combined earned income, may be deducted.

15. Medical marijuana is not federally recognized as legal and, as such, is not considered an allowable medical deduction.

16. Children with Disabilities (CWD) monthly premium except when determining eligibility for CWD.

17. Workers with Disabilities (WWD) one-time enrollment fee and monthly premium except when determining eligibility for WWD.

The following deductions are allowed in determining Medicare Premium Assistance Program eligibility:

1. Reasonable expenses, such as food and veterinarian expenses, necessary to maintain a dog that is trained to detect seizures for a member of the Medicaid unit.

2. Non-voluntary child and spousal support payments (including surcharges and arrearages) may be deducted if actually paid by a member of the Medicaid unit. If the support payment is withheld from an extra check that is disregarded, the support payment withheld from that check is not allowed as a deduction.

3. Reasonable childcare expenses, not otherwise reimbursed, that the Medicaid unit is responsible for paying, may be deducted if necessary to engage in employment or training. Reasonable childcare expenses do not include payments to parents to care for their own children. The child must be a member of the Medicaid unit for the deduction to be allowed.

4. Reasonable adult dependent care expenses may be deducted. These are costs for care of an incapacitated or disabled adult who is living in the home so a caretaker or a spouse can work or attend training. The incapacitated or disabled adult must be a member of the Medicaid unit for the deduction to be allowed.

5. The cost to purchase or rent a car safety seat for a child through age ten is allowed as a deduction if a seat is not otherwise reasonably available. This deduction is not allowed if any third party, including TANF, pays the cost.

6. A disregard of $20 per month is deducted from any income, except income which is based on need such as SSI, and need-based veteran's pensions. This deduction applies to all aged, blind, and disabled applicants or recipients provided that:
    a. When more than one aged, blind, or disabled persons live together, no more than one $20 disregard may be deducted.

b. When both earned and unearned income is available, apply the $20 disregard to the unearned income, and
c. When only earned income is available, the $20 disregard must be applied before the deduction of $65 plus one-half of the remaining monthly gross income.

7. The cost of services of an applicant's or recipient's guardian or conservator, up to a maximum equal to five percent of countable gross monthly income excluding nonrecurring lump sum payments.

8. With respect to each individual in the Medicaid unit who is employed or in training, but who is not aged, blind, or disabled, $30 may be deducted as a work or training allowance, but only if the individual's income is counted in the eligibility determination.

9. The deductions described in this subsection may be allowed only on the earned income:
   a. For all individuals, except for aged, blind, or disabled applicants or recipients:
      i. Mandatory payroll deductions and union due withheld, or $90 whichever is greater.
      ii. Mandatory retirement plan deductions.
      iii. Union dues actually paid; and
      iv. Expenses of non-disabled blind person, reasonably attributable to earning income.
   b. For all aged, blind, or disabled applicants or recipients, $65 plus one-half of the remaining monthly gross earned income; provided that, when more than one aged, blind, or disabled person lives together, no more than $65 plus one-half of the remaining combined earned income, may be deducted.

10. Children with Disabilities (CWD) monthly premium except when determining eligibility for CWD.

11. Workers with Disabilities (WWD) one-time enrollment fee and monthly premium except when determining eligibility for WWD.

Income Levels 510-05-85-40

(Revised 7/1/2025 ML #3935)

View Archives

(N.D.A.C. Sections 75-02-02.1-40, 75-02-02.1-22(7), 75-02-02.1-24.2(8), and 75-02-02.1-24(5))

Levels of income for maintenance must be used as a basis for establishing financial eligibility for Medicaid. The Medicaid income levels represent the amount of income reserved to meet the maintenance needs of an individual or family. The income levels applicable to individuals and units are:

1. Categorically needy income levels.

    a. Categorically needy aged, blind, and disabled recipients. Except for individuals subject to the nursing care income level, the income level which establishes SSI eligibility.

2. Medically needy income levels.
    a. Medically needy income levels are applied when a Medicaid individual or unit resides in their own home or in a specialized facility, and when a Medicaid individual has been screened as requiring nursing care, but elects to receive HCBS. The income level is equal to 90% of the poverty level applicable to a Medicaid Unit of the size involved.

        The Medicaid Unit size is increased for each unborn when determining the appropriate Medicaid Unit size.

	Monthly Income Level
1	$1,174
2	$1,587
3	$1,999

	Monthly Income Level
4	$2,412
5	$2,824
6	$3,237
7	$3,649
8	$4,062
9	$4,474
10	$4,487
(+1)	$413
Effective April 1, 2025	

b. Nursing care income level. The nursing care income level is $115 per month and must be applied to residents receiving psychiatric or nursing care services in nursing facilities, the state hospital,Prairie Saint John's, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital.

c. ICF-ID income level. The income level for a resident of an Intermediate Care Facility for the intellectually disabled (ICF-ID), is $150 effective July 1,2025.

d. Community spouse income level. The income level for a community spouse who is eligible for Medicaid is subject to the categorically needy, medically needy, or poverty level income levels. The level for an ineligible community spouse is $2644, or a higher amount if ordered by a court or hearing officer.

e. Family member income level. The income level for each ineligible family member in a spousal impoverishment case is $881 effective July 2025 ($822 effective July 2023, $852 effective July 2024).

3. Poverty income levels.

a. Qualified Medicare Beneficiaries The income level is equal to 100% of the poverty level applicable to a Medicaid Unit of the size involved.

For Qualified Medicare Beneficiaries these levels apply regardless of living arrangements (i.e., in home or in a nursing facility...).

Annual Title II cost of living allowances effective in January shall be disregarded when determining eligibility for QMBs for January, February, and March. This disregard prevents QMBs from becoming ineligible pending issuance of the new poverty levels which are effective April 1 of each year.

The Medicaid Unit size is increased for each unborn when determining the appropriate Medicaid Unit size.

Number of Persons	Monthly Income Level
1	$1,305
2	$1,763
3	$2,221
4	$2,680
5	$3,138
6	$3,596
7	$4,055
8	$4,513
9	$4,971
10	$5,430
(+1)	$459
Effective April 1, 2025	

b. Specified Low-Income Medicare Beneficiaries. The income level is equal to 120% of the poverty level applicable to a Medicaid Unit of the size involved. This is the maximum income level for SLMBs. Applicants or recipients who have income at or below one hundred percent of the poverty level are not eligible as a SLMB, but must be a QMB. These income levels apply regardless of living arrangements (i.e., in home or in a nursing facility. . .).

Annual Title II cost of living allowances effective in January shall be disregarded when determining eligibility for SLMBs for January, February, and March. This disregard prevents SLMBs from becoming ineligible pending issuance of the new poverty levels which are effective April 1 of each year.

The Medicaid Unit size is increased for each unborn when determining the appropriate Medicaid Unit size.

Number of Persons	Monthly Income Level
1	$1,565
2	$2,115
3	$2,665
4	$3,215
5	$3,765
6	$4,315
7	$4,865
8	$5,415
9	$5,965
10	$6,515
(+1)	$550
Effective April 1, 2025	

c. Qualifying Individuals. The income level is equal to 135% of the poverty level applicable to a Medicaid Unit of the size involved. This is the maximum income level for QIs. Applicants or recipients who have income at or below 120% of the poverty level are not eligible as a QI, but may be eligible as a SLMB or QMB. These income levels apply regardless of living arrangements (i.e., in home or in a nursing facility...).

Annual Title II cost of living allowances effective in January shall be disregarded when determining eligibility for QIs for January, February, and March. This disregard prevents QIs from becoming ineligible pending issuance of the new poverty levels, which are effective April 1 of each year.

The Medicaid Unit size is increased for each unborn when determining the appropriate Medicaid Unit size.

Number of Persons	Monthly Income Level
1	$1,761
2	$2,380
3	$2,999
4	$3,617
5	$4,236
6	$4,855
7	$5,474
8	$6,092
9	$6,711
10	$7,330
(+1)	$619
Effective April 1, 2025	

d. Workers with Disabilities. The income level is equal to 225% of the poverty level applicable to a Medicaid Unit of the size involved.

The Medicaid Unit size is increased for each unborn when determining the appropriate Medicaid Unit size.

Number of Persons	Monthly Income Level
1	$2,935
2	$3,966
3	$4,997
4	$6,029
5	$7,060
6	$8,091
7	$9,122
8	$10,154
9	$11,185
10	$12,216
(+1)	$1,032
Effective April 1, 2025	

e. Children with Disabilities. The income level is equal to 250% of the poverty level applicable to the Medicaid Unit size involved.

The Medicaid Unit size is increased for each unborn when determining the appropriate Medicaid Unit size.

Number of Persons	Monthly Income Level
1	$3,261

Number of Persons	Monthly Income Level
2	$4,407
3	$5,553
4	$6,698
5	$7,844
6	$8,990
7	$10,136
8	$11,282
9	$12,428
10	$13,573
(+1)	$1,146
Effective April 1, 2025	

4. Breast and Cervical Cancer Early Detection Program and Refugee Medical Assistance income levels.
    a. The income level is equal to 200% of the poverty level applicable to a Medicaid Unit of the size involved.

Number of Persons	Monthly Income Level
1	$2,609
2	$3,525
3	$4,442
4	$5,359
5	$6,275
6	$7,192

Number of Persons	Monthly Income Level
7	$8,109
8	$9,025
9	$9,942
10	$10,859
(+1)	$917
Effective April 1, 2025	

Determining the Appropriate Income Level in Special Circumstances 510-05-85-45

(Revised 8/1/2024 ML #3851)

View Archives

(N.D.A.C. Sections 75-02-02.1-40 and 75-02-02.1-24.2)

This section applies to individuals who are subject to the Non-ACA Medicaid policies.

1. A child who is away at school is not treated as living independently, but is allowed the appropriate income level for one during all full calendar months. This is in addition to the income level applicable for the Medicaid Unit remaining at home.
2. A child who is living outside of the parental home, but who is not living independently; or a spouse who is temporarily living outside of the home to attend training or college, to secure medical treatment, because of temporary work relocation required by an employer, or for other reasons beyond the control of the spouse, is allowed a separate income level during all full calendar months during which the child or spouse lives outside the home.

   This does not apply to situations where an individual simply decides to live separately.

3. During a month in which an individual enters a specialized facility, or leaves one to return home, the individual will be included in the Medicaid Unit in the home for the purpose of determining the Medicaid Unit and the appropriate income level. Individuals in a specialized facility will be allowed the medically needy income level for one during all full calendar months in which the individual resides in the facility. In determining eligibility for Workers with Disabilities and Children with Disabilities coverages, individuals in a nursing facility, or in receipt of HCBS, will be allowed the appropriate Workers with Disabilities or Children with Disabilities income level for one during all full calendar months in which the individual resides in the facility.
4. During a month in which an individual with eligible family members in the home enters or leaves a Psychiatric Residential Treatment Facility (PRTF); an Intermediate Care Facility for the intellectually disabled (ICF-ID), or a nursing facility to return home, or elects to receive HCBS or terminates that election, the individual will be included in the Medicaid Unit in the home for the purpose of determining the Medicaid Unit and the appropriate medically needy income level. Individuals in a Psychiatric Residential Treatment Facility (PRTF), an Intermediate Care Facility for the intellectually disabled (ICF-ID), or a nursing

facility will be allowed the appropriate nursing care or Intermediate Care Facility for the intellectually disabled (ICF-ID) income level to meet their maintenance needs during all full calendar months in which the individual resides in the facility and is screened as needing that level of care. Recipients of HCBS will be allowed the medically needy income level for one during all full calendar months in which the individual receives HCBS. In determining eligibility for Workers with Disabilities and Children with Disabilities coverages, individuals in a nursing facility, or in receipt of HCBS, will be allowed the appropriate Workers with Disabilities or Children with Disabilities level for one during all full calendar months in which the individual resides in the facility.

5. For an institutionalized spouse with an ineligible community spouse the $100 income level is effective in the month of entry, during full calendar months, and in the month of discharge. The ineligible community spouse, and any other family members, remaining in the home must be given the community spouse and family member income levels.
6. For a spouse electing to receive HCBS who has an ineligible community spouse, the medically needy income level for one is effective in the month the HCBS services begin, during full calendar months, and in the month the HCBS are terminated. The ineligible community spouse, and any other family members, remaining in the home must be given the community spouse and family member income levels.
7. An individual who enters a nursing facility may receive the medically needy income level for one if a physician certifies that the individual is likely to return to the individual's home within six months. The six-month period begins with the first full calendar month the individual is in the nursing facility. If, at any time during the six-month period, the individual's status changes and the stay in the nursing facility is expected to exceed the six months, the individual is only allowed the $100 nursing care income level beginning in the month following the month of the status change.

   For a married couple, budget one spouse at the medically needy income level and the other as permanent long-term care when:

   a. Both spouses are admitted to a nursing facility for temporary stays, or
   b. One spouse is permanently in a nursing facility and the other spouse requires temporary nursing care level services.

   Only one six-month period is allowed per period of institutionalization. If an individual is discharged, then readmitted to the nursing facility, there must be a break of at least one full calendar month between the periods of institutionalization for the new stay to be considered a new period of institutionalization.

8. An individual who is residing in a Psychiatric Residential Treatment Facility (PRTF) or a nursing facility but who is not certified or screened as needing that level of care is allowed the medically needy income level. If the individual appeals the certification or screening and wins, the nursing care income level applies to all full calendar months the appeal covers.
9. An individual's living arrangement or income level does not change when the individual enters a hospital for a temporary stay unless the individual receives nursing care/swing bed services in the hospital.

Deeming of Income 510-05-85-50

(Revised 3/1/20 ML #3575)

View Archives

(N.D.A.C. Section 75-02-02.1-41)

This section applies to individuals who are subject to the Non-ACA Medicaid policies.

Excess income may be deemed to other members of the Medicaid unit as described in this section. Excess income is the amount of net income remaining after allowing the appropriate disregards, deductions and Medicaid income level.

1. An ineligible Medicaid unit in the home is allowed a disregard of seventy-five percent of their excess income when determining client share (recipient liability) for an eligible recipient residing in a specialized facility. The excess income may be deemed to a non-SSI recipient in a specialized facility to bring the individual's income up to the medically needy income level for one. Any remaining income becomes client share for the individual in the specialized facility. The 75% disregard applies during any full calendar month in which the recipient resides in a specialized facility.

   Excess income of an eligible Medicaid unit in the home may be deemed to a non-SSI recipient in a specialized facility to bring the individual's income up to the medically needy income level for one. Any remaining income becomes client share for the individual in the specialized facility and becomes client share for any other medically needy recipients in the Medicaid unit.

   Refer to subsection **3 of 05-85-45** for instructions for the month the individual enters or leaves the facility.

2. No income may be deemed to an SSI recipient in a specialized facility or receiving HCBS as such a recipient's maintenance needs are met by the SSI payment.
3. The excess income of an individual in nursing care, an intermediate care facility for the intellectually disabled, the state hospital, the Anne Carlsen facility, or receiving swing bed care in a hospital or HCBS may be deemed to his or her legal dependents to bring their income up to the appropriate medically needy income level under the following conditions:

a. The legal dependents who are also eligible for Medicaid do not receive a TANF payment or SSI. The maximum income that may be deemed is to the extent that it raises the legal dependent's net income to the appropriate medically needy income level. Payments received specifically for increased medical costs are not income and cannot be deemed (e.g., Aid and Attendance, etc.).
b. The legal dependents are ineligible or choose not to be covered by Medicaid. The maximum income that may be deemed is to the extent that it raises the legal dependents net income to the appropriate community spouse or family member income level. Payments received specifically for increased medical costs cannot be deemed (e.g., Aid and Attendance, etc.).

    i. Deeming to an ineligible community spouse is allowed only to the extent income of the institutionalized or HCBS spouse is made available to the community spouse.
    ii. Excess income must be deemed to family members, in spousal impoverishment cases, up to the family member's income level.

4. The excess income of a spouse or parent(s) cannot be deemed to a recipient to meet medical expenses during any full calendar month in which the recipient receives psychiatric or nursing care services in a nursing facility, an intermediate care facility for the intellectually disabled (ICF-ID), the state hospital, the Anne Carlsen facility, the Prairie at St. John's center, the Stadter Psychiatric Center, a Psychiatric Residential Treatment Facility (PRTF), or receives swing bed care in a hospital or HCBS. Income of the eligible spouse or parent(s), however, may be deemed to bring the individual to the appropriate income level when the individual is ineligible for SSI.
5. For purposes of determining eligibility for Workers with Disabilities coverage, income of a spouse or parent may be deemed to a non-SSI spouse or child, who is in the Medicaid unit, but who is not residing with the applicant or recipient, to bring their income up to the Workers with Disabilities income level.
6. For purposes of determining eligibility for Children with Disabilities coverage, income of a spouse or parent may be deemed to a non-SSI spouse or child, who is in the Medicaid unit, but who is not residing with the applicant or recipient, to bring their income up to the Children with Disabilities income level.

Client Share (Recipient Liability) 510-05-85-55

(Revised 4/1/12 ML #3321)

View Archives

(N.D.A.C. 75-02-02.1-41.1)

Client Share (Recipient Liability) is the amount of monthly net income remaining after all appropriate deductions, disregards, and Medicaid income levels have been allowed. All such income must be considered to be available for payment of medical services provided to the eligible individual or family.

Offset of Client Share (Recipient Liability) 510-05-85-60

(Revised 4/1/12 ML #3321)

View Archives

(N.D.A.C. 75-02-02.1-41.1)

1. Up to fifteen dollars per month of expenses for necessary medical or remedial care, incurred by a member of the Medicaid unit, or a spouse or child they were legally responsible for, in a month prior to the month for which eligibility is being determined, may be subtracted from client share (recipient liability), other than client share created as a result of medical care payments, to determine remaining client share, provided that:

    a. The expense was incurred in a month during which the individual who received the medical or remedial care was not a Medicaid recipient or the expense was incurred in a month the individual was a Medicaid recipient, but was for a service not covered by Medicaid;
    b. The expense was not previously applied in determining eligibility for, or the amount of, Medicaid benefits for any Medicaid recipient;
    c. The medical or remedial care was provided by a medical practitioner licensed to furnish the care;
    d. The expense is not subject to payment by any third party, including Medicaid and Medicare;
    e. The expense was not incurred for swing bed services provided in a hospital, nursing facility services, or HCBS during a period of ineligibility because of a disqualifying transfer;
    f. Each expense claimed for subtraction is documented by the applicant or recipient in a manner which describes the service, the date of the service, the amount of the cost incurred, the amount of the cost remaining unpaid, the amount of the cost previously applied in determining Medicaid benefits for any Medicaid recipient, and the name of the service provider; and
    g. The Medicaid unit is still obligated to pay the expense.

2. The Medicaid unit must apply the remaining client share to expenses of necessary medical care incurred by a member of the Medicaid unit in the month for which eligibility is being determined. The Medicaid unit is eligible for Medicaid benefits to the extent the expenses of necessary medical care incurred in the

month for which eligibility is being determined exceed remaining client share in that month.

Budgeting 510-05-90

Definitions 510-05-90-05

(Revised 4/1/12 ML #3321)

View Archives

(N.D.A.C. Section 75-02-02.1-41.2(1))

1. For purposes of this section:

    a. "Base month" means the calendar month prior to the processing month.
    b. "Benefit month" means the calendar month for which eligibility and client share (recipient liability) is being computed.
    c. "Best estimate" means an income, expense, or circumstance prediction based on past amounts of income and expenses and known factual information concerning future circumstances which affect eligibility, expenses to be incurred; or income to be received in the benefit month. Factual information concerning future circumstances must be based on information by which the applicant or recipient demonstrates known changes or highly probable changes to the income, expense, or circumstances which offset eligibility, from the base month to the benefit month.
    d. "Processing month" means the month between the base month and the benefit month.
    e. "Prospective budgeting" means computation of a household's eligibility and client share based on the best estimate of income, expenses, and circumstances for a benefit month.

10-10-10 Rule 510-05-90-10

(Revised 6/01 ML #2590)

View Archives

1. The "10-10-10 Rule" means:

    a. The recipient has ten days from the date they become aware of a change to report that change to the county agency.
    b. The county agency has ten days in which to act on a reported change.
    c. The county agency must allow ten days for an advance notice before any adverse action can be taken on a case (unless the change is one of the exceptions to the Ten-Day Advance Notice).

2. The purpose of the 10-10-10 rule is to describe the Medicaid unit's responsibility to report changes and to determine when the county agency can or cannot act on changes. It can, and should be, used as a caseload management tool.

Guidelines for Anticipating Income 510-05-90-15

(Revised 3/1/12 ML #3312)

View Archives

Use prospective budgeting to determine eligibility based on the income which is anticipated to be received and the expenses that are anticipated to be incurred. Anticipated income and expenses are an estimate based on reasonable expectations and knowledge of past, current, and future events. The following guidelines are offered to assist in this determination.

An employed individual who does not expect a significant change should have the previous month's earnings and employment deductions verified by pay stub or employer's statement. The previous month's earnings serve as the basis for estimating the income likely to be received during the initial prospective month. To illustrate, a person applies for assistance on November 15 and reports there should be no significant change in income and deductions from the month of October. The October income should be verified to anticipate the income and deductions likely to be available in November.

If the applicant or recipient indicates that he or she expects to begin working or that a material change in income is likely, the statement shall be documented as the basis for the "best estimate" of income to be received. The employer may be contacted, with the applicant's or recipient's permission, to verify the statement that income will be reduced or increased during the prospective month. Or, the applicant or recipient may provide other documentation supporting the expected change.

If new income is expected during the prospective month, the worker needs to arrive at a "best estimate" of the income likely to be available. If the income is from employment in which "tips" are likely, these also need to be estimated.

When anticipating income, also anticipate bonuses, profit sharing, and other such additional income whenever possible. This type of income can be anticipated based on prior receipt of such income. The amount anticipated can be estimated based on amounts previously received, unless factual information suggests otherwise.

To summarize, the method(s) used to anticipate income will vary according to the circumstances in each case. It is the responsibility of the county agency to decide on

the best approach. Whatever the method used, it is imperative that the rationale for arriving at estimated income be clearly and thoroughly documented in the case file.

Computing Client Share (Recipient Liability) 510-05-90-20

(Revised 6/1/22 ML #3675)

View Archives

(N.D.A.C. Section 75-02-02.1-41.1)

1. Computing client share (recipient liability) for previous month. Compute the amount of client share by use of actual verified information, rather than best estimate, in each of the previous months for which eligibility is sought.

   Note: For an ongoing eligible individual, reduction to 'Client Share' can be made retroactively upon receipt of actual verified information for the month the 'Client Share' is being reduced. This is allowed up to twelve months back.

2. Computing client share for the current month and next month at time of approval of the application. Compute the amount of the client share prospectively for the current month and the next month. The income received or best estimate of income to be received during the current month must be used to compute the client share for the current month. The best estimates of income to be received during the next month must be used to compute the client share for the next month.
3. Computing client share for ongoing cases.

   a. For cases with fluctuating income (monthly reporting), compute the client share using verified income, expenses, and circumstances which existed during the base month, unless factual information concerning future circumstances is available. Recipients must report their income, expenses, and other circumstances on a monthly basis to determine continued eligibility.

      When a case is required to report monthly, there is no requirement to use a specific reporting form. A report form, however, will be sent to the recipient each month as a tool and reminder for them to report. The county agency has the flexibility to determine whether a case must report monthly.

   b. For cases with stable income (non-monthly reporting), compute the client share using the best estimate of income, expenses, and circumstances. Recipients with stable income must report changes in income, expenses, and other circumstances within ten days of the day they became aware of the change. A determination of continued eligibility, after a change is

reported and demonstrated, is based on a revised best estimate, which takes the changes into consideration.

Non-monthly reporting cases may be given a change report form that they can use to report changes. This form is not required to be used by the client but is provided as a tool.

Budgeting Procedures for Financially Responsible Absent Parents 510-05-90-23

(Revised 7/1/14 ML #3406)

View Archives

This section applies to individuals are subject to the Non-ACA Medicaid policies.

When a **disabled** child resides with a caretaker other than the parent, and the parent's whereabouts are known, an attempt must be made to obtain the parent's income information. When the parent's income information is received, it is necessary to determine the amount of income that is available to meet the child's needs. The following steps describe the procedure.

1. Compute an Affordable Care Act Medicaid budget based on the absent parents household. All income is considered unearned income for the child and is used in the child's budget.

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

(Revised 10/1/2023 ML #3747)

View Archives

(N.D.A.C. 75-02-02.1-21)

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

When a pregnant woman becomes eligible for Medicaid, she continues eligible, without regard to any increase in income of the Medicaid unit, through the last day of the twelfth month. Decreases in income, however, will be considered to further reduce any client share (recipient liability). Likewise, a pregnant woman can move from one coverage type to another (e.g. from Family Coverage to poverty level); however, if poverty level eligible and income increases, the pregnant woman remains poverty level eligible. All other Medicaid eligibility factors continue to apply.

Pregnancy must be medically confirmed only if questionable. For determinations made after the birth of the baby, the child's birth certificate may be used as verification of pregnancy.

Budgeting Procedures When Adding and Deleting Individuals 510-05-90-30

(Revised 7/1/14 ML #3406)

View Archives

(N.D.A.C. 75-02-02.1-41.2(5) & (6))

1. Budgeting procedures used when adding individuals to an eligible unit. Individuals may be added to an eligible unit up to one year prior to the current month, provided the individual meets all eligibility criteria for Medicaid, the eligible unit was eligible in all of the months in which eligibility for the individual is established, and the individual was in the unit in the months with respect to which eligibility for that individual is sought. Client share (recipient liability) will be based on the unit's actual income and circumstances when adding each individual for retroactive periods. Client share must be based on the unit's income and circumstances from the base month, plus the best estimate of each individual's income and circumstances when adding each individual to the current or next month.

   Client share for other individuals in the Medicaid unit who were medically needy eligible may increase or decrease with the addition of the new member. Any client share, or lack of, applied to previously paid claims will not be adjusted; however, the new client share will be applied to any claims billed in the future.

   Other individuals in the Medicaid unit who were previously determined to be poverty level eligible remain poverty level eligible, regardless of any income change, when adding an individual to the unit.

2. Budgeting procedures when deleting individuals from a case. When a member of an existing unit is expected to leave the unit during the benefit month, that person may remain as a member of the unit until the end of the benefit month.

Budgeting Procedures for Stepparents 510-05-90-35

(Revised 7/1/14 ML #3406)

View Archives

Under North Dakota law, a stepparent has no legally enforceable obligation to support stepchildren. Therefore, the stepparent's own personal income and assets cannot be considered available in determining Medicaid eligibility for the stepchildren. The natural parent, however, is legally responsible for supporting the children. The income of the natural parent cannot be first applied to the children if by doing so other members of the family are deprived of basic necessities. To determine eligibility when both the stepparent and natural parent have income, the county agency must first apply the stepparent's net income against the appropriate income level for the stepparent, spouse and the stepparent's children or children born of this marriage. If the stepparent's income is adequate to meet their needs, the natural parent's net income may then be considered in relation to the needs of the children for whom application is being made. If the stepparent has no income, or if it is sufficient to meet only a portion of the needs of those for whom he is legally responsible, the natural parent's net income shall first be allocated to the remaining unmet needs of those persons (that he or she is legally responsible for) before being considered available to the children in determining client share (recipient liability).

If the stepparent refuses to provide income or assets, all of the natural parent's income and assets are used to determine the children's need and the natural parent's needs cannot be met.

In double stepparent cases (each spouse has children from a previous relationship) the parents are first budgeted in the unit with their spouse and common children. Any income of the common children is first used to meet the needs of the budget unit of the parents and common children. The budget units unmet needs are then split evenly between the parents, and the parents' income is used to meet the remaining unmet needs. If one parent does not have sufficient income to meet their half of the unmet need, the remaining need for the budget unit can be met with the other parent's income. Any excess income from each parent is then deemed to meet the needs of their own (not common) child(ren).

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

(Revised 7/1/14 ML #3406)

View Archives

When budgeting for children whose parents are living together, but are not married:

1. If paternity has not been legally established, but the father's name is on the birth certificate or he has signed the "North Dakota Acknowledgment of Paternity" form, SFN 8195, with a revision date of 4/98 or later, the income of the father must be used to determine Medicaid eligibility. The assets of the father must also be used if the child is eligible as a disabled individual.

   For the month of birth a child's eligibility follows that of the mother. If the mother is eligible for the 60 free days after birth, the child is too. The father's income and, if appropriate, assets are used beginning with the month of birth, however, if they would cause Medicaid ineligibility for the child, the child will remain eligible through the month in which the 60th day falls.

   Child care expenses for the child are split between the two parents; however, if half of the deduction is more than one parent's available income, the unused amount of the expense can be deducted from the other parent's income.

2. If paternity has not been legally established, and the father's name does not appear on the birth certificate or he has not signed the "North Dakota Acknowledgement of Paternity" form, SFN 8195, with a revision date of 4/98 or later, the income and assets of the father will not be used to determine eligibility.
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.

Budgeting Procedures for SSI Recipients 510-05-90-45

(Revised 7/1/14 ML #3406)

View Archives

For aged, blind, or disabled individuals who are categorically needy SSI beneficiaries, the following procedures apply:

1. SSI recipient living in their own home: All income, including deemable income, is normally considered by the Social Security Administration in determining the SSI benefit amount. In those situations it is not necessary to rebudget to determine Medicaid income eligibility. There are situations, however, when the Social Security Administration may be unaware of income. In such cases, the county agency must take the necessary steps to insure that the individual is eligible for SSI if all income is considered before certifying the individual as categorically eligible for Medicaid.

   A SSI recipient is considered part of the family unit as described below:

   a. A SSI recipient is included as part of the family unit when determining asset eligibility;
   b. A caretaker receiving SSI benefits is included in the family unit for budget purposes due to the caretaker's financial responsibility for spouse and children; and
   c. A child receiving SSI benefits is not included in the family unit for budget purposes.

2. SSI recipients residing in an intermediate care facility for the intellectually disabled (ICF-ID) (including the Anne Carlsen facility) are allowed the ICF-ID income level. Those residing in a nursing facility, the state hospital, the Prairie at Saint John's Center, the Stadter Center, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital: The SSI recipient is allowed the nursing care income level. Also see State LTC Subsidy Program 510-05-95-45.

   Parental and spousal income is not considered available to the recipient.

   Individuals between the ages of 21 and 65 are not eligible for Medicaid in the state hospital.

3. SSI recipients living in a specialized facility: All income is normally considered by the Social Security Administration in determining the SSI benefit amount. There

are situations, however, when the Social Security Administration may be unaware of income. In such cases, the county agency must take the necessary steps to insure that the individual is eligible for SSI if all income is considered before certifying the individual as categorically eligible for Medicaid.

If the individual is under 18 years of age and enters the specialized facility from a public institution or the parental home, consider the income of the individual and parents. If the Medicaid unit in the home is not receiving Medicaid, 75% of the excess income shall be disregarded in determining client share (recipient liability).

If the individual is married, the income of the individual and of the spouse must be considered. If the Medicaid unit in the home is ineligible, a disregard of 75% of the excess income is allowed in determining client share.

4. SSI recipients electing to receive HCBS: Verification of SSI eligibility satisfies income eligibility for Medicaid, and it is not necessary to rebudget to determine Medicaid income eligibility. There are situations, however, when the Social Security Administration may be unaware of income. In such cases, the county agency must take the necessary steps to insure that the individual is eligible for SSI if all income is considered before certifying the individual as categorically eligible for Medicaid.

   The maintenance needs of the SSI recipient are considered met by virtue of receipt of SSI, so income of a spouse or parents cannot be deemed to bring the recipient up to the medically needy income level.

Budget Procedures for Medically Needy and Poverty Level 510-05-90-55

(Revised 10/5/2023 ML #3766)

View Archives

1. Individuals and Families living in their own home: All income of the individuals in the Medicaid unit is considered in determining Medicaid income eligibility. The appropriate medically needy or poverty levelincome level is used based on Medicaid Unit size.

   A budget worksheet for the medically needy and poverty level can be found at 05-100-90.

2. Recipients screened for and receiving services in a nursing facility, the state hospital, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital: The recipient is allowed the $100 nursing care income level. Individuals age 65 and over who have entered an IMD do not require a screening. Those admitted for a temporary stay keep the same living arrangement they had prior to being admitted to the IMD and remain at the same income level for that living arrangement. Those admitted for an indefinite stay are allowed the $100 nursing care level for one.

   Recipients residing in an intermediate care facility for the intellectually disabled (ICF-ID): The recipient is allowed the $135 ICF-ID income level.

   For a single individual under age 21, or if blind or disabled under age 18, parental income is not considered available during any full calendar month the recipient is in the facility. Likewise, for a married recipient, income of the spouse is not considered available during any full calendar month, or when the community spouse is ineligible for Medicaid (spousal impoverishment case), during any full or partial month.

   If the individual has no source of income, and is ineligible for SSI, the income of the spouse or parents may be deemed in the amount of $65 (or $100 if the individual is in an ICF-ID) to meet the maintenance needs of the individual.

   Individuals between the ages of 21 and 65 are not eligible for Medicaid in the state hospital.

3. Recipients living in a specialized facility: The recipient is allowed the medically needy income level for one. The members of the Medicaid unit remaining in the home are allowed the appropriate income level.

   If the individual is under age 21, or if blind or disabled under age 18, and enters the specialized facility from a public institution or the parental home, consider the income of the individual and parents.

   If the individual is married, the income of the individual and of the spouse must be considered. If the Medicaid unit in the home is not receiving Medicaid, 75% of the excess income shall be disregarded in determining client share (recipient liability).

   If the individual in the specialized facility is eligible for SSI, do not deem income from the Medicaid unit at home to the individual because the maintenance needs are considered to be met.

   If the individual in the specialized facility is not eligible for SSI and has no source of income or insufficient income, the family at home may deem income to the individual up to the medically needy income level for one.

   Remedial services provided in a specialized facility cannot be paid through Medicaid, but can be allowed as a deduction. Remedial services are determined by subtracting the medically needy income level for one from the recipient's remedial cost of care at the specialized facility. The resulting amount is deducted from the individual's income to determine client share. If the actual remedial expense is less than the calculated amount, use the actual amount.

4. Recipients electing to receive HCBS: The recipient is allowed the medically needy income level for one. A Medicaid unit with a HCBS individual, who has no income or inadequate income, can deem income to that individual, to the medically needy income level for one.

   Income of a parent or eligible spouse is not considered available in determining an individual's eligibility during any full calendar month in which HCBS are received. For a married recipient whose community spouse is ineligible for Medicaid, the income of the spouse is not considered available during any full or partial month.

   The recipient must be screened for and receiving HCBS

Budgeting Procedures for the Medicare Savings Programs 510-05-90-60

(Revised 1/03 ML #2833)

View Archives

All income of the applicant or recipient and other members of the Medicaid unit who are living with the applicant or recipient must be considered. Deductions for the Medicare premium, any health or nursing home insurance premiums, or any other medical expenses are not allowed.

The same budgeting applies regardless of whether the individual lives in the individual's own home, a specialized facility, or a nursing facility.

Recipients with income at or below 100% of the poverty level can only be eligible as a QMB. If income is above 100% but not more than 120% of the poverty level, the recipient can only be eligible as a SLMB. If income is above 120% but not more than 135% of the poverty level, the recipient can only be eligible as a QI.

Individuals between the ages of 21 and 65 are not eligible for Medicaid in the state hospital.

Budgeting Procedures for Workers with Disabilities 510-05-90-65

(Revised 6/1/04 ML #2925)

View Archives

All income of the applicant or recipient and other members of the Medicaid unit must be considered.

The same budgeting applies regardless of whether the individual lives in the individual's own home, a specialized facility, or a nursing facility.

Recipients with family income at or below 225% of the poverty level can be eligible under the Workers with Disabilities coverage.

If the 225% eligibility test is passed, the premium required to obtain the coverage is equal to 5% of the eligible individual's gross income. If more than one individual in the case is eligible for Workers with Disabilities coverage, each individual's premium is determined separately based on their own income.

Budgeting Procedures for Children with Disabilities 510-05-90-70

(Revised 12/1/19 ML #3569)

View Archives

All income of the applicant or recipient and other members of the Medicaid unit must be considered.

The same budgeting applies regardless of whether the individual lives in the individual's own home, a specialized facility, or a nursing facility.

Recipients with family income at or below 250% of the poverty level can be eligible under the Children with Disabilities coverage.

If the family passes the 250% eligibility test, the premium required to obtain the coverage is equal to 5% of the family's gross countable income. The Children with Disabilities premium is offset by any premium amount the family pays toward a family health insurance policy in which the disabled child is covered.

Budgeting Procedures for Continuous Eligibility for Children Under Age 19 510-05-90-75

(Revised 10/5/2023 ML #3766)

View Archives

1. When a child becomes continuously eligible for Medicaid, that child continues to be eligible without regard to any changes in income and/or expenses of the Medicaid unit until the next review. Likewise, a continuously eligible child can move from one coverage category to another (e.g. Foster Care to Poverty Level); however, if PL eligible and income increases to above PL, the child remains PL eligible until the end of their continuous eligibility period.
2. For a continuously eligible child residing in a nursing facility, the state hospital, a Psychiatric Residential Treatment Facility (PRTF), or receiving swing bed care in a hospital: the recipient is allowed the $100 nursing care income level and excess income becomes client share (recipient liability).

   Recipients residing in an intermediate care facility for the intellectually disabled (ICF-ID) (including the Anne Carlsen facility): The recipient is allowed the $135 ICF-ID income level.

   For a single individual under age 19, parental income is not considered available during any full calendar month the recipient is in the facility.

   If the individual has no source of income, and is ineligible for SSI, the income of the parents may be deemed in the amount of $100, (or $135, if the individuals is in an ICF-ID) to meet the maintenance needs of the individual.

   NOTE: The premium calculation for Children/Workers with Disabilities is still required.

Related Programs 510-05-95

General Information 510-05-95-05

(Revised 1/02 ML #2762)

View Archives

There are other non-Medicaid programs that help meet the health needs of individuals and families. Some of these programs closely interact with Medicaid. Applicants who are ineligible for Medicaid may qualify for these other programs and should be referred accordingly.

Basic Care Assistance Program 510-05-95-15

(Revised 1/02 (ML #2762)

View Archives

The Basic Care Assistance Program is a program for individuals who are at least age 18, who are blind or disabled, or age 65 and over, who need the services provided by a licensed basic care facility. The intent of the 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. Information and eligibility criteria can be found in Service Chapter 400-29.

Refugee Medical Assistance Program 510-05-95-20

(Revised 5/1/2025 ML #3931)

View Archives

1. A refugee who meets all Medicaid eligibility criteria must be enrolled in Medicaid, including Optional Children's Group (CHIP) except:

- Individuals who would be eligible for Medicaid with a client share will be enrolled in Refugee Medical Assistance (RMA) instead Medicaid Med Needy.

2. RMA provides health care coverage for legally admitted refugees:

- Who are not eligible for Medicaid, including the Optional Children's Group (CHIP).
- Who are no longer eligible for Medicaid during the first four months in the country due to increase\ an in earnings.
    - The individual will be transferred to RMA without a review of eligibility.

3. RMA has two coverage types:

- Refugee Coverage
    - Covers refugees whose earned income makes them ineligible for Medicaid, but who are receiving a Refugee Cash Assistance (RCA) payment in a month in which the earned income is counted.
- RMA Med Needy
    - Covers refugees who are not or no longer receiving a Refugee Cash Assistance (RCA) payment and whose earned income makes them ineligible for Medicaid. If the individual’s earned income is under 200% of the FPL, they will not have a client share. If their wages are over 200% of the FPL, they will have a client share.

Both coverage types are limited to four months. A review will be due in month four. The month the US entry is considered month one of the four month period.

4. RMA individuals:

- Who receive a Refugee Cash Assistance (RCA) payment and who are not eligible for Medicaid or Optional Children's Group (CHIP) due to their earned income are eligible for Refugee coverage.
- Who are eligible for RMA Med Needy coverage will continue to qualify for this coverage without regard to increases in earned income through the end of the four-month period.
- Who are eligible for RMA Med Needy coverage with a client share will not have an increase in client share if their income increases. The client share can decrease if income decreases or expenses increase.

5. Refugee Cash Assistance (RCA) payments:

Most, but not all, refugees will receive an RCA payment upon entering the U.S. RCA payments are not considered countable income for Medicaid. The RCA payments must be prorated based on the number of refugees in the household that the payment covers.

Example: A husband and wife will receive one payment. The payment must be split in half and entered for each of them.

Example: A household with parents and three children under age 18 will receive one payment. The payment must be split between the five individuals and entered for each of them.

Example: Individuals over age 18, even if residing with a parent(s), will receive their own payment.

RCA payments will end when the individual starts working. When an individual reports they are working, we must verify when their RCA payment will end, and the end date must be entered in Spaces. Ending the payment will ensure they will receive the correct RMA coverage.

Note: Reference policy 510-05-35-58 (Qualified Noncitizens) for a list of eligible groups who qualify under RMA.

Note: Unaccompanied Refugee Minors (URM) eligibility policy is located at 510-03-55-05 and 510-05-55-05.

Children's Special Health Services 510-05-95-40

(Revised 3/1/12 ML #3312)

View Archives

Children's Special Health Services provides services for children with special health care needs and their families. Services include coverage for diagnosis and treatment for children who have disabilities or chronic conditions. The program supports family-centered, community-based, coordinated services and systems of health care that meet the diverse needs of families. For information, contact the Children's Special Health Services Program, North Dakota Department of Health, Division of Maternal and Child Health, 600 East Boulevard Ave, Dept 301, Bismarck ND 58505-0200, or call 701-328-2436, 1-800-755-2714, or FAX: 701-328-1645.

State LTC Subsidy Program 510-05-95-45

(Revised 7/1/2023 ML #3734)

The State LTC (Long-Term Care) Subsidy Program is a state funded program that provides additional income to qualifying Medicaid recipients who are subject to Post Eligibility Treatment of Income budgeting. The state subsidy provides funds to help meet current maintenance needs of recipients. This program began January 1, 2010.

1. To qualify, an individual must:

    a. Be a Medicaid recipient;
    b. Be a SSI recipient who receives a SSI payment of $30 per month or less;
    c. Reside in a nursing facility, the state hospital, the Anne Carlsen Center; Prairie at St. John's Center; the Stadter Center; a Psychiatric Residential Treatment Facility (PRTF), an Intermediate Care Facility for the intellectually disabled (ICF-ID); or receive swing bed care in a hospital;
    d. Have total income, between SSI and any other source, of less than $100 per month; and
    e. Be expected to reside in the facility for the entire calendar month.

2. Determining the amount of the subsidy payment:

    a. The subsidy payment is the difference between the $30 SSI payment level and $100, less any other income available to the recipient. The maximum subsidy cannot exceed $70 per month.
    b. If a recipient receives less than $30 in SSI benefits due to a SSI overpayment, because SSI benefits have not yet been paid, because of other income received by the recipient, because the SSI recipient is eligible under 1619(b), or for any other reason, the subsidy does not increase due to the lower SSI payment. For subsidy calculation purposes, the SSI benefit is calculated at $70, even if the amount actually paid is less than that amount.

        When a child who is a SSI recipient chooses to be eligible for Medicaid under a children and family eligibility category instead of as a disabled child, the child can still qualify for the subsidy.

    c. Subsidy payments may be established for the application month and prospective months if the recipient is anticipated to be in the facility for the entire month for which the subsidy is determined. Subsidy payments are not established for the three months prior to application.

d. When a recipient's budget, including a retroactive budget in which a subsidy payment was previously established, is reworked for a month and results in an underpayment, the recipient will receive a supplement for the month. If a reworked budget results in an overpayment for the month, the overpayment will be disregarded.
e. Subsidy payments, including underpayments, are automatically calculated when Medicaid eligibility is authorized.

3. Paying the subsidy

   a. There is no minimum payment amount required, however, if a payment amount is less than $10, the payment will be held until the total of the payment plus any subsequent payments total or exceed $10. If the payment amount plus any subsequent payment amounts do not exceed $10 after three months, the payment will be paid regardless of the amount.
   b. Payments will be paid by check to the recipient. A recipient may request a direct deposit of the payment by providing bank routing and account numbers to the county agency. Questions related to checks or direct deposits should be directed to the Fiscal Administration Unit.
   c. Subsidy payments are issued on a weekly basis to accommodate new approvals and supplemental payments. Checks are normally mailed on Fridays and direct deposits are normally processed on Thursday nights.

4. Subsidy payment determinations are not appealable.
5. There is no estate recovery for subsidy payments.

North Dakota Health Tracks 510-05-95-50

(New 1/1/2024 ML #3779)

North Dakota Health Tracks (formerly EPSDT) is a preventive health benefit that is free for children age 0 to 21, who are eligible for Medicaid. Health Tracks pays for screenings, diagnosis, and treatment services to help prevent health problems from occurring or help keep health problems from becoming worse. Health Tracks also pays for orthodontics (teeth braces), glasses, hearing aids, vaccinations, counseling and other important health services. Some services require prior authorization so be sure to check with your screener about these requirements.

Federal legislation requires states to make available to all Medicaid-eligible children under age 21 comprehensive, periodic health assessment, dental, vision and hearing services, and "medically necessary" follow-up diagnostic and treatment service.

Forms Appendix 510-05-100

SFN 560, "Assignment of Benefits" 510-05-100-05

(Revised 6/01 ML #2590)

View Archives

This form is used to obtain the signature of someone legally able to assign benefits when the individuals who signs the application do not have the right to do so.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (42 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 817, "Health Insurance Cost-Effectiveness Review" 510-05-100-10

(Revised 6/01 ML #2590)

View Archives

This form is used by the county agency to refer Medicaid eligible cases with health insurance to the state Medicaid Eligibility unit to determine if the health insurance is cost-effective and can be paid by Medicaid.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (96 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

DN 555, "Medicaid Program Brochure" 510-05-100-15

(Revised 6/01 ML #2590)

View Archives

Medicaid Program Brochure (4,043 kb pdf)

Brochures are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

DN 143, "Your Civil Rights Brochure" 510-05-100-20

(Revised 11/1/06 ML #3047)

View Archives

This brochure is available through the Department of Human Services.

DN 143, "Your Civil Rights Brochure" (33 kb pdf)

Family Planning Program 510-05-100-25

(Revised 6/01 ML #2590)

View Archives

This information is available through the Department of Human Services.

Family Planning Program (pdf)

DN 538, "ND Health Tracks" 510-05-100-30

(Revised 1/1/2024)

View Archives

These flyers are available through the Department of Health and Human Services.

DN 538 " Health Tracks/Well-Child Checks

Health Tracks/Well-Child Checks

WIC Program 510-05-100-35

(Revised 6/01 ML #2590)

View Archives

This information is available through the Department of Human Services.

WIC: Because You Care brochure (tif)

SFN 451, "Eligibility Report on Disability/Incapacity" 510-05-100-40

(Revised 6/01 ML #2590)

View Archives

This form may be used by the county agency to submit social information to the State Review Team for the evaluation of disability or incapacity.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (180 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 228, "Workers with Disability Report Part II" 510-05-100-41

(Revised 8/1/05 ML #2981)

View Archives

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (412 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 443, "Notice of Right to Claim 'Good Cause'" 510-05-100-45

(Revised 6/01 ML #2590)

View Archives

The front of the form briefly summarizes the legislative intent of the IV-D Program and the applicant's or recipient's obligation to cooperate with Child Support. The back of the form describes in some detail the circumstances under which cooperation may be "against the best interests" of the child and provides examples of the kinds of evidence necessary to substantiate a claim.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (34 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 446, "Request to Claim 'Good Cause" 510-05-100-50

(Revised 6/01 ML #2590)

View Archives

The form provides the caretaker with the opportunity to describe the circumstances which he/she believes will have a bearing on the claim.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (44 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 828, Credit Form 510-05-100-55

(Revised 2/04 ML #2900)

View Archives

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

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

$6,000/6 Percent Rule 510-05-100-60

(Revised 6/01 ML #2590)

View Archives

If the equity value (EV) is...	And the 6 percent annual return (AR) requirement is...	Then...
$6,000 or less	met on the excluded equity (i.e., equity is $5,000; AR must be at least $300)	exclude the entire EV of the property.
$6,000 or less	not met on the excluded equity (i.e., equity is $5,000; AR is less than $300)	count the entire EV of the property toward the asset limit.
greater than $6,000	met on the amount of excluded equity (i.e., EV is $8,000; AR must be at least $360)	count the excess EV ($2,000) toward the asset limit.
greater than $6,000	not met on the excluded equity (i.e., EV is $8,000; excluded equity is $6,000; AR must be at least $360	count the entire EV (i.e., $8,000 toward the asset limit.
$6,000 or less on the total of more than one income-producing property	met on the EV of each property	exclude the total EV's of the properties.
$6,000 or less on the total of more than one income-producing property	not met on the EV of one or more of the properties	count the entire value of any property not meeting the 6 percent AR toward the asset limit.

greater than $6,000 on the total EV's of more than one income-producing property	met on the EV of each property	total the EV's and count the amount in excess of $6,000 toward the asset limit.
greater than $6,000 on the total EV's of more than one income-producing property	not met on the EV of one or more of the properties	the entire EV of any property not meeting the 6 percent AR is counted toward the asset limit as well as any excess over $6,000.

SFN 200, "Asset Assessment" 510-05-100-65

(Revised 2/04 ML #2900)

View Archives

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

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 52, Spousal Assets Log 510-05-100-70

(Revised 6/01 ML #2590)

View Archives

IM 5388

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (293 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

Life Expectancy Table 510-05-100-75

(Revised 12/1/19 ML #3569)

View Archives

The following link is used to determine life expectancy.

https://www.ssa.gov/OACT/population/longevity.html

Life Estate and Remainder Interest Table 510-05-100-80

(Revised 6/01 ML #2590)

View Archives

Age	Life Estate	**Remainder Interest**
0	.97188	.02812
1	.98988	.01012
2	.99017	.00983
3	.99008	.00992
4	.98981	.01019
5	.98938	.01062
6	.98884	.01116
7	.98822	.01178
8	.98748	.01252
9	.98663	.01337
10	.98565	.01435
11	.98453	.01547
12	.98329	.01671
13	.98198	.01802
14	.98066	.01934

15	.97937	.02063
16	.97815	.02185
17	.97700	.02300
18	.97590	.02410
19	.97480	.02520
20	.97365	.02635
21	.97245	.02755
22	.97120	.02880
23	.96986	.03014
24	.96841	.03159
25	.96678	.03322
26	.96495	.03505
27	.96290	.03710
28	.96062	.03938
29	.95813	.04187
30	.95543	.04457
31	.95254	.04746
32	.94942	.05058
33	.94608	.05392
34	.94250	.05750
35	.93868	.06132

36	.93460	.06540
37	.93026	.06974
38	.92567	.07433
39	.92083	.07917
40	.91571	.08429
41	.91030	.08970
42	.90457	.09543
43	.89855	.10145
44	.89221	.10779
45	.88558	.11442
46	.87863	.12137
47	.87137	.12863
48	.86374	.13626
49	.85578	.14422
50	.84743	.15257
51	.83674	.16126
52	.82969	.17031
53	.82028	.17972
54	.81054	.18946
55	.80046	.19954
56	.79006	.20994

57	.77931	.22069
58	.76822	.23178
59	.75675	.24325
60	.74491	.25509
61	.73267	.26733
62	.72002	.27998
63	.70696	.29304
64	.69352	.30648
65	.67970	.32030
66	.66551	.33449
67	.65098	.34902
68	.63610	.36390
69	.62086	.37914
70	.60522	.39478
71	.58914	.41086
72	.57261	.42739
73	.55571	.44429
74	.53862	.46138
75	.52149	.47851
76	.50441	.49559
77	.48742	.51258

78	.47049	.52951
79	.45357	.54643
80	.43659	.56341
81	.41967	.58033
82	.40295	.59705
83	.38642	.61358
84	.36998	.63002
85	.35359	.64641
86	.33764	.66236
87	.32262	.67738
88	.30859	.69141
89	.29526	.70474
90	.28221	.71779
91	.26955	.73045
92	.25771	.74229
93	.24692	.75308
94	.23728	.76272
95	.22887	.77113
96	.22181	.77819
97	.21550	.78450
98	.21000	.79000

99	.20486	.79514
100	.19975	.80025
101	.19532	.80468
102	.19054	.80946
103	.18437	.81563
104	.17856	.82144
105	.16962	.83038
106	.15488	.84512
107	.13409	.86591
108	.10068	.89932
109	.04545	.95455

SFN 687, "Medicaid Budget Worksheet" 510-05-100-90

(Revised 6/01 ML #2590)

View Archives

SFN 687 is intended to serve as a basic tool to be utilized in understanding the determination of initial and continuing eligibility for Medicaid.

This form is available through the Department of Human Services and may also be obtained electronically via E-Forms. (158 kb pdf)

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

SFN 1186, "Notice to Insurer of Annuity" 510-05-100-96

(Revised 11/1/06 ML #3047)

View Archives

This notice is available through the Department of Human Services and may also be obtained electronically via E-Forms.

E-Forms are presented in Adobe Acrobat and require the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the get Adobe Reader icon below.

Budgeting Workbook 510-05-100-100

Revised 7/1/14 ML #3406

View Archives

The following information will be presented in Adobe Acrobat and requires the Adobe Acrobat reader. If you do not currently have Adobe Acrobat reader installed, you may download a free copy by clicking the Get Adobe Reader icon below.

Rules for Building Asset and Budget Units

Optional Cat Needy Budget Examples

Medically Needy Budget Examples (including ABD, non LTC & LTC)

Poverty Level Budget Examples

Medicare Savings Programs Budget Examples

Workers With Disabilities Budget Examples

Medicaid Living Arrangement Reference Hard Card 510-05-105-10

(New 11/1/2023 ML #3771)

510-05-105-10 Medicaid Living Arrangement Reference Hard Card

Living Arrangement	SPACES Liv Arrange	Examples	MA Income Level	Post Eligibility Treatment of Income (PETI)	Eligible through CE Period Age 1-19	Budgeting Policy Reference	Comments
Away at School	IS	Boarding school-Dormintory-Living in another community to attend any school					
Away from Home (not in school)	AH	living in another community for work or medical care- Job Corp					
Home and Community Based Services/In Own Home	HH	HCBS screened living in a **home** setting Examples: House-Apartment-Mobile home-Assisted living- Hospitalized-Halfway house	med needy level for one--1st full month		Y	510-05-90-55(4)	~ Exception Spousal Impoverishment ~ Count only income of individual in living arrangement in the 1st full month
Home and Community Based Services/Specialized facility	HS	HCBS screened living in a **facility** setting-- examples Able Inc.-Alpha Opportunities-Hit--DD Waiver HCBS Group Home	med needy level for one--1st full month		Y	510-05-90-55(4)	~ Exception Spousal Impoverishment ~ Count only income of individual in living arrangement in the 1st full month
In own home	**IH**	**House-Apartment-Mobile home-Assisted living- Hospitalized-Halfway house**					
Inpatient inmate/prisoner care	IP	Prisoner admitted to medical institution for a 24 hour or longer period				510-03-35-95-05 510-05-35-95-05-05 through 510-05-35-95-05-35	
Institution of Mental Diseases (IMD)	IC	Prairie St John's -Share House Fargo-Sumit Prairie Recovery Center Raliegh-Home on the Range Centinal Butte	temporary--same as prior to entry--$100 admitted indefinitely		Y	510-05-90-55(2)	
Intermediate care facility for intellectually disabled (ICF/IID's)	IM	example--Anne Carlsen-Life Skills Transition Center (see additional listing below)	$135	Y	Y	510-05-90-55(2)	~ Requires a level of care (LOC) screening--starting with the 1st full calendar month - med needy level for one, exception Spousal Impoverishment starts in month of entry ~ Count only income of individual in living arrangement 1st full month
Long term care facility (LTC)	LT	nursing home-swing bed	6 months or less-Med needy level for one--longer than 6 months $100	Y	Y	510-05-90-55(2)	~ Requires a level of care (LOC) screening--starting with the 1st full calendar month - med needy level for one, exception Spousal Impoverishment starts in month of entry
Psychiatric Treatment Center (PRTF)	LT	Dakota Boy's and Girl's Ranch--Manchester House	6 months or less-Med needy level for one--longer than 6 months $100	Y	Y	510-05-90-55(2)	~ Requires a level of care (LOC) screening--starting with the 1st full calendar month - med needy level for one, exception Spousal Impoverishment starts in month of entry
Public institution(inmate/prisoner)	AI	ND state Penitentiary-county jails-tribal jails-Youth Correctional Center(YCC)-James River Correction Center-Dakota Women's Correctional Center-Missouri River Correctional Center-Teen/Adult Challenge Mandan	Suspended		Y		~ Children age 1-19 are eligible through there CE and then will be suspended
Specialized facility-former foster care	IH	Aged out of foster care at age 18					~ No income test except when a former foster care individual enters a facility
Specialized facility-foster care	SF	Foster Care-IV-E, Tribal IV-E or Non IV-E			Y	510-05-55-10	
Specialized facility-not foster care	SF	Basic Care facility-School for the Blind--School for the deaf-residential treatment center	med needy level for one--1st full month		Y	510-05-90-55(3)	~ Count only income of individual in living arrangement first full month
State Hosp < Age 21	JH	ND State Hospital in Jamestown	temporary--same as prior to entry--$100 admitted indefinitely	Y--if the stay is considered indefinite	Y	510-05-90-55(2)	
State hospital >Age 21 (21-<65)	SH	ND State Hospital in Jamestown	Suspended			Suspended	
State hospital >Age 21 (65 and older)	SH	ND State Hospital in Jamestown	Eligible			510-05-90-55(2)	

ICF-IID Facilities in North Dakota

ICF-IID Facilities in North Dakota						
	Individuals residing at the listed address would be given the Living Arrangement of Intermediate Care Facility for Individuals with Intellectual Disabilities					
PROVIDER	**RESIDENTIAL ADDRESS**	**LOCATION**		**PROVIDER**	**RESIDENTIAL ADDRESS**	**LOCATION**
4th Corporation	1110 Central Avenue	New Rockford		HIT, Inc.	1004 27th Street N. W.	Mandan
4th Corporation	927 3rd Street Northeast	Fessenden		HIT, Inc.	1417 S. Washington Street	Bismarck
ABLE, Inc.	1813 3rd Ave E	Dickinson		HIT, Inc.	1201 7th Ave. SE	Mandan
ABLE, Inc.	1304 2nd Avenue S.	Hettinger		HIT, Inc.	1203 7th Ave. SE	Mandan
ABLE, Inc.	2357 Country Oaks Drive	Dickinson		HIT, Inc.	1301 7th Ave SE	Mandan
ABLE, Inc.	1153 24th St W	Dickinson		HIT, Inc.	1303 7th Ave SE	Mandan
ABLE, Inc.	1750 4th Ave E	Dickinson		Lake Region Corporation	923 6th Avenue	Devils Lake
Alpha Opportunities, Inc.	112 6th Avenue Southeast	Jamestown		Lake Region Corporation	2017 Highway 20 South	Devils Lake
Alpha Opportunities, Inc.	1510 8th Avenue Northeast	Jamestown		Minot Vocational Adj. Workshop	1007 11th Avenue Southeast	Minot
Anne Carlsen Center	701 3rd Ave. N.W.	Jamestown		Minot Vocational Adj. Workshop	1005 11th Avenue Southeast	Minot
Anne Carlsen Center	603 3rd St N.W.	Jamestown		Minot Vocational Adj. Workshop	11 Park Drive	Rolla
Anne Carlsen Center	605 3rd St N.W.	Jamestown		Open Door Center	220 5th Avenue SW	Valley City
Anne Carlsen Center	601 3rd St N.W.	Jamestown		Open Door Center	491 2nd Avenue NE	Valley City
Development Homes, Inc.	2585 South 19th Street	Grand Forks		Open Door Center	664 10th Avenue SE	Valley City
Development Homes, Inc.	1551 24th Avenue South	Grand Forks		Open Door Center	240 4th Avenue SE	Valley City
Development Homes, Inc.	2720 17th Street South	Grand Forks		Opportunity Foundation, Inc.	821 5th Avenue West	Williston
Enable, Inc.	3656 East Princeton	Bismarck		Opportunity Foundation, Inc.	1808 17th Court West	Williston
Enable, Inc.	3665 West Princeton	Bismarck		Opportunity Foundation, Inc.	723 2nd Street Southwest	Stanley
Enable, Inc.	1549 South Washington	Bismarck		Opportunity Foundation, Inc.	220 North Gilbertson Street	Tioga
Enable, Inc.	2100 12th Avenue Southeast	Mandan		Red River Human Services Found.	348 14th Street North	Wahpeton
Enable, Inc.	2004 8th Avenue Southeast	Mandan		Red River Human Services Found.	821 Western Road	Wahpeton
Fraser, LTD.	2574 Arrowhead Road	Fargo		Red River Human Services Found.	1348 15th Avenue North	Wahpeton
Fraser, LTD.	2726 18th Street South	Fargo		Red River Human Services Found.	903 Mulberry Lane	West Fargo
Fraser, LTD.	631 22nd Street East	West Fargo		REM-North Dakota, Inc.	415 North 51st Street	Grand Forks
Fraser, LTD.	651 12 1/2 Avenue East	West Fargo		REM-North Dakota, Inc.	5017 7th Avenue North	Grand Forks
Friendship, Inc.	1635 34th Avenue South	Fargo		REM-North Dakota, Inc.	301 39th Avenue South	Grand Forks
Friendship, Inc.	2502 33rd Avenue South	Fargo		REM-North Dakota, Inc.	1575 Manvel Avenue	Grafton
Friendship, Inc.	2302 18th Street South	Fargo		REM-North Dakota, Inc.	730 Summit Avenue	Grafton
Friendship, Inc.	2424 18th Street South	Fargo		REM-North Dakota, Inc.	1824 1st Street Southeast	Minot
Friendship, Inc.	412 East 10th Street	Grafton		REM-North Dakota, Inc.	1405 32nd Avenue Southwest	Minot
Friendship, Inc.	503 Hilltop Drive	Park River		REM-North Dakota, Inc.	1404 18th Avenue Southwest	Minot
Friendship, Inc.	605 Hilltop Drive	Park River		REM-North Dakota, Inc.	506 13th Street West	Devils Lake
HIT, Inc.	324 West Apollo Ave.	Bismarck		REM-North Dakota, Inc.	1104 15th Street South	Devils Lake
HIT, Inc.	1901 2nd Street N. E.	Mandan				

Development Disabilities (DD) Waiver HCBS Group Homes

Development Disabilities (DD) Waiver HCBS Group Homes						
	Individuals residing in Facilities at the listed address would be given the Living Arrangement of Home and Community Based Services-Specialized Facility					
PROVIDER	RESIDENTIAL ADDRESS	City		PROVIDER	RESIDENTIAL ADDRESS	City
4th Corporation	1006 2nd Avenue North	New Rockford		Minot Vocational Adj. Workshop	1101 11th Avenue Southeast	Minot
Alpha Opportunities, Inc.	705 14th Street Northeast	Jamestown		Minot Vocational Adj. Workshop	1109 11th Avenue Southeast	Minot
Development Homes, Inc.	1211 10th Avenue South	Grand Forks		Open Door Center	931 4th Street SW	Valley City
Development Homes, Inc.	101 Chestnut Street	Grand Forks		Opportunity Foundation, Inc.	701 8th Street East	Williston
Development Homes, Inc.	210 Chestnut Street	Grand Forks		Opportunity Foundation, Inc.	526 Reclamation Drive	Williston
Development Homes, Inc.	802 North 4th Street	Grand Forks		Opportunity Foundation, Inc.	1814 21st Ave. W.	Williston
Fraser, LTD.	4311 9th Ave. Circle South	Fargo		Pride, Inc	708 Boundary Rd	Mandan
Fraser, LTD.	717 South University Drive	Fargo		Pride, Inc.	2611 Gateway Avenue	Bismarck
Fraser, LTD.	514 South University Drive	Fargo		Pride, Inc.	3011 E Rosser Avenue	Bismarck
Fraser, LTD.	3419 & 3421 58 Court South	Fargo		Pride, Inc.	1913 E Capitol Avenue	Bismarck
Fraser, LTD.	3585 & 3587 58 Court South	Fargo		Pride, Inc.	1102 S. 3rd St.	Bismarck
HAV-IT ADULT SERVICES	301 Jackson Avenue	Harvey		Pride, Inc.	3318 E Rosser Avenue	Bismarck
HAV-IT ADULT SERVICES	300 W North Street	Harvey		Red River Human Services Found.	608 South 4th Street	Wahpeton
HIT, Inc.	304 11th Street N.E.	Mandan		Red River Human Services Found.	109 4th Avenue South	Wahpeton
HIT, Inc.	1007 18th St. NW	Mandan		Red River Human Services Found.	808 South 6th Street	Wahpeton
HIT, Inc.	1509-11 S. Washington	Bismarck		Red River Human Services Found.	1685 6th St W.	West Fargo
HIT, Inc.	1517-19 S. Washington	Bismarck		Red River Human Services Found.	1689 6th St W.	West Fargo
HIT, Inc.	1140 N. Collins Ave	Mandan		Red River Human Services Found.	1693 6th St W.	West Fargo
HIT, Inc.	1150 N. Collins Ave	Mandan		Red River Human Services Found.	1697 6th St W.	West Fargo
Lake Region Corporation	116 20th Street	Devils Lake		Red River Human Services Found.	812 6th St. S.	Wahpeton
Lake Region Corporation	1201 4th Avenue	Devils Lake		Red River Human Services Found.	207 4th Ave S	Wahpeton
Minot Vocational Adj. Workshop	1105 11th Avenue Southeast	Minot		REM-North Dakota, Inc.	1345 Tuxedo Road	Minot
Minot Vocational Adj. Workshop	1325 17th Ave SW	Minot		REM-North Dakota, Inc.	1422 10th St S	Grand Forks
Minot Vocational Adj. Workshop	10 Park Drive	Rolla		REM-North Dakota, Inc.	224 Summit Ave	Grafton
Minot Vocational Adj. Workshop	505 Turtle Creek Dr. NE	Belcourt		REM-North Dakota, Inc.	824 7th Ave NW	Minot
Minot Vocational Adj. Workshop	1320 6th Ave SE	Minot				
Minot Vocational Adj. Workshop	1508 17 1/2 Ave SW	Minot				

Policy Processing Appendix 510-05-110

Process for the Medicaid Breast and Cervical Cancer Early Detection Program (BCCEDP) 510-05-110-05

(New 2/1/2024 ML #3802)

Following is the process when an individual has submitted a Medicaid application, and the State has a referral from the *Women's Way* Screening Program:

- If the State has received required documentation from the *Women's Way* Screening Program regarding an individual, contact with the Customer Support Center is made by the State sending an email to applyforhelp@nd.gov
- Upon receipt of the Medicaid application, the zone office will process the Medicaid application in the usual way but will NOT authorize it.
- Once the zone office has processed the Medicaid application and has informed the State that the case is processed but not authorized, the State will determine if the individual is eligible for coverage under the Medicaid BCCEDP.
- If the State determines the individual is eligible for coverage under the Medicaid BCCEDP , applicable information is entered in SPACES under the Special Health Care Coverage question and the Detail screen. If the State determines the individual is not eligible for coverage under BCCEDP coverage, no information is entered in SPACES. After determination is made, the State will contact the zone office to continue the processing of the Medicaid application in the usual way including authorization. Immediately after the zone authorizes the case, contact with the State must be made by sending an email to medicaidcc@nd.gov and include 'Medicaid BCCEDP' in the subject line as the state must add additional verbiage to the pending notice regarding the Medicaid BCCEDP coverage determination.

Following is the process for ongoing cases with an individual who has coverage under Medicaid BCCEDP:

- The zone office must contact the State by sending an email to medicaidcc@nd.gov and include 'Medicaid BCCEDP' in the subject line on a case that includes an individual who has coverage under the BCCEDP when:
    - A review is due for Medicaid

- A reported change is received and is being processed by the zone office.
- Updating the review period(s) or
- The individual becomes Medicare or Medicaid eligible.

- If the state acts on reported change on an individual who has coverage under the Medicaid BCCEDP which can include BCCEDP coverage closing, contact with the zone will be made through email at applyforhelp@nd.gov.
- When the zone office receives a review for the household that includes an individual who has coverage under the Medicaid BCCEDP, contact with the State must be made by sending an email to medicaidcc@nd.gov and include 'Medicaid BCCEDP' in the subject line as the review must be processed jointly.

Note: A detailed narrative must be entered in SPACES by the state and the zone for actions taken in the case.

Medicaid Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities 510-05-110-20

(New 3/1/2024 ML #3811)

When an individual is determined eligible:

Enter the information in SPACES just like any other case with the following exceptions:

- Enter the address of the facility where the individual is residing for the individual's address.
- Enter the Living Arrangement of " In Own Home" with a date equal to the first day of the first month they began residing in one of these facilities. See Coverage for Inmates Residing in Corrections-related Supervised Community Residential Facilities 510-03-35-95-10 for a list of facilities.