MANUAL MATERIAL TRANSMITTED

MANUAL: Income Maintenance

CHANGE NUMBER: 47

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This change is being made to implement a long-awaited change in Medicaid spenddown procedures.

Generally, the change requires that medical expenses used to meet spenddown be submitted during the application processing time limit and that the lack of medical bills to reduce countable income to the MNIL be treated as any other missing information that must be provided prior to case approval. Spenddown cases will no longer be entered in the M-219 system and be held there pending entry of medical expenses to satisfy a spenddown. Instead, the Worker will take no data system action to approve a case until all eligibility requirements are met, including enough medical expenses to satisfy the spenddown. When all requirements are met, the case is entered in the M-219 system as it currently is. The approval must be followed **IMMEDIATELY** by a WESDN transaction(s) which reduces the spenddown to $0. All of this must happen within the 30-day application processing time limit.

If the client does not submit sufficient medical expenses to meet his spenddown by the end of the application processing time limit, the application is denied, even if he meets all other eligibility requirements. A special reason code (0136) has been developed for use when failure to meet a spenddown is the sole reason for the denial. When reason code 0136 is used in a NEWDN or DENIL transaction, the M-219 system actually performs the calculations it normally performs for approvals, i.e., countable income is determined and a spenddown amount is determined. This is done so that a special client notification letter can be produced with complete information about the client's specific circumstances. So that the letters can be correct without tying up the Worker and the Terminal Operator in entering WESDN transactions, a new Block (66) has been established. The Worker is to enter the total amount of bills submitted by the client that was used to try to eliminate the client's spenddown. **THIS BLOCK IS USED ONLY FOR CLIENT NOTIFICATION**. A desk guide showing the new procedures is attached to this DW-17.

A new form, ES-6A, has been developed. It must be attached to the ES-6 when the Worker determines that the client will have a spenddown. It is an informational sheet for the client, which we hope will make the Worker's job of explaining all facets of the spenddown process a little easier.

The ES-MS-1 is now obsolete. It has been replaced by the IM-MS-1. It is now Worker-completed and is simply a memorandum to Medical Processing from the Worker. A copy must still be filed in the case record.

according to the "old" policy until the end of their current POC's. Cases which have already met a spenddown or meet a spenddown prior to the expiration of their current POC's are to remain eligible until the end of the POE, unless a change in circumstances forces the case into another spenddown during the same POC. Should this occur, the new policy is to be applied.

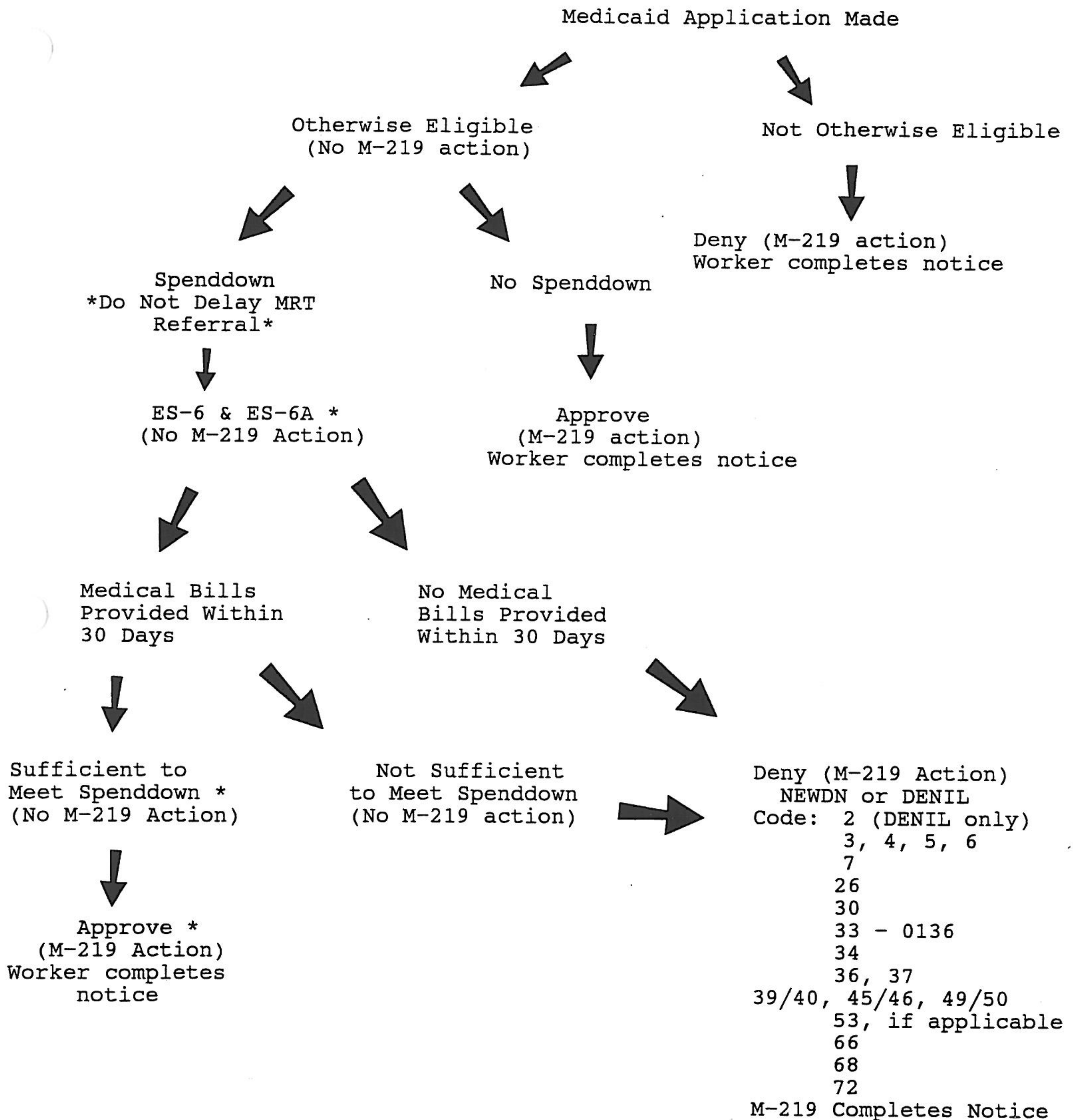
Many people have helped in developing this new procedure since November, 1993. They are too numerous to mention, but we would like to thank those who helped in the final review of the finished policy. Thanks to: Trina Branham (Marion/Monongalia), Region I; Terri Morton and Betty Stanton (Putnam), Region II; Flora Lea Post and Karen Spiker (Barbour/Taylor/Preston), Region III; Sheila Goodwin and Chris Nelson (Raleigh), Region IV; Sarah Catron, Client Services; Jack Frazier, BMS; Dennis Rhodes and Frank McCartney, Inspector General's Office; Debbie Mullins, Brenda Loving and Roger Neptune, RAPIDS; and Karen Thornton, OFS Attorney. Their help was invaluable in finalizing the policy.

Implementation was delayed over the years due to lawsuits and other projects that were forced into a higher priority, but we are pleased that we are finally able to implement a policy that so many Workers, Supervisors and Coordinators have looked forward to for so long.

In addition to the changes related to spenddown, the pages that were missing from Change Number 36 are included here.

Questions should be directed to the IM Policy Unit in the Office of Family Support.

CHART OF SPENDDOWN PROCEDURES



At any point, failure to meet any eligibility requirement other than meeting a spenddown, results in denial of the application, whether or not sufficient medical bills to meet the spenddown have been received. Approval is based on <u>all</u> eligibility requirements having been met. The Worker must provide client notification for all actions except denial due solely to failure to meet the spenddown within the application processing time limit.

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APPENDIX A COMMONLY USED ACRONYMS AND ABBREVIATIONS A-1

Each CSM must establish a process to ensure prompt mailing to the TPL Unit.

B. ES-MCAT-2

The ES-MCAT-2 is used for QMB and SLIMB applications only. The form is self-explanatory.

The form is designed for use as a data system transmittal sheet, as well as a client-completed application form.

C. ES-PW-4

The ES-PW-4 is used for Poverty-Level pregnant women, Poverty-Level children and QC's.

The form is designed for use as a data system transmittal sheet, as well as a client-completed application form.

D. ES-5, RECORDING LOG

An ES-5 is used to approve applications when the Medicaid coverage group does not require completion of an application form, but data system action is required. A narrative recording must explain the reason for the action, and the coding is shown for entry by a Terminal Operator.

In addition, reapplications which do not require completion of a new application form are approved on the ES-5. See item E below for circumstances under which a new application form is not required.

E. REAPPLICATIONS NOT REQUIRING A NEW FORM

NOTE: Cases reopened without completion of an application form must remain in the same redetermination cycle in effect when the case was last closed. The only exception is for Medicaid cases for which the last case action was a denial due solely to failure to meet spenddown within the application processing time limit. In this case, the POC and/or POE is backdated, if appropriate, based on the date the client requests reconsideration of his application.

Reapplications do not require completion of a new application form when all of the following conditions are met:

- The reapplication occurs no later than the second month following the month of the most recent case closure.

- Verification required for the new Program or coverage group is in or recorded in the case record.
- The ES-2 contains the signatures required for the new Program or coverage group, and the appropriate

R. REDETERMINATION VARIATIONS

No redetermination is completed.

S. THE BENEFIT

1. Special Pharmacy Program

There is no medical card issued.

2. HIV GRANT PROGRAM

There is no medical card issued.

3. Ending Date Of Eligibility

If the client becomes eligible under any other coverage group or meets his spenddown, the Worker must notify OMS immediately by memorandum and specify the beginning date of Medicaid eligibility. Some of the services provided may be paid for with the medical card.

Otherwise, OMS determines when eligibility ends.

verbal statement of a physician, social worker, attorney or other responsible person.

When the specified relative with whom the child lives has a legal committee, the committee must be interviewed.

When the child is living with only one specified relative, and that relative is unable to participate in the interview, a representative may be interviewed. A written statement, signed by the relative, which gives the representative authority to apply on his behalf, is required.

F. WHO MUST SIGN

The individual(s) who is interviewed must sign the ES-2.

G. CONTENT OF THE INTERVIEW

In addition to the interview requirements in Section 1.2, the following must be discussed in the interview:

- That any child under age 18 may be evaluted for SSI-Related Medicaid based on blindness or disability
- The spenddown process
- The MRT process, if applicable
- They may receive more than one medical card if a child(ren) has income or there is income deemed to a parent.

H. DUE DATE OF ADDITIONAL INFORMATION

Additional information is due 30 days from the date of application.

I. AGENCY TIME LIMITS

Data system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.

EXCEPTION: When delay is a result of factors outside the control of the Department and the applicant, e.g., inability to obtain medical reports. This must be documented on each case as specified in Section 1.24, regarding documentation for pending applications.

2. Spenddown

The date of eligibility is the day on which the client incurs medical expenses which bring the spenddown amount to $0.

NOTE: Although eligibility begins on the date that medcial bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form IM-MS-1, are not paid by Medicaid.

N. REDETERMINATION SCHEDULE

1. Non-Spenddown

Non-spenddown cases are redetermined in the 6th month of the POC. The 6-month period begins with the date in Block 7. The date the next redetermination is due is coded in Block 87 in the M-219 system.

2. Spenddown

Spenddown cases are not scheduled for a redetermination and are closed at the end of the 6th month of the POC. The client must reapply for a new POC. The last month of the 6-month POC is coded in Block 87.

O. EXPEDITED PROCESSING

There is no expedited processing requirement.

P. CLIENT NOTIFICATION

See Chapter 6.

Q. DATA SYSTEM ACTION

Data system action is required. See Chapter 23.

R. REDETERMINATION VARIATIONS

The redetermination process is the same as the application process with the following exceptions:

b. The Date Of The Redetermination

Spenddown cases may come into the office at any time to reapply for a new POC.

c. Scheduling The Redetermination

These cases are not scheduled for redetermination. The client must reapply for a new POC.

d. Client Notification

Spenddown cases receive a computer-generated letter at the end of the 5th month of the POC. This letter informs the client that his eligibility will end at the end of the following month and that he must reapply for Medicaid coverage.

NOTE: Closed spenddown cases are reported on a monthly printout titled Cases Closed or Deleted for the Month of _________________.

S. THE BENEFIT

A medical card is issued for each eligible child who has income of his own. Parents and any of their children who have no income of their own appear on one medical card, unless the parent has deemed income from an ineligible spouse. When this occurs, the parent is issued his own medical card. A specified relative, other than a parent, who has income appears on his own card.

1. Non-Spenddown

a. Retroactive Benefits

The first medical card generated by the data system shows retroactive eligibility, based on Block 7, and eligibility through the end of the current month.

b. Ongoing Eligibility

The ongoing medical card shows the eligibility dates for the current month. A new card is issued monthly which shows that month's eligibility dates.

1.22 SSI-RELATED MEDICAID, AGED, BLIND AND DISABLED

A. APPLICATION FORMS

An ES-2 is used.

A reapplication is treated as any other application except in some situations when a new form is not required. See Section 1.3.

B. COMPLETE APPLICATION

The application is complete when the client or his representative signs an ES-2 which contains, at a minimum, the client's name and address.

C. DATE OF APPLICATION

The date that the client or his representative signs the ES-2 which contains, at a minimum, his name and address.

For clients who reapply within 60 days of the previous application which was denied due solely to failure to meet spenddown, the date of application is the date the client requests reconsideration. No ES-2 is required when the requirements in Section 1.3 are met.

D. INTERVIEW REQUIRED

A face-to-face interview is required.

E. WHO MUST BE INTERVIEWED

The interview is conducted with the applicant and his spouse, if any, with whom he resides, regardless of whether or not the spouse is also an applicant.

The interview is conducted with the applicant alone, if the spouse cannot be present because:

- He is hospitalized; or
- He is incarcerated; or
- He is employed and his working hours preclude being present for an interview during the Department's normal working hours; or
- He is physically/mentally unable to participate in the interview, and this is established by a written

I. AGENCY TIME LIMITS

1. Application Processing Limits

NOTE: When an applicant, age 65 or over, wishes to have his eligibility evaluated as a blind or disabled person and the process of establishing disability or blindness will result in a delay, his application is approved based on age. If at a later date his blindness of disability is established, the deprivation factor is changed.

- SSI Age-Related Medicaid: Data system action to approve, deny or withdraw the application must be taken within 30 days of the date of application.
- SSI Blind-Related Medicaid: Data system action to approve, deny or withdraw the application must be taken within 60 days of the date of application.
- SSI Disability-Related Medicaid: Data system action to approve, deny or withdraw the application must be taken within 90 days of the date of application.

2. MRT Time Limits

To ensure that the 90-day processing limit is met for MRT cases, the following time limits apply to the MRT process:

REQUIRED ACTION	TIME LIMIT
Interview client and request medical records and reports	By the 7th calendar day after application
Follow-up request(s) for medical records or reports	By 30 days after initial request, and each 30 days thereafter
Submission to MRT	By 7 days after medical records/reports received.
Receipt of file and logged in by MRT	By 2 days after receipt by MRT

redetermination date is coded in Block 87. This is the 6th month of the POC, beginning with the month in Block 7.

2. Spenddown Cases

a. The Redetermination List

Spenddown cases which meet spenddown appear on the listing WEM530P1, Due and Overdue For Review.

b. The Date of the Redetermination

Cases may come into the office at any time to reapply for a new POC.

c. Scheduling the Redetermination

These cases are not scheduled for a redetermination. The client must apply for a new POC.

d. Client Notification

Spenddown cases receive a computer-generated letter at the end of the 5th month of the POC. This letter informs the client that his eligibility will end at the end of the following month and that he must reapply for Medicaid coverage.

NOTE: Closed spenddown cases are reported on a monthly printout titled Cases Closed or Deleted for the Month of ________________.

S. THE BENEFIT

A medical card is issued for each eligible individual or couple.

1. Non-Spenddown

a. Retroactive Benefits

The first medical card generated by the data system shows retroactive eligibility, based on Block 7, and eligibility through the end of the current month.

1.24 SPECIAL PROCEDURES IN THE MEDICAID APPLICATION PROCESS

A. SPOUSES APPLY - ONE APPROVED, ONE PENDING

When an application is made for a couple and one spouse is eligible, but the application for the other remains pending because disability has not been established, the procedure is as follows:

- Approve the application for the eligible spouse. Deeming procedures in Chapter 10 apply.
- Send an ES-NL-A to the eligible individual and include an explanation that eligibility for the spouse has not been established and the reason.
- If the spouse is determined eligible at a later date, the procedures depend upon whether or not the previously ineligible spouse has income, whether or not such income was deemed to the recipient and whether or not there is a spenddown.
  - When the income of the previously ineligible spouse: equals $0, or has been deemed to the recipient spouse, or does not cause the case to have a spenddown, the following procedures apply.
    - Take data system action to add the spouse to the case. The beginning POC or POE for the spouse is the same as for the recipient;
    - Send form ES-NL-A to the recipient to inform him that eligibility for the spouse has been established and the date on which his medical coverage begins.
    - If the individual is added after the deadline date in the 6th month of the POC, a manually completed medical card must be provided to the client, showing eligibility dates that correspond to the POC.
  - When the previously ineligible spouse has income, but it was not deemed to the recipient spouse, and it causes the case to

C. DOCUMENTATION AND REVIEW OF PENDING MEDICAID APPLICATIONS

To document the reason for any delay in processing a Medicaid application, the Worker must document in the case record:

- All actions taken in processing the application.

- The results of required case reviews.

The instructions for these procedures are found below. A rebuttable presumption that the application was not acted on within a reasonable period of time exists when conditions such as, but not limited to, are met:

- Proper documentation, as shown below, which establishes that delay is due exclusively to factors beyond the control of the Department, is not in the case record;

- Documentation for the required case review is not in the case record.

This presumption may be rebutted only by clear and convincing evidence that all necessary actions by the Department for processing the application were undertaken in a timely fashion. This presumption may not be rebutted solely by the testimony of a Worker who failed to meet the documentation requirements.

1. Instructions For Documentation For Pending Medicaid Applications

   Action on each application must be noted on the ES-5.

- Date medical reports are received in the county office
- Date additional medical information, as indicated on the initial medical report or as requested by MRT, is requested
- Date of follow-up activity required to obtain the additional medical information
- Date additional medical reports are received in the county office
- Date material is referred to MRT
- Date the Worker is notified of the final MRT decision

2. Procedure For Review Of Pending Applications

Applications that have not been entered in the data system must be reviewed at least each 30 days.

The county office must establish procedures to ensure that each pending application is reviewed a minimum of once every 30 days. The results of the review must be documented in the case record. The case record must document the reason the application has not been acted on. If this reason is not beyond the control of the Department, the Worker must immediately take any actions are necessary to process the application. If the application has not been acted on within the required time limit, the Worker must send an ES-20 to the applicant informing him of the information which has not been received by the Department. The ES-20 is sent to the client at the time of the expiration of the maximum allowable time for acting on the application.

D. DETERMINING REASONABLE PERIOD OF TIME FOR SPENDDOWN ENTRY

The NEWAP, REOPN or APPRV transaction that activates the case number of the case with a spenddown must be followed immediately by a WESDN transaction which results in eligibility.

E. PRIOR ELIGIBILITY FOR CASES NOT CURRENTLY ELIGIBLE

When it is established that eligibility requirements for prior Medicaid coverage were met, but the case is

2.15 AIDS PROGRAMS

OMS is notified when the client becomes eligible for full Medicaid coverage, including meeting a spenddown.

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6.2 NOTIFICATION OF ACTION TAKEN ON AN APPLICATION

Five (5) forms are used for notifying an applicant of the status of his application. They are the ES-6, ES-6A, ES-NL-6, ES-NL-A, and ES-20.

The final disposition of the application is reported to the client only on the ES-NL-A or the ES-NL-6. When the ES-NL-A is used, it must always be accompanied by the ES-NL-A1.

A. ES-6, NOTICE OF INFORMATION NEEDED; ES-6A, SPENDDOWN EXPLANATION

The ES-6 may be used during any phase of the eligibility determination process. At the time of application, it is given or mailed to the applicant to notify him of information or verification he must supply to establish eligibility. The client must receive the ES-6 within five (5) working days of the date of application, when the ES-6 is mailed.

NOTE: If the client fails to adhere to the requirements detailed on the ES-6, the application is denied or the deduction disallowed, as appropriate. The client must be notified of the subsequent denial by form ES-NL-A.

This form also notifies the client that his application will be denied or a deduction disallowed, if he fails to provide the requested information by the date specified on the form. The Worker determines the date to enter to complete the sentence, "If this information is not made available to this office by _______..." as follows:

1. Food Stamps

The date entered here must be 30 days from the date of application.

If the information is not provided by the date indicated, and the client has not contacted the Worker to explain the delay, the application is denied, if an eligibility factor is involved, using an ES-NL-A. If eligibility is established, but the client does not provide proof of entitlement to a deduction, the deduction is not allowed, but the case is approved, using an ES-NL-A.

NOTE: Federal regulations require that the ES-6 be given to the client no later than 30 days after the date of application. He must also be allowed 30 days to respond to the ES-6. Therefore, benefits

B. ES-NL-6 - NOTICE OF WITHDRAWAL OF APPLICATION

If the applicant withdraws his application, the Worker must give or mail him an ES-NL-6.

C. ES-NL-A

NOTE: The ES-NL-A must always be used with a Hearing/Pre-Hearing Conference Request Form, ES-NL-A1, and the appropriate computation forms.

The ES-NL-A is used for approvals and denials for all programs. The form is self-explanatory, but must be completed in such a way as to provide the client with a full understanding of the reason for the action taken. The Worker must use terms understandable to the client and avoid the use of agency jargon. Examples of proper and improper completion of sections of the form are shown below:

Improper Completion of the Form	Proper Completion of the Form
The action taken in your case is: your application has been denied.	The action taken on your case is: your Food Stamp application has been denied. You do not meet the Food Stamp eligibility requirements.
The action was taken because: failure to cooperate.	The action was taken because: you did not verify the amount of your earnings by 2/10/95. Income must be verified before a Food Stamp case can be approved. The penalty for not doing this is denial of the application.
The Department's policies requiring this action are found in Chapter 1 of the Manual.	The Department's policies requiring this action are found in Section(s) ______ __________ of the Income Maintenance Manual.

In the space provided, the Worker must indicate the name, address and telephone number of local agencies or organizations which provide legal services without charge. Refer to Appendix A.

NOTE: If the denial is due to excessive assets, the notification letter must specify the asset limit and the total value counted for all the client's assets. In addition, the letter must contain the following statement: "You may request a detailed accounting of the asset calculations used by the Department. If you so request, this will be mailed to you within five (5) working days of receipt of your request. You may request this in writing, by phone or in person."

NOTE: If the case being denied would have been an AFDC/U absence case, or any child has an absent parent the following statement must be shown on the denial letter: "You may still receive help in locating and obtaining support from the absent parent(s) of your child(ren). Please call the telephone number shown above and ask to speak to a CSE Worker. You may also write or visit your local Human Resources Office for help."

For Food Stamp Denials Only: When the applicant has an SSI application pending with SSA, the Food Stamp denial notice must explain the possibility of Categorical Food Stamp Eligibility if his SSI application is approved. He must be advised to contact the Department upon SSI approval.

For Medicaid Cases With Unmet Spenddowns: When the client does not meet his spenddown within the application processing time limits, but is eligible in every other way, a NEWDN or DENIL transaction using reason code 0136 produces a client notification letter to explain the denial to the client. See Section 23.19,F.

D. ES-20

If the application is not acted on within the required time limit, the Worker must send an ES-20 to the applicant, informing him of the required information which has not been received by the Department. The ES-20 is sent at the time of the expiration of the maximum allowable time for acting on the application. A copy of the ES-20 must be filed in the case record.

DUE TO THE DELETION OF
SOME MATERIAL,
THERE IS NO LONGER A PAGE 8.

6.3 NOTICE OF ACTION RESULTING FROM A REDETERMINATION OR CASE MAINTENANCE ACTIVITY

Two (2) forms are basic to client notification of a change in benefits, whether this change occurs at redetermination, or as a result of a case maintenance activity. These are the ES-NL-B and the ES-NL-C.

The ES-NL-B is used to notify the client of an increase in benefits, of action taken resulting in no benefit change, and, in very few instances, of a decrease or case closure.

The ES-NL-C is used to notify the client of case closure or a decrease in benefits when advance notice is required.

Closely involved in the determination of whether an ES-NL-B or an ES-NL-C is used is the ES-NL-5, Waiver of 13-Days Advance Notice. In addition to these forms, the ES-6 Notice of Information Needed, and the ES-10, Appointment Letter, may be used for client notification. The use of each of these forms is detailed below.

A. ES-6, NOTICE OF INFORMATION NEEDED; ES-6A, SPENDDOWN EXPLANATION

If, at redetermination, or the time of any other change in client circumstances, it becomes clear that further information or verification is needed, the ES-6 is used to notify the client in writing of the needed information and the date by which the information must be received. The ES-6A is used in addition to the ES-6 when it is necessary to explain the spenddown process to the client.

1. Food Stamp Redeterminations

The date entered must be at least 10 days from the date of the ES-6. If the information is not available by the date indicated, and the client has not contacted the Worker, the case is closed (before automatic closure by the data system), or the deduction disallowed. The client must be notified of the denial or disallowance by form ES-NL-B. Benefits must not be continued beyond the certification period, unless a redetermination is completed and the client remains eligible.

2. Case Maintenance for All Programs and Redeterminations for AFDC/U and Medicaid

The date entered must be no earlier than 10 days from the date the ES-6 is completed.

FOOD STAMPS	AFDC/U	MEDICAID
Case Closure Decrease in Food Stamp Allotment **NOTE:** The following are not adverse actions, but do require client notification: - When the coupon allotment does not increase following an AFDC/U or SSI check reduction for repayment of an error caused by the client's intentional misrepresentation. - When the coupon allotment does not increase following a reduction, suspension or termination of a federal, State or local means-tested welfare or public assistance program due to the client's intentional failure to comply with the program's requirements.	Case Closure Termination of AFDC/U Medicaid coverage when the AFDC/U case is closed Reduction in the payment amount Removal of an individual from the AFDC/U payment when the payment decreases Placing the case in protective payment status Placing the case in vendor payment status	Case Closure Removal of an individual from the benefit group Reclassification of a non-spenddown case to a spenddown case Reclassification of a spenddown case in a POE (spenddown met) to a case which is required to spenddown again during the same POC Termination of Medicaid when the client is ineligible for Medicaid under any other coverage group

NOTE: Client notification must be sent even when the only recipient in the case dies. When this happens, the notification letter must be sent to the Executor, estate of (client's name), and the salutation must be "Dear Executor".

Removal of an individual from the Medicaid benefit group: The name of the individual being removed.

Change to a spenddown case: The fact that the eligibility status has changed, reason for and the effective date of the change, beginning and ending dates of the new POC.

NOTE: If the closure is due to excessive assets, the notification letter must specify the asset limit and the total value counted for all the client's assets. In addition, the letter must contain the following statement: "You may request a detailed accounting of the asset calculations used by the Department. If you so request, this will be mailed to you within five (5) working days of receipt of your request. You may request this in writing, by phone or in person."

3. Changes Not Affecting the Benefit Level

a. Food Stamps Only

The following are not adverse actions, but do require client notification:

- When the coupon allotment does not increase following an AFDC/U or SSI check reduction for repayment of an error caused by the client's intentional misrepresentation

- When the coupon allotment does not increase following a reduction, suspension or termination of a federal, State or local means-tested welfare or public assistane program due to the client's intentional failure to comply with the program's requirements.

When used to notify the client of these actions, the ES-NL-B must specify that Food Stamp benefits would normally increase following a reduction in income, but that, due to the fact that the client caused these reductions by his own intentional actions, benefits will not increase. The Worker must also indicate which agency made the determination of the client's intent.

Instructions for completion of the ES-NL-B also apply to the ES-NL-C.

When used to notify of a pending closure due to an incomplete QR Form, the ES-NL-C must specify the information/verification needed.

NOTE: If the Food Stamp coupon allotment is reduced or terminated within the certification period because a member is being disqualified, the reason for the disqualification, the eligibility and benefit level of the remaining benefit group members and the action the benefit group must take to end the disqualification, if applicable, must be shown on the form. For persons sanctioned due to a Food Stamp Employment and Training (FS E & T) violation, the notice must specify the particular violation and the proposed penalty period. In addition, form letter ES-FS-100 must accompany each ES-NL-C sent due to non-compliance with FS E & T requirements. This form explains that there are certain actions which may end or avoid the sanction, and also notifies the client that the individual or the benefit group may reapply and be found eligible again at the end of the disqualification period. The ES-NL-C must refer to this enclosed form.

The ES-NL-C is used to notify a client of an adverse action in situations requiring a 13-day advance notice period as described below.

1. Situations Requiring 13-Days Advance Notice

   A client must receive 13 days advance notice in all situations involving adverse case actions except those described in Section 6.3,C,2. The 13-day advance notice period requires that notification be received by the client at least 13 days prior to the first day of the month in which the benefits are affected.

2. Timing of Worker Action

   a. Beginning and Ending of 13-Day Advance Notice Period

      The 13-day advance notice period begins the day after the date shown on the notification letter. It ends after 13 calendar days have elapsed.

      EXAMPLE: ES-NL-C is dated October 1. The 13-day advance notice period begins October 2, the day after the date on the ES-NL-C. The 13-day

(ii) Determining the Income Used For the mp

The mp's own non-excluded income is added to that of the MP(s). When income has been deemed to the MP from the MP's spouse, who is not a parent of the mp, none of the amount deemed to the MP is counted for the mp.

(iii) Determining the Income Used For the Child

The child's own non-excluded income is added to the mp's own non-excluded income. None of the amount deemed from the MP(s) to the mp is counted for the child.

(c) When the Benefit Group Includes Only the MP(s) and the mp

(i) Determining the Income Used For the MP(s)

See item (b), (i) above.

(ii) Determining the Income Used For the mp

The mp's own non-excluded income is added to that of the MP(s). When income has been deemed to the MP from the MP's spouse, who is not a parent of the mp, none of the amount deemed to the MP is counted for the mp.

5. Strikers

If any member of the BFU is a striker, no member of the BFU is eligible for AFDC/U-Related Medicaid. Eligibility under other coverage groups must be explored.

to the ES-6 which notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses. The ES-6 must also contain any other information the client must supply in order to determine eligibility.

Once the client presents sufficient medical expenses to meet his spenddown obligation and all other Medicaid eligibility requirements are met, a NEWAP, REOPN or APPRV transaction, is completed. Immediately after the approval transaction, medical expenses are entered in the data system according to the date incurred, i.e., oldest expense first. This is accomplished using a WESDN transaction coded on the ES-5.

EXCEPTION: When the client reports that he owes old medical bills, these expenses must be entered in the data system before any other expenses are entered. The date entered for the expense is the first day of the POC, not the actual date of the old unpaid bills.

If there are expenses on more than one date, the expenses are entered in chronological order, beginning with the earliest date. All expenses incurred on one date are added together and transmitted as one amount for that date.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form IM-MS-1, are not paid by Medicaid.

The Worker enters only those expenses that allow the spenddown amount to reach $0. At the end of the WESDN transaction(s), the spenddown must have been met.

The following procedures are required to accomplish the spenddown process.

- The Worker prepares an ES-6, attaches an ES-6A and gives them to the client

- The Worker uses the ES-5 to code the spenddown transaction at the same time the case approval is coded. The Worker routes the approval and the ES-5 to the Terminal Operator, who notes the M-219 system's response on the ES-5.

- The Worker must highlight, or circle in red, the bill that met the client's spenddown and send a copy of the highlighted IM-MS-1 to Medical Processing in the Bureau of Medical Services. A copy of the IM-MS-1 is filed in the case record. The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount.

  NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form IM-MS-1, are not paid by Medicaid.

- If the client does not submit sufficient medical bills by the application processing deadline, the application is denied using reason code 0136. See Section 23.19,F for information about computer-generated client notification produced from reason code 0136.

b. Whose Medical Expenses Are Used

The medical bills of the following persons are used to meet the spenddown. There is no limit on the amount of one individual's bills which can be used to meet another individual's spenddown.

(1) Meeting the Spenddown of Adults

Use the bills of:

- The adult(s) who is the parent(s) or other caretaker relative

EXAMPLE: A mother applies for Medicaid for herself and her two children. Also in the home are her husband and his two children, who are also applying for Medicaid. The medical bills of the husband and his children are used to meet the spenddowns of his wife and stepchildren as well as his own and his children's spenddown.

EXAMPLE: Same situation as above, except that the husband and his children are not applying for Medicaid. The medical bills of the husband and his children are used to meet the spenddown of the mother and her children.

EXAMPLE: A man and woman live together, but are not married. They each have two children from previous marriages, and all are applying for Medicaid. The medical bills of the woman and her two

Step 12: Subtract the maximum SSI payment for a couple from the Step 11 amount.

The amount remaining after Step 12 is deemed to the SSI-Related child as unearned income. If there is more than one SSI-Related child, divide the amount equally among the SSI-Related children.

5. Strikers

The presence of a striker has no effect on SSI-Related Medicaid.

6. Irregular Income

Regardless of the source, irregular income is excluded because it cannot be anticipated.

7. Lump Sum Payments

Lump sum payments are treated as unearned income in the month received.

8. Withheld Income

a. From Earned Income

Earnings withheld to repay an advance payment are disregarded if they were counted in the month received. If not counted in the month received, the withheld earnings is income. No other earned income is excluded just because it is withheld by the employer.

b. From Unearned Income

All withheld unearned income is counted, unless an amount is being withheld to repay income that was previously used to determine Medicaid eligibility.

9. Funds Diverted To A PASS

Funds diverted to a PASS account are disregarded.

FDG size, or until the POC expires. The spenddown process applies only to AFDC/U-Related and SSI-Related Medicaid.

a. Procedures

The Worker must determine the amount of the client's spenddown at the time of application based on information provided by the client. The spenddown amount may have to be revised if the verified income amount differs from the client's statement. He must also explain the spenddown process to the client during the intake interview. An ES-6A is attached to the ES-6 which notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses. The ES-6 must also contain any other information the client must supply in order to determine eligibility.

Once the client presents sufficient medical expenses to meet his spenddown obligation and all other Medicaid eligibility requirements are met, a NEWAP, REOPN or APPRV transaction, is completed. Immediately after the approval transaction, medical expenses are entered in the data system according to the date incurred, i.e., oldest expense first. This is accomplished using a WESDN transaction coded on the ES-5.

EXCEPTION: When the client reports that he owes old medical bills, these expenses must be entered in the data system before any other expenses are entered. The date entered for the expense is the first day of the POC, not the actual date of the old unpaid bills.

If there are expenses on more than one date, the expenses are entered in chronological order beginning with the earliest date. All expenses incurred on one date are added together and transmitted as one amount for that date.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated

the client on the IM-MS-1. This includes, but is not limited to, the following:

- The date of service
- The provider of the service
- The total amount of the bill
- The amount used toward the spenddown.

- The Worker uses the ES-5 to code the spenddown transaction at the same time the case approval is coded. The Worker routes the approval and the ES-5 to the Terminal Operator, who notes the M-219 system's response on the ES-5.

- The Worker must highlight, or circle in red, the bill that met the client's spenddown and send a copy of the highlighted IM-MS-1 to Medical Processing in the Bureau of Medical Services. A copy of the IM-MS-1 is filed in the case record. The client's eligibility begins the day the amount of incurred medical expenses at least equals his spenddown amount.

  NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form IM-MS-1, are not paid by Medicaid.

- If the client does not submit sufficient medical bills by the application processing deadline, the application is denied using reason code 0136. See Section 23.19,F for information about computer-generated client notification produced from reason code 0136.

- Health insurance premiums, including Medicare

- Medicare co-insurance, deductibles and enrollment fees

- Necessary medical or remedial care expenses. This includes, but is not limited to:

  - Office visits to a physician
  - Hospital services, inpatient and outpatient
  - Emergency room services
  - Prescriptions
  - Over-the-counter drugs prescribed by a physician
  - Eye examinations
  - Eye glasses
  - Dental services
  - Therapy prescribed by a physician
  - Chiropractic services
  - Prosthetic devices

The individual is considered disabled if he has a medically determined physical or mental impairment which is expected to last for at least 6 months from the date of application and which prevents him from performing substantial gainful activity.

C. DEFINITION OF BLINDNESS

To meet the definition of blindness, the individual must have:

- Central visual acuity of 20/200 or less in the better eye with corrective glasses, or
- A limited visual field of 20 degrees or less in the better eye with the use of eyeglasses.

D. CONSIDERATION OF MEDICAL AND SOCIAL FACTORS IN DETERMINING DISABILITY

In determining whether or not an individual is disabled, medical and social factors and the relationship between the two must be considered.

If the medical information indicates that the individual has an impairment which has lasted or can be expected to last the required length of time, social factors must be examined to determine the effect of the impairment on the individual.

When a case is referred to MRT for a disability decision, the Worker completes form ES-RT-1, Social Summary Outline. This form is designed to identify the social information used by the Worker in making a presumptive decision and by MRT in making the final disability decision.

B. SSI-RELATED DISABILITY PROCESSING REQUIREMENTS

1. Target Time Frames

Target time periods have been established to assure that SSI-Related disability cases are processed within the 90-day processing time limit except when the delay is beyond the Department's control.

REQUIRED ACTION	TIME LIMIT
Interview client and request medical records and reports	By the 7th calendar day after application

16.1 INTRODUCTION

The West Virginia Medicaid Program provides payment for covered medical services to certified medical providers for eligible individuals who are aged, blind or disabled and to eligible members of families with dependent children.

The determination of which medical services are covered under Medicaid and which medical providers are certified to accept Medicaid patients is the responsibility of the Office of Medical Services and is not addressed in this Manual. Unless otherwise specified, the coverage group receives all services covered under Medicaid.

For eligibility for nursing care services and MR/DD and HCB Waiver coverage groups, refer to Chapter 17.

This Chapter provides an overview of the Medicaid Program. In addition, each coverage group has specific requirements which must be met and procedures to follow that may not apply to other Income Maintenance programs or other Medicaid coverage groups. These are contained in this Chapter.

In addition to the coverage groups described in this Chapter which make up the Medicaid Program, the Department has special procedures in place to pay for certain necessary drugs for individuals not eligible for Medicaid. These costs are paid from State money only and cover only the costs shown in items A and B below. Procedures to obtain payment for these expenses are also described below. Workers must submit information about all persons who might qualify for payment of such services. None of the costs paid for through this process may be used to meet spenddown.

A. SPECIAL APPROVAL, IMMUNOSUPPRESSANT DRUGS FOR TRANSPLANT PATIENTS

Individuals who have received a transplanted organ and who are not eligible for Medicaid due solely to failure to meet a spenddown may have the cost of anti-rejection drugs paid by the Department. To qualify, it must be established that the client does not have sufficient income available to pay for the medication. The individual must have been denied Medicaid for the above reason within six months of the date of the client's request for payment. In addition, the Worker must review the previous application to determine if the client's circumstances have changed. If he continues to be ineligible for Medicaid, at the time he requests payment of the drugs, due solely to failure to meet a spenddown, special approval is considered.

information specified in item A above with the following two additions:

- Weekly cost of lab tests
- Name of facility which will perform the lab tests.

No verification of the information submitted is required unless the client does not know the information or the Worker has reason to doubt the client's statement.

Once the eligibility decision is made, the county office is notified by the Director of the IM Policy Unit. The Worker must then notify the client and provide him with all necessary information to obtain the services.

C. ASSIGNMENT OF RIGHTS

As a condition of eligibility, all applicants and recipients must assign to the Department any rights to medical support and to payments for medical care from any third party, provided they are legally able to do so. They must cooperate in identifying and providing information to use in pursuing third parties, unless good cause is established for not cooperating. Cooperation includes establishing paternity and obtaining medical support and payments. Good cause will be determined by OFS based on written information submitted by the Worker to the Policy Unit.

When an otherwise eligible individual cannot legally assign his own rights, and the person legally able to do so does not cooperate, the individual remains eligible.

EXAMPLE: A mother refuses to assign benefits for herself and her children, for whom she can legally make an assignment. The mother is ineligible and the children remain eligible for Medicaid.

NOTE: Poverty-Level Pregnant Women, through the two months postpartum, are exempt from establishing paternity and obtaining medical support.

An SSI applicant is required to assign third party rights to the Department as part of his application for SSI. If he refuses to assign these rights, he is ineligible for Medicaid.

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APPENDIX D: TERMINAL OPERATOR'S MANUAL FOR SAS ASSET ASSESSMENT SYSTEM D-1

Code	C-219	M-219
REOPN	Approval of an application. Case number in the system, because formerly active case was closed.	Approval of an application. Case number currently in the system as a result of a previous action to deny or withdraw an application or to close an active case.
NEWDN	Denial of an application when no case number is in the system.	Denial of an application when no case number is in the system. **NOTE:** When reason code 0136 is used, the M-219 system performs countable income calculations and determines a spenddown amount. This is necessary to produce a computer-generated client notification letter.
DENIL	Denial of an application when previous case number is in the system.	Denial of an application when previous case number is in the system. **NOTE:** When reason code 0136 is used, the M-219 system performs countable income calculations and determines a spenddown amount. This is necessary to produce a computer-generated client notification letter.

Code	C-219	M-219
CLOSE	Closure of an active case.	
CHANG	Any type of change, including changes as a result of a redetermination, on an active case which is not covered by another Transaction Type Code.	
WESDN	N/A	Spenddown transaction, used when amounts of medical bills and dates of service are transmitted.
NEWPN	To obtain a case number to issue benefits when approval is required between deadline and the first of the following month.	
PENDG	To change the address prior to a WEKR transaction.	At the county's discretion.

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
27	Approval Date	N/A	6	Numeric

The M-219 system determines the date in this Block as follows:

When the case is a non-nursing home, spenddown case, the system enters the date the spenddown is met.

NOTE: Although eligibility begins on the date that medical bills bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated by the Worker on form IM-MS-1, are not paid by Medicaid.

In all other cases, the date the Worker enters in Block 7 is moved to this Block.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N/A	Y	All	7

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
57	Spenddown Indicator	N/A	1	Alpha

The system enters an S here when the AFDC/U- or SSI-Related case has a spenddown. When the spenddown is met, the system removes the S. Cases which receive nursing care or reside in ICF/MR facilities show an S here when Block 67 is greater than $0.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
System	N/A	Y	AFDC/U- and SSI-Related Medicaid	58, 80

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
65	Child Care Expenses	Y-NEWAP, REOPN	3	Numeric

Enter the amount of dependent care expenses the families of Poverty-Level, Qualified and Newborn children pay. Include the total amount paid, whether out of the client's pocket or not.

This Block is used for gathering statistical information only and has no effect on the benefit calculation.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	N	N	PL, QC and Newborns	None

BLOCK #	TITLE	MANDATORY ENTRY	MAX. LENGTH	ALPHA OR NUMERIC
67	LTC Spenddown	N	5	Numeric

A single individual who is a resident of a nursing facility or ICF/MR and who must meet a spenddown as part of his contribution toward his cost of care has the spenddown amount entered here. The amount entered here is automatically moved to Blocks 58 and 80.

Individuals with a community spouse who are in a nursing facility or ICF/MR and who have a spenddown must have $0 entered here.

ENTERED BY	FORCES RECALCULATION	AUTO REMOVED	PROGRAMS	INTERRELATED TO OTHER BLOCKS
Worker	Y	N	NF and ICF/MR Residents in Medically Needy Cases	47, 69, 70, 71, 78, 79, 51, 58, 80, 48

23.15 M-219 SYSTEM RESPONSES

After entry of information, the system responds with

A. SPENDDOWN CASES

- Spenddown amount prior to entry of a WESDN transaction
- Period of Consideration

B. NON-SPENDDOWN OR CASES WHICH HAVE MET SPENDDOWN

Period of Eligibility

72 Worker Number

E. TRANS

Case Number

Blocks 2 Date of Last Change (mmddyy)

30 Effective Date (mmyy)

33 Reason Code

38 Transfer Code

County must be 01-55

Category must be A, B, C, D or U

72 Worker Number

87 Redetermination Date for all M-219 system cases, except Poverty-Level Cases, Qualified and Newborn Children

Additional data needed to change update the case to a new category or county and to make any other related or necessary changes

F. NEWWD/NEWDN

See item H for a NEWDN solely for failure to meet a spenddown during the application processing time limit.

Category prefix and county number

Blocks 3 Name

5 City/State

6 Zip Code

26 Application Date (mmddyy)

30 Effective Date (mmyy)

7 Beginning Period of Consideration (mmddyy)

26 Application Date (mmddyy)

30 Effective Date (mmyy)

33 0136 (Reason Code)

34 Race Code

36 Number in BFU or Needs Group

37 Number in Benefit Group

39/40, 45/46 and/or 49/50 Income Source/Amount

53 AFDC/U-Related Deductions, if applicable

66 Incurred Expenses

68 Disposition Code

72 Worker Number

2. DENIL

Case Number

Blocks 2 Date of Last Change (mmddyy)

3 Name

4 Address

5 City/State

6 Zip Code

7 Beginning Period of Consideration (mmddyy)

26 Application Date (mmddyy)

30 Effective Date (mmyy)

23.17 M-219 SYSTEM MEDICAID ELIGIBILITY COMPUTATIONS

The M-219 System determines income eligibility for only the following coverage groups:

- AFDC/U-Related Medicaid
- SSI-Related Medicaid
- QMB, but not when dually eligible
- SLIMB, but not when dually eligible

For the following M-219 system cases, the Worker determines financial eligibility prior to entry, and the M-219 system serves as a vehicle for Medicaid card issuance only.

- Poverty-Level pregnant women
- Deemed Poverty-Level pregnant women
- Poverty-Level children
- Qualified children
- Newborns
- HCB and MR/DD Waiver participants
- Illegal aliens
- Dually eligible QMB's and SLIMB's

NOTE: For Medicaid recipients who receive nursing care services, eligibility is determined by the Worker prior to entry into the data system, but the system determines the amount of the client's contribution toward his cost of care in the post-eligibility calculations.

Income eligibility is determined by the M-219 system as follows:

- The appropriate MNIL is subtracted from the amount in Block 51. The remainder is multiplied by 6 to determine the excess income for the POC. This amount is entered in Blocks 58 and 80.

- An S is entered in Block 57.

- Incurred medical expenses and the dates they are incurred are required entries in a WESDN transaction immediately following the approval. The amount in Block 58 is reduced to $0 to indicate that the spenddown has been met.

- When Block 58 reduces to $0, the system takes the following actions:

  - The S is removed from Block 57

  - Beginning and ending dates of eligibility are entered in Blocks 9 and 10.

  - A medical card is issued.

NOTE: The case must not be approved unless the client presents medical expenses at least equal to his spenddown amount during the application processing time limits.

B. SSI-RELATED MEDICAID CASES

If the second prefix of the case is A, B or D, the computations are as follows

Step 1: Unearned income amounts form Blocks 46 and 50 are added together.

Step 2: Twenty dollars ($20) is subtracted from Step 1. If there is no unearned income, or the amount in Step 1 is less than $20, the remainder is retained and subtracted in Step 3.

- The appropriate MNIL is subtracted from the amount in Block 51. The remainder is multiplied by 6 to determine the excess income for the POC. This amount is entered in Blocks 58 and 80.

- An S is entered in Block 57.

- Incurred medical expenses and the dates they are incurred are required entries in a WESDN transaction immediately following the approval. The amount in Block 58 is reduced to $0 to indicate that the spenddown has been met.

- When Block 58 reduces to $0, the system takes the following actions

  - The S is removed from Block 57.

  - Beginning and ending dates of eligibility are entered in Blocks 9 and 10.

  - A medical card is issued.

  NOTE: The case must not be approved unless the client presents medical expenses at least equal to his spenddown amount during the application processing time limits.

C. POST-ELIGIBILITY CALCULATIONS

The second prefix of the case is A, B or D. The client's total contribution toward his cost of care in a nursing facility or ICF/MR is determined as follows:

NOTE: The client's Medicaid eligibility must be determined outside the data system by the Worker. See Chapter 17.

Step 1: Income from Blocks 40, 46 and 50 is added together.

E. M-219 SYSTEM
SPECIAL CIRCUMSTANCE NOTICES

Reason Code	Used for	Category	Letter No.	Mailed with	Transaction Type
N/A	Mailed at the end of the 5th month of the POC when the client has met spenddown.	AFDC/U- and SSI-Related Medicaid	ES-NL-CG-C200	ES-NL-CG-C1	N/A

23.20 C-219 SYSTEM REASON CODES FOR FOOD STAMPS

The following reason codes are used for Food Stamp benefits in A, B, D, C, U and F cases.

If action is the result of information gained form a QR form, use 6_ _ prefix in place of 5_ _. If no computer-generated letter is desired, use 4_ _ prefix in place of 5_ _.

PENDING

	Code	Description
	500	Special code to pend applications under PENDG or NEWPN
	800	Special code used with PENDG or NEWPN transactions when the case is approved for a Combined Issuance prior to deadline in the month of application.

SPECIAL SITUATIONS

	Code	Description
cg	200	First closure letter for not returning QR form
cg	201	Second and final closure letter for not returning QR form

APPROVALS

Used for F approvals and to add Food Stamps to A, B, D, C and U cases. Also A, B, D and F redeterminations.

	Code	Description
cg	501	Multiple-months certification
cg	502	Single-month certification
	503	Multiple-months certification based on Categorical Eligibility
	504	Single-month certification based on Categorical Eligibility
	505	Categorically Eligible, for $0 benefits
	506	Financially eligible, for $0 benefits

cg: computer-generated Letters	cg 31: c-g & Block 31 Required	31: Block 31 Required

M-219 SYSTEM

The following Reason codes are used for Medicaid benefits in the M-219 System

APPROVALS:

0001	Initial application, no recent change in circumstances
0002	Disability or blindness
0003	Incapacity of the father
0004	Incapacity of the mother
0005	Incapacity of another adult
0006	Death of a household member, including father or mother
0007	Lay-off or discharge
0008	Lay-off or discharge of father
0009	Lay-off or discharge of mother
0010	Lay-off or discharge of another adult
0011	Discontinuance or reduction of support by absent parent
0012	Discontinuance or reduction of support as a result of parent leaving home
0013	Discontinuance or reduction of support by another person outside the home
0014	Discontinuance or reduction of other cash benefits
0020	Need for/or increased cost of nursing care services
0021	Clients income/assets within Medically Needy limits
0022	Income/assets unchanged. Client turned age 65.
0023	QC approval
0024	Case previously closed in error
0025	Recent change in law or policy
0026	Client's income in excess of MNIL, in spenddown status
0027	Case reentered to make corrections
0028	Poverty-Level pregnant woman approval

DENIALS

0100	Income exceeds MNIL
0101	Excess assets
0102	Failure to develop potential resources
0103	Ineligible as a QC
0106	Incapacity, disability or blindness not established
0108	Definition of unemployment not met
0109	Age requirement not met
0110	Parent not absent

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES

ABOUT YOUR MEDICAID APPLICATION...

Right now, your income is too high for you to receive a Medicaid card. However, we can subtract *paid and unpaid* medical bills from your income to lower the amount we have to count. In order to do this, you must provide proof of your medical expenses by the date shown on the attached form. You need to keep in mind the following conditions while you are gathering your medical bills:

1. We can only subtract the amount that you are **personally** responsible to pay. If Medicare, an insurance company or someone else will pay part of the bill, we can only subtract the amount you are responsible for. *The bill does not have to be paid for us to subtract it from your income.* Unpaid bills may be from your 6-month period (see back of this form) or from an earlier time. If you have already paid the bill, it must have been paid in your 6-month period.

2. Proof of the medical expense must be from the person or place you owe for the expense. A statement or bill from a doctor, hospital, pharmacy or other medical service provider is necessary for us to know the correct amount to subtract from your income. If you are making payments on an old bill, we will need a statement showing the amount you have left to pay, how much and how often you make payments. If you have an old bill that you still must pay, but are not currently making payments on, be sure to give us a statement showing the amount you owe. We will also need to know if you plan to make payments on it or not, so we will know whether to subtract the entire bill or just the payments you make.

3. Even if you are the only person in your family who applied for a Medicaid card, we can also subtract the medical expenses of your husband or wife and any of your minor children who live with you. If you have minor step-children who live with you, their medical bills may also be used and subtracted from your income to make you eligible for Medicaid. *If you are not sure whether or not a medical expense can be subtracted from your income, be sure to give it to us. We will decide on each bill you give us and will let you know which ones are used.*

4. The amount of medical bills you must show us was based on the amount of income you reported to us. If the verified amount of your income is different or changes, the amount of medical bills you must have will change.

This process of subtracting medical expenses from your income in order to make you eligible to receive a Medicaid card is called the **Spenddown Process.** You may hear your Worker refer to it as **having a spenddown** or as **having to meet a spenddown** or as **spending down.** If you have questions about the process or need help to obtain copies of medical bills, please contact the Worker whose name is on the attached page.

WV DEPARTMENT OF HEALTH AND HUMAN RESOURCES

DATE: ____________________

TO: Medical Processing, Bureau for Medical Services

FROM: ____________________

SUBJECT: Medical Expense Record for Spenddown

____________________ Case Name

____________________ Case Number

____________________ Period of Consideration

____________________ Spenddown Amount

____________________ Dates Of Eligibility

Date of Service	Provider	Recipient of Service	Total Amount Incurred	Amount Used to Spenddown

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New 9/96