Step 1: Determine the Income Group's non-excluded gross earned income. Do not count the income of a child's sibling or count any child's income for his parent(s).

Step 2: Subtract the AFDC Medicaid Standard Work Deduction for each working person.

Step 3: Subtract the AFDC Medicaid Dependent Care Deduction up to the maximum allowable amounts. The maximum amounts of the deduction are determined as for AFDC Medicaid. See Section 10.6.

Step 4: Add the non-excluded gross unearned income of the Income Group to the amount remaining from Step 3. This includes the child's countable child support. Do not count the income of a child's sibling or count any child's income for his parent(s).

Step 5: Determine the appropriate MNIL for the Needs Group.

Step 6: Compare the result of Step 4 to the amount in Step 5.

If the net countable monthly income is equal to or less than the appropriate MNIL, the AG is eligible without a spenddown. If it is in excess of the appropriate MNIL, the AG must meet a spenddown. See **Spenddown in Special Situations Section** below.

D. SPECIAL SITUATIONS

1. Self-Employment

Self-employment income is treated the same way it is for AFDC Medicaid. See Section 10.7.

2. Annual Contract Employment

Annual contract employment is treated the same way it is for AFDC Medicaid. See Section 10.7.

3. Educational Income

Educational income is treated the same way it is for AFDC Medicaid. See Section 10.7.

8. Withheld Income

Withheld income is treated the same way it is for AFDC Medicaid. See Section 10.7.

9. Funds Diverted To A PASS

Funds diverted to a PASS account are treated as earned or unearned income, depending on the source.

10. Unstated Income

There is no provision for counting unstated income.

11. Spenddown

To receive a Medicaid card, the Income Group's monthly countable income must not exceed the amount of the MNIL. If the income exceeds the MNIL, the AG has an opportunity to spend the income down to the MNIL by incurring medical expenses. These expenses are subtracted from the income for the 6-month POC, until the income is at or below the MNIL for the Needs Group size. The spenddown process applies only to AFDC-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. An DFA-6A is attached to the DFA-6 which notifies the client that an eligibility decision cannot be made until he meets his spenddown by providing proof of medical expenses. The RAPIDS verification checklist includes the DFA-6A information when RAPIDS detects a spenddown AG. The verification checklist or DFA-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, appropriate RAPIDS procedures are followed to approve the AG and enter the spenddown.

NOTE: Although eligibility begins on the date of service of the medical bills which bring the spenddown amount to $0, expenses incurred on that date which are used to meet the spenddown, as indicated on Screen AGTM, are not paid by Medicaid.

NOTE: An AG which meets a spenddown remains eligible until the end of the POC in the following situations, regardless of whether or not the individuals is an AG member.

- A member(s) of the Income Group experiences an increase in income; or

- An individual(s) with income is added to the Income Group; or

- An individual(s) is removed from the Needs Group

The following procedures are required to accomplish the spenddown process.

- The Worker prepares the verification checklist or **DFA**-6, attaches an **DFA**-6A and gives them to the client **or mails them.**

  If the client indicates he needs help to understand the procedure for meeting his spenddown, the Worker provides all help needed. In no instance is the client to be denied Medicaid because he is physically, mentally or emotionally unable to verify his medical expenses.

- The client is requested to provide proof of his medical expenses, date incurred, type of expense and amount and to submit them to the Worker by the application processing deadline.

- When the bills or verification are received, the Worker reviews them to determine:

  - The expenses were incurred, they are not payable by a third party, and the client will not be reimbursed by a third party.