DEPARTMENT OF HEALTH & HUMAN RESOURCES
OFFICE OF FAMILY SUPPORT
TRANSITIONAL MANUAL GUIDE

DATE: 8/3/95

The following Income Maintenance/Economic Services policy is currently in effect:

NEW INCOME MAINTENANCE MANUAL

Chapter 1 - Application/Redetermination Process
Chapter 2 - The Case Maintenance Process
Chapter 3 - Income and Eligibility Verification System
Chapter 4 - Verification
Chapter 5 - Resource Development
Chapter 6 - Client Notification
Chapter 7 - Quarterly Reporting
Chapter 8 - Common Eligibility Requirements
Chapter 9 - Eligibility Determination Groups
Chapter 10 - Income
Chapter 11 - Assets
Chapter 12 - Determining Disability, Incapacity and Blindness
Chapter 13 - JOBS and FSE&T
Chapter 14 - Specific Food Stamp Program Requirements
Chapter 15 - Specific AFDC/U Requirements
Chapter 16 - Specific Medicaid Requirements
Chapter 17 - Long Term Care
Chapter 18 - Aliens, Refugees and Citizenship
Chapter 19 - Emergency and Special Assistance Programs
Chapter 20 - Benefit Repayment
Chapter 21 - Benefit Replacement
Chapter 22 - Medicare Buy-In Procedures
Chapter 23 - Data Systems

Three appendices to the old Economic Services Manual are to be retained and moved to the new Income Maintenance Manual as appendices to Chapter 10. They are Appendix D to Chapter 2,000 and Appendices D and E to Chapter 70,000.

MANUAL MATERIAL TRANSMITTED					
MANUAL: Income Maintenance			CHANGE NUMBER: 3		
DELETE			INSERT OR CHANGE		
PAGES	CHAPTER	DATED	PAGES	CHAPTER	DATED
Table of Contents	19	10/94	Table of Contents	19	8/95
6 - 7	19	10/94	6 - 7-a	19	8/95
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249 - 250	19	10/94	249 - 250	19	8/95
Appendix A-1	19	10/94	Appendix A-1	19	8/95
			Appendix C	19	8/95
DATE: August 1995			TO: ALL INCOME MAINTENANCE MANUAL HOLDERS		

Please review the narrative below for an explanation of the changes above:

A. CONTENTS

B. EMERGENCY ASSISTANCE

Page 6 - New income exclusion consists of certain JTPA payments.

Page 16 - The definition of what constitutes the duration of an emergency and how it is measured is expanded in #14.

Pages 17 through 19 - This revision involves the new policy which became effective November 1, 1994 via field release dated October 31, 1994. Therefore, this release is now obsolete.

Pages 25-26 - The margin spacing is being corrected because the original spacing was incorrect.

Page 27 - This page consists of additional corrections to the margin plus a reference to Page 195 for instructions on how to compute EA benefits when other programs are involved.

19.3 NON-EMERGENCY MEDICAL TRANSPORTATION

19.6 LOW-INCOME EMERGENCY ASSISTANCE PROGRAM (LIEAP)

19.7 PUBLIC UTILITY PROGRAM

19.8 TEL-ASSISTANCE

- Payments under Title I of the Domestic Volunteer Service Act of 1973 (VISTA, ACTION, University Year of Action, Urban Crime Prevention Program).

- Payments to volunteers in a program administrated through the U.S. ACTION Agency.

- Payments from Senior Companion Program funded under Title XX.

- The value of food coupons and commodities.

- The value of supplemental food program for women, infants and children (WIC) public Law 94-105.

- Value of National School Lunch Program, public law 90-302.

- Payment, allowances or reimbursements for transportation and attendant care costs Under Title VI of the Rehabilitation Act of 1973, Title II, Public Law 95-607.

- Payments from Community Service Employment Program (CSEP) as authorized under Title V of the Older Americans Act.

- Reimbursement for expenses incurred in connection with employment and training limited to mileage, tools and clothing.

- Reimbursement for medical expenses or for round trip transportation costs incurred to obtain medical treatment.

- Grants and loans from HUD Community Development Block Grant Funds made to individuals to rehabilitate their private residence.

- All JTPA payments except those considered as wages for on-the-job training.

found INELIGIBLE to receive Emergency Assistance. Workers must make every effort to see that these individuals receive assistance from community resources until they receive their income.

EXAMPLE: An individual makes application for Emergency Assistance on November 1. His countable income will exceed the maximum, but the income will not be received until November 15. His emergency will occur on November 10, but he will be found ineligible because his income exceeds the maximum.

The Worker should evaluate very closely the information obtained from the applicant. Applicants should be instructed to provide the income of each benefit group member. The Worker must use care in determining the actual dates the income is to be received.

6. Assets

In determining eligibility for Emergency Assistance, the Worker must evaluate the availability of assets owned by members of the benefit group.

The following assets owned by members of the benefit group will be considered potentially available unless, as explained below, the assets cannot be used in time to eliminate or prevent the emergency:

- Cash.

- Savings and checking accounts.

11. Applicant's Social Security Number

The applicant's Social Security number must be verified to maintain the integrity of the CHET system. Failure on the part of the applicant to verify his Social Security number will result in the denial of the application. Verification may consist of the Worker viewing the Social Security card or some other document (driver's license, award letter, etc.)

Applicants having no Social Security number will receive case identification from the back-up identification system provided by CHET. However, all such applicants must be informed by the Worker that a Social Security number must be obtained in order to receive future benefits under the Emergency Assistance Program.

12. Specific Eligibility Requirements for Federally Matched Emergency Assistance (Title IV-A)

If a family or benefit group meets certain eligibility requirements, a percentage of the cost of emergency financial assistance they receive will be reimbursed to the Department by the Department of Health and Human Services.

Any family with children under the age of 21 or any individual child under 21, including migrant families and children, may be eligible for Federally matched assistance providing the child is living with a specified relative.

If the individual child is not currently living with a specified relative, he may still be eligible, providing he lived with a specified relative within six months prior to the month in which Emergency Assistance is requested. Families and children faced with emergency needs and eligible for Federal matching funds include:

- Families and children who are recipients of financial assistance.

- Families and children who are likely to become applicants for, or recipients of, financial assistance.

14. Defining the Elimination of the Emergency/ Vendor Refuses to Eliminate the Emergency

"Eliminate the Emergency" will be defined as delaying or preventing the emergency from occurring for a period of not less than 30 days from the date the vendor is made aware of and accepts the Department's offer. The client should be made aware of this so there is no mistake on how long the emergency will be delayed. This time period is most important for rent and utilities. The client must be informed that the DF-67 voucher be taken to the vendor without delay.

When the applicant is otherwise eligible for or approved for Emergency Assistance yet the vendor refuses to eliminate the emergency, payment must be denied to the vendor. This occurs mostly when the vendor is not satisfied with the amount of payment. However, the reason for refusing to eliminate the emergency is unimportant insofar as the payment is concerned. Payment will not be made to any vendor who has refused to eliminate the emergency. If payment has already been made to the vendor, a statement requesting reimbursement must be sent to the vendor. If the vendor refuses to reimburse the Department, a fraud summary must be completed and sent to Investigations and Fraud Management. Otherwise, the applicant must locate a new vendor with assistance from the worker, if necessary.

Whenever a vendor refuses to eliminate the emergency, the application is denied only when another vendor cannot be located by the applicant and/or Worker to eliminate the emergency. When this occurs, the Worker will enter denial code E70.

C. SPECIFIC ELIGIBILITY REQUIREMENTS

The following section describes the specific eligibility requirements of the various emergency needs and services provided by the Emergency Assistance program. Verification requirements and instructions for determining the amount of payment are also included.

Only the items listed below will qualify as items of

if he actually intends to evict the applicant. This procedure will include action taken against mobile home owners who are forced to vacate their rental space.

(2) Individuals or Families Facing Eviction from their Motel or Hotel Room

The applicant must submit verification in the form of a written statement signed and dated by the hotel or motel manager which indicates that the applicant and/or his family are facing eviction from their room for non-payment of rent.

(3) Tenant-Landlord Relationship

It is necessary that a tenant-landlord relationship must have existed in situations involving requests for payment of rent on behalf of applicants who are facing eviction. THIS POLICY DOES NOT APPLY TO HOMELESS APPLICANTS.

A tenant-landlord relationship exists when rent (or room and board) payments are made by the applicants to the landlord or family who are the original tenants. Payment must consist of cash or in-kind.

The need to verify the tenant-landlord relationship will be the decision of the Worker. When rent payments are involved, for example, such verification could be provided via rent receipts. When payment of rent is being made in-kind (such as housework, or other types of labor performed in lieu of cash payment), the landlord must state in writing that such an arrangement exists and indicate a monthly dollar value for the in-kind payment.

(4) Individuals or Families who are Actually Homeless

The definition of Homelessness shall

CIRCUMSTANCES OUTLINED IN (4) ABOVE EXIST.

The Worker must thoroughly explore available resources such as alternate temporary housing with friends and relatives (after obtaining permission from the client to pursue such resources) prior to authorizing payment for overnight lodging. Through the process of exploring available resources with the client and other community contacts, the Worker will have verified whether or not the family meets the definition for this type of Emergency Assistance. When resources of this type are not available, payment may be made ONLY pending the completion of a PLAN for permanent housing.

d. Determining the Amount of Payment

(1) Rent

- Eviction

Regardless of the type of shelter or the time unit by which it is being paid, the maximum allowable payment for shelter will not exceed ONE MONTH, FOUR WEEKS, or THIRTY DAYS. Therefore, when the benefit group is found eligible for more than one shelter payment within the thirty day period of eligibility, the maximum allowable payment must be observed. It will be necessary in these situations to compute the weekly or daily rate in order to arrive at fractional amounts. This policy will apply in situations when the group is homeless or facing eviction from the living quarters.

- Service charges required by the utility provider to start service in new living quarters when the applicant has moved to a new housing facility as a result of an eviction, fire, condemnation, etc.,or some other EMERGENCY that has forced the applicant to move into new living quarters. Service charges are NOT utility deposits. UTILITY DEPOSITS ARE NOT INCLUDED AS AN ITEM FOR PAYMENT UNDER THE EMERGENCY ASSISTANCE PROGRAM.

(1) Payment Amount for Gas, Electric, Water and Sewage

NOTE: "Sewage utility service" shall NOT include garbage pick-up service.

When the client is eligible to receive payment for any of the utility services indicated above, the Worker will consider the following:

- OVERDUE Utility Bill Covers a Billing Period from 0 to 30 days:

The Worker shall authorize payment to the vendor on behalf of the client.

- OVERDUE Utility Bill Covers a Billing Period Beyond 30 Days:

Since most utility billing periods are on a monthly basis, overdue bills covering a period in excess of 30 days are often submitted for payment. When this occurs, the Worker determines the average daily amount of the overdue bill. THE AVERAGE DAILY AMOUNT TIMES 30 DAYS WILL BE THE AMOUNT OF THE EMERGENCY ASSISTANCE PAYMENT. Utility bills often have an OVERDUE amount and an amount labeled "DUE." The "DUE" amount cannot be considered for payment nor may this amount be used in calculating the amount of the payment.

EXAMPLE: An applicant submits an overdue utility bill in the amount of $235 which

cannot or refuses to provide this information, the total number of months in the entire budget period will be used to determine the amount of payment referred to above. (The length of the budget period is usually 365 days unless correct information is otherwise obtained.)

Complicating this procedure are situations in which the overdue budget settlement bill is combined with or added to a routine overdue bill on the same notice of termination. In these situations, the amount of the overdue budget settlement bill must be separated from the amount of the routine overdue bill. A daily average is then determined for each overdue bill in excess of 30 days. The two amounts are multiplied by 30 and the two products are added. The result is the amount of payment.

EXAMPLE: The total amount of the overdue bill on the termination statement is $235.50. The overdue budget settlement bill is $85.50. Budget overruns occurred during 243 of the the 365 day budget period. The regular overdue bill is $150.00 accumulated over a period of 45 days.

Computation of overdue budget bill:

$85.50 divided by 243 - $0.35 x 30 days = $10.50

Computation of regular overdue bill:

$150.00 divided by 45 days = $3.33 x 30 days
$ 99.90

Amount of payment $110.40

- Determining the amount of payment in which the applicant has made partial payment(s) upon the original overdue bill.

  Situations arise in which the applicant

charges of up to 30 days for the type of service received plus federal tax. Payment cannot be authorized for long-distance calls, cables or other special services.

(3) Payment Amount for Bottled Gas, Fuel Oil, Coal and Wood

When the applicant uses energy that is not regulated by the Public Service Commission, the Worker will determine the amount of payment as follows:

When the applicant is eligible to receive payment for fuel costs, it is necessary to determine the amount of payment by referring to the chart below.

The following data represents the maximum amount of fuel that may be purchased on behalf of eligible clients for a 30-day supply of fuel.

TYPE	UNIT	MAXIMUM AMOUNT
Bottled Gas	Gallons	135
Bottled Gas	Pounds	300
Coal	Tons	1
Wood	Cords	1
Fuel Oils	Gallons	150

The following statement must be entered on all DF-67 forms authorizing any type of liquid fuel: "The client must specify the correct grade and type of fuel." (Please refer to Section 19.4 item C-7 for instructions in completing the DF-67 form).

A situation may exist when the provider refuses to make a delivery because of an existing unpaid balance. In this case, the Worker should allow the client and provider to determine what item will be paid. (The unpaid balance or the

Situations will occur when the person who should apply for benefits is unable or unwilling to do so. In these situations, the Worker must use judgement to determine if someone else in the benefit group can apply. Consideration should be given to the nature of the crisis and if a suitable person is available to apply. In most situations, the spouse of the head of the household would be the best choice.

4. The Benefit Group

The benefit group will consist of one or more persons who are living together. The only exception to this policy is when a person is paying for the privilege of living in the household. When this occurs, that person and his income will not be considered in determining eligibility of the benefit group. However, the payment being made for the privilege of living in the household will be added to the total income of the benefit group. This payment must be consistent with that amount which is locally usual and customary for the privileges covered. The worker may decide to request written verification of these situations. Written verification must consist of a statement having the amount of payment and what it covers, the time period covered by the payment and the dated signature of the person to whom payment is made.

5. Completion of Form ES-6, Notice of Information Needed

When the Worker has insufficient information to make a decision on the application, it is necessary to complete Form ES-6 to inform the applicant of the information needed.

The Worker should enter the specific information that clearly states what items must be returned by the applicant. As well, care should be used to enter the correct date by which the information is to be returned.

After giving careful consideration to the above, the Worker will approve or deny the application by entering the appropriate code on the ES-CHET-1 form. (Please refer to Section 19.4, item c-5.)

A decision must be rendered on all Emergency Assistance applications as soon as possible if the emergency currently exists or prior to an imminent emergency but never beyond three state government business days from the date of application.

EXAMPLES: An applicant submits a notice of termination from a utility provider on Monday which states that the service will end in five days. A decision must be rendered on the application no later than Wednesday. (The date of application will be counted as the first day.)

The Worker shall determine the appropriate social service via discussion with the applicant/recipient, and make a referral via the HS-1 form to the Social Service Unit. An individual applies for payment of a utility bill on Friday. He does not have the notice of termination to verify the emergency and is informed by the Worker to submit the termination notice no later than Tuesday. Applicant fails to submit the notice. Worker must render a decision on Tuesday. In the absence of a verification, this decision would be a denial. The applicant may reapply.

7. Case Action

a. Approval

If the applicant meets the eligibility criteria for the Emergency Assistance Program, the Worker will approve the application by entering the appropriate code in the disposition code block on the ES-CHET-1 form. (Refer to Section 19.4, item c-5 for the correct approval code.) Next, the Worker will authorize payment by completing the DF-67 form. (Refer to Section 19.4, item c-7

this occurs, the Worker will be required to complete form ES-NL-A, Notification Letter, and either give or mail the form letter to the applicant.

9. Referrals to Social Services

After the Worker has evaluated the applicant's eligibility for Emergency Assistance and other Income Maintenance programs, consideration should be given to the applicant's need for social services.

For example, a family may be in need of ongoing homemaker's service or money management counseling although the emergency has been eliminated or averted through the authorization of Emergency Assistance.

The Worker shall determine the appropriate social service via discussion with the applicant/recipient, and make a referral via the HS-1 form to the Social Service Unit.

19.3 NON-EMERGENCY MEDICAL TRANSPORTATION

A. Introduction

1. Funding Sources

Transportation for non-emergency medical purposes is funded through three different sources. These sources are:

- Title XIX funds for all Medicaid recipients including foster children,
- Title V funds for non-Medicaid eligible recipients of Handicapped Children's Services, and
- Agency administrative funds for applicants of financial or medical assistance who need a physical examination in order to complete the eligibility determination process.

2. Services Provided

Services provided under this program are:

- Transportation and certain related expenses necessary to secure medical and other services covered by the Medicaid Program including medical services under the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT).
- Transportation and certain related expenses necessary to secure medical services covered by the Handicapped Children' Program for non-Medicaid eligible children.
- Transportation and certain related expenses necessary to secure medical examinations required in the eligibility determination process for the financially needy and medical assistance only programs.

receiving services under the Individuals with Disabilities Education Act (IDEA). However, this exception exists only when the following conditions are met:

1. The child receives transportation primarily to obtain a Medicaid-covered service, and

2. Both the Medicaid-covered service and the need for transportation are included in the child's Individualized Education Plan (IEP).

- Incur transportation and/or certain related costs for the round-trip to the medical vendor.

- Receive medical treatment or services covered by the Medicaid program.

- Receive pre-authorization in certain situations for the transportation costs as described on the application form and in this policy.

- Have an appointment or plan for the medical treatment or service.

- Comply with the 60-day application submittal deadline.

2. Specific Eligibility Requirements

a. Transportation Requests Which Require Prior Approval from the Office of Medical Services

All requests for out-of-state transportation and certain related expenses must have prior approval from the Office of Medical Services, Case Planning Unit. Certain medical providers residing in bordering states near the West Virginia state line have been granted border status. These providers are considered in-state providers and should have a West Virginia Medicaid provider number as though they were physically located in

b. Transportation Requests Which Require Prior Approval from the Local or County Worker

- Transportation of an immediate family member to visit/stay with a patient at the medical facility. An immediate family member will be limited to a parent to visit/stay with a child(ren), a child to visit/stay with a parent(s) and a spouse to visit/stay with his/her spouse. The need to visit/stay must be based upon a medical necessity and be documented in writing by physician. In emergencies, verbal documentation may be accepted. In all situations, the physician must state why the visit/stay is necessary and the reason must be based upon a medical necessity. Exceptions to the definition of what constitutes family members may be granted after supervisory approval.

- Lodging plus meals as required with lodging.

- Transportation via common carrier.

If the applicant, during the interview, insists upon incurring transportation costs and certain related expenses beyond that which is offered or approved by the Department, the Worker will share with the applicant that such costs will not be reimbursed by the Department.

c. Routine Automobile Transportation Requests

Routine automobile transportation requests plus meals and tolls may be received by eligible Medicaid recipients WITHOUT pre-authorization. If the applicant meets the

f. Handicapped Children's Services Recipients

Recipients of Handicapped Children's Services receive reimbursement of transportation and certain related expenses in order to obtain planned medical services. Transportation services are limited to those patients whose family income falls within the Handicapped Children's Services' financial guidelines.

(1) Medicaid Eligible Handicapped Children's Service Recipients

Handicapped Children's Services patients may also be Medicaid eligible (i.e. they are foster children or members of an AFDC/U, Medicaid or SSI benefit group). Medical services provided by Handicapped Children's Services for these patients are billed to the Medicaid program. Transportation services for these patients are also charged to the Medicaid program. Services provided due to Medicaid eligibility must meet the requirements in item B. Requests for transportation that require approval from the Office of Medical Services are submitted to Handicapped Children's Services staff for approval.

(2) Transportation Requests which Require Prior Approval from Handicapped Children's Services staff (Local or office staff)

In all situations when the child must secure medical care outside the state, Handicapped Children's Services staff must approve the necessary transportation and certain related expenses.

(a) Medicaid-Covered and Non-Medicaid covered Handicapped Children's Services:

In ALL situations when the child must secure medical care outside

examination is required may request transportation benefits for the trip.

In determining eligibility for these requests, the Worker should consider the following:

- The required medical examinations MUST be only for the purpose of determining eligibility for a program operated by the Department (such as AFDC-Incapacity).

- The Worker will apply the eligibility guidelines outlined under B, Eligibility Requirements, with the exception of the first and third items since the applicant is not yet a Medicaid recipient.

C. Transportation Providers

The transportation providers listed below must be used according to the priority in which they are listed. THIS MEANS THAT THE LESS EXPENSIVE METHOD OF TRANSPORTATION MUST ALWAYS BE CONSIDERED AND, IF POSSIBLE, USED FIRST:

- The patient or a member of his family, friends, interested individuals, foster parents, adult family care providers or Volunteers.

- Volunteers or paid employees of community-based service agencies such as Community Action Programs and Senior Citizen Programs.

- Common carriers (bus, train, taxi or airplane).

- An employee of the Department with Supervisory Approval ONLY AFTER IT HAS BEEN DETERMINED THAT THE PROVIDERS INDICATED ABOVE ARE NOT AVAILABLE.

Whenever patients/applicants use more expensive transportation than the private auto mileage rate without prior authorization, they must show that only the more expensive transportation was available when the trip was taken. If the patient/applicant, for example, uses a taxi to make the trip but is unable to

of waiting time is included, the Worker must obtain from the taxi company a dated and signed statement indicating the rate, elapsed time, and total charges for waiting time.

When intra-city travel is required (travel within the city limits), the cost of waiting time will not be included in the payment, and the patient(s) and taxi driver must be aware of this.

2. Car Pool

Car pooling will be maintained for all recipients when appointment dates at the same medical facility coincide for more than one patient. However, the Worker should use judgement and input from the transportation provider in determining the safe number of persons to be included in each vehicle.

In special situations, car pooling may not be appropriate for certain clients. For example, various types of physical infirmity may prohibit car pooling in order to maintain the appropriate level of safety and comfort for all involved. Judgement, and if required, verbal or written medical certification must be exercised by the Worker in determining when car pooling is appropriate.

3. Use of Volunteers as Transportation Providers

a. Definition of a Volunteer

In order to maintain the records for volunteer transportation providers, a "volunteer" will be defined as anyone who provides assistance to clients or recipients of the Department without compensation or with reimbursement of expenses only.

b. Limitations on the Use of Volunteers as Transportation Providers

In the case of Burnsville Community Cab, Inc. vs. Alice Knicely and the Department of Human Services, the Public Service Commission has made the following adjustment in regard to

The policy statement regarding the limitation will not apply to Transportation Remuneration Incentive Program tickets or to the reimbursement of common and contract carriers operating under the authority of the Public Service Commission.

D. Certain Related Expenses

1. Allowable Expenses

Certain related expenses will be limited only to the following items:

- Meals
- Lodging
- Turnpike Fees

2. Determining the Amount of Payment for Certain Related Expenses

a. Meals

Necessary meals at the rate of $5.00 per meal per person will be considered only in the following circumstances:

- When the time of the appointment and the length of the round trip extend through meal hour(s) during the trip **AND** the single day round trip is not less than 100 miles. Meal hours of noon for lunch and 6:00 p.m. for dinners will be observed. Breakfast is permitted only when lodging has been approved, or otherwise obtained.
- When lodging has been approved, meals will be permitted for the patient when out-patient treatment is received and/or for one person who was approved to accompany or visit the patient.
- Meals are permitted for the driver only when a private automobile is used.

NOTE: When an employee of the Department is the provider and overnight lodging is required, the employee will observe for his expenses only the state travel regulations.

Ronald McDonald Houses and NEMT -

At the present time, only three Ronald McDonald Houses exist in West Virginia:

Charleston - CAMC (346-0279)

Huntington - Cabell-Huntington Hospital and St. Marys Hospital (529-1122)

Morgantown - Chestnut Ridge Hospital, Monongalia General Hospital, Ruby Memorial Hospital and Mountaineer Rehabilitation Center (598-0050)

Certain Medicaid-eligible clients arrive at Ronald McDonald Houses without being pre-approved for NEMT at the county office. These clients are referred to by Ronald McDonald staff as "emergencies." Income Maintenance personnel stationed at any of the facilities listed above will take the NEMT applications for Medicaid-eligibles designated as "Emergency" and in need of lodging benefits from the Ronald McDonald Houses. All other benefits available from NEMT, such as food and transportation, can be evaluated as well.

Otherwise, the local worker may contact the Ronald McDonald Houses listed above when referrals need to be made for NEMT patients.

c. Turnpike Fees

Turnpike fees for round-trip travel will be permitted for private automobiles only. No receipts must be submitted.

E. Application Process

The application process consists of obtaining sufficient information required to make a decision

are provided in situations where additional cases with different numbers exist in one household.

b. Applicant/Patient Responsibilities/Signatures

ALL statements must be checked either "yes" or "no" and the applicant's signature and date must be entered before an eligibility decision can be rendered.

c. For Agency Use only

The Worker will record in the space provided whether the application was approved or denied plus additional information as required.

The Worker will also enter in the upper right corner the categorical I.D. for the case. If different categorical I.D.'s exist, the Worker should enter the correct I.D. in the upper right corner of the appropriate trip. (Refer to the verification of travel page.)

A space to enter the CHET vendor number is also located in the upper right corner. If different vendors are used, the Worker may enter the CHET vendor number and label it as such on the appropriate trip. (Refer to the verification of travel page.) Finally, the Worker must sign and date the form.

d. Verification of Attendance/Travel Costs

The instructions are self-explanatory and are provided to assist the applicant in completing the verification form(s).

Upon receipt of the complete application form, the Worker must carefully review the verification of travel. All items that pertain to the claim must be completed. Incomplete applications must be returned to the applicant with instructions for making corrections.

CASE NAME, ADDRESS AND SOCIAL SECURITY NUMBER - Enter the case name, address and Social Security number of the person who is the case name.

VENDOR'S NAME/ADDRESS/NUMBER - When the vendor has previously been entered in the CHET system, a VENDOR NUMBER will be the only entry required in this column. Otherwise the name and full address must be entered.

PATIENT'S NAME(S) - Enter the name of the PATIENT(S) who is attending the clinic.

NOTE: At this point on the DF-67-B form, the application has been completed. The completed DF-67-B form (or a copy) must be returned to the patient's home for processing of payment. For example, if a patient residing in Clarksburg attended a clinic in Morgantown, the Clarksburg office would make payment to the transportation provider based upon information received at the Morgantown clinic. Completing the remainder of the form is necessary to make payment for transportation and other related expenses. This is described below in item F, Payment Process.

3. Categorical Identification

The categorical identification illustrates the type of assistance being received by the recipient of NEMT benefits. THE DEPARTMENT MUST REPORT THIS IDENTIFICATION WHEN REQUESTING REIMBURSEMENT OF FEDERAL FUNDS. Therefore, the identification is entered upon the OIM-NEMT-1 application/verification form. Ultimately, the identification must be entered into the CHET system in order to make payment.

The following instructions apply in determining the correct identification to be used for each type of assistance. All Medicaid patients will be categorically identified by matching the letter prefixes or codes listed below on the left with the categorical program identification listed in the column on the right:

- The Worker approves the application prior to the trip and instructs the client to obtain verification of attendance.

b. Denial

Notification of denial is fulfilled when form letter ES-NL-A is completed and given (or mailed to) the applicant.

F. Payment Process

The payment or reimbursement of transportation and certain related expenses can be generated via CHET or generated by the Financial Clerk when advance payment is required. THE PAYMENT PROCESS BEGINS WITH THE COMPLETION BY THE WORKER OF FORM DF-67-B REGARDLESS OF THE METHOD IN WHICH PAYMENT IS TO BE MADE. After the form is completed by the Worker, it must be approved by the Worker's supervisor and then checked and approved by the Financial Clerk. If advance payment (or payment otherwise generated by the Financial Clerk) must be made, the Clerk will write the check based on the information contained on the DF-67-B form.

The payment process is the same for ALL transportation vendors or providers. THIS MEANS THAT DEPARTMENTAL STAFF WHO HAVE PERFORMED AS TRANSPORTATION PROVIDERS WILL NOT CHARGE ALLOWABLE EXPENSES ON THE IN-STATE TRAVEL EXPENSE ACCOUNT FORM. INSTEAD, THE WORKER WILL RECEIVE REIMBURSEMENT VIA THE NEMT PAYMENT PROCEDURE AS ANY OTHER TRANSPORTATION PROVIDER.

1. Function of the DF-67-B Form in the Payment Process

In addition to serving as an application and verification form for approved clinics, the DF-67-B form continues its multi-purpose in the payment process:

- Voucher - The form serves as a voucher from which checks may be written by the Financial Clerk for advance payment or in other unusual situations when payment is not made via CHET.

mandatory requirements:

- Encumbrance entries plus denials and withdrawals for Emergency Assistance and Homeless Program cases must be made no later than the end of the next working day after the date the decision was made on the application.

- Supervisory approval or designee must be obtained on the DF-67 or DF-67-B forms.

- Final approval and clearance on the DF-67 and DF-67-B forms must be obtained from the Financial Clerk or designee.

- The Financial Clerk or designee must determine the date authorized or date paid necessary for the payment entry.

- Accountability and security must be established to control the payment entry transmittal document (ES-CHET-1, DF-67 or DF-67-B) and prevent unauthorized payment. The minimum requirement is that either document be initialed and dated by each person involved in the approval and transmittal process.

available resources, the Worker will find the case eligible for benefits providing other eligibility requirements are met.

4. Responsible Relatives

If a responsible relative (i.e., one who is LIABLE or one who simply wishes to pay the allowable amount) indicates that he agrees to make the allowable payment (child - $625; adult - $1,600), the Worker must find the case ineligible for payment of burial.

If the responsible relative agrees to pay any amount less than the allowable amount, or indicates that he cannot make any payment toward the allowable amount, the Worker will find the case eligible for a burial payment providing all other eligibility requirements are met.

5. Maximum Allowable Payment

The maximum allowable payment is a ceiling or limitation on the amount of payment that can be received by the funeral home when the Department participates in the payment of a burial. The extent of the Department's participation, or the amount of the program benefit, is determined by the burial rate and, when applicable, the amount which exceeds the maximum allowable payment.

The maximum allowable PAYMENT is not to be confused with the burial RATE. The maximum burial RATE is the amount the Department will make toward the cost of all funeral related expenses.

The maximum allowable payment is also used to establish eligibility for a burial payment in relation to the resources of the deceased and to contributions made by responsible relatives.

Finally, the maximum allowable payment is used to establish the amount of resources (i.e., payment

The burial rates for adults and children will include the funeral service, casket, outside wood or concrete box, clothing and transportation. There is no extra allowance for local or long distance transportation for the deceased.

a. Casket and Casket Size

The following is a description of the type of casket WHICH MUST BE USED when the Department is making payment of the adult or child burial rate:

A casket shall be at least but shall not exceed a Flat Top or Oval Top constructed with wood or wood products and covered with such exteriors as doeskin, lambskin, moleskin, plan or embossed cloth. The outside container shall consist of wood or concrete box.

NO CASKET OR OUTSIDE CONTAINER OTHER THAN THAT AS DESCRIBED ABOVE SHALL BE USED UNLESS THE FUNERAL DIRECTOR HAS NO CASKET OR OUTSIDE CONTAINER (as described above) AVAILABLE AND HE AGREES TO ABSORB THE HIGHER COST OF A MORE EXPENSIVE CASKET OR OUTSIDE CONTAINER.

IF ANYONE (e.g. relative, friend, etc.) PROVIDES A BETTER OR MORE EXPENSIVE CASKET OR OUTSIDE CONTAINER THAN THAT AS DESCRIBED ABOVE, THE DEPARTMENT WILL NOT PARTICIPATE IN THE PAYMENT OF THE BURIAL EXPENSES.

- 200	Excess
$ 200	Amount of payment received by the funeral director from the Department.
$1,400	Resources
+ 200	Burial Payment
$1,600	Maximum allowable payment (total payment received by the funeral director)

#2 The funeral director receives payment of resources on an adult burial for $500.

$ 500	Resources
-1,200	Exempted resource amount
$ 0	Excess
$ 400	Adult Burial Rate
- 0	Excess
$ 400	Amount of payment received by the funeral director from the Department.
$ 500	Resources
+ 400	Burial Payment
$ 900	Total payment received by the funeral director)

In this example, the Funeral Director is entitled to receive $700 in additional resource before the maximum allowable payment of $1,600 is reached. Assume further that the funeral director receives $800 in additional resources after the burial payment from the Department was received. The funeral director must reimburse the Department $100 because the maximum allowable payment was exceeded by $100.

1. Resources Obtained for Child and Adult Burials

a. Resources Obtained for Child Burial

Resources up to $300 may be obtained toward the cost of a child's burial for a total maximum payment of $625 before the resources are deducted from the child burial rate.

estate (the county in which the deceased maintained his residence or the county in which the deceased owned real estate).

This action is taken only when the value of the deceased's estate warrants such action. The Worker must attempt to obtain sufficient information about the deceased's estate in order to make decisions to seek reimbursements. When the Worker determines that the estate is valued at at least $400 after the costs of administration are deducted, the decision should be to seek reimbursement.

b. Instructions for Completing Form ES-BU-3

The Financial Clerk will complete the ES-BU-3 form on those cases in which it has been determined that the estate after administrative costs have been deducted is valued at $400. The Affidavit of Burial Costs is a form letter and is completed as follows:

Introductory Statement

The Financial Clerk will enter the name and address of the County Clerk. The name of the deceased and the amount of the claim will be entered in the spaces provided. <u>The amount of the claim shall not exceed $400</u>.

Affidavit and Verification

- The Financial Clerk shall enter her name, the amount of the claim against the deceased's

INCOME CHART

Income Exclusions	LIEAP	Emergency Assistance	NEMT	Burial
Grants and loans from HUD Community Development Block Grant Funds made to individuals to rehabilitate their private residence	Excluded	Excluded	DNA	DNA
All JTPA payments except those considered as wages for on-the-job training	Excluded	Excluded	DNA	DNA
Income Deductions				
20% deduction from gross monthly income for self-employed persons to determine countable income	Yes	No	DNA	DNA
25% deducted from gross monthly income for self-employed persons to determine countable income	No	Yes	DNA	DNA
Income disregards	None	None	DNA	DNA

APPENDIX A

EMERGENCY ASSISTANCE INCOME

A. Monthly Allowable Countable Income to Determine Eligibility for Emergency Assistance

Number of Persons in the Benefit Group	Monthly Allowable Countable Income of the Benefit Group
1	$ 355
2	$ 533
3	$ 566
4	$ 711
5	$ 819
6	$ 939
7	$ 1,046
8	$ 1,165
9	$ 1,273
10	$ 1,394

For Benefit Groups in which the number of persons exceeds ten, add $144 for each additional person.

DESK GUIDE FOR CHET DISPOSITION CODES

I. EMERGENCY ASSISTANCE

A. Approval Codes

E1 - Shelter

E2 - Food

E3 - Utility

E4 - Bulk Fuel

E5 - Household Supplies and Furnishing

E6 - Clothing

E7 - Child Care

E8 - Transportation - Transient

E9 - Transportation - Emergency Transportation to Medical Facility

E - Other

EO - Emergency Medical Care - Outpatient

EP - Emergency Medical Care - Pharmacy

EM - Both of the above benefits

AFFIXES

"F" - Fire

"D" - Disaster

"E" - Exceptions

B. Denial and Withdrawal Codes

E01 because your income exceeded the amount allowed by $.

E02 because a resource referral was not accepted.

E19 because you did not apply for certain benefits from other programs in order to eliminate or assist in the elimination of the emergency.

E20 because you failed to complete the application form.

E21 because you failed to verify your social security number.

E22 because you failed to submit a correctly written statement to verify the impending eviction.

E23 because you failed to submit a correct statement to verify the impending mortgage foreclosure.

E24 because you failed to verify the existence of a landlord-tenant relationship.

E25 because it could not be verified that you were a homeless stranded transient for which transportation arrangement to your community is incomplete.

E26 because it could not be verified you were homeless due to the destruction of your living quarters.

E27 because it could not be verified you were homeless due to eviction.

E28 because it could not be verified you were homeless due to mortgage foreclosure.

E29 because it could not be verified you were homeless due to being evicted from shared living quarters.

E30 because it could not be verified you were homeless due to being evicted from condemned quarters.

E31 because it could not be verified you were homeless due to being locked out of your hotel or motel living quarters.

E32 because it could not be verified you were homeless due to being physically battered and your living quarters were too dangerous.

E33 because it could not be verified you were homeless due to being released from a state mental health facility with no available living quarters.

by an unusual or catastrophic event which rendered your food coupons unusable.

E48 because your household supplies or furnishings were not destroyed in a man-made or natural disaster.

E49 because you and the persons in the benefit group were not homeless and the Department was not seeking or had located housing on your behalf. Therefore, you are ineligible for household supplies and furnishings.

E50 because emergency household supplies or furnishing were not needed for homeless persons.

E51 because your clothing was not destroyed in a man-made or natural disaster.

E52 because children were not abandoned and therefore ineligible for clothing.

E53 because the parent(s) of the children were not hospitalized.

E54 because the parent(s) of the children were not incarcerated.

E55 because the children were not abandoned and immediate arrangements for care were unnecessary.

E56 because you were not passing through the locality and experienced an emergency which made it necessary to return to your home community.

E57 because the Department was unable to verify or establish that you had a place to live in the community to which you wish to return.

E58 because you did not have a need for emergency medical treatment.

E59 because transportation was available to you at the time of your need for emergency medical transportation.

E60 because you are eligible to receive transportation benefits under the Medicaid program.

E61 because inpatient medical care, emergency or

HF	Food	HF4
HO	Medical Care-Outpatient	HO4
HI	Medical Care-Inpatient	None
HP	Medical Care-Pharmacy	HP4
HM	Medical Care-multiple benefits	None
	Medical Care-Outpatient/ pharmacy	HM4
HU	Utilities	HU4
HT	Transportation	HT4
HH	Other	None

No IV-A approval code exists for inpatient benefits. Multiple benefits under Non-IV-A eligibility consist of outpatient, inpatient and pharmacy. IV-A multiple medical benefits consist only of outpatient and pharmaceutical treatment.

B. Denial Codes

H40 Failed to meet the definition of Homeless.

H41 Failed to meet the resource eligibility requirement.

H42 Failed to accept the homeless program benefit.

H43 Failed to manage resources after the initial period of eligibility.

H44 Failed to cooperate with Social Service plan.

H45 Failed to accept referral to community resources.

H46 Failed to accept community resources.

H47 Failed to cooperate with vendor.

T8 - Tolls

T9 - Transportation and Tolls

T0 - Other

B. Categorical Identification Codes

M - MAO

C - AFDC

U - AFDC/U

A - SSI/A

B - SSI/B

D - SSI/D

E - EPSDT

H - Handicapped Children Patients

G - Medicaid Eligible Handicapped Children's Patients

P - Pending Medical Examination Case

F - Foster Children who do not come under any of the codes above

All codes will be entered with the county code affixed to the letter code:

EXAMPLE:

M.41

B.28

H.42

IV. RELATIONSHIP CODES

Relationship codes will be used in the benefit group data section of the client file. These codes are arranged into two lists. The first list contains codes for Title IV-A

F - Father

SM - Step-mother

SF - Step-father

A - Aunt

U - Uncle

OM - Other Male Adult

OF - Other Female Adult

S - Son

D - Daughter

B - Brother

SI - Sister

NI - Niece

NE - Nephew

GS - Grandson

GD - Granddaughter

MANUAL MATERIAL TRANSMITTED					
MANUAL: INCOME MAINTENANCE			CHANGE NUMBER: 3		
DELETE			INSERT OR CHANGE		
PAGES	CHAPTER	DATED	PAGES	CHAPTER	DATED
TABLE OF CONTENTS	18	10/94	TABLE OF CONTENTS	18	8/95
14-15	18	10/94	14 - 15-a	18	8/95
20-21	18	10/94	20 - 21-a	18	8/95
26-27	18	10/94	26 - 27-a	18	8/95
32-33	18	10/94	32 - 33	18	8/95
A-3 - A-4	18	10/94	A-3 - A-4	18	8/95
DATE: August 1995			TO: All Income Maintenance Manual Holders		

This change is being made in Chapter 18 to the following Sections:

18.4-A (page 14): to include additional INA citations.

18.6-B (page 20) and 18.7A (page 26): To clarify non-consideration of income from alien sponsors in AFDC/U-related Medicaid.

18.8-A (page 32): Clarify illegal/ineligible aliens will use the ES-2 for application for Emergency Medicaid.

Appendix A (page A-3): I-151 - Alien Registration Receipt Card: INS is conducting a program to replace Form I-151 with the more recent green card Form I-551. This program has been extended to March 20, 1966. INS will continue to honor the I-151 cards in order to avoid confusion over employment rights and entitlement benefits such as food stamps for those lawful permanent residents who either have not yet applied for the new card or are awaiting receipt of the document. INS requests that workers urge alien recipients to apply for the new I-551 green card as soon as possible. Individuals seeking to replace their green cards may be referred to the INS toll-free number, (800)755-0777, for information on how and where to apply for the new card.

18.4 BENEFIT PROGRAMS

To receive AFDC/U, Medicaid or Food Stamps, the individual applying must be a resident of the United States as a citizen or a legal alien and meet eligibility standards as set by each program. Among those excluded are alien visitors, tourists, diplomats and students who enter the U.S. temporarily with no intention of abandoning their residence in a foreign country.

An illegal or ineligible alien residing in the U.S. who has need for emergency medical care is eligible for Medicaid for the length of time medically required to avert the medical emergency (see Section 18.6 of this chapter).

A. Food Stamps (Also Refer to Appendix B)

1. Those aliens who are eligible are:

(a) Lawful Permanent Residents except: aliens who legalized under general amnesty programs are ineligible for food stamps for five years unless they are 65 or older, blind or disabled.

NOTE: Some aliens are subject to three year sponsor deeming.

(b) Lawfully admitted as an immigrant as defined in Sections 101(a)(15) and 101 (a)(20) of the Immigration and Nationality Act (INA).

(c) Permanent resident (entered prior to January 1, 1972).

(d) Lawful Temporary Residents under the 210 farm worker (SAW) program or under the 245A general amnesty program if 65 or older, blind or disabled.

(e) Refugees

(f) Asylees

(g) Parolees Section 212(d)(5)

(h) Aliens granted withholding of deportation

- Some aliens are subject to three year sponsor deeming.

(b) PRUCOL Aliens

- Lawful Temporary Residents under the amnesty program, if 65 or older, blind, or disabled,

- Persons fleeing persecution which include refugees, aliens granted asylum, parolees, Cuban/Haitian entrants, or conditional entrants.

2. Aliens Permanently Residing in the U.S. Under Color of Law (PRUCOL)

NOTE: PRUCOL is not a definition under immigration law and is not a separate immigration classification like "refugee" or "lawful permanent resident." AFDC/U is a federal program that uses PRUCOL as a basis of eligibility.

Aliens who are PRUCOL include: *

- Aliens admitted as refugees,

- Aliens granted asylum,

- Conditional entrant refugees,

18.6 DEEMING INCOME OF ALIEN'S SPONSOR

A. Introduction

Some legal immigrants come to the United States with the aid of citizens who serve as their "sponsors." A sponsor is someone who files an "affidavit of support" to help the sponsored immigrant obtain lawful permanent resident status. As a result of this relationship, the federal government requires any sponsored immigrant to include the sponsor's resources in any application for AFDC, SSI, and food stamps for their first three years in the United States. The sponsor's income is therefore "deemed" available to the sponsored immigrant. However, the affidavit does not legally obligate sponsors to share their resources with the sponsorees. Income of ineligible aliens is also deemed.

B. Deeming Income of Alien's Sponsor (AFDC/U and AFDC/U-Related Medicaid)

Note: Income from an alien sponsor is prohibited under Medicaid regulations and therefore does not apply to AFDC/U-related Medicaid.

The income of the sponsor (and the sponsor's spouse if living with the sponsor) will be deemed to a sponsored alien if ALL of the following conditions are met:

1. The alien must NOT be one of the following:

   (a) admitted prior to April 1, 1980 under Section 203 (a) (7) of the Immigration and Nationality Act (INA), OR

   (b) admitted after March 31, 1980 under Section 207 (c) of the INA, OR

   (c) paroled into the United States as a refugee under Section 212 (d) (5) of the INA, OR

   (d) granted political asylum by the Attorney General under Section 208 of the INA, OR

   (e) a Cuban or Haitian entrant as defined in Section 501 (e) of the Refugee Assistance Act of 1980.

2. From the amount, subtract 20% of the gross monthly earnings or $175, whichever is less.

3. To this figure, add the sponsor's total monthly unearned income.

4. Subtract the amount of the appropriate standard of need from Standard of Need Chart for the number of individuals living with the sponsor who are claimed by the sponsor as dependents for federal personal income tax purposes but who are not included in an AFDC/U benefit group.

5. Subtract any amounts actually paid by the sponsor to the individuals not living with him but who he claims as dependents for federal income tax purposes.

6. Subtract any amounts actually paid by the sponsor for alimony or child support.

7. The amount remaining is divided by the number of eligible aliens and the resulting figure is deemed to each eligible alien sponsored by the individual.

18.7 DEEMING ASSETS OF ALIEN'S SPONSOR

A. Introduction

Assets will be deemed to sponsored aliens only for the Food Stamp and AFDC/U Programs. **EXCEPTION:** Income from an alien sponsor is prohibited under Medicaid regulations and therefore does not apply to AFDC/U-Related Medicaid.

B. Special Verification Procedures - Foreign Real Property of Philippine Aliens (SSI-Related Medicaid)

When an alien of the Philippines makes application for SSI-Related Medicaid, it will be necessary to verify whether he owns any property in that country and/or the United States.

If either the alien or the alien's spouse was born in the Philippines, has resided in the United States for less than five years, and appears to be otherwise eligible, the following special verification procedures must be followed:

1. Contact the Veterans' Administration Regional Office in Manila requesting a check of property records to determine whether the applicant or his spouse own any real property and an estimate of the current market value of any property that is discovered.

   The address is: VARO, 1131 Roxas Boulevard (Manila), APO San Francisco, California 96528. Please indicate AIR MAIL on the envelope.

   The Worker must provide the Veteran's Administration the full names including maiden name of the applicant and/or his spouse and the address of their last residence in the Philippines.

2. If the applicant has not indicated that he owned any real property in the Philippines and is otherwise eligible, approve the application. The Worker must, however, request verification through the Veteran's Administration as per instructions in number 1 above.

3. Make a recording on the ES-5 to indicate the VA was contacted.

Should the alien change sponsors, the amount of income deemed must be recalculated to reflect the circumstances of the new sponsor and the income of the former sponsor will no longer be counted.

The responsibilities for obtaining information from the sponsor are the same for the deeming of assets as for the deeming of income as found in Section 18.4 G.

2. Determining Amount to be Deemed

The following steps are to be used to determine the amount of the sponsor's assets and the assets of the sponsor's spouse (if living with the sponsor) which will be deemed to the alien:

a. Determine the total countable value of the assets of the sponsor and the sponsor's spouse as if they were applicant's for the Food Stamp Program. Count only assets not excluded by this Chapter and determine the value of the non-excluded assets as would be done for any Food Stamp client.

18.8 EMERGENCY MEDICAID FOR ILLEGAL/INELIGIBLE ALIENS

A. Introduction

Any alien who does not fall under one of the "Eligible Aliens" categories will not be eligible for Medicaid except in the emergency situations discussed below. Applications will be accepted on the ES-2 and entered into the M219 Data System.

B. Eligibility Requirements

1. Illegal/Ineligible Alien Pregnant Woman

An illegal/ineligible pregnant woman who is diagnosed as having an emergency medical condition as a result of being in active labor and delivery is imminent may be eligible for Medicaid for emergency services only.

2. Illegal/Ineligible Alien

Any illegal/ineligible alien diagnosed as having a medical condition 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 the alien's health in serious jeopardy; or

b. Serious impairment to bodily functions; or

c. Serious dysfunction (impairment or abnormal functioning) of any bodily organ or part.

3. The alien must meet the income, asset, and categorical requirements of either AFDC/U or SSI. This means that the alien must, except for his alien status, otherwise qualify for Medicaid as a categorically needy individual.

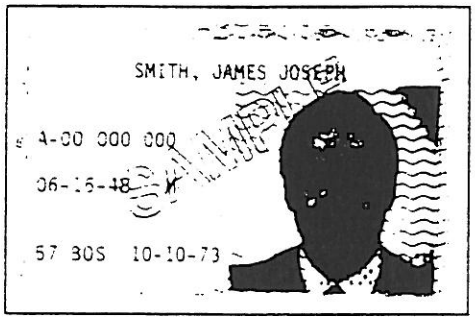
C. Special Procedures

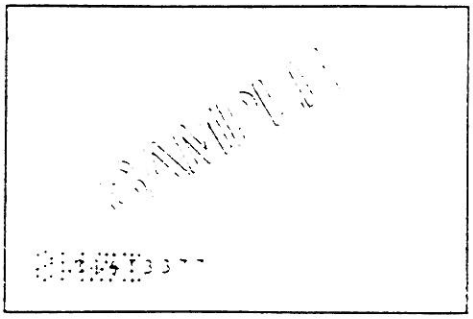
1. Applications from or on behalf of illegal/ineligible aliens must be filed at the local DHHR Office within 30 days of the need for emergency medical care as defined in B1 or B2 above.

2. Enter the application into the M219 System with the following special codes:

I-151

Alien Registration Receipt Card: Issued by INS to lawful permanent resident aliens. This card is no longer issued. INS is conducting a program to replace Form I-151 with the more recent green card Form I-551. This program has been extended to March 20, 1966. INS will continue to honor the I-151 cards in order to avoid confusion over employment rights and entitlement benefits such as food stamps for those lawful permanent residents who either have not yet applied for the new card or are awaiting receipt of the document. INS requests that workers urge alien recipients to apply for the new I-551 green card as soon as possible. Individuals seeking to replace their green cards may be referred to the INS toll-free number, (800)755-0777, for information on how and where to apply for the new card.





I-185

Canadian Border Crossing Card: Eligible Canadian citizens and British subjects residing in Canada may be issued border crossing cards to allow them to travel to the United States. A person who enters the United States using a border crossing card does not have permission to reside in the United States for more than six (6) months at a time. The card is valid indefinitely. (Sample card not available.)