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Coverage Groups

2010.0000 Food Stamps

If financial and technical requirements have been met, the assistance group may be eligible for the coverage groups described in this section.

2010.0100 CATEGORY CODES (FS)

The following section details the category codes for FLORIDA.

2010.0101 Food Stamp Category Code (FS)

FS is the only code that will appear for a food stamp assistance group.

2010.0200 FOOD STAMPS (FS)

If all program requirements have been met, the assistance group is entitled to food stamps. The assistance group may be categorically (PA) eligible or non-categorically (NA) eligible. Refer to passage 2010.0201 for a discussion of PA eligibility or to passage 2010.0202 for a discussion of NA eligibility.

2010.0201 Categorically Eligible Assistance Groups (FS)

A categorically eligible assistance group is one in which all members are receiving or are authorized to receive Temporary Cash Assistance or Supplemental Security Income (SSI) benefits or a combination of Temporary Cash Assistance and SSI. A broad-based categorically eligible standard filing unit (SFU) is one that receives information about Temporary Assistance for Needy Families or Maintenance of Effort funded services or benefits on an ACCESS Florida notice and does not contain a disqualified member. An individual is considered a recipient of Temporary Cash Assistance or SSI if the benefits have been authorized but not received, if the benefits are suspended or recouped, or if the benefits are not paid because they are less than a minimum amount.

Families that are receiving or are authorized to receive services through Healthy Families Florida are considered categorically eligible.

The assistance group cannot be considered categorically eligible for months in which an individual opts not to receive Temporary Cash Assistance, months that a SFU contains an ineligible or disqualified member or receives medical assistance only.

Individuals who are categorically eligible for food stamps are considered to have met gross and net income limits, asset limits, SSN requirements, and residency without further verification, unless questionable.

Broad-based categorically eligible SFUs must meet the 200% gross income limits. If the SFU contains a member who is age 60 or over or meets the definition of food stamp disabled, the SFU must meet the gross income limit of 200% of the federal poverty level for the AG size. If the SFU does not meet the 200% of the federal poverty income limit, the SFU must meet the net income limit of 100% of the federal poverty level for the AG size and the asset limit of $4,250.

2010.0202 Noncategorically Eligible Assistance Groups (FS)

If the standard filing unit does not contain all individuals who receive or are authorized to receive Temporary Cash Assistance, SSI, or services through Healthy Families Florida, the assistance group is not considered categorically eligible. Standard filing units that contain any disqualified members due to IPV, felony drug trafficking including agreeing, conspiring, combining, or confederating with another person to commit the act committed on or after 8/22/1996, fleeing felon, or employment and training requirements are not broad-based categorically eligible. These

assistance groups are referred to as noncategorical assistance groups (NA). Medical assistance only assistance groups, except for under $10 Temporary Cash Assistance cases, are considered NA assistance groups.

2020.0000 Temporary Cash Assistance

If financial and technical requirements have been met, the assistance group may be eligible for the coverage groups described in this section.

Additionally, this section provides the category codes for each coverage group used in FLORIDA.

2020.0100 CATEGORY CODES (TCA)

The following section details the category codes for FLORIDA.

2020.0102 Temporary Cash Assistance Category Codes (TCA)

ADCU = TCA Unemployed Parent
ADCR = TCA Regular (deprived)
ADCI = TCA Incapacitated Parent

2020.0300 TEMPORARY CASH ASSISTANCE (TCA)

If financial and technical requirements have been met, the assistance group may receive assistance under the following coverage groups:

1. Two-parent TCA (mutual children);
2. Regular TCA (deprived children or pregnant women in the ninth month, or third trimester if unable to participate in work activities);
3. Regular TCA (parents/caretaker relative of only eligible child in receipt of SSI);
4. Incapacitated parent TCA; and
5. Refugee Assistance Program (RAP).

2020.0301 Two-parent Temporary Cash Assistance Mutual Children (TCA)

Temporary Cash Assistance may be provided under this coverage group to two-parent families with children. The parents must have at least one mutual child to be eligible under this coverage group. Nonmutual children who meet all technical eligibility criteria must be included in the standard filing unit and assistance group. If the family is ineligible for cash assistance benefits (i.e., countable net income exceeds the payment standard), Temporary Cash Assistance cannot be provided separately to the nonmutual children and their parent.

Note: If the only mutual child is an unborn child, the father is not eligible to receive benefits until the birth of the child.

2020.0302 TCA Deprived Children or Pregnant Women (TCA)

Temporary Cash Assistance may be provided under this coverage group to families with children when the children are considered deprived based on specific deprivation requirements. Assistance is also provided under this coverage group to certain pregnant women. Refer to Chapter 1400 and passage 2030.0633.03 for more information on direct cash assistance for these pregnant women.

2020.0303 Deprived Children Receiving SSI (TCA)

Assistance may be provided to the parent(s) or caretaker relative in households where the only potentially eligible child is receiving SSI benefits. Refer to Chapter 2200 for information when a caretaker relative may be included.

2020.0304 Incapacitated Parent Temporary Cash Assistance (TCA)

Temporary Cash Assistance may be provided under this coverage group when both parents live together and one or both parents are determined to be physically or mentally incapacitated. The specific deprivation requirements for incapacity must be met. Refer to Chapter 1400.

2020.0305 Transitional Child Care Benefits (TCA)

A recipient of Temporary Cash Assistance (TCA) who has new or increased income or child support earnings that make them ineligible for TCA or who opts not to receive TCA may receive transitional child care (TCC) for up to two years after the termination of their TCA grant.

The TCA recipient can be referred for TCC by their eligibility specialist at the Department of Children and Families (DCF) or their local Regional Workforce Board (RWB).

If the TCA recipient requests TCC, the eligibility specialist will complete the Child Care Application and Authorization form (AWI 5002). The recipient's statement of new or increased earnings that make them ineligible for TCA is acceptable to close the case and make the TCC referral.

The Regional Workforce Board will complete TCC referrals and forward them to the 4-C agency for applicants of up-front diversion.

The eligibility specialist or the Regional Workforce Board designee will authorize care up to 24 months after the recipient has stopped receiving TCA. The assistance group may apply for TCC at any point during the 24 month period after leaving TCA.

The individual is not eligible for TCC if their income exceeds 200 percent of the federal poverty level at any time during the two-year period following closure of TCA. The 4-C agency will make this determination. The recipient will be required to pay a portion of the child care based on a sliding fee scale (this is computed by the community child care coordinating 4-C agency). If the family's income exceeds 200% of the federal poverty level, the assistance group is not eligible for subsidized child care.

2020.0306 Transitional Child Care Cooperation with Child Support Enforcement (TCA)

Child Support Enforcement (CSE) cooperation is not required for a transitional child care (TCC) individual. However, an individual is not eligible for TCC if their Temporary Cash Assistance case was closed due to a CSE sanction. Prior to receiving TCC, the individual must first cure the CSE sanction and meet TCC eligibility criteria as stated in 2020.0305.

2020.0307 Basic Eligibility Requirements for Transitional Child Care (TCA)

Following are the conditions of eligibility for TCC benefits:

1. The recipient must need child care in order to retain employment. The child for whom TCC is provided must be under age 13.

   Note: Homes where another adult, other than a parent, is present in the home, have no affect on the referral for child care. If another parent is in the home, the need for care must be explored prior to authorization.

2. To be eligible for TCC the family's income cannot exceed 200% of the federal poverty level.

3. The child for whom the transitional care is provided must be dependent and within the specified degree of relationship. This includes a child who would be an assistance group

member except for the receipt of Supplemental Security Income (SSI), a fully capped child, or a child excluded due to immunization penalties.

4. A Temporary Cash Assistance (TCA) recipient receiving benefits through a protective payee for children under age 16 due to noncompliance (second or subsequent sanction) with the Regional Workforce Board may receive TCC if the assistance group loses TCA because of earnings or receipt of or an increase of child support. The children for whom TCC is requested must be under the age of 13.

2020.0309 Eligibility Period for Transitional Child Care (TCA)

Eligibility for Transitional Child Care (TCC) begins with the first month after a participant has stopped receiving Temporary Cash Assistance (TCA), and continues for up to 24 consecutive months.

An assistance group loses eligibility for TCC when the individual is no longer employed or is receiving TCA.

A new TCC eligibility period may be established when the individual again becomes TCA eligible and becomes employed. When establishing TCC eligibility after a break in assistance, the eligibility should be based on what is most beneficial to the assistance group.

Note: An up-front diversion payment to current recipients of TCC should not interrupt service delivery or the existing time frame for TCC.

2020.0400 RELATIVE CAREGIVER PROGRAM (TCA)

The Relative Caregiver Program provides payments for certain children placed with relatives by the Department or a contracted agency as an alternative to foster care. Eligibility factors are consistent with TCA **but must include the following**:

1. Child Welfare Communications Form. The eligibility specialist initiates the relative caregiver eligibility determination upon receipt of the Child Welfare Communication Form from the child welfare professional.

2. Persons wishing to apply for the Relative Caregiver payments may do so with or without a referral from Office Child Welfare. The eligibility specialist must inform all relatives caring for children who are placed with them by a court about the Relative Caregiver Program and give all persons caring for children who are relatives a Relative Caregiver Program Request for Eligibility Consideration Form.

3. If the request for Relative Caregiver payments is a self referral, it can be done using the paper application, through the web application or by the Relative Caregiver Request for Eligibility Consideration Form. In these situations, the eligibility specialist initiates the Child Welfare Communication Form.

Note: A child cannot receive Relative Caregiver payment during the same month as a Guardianship Assistance Program or foster care payments.

2020.0401 Relative Caregiver Payment Standards (TCA)

Payments vary depending on the child's age and the child's own income and may be adjusted periodically to reflect changing circumstances.

Each child's eligibility is determined separately. The payment standard applied is based upon the child's age as follows:

$242 for children age zero through five
$249 for children age six through 12
$298 for children age 13 to 18

2020.0402 Eligibility Requirements for Relative Caregiver Program (TCA)

In order for the child to be eligible for a relative caregiver payment, the child must:

1. reside in the State of Florida;
2. be under 18 years old and adjudicated dependent by the court and either be placed in the relative's legal custody by a Florida court, or placed in the relative's home by Florida court under protective supervision by the Department;
3. live in an approved home based on a home study completed by a representative of the Family Safety Program;
4. meet specified technical and financial requirements;
5. not be included in a TCA benefit;
6. reside with a relative who is within the fifth degree of relationship by blood or marriage to the parent or stepparent of the child for whom assistance is being requested;

   Exception: Children unrelated to their caregiver who are in the same placement with their half-sibling, who is related to the caregiver are eligible for the relative caregiver payment if the:

   1. non-related half-sibling meets all eligibility factors for the Relative Caregiver Program.
   2. related half-sibling in the home is under age 18 and continues to meet the placement criteria for the Relative Caregiver Program. It is not necessary for the related half-sibling to meet the technical or financial requirements of the TCA Program or to actually receive a Relative Caregiver payment in order for the non-related half-sibling to qualify for a Relative Caregiver payment.

7. not reside in the same home with their parent(s). If the parent is in the home 30 consecutive days or longer the relative caregiver payment must be terminated.

   Exception: A relative may receive a Relative Caregiver payment for both the teen parent and their minor child when both have been adjudicated dependent by a court and placed in the home of a relative.

A child placed with relatives in Florida by an out-of-state court is not eligible for a relative caregiver payment.

2030.0000 Family-Related Medicaid

Family-Related Medicaid has several coverage groups, which will be discussed in detail in this chapter.

2030.0100 FAMILY-RELATED MEDICAID (MFAM)

A coverage group is selected based on the individual for whom assistance is requested and individuals in the filing group.

2030.0200 COVERAGE GROUPS (MFAM)

The following are the Medicaid coverage groups:

1. Parents and other caretaker relatives
2. Pregnant women
3. Infants and children under age 19
4. Children Ages 19-21
5. Emergency Medical Assistance to Noncitizens
6. Former Foster Care Children

2030.0201 Parents and Other Caretaker Relatives (MFAM)

Parents (including step-parents), caretaker relatives, and their spouses living together may receive Medicaid coverage when household income is equal to or below the appropriate income limit.

2030.0202 Extended Medicaid (MFAM)

Medicaid must be extended for up to four months if the conditions below are met:

1. The parents and other caretaker relatives and their dependent children become ineligible for Medicaid due solely or in part to the receipt of, or increase in, spousal support for an individual whose needs are included in the assistance group.

2. The parents and other caretaker relatives assistance group was eligible for and received Medicaid as a parent or other caretaker relative in at least three of the six months preceding the month of ineligibility. The three months can include months in which Medicaid was received in another state.

3. Only those members included in the benefit computation for the month prior to cancellation are entitled to extended Medicaid.

2030.0203 Transitional Coverage (MFAM)

Transitional coverage provides extended coverage for up to 12 months, beginning with the month of ineligibility. Changes during this period, other than the child turning 18 or loss of state residence, do not affect the transitional Medicaid period. An ex parte determination must be completed prior to cancellation at the end of the transitional period.

Conditions that must be met:

1. The assistance group must be ineligible for Medicaid based on initial receipt of earned income or receipt of increased earned income by the parent or caretaker relative. The initial income budgeted for the assistance group must have been below the parent/other caretaker relative income limit (MA R- previously referred to as 1931 Medicaid). If more than one

budget change is being acted on at the same time, a test budget(s) will be necessary to determine if the change in earned income is the sole cause of ineligibility.

2. At least one assistance group in the household was eligible for and received Medicaid with income below the parent/other caretaker relative income limit (MA R- previously referred to as 1931 Medicaid) in at least three of the preceding six months. The three months can include a month in which Medicaid was received in another state, or a retroactive month. All assistance groups (except individuals previously requesting not to receive Medicaid and children ages 18 to 21) in which the parent or other caretaker relative with new or increased earned income is a counted or eligible member are eligible for transitional coverage, provided all requirements are met.

Note: It is not necessary to change a child's coverage group to Transitional Medicaid if they remain eligible for Medicaid as a child. If the initial receipt or increase in earned income does not cause ineligibility for other SFU members, do not change those individuals' Medicaid coverage.

Example: A parent reports increased income over the Parent and Other Caretaker Relative income limit (19% federal poverty level(FPL)), but the increased earned income does not go over the income limit for Children Under Age 19 (133% FPL).

2030.0204 Verification of Initial Earnings (MFAM)

Information regarding the date of initial receipt of earnings or the increased earnings must be obtained in order to establish the 12-month period. The recipient's statement of earnings and the begin date is acceptable.

2030.0600 PRESUMPTIVE ELIGIBILITY COVERAGE (MFAM)

Presumptive eligibility is a determination of eligibility made by a Qualified Hospital (QH) based on the applicant's verbal statements about the SFU's income. The income must be equal to or below the income limit. Citizenship status is not a factor of eligibility for this coverage group.

The following are presumptive eligibility coverage groups:

1. Parents and other caretaker relatives
2. Pregnant women
3. Infants and children under age 19
4. Former Foster Care Children

This is temporary coverage that begins with the date the presumptive eligibility determination is completed by the Qualified Hospital (QH) and ends on the date of the Medicaid determination if an application for regular Medicaid is filed by the last day of the month after the presumptive eligibility determination. If an application for regular Medicaid is not filed by then, presumptive eligibility ends on the last day of the month after the presumptive eligibility determination. Only one presumptive period per 12 months is allowed. For the individual to receive coverage beyond the presumptive period, a regular Medicaid application is necessary and the QH is expected to assist with this application process.

2030.0700 PREGNANT WOMEN (MFAM)

Medical assistance for the pregnant woman will be under one coverage group. The coverage group under which the pregnant woman receives benefits is determined by the household composition and income.

The following are coverage groups for pregnant women who:

1. have household income at or below the applicable income standard (no asset test),

2. are Medically Needy,
3. are presumptively eligible.

A pregnant woman who is eligible for regular Medicaid for at least one month, including a retroactive month, is eligible to receive Medicaid through her pregnancy and until the end of the 12th month after the birth (postpartum period), regardless of any changes except for Presumptive Eligibility for Pregnant Women and Emergency Medical Assistance for Noncitizens.

2030.0702 Pregnancy Verification (MFAM)

Self attestation of pregnancy, the anticipated due date, and the number of unborns is acceptable.

2030.0704 Presumptively Eligible Pregnant Women (MFAM)

Presumptive eligibility is a determination of eligibility made by a designated provider based on the applicant's verbal statements about the SFU's income. The income must be equal to or below the income limit. Citizenship status is not a factor of eligibility for this coverage group.

This is temporary coverage that begins with the date the presumptive eligibility determination is completed by the Qualified Designated Provider (QDP) and ends on the date of the Medicaid determination if an application for full Medicaid is filed by the last day of the month after the presumptive eligibility determination. If an application for full Medicaid is not filed by then, presumptive eligibility ends on the last day of the month after the presumptive eligibility determination. Only one presumptive period per pregnancy is allowed and these benefits cover only ambulatory prenatal services. It does not cover inpatient hospital services or delivery. For the pregnant woman to get coverage beyond the presumptive period, a full Medicaid application is necessary and the QDP is expected to assist with this application process.

2030.0800 RETROACTIVE MEDICAID (MFAM)

The following passages covers the Retroactive Medicaid requirements and the date of entitlement for Retroactive Medicaid.

2030.0812.01 Retroactive Medicaid (MFAM)

Medicaid maybe authorized for up to three months prior to the date of application for children under age 21 and pregnant women, including their postpartum period.

2030.0812.02 Requirements for Retroactive Coverage (MFAM)

The following requirements must be met in order to be eligible for retroactive Medicaid coverage, for children under age 21 and pregnant women, including their postpartum period:

1. A request for retroactive Medicaid can be made by the individual or for a deceased individual by a designated representative or caretaker relative, by filing a medical assistance application.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that there were unpaid medical bills for any of the three months will be accepted. The individual is not required to verify that the bills exist or the services will be covered by Medicaid.
3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the type of coverage for which the individual applied.
4. A determination of eligibility must be made for each of the month(s) in the period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual's income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to

the agency suggests the individual's circumstance may have changed in the retroactive period.

2030.0812.03 Date of Entitlement for Retroactive Medicaid (MFAM)

The period of entitlement for each retroactive month is the calendar month for which eligibility is established; that is, if the individual is determined to be eligible for any day in a month, he is eligible for the full calendar month, except for Medically Needy. Medicaid eligibility in the Medically Needy Program is determined by the day the individual meets their share of cost.

2030.0900 CHILDREN'S COVERAGE GROUPS (MFAM)

The following sections describe coverage groups available for children up to age 21.
A child is Medicaid eligible for the entire month of their birthday, unless the child was born on the first day of the month, in which case eligibility for Medicaid terminates on the first day of the child's birth month.

Exception: If the child is hospitalized the day Medicaid coverage is scheduled to end and the child has not yet exhausted all inpatient days, the child will remain eligible through the month of discharge from the hospital. If doctor visits occur after the hospitalization has ended as part of the follow up, additional months of Medicaid coverage may need to be authorized.

2030.0901 Infants Under Age One (MFAM)

A newborn is presumed eligible for Medicaid through the birth month of the following year when born to a mother eligible for Medicaid on the date of the child's birth, including a mother on Emergency Medical Assistance for Noncitizens. The child remains eligible for Presumptively Eligible Newborn (PEN) coverage as long as the child remains a resident of Florida or until the child's death. If the child was born on the first of the month, PEN eligibility ceases effective the birth month. All newborns are considered to be living with the mother the month of birth.

Eligibility for PEN does not apply to a child born to a parent receiving Presumptively Eligible Pregnant Woman (PEPW) coverage only. If a PEPW woman is later determined eligible for regular Medicaid for the month of delivery, the child will be PEN eligible.

If the mother is Medically Needy and meets her share of cost on or before the date of birth, the child is eligible for presumptive coverage.

Notification of birth may be received from the Medicaid provider or from the parent(s). All PENs must be added to Medicaid within five days of notification of their birth. No application or face-to-face interview is required for PEN coverage.

A Medicaid notice of case action must be sent with the newborn's Medicaid number to the parent stating the following information: "Medicaid is being authorized for up to one year from the date of the child's birth". This will serve as the 10-day advance notice unless the case is canceled prior to the end of one year.

No verification of U.S. citizenship or identity will be needed for these children, even after the presumptive period ends.

2030.0902 Children Under Age 19 (MFAM)

When a child who meets the technical criteria for residency, age, identity and citizenship/noncitizen and the tax household's income is at or below the income limit for the coverage group, the child is eligible for Medicaid. If the income is higher than the income limit, the child may be enrolled in Medically Needy and/or referred to the Children's Health Insurance Program (CHIP) or the Federally Facilitated Marketplace (FFM).

2030.0903 Children Age 19 to 21 (MFAM)

When a child age 19 to 21 who meets the technical criteria for residency, age, identity and citizenship/noncitizen and the tax household's income is at or below the same income limit as parents and caretakers, the child is eligible for Medicaid. If the income is higher than the income limit, the child may be enrolled in Medically Needy and/or obtain coverage through the FFM.

2030.1100 EMA TO INELIGIBLE NONCITIZENS (MFAM)

To be eligible for Emergency Medical Assistance for Noncitizens (EMA) benefits, the noncitizen must meet all technical (including residency) and financial requirements for a Medicaid coverage group, except: citizenship, child support enforcement cooperation, Social Security number requirement and the requirement to apply for Social Security benefits.

2030.1100.01 Coverage of Emergency Only (MFAM)

Medicaid benefits will only be authorized to cover the emergency medical situation. An emergency medical condition is a medical condition of sufficient severity (including severe pain) that could result in placing the individual's health in serious jeopardy. This includes emergency labor and delivery. Accept the medical provider's statement regarding the emergency and date(s) of service.

A medical provider or Utilization Review Committee (URC) will determine if an emergency medical condition exists. The URC is a group affiliated with a hospital which determines an individual's need for emergency treatment. The provider or URC will also determine the length of time the emergency situation is expected to exist.

An applicant may receive retroactive Medicaid and posthumous Medicaid for a deceased individual under the EMA coverage group if eligible.

2030.1100.02 Exceptions to Medicaid Policy and Procedures (MFAM)

The following Medicaid exceptions to policy and procedures apply to Emergency Medical Assistance for Noncitizens:

1. An ex parte determination is not required.
2. Dates of eligibility will be for the time period of the emergency only.
3. There is no postpartum coverage for pregnant women.
4. Ten days advance notice of termination is not required.
5. There is no requirement to apply for Social Security benefits.

2030.1200 FORMER FOSTER CARE CHILDREN (MFAM)

Individuals may receive Medicaid up to age 26 if they were in foster care and receiving Medicaid when they aged out of foster care in Florida. There is no income limit for eligibility.

To be eligible, an individual must:

1. Be under age 26,
2. Be enrolled in or received Medicaid when they aged out of Florida's Foster Care Program at age 18 (or 21 as appropriate), and
3. Not otherwise eligible for or enrolled in mandatory Medicaid coverage.

Note: A child aging out of adoption subsidy cash payment at 18 or 21 does not meet the criteria as a child who aged out of Foster Care. Do not evaluate for Former Foster Care coverage but complete an ex-parte review for potential eligibility under other coverage group.

2030.1400 MEDICALLY NEEDY COVERAGE (MFAM)

The Medically Needy Program is for individuals who meet the technical requirements of one of the above coverage groups but whose income exceeds the income limit. If the household's income is greater than the income limit, the exceeding amount is determined as the share of cost. The individual is enrolled but is not eligible until the share of cost is met. Medically Needy provides month-to-month coverage when individuals have incurred medical bills that meet their share of cost.

2040.0000 SSI-Related Medicaid, State Funded Programs

If financial and technical requirements have been met, the assistance group may be eligible for the coverage groups described in this section.

Additionally, this section provides the category codes for each coverage group used in FLORIDA.

2040.0100 CATEGORY CODES (MSSI)

The following section details the category codes for FLORIDA.

Please note that the following programs are not part of FLORIDA:

1. State Funded Assistance Programs,
2. Optional State Supplementation,
3. Personal Needs Allowance Supplement, and
4. Home Care for the Disabled Adult.

2040.0107 SSI-Related Medicaid Category Codes (MSSI)

1. MS = SSI Medicaid for SSI direct assistance recipients
2. Protected SSI Medicaid
   a. MT-C = Regular COLA
   b. MT-W = Widows II
   c. MT-D = Disabled Adult Children
3. MM-S = MEDS for aged or disabled
4. ML-S or NL-S for Medically Needy = Emergency Medical Assistance for Noncitizens
5. NS = SSI-Related Medically Needy
6. Institutional Care Program (ICP)
   a. MI-S = SSI eligible
   b. MI-I = Regular
   c. MI-T = Transfer of Assets
   d. MI-M = MEDS
7. Hospice Services
   a. MH-S = SSI eligible
   b. MH-H = Regular
   c. MH-M = MEDS
8. Home and Community Based Services (HCBS)
   a. MW-A = All HCBS waivers
   b. For PACE individuals in the community, the category will be MWA. If the PACE individual is placed in a nursing home, the code will change to the appropriate ICP code.
9. Medicare Savings Programs
   a. QMB = Qualified Medicare Beneficiaries (QMB)
   b. WD = Working Disabled
   c. SLMB = Special Low Income Medicare Beneficiary (SLMB)
   d. QI-1 = Qualifying Individual 1 (QI-1)

2040.0800 SSI-RELATED MEDICAID COVERAGE GROUPS (MSSI)

1. Aged, Blind and/or Disabled Medicaid for SSI eligible individuals (could be ICP, Hospice or HCBS);
2. Protected SSI Medicaid, including Regular COLA Protected Medicaid and Disabled Adult Child Protected Medicaid;
3. SSI-Related MEDS for Aged or Disabled (Medicaid Expansion designated by SOBRA - Aged or Disabled);
4. Emergency Medical Assistance for Noncitizens, from an SSI-Related Medicaid category;
5. Medically Needy from an SSI-Related Medicaid category;
6. SSI Eligible ICP (includes Hospice);
7. SSI-EEI ICP (includes Hospice);
8. SSI-Related ICP except for transfer of assets (not eligible for ICP due solely to transfer of assets, cannot receive vendor payments for institutional services, but is eligible for all other services);
9. SSI MEDS ICP for Aged and Disabled;
10. SSI Medically Needy in a Long-Term Care Facility;
11. Hospice Services Medicaid, including SSI Eligible Hospice Services, SSI-EEI Hospice Services, SSI MEDS Hospice Services for Aged and Disabled, and SSI Medically Needy Hospice Services;
12. Home and Community Based Services (HCBS) Medicaid waivers, including, Model Waiver, Familiar Dysautonomia, Individual budget (iBudget) program; and Statewide Medicaid Managed Care - Long Term Care Programs;
13. Qualified Medicare Beneficiaries Medicaid for all categorical Medicaid where the individual is Part A Medicare eligible;
14. Special Low Income Medicare Beneficiary Medicaid;
15. Qualified Individuals 1;
16. Working Disabled entitled to payment of Part A Medicare premium only (cannot receive other coverage);
17. Retroactive Medicaid;
18. Posthumous Medicaid;
19. Breast and Cervical Cancer Treatment;
20. Program of All-Inclusive Care for the Elderly (PACE) and
21. Modified Project Aids Care (MPAC).

2040.0801.01 Supplementary Security Income Coverage Group (MSSI)

Any Florida resident who has been determined eligible for SSI benefits is automatically entitled to Florida Medicaid. However, the individual must meet additional Title XIX requirements in order to be entitled to the Medicaid benefit of institutional care. SSI is a Direct Assistance Program administered by the Social Security Administration (SSA) under Title XVI of the Social Security Act. The State of Florida elected to accept the determination of SSI eligibility, made by SSA, as determination of Medicaid eligibility.

The individual must reside in Florida and be entitled to SSI benefits.

2040.0801.02 Identification by SSA of SSI-DA (MSSI)

SSA identifies to the state those individuals who are SSI eligible and residing in Florida by means of the State Data Exchange (SDX). The individual's name in SDX constitutes verification of SSI eligibility.

2040.0801.03 Entitlement Due to Receipt of SSI (MSSI)

Some SSI eligible individuals also receive other types of benefits such as optional state supplementation, institutional care, home care for the elderly, and Hospice. When an individual is

eligible for SSI, Medicaid entitlement always results from SSI entitlement (verified through the SDX system), rather than from entitlement under the other program.

There are situations in which an individual receives Medicaid due to SSI eligibility but is not entitled to an SSI check. These individuals are eligible for Medicaid and are identified as if they were an SSI eligible individual on SDX. An example of this type of individual is someone who participates in SSA's Work Incentive Program known as 1619(b), which allows SSI beneficiaries to keep their Medicaid coverage when their earnings, along with other income, become too high for an SSI cash payment. Although these persons do not receive an SSI cash payment, they retain their SSI recipient status, which allows them to retain their rights to Medicaid eligibility.

In the following situations, the special emergency Medicaid certification procedure must be used to issue SSI-DA individuals Medicaid assistance:

1. When the individual is receiving SSI-DA but is not on the FMMIS, some reasons this would occur include: delay or error on FMMIS or SDX, or individual is new to the state.

2. When the individual has not received or does not have his Medicaid card, some reasons for this are: delay or error on FMMIS or SDX, individual has moved and the FMMIS has not been updated by the SDX, or individual lost or destroyed his Medicaid card.

The emergency Medicaid procedures for SSI-DA recipients are in the desk guide.

2040.0801.04 Date of Entitlement for SSI Individuals (MSSI)

The initial date of entitlement for Medicaid benefits is the first day of the month for which the individual's application for SSI benefits is approved.

An exception to this occurs when an individual who is receiving SSI benefits moves to Florida. The date of entitlement for Medicaid benefits is the first day of the month in which the individual moved to the state even though the individual does not yet appear on the Medicaid Eligibility file.

2040.0801.05 Institutional Care SSI Eligible Except for Income (MSSI)

Any Florida resident who has been determined eligible for "SSI Eligible Except for Income" is entitled to Florida Medicaid. Any Florida resident who would be eligible for SSI in the institution except for the amount of their income and who meets all additional eligibility criteria under the Institutional Care Program is also entitled to full Medicaid benefits.

The initial date of entitlement for ICP Medicaid benefits is the first day of the month in which the individual files an application, provided the individual meets all factors of eligibility for that month, including placement in a Title XIX facility.

2040.0802.01 Protected Medicaid (MSSI)

Protected Medicaid is a categorical Medicaid coverage group that is extended to certain eligible individuals. There are five Protected Medicaid coverage groups.

Passages 2040.0802.02 through 2040.0802.05 give the technical criteria for Protected Medicaid eligibility.

Passages 2040.0804.01 through 2040.0809 describe Protected Medicaid coverage groups and give the special eligibility criteria for each group.

2040.0802.02 Aged Criteria for Protected Medicaid (MSSI)

Eligibility due to aged criteria must be verified. The individual must be age 65 or older. Acceptable verification of age would include verification that the individual received SSI or is

receiving SSA as an aged individual. Refer to Chapter 1400 for additional information concerning other types of evidence that can be used to establish eligibility on this factor.

2040.0802.03 Disability/Blindness Requirement for Protected MA (MSSI)

Eligibility due to disability or blindness must be verified. The individual must be disabled or blind in accordance with the SSI disability or blindness criteria. If the individual is receiving SSA disability benefits, verification that the individual's disability has been established as a condition for continued receipt of SSA benefits is sufficient to establish eligibility on the factor of disability/blindness.

If the individual's receipt of SSA benefits is not based on disability, a disability or blindness determination must be obtained from the Division of Disability Determinations at the time of application.

2040.0802.04 Citizenship Requirement for Protected Medicaid (MSSI)

Eligibility on this factor is established by previous receipt of SSI, unless there is reason to question the individual's current status.

2040.0802.05 Residence (MSSI)

The individual must meet the U.S. and Florida residence criteria.

2040.0802.06 Assets (MSSI)

The individual must not have countable assets that exceed the currently prescribed maximum assets limit for SSI. The policy in Chapter 1600 of this manual is to be used in determining eligibility on this factor.

2040.0802.07 Income (MSSI)

The individual's countable income, after disregard of SSA cost of living adjustments received since the individual was last eligible for (and received concurrently) SSA and SSI benefits, must not exceed the current SSI FBR. The policy in Chapters 1800 and 2400 is to be used in determining what income is and how it is counted.

2040.0802.08 Disregard of COLAs (MSSI)

The COLAs of the individual, the financially responsible family members (spouse or parent), and any other family member whose income is used in determining the individual's eligibility must be disregarded.

2040.0802.09 Disregard of the Title II COLAs (MSSI)

The following applies to the disregard of COLAs:

Step 1 - The eligibility specialist must establish the last date (month and year) in which the individual received and was eligible for both SSA and SSI benefits.

Step 2 - Using the table in Appendix A-11, the eligibility specialist must determine the date of the first COLA received following the date established in step 1.

Step 3 - The eligibility specialist must multiply the current SSA amount for the individual and appropriate family members by the conversion factor associated with the date obtained in step 2. This computation will determine the SSA benefit amount without the COLAs, that is, the SSA benefit amount to be used in the budget.

2040.0802.10 Budgeting (MSSI)

Determine gross monthly income per the policy in Chapters 1800 and 2400, applying the applicable income deductions and exclusions.

Measure the countable income against the current SSI FBR. If the countable income does not exceed the current SSI FBR, the individual is eligible for Medicaid under the Protected Medicaid provision.

2040.0803 Ex Parte to Medically Needy (MSSI)

Cases that meet the Protected Medicaid or MEDS-AD criteria but have too much income must be considered under the Medically Needy Program. COLAs are not disregarded in the MEDS-AD or Medically Needy income determination.

2040.0804.01 Regular COLA Protected Medicaid (MSSI)

To be eligible for this Regular COLA Protected Medicaid, the individual must meet all the SSI criteria, with the exception that the Title II COLAs will be disregarded in determining eligibility on the factor of income.

The individual must also meet the following special requirements:

1. is currently receiving Title II (Social Security benefit);
2. was concurrently receiving Title II benefits and SSI benefits in any month subsequent to April 1977;
3. lost SSI eligibility for any reason; and
4. would now be eligible for SSI if the Title II COLAs, which they received after they were last eligible for (and received) SSI and Title II benefits concurrently, were deducted from their countable income.

2040.0804.02 Effective Date of Coverage (MSSI)

The individual must have concurrently received Title II and SSI benefits in any month subsequent to April 1977. The first month of entitlement cannot be previous to April 1977.

An individual may apply for up to three months retroactive Medicaid based on the month of application under this coverage group.

2040.0805.01 Protected Medicaid for Disabled Widows(ers) I (MSSI)

Individuals who make application for Medicaid prior to July 1, 1987, may be eligible for Protected Medicaid for Widow(er)s if the individual:

1. was entitled to a monthly insurance benefit under Title II of the Social Security Act of December 1983;
2. was entitled to and received a widow's or widower's benefit based on a disability under the Social Security Act of January 1984;
3. because of the increase in the amount of widow's or widower's benefit which resulted from the elimination of the reduction factor for disabled widows and widowers entitled before age 60, became ineligible for SSI in the first month in which that increase was paid (and in which a retroactive payment of that increase for prior months was not made); or
4. has been continuously entitled to a widow's or widower's benefit from the first month that increase in the widow's or widower's benefits were disregarded.

2040.0805.02 Written Application Necessary for Widows(ers) I (MSSI)

Individuals who are eligible under this coverage group must have filed a written application for Medicaid before July 1, 1987.

If an individual did not file a written application before July 1, 1987, the individual cannot be eligible under the coverage group.

2040.0805.03 Effective Date of Coverage for Widows(ers) I (MSSI)

Eligibility for categorical Medicaid under this coverage group is effective no earlier than July 1, 1986.

An individual may apply for up to three months retroactive Medicaid based on the month of application under this coverage group.

2040.0805.04 Processing Application for Disabled Widows(ers) I (MSSI)

Upon receipt of an application for Medicaid under this coverage group, an eligibility determination must be completed based on the criteria in passage 2040.0806.01. Eligibility determinations must be made for individuals who apply and are not currently eligible under Medicaid, as Medically Needy (Family-Related or SSI-Related), or under one of the Optional Categorically Needy Programs.

2040.0806.01 Individuals Who Lost SSI Due to Widows(ers) II (MSSI)

Individuals who make application for Protected Medicaid - Widows(ers) II may be eligible if the individual:

1. is receiving or received SSI prior to age 60 and is (or was) mandated to file for widow's or widower's benefits under Title II;
2. lost SSI benefits due to the receipt of widow(er)'s benefits; and
3. is not entitled to Medicare, Part A.

2040.0806.02 Date of Entitlement for Widows(ers) II (MSSI)

Eligibility for categorical Medicaid under Widows(ers) II coverage group is effective no earlier than July 1, 1988.

Eligibility for Widows(ers) II Protected Medicaid terminates when the individual becomes entitled to Medicare, Part A.

2040.0807.01 Protected Medicaid for Disabled Widows(ers) III (MSSI)

OBRA '90 changed the disability test criteria requirements for disabled widows(ers) and disabled surviving divorced spouses.

Effective January 1, 1991, if an individual in this group loses their SSI benefits because of receipt of Title II benefits, they would remain eligible for categorical Medicaid if they:

1. were receiving SSI for the month prior to the month they began receiving Title II benefits;
2. would continue to be eligible for SSI if the amount of the Title II benefits were not counted as income; and
3. are not entitled to Medicare, Part A.

2040.0807.02 Date of Entitlement for Widows(ers) III (MSSI)

Eligibility for categorical Medicaid under Widows(ers) III Protected Medicaid coverage group is effective no earlier than January 1, 1991. Eligibility under this coverage group terminates when the individual becomes entitled to Medicare, Part A.

2040.0808 Protected Medicaid for Disabled Adult Children (MSSI)

Effective July 1, 1987, disabled adult children who lose their SSI benefits because of an increase in or receipt of Social Security disability benefits under one of their parent's work records, may continue to be eligible for Medicaid if: the disabled adult child meets all SSI criteria except for

income; and has income equal to or below the SSI FBR when, beginning July 1, 1987, any increase in SSA benefits or receipt of SSA benefits is subtracted from other income.

2040.0809 Protected Medicaid for SSI Children (MSSI)

Children who were eligible for Supplemental Security Income (SSI) direct assistance on 8/22/96, but who became ineligible based solely upon a change in the definition of "childhood disability", continue to be Medicaid eligible until their 18th birthday, as long as they continue to meet the definition of disability in effect prior to 8/22/96, and all other SSI eligibility factors.

To be eligible for continued Medicaid benefits under this category, a child must meet all of the following eligibility criteria:

1. must have received SSI cash benefits on 8/22/96;
2. have been found ineligible for SSI on or after 7/1/97, based solely upon a change in the definition of "childhood disability";
3. must be under age 18;
4. must be a U.S. citizen or have an acceptable qualified noncitizen status;
5. cannot have assets which exceed $2,000;
6. cannot have income which exceeds the current SSI federal benefit rate (see Appendix A-9); and
7. must apply for all other benefits for which the child may qualify (excluding SSI).

Periodic eligibility reviews must be conducted by the Division of Disability Determinations to ensure the child continues to meet the disability criteria in effect prior to 8/22/96.

The parents' assets and income must be deemed to the child if the child and parents live together. Refer to Chapter 2600 for parent to child deeming policies.

Children who become ineligible for Protected Medicaid for Disabled Children due to factors other than disability may become eligible for Protected Medicaid in the future if the child would be SSI eligible except for the new definition of "childhood disability". Eligibility for Protected Medicaid for Disabled Children should be evaluated at reapplication.

Children whose SSI benefits are terminated for reasons other than the new definition of "childhood disability" do not qualify for Protected Medicaid for Disabled Children coverage. In addition, these children may not be ex parted into other programs that require the child to be disabled. A determination of disability using the criteria in effect prior to 8/22/96, does not meet the definition of disability for any program other than the Protected Medicaid for Disabled Children coverage group.

Many of these children receive assistance as part of a Temporary Cash Assistance household. To maintain their Protected Medicaid coverage, the child must be entered on FLORIDA under the MTA code according to special workaround instructions, regardless of other Medicaid coverage that may be passing on FLORIDA.

2040.0810.01 Emergency Medicaid for Noncitizens (MSSI)

Noncitizens with an emergency medical condition who meet all technical (except citizenship and welfare enumeration) and financial requirements for Medicaid may be eligible for Medicaid.

To qualify for this coverage group, the ineligible noncitizen must qualify for SSI-Related categorical or Medically Needy Medicaid except for their noncitizen status.

2040.0810.02 Limited Coverage for Emergency Medicaid for Noncitizens (MSSI)

Medicaid benefits will be provided to cover the emergency situation only. Medicaid payments will not be authorized to cover medical bills unrelated to the emergency.

2040.0810.03 Definition of a Noncitizen (MSSI)

A noncitizen for this coverage group is any unnaturalized foreign resident of the U.S., noncitizen awaiting assignment of official USCIS status, and noncitizen without legal status.

2040.0810.04 Emergency Medical Condition (MSSI)

A medical condition of sufficient severity (including severe pain) must exist such that, without immediate medical attention, it could result in placing the individual's health in serious jeopardy. This includes emergency labor and delivery.

2040.0810.05 Technical Criteria for EMA (MSSI)

The following technical criteria apply to this coverage group:

1. The noncitizen is not required to be lawfully admitted for permanent residence or permanently residing in the U.S. under color of law.
2. The noncitizen is not required to meet the enumeration requirements.
3. The noncitizen must be aged, blind, or disabled as defined by SSI.
4. The noncitizen must assign to the state the right to any payments for medical care and cooperate with the state in obtaining such third party payments.
5. The noncitizen must be a Florida resident.
6. The noncitizen is not required to file for Social Security benefits.

2040.0810.06 Financial Criteria - EMA (MSSI)

The noncitizen must meet the financial requirements for the SSI-Related Medicaid or SSI Medically Needy Programs. Refer to Chapter 2400 for the income levels for these two groups.

2040.0810.07 Administrative Policy for EMA (MSSI)

The medical provider (generally a hospital) will initiate the referral process. The referral source will attach the necessary documentation for establishing the emergency and the time period of the emergency. If possible, a signed and dated application will also be attached.

If self-referred, the application must be pended until documentation of the emergency medical services can be obtained. If this is not provided, the application must be rejected.

If the time period of the emergency was originally over or under the estimated time, then the referral source must submit additional documentation to adjust the period.

Upon approval, a Medicaid Notice of Case Action must be provided to the applicant.

The administrative policies of the SSI-Related Medicaid Program will apply to this coverage group except as specified below.

1. An ex parte determination is not required for individuals in this program.
2. The ten days advance notice of termination is not required in this program.
3. Dates of entitlement will be for the time period of the emergency only.

2040.0812.01 Retroactive Medicaid (MSSI)

Medicaid may be authorized for up to three months prior to the date of application for children under age 21 and pregnant women, including their postpartum period when the requirements are met.

2040.0812.02 Requirements for Retroactive Coverage (MSSI)

The following requirements must be met in order to be eligible for retroactive Medicaid coverage, for children under age 21 and pregnant women, including their postpartum period:

1. A request for retroactive Medicaid can be made by the individual or for a deceased individual by a designated representative or caretaker relative, by filing a medical assistance application.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that he has unpaid medical bills for any of the three months will be accepted; the individual is not required to verify that the bills exist or that the services will be covered by Medicaid.
3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the type of coverage requested by the individual on the application.
4. A determination of eligibility must be made for each of the month(s) in the period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual's income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to the agency suggests the individual's circumstance may have changed in the retroactive period.

All SSI-Related noninstitutionalized applications for retroactive Medicaid due to a disability must have the disability determined by the Division of Disability Determinations (DDD).

For disability cases, the eligibility specialist should call DDD for a Title II diary date and onset date prior to completing the disability forms. If the retroactive Medicaid date is covered by the Title II onset date, then DDD will adopt the decision and completion of the disability forms will not be necessary. (Also see Chapter 1400, Blindness/Disability Determinations.)

All SSI-Related institutionalized applications for retroactive Medicaid (i.e., ICP and HCBS) due to a disability must have the disability determined by the District Medical Review Team (DMRT).

Note: There is no retroactive Medicaid coverage for QMB. For the State Funded Programs (SFP), there is no retroactive coverage. This includes OSS and HCDA.

2040.0812.03 Date of Entitlement for Retroactive Medicaid (MSSI)

The period of entitlement for each retroactive month is the calendar month for which eligibility is established; that is, if the individual is determined to be eligible for any day in a month, he is eligible for the full calendar month, except for Medically Needy. Medicaid eligibility in the Medically Needy Program is determined by the day the individual meets their share of cost.

2040.0813.01 Medicaid Designated by SOBRA - MEDS-AD (MSSI)

Individuals who are aged and/or disabled may be eligible to receive Medicaid coverage if they meet the SSI technical requirements and have income at or below 88 percent of the poverty level.

2040.0813.02 Financial Requirements for MEDS-AD (MSSI)

Any aged or disabled individual may be eligible for Medicaid under this coverage group if the individual has assets equal to or below the Medically Needy asset limit and has income at or below 88 percent of the federal poverty level.

2040.0813.03 Technical Requirements for MEDS-AD (MSSI)

The individual must meet all of the following criteria:

1. age or disability,
2. Florida residency,
3. citizenship,
4. welfare enumeration,
5. third party liability,
6. application for other benefits they may be eligible to receive,

7. not be receiving Medicare, or
8. if receiving Medicare also be receiving institutional, hospice or home and community based services.

Individuals are considered to be receiving home and community based services (HCBS) when they are:

1. enrolled in and meet the level of care (LOC) as determined by the Department of Elder Affairs (DOEA), and Comprehensive Assessment and Review for Long-Term Care Services (CARES) or
2. enrolled in the Program of All-Inclusive Care for the Elderly (PACE).

2040.0813.04 Date of Entitlement for MEDS-AD (MSSI)

The date of entitlement for Medicaid benefits begins the first day of the month in which the individual files an application and is determined to meet all factors of eligibility for the month of application and subsequent months.

2040.0813.05 Benefits Received through MEDS-AD (MSSI)

Individuals who are eligible under this coverage group are eligible for all Medicaid benefits. An individual may also be eligible for institutional care, Hospice or HCBS services under this coverage group if the individual also meets the additional Title XIX criteria.

2040.0814.01 Hospice (MSSI)

The Medicaid Hospice Program is a Medical Assistance Program. It provides special services to terminally ill individuals to maintain the individual at home for as long as possible, providing the best care available. (Hospice services are also available to an individual in a nursing home.)

If the individual is not already Medicaid eligible, he must meet all SSI-Related Medicaid technical criteria and have income and assets within the limits for ICP, MEDS-AD or MN. In addition, all individuals must meet additional criteria to receive Hospice services.

2040.0814.02 Additional Criteria for Hospice Eligibility (MSSI)

The additional criteria for Hospice eligibility include:

1. prognosis that life expectancy is six months or less (if the illness runs its normal course), certified by medical statement of the physician's or medical director's judgment regarding the normal course of the individual's illness. (This serves as certification of disability.)
2. a signed Hospice election statement stating that he selects Hospice to the exclusion of other regular Medicaid services.
3. individual must be served by a qualified Hospice provider.

2040.0814.03 Hospice for Institutionalized Individual (MSSI)

If an individual requires Hospice care in a nursing home and has a spouse in the community, spousal impoverishment policies apply. (Refer to Chapters 1600 and 1800 for specific policy.)

2040.0814.04 Medically Needy Hospice (MSSI)

If an individual has income and/or assets over the ICP income limit but within the Medically Needy limit, he can be eligible for Medicaid Hospice care when the share of cost has been met.

2040.0815.01 Home and Community Based Services (MSSI)

Home and Community Based Services (HCBS) Programs is considered as the Medicaid Waiver Programs. Their purpose is to prevent institutionalization of the individual by providing care in the community with specific providers. Refer to 0240.0111 for a list of Medicaid Waiver Programs.

To be eligible for HCBS, the individual must meet all SSI-Related technical criteria and have income and assets within the limits for ICP or MEDS-AD. Individuals cannot qualify for HCBS under the Medically Needy Program.

Effective January 1, 2020, the HCBS/Working People with Disabilities (WPwD) Program was implemented for individuals with earned income from paid employment or a combination of earned and unearned income to have higher income and asset limits than regular HCBS. Refer to 1640.0205 for the asset limit and 2440.0103 for the income limit.

2040.0815.03 Additional Criteria - HCBS Familial Dysautonomia Waiver (MSSI)

For the Familial Dysautonomia (FD/HCBS) waiver individuals must:

1. be aged three or older (must meet disability criteria if under age 65);
2. meet a level of care for being at risk of hospitalization as determined by CARES;
3. have a diagnosis of Familial Dysautonomia and a need for medically necessary services provided by the waiver as determined by CARES; and
4. be enrolled in the Familial Dysautonomia waiver as documented by form CF-ES 2515

2040.0815.04 Additional Criteria - HCBS Individual Budgeting Florida (iBudget) Developmental Disabilities (MSSI)

For the (iBudget) Developmental Services program individuals must:

1. be disabled or aged;
2. meet the appropriate level of care for an ICF/DD as determined by the Agency for Persons with Disabilities, and
3. be enrolled in the waiver as documented by form CF-ES 2515.

2040.0815.05 Additional Criteria - HCBS Model Waiver (MSSI)

For the Model waiver, individuals must:

1. be under 21 years of age,
2. be diagnosed as having a degenerative spinocerebeller disease,
3. meet the appropriate level of care for inpatient hospital care as determined by Children's Medical Services; and
4. be enrolled in the waiver through Children's Medical Services as documented by form CF-ES 2515.

2040.0815.07 Additional Criteria HCBS Statewide Managed Medicaid Care Long Term Care (SMMC LTC)

For Statewide Managed Medicaid Care Long Term Care (SMMC LTC), an individual must

1. be aged 65 years of age or older
2. be 18 years through 64 years of age and disabled
3. meet level of care requirement as determined by CARES
5. be enrolled in the waiver with specific managed care providers as documented by form CF-ES 2515 for HCBS services.

2040.0816 Working Disabled (MSSI)

Most individuals with disabilities who work will continue to receive at least 93 consecutive months of hospital (Part A) and medical (Part B) insurance under Medicare. They pay no premium for Part A. After premium-free Medicare Part A coverage ends, they can continue receiving Medicare, as long as they remain medically disabled and continue to work, but must pay a premium for Part A. The state can pay the Medicare Part A premium for qualified individuals who meet all of the following eligibility criteria:

1. Are enrolled in Medicare Part A under this special extended coverage (as confirmed by SSA)
2. Are under age 65,
3. Have assets at or below $4,000 for an individual and $6,000 for a couple,
4. Have income at or below 200% of the federal poverty level (individual or couple),
5. Are U.S. citizens or qualified noncitizens,
6. Take necessary steps to access any other benefits to which they may be entitled.

2040.0817 Qualified Medicare Beneficiaries Medicaid (MSSI)

To be eligible to receive Medicaid through the Qualified Medicare Beneficiaries Program (QMB), an individual must meet all the following criteria:

1. Be enrolled (or conditionally enrolled) in Medicare Part A;
2. Have income that does not exceed 100% of the federal poverty level;
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9);
4. Be a U.S. citizen or qualified noncitizen; and
5. Take necessary steps to access any other benefits to which they may be entitled.

Individuals who are QMB eligible receive limited Medicaid benefits. Medicaid benefits are limited to payment of the Medicare premiums, coinsurances and deductibles for qualified individuals. This includes full Medicare coinsurance payment for nursing home care. The QMB eligible individual has no patient responsibility while under the Medicare coinsurance benefit period.

Medicaid eligible individuals who meet QMB criteria do not have to apply for the Institutional Care Program (ICP) if they do not remain in the nursing facility beyond their Medicare benefit period. The facility can automatically bill for the Medicare coinsurance payment. If the individual remains in the facility beyond the Medicare benefits period, conduct a partial review (or eligibility review if an eligibility review is due or extensive verification is needed) to provide full ICP services if necessary.

Note: Cross reference passage 1440.1504.

2040.0818 Special Low Income Medicare Beneficiary (MSSI)

To receive benefits through the Special Low Income Medicare Beneficiary Program (SLMB), an individual must meet all of the following eligibility criteria:

1. Be enrolled in Medicare Part A;
2. Have income between 100% and 120% of the federal poverty level;
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9);
4. Be a U.S. citizen or qualified noncitizen; and
5. Take necessary steps to access any other benefits to which they may be entitled.

Individuals who are SLMB eligible receive payment of their Medicare Part B premiums.

Note: Cross reference passage 1440.1504.

2040.0819 Qualifying Individuals 1 (QI1) (MSSI)

This mandatory federal program pays the monthly Medicare Part B premium for individuals who would be, QMB or SLMB eligible except for the fact that their income exceeds those program limits. This is not an open entitlement program as funding is limited to an annual federal allocation.

To qualify as a Qualifying Individuals 1 beneficiary, an individual must meet all the following eligibility criteria:

1. Be enrolled in Medicare Part A;
2. Have income greater than 120% of the federal poverty level but equal to or less than 135% of the federal poverty level;
3. Have assets not exceeding three times the SSI resource limit with annual increases based on the yearly Consumer Price Index (refer to Appendix A-9);
4. Be a U.S. citizen or qualified noncitizen;
5. Take necessary steps to access any other benefits to which they may be entitled; and
6. Does not qualify for Medicaid under any other Medicaid coverage group, except Medically Needy.

Note: Cross reference passage 1440.1504.

2040.0821 Breast and Cervical Cancer Treatment Program (MSSI)

A special Medicaid Program is available for women needing treatment for breast and cervical cancer.

To be eligible, a woman must:

1. be screened and diagnosed for breast or cervical cancer by the Department of Health (DOH) under the Center for Disease Control (CDC) Screening Program in Florida,
2. need treatment for the disease,
3. be uninsured or have health coverage that does not cover the necessary treatment,
4. not be eligible under a Medicaid group (excluding Medically Needy),
5. be under age 65, and
6. be a citizen or qualified noncitizen.

   Exception: Apply EMA policy for noncitizens who meet all technical requirements, except citizenship.

Do an ex parte when a woman becomes ineligible, unless she moves out of state or dies.

Refer women who do not meet the above qualifications to the toll-free the American Cancer Society National Hotline at 800 227-2345.

2040.0822 Optional State Supplementation Program (SFP)

An individual must qualify under one of the following coverage groups to be eligible for OSS assistance:

The individual must be eligible for and receiving a check from Social Security's Supplemental Security Income Program. The Department accepts receipt of SSI as meeting all factors of OSS eligibility criteria in 0240.0118 except age and placement, which must be verified by the Department.

The individual must meet all SSI and OSS eligibility criteria, except for the amount of their income, which must be equal to or less than the OSS income standard established by the Department.

The individual must have been eligible for and receiving Aid to the Aged, Blind or Disabled (AABD) from the state as of December 1973. This federally protected coverage group lives in Homes for Special Services, which generally is a private family home.

The individual must reside in an ALF or MHRTF eligible for reimbursement for Medicaid assistive services; must have been eligible for an OSS payment for August 2001 but ineligible for OSS as of September 2001 solely because their income exceeds the applicable OSS income standard of $609.40; and they are not categorically eligible for full Medicaid benefits as of September 2001. As long as the individual continues to meet all OSS eligibility criteria and their income is equal to or less than the August 2001 income standard (plus any cost of living adjustment), the individual can continue to receive OSS payments. Once the individual becomes ineligible for OSS and the case is closed, the individual cannot be considered under this coverage group.

2040.0823 Program of All-Inclusive Care for the Elderly (MSSI)

Program of All-Inclusive Care for the Elderly (PACE) is an optional Medicaid benefit developed to serve the frail elderly in the home and community. This program offers comprehensive services that include acute and long-term care. For most participants, the comprehensive service package permits them to continue living at home while receiving services rather than being institutionalized. However, once enrolled in PACE, an individual may continue PACE services even if the individual moves to an assisted living facility or a nursing home.

Eligibility for PACE is determined in accordance with Institutional Care Program (ICP) rules, including transfer of assets and spousal impoverishment policies regardless of the individual's living arrangement. The individual must also meet additional criteria as follows:

1. be at least 55 years of age,
2. be a resident of the state and reside within the PACE service area,
3. meet the level of care,
4. be determined disabled if under 65 years of age, and
5. elect the PACE provider as his/her sole source of Medicare and/or Medicaid service delivery.

Note: A PACE participant cannot elect Hospice while simultaneously receiving PACE services. PACE participants may qualify for an OSS payment if OSS criteria are met.

2050.0000 Child In Care

If financial and technical requirements have been met, the assistance group may be eligible for the coverage groups described in this section. Additionally, this section provides the category codes for each coverage group used in FLORIDA.

2050.0100 CATEGORY CODES (CIC)

The following section details the category codes for FLORIDA.

2050.0104 Child in Care Category Codes (CIC)

ADCF = AFDC for Title IV-E FC Family
MCE = Emergency Shelter and Delinquent Youth
MCFE = Title IV-E Foster Care
MCFN = Non-Title IV-E Foster Care and Independent Living
NCFN = Medically Needy CIC Case
MCAE = Title IV-E Adoption Subsidy
MCAN = Non-Title IV-E Adoption Subsidy

2050.0500 CHILD IN CARE (CIC)

If financial and technical requirements have been met, the assistance group may be eligible for the following coverage groups:

1. Title IV-E Board Rate and/or Medicaid for Children in Emergency Shelter,
2. Title IV-E Foster Care and Board Rate for Foster Care,
3. Title IV-E Medicaid for Adoption Subsidy,
4. Adoption Subsidy Medicaid,
5. Medicaid for Youth in Independent Living Situations,
6. Medicaid for Delinquent Youth,
7. MEDS, and
8. Medically Needy.

2050.0501 Children in Emergency Shelter (CIC)

Title IV-E or non-Title IV-E Medicaid may be provided under this coverage group for children placed in emergency shelter by the Family Safety office. Coverage is available to children who meet the technical and financial requirements.

2050.0502 Title IV-E Foster Care (CIC)

Title IV-E Medicaid may be provided under this coverage group for children in foster care homes who meet the Title IV-E technical and financial criteria. Federal matching funding is available for the foster care board rate.

An infant of a teen parent in Title IV-E foster care must be included in the foster care Title IV-E payments. Medicaid coverage for the infant must be explored, including income and assets belonging to the infant.

2050.0503 Title IV-E Foster Care Medicaid (CIC)

Title IV-E foster care children are automatically eligible for Medicaid and no independent Medicaid determination is made. Generally, when an application for a child is submitted for Title IV-E foster care payments (board rate), the child will have been receiving Medicaid benefits as an emergency shelter, Title IV-A or Non Title-E child. Medicaid benefits must then be determined through Title IV-E foster care at the notification by Family Safety staff that the child's Title IV-A eligibility is ending and an application for Title IV-E funding is received.

The first month of Title IV-E Medicaid authorization and the initial month of Title IV-E foster care payment (board rate) will not always coincide.

When a Title IV-E foster care child is placed in another state, the receiving state (state where child was placed) is responsible for providing Medicaid and the sending state retains responsibility for the Title IV-E determination. Title IV-E children who are placed by Florida in another state receive Medicaid coverage in the state in which they reside. Title IV-E children placed in Florida by another state are automatically eligible for Florida Medicaid.

2050.0504 Medicaid for Foster Care Youth in Independent Living Situations (CIC)

This program is designed for foster children age 16 or older who have demonstrated an ability to handle independence based on certain criteria such as:

1. responsible behavior during placement;
2. maintenance of a dependable employment record;
3. establishment of a savings program; and
4. maintenance of regular attendance at a school or in a training program.

Each youth in the program receives an independent living subsidy. This independent living grant is made out directly to the youth, and is not subject to maintenance fee collection since the payments are an integral part of the case plan of eventual independence. Funds for the grant are drawn directly from the state foster care budget. This grant provides for the same basic coverage (food, shelter, transportation, etc.) as foster care maintenance payments.

Youth may be eligible for non-Title IV-E Medicaid if technical and financial factors of eligibility are met.

Note: The subsidy payment is considered the board rate and the income is exempt.

2050.0505 Title IV-E Adoption Subsidy (CIC)

Title IV-E adoption subsidy cash assistance is provided to children who meet the technical and financial criteria and are determined to be a special needs child by CW/CBC staff and annotated on the CF-ES 2626A at the time of application or on the CF ES 2694 when the child moves from foster care to adoption. Title IV-E related Medicaid is authorized for children who are eligible for Title IV-E cash benefits.

2050.0506 Non-Title IV-E Foster Care Medicaid (CIC)

Medicaid may be provided under this coverage group for children in foster care who do not meet Title IV-E requirements. Medicaid coverage is available to children who meet the technical and financial requirements.

An infant of a minor mother receiving non-Title IV-E foster care payments, which do not include the infant's needs, may be eligible for TCA for the infant. Only the needs, income and assets of the infant are considered in this determination.

2050.0507 Adoption Subsidy Medicaid (CIC)

Child in Care assistance is provided under this coverage group to children who were previously determined eligible for Medicaid prior to an adoption subsidy agreement.

Medicaid is authorized for children who meet the technical and financial requirements.

A non-Title IV-E child who receives adoption assistance, placed out-of-state by Florida in an ICAMA member state, is eligible for Medicaid in the state in which the child lives. A non-Title IV-E child who receives adoption assistance, placed in Florida by an ICAMA member state, is considered to be a resident of Florida and is eligible for Florida Medicaid.

A non-Title IV-E child, who receives adoption assistance, moving to Florida from a non-ICAMA member state, is not considered a resident of Florida and is not eligible for Florida Medicaid eligibility.

2050.0508 Medicaid for Delinquent Youth (CIC)

Children who are in the care of the state through the delinquency system receive a continuum of supervision that corresponds to the youth's degree of delinquency or need for services. This supervision could range from a simple civil citation to a commitment in a residential facility.

Only delinquent youth who are committed to the state and who reside in a residential facility that meets the following criteria are potentially eligible for non-Title IV-E Medicaid. The facility must be:

1. nonsecure, privately owned, and 25 beds or less designated for an alcohol, drug abuse or mental health facility, or no limit for all other facilities; or
2. nonsecure, state operated and 16 beds or less.

Note: The nonsecure residential facilities that meet the requirements are compiled by the Department of Juvenile Justice (DJJ) and are continually updated; however, DJJ staff will indicate on the CIC application whether or not the child is residing in an eligible placement.

Children must meet technical and financial criteria to be eligible.

2050.0800 RETROACTIVE MEDICAID (CIC)

The following passages will discuss Retroactive Medicaid requirements and the date of entitlement for Retroactive Medicaid.

2050.0812.01 Retroactive Medicaid (CIC)

DCF may authorize Medicaid coverage for any one or more of the three calendar months preceding the month of application for ongoing Medicaid benefits when the requirements are met.

2050.0812.02 Requirements for Retroactive Coverage (CIC)

The following requirements must be met in order to be eligible for retroactive Medicaid:

1. The individual must file an application for ongoing assistance. A request can be made for a deceased individual.
2. In the retroactive period, the individual must have received medical services which would be reimbursable by Medicaid. The individual's statement that he has unpaid medical bills for any of the three months will be accepted; the individual is not required to verify that the bills exist or that the services will be covered by Medicaid.

3. The eligibility specialist will determine eligibility for each of the retroactive month(s) using eligibility criteria for any Medicaid coverage group, regardless of the program for which the individual applied.
4. A determination of eligibility must be made for each of the month(s) in the period.
5. Once current income has been verified and any discrepancies resolved, staff must accept self-attestation that the individual's income was consistent during the retroactive period. Request additional information only if the income is inconsistent or information known to the agency suggests the individual's circumstance may have changed in the retroactive period.

2050.0812.03 Date of Entitlement for Retroactive Medicaid (CIC)

The period of entitlement for each retroactive month is the calendar month for which eligibility is established; that is, if the individual is determined to be eligible for any day in a month, he is eligible for the full calendar month, except for Medically Needy. Medicaid eligibility in the Medically Needy Program is determined by the day the individual meets their share of cost.

2060.0000 Refugee Assistance Program

If financial and technical requirements have been met, the assistance group may be eligible for the coverage groups described in this section. Additionally, this section provides the category codes for each coverage group used in FLORIDA.

2060.0100 CATEGORY CODES (RAP)

The following section details the category codes for FLORIDA.

2060.0103 Refugee Assistance Program Category Code (RAP)

RAP = RAP

2060.0106 RAP Medicaid Category Codes (RAP)

1. MRR or NRR for Medically Needy = Non-Temporary Cash Assistance (TCA) RAP
2. No code = Eligible but not receiving due to benefit less than $10
3. MRE-I = Transitional RAP Medicaid due to increased caretaker income
4. MRO-T = Failed RAP direct assistance due to transfer of assets
5. MRP-N or NRP-N for Medically Needy = PMA child born on or after 1/1/79 who is not yet 19 and living with nonrelatives
6. MRN or NRN for Medically Needy = Presumptively Eligible Newborn
7. MRM-P or NRM-P for Medically Needy=Pregnant Woman
8. MRM-I= Infants under 1 year
9. MRM-C=Children over 1 year born on or after 1/1/79
10. MRM-S or NRM-S=Aged and/or disabled
11. Protected SSI
    a. MRT-C = Regular COLA
    b. MRT-A = Widows I
    c. MRT-W = Widows II
    d. MRT-D = Disabled Adult Children
12. MRI-A,S,I,T,M,P = ICP
13. MRH-A,S,H,M,P = Hospice
14. NRS = SSI-Related MN for RAP

2060.0400 REFUGEE ASSISTANCE PROGRAM (RAP)

If financial and technical requirements have been met, the assistance group may be eligible for the coverage group Refugee Assistance Program (RAP).

All refugees must be screened for potential Temporary Cash Assistance and Family-Related Medicaid eligibility. Refugees who meet Temporary Cash Assistance deprivation requirements are to be approved under the appropriate Temporary Cash Assistance related RAP coverage group.

2060.0401 Refugee Assistance Program (RAP)

Assistance through the Refugee Assistance Program (RAP) may be provided under this coverage group to refugee families and individuals who meet the eligibility criteria. Assistance under this coverage group is limited to the first eight months refugees are in the United States. The eight month period begins with the date of entry into the United States.

2060.0700 RAP MEDICAID COVERAGE GROUPS (RAP)

The following coverage is available through the RAP Program. The policy corresponds to the Family-Related Medicaid policy found in Section 2030.0600 and SSI-Related policy found in Section 2040.0800.
Family-Related:

1. Family-Related RAP Medicaid,
2. RAP MAO due to transfer of assets,
3. Institutional Care Coverage,
4. Coverage for Pregnant Women, and
5. Coverage for Children and Infants.

SSI-Related:

1. Protected SSI,
2. Institutional Care Coverage, and
3. Hospice services.

Additional coverage is also available (refer to passages 2050.0701 through 2050.0705).

2060.0701 Refugee Medical Assistance (RAP)

Refugees who meet the income and asset standards for Refugee Cash Assistance (RAP) may opt to receive refugee medical assistance only. Process these cases like any other "opt not to receive" AG.

2060.0702 Extended Medicaid (RAP)

Medical coverage for the refugee assistance group and MAO under $10 or refugee medical assistance AGs must be extended for up to the end of the eight month time limit beginning with the month of ineligibility for RAP or medical assistance.

2060.0703 Conditions of Eligibility for Extended Medicaid (RAP)

The following conditions must be met:

1. The RAP assistance group was ineligible based solely on initial receipt of earned income or receipt of increased earned income.
2. A redetermination of eligibility is not required during the extended period unless information is received from the recipient indicating ineligibility on some factor of eligibility other than need.

2060.0704 Date of Entitlement (RAP)

The date of entitlement for extended medical coverage begins with the month of ineligibility for Temporary Cash Assistance or MAO for under $10 cases.

The month of ineligibility is defined as:

1. the effective date of cancellation if the earnings were reported promptly and no Temporary Cash Assistance overpayment occurred, and
2. if the earnings were not reported promptly during the first month in which reportable overpayment occurred.

Only those members included in the SFU for the month prior to termination are entitled to extended medical benefits.

2060.0705 Length of Benefit (RAP)

The eligibility period for extended Medicaid for refugees is when the refugee reaches the end of his time limited eligibility for refugee medical assistance (eight months).