Division of Family Support
OPERATION MANUAL
Volume V OMTL - 527

State Supplementation
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MS 1100* STATE SUPPLEMENTATION OVERVIEW (1)

State Supplementation is a money payment made to an aged, blind, or disabled individual who is age 18 years or older. These individuals have insufficient income to pay for care in a licensed Personal Care Home (PCH) or licensed Family Care Home (FCH), to maintain residence in a Community Integration Supplementation (CIS) arrangement, or to purchase Caretaker Services to prevent institutionalization. Individuals receiving State Supplementation are categorically eligible for Medicaid; a separate application is not required.

A. Individuals age 21-64 who reside in a personal care unit of an Institution for Mental Diseases (IMD) cannot receive Medicaid, but are eligible for the State Supplementation payment. The only remaining personal care unit in an IMD is Central Kentucky Recovery Center located at Eastern State Hospital. Worker Portal will not issue Medicaid to an individual residing at this facility, unless they receive SSI. If an SSI recipient resides at this facility, a “stop” must be placed on their SSI Medicaid. A stop request should be sent to the Medical Support and Benefits Branch (MSBB) through regional chain of command. When the individual is discharged, a request must be sent to MSBB to remove the Medicaid stop. The stop can be found on SDX under “Date Maid Iss. Stop by CO”.

B. State Supplementation recipients are automatically eligible for SMI Buy-In. If Medicaid is not selected when adding a program, Worker Portal will not display a QMB or SLMB EDG; however Medicaid pays the SMI premium for all State Supplementation recipients with Medicare Part B regardless of their income unless the individual is ineligible due to living in an IMD.

C. Individuals receiving State Supplementation while residing in a FCH, CIS, or receiving Caretaker Services are eligible for waiver services, as long as it is verified that there is no duplication of services between the two providers. Residents in a PCH are not eligible for waiver services.

D. The State Supplementation payment is considered the individual’s money. It is the individual’s responsibility to pay the PCH, FCH, caretaker, or person(s) providing CIS services. The payment is issued in the name of the applicant, unless they have a statutory benefit payee or court appointed legal guardian. The payment can be in the payee or legal guardian’s name at their request, if verification is provided. For SSI recipients, the payee can be verified on SDX. The payment may be issued by check or direct deposit into the individual, payee, or legal guardian’s checking account.

E. The Type Of Assistance (TOA) for the State Supplementation payment is SSPP. The TOA for the Medicaid with State Supplementation is SSPM.

MS 1200 STATE SUPPLEMENTATION STANDARDS (1)

The State Supplementation payment is the difference between the appropriate standard and the countable income.

A. [Standards for State Supplementation:

1. Personal Care Home (PCH)	$1,291
2. Community Integration Supplementation (CIS)	$1,291
3. Family Care Home (FCH)	$ 943
4. Caretaker Services:	
a. Individual	$ 833
b. Individual with Ineligible Spouse	$ 833
c. Eligible Couple (One Receives Care)	$1,218
d. Eligible Couple (Both Receive Care)	$1,272

B. Calculating the State Supplementation Payment:

1. To determine the PCH payment, subtract the individual's countable income from the PCH standard.

   Example: Bob receives $771 per month in Supplemental Security Income (SSI) and resides in a PCH. His State Supplementation payment is $520 ($1,291 - $771).

2. To determine the CIS payment, subtract the individual's countable income from the CIS standard.

   Example: Sue receives $1,000 per month in Retirement, Survivors, Disability Insurance (RSDI) and lives in an apartment and receives CIS. Her State Supplementation payment is $291 ($1,291 - $1,000).

3. To determine the FCH payment, subtract the individual's countable income from the FCH standard.

   Example: Ann receives $771 per month in SSI and resides in an FCH. Her State Supplementation payment is $172 ($943 - $771).

4. To determine the Caretaker Services payment for an individual, subtract the individual's countable income from the Individual standard.

   Example: John receives $771 per month in SSI and is single, residing in his own home, and receives Caretaker Services. His State Supplementation payment is $62 ($833 - $771).

5. To determine the Caretaker Services payment for an eligible individual with an ineligible spouse, subtract the countable income from the Individual with Ineligible Spouse standard.

   Example: Dan is disabled and receives $772 per month in RSDI and receives Caretaker Services. His spouse, Joan, is not aged, blind, or disabled and has no income. His State Supplementation payment is $61 ($833 - $772).

6. To determine the Caretaker Services payment for an eligible couple, but only 1 requiring care, subtract the countable income from the Eligible Couple (One Receives Care) standard.

   Example: Mark and Amy are disabled and each receive RSDI in the amount of $575. However, only Mark requires care and receives Caretaker Services. His State Supplementation payment is $36 ($1,218 - $1,150 combined income).

7. To determine the Caretaker Services payment for an eligible couple, both requiring care, subtract the countable income from the Eligible Couple (Both Receive Care) standard.

   Example: Charlie and Becky are both disabled and receive RSDI. They both require care and each receive Caretaker Services. The State Supplementation payment is $1,218 - $1,160 (combined income) = $58/2 (divided by 2 as they both require care) =$29 each.

C. Individuals residing in a PCH or FCH retain a Personal Needs Allowance (PNA) from the State Supplementation payment. This PNA is not displayed on Worker Portal.

   1. PCH - $60

   2. FCH - $40

   Example: Bob resides in a PCH. He receives RSDI of $900 a month. The PCH standard is $1291. His State Supplementation payment is $391. Bob must pay the PCH $1231 and he will keep $60.]

MS 1300* AUTHORIZED REPRESENTATIVE (1)

An Authorized Representative (AR) may act on behalf of an individual if the AR has appropriate consent. Documentation must be provided to verify an individual is authorized to act on the client's behalf before they can be established as the client's AR on Worker Portal.

A. The following individuals may act as AR for an applicant or recipient:

1. The spouse, if currently married and there is NO existing divorce decree;

2. The verified statutory benefit payee;

3. The representative payee receiving the SSI benefit. For payees listed on SDX, no further verification is required;

4. The court appointed guardian (with documentation); or

5. The Power of Attorney (POA) (with documentation).

B. Individuals who do not meet the authorized representative criteria listed above must provide a written statement signed by the applicant/recipient specifically allowing them to act on their behalf for State Supplementation. Written statements must be dated and must be provided at application, reapplication, and recertification.

Note: Form MAP-14, Authorized Representative CANNOT be used for State Supplementation. Form MAP-14 is for Medicaid use only.

MS 1400* APPLICATION PROCESS (1)

Applications for State Supplementation may be conducted in-person, by telephone, or by home visit, if requested. Individuals may not apply for State Supplementation on the benefind Self-Service Portal (SSP). Individuals are never refused the right to apply, even if it appears that they do not meet technical or financial eligibility requirements. If an individual cannot physically come into the office to apply, he/she can designate an Authorized Representative (AR) to apply on his/her behalf. A signed, dated statement from the individual is required to authorize anyone other than the spouse, Power of Attorney (POA), benefit payee, or court appointed legal guardian to apply on their behalf. Refer to MS 1300 for more information regarding ARs.

Note: Form MAP-14, Authorized Representative, cannot be used to authorize someone to apply for State Supplementation as this form is used for Medicaid only.

If an individual wishes to submit an application, but is unable to be interviewed at the time they initially contact the agency, he/she may complete and sign form PA-77, Intent to Apply for KTAP, Medicaid, State Supplementation, or Child Care Assistance, to protect their filing date. When form PA-77 is received, the worker must complete Application Registration in Worker Portal and schedule an appointment to complete the application interview with a worker either in-person or by phone.

A new application is not required when an individual moves from one type of State Supplementation to another. For example, when an individual moves from a Personal Care Home (PCH) to the community and wishes to receive Community Integration Supplementation (CIS) a case change is completed, not a new application.

Use the following procedures when conducting an interview:

A. Provide reasonable accommodations to any special needs the individual may have no matter where the interview is conducted. Accommodation to special needs may include but is not limited to:

   1. Interpreter services for hearing impaired individuals. For more information on interpreter services for the hearing impaired, refer to Volume I MS 0220;

   2. Additional space for the interview to accommodate an individual in a wheelchair;

   3. Scheduling appointments when special transportation services are available;

   4. If the individual does not speak English, obtain interpreter services. For more information on interpreter services, refer to Volume I, MS 0230; or

   5. Making a home visit.

B. Inquire KAMES and Worker Portal to determine if an individual has previously received State Supplementation. If so, review the case(s) thoroughly.

C. Run system checks as appropriate, i.e. BENDEX, SDX, external agency searches, etc. to review for potential income and resources.

D. Ask all questions on Worker Portal as the interview progresses.

E. Enter Case Notes as the interview progresses while the applicant is still present or on the phone.

F. Inform individuals of their rights and responsibilities:

1. Provide all mandatory informational pamphlets and/or forms required at application. Thoroughly explain all forms.

   a. For face-to-face interviews, forms requiring signature may be signed electronically or hardcopy;
   b. For phone interviews:
      (1) Inform the applicant of all forms they can expect to receive;
      (2) Explain the information contained on the forms; and
      (3) For any forms not signed by voice signature, explain that they must be signed and returned.

2. Advise the individual that all changes must be reported within 10 days of the date of change.

3. Explain form MA-2, Medicaid Penalty Warning. Form MA-2 must be signed by the applicant to verify they understand the potential consequences for committing Medicaid fraud. The form may be signed electronically or hardcopy at face-to-face interviews. For phone interviews, form MA-2 may be signed with voice signature. Otherwise, Worker Portal will mail form MA-2 to the individual for signature and the case will pend for its return.

4. Advise the individual of their right to request a hearing to appeal any adverse decision.

5. Explain the voter registration process and complete the voter registration question on Worker Portal.

G. Explain to the individual about the State Supplementation payment:

1. Explain how the payment is issued whether by check or direct deposit. The payment cannot be issued into a savings account. If an individual chooses direct deposit, provide form PA-63, Direct Deposit Authorization, for completion. If the individual provides a blank check, write “VOID” across the front and scan the check with the completed and signed form PA-63 into the Electronic Case File (ECF). If the individual does not have a blank check available, advise the individual to take form PA-63 to the bank for completion.

2. Explain to the applicant that it is the individual’s responsibility to pay the PCH, FCH, caretaker, or person(s) providing CIS services.

H. Inform the individual of the MA processes:

1. Advise the applicant/recipient that Medicaid Member Services answers all questions regarding Medicaid coverage or billing.

2. Explain the Managed Care program. Refer to Volume IVA, MS 1340 for more information regarding Managed Care.

3. Explain Third Party Liability (TPL). Ensure the client understands that MA is always the payer of last resort and any other health or hospital insurance is billed before MA. Enter all health insurance information on Worker Portal.

I. Explain to the applicant what is required to process the case timely and that the case will be denied if mandatory verification is not returned within the allotted timeframes. Individuals have 30 days to return requested information before the application denies.

J. Ensure that all of the applicant's questions are answered.

K. The applicant or their AR must sign the application. If the interview is face-to-face, electronic or hardcopy signature is acceptable. If the interview is by phone, the application summary can be signed by voice signature. Otherwise, Worker Portal will mail the application summary to the individual for signature and the case will pend for its return.

Note: The application can be signed by the applicant, the applicant's statutory benefit or SSI payee, court appointed legal guardian, POA, or other AR as designated in writing. If the application summary is signed by a mark (X), another person, either related or unrelated, must sign the application as a witness.

L. Any verification provided at the interview must be scanned into ECF at that time.

M. If additional verification is required, run eligibility to generate a Request for Information (RFI). Individuals may return information or verification by mail, fax, to any DCBS office, or to the Centralized Mail Center.

N. If all verification is provided at the time of the interview, dispose the application at that time. The payment is effective the month of application. There is no retroactive eligibility for State Supplementation. The MA effective date is the 1st day of the month of application. If the individual requires retroactive Medicaid due to unpaid medical expenses, Medicaid must be selected on the Program Request screen. Retroactive Medicaid cannot be issued through the State Supplementation application

O. Worker Portal automatically issues appropriate notifications.

P. Prior to approving State Supplementation, contact the PCH, Family Care Home (FCH), caretaker, or care coordinator to verify that the individual is still receiving services. Enter the contact date on Worker Portal.

MS 1500* RECERTIFICATION PROCESS (1)

State Supplementation cases require a recertification every 24 months and a review every 12 months. Every 12 months, review items subject to change, such as living arrangement, income, and resources. Update the system with findings as appropriate and document thoroughly in Case Notes. At recertification, all technical and financial requirements must be reviewed to ensure the recipient continues to be eligible for State Supplementation.

Interviews may be conducted in-person, by telephone, or by a home visit, if requested. State Supplementation reviews and recertifications cannot be completed on the benefind Self-Service Portal (SSP). A review or recertification with an Authorized Representative (AR) may be completed with a signed statement. An appointment is not required for a recertification. However, if an individual requests an appointment, schedule it on Worker Portal.

A. The 24 month certification period begins with the month of application for approvals. Worker Portal generates a notice informing the recipient to contact DCBS for the 12 month review and the 24 month recertification.

B. Prior to completing the review and/or the recertification, contact the Personal Care Home (PCH), Family Care Home (FCH), caretaker, or care coordinator to verify if the individual is still receiving services. Enter the contact date on Worker Portal.

C. NEVER use the Reinstate or Reactivate function for cases that discontinue at recertification regardless if the discontinuance is correct or due to agency error. Workers must ALWAYS use the Add/Reapply function on the Case Summary screen for cases that discontinue at recertification.

MS 1600* GENERAL TECHNICAL ELIGIBLITY REQUIREMENTS (1)

State Supplementation recipients must meet all technical eligibility requirements, including enumeration, citizenship, identity, residency, Third Party Liability (TPL), and application for statutory (entitled) benefits. Recipients must also be aged, blind, or disabled. Refer to MS 1700 for aged, blind, disabled criteria.

A. Everyone applying for or receiving State Supplementation is required to furnish his/her Social Security Number (SSN) or apply for an SSN if one has not been issued. Worker Portal will verify each individual's SSN with the Social Security Administration (SSA).

1. If an individual refuses to provide an SSN or fails to apply for an SSN and does not meet one of the exemptions below, that individual will be ineligible for State Supplementation.

   a. Religious objections;
   b. Alien status;
   c. Issued an SSN for valid non-work reasons only; or
   d. If good faith effort is being made to obtain documentation that is necessary for completing form SS-5, Application for a Social Security Card, such as an out-of-state birth record.

2. If the individual does not have an SSN or if Worker Portal is unable to verify the SSN, the individual is temporarily approved and given 90 days to provide verification.

3. Worker Portal will exclude members who fail to comply with enumeration requirements. The excluded household member becomes eligible upon providing DCBS with an SSN, or applying for an SSN, if otherwise eligible.

4. Individuals not seeking coverage for themselves, but who are included in the applicant's household, are not required to provide an SSN.

B. An individual must be a citizen of the United States or a qualified alien to be eligible to receive State Supplementation.

1. Citizenship or alien status may be automatically verified by an interface with the SSA and/or the Department of Homeland Security (DHS). Additional proof of identity is not required for individuals whose citizenship is verified by the SSA/DHS interface.

2. If Worker Portal is unable to verify citizenship/alien status and identity through the interface, the individual must provide proof as outlined in Volume IVA, MS 1570 or Volume IVA, MS 1577. The individual will be temporarily approved and allowed 90 days to provide verification.

3. The following individuals are not required to verify citizenship or identity:

   a. SSI recipients;
   b. Medicare recipients; or
   c. RSDI recipients receiving benefits based on disability.

C. An individual must be a Kentucky resident to receive State Supplementation. Accept client statement as proof of residency, unless questionable.

1. Individuals are considered residents if they:

a. Live in Kentucky with intent to remain; or
b. Live in Kentucky and are incapable of stating intent.

2. DO NOT deny State Supplementation because the individual:

a. Has not lived in the state for a specified period; or
b. Did not establish residence in the state before entering a Personal Care Home (PCH) or Family Care Home (FCH).

D. As a condition of eligibility for Medicaid (MA), federal law requires the assignment of rights for third party health insurance payments to the Cabinet for Health and Family Services (CHFS). It is also mandated by state law, that MA is the payer of last resort, therefore other health or hospital insurance is billed before MA.

If the individual refuses to cooperate with TPL, without good cause, the individual is not MA eligible. Non-cooperation with TPL requirements DOES NOT affect eligibility for the State Supplementation payment. Good cause reasons for the individual's inability to cooperate with TPL may be considered if one of the following applies:

1. The applicant and spouse are estranged, therefore the applicant is unable to provide the requested TPL information; or

2. Due to a physical and/or mental impairment of the applicant, the TPL information cannot be provided.

E. Statutory benefits are paid due to federal law and include RSDI, Railroad Retirement, Black Lung, Veteran's pension or compensation, Worker's Compensation, annuities, IRA disbursements, retirement, Unemployment Insurance Benefits (UIB), or other pensions. SSI is NOT considered as a statutory benefit.

All individuals are required to apply for or comply with the requirements to receive statutory benefits if potential entitlement exists. If an individual refuses to apply for entitled benefits, the entire benefit group is ineligible. Individuals who are applying for or receiving State Supplementation are only required to verify application for, or compliance with, potential entitlement for other benefits. The State Supplementation case should NEVER be held pending for a decision of eligibility for other benefits.

MS 1700* AGED, BLIND, DISABLED (1)

Individuals must meet the technical eligibility requirement of being aged, blind, or disabled in order to be eligible for State Supplementation.

A. To receive State Supplementation as an aged individual, the applicant must be age 65 or older. If there is reason to doubt an applicant's age, request verification. Use any reasonably authentic document to verify age, such as birth certificate, passport, Social Security Administration (SSA) or Medicare records, etc.

B. To receive State Supplementation as a blind individual, the applicant must meet the SSA definition of blindness which is, “central visual acuity of 20/200 or less in the better eye with the use of a correcting lens.”

If an individual has not been determined blind by SSA, submit a referral to the Medical Review Team (MRT). A determination of blindness by SSA or MRT is required for all State Supplementation applications based on blindness.

C. To receive State Supplementation as a disabled individual the applicant must meet the SSA definition of disability which is, “the inability to engage in any substantial gainful activity by reason of a medically determinable physical or mental impairment, which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months."

Disability can be established by a field determination or by the completion of an MRT referral.

1. A field determination of disability can be made if:

   a. Retirement, Survivors, Disability, Insurance (RSDI) or Railroad Retirement benefits based on disability are received;
   b. The individual has End Stage Renal Disease;
   c. Life-Time payments from workers compensation are received;
   d. SSI was received during any portion of the 12 months prior to their application with DCBS, provided the SSI discontinuance was due to income or resources and not due to no longer being disabled. Always review the Payment Status Code on SDX to determine why SSI was terminated. If a field determination of disability is made, submit an MRT referral for a disability determination at the next recertification;
   e. State Supplementation eligibility is requested only for the month of death;
   f. SSA has established disability but entitlement is pending due to the 5-month durational requirement on some disabilities. View notification establishing entitlement;
   g. Disability has previously been determined by MRT, Hearing Officer, Appeal Board, or Circuit Court and decision states no reexamination is necessary;
   h. Division of Disability Determination Services (DDS) has made a determination of disability which includes the State Supplementation

application date and the onset of disability date if needed for retroactive months; or

i. A copy of the favorable hearing decision from SSA, Bureau of Hearings and Appeals is presented.

2. The receipt of the following cannot be used to make a field determination of disability and a MRT referral is required:

   a. Receipt of Black Lung;
   b. Receipt of Veteran's Administration (VA) benefits (even if 100% disabled);
   c. Teacher's Retirement Disability; or
   d. An SSI determination of presumptive eligibility.

3. Individuals with income and resources below the SSI standard must still apply for SSI. However, for State Supplementation only, if an individual is potentially eligible for SSI or has a pending SSI application, an MRT referral should still be completed.

4. Once the MRT request is completed on Worker Portal, a task is generated for MRT staff to complete the disability determination. MRT will prioritize disability determinations for State Supplementation applications to expedite the eligibility determination and ensure the individual does not lose their placement. Once a determination has been made, a task is generated for a worker to take appropriate action based on MRT's decision.

5. If statutory benefits, such as RSDI, are discontinued, and eligibility is based on receipt of those statutory benefits, an MRT decision is required if the individual continues to allege disability. Submit an MRT Referral and continue eligibility until the MRT decision is received.

MS 1800* STATE SUPPLEMENTATION CATEGORIES (1)

State Supplementation can be received in one of four categories, Personal Care Home (PCH), Family Care Home (FCH), Community Integration Supplementation (CIS), or Caretaker Services. To receive a State Supplementation payment for a PCH or FCH, the individual must be residing in a PCH or FCH licensed by the Certificate of Need and Licensure Board. A directory listing all PCHs and FCHs is available on the Office of Inspector General's (OIG) website: https://chfs.ky.gov/agencies/os/oig/dhc/Pages/hcf.aspx. For PCH beds located in a Nursing Facility (NF), choose the Long Term Care list. If the NF has approved PCH beds, there will be a number in the PC column.

NOTE: If a PCH or FCH is not found on the listings, it is not an OIG licensed facility. If a PCH or FCH is on the lists but is not on Worker Portal, send to MSBB through the Regional Program Specialist.

A. Personal Care Homes are an establishment with permanent facilities including resident beds. Services provided include continuous supervision of residents, basic health and health-related services, personal care services, residential care services, and social and recreational activities. A PCH may be a stand-alone facility or be housed within a Nursing Facility (NF) or Institution for Mental Diseases (IMD).

1. State Supplementation recipients are categorically eligible for Medicaid unless they reside in a PCH located in an IMD and are between the ages of 21 and 64. Refer to MS 1100 for more information on PCHs located in IMDs.

2. Individuals residing in any PCH are not eligible for waiver services.

B. Family Care Homes provide residential accommodations for individuals who need assistance with activities of daily living, but do not require constant medical care or skilled nursing services. An FCH is a residential home for no more than 2 or 3 individuals.

Individuals in a FCH may receive waiver services as long as it is verified that there is no duplication of services. The worker must request a list of services from both providers for verification.

C. Community Integration Supplementation (CIS) allows individuals residing in a PCH, or are at risk of entering a PCH or other institution, an alternative living arrangement. To be eligible for State Supplementation in the CIS category individuals must meet all criteria listed in 1, 2, and 3 below.

1. Individuals must reside in a private residence or reside in a PCH but intend to move to a private residence.

2. Individuals must have a serious mental illness which:

a. Impairs or impedes the individual's functioning in at least one major area of living;

b. Is unlikely to improve without treatment, services, or supports; and
c. Does not include a primary diagnosis of Alzheimer's disease or dementia.

Individuals must provide a written statement at application, annual review, and recertification verifying they have a serious mental illness that meets the above criteria. The statement must be signed by a licensed physician, licensed psychiatrist, certified psychologist, licensed registered psychiatric nurse, licensed clinical social worker, licensed marriage and family therapist, or credentialed professional counselor

3. Individuals must have the need for care and support above and beyond room and board.

Written verification of care and support is required at the initial eligibility determination, whether by application or case change, annual review, and a at recertification. The verification may be provided by the individual, authorized representative (AR), care coordinator, or by the person(s) providing care to the individual. Verification of care and support must include the following information:

a. The services required and how often each service is provided;
b. The amount and how often payment is made for the service; and
c. That the services provided prevent institutionalization.

Note: An individual's care coordinator or the person(s) providing care to the individual may complete form CIS-1, Community Integration Supplementation Optional Checklist, to verify care and support needs. The completion of form CIS-1 is not a mandatory.

4. Individuals receiving CIS may receive waiver services as long as it is verified that there is no duplication of services. The worker must request a list of services from both providers for verification.

D. Caretaker Services may be provided by someone hired to come to an individual's house on a regular basis to do light housekeeping, assist with medications, assist with meal preparation, or provide other similar services. Services must prevent institutionalization in a NF or other facility.

1. Services must be provided by the caretaker at regular intervals to prevent institutionalization and allow an individual to remain in a home setting.

2. Services may be provided by either a live in attendant or one or more persons hired to come to the home.

3. Individuals are not eligible for State Supplementation for Caretaker Services:

a. If the caretaker is the individual's spouse, parent, or adult child IF living in the same home; or
b. If the individual is taken to the home of the caretaker, such as a sitter type arrangement.

4. Verification

   a. A written statement from the caretaker must be provided at application, annual review, and recertification. The written statement must contain the types of services the caretaker is providing, how often each service is provided, and how much and how often payment is made for the service.
   b. A written statement from a medical provider must be provided at application, annual review, and recertification to verify that services provided prevent institutionalization. The statement must specify the medical condition which prevents the individual from caring for themselves and the types of services needed to prevent institutionalization.

5. Individuals receiving Caretaker Services may receive waiver services if it is verified that there is no duplication of services. The worker must request a list of services from both providers for verification.

MS 1900* TEMPORARY STAY IN A MEDICAL INSTITUTION (1)

State Supplementation recipients may be eligible for continuation of benefits during a temporary stay in a medical facility such as a hospital or Nursing Facility (NF). This allows individuals to continue their State Supplementation so they can pay the necessary expenses to maintain their living arrangement while temporarily institutionalized. The continuation of benefits is only allowed when it is verified that the stay is expected to be temporary.

A. A temporary stay is defined as 3 full months in a medical facility. This can also include the partial month prior and the partial month after the three full months.

   1. If an individual is admitted on the first day of the month, the 3-month count begins with the month of admission to the facility. Otherwise, the 3-month count begins the first day of the month following the month of admission.

   2. If the recipient is discharged prior to the last day of the month following the third full month of institutionalization, the stay is still considered temporary.

      Example: Bob broke his hip in December and entered the NF for rehabilitation on January 13th. Bob's 3-month count begins February. He remained in the NF until May 17th so his three full months are February, March, and April. January and May are not considered in the 3-month count because they are partial months.

B. The following are the reasons to continue State Supplementation benefits:

   1. The recipient maintains his/her home or other living arrangement during a temporary admission to a health care facility; and

   2. The recipient is anticipated to be institutionalized no longer than 3 full months as verified by a physician.

C. A temporary admission shall be limited to the following medical facilities:

   1. Hospital;

   2. Psychiatric hospital; or

   3. Nursing Facility.

D. When a Level of Care (LOC) is received for a State Supplementation individual, a task will be generated called 'State Supplementation Recipient Institutionalized'.

   1. If the appropriate verification is received verifying institutionalization is temporary;

a. Add a new record to the State Supplementation case to update the living arrangement to LTC facility; and
b. Answer the appropriate questions regarding temporary admission to a health care facility and the expected date of return; and
c. Enter the cost of the Personal Care Home (PCH), Family Care Home (FCH), or Community Integration Supplementation (CIS) as a medical deduction in the patient liability calculation. The cost for a PCH or FCH is the standard minus the personal needs allowance. A deduction for caretaker services is not an allowable medical expense.

2. If the stay has not been verified as temporary Worker Portal will run eligibility and discontinue the State Supplementation.

a. If Medicaid eligibility remains active when the State Supplementation is discontinued, a new Medicaid application is not required. Complete the necessary case changes to determine Medicaid eligibility for LTCM Type of Assistance (TOA).
b. If Medicaid eligibility discontinues when the State Supplementation is discontinued, a new application for Medicaid is required.

E. If the individual remains in LTC longer than 3 full months, follow established policy for SSI/State Supplementation individuals admitted to an LTC facility.

MS 2000* OVERVIEW OF INCOME (1)

Income is money received from any source, either earned or unearned. Earned income, such as wages, is money derived from the direct involvement in a work related activity. Unearned income, such as RSDI, SSI, pensions, etc. is money received which does not involve direct activity. It is important to determine if income is earned or unearned so Worker Portal will allow the correct deductions.

A. All income must be verified and documented at application, recertification, and any reported income change.

B. Verify the gross income before any taxes or other withholdings. The gross income is always entered on the system.

C. Worker Portal applies the $65 and ½ the remainder deduction from earned income. The $20 general exclusion from unearned income and deductions for medical expenses are not allowed in State Supplementation.

D. When determining income eligibility, the total countable income is compared to the State Supplementation Payment Standards. If the total countable income is equal to or less than the appropriate State Supplementation Payment Standard, income eligibility is met. Current State Supplementation Payment Standards may be found on Worker Portal under Tools > Reference Tables.

E. Document any unusual circumstances related to income in Case Notes. Scan income verification into the Electronic Case File (ECF).

MS 2100* EARNED INCOME (1)

Earned income is money derived from the direct involvement in a work related activity. The following are types of earned income.

A. Wages are salaries from full-time or part-time employment where taxes are withheld prior to receipt of pay. Wages include odd jobs, occasional, seasonal or contract employment.

1. Verification.

a. Pay stubs;
b. Written statement from employer;
c. Collateral contact with employer; or
d. Eligibility Advisor (EA).

2. Consideration.

a. To determine the estimated monthly income, verify and use income from all pay periods in the last two calendar months. If the last two calendar months' income does not represent the ongoing situation, use information available which best indicates the ongoing income
b. Count gross income. Garnishments on salary ARE NOT deducted.
c. For individuals obtaining employment who have not received a pay check or do not have a full month's pay stubs, consider the anticipated earnings. Calculate anticipated earnings based on the hourly rate and the estimated number of hours to be worked during a pay period.

B. Wages which are received under the Senior Community Service Employment Program (SCSEP) as authorized by Title V of the Older Americans Act, P.L. 100-175, if taxes are withheld.

Organizations that receive Title V funds are:

- Green Thumb;
- National Council on Aging;
- National Council of Senior Citizens;
- American Association of Retired Persons;
- U.S. Forest Service;
- National Association for Spanish Speaking Elderly;
- National Urban League; and
- National Council on Black Aging.

1. Verification.

a. Pay stubs;
b. Written statement from employer; or
c. Collateral contact with employer;

2. Consideration. Consider as continuing income.

C. Seasonal employment is income from employment during a limited period each year.

1. Verification.

a. Pay stubs;
b. Collateral contact with employer;
c. Current income tax return; or
d. Records maintained by individual.

2. Consideration.

a. Count anticipated earnings or actual earnings received in the month.
b. If employment has terminated before action can be effective, do not consider this income.

D. Self-Employment Income is income where taxes are NOT withheld prior to receipt of pay. Refer to Volume IVA MS 2450 for self-employment consideration.

MS 2200* UNEARNED INCOME (1)

Unearned income is money received which does not involve direct activity. The following types of income are considered unearned income.

A. Supplemental Security Income (SSI)

1. Verification.

a. State Data Exchange (SDX);
b. Award letter; or
c. Collateral contact with the Social Security Administration (SSA).

2. Consideration.

a. SSI payments are countable in the eligibility determination for State Supplementation.
b. If SSA withholds income due to overpayment, the amount actually received is the amount considered.

B. Statutory Benefits include RSDI, Railroad Retirement, Black Lung, Worker's Compensation, Unemployment Insurance, Veterans pension or compensation, Veterans Administration Improved Pension (VAIP), or other pensions. Verify the gross amount of the entitled benefit.

1. Verification.

a. System Inquiry—when using system inquiry, use the amount shown as "NET";
b. Award Letter; or
c. Collateral contact with the payer of benefits.

2. Consideration.

Enter the gross statutory benefit for all individuals. For benefits where income is not assigned to a specific individual, such as Veterans' benefits, consider as follows:

a. When only one individual is receiving the benefit, count the entire amount.
b. When the statutory benefit is intended to cover more than one individual, divide the total benefit by the number of recipients. Enter each individual's share in the case and Worker Portal will count appropriately using relative responsibility rules.

C. Annuities

1. Verification. Obtain the entire annuity contract.

2. Consideration.

a. All payments received from an annuity are considered countable income.
b. Payments received less frequently than monthly are converted to a monthly amount.

D. Contributions received from any source, including third party payments made on behalf of the recipient.

1. Verification. Statement from the individual providing the contribution or making the payment. A copy of the check is also acceptable.

2. Consideration. To determine the monthly amount of contributions or third party payments, average amounts received from previous 3 months if contributions are expected to continue.

E. Home Equity Plans (HEP) are designed to allow elderly homeowners to convert the equity value of their homes into cash without being forced to leave their homes.

1. Verification. Copy of specific HEP, such as a reverse mortgage, time sale, sale-leaseback, or loan.

2. Consideration. Carefully review the plan to determine the type of compensation, the amount received, and how often payments are received.

a. Payments and interest are considered as unearned income in the month received.
b. Proceeds other than interest and regular payments, i.e., lump sum payments and line of credit, are not considered income.

F. Income Supplementation is money received by the individual from the Bureau for Rehabilitation Services, an income protection plan or hospital confinement policy, such as AFLAC, etc., not used to reimburse actual costs of care.

1. Verification

a. Statement from Bureau for Rehabilitation Services;
b. Copy of income protection plan; or
c. Hospital confinement policy, etc.

2. Consideration. Consider regular monthly payments in determining initial and ongoing eligibility.

G. Loans are amounts of money borrowed which require repayment.

1. Verification. Form PAFS-73, Verification of Contributions-Loans-Roomer/Boarder Payments, is completed and signed by the lender and borrower when the loan is not from a legal lending institution.

2. Consideration.

a. Exclude loans verified by form PAFS-73 or from a legal lending institution.
b. If a completed form PAFS-73 is not received, consider the loan as income:
(1) A contribution if regularly received; or
(2) A nonrecurring lump sum if received once.

H. Lump Sum Payments are considered as unearned income in the month received.

1. Verify the lump sum amount by:

a. Statement from lawyer/trustee;
b. Award letter; or
c. Check stub.

2. Exceptions

a. Exclude lump sums from a federal or state income tax refund.
b. Exclude accumulated back payments of SSI and/or RSDI.
c. If the lump sum is from a worker's compensation settlement and includes a one-time lump sum payment and continuing weekly or monthly benefits, consider the one-time payment as a nonrecurring lump sum payment and the continuing benefits as unearned income in the appropriate month.
d. If the lump sum is from accumulated vacation or leave or severance pay it is considered earned income, not a nonrecurring lump sum.

I. Other Unearned Income includes, but is not limited to miner's benefits, pensions, dividends, oil leases, mineral rights, income received from an income indemnity policy, and trust income actually available.

1. Verification.

a. Check stubs;
b. Award letters;
c. Contract;
d. Trust agreement;
e. Written verification from the company or source; or
f. Bank and other financial statements (for investments only).

2. Consideration.

a. Consider regular payments as unearned income in the month received.
b. If unearned income is irregular, average the prior 3 months' actual income, even if some of the months have zero income. Sixty dollars per quarter is excluded from the calculation of irregular and infrequent unearned income.
c. If disbursements from IRAs are not received monthly, then the amount received is prorated over the period of time it is intended to cover. For example, a quarterly payment is divided by 3 and is considered as monthly income.

J. Promissory Notes, Loans, Mortgages, and Land Contracts are written promises, claims, or contracts for which payment is received by the recipient over a period of time.

1. Verification. Contract or other written agreement.

2. Consideration.

a. Consider both the principal and interest of payments received as unearned income.
b. For payments received on a land contract, deduct any verified amounts the client pays for mortgage, insurance, and taxes to determine total countable income.

K. Unearned Farm Business is Farm/business income with no direct involvement in farm/business activities. Refer to Volume IVA MS 2250 for Unearned Farm Business income consideration.

MS 2300* EXCLUDED INCOME (1)

Excluded income is income received, but not considered, in determining financial eligibility for State Supplementation.

A. Low Income Home Energy Assistance Program (LIHEAP) payments.

B. Any payment made for child foster care, adult foster care, subsidized adoptions or personal care assistance.

C. In kind income.

D. Replacement of income already received. If income is lost, stolen or destroyed and the individual receives a replacement, the replacement is not income.

E. Cash, including interest accruing from cash, or an in kind item received to repair or replace a damaged, lost or stolen excluded resource.

F. Educational grants and scholarships obtained and used under conditions that preclude their use for current living costs, including payments for actual education costs made under the Montgomery GI Bill and educational payments made under the Carl D. Perkins Vocational and Applied Technology Educational Act Amendments of 1990 made available for attendance costs. Attendance costs are described as:

1. Tuition and fees normally assessed a student carrying the same academic workload required of all students in the same course of study as determined by the institution, including cost for rental or purchase of any equipment, materials or supplies; and

2. An allowance for books, supplies, transportation, dependent care and miscellaneous personal expenses for a student attending the institution on at least a half-time basis, as determined by the institution.

G. Principal of loans, including educational loans. Verify the loan by a commercial loan contract, form PAFS-73, Verification of Contributions – Loans – Roomer/Boarder Payments. When verification is received, exclude the loan amount. If verification is not received, consider the principal of the loan as a contribution in the month received and any remaining amount as a resource in subsequent months.

H. Highway relocation assistance.

I. Urban renewal assistance.

J. Federal disaster assistance and State disaster grants.

K. Payments by credit life or credit disability insurance.

L. Experimental housing allowance program payment made under annual contributions contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended, and HUD Section 8 payments or existing housing under Title 24, Part 882.

M. Reparation payments from the Republic of Germany.

N. Public Law benefits and payments to:

1. Elderly persons under Title VII, Nutrition Program for the Elderly, of the Older Americans Act of 1965, as amended;

2. Elderly persons receiving unearned income or payments with no taxes withheld under the Senior Community Service Employment Program (SCSEP) as authorized by Title V, of the Older Americans Act P.L. 100-175;

   Organizations that receive Title V funds are:

   a. Green Thumb;
   b. National Council on Aging;
   c. National Council of Senior Citizens;
   d. American Association of Retired Persons;
   e. U.S. Forest Service;
   f. National Association for Spanish Speaking Elderly;
   g. National Urban League; and
   h. National Council on Black Aging.

3. VISTA volunteers under Title I of PL 93-113 pursuant to Section 404(g);

4. Individual volunteers for supportive services or reimbursement of out-of-pocket expenses while serving as foster grandparents, senior health aides, or senior companions and to persons serving in Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE), and any other programs under Titles II and III, pursuant to Section 418 of PL 93-113; and

5. Indian tribe members under PL 92-524, PL 93-134, PL 94-114 pursuant to Section 5 effective October 17, 1975 or PL 94-540.

O. Up to $12,000 to Aleutians and $20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardship experienced during World War II. All recipients of these payments are provided with written verification by the federal government.

P. VA Aid and Attendance Allowance (VA A&A), VA Unreimbursed Medical Expenses (VA UME), and VA Compensated Work Therapy (VA CWT).

Q. All payments received from Agent Orange.

R. Victim compensation payments received from a fund established by a state to aid victims of crime.

S. Income included in a Plan for Achieving Self-Support (PASS).

T. Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

U. All student work study income, educational grants and loans to any undergraduate made or insured under any program administered by the U.S. Commissioner of Education or under the Bureau of Indian Affairs student assistance programs.

V. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.

W. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using SSI standards. This income is NOT excluded by SSA, so these recipients should not be SSI eligible. If the hemophiliac is income ineligible for some other reason, pend the application and contact MSBB at DFS.Medicaid@ky.gov through your Regional Program Specialist for further instructions.

X. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.

Y. Payments made from the Crime Victims Funds.

Z. Section 401 of the Veterans Benefits and Health Care Improvement Act of Public Law 106-149, provides for certain benefits for individuals with covered birth defects during the Vietnam era. There is no age limit for recipients of these benefits. These individuals will receive the benefits until they die.

AA. Thirty dollars per quarter of infrequent/irregular earned income from an employer, a trade, or a business. Income is considered to be received infrequently if an individual receives it only once during a calendar quarter and the individual did not receive that type of income in the months immediately before and/or after, regardless of whether or not these payments occur in different calendar quarters. Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

BB. Sixty dollars per quarter of infrequent/irregular unearned income received from an individual, a household, an organization, or an investment. Income is considered to be received infrequently if an individual receives it only once during a calendar quarter and the individual did not receive that type of income in the months immediately before and/or after, regardless of whether or not these payments occur in different calendar quarters.

Income is considered to be received irregularly if an individual cannot reasonably expect to receive it.

CC. All interest and dividend income.

DD. Tobacco Settlement Income is excluded in the month of receipt and the month after receipt. It is considered a countable resource in the third month and thereafter.

EE. Military combat pay.

FF. Placing Adults in Competitive Employment (PACE) income.

MS 2400* INCOME CALCULATIONS FOR COUPLES (1)

The amount of countable income in cases involving couples is determined by whether the spouses are eligible or ineligible. An eligible spouse is someone who has been determined as aged, blind, or disabled. An ineligible spouse is someone who has not been determined as aged, blind, or disabled. The following steps are completed by Worker Portal to calculate the amount of countable income in the eligibility determinations for State Supplementation cases involving couples.

A. Caretaker Services, with both members determined to be aged, blind, or disabled:

1. There are no income allowances made for minor dependent children of the couple.

2. If the eligible spouse has income:

a. The income of both spouses is combined; and
b. The total amount is considered as countable income and is compared to the standard for Eligible Couple (One Receives Care) or Eligible Couple (Both Receive Care); whichever is appropriate.

B. Caretaker Services, with a spouse who is NOT aged, blind, or disabled:

1. No income deductions are allowed from the eligible spouse's income for the ineligible spouse and/or minor children.

2. None of the ineligible spouse's income will be counted in the eligibility determination if his/her gross income is less than or equal to the difference between the SSI payment standard for an individual and the SSI payment standard for a couple.

3. If an ineligible spouse has gross income greater than the difference between the SSI payment standard for an individual and the SSI payment standard for a couple, Worker Portal will determine how much of the ineligible spouse's income is counted in the eligibility determination using the following steps.

a. $65 and 1/2 the remainder is subtracted from the ineligible spouse's gross earned income;
b. The result is added to the ineligible spouse's gross unearned income and the following are deducted, as appropriate:
(1) 1/2 the SSI payment standard;
(2) For each minor child with no income, 1/2 the SSI payment standard;
(3) For each minor child with income less than 1/2 the SSI payment standard, the difference between 1/2 the SSI payment standard and the child's income; or
(4) For each minor child with income greater than 1/2 the SSI payment standard, no deduction is allowed.

4. If any of the ineligible spouse's income remains after deductions, that amount is considered in the applicant's eligibility determination.

5. The final amount is compared to the Caretaker Services standard for Individual With Ineligible Spouse.

C. Couples receiving Community Integration Supplementation (CIS) or residing in the same Personal Care Home (PCH) or Family Care Home (FCH).

1. Couples residing in the same PCH or FCH or couples receiving CIS are considered as individuals, for relative responsibility purposes, the month after the month they begin residing in a PCH or FCH or begin receiving CIS services.

2. For the first month that the couple is receiving State Supplementation, combine the total income of the couple and consider ½ as available to each.

3. Consider each member as an individual the following month.

4. Compare the total countable income for each individual to the standard for PCH, FCH, or CIS Individual, whichever is appropriate.

   Note: If approved, each individual will receive a separate payment.

5. If consideration as an individual results in ineligibility for either spouse at any time, compute income as a couple. This means that half of the total combined income is considered as available to each.

   Example: Jim and Sally are a couple and both are technically eligible for CIS. Jim receives $1300 RSDI each month and Sally receives $750 RSDI each month. Jim is over the income limit for CIS. Combine Jim and Sally's income for a total of $2050 and count 1/2 ($1025) to each so both will be eligible for CIS.

D. Couples living in different PCH or FCH with both applying for, or receiving, State Supplementation benefits.

1. For the month the couple cease living together in a household, combine the total income of the couple and consider ½ as available to each.

2. Consider only the income of the individual beginning the month after the month of separation.

3. Compare the total countable income to the standard for PCH Individual or FCH individual, whichever is appropriate.

4. If either spouse is over the income limit, his or her State Supplementation payment is denied or discontinued. Income cannot be combined if the spouses are living in a different PCH or FCH.

E. Couples with one residing in a PCH or FCH and the other remaining at home, or in an institution, and both determined to be aged, blind, or disabled, follow steps 1 through 4 in part D above.

MS 2500* OVERVIEW OF RESOURCES (1)

Resources are defined as assets an individual or couple own and can use to meet basic needs of food, clothing, and/or shelter. Resources may be available money, real property, personal property, or other assets. When litigation is pending to determine to whom resources belong, the resources are not considered available.

A. Resources must be verified and documented in the case as to whether they are countable or excluded. Obtaining verification of resources is the applicant's responsibility. Scan resource verification into the Electronic Case File (ECF).

B. Verify and document resources at application, reapplication, and recertification. Whenever resources are near the limit, workers must make the applicants/recipients aware, and remind them of the requirement to report all changes in circumstances timely.

C. The total countable resources an individual or couple may have to be considered resource eligible for State Supplementation are:

INDIVIDUAL	$2,000
COUPLE	$3,000

1. Do not count the current month's income as both income and a resource.

   EXAMPLE: Bill applies for State Supplementation on December 29th and his verified checking account balance is $2,500. His Supplemental Security Income (SSI) of $750 was direct deposited into the account on December 3rd. Bill's countable resource would be $1,750.

2. If resources exceed limits, reduce the countable resources by any verified liability against them, such as outstanding checks drawn against an account.

   EXAMPLE: John applied for State Supplementation on February 15th and verified that his checking account balance was $2,300. He explained that his rent check of $500 had not yet cleared the bank and provided his check register as proof. John's countable resources would be $1,800.

3. If the total countable resources are equal to or less than the limit at the time an application or recertification is processed, the case is resource eligible. If the total countable resources exceed the limit at the time the application or recertification is processed the case is resource ineligible.

   EXAMPLE: Ann is single and applies for State Supplementation on March 1st. Her verified checking account balance is $4,000. She says she has some bills she needs to pay and will bring back verification. On March 29th, she brings in a new bank statement. Her verified balance is now $1,500 and Ann is resource eligible.

D. Transfer of resources are not considered in State Supplementation. However, if the member is also receiving waiver services or enters a Nursing Facility (NF), refer to Volume IVA MS 2050 for policy regarding transfer of resources.

MS 2600* CONSIDERATION OF RESOURCES (1)

Countable resources are assets that are considered in the State Supplementation eligibility determination. When a resource is sold, the proceeds are not considered income, but a change in the type of resource. It must be determined if the proceeds are a countable or excluded resource.

The following resources are countable.

A. Liquid assets, including cash, bank accounts, cash cards such as Direct Express cards, certificate of deposit (CD), stocks, bonds, mutual fund shares, promissory notes, mortgages, and land contracts.

1. Verification

The following are acceptable source of verification for liquid assets:

a. Eligibility Advisor (EA);
Note: Although EA can be used for verification, reasonable compatibility is not performed on, and does not apply to, State Supplementation.
b. Statements from banks or other financial institutions;
c. Account printouts from the bank or the bank's website;
d. Stock certificates;
e. Copies of bonds;
f. Financial instruments, such as contracts; or
g. Other sources of documentation such as dated ATM receipts.
Note: ATM receipts are only allowed if no other documentation is obtainable. The ATM receipt must have a legible date and may only verify account balances for the month dated. The account holder must sign the ATM receipt.

2. Consider liquid assets in the State Supplementation eligibility determination, unless listed in MS 2700 as excluded.

3. The value of stocks, bonds, and mutual fund shares is based on the market value the day they are verified.

4. Promissory notes, loans, mortgages, and land contracts that can be sold and are negotiable.

5. Interest from an interest bearing checking and/or savings account is countable beginning the month after it is received.

6. Both the principle and interest of a CD if the interest is allowed to accrue and is not paid directly to the individual owner. If the owner receives the interest directly, the remaining CD principle is considered.

7. Cash payments for medical or social services that are still held in the second month following receipt.

EXAMPLE: In January, Bob receives $200 from his church for eyeglasses. He deposits the money in his checking account. If Bob does not use the money, the $200 is countable in March.

B. Vehicles that are not excluded for reasons listed in MS 2700. Note: $4,500 is excluded from the total equity value of all countable vehicles.

The following may be used when verifying the value of a vehicle:

1. The vehicle's registration;

2. Avis, which is accessed through the DCBS External Agency Search located on KOG;

3. Program 68, Vehicle Reg-Avis, which is accessed through KYIMS located on the KAMES Mainframe; or

4. The National Automobile Dealers Association (NADA) located at www.nada.com.

NOTE: If the client states the vehicle is not worth the value verified by NADA or Vehicles Reg-Avis, a written statement from a mechanic, wrecker services, or used car dealer verifying the value can be accepted. The written statement must be on the business letterhead.

C. Life insurance policies that accrue cash surrender value (CSV), which includes Modified Term Life and Whole Life insurance policies. The current anniversary CSV is considered, not the face value of the policy. If the client states that the policy is being used for burial, refer to MS 2700 for consideration.

Verification: The following must be verified and documented (all are required):

1. Name of policy owner;

2. Name of covered individual;

3. Name of Company;

4. Policy number;

5. Face value;

6. Cash Surrender Value (at application, reapplication and recertification); and

7. Loan balance, if any (at application, reapplication and recertification)

D. Non-home real property, or non-homestead property. Worker Portal determines the equity value of non-home real property by subtracting any debt owed on the property from the FMV.

Verification:

1. County tax records or an appraisal completed by an independent licensed appraiser may also be used to verify FMV.

2. The individual must verify any debt reported on the property to determine equity value. If the individual does not provide verification of debt, the entire FMV of the property is considered.

3. Document case notes regarding ownership of real property and indicate method of verification.

E. Trusts may be excluded or countable, depending on how it is established. OLS reviews all trusts to determine if they should be countable or excluded.

F. Home Equity Plans (HEP), such as Deferred Payment Loans, Reverse Mortgages, Sale-Leasebacks and Time Sales, that establish a line of credit. Consider the entire amount of the line of credit as a countable resource effective the month the line of credit becomes available.

Verification: Copy of the HEP.

G. Home Equity Plans that are paid to the State Supplementation applicant/recipient as a lump sum payment and/or a down payment are considered a countable resource in the month the lump sum and/or down payment is received.

Verification: Copy of the HEP.

MS 2700* EXCLUDED RESOURCES (1)

Excluded resources are assets that are not counted in the State Supplementation eligibility determination. Workers must review all resources thoroughly and compare to the list of excluded resources below to see how the resources will be considered in the case.

When an excluded resource is sold, the proceeds are not considered income, but a change in the type of resource. It must be determined if the proceeds are a countable or excluded resource.

The following resources are excluded:

A. A vehicle, if used by the spouse, for employment, as a home, to obtain medical treatment, or is specially equipped for the disabled.

   1. Exclude $4,500 from the total value of non-excluded vehicles.

   2. Recreational vehicles are counted in their entirety unless excluded for one of the reasons above.

B. Homestead Property

C. Burial space items such as conventional gravesites, crypts, mausoleums, urns, vaults, caskets, headstones, and opening and closing of the grave.

D. Term and burial life insurance policies that do not accrue cash surrender value.

   Verification: The following must be verified and documented (all are required):

   1. Name of the policy owner;

   2. Name of the covered individual;

   3. Name of the company;

   4. Policy number; and

   5. Face value.

E. Burial funds, if verified to be payable upon death.

F. $1500 from burial reserves for each member of the assistance group for the following assets set aside for burial such as cash, whole life insurance policies, or prearranged funeral contracts without an irrevocable assignment.

G. Interest on burial reserves, if allowed to accrue.

H. The value of a prearranged funeral contract if:

   1. There is a detailed itemized statement of goods and services, that includes prices for the individual items, and is signed by the funeral home and the individual or individual's spouse, power of attorney (POA), or legal guardian; and either

2. Funded by life insurance that has been irrevocably assigned to the funeral home. Verification is required from the insurance company stating the policy number, face value (FV), cash surrender value (CSV), and irrevocable assignment to the funeral home; or

3. Funded by cash with an Irrevocable Funeral Trust Agreement, Verification of the source of cash, such as a copy of the check or receipt is required; or

4. Funded by both cash and life insurance; or

5. Funded by cash with a purchase of an insurance policy through the funeral home.

I. Proceeds from the sale of a home, or insurance payments from the loss of a home, are excluded for 3 months if the intent is to use them to purchase another home.

J. Annuities, if OLS determines they are irrevocable and cannot be sold or transferred. Except for the following, OLS reviews all annuities to determine if criteria is met.

1. Pension annuities are never a countable resource and should not be entered on Worker Portal as annuities. This includes:

   a. United States Office of Personnel Management Annuities;
   b. New York Life Polyone Merged Pension Plan Annuities; and
   c. GE Retirement Services Annuities.

2. Any annuity designated as a Retirement Account; and

3. Any annuity designated as an Individual Retirement Account (IRA).

K. Trusts may be excluded or countable, depending on how it is established. OLS reviews all trusts to determine if they should be countable or excluded.

L. Life estate interest in real property or other property, such as mineral rights or an oil lease.

M. The first $6,000 of equity value of non-home, income producing property if it is essential for self-support of the individual, spouse, or family group. The remaining equity value is a countable resource.

Verification:

1. Eligibility Advisor (EA)
2. County tax records or an appraisal completed by an independent licensed appraiser may also be used to verify Fair Market Value (FMV).
3. The individual must verify any debt reported on the property to determine equity value. If the individual does not provide verification of debt, the entire FMV of the property is considered.
4. Document case notes regarding ownership of real property and indicate method of verification.

N. Non-home property that is unable to sell is excluded, but not permanently. At each certification or reapplication, reasonable effort to sell must be verified. A reasonable effort to sell shall consist of:

1. Listing the property with a real estate agent. Obtain a copy of the sales agreement or contract and verify:

   a. Verification of a “For Sale” sign being placed on the property which is clearly visible from the nearest public road; and
   b. Is advertised in the local newspaper, television or radio stations or the internet.

2. If the property is being sold privately, a combination of at least two of the following actions must occur:

   a. Advertising the property in the local newspaper, on local television or radio stations, or the internet;
   b. Placing a “For Sale” sign on the property that is clearly visible from the nearest public road;
   c. Distributing fliers advertising the property for sale;
   d. Posting notices regarding availability of the property on community bulletin boards; or
   e. Showing the property to interested parties on a continuing basis, documented on a log with dates.

O. Property in which a co-owner refuses to sell. Require written verification from the co-owner.

   EXAMPLE: Betty owns a property with her brother, Doug, which is valued at $100,000. Betty states Doug refuses to sell the property. She provides a written statement from Doug verifying that he refuses to sell. The entire property value is excluded.

P. Household equipment, such as furniture or appliances, and personal effects, such as clothing or jewelry.

Q. Equity value of all equipment, livestock, or other inventory used in a farming or self-employment enterprise.

R. Lump sum back payments from SSI and/or RSDI are excluded for the first 6 months following the month of receipt. Deduct current month's benefits from the back payment prior to determining the excluded resource amount. At the end of the 6 month period, consider any remaining amount as a countable resource.

S. Retirement plans, such as IRAs, KEOGH plans, deferred compensation, tax deferred retirement plans and other tax deferred assets are excluded from consideration as a resource.

T. An Individual Development Account (IDA) up to a total of $5,000, plus accrued interest.

U. ABLE accounts (known as STABLE accounts in Kentucky) are excluded in their entirety regardless of which state the account is located.

V. Money received to repair or replace a damaged, lost, or stolen excluded resource is excluded for 9 months, with an additional 9 months if the client requests and can

show good cause. Exclude any interest that accrues while waiting for the repair or replacement of the item.

W. Resources which are inaccessible for 30 days or more. Require written verification of inaccessibility of the resource from the institution holding the resource.

X. Earned Income Tax Credit (EITC) payments for 12 months from the month of receipt.

Y. All payments received from Agent Orange.

Z. Relocation assistance provided by a state or local government comparable to assistance provided under Title II of the Uniform Relocation Assistance and Real Property Acquisitions Policies Act of 1970, which is Relocation subject to the treatment required by Section 216 of such Act.

AA. Payments for a medical or social service are excluded in the month of receipt and the following month.

Medical or social services include:

1. A medical expense not covered by insurance or Medicaid;

2. A social service expense, such as drug counseling; or

3. A reimbursement for a medical or social service bill the individual has already paid.

BB. Disaster relief assistance.

CC. Refunds from a waiver provider made to a waiver recipient who was determined to be otherwise Medicaid eligible retroactively and should not have incurred a patient liability. This includes individuals who should have been previously determined eligible for Pass Through. There is no time limit to this exclusion.

DD. Energy Employees Occupational Illness Compensation (EEOIC). These payments must be kept separate and not comingled with other countable resources. Interest on the unspent EEOIC payment is a countable resource the month after receipt.

EE. Victims Compensation payments. Exclude completely for nine months any payments received for losses and incurred expenses, such as lost wages or property, medical treatment, etc. Victim compensation payments received from a fund established by a state to aid victims of crime, to the extent that the individual can verify that the amount was paid as compensation for pain and suffering purposes, for expenses incurred, or losses suffered as a result of a crime.

FF. Money paid to hemophiliacs as part of a class action suit for Factor VIII or IX clotting agent. Additionally, these hemophiliacs must have their financial eligibility determined using the SSI standards. This resource is NOT excluded by SSA, so these recipients should not be SSI eligible. Enter these applications on Worker Portal. If the hemophiliac is resource ineligible for some other reason, pend the application and contact the Medical Support and Benefits Branch (MSBB) through your Regional Program Specialist for further instructions.

GG. Money paid to individuals in the Susan Walker vs. Bayer Corporation class action suit.

HH. Payments made by the Nazi Persecution Victims Eligibility Benefits Act (P.L. 103 286) to compensate victims of Nazi persecution. Accept a signed statement from the individual of the amounts involved and the dates payments were received. No additional documentation is required.

II. Austrian social insurance payments based, in whole or in part, on wage credits granted under Paragraphs 500-506 of the Austrian General Social Insurance Act.

JJ. Up to $12,000 to Aleutians and up to $20,000 to individuals of Japanese ancestry for payments made by the federal government to compensate for hardships experienced during World War II. All recipients of these payments are provided with written verification by the federal government.

KK. Resources included in a Plan for Achieving Self-Support (PASS).

MS 2800* RETURN OF STATE SUPPLEMENTATION CHECKS (1)

Individuals must return any State Supplementation payment received for which they are not eligible. Individuals, their Authorized Representative (AR), or any other interested party may return checks to the local Department for Community Based Services (DCBS) office.

Individuals are eligible for the State Supplementation payment for a month in which services were received; however, any checks received in the following month must be returned.

Example: Fred is discharged from the Personal Care Home (PCH) to live with his sister on 12/23/2017. Fred isn't eligible for the January 2018 State Supplementation payment. He must return the January check.

A. The individual, or their AR, payee, or guardian, is required to return any State Supplementation checks received the month after:

   1. An individual is discharged from a PCH, unless they are going to another PCH or are receiving Community Integration Supplementation (CIS);

   2. An individual is discharged from a Family Care Home (FCH) unless they are going to another FCH;

   3. The death of the recipient; or

   4. The individual stops receiving Caretaker Services or CIS services.

B. The PCH or FCH is required to return any State Supplementation checks received the month after:

   1. The individual is discharged from the PCH or FCH; or

   2. The death of the recipient; or

   3. The PCH or FCH voluntarily relinquishes their license to the Cabinet for Health and Family Services (CHFS).

C. When a State Supplementation check is returned to the local office, a worker must review the case to determine why the check was returned and whether or not the individual is eligible to keep the check. The worker must contact the PCH, FCH, Caretaker, or CIS care coordinator (or the AR if there is no care coordinator) to determine if the individual is still receiving services.

   1. If the individual is eligible to keep the check and it was returned due to a change of address or change in State Supplementation living arrangement. Complete the follow steps below:

a. Update the individual's mailing address, if required;
b. Update the Living Arrangement screen to reflect the new PCH, FCH, or in home arrangement of Caretaker Services or CIS;
c. Document thoroughly in Case Notes; and
d. Mail the check to the updated address.

2. If the individual is not eligible to keep the check because they are no longer receiving services, or have moved to a Nursing Facility (NF), or they are deceased:

   a. The worker must take appropriate action in Worker Portal to update case information and document Case Notes thoroughly.
   b. Send the check, along with a completed form PAFS-61, Disposition of Returned check, to the Division of Family Support (DFS) at the address below:

      Division of Family Support
      Family Self-Sufficiency Branch
      KTAP Section
      275 E. Main Street, 3E-I
      Frankfort, KY 40621

3. If an individual reports they did not receive their State Supplementation payment, or that it was lost or stolen, refer to Volume I, MS 0110.