Cheryl Roberts
DIRECTOR

Department of Medical Assistance Services

SUITE 1300
600 EAST BROAD STREET
RICHMOND, VA 23219
804/786-7933
800/343-0634 (TDD)
www.dmas.virginia.gov

July 1, 2025

Virginia Medical Assistance Eligibility Manual Transmittal
#DMAS-35

The following acronyms are contained in this letter:

- ABD FPL – Aged, blind or disabled Federal Poverty Level
- AR – Authorized Representative
- CBC - Community Based Care
- DDS – Disability Determination Services
- DMAS – Department of Medical Assistance Services
- FC – Foster Care
- LDSS – Local Department of Social Services
- MN – Medically Needy
- ROP – Reasonable Opportunity Period
- SBE – State Based Exchange
- SSA – Social Security Administration
- TANF – Temporary aid to Needy Families
- TN – Transmittal

TN #DMAS-35 includes policy clarifications, updates and revisions. Unless otherwise noted in the Cover Letter and/or policy, all provisions included in this transmittal are effective with eligibility determinations and post-eligibility (patient pay) calculations made on or after July 1, 2025.

The following changes are contained in TN #DMAS-35:

Changed Sections	Changes
Subchapter M0120.200	Department of Juvenile Justice staff may sign the application and act as an Authorized Representative for individuals under age 18.
Subchapter M0130.001 B.3.	System inquiries are considered agency knowledge and should be inquired prior to application processing.
Subchapter M0130.200	Income and resource documentation can be used for 6 months, not 12.
Subchapter M0130.500	Adds texting as a method to communicate with clients. Adds AR mail and procedures and that these procedures apply to intake, renewals and changes.
Subchapter M220	Adds dates to ROP policy. Explains that any additional ROP starts the day after the last ROP and that the individual will be given no more than 2 within a certification period. Removes requirement to apply for other benefits.
Subchapter M0310.112.H.3	If DDS is still processing the client's disability claim on the 75th day from when the claim was received from the LDSS, they will send a delay letter to the worker and the client. Upon receipt of the delay letter, LDSS should send an "extend pend" notice to the applicant. No alert will generate in VaCMS.
Subchapter M0310 App 1	Updated DDS contact information.

Subchapter M0320.400	Formatting updated. Medicaid Works recipients do not require a medical screening to receive personal care services. Medicaid Works enrollees who lose SSA monetary payments remain considered disabled. Remove references to good cause and the 6 month grace period (if the Medicaid Works recipient loses their job). Update 1619(b) threshold for 2025.
Subchapter M0330.109	Clarify that no financial calculation is required for Former Foster Care eligibility.
Subchapter M0440.100 p15	Reference Appendix 8 instead of Appendix 7. Update Tax Filing Threshold for individuals under 65.
Subchapter M0410.100.C.7	Updates link and level C information.
M0420.100 p 4 M0440.100 p 14	Income and resource documentation can be used for 6 months, not 12.
Subchapter M0450.100 A.2; M0440.100 p 33	Updates MAGI household composition if a child is a resident of a Level C PRTF for at least 30 days. Income and resource documentation can be used for 6 months, not 12.
Chapter M04 Appendix 8	Difficulty of care payments added to income chart and income limits updated.
Chapter M07; Subchapter M0710.001	MN income limits updated. Income and resource documentation can be used for 6 months, not 12.
Subchapters M0810,002 M0810.500	Dates corrected for ABD FPL income updates. Income and resource documentation can be used for 6 months, not 12.
Subchapter S0815.270	Removed 12 month limit to exempt COVID-19 payments.
Subchapter M0830.225 M0830.645	Written release from the client must be provided to OPM when requesting information. Refugees are eligible for RMA for first four months of U.S. residence.
Subchapters M1110.200 M1130.679	Resources funded by needs-based programs such as TANF, FC are exempt.
Subchapter 1130.410	Remove requirement to reverify burial funds at renewal.
Subchapter M1420.200; .400	Clarify screening requirements for Medicaid Works participants and individuals residing in nursing facilities
Subchapter M1450.630; 700; 830	Update private average daily nursing facility rate. Clarify that any medical provider's statement regarding whether the inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care; not only "physicians". Remove requirement for local workers to send the DMAS-225 to DMAS when a penalty period is determined.
Subchapter M1470.910	Add exception for reduction of patient pay in the past when there is no other way to make the member whole (e.g. ongoing patient pay is zero).
Subchapter M1470 and M1480; M1480.400	Clarify which Medicaid recipients do not have a patient pay liability. Update monthly maintenance needs allowance and excess shelter standard.
Subchapter M1520.200 & M1520.402	Ex Parte applies to all types of Medicaid cases. Clarify timing for when the screening period and Extended Medicaid periods occur.

Please retain this TN letter for future reference. Should you have questions about information contained in this transmittal, please contact Sara Cariano, Director, DMAS Eligibility Policy & Outreach Division, at sara.cariano@dmas.virginia.gov or (804) 229-1306.

Sincerely,

Sarah Hatton

Sarah Hatton, M.H.S.A.
Deputy of Administration and
Coverage

Attachment

M0120 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 2 and 5
TN #DMAS-30	1/1/24	Page 17
TN #DMAS-25	10/1/22	Page 7
TN #DMAS-23	4/1/22	Pages 9, 10, 16, 17, 19
TN #DMAS-18	1/1/21	Pages 11, 17 Page 12 is a runover page. Page 12a was added as a runover page.
TN #DMAS-17	7/1/20	Pages 2, 2a, 5, 7, 8, 13, 16 Page 6 is a runover page. Page 14 was removed. Pages 15-20 were renumbered.
TN #DMAS-14	10/1/2019	Pages 7, 10, 11, 18 Page 20a was deleted.
TN #DMAS-12	4/1/19	Pages 2, 12-13,15, 20a
TN #DMAS-10	10/1/18	Pages 2, 4, 15, 17-20 Page 20a was added as a runover page.
TN #DMAS-8	4/1/18	Page 12
TN #DMAS-6	10/1/17	Page 1
TN #DMAS-5	7/1/17	Page 2a
TN #DMAS-4	4/1/17	Pages 2a, 7, 10, 13
TN #DMAS-3	1/1/17	Page 15
TN #DMAS-2	9/1/16	Pages 2, 15 Page 2a is a runover page.
TN #DMAS-1	6/1/16	Pages 7, 10, 11, 16-20
TN #100	5/1/15	Table of Contents Pages 1, 2, 15, 20 Page 2a and 16 are runover pages.
UP #10	5/1/14	Table of Contents Pages 11, 16-18 Pages 11a and 11b were deleted. Pages 19 and 20 were added.
TN #99	1/1/14	Page 11 Pages 11a and b were added.
TN #98	10/1/13	Table of Contents Pages 1-17
UP #9	4/1/13	Page 13, 15, 16
UP #7	7/1/12	Pages 1, 10-12
TN #96	10/1/11	Table of Contents Pages 6-18
TN #95	3/1/11	Pages 1, 8, 8a, 14
TN #94	9/1/10	Pages 8, 8a
TN #93	1/1/10	Pages 1, 7, 9-16
Update (UP) #1	7/1/09	Page 8
TN #91	5/15/09	Page 10

- a change in the case name,
- a change in living arrangements, and
- a change in income.

A change in living arrangements may require a partial review of the individual's eligibility when the change results in a change to the assistance unit. Whenever the change requires verifications that can be used to complete a renewal, the annual renewal should be completed at the time the change is reported.

M0120.200 Who Can Sign the Application

A. Incarcerated Individuals

Offenders of any age who are being held in Department of Corrections (DOC) or Department of Juvenile Justice (DJJ) facilities may have applications submitted with the assistance of DOC or DJJ staff. *DJJ staff may sign the application and act as Authorized Representatives for individuals under age 18.*

Offenders of local and regional jails may submit applications for themselves, authorize facility staff to assist, or designate an authorized representative to assist in applying.

For new applications, send all notices and correspondence to the mailing address listed on the application (normally the facility address). For re-entry and pre-release applications, send all notices and correspondence to the post-release mailing address of the individual.

B. Applicants Age 18 or Older

The applicant must sign the application, even if the form is filled out by another person, unless the application is filed and signed by the applicant's legal guardian, conservator (known as the “committee” for persons declared incompetent prior to the 1997 changes in the guardianship section of the Code of Virginia), attorney in fact, or authorized representative. A spouse, aged 18 or older, may sign the application for his spouse when they are living together.

EXCEPTION: A parent can submit and sign an application for a child under age 21, when the child is living with the parent. The child does not need to authorize the parent to apply or conduct Medicaid business on his behalf.

If the applicant cannot sign his or her name on a paper application but can make a mark, the mark must be correctly designated (the individual's first and last name and the words "his mark" or "her mark" must be printed adjacent to the mark) and witnessed by one person as in the example below:

E.g.: (X) John Doe, his mark

Witness's signature:_____

NO: Does the applicant have at least one of the following who is age 18 or older:

- spouse,
- child,
- parent,
- sibling,
- grandchild, niece or nephew, or
- aunt or uncle?

YES: The authorized representative is the individual identified above who is willing and able to act on the applicant's behalf.

NO: Verify the inability of the applicant to sign the application because of a diagnosis or condition through a written statement from the applicant's doctor. Refer to APS. Pend the application. At the conclusion of the APS investigation, if APS concludes that guardianship proceedings will not be initiated, the applicant must sign or make a mark on the application or designate an authorized representative in writing. If the signed application form is not received by the specified date, deny MA.

C. Applicants Under Age 18

1. Child Applicant

A child under age 18 years is not legally able to sign his own *MA* application unless he is legally emancipated from his parents. If the child is not legally emancipated, one of the following individuals who is age 18 or older must sign the application:

- his parent (custodial or non-custodial)
- legal guardian,
- authorized representative *(including Department of Juvenile Justice staff for individuals under 18)*, or
- an adult related by blood or marriage with whom the child lives (documentation of the relationship is not required).

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 1, 9, 10 and 15
TN #DMAS-34	1/1/25	Page 9
TN #DMAS-33	10/1/24	TOC, Pages 1, 6, 6a, 12-14 Page 15 is added.
TN #DMAS-32	7/1/24	Pages 9 and 10
TN #DMAS-29	10/1/23	Page 12
TN #DMAS-27	4/1/23	Page 6a
TN #DMAS-25	10/1/22	Pages 9,10
TN #DMAS-23	4/1/22	Pages 5, 12
TN #DMAS-21	10/1/21	Page 14
TN #DMAS-20	7/1/21	Page 2 Page 2a is a runover page.
TN #DMAS-18	1/1/21	Pages 4, 8, 13

M0130.001 Medical Assistance Application Processing Principles

A. Introduction

Under the Affordable Care Act (ACA), the Medicaid and FAMIS medical assistance (MA) programs are part of a continuum of health insurance options available to Virginia residents. MA application processing is based on several principles that are prescribed by the ACA.

B. Principles

1. Single Application

Applications for affordable health insurance, including qualified health plans with Advance Premium Tax Credit (APTC) assistance and MA, are made on a single, streamlined application. The application gathers information needed to determine eligibility for both APTC and MA.

2. No Wrong Door

Individuals may apply for MA through their local department of social services (LDSS), the Virginia Health Insurance Marketplace (VIM), at the CommonHelp website, or the Cover Virginia Call Center. Applications may be routed to either the LDSS or Cover Virginia for processing.

Effective 11/1/2018, applications made through the VIM that require MAGI eligibility determinations will have the eligibility determination made by the VIM. If an application is approved, the case will be routed to either the CPU or LDSS, where it should be accepted and enrolled without delay. ABD applications received by the VIM will be routed to the local agencies for processing.

3. Use of Electronic Data Source Verification

The eligibility determination process for MA is based on electronic data source verification (EDSV) to the fullest extent possible. The Federally-managed Data Services Hub (the Hub) provides verification of a number of elements related to eligibility for MA applications processed in the Virginia Case Management System (VaCMS). Data from on-line sources including the Virginia Employment Commission (VEC), the Work Number, *Asset Verification System (AVS) and the Virginia Department of Motor Vehicles (DMV)* are also acceptable for both initial applications and renewals. *Electronic sources should be automatically inquired prior to worker evaluation. Information available electronically is considered agency knowledge.*

Eligibility workers are to request information from the applicant or authorized representative(s) only when it is not available through an approved data source or the information is inconsistent with agency records.

Searches of online information systems, including but not limited to the Hub, State Online Query-Internet (SOLQ-I) and the State Verification Exchange System (SVES) are permitted **only** for applicants and family members whose income and/or resource information is required to determine eligibility for the applicant or patient pay for an enrollee. This includes spouses of applicants and parents of child applicants.

4. Processing Time

Agencies are required by the State Plan to adhere to prescribed standards for the processing of MA applications, including applications processed using the self-directed functionality in VaCMS. The amount of time allowed to process an application is based on the availability of required information and verifications, as well as the covered group under which the application must be evaluated.

If the client is eligible for benefits to be used exclusively for the payment of medical expenses (i.e. an insurance settlement), but there is no TPL code for that benefit, the worker must email the information to the DMAS TPL Unit at TPLUnit@dmas.virginia.gov, or send the information to:

DMAS Third Party Liability Section 600
East Broad Street, Suite 1300
Richmond, Virginia 23219

G. Health Insurance Premium Payment (HIPP) Program

The HIPP program is a cost-savings program for individuals enrolled in Medicaid which may reimburse some or all of the employee portion of the employer group health insurance premium. Eligibility for HIPP is determined by the HIPP Unit at DMAS. Participation in HIPP is voluntary.

The local DSS agency must give each applicant or enrollee who reports that he or someone in his family is employed more than 30 hours each week and is eligible for health insurance coverage under an employer's group health plan must be given a HIPP Fact Sheet, which provides a brief description of the program and the contact information for the HIPP Unit at DMAS. The HIPP Fact Sheet is available at https://fusion.dss.virginia.gov/Portals/[bp]/Medicaid/Resources%20and%20Job%20Aids/MA%20Fact%20Sheets/HIPP%20Fact%20Sheet%2024_d032_03_0842-04-eng_.doc?ver=2024-07-15-082927-803. Enrollees and other members of the public may contact the HIPP Unit for additional information at hippcustomerservice@dmas.virginia.gov.

If the health insurance policy holder lives outside of the home, a HIPP Consent Form must be completed by both the policy holder and the parent/authorized representative so the DMAS HIPP Unit can process the HIPP application. If the form is required, the DMAS HIPP Unit will send it to the applicant for completion.

H. Verification of Financial Eligibility Requirements

The eligibility worker must verify the following financial eligibility requirements:

- the value of all countable, non-excluded resources, if the reported values of the resources are not both reasonably compatible with electronic sources AND below the resource limit. In all situations the sources of the resources do not have to match. If the member attests to having resources below the limit and values received from electronic sources are above the limit, additional verification should be requested. Reasonable compatibility for resource evaluation is effective for all case actions as of June 3, 2024.
- asset transfer information for individuals in need of long-term care services, including the date of transfer, asset value, and compensation received.
- earned and unearned income. For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a Medically Needy (MN) covered group, verification of income **is required** to determine spenddown liability.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and

information from SSA through SVES or SOLQ-I. Verification of income is valid if the information is less than *6* months old. The agency must include in each applicant's case record facts to support the agency's decision on the case.

1. Resources

The value of all countable, non-excluded resources must be verified. If an applicant's attested resources are over the resource limit, the applicant or authorized representative must be given the opportunity to provide verification of the resources. All available resource verification system(s) must be searched prior to requesting information from the applicant.

2. Use of Federal Income Tax Data

The Hub provides verification of income reported to the IRS. Income information reported to the IRS may be used for eligibility determinations for Families and Children (F&C), MAGI Adults, and ABD covered groups when IRS information is available. The income reported on the application is compared to the data obtained from the Hub for reasonable compatibility per M0420.100. When IRS verification is used for an ABD individual, reasonable compatibility is acceptable as verification of earned (i.e. taxable) income.

3. SSA Data

Social Security and/or Supplemental Security Income must be verified through SSA. The Federal Hub links to SSA data. SOLQ-I may also be used. The State Data Exchange (SDX) system should only be used as an alternate method when the Hub or SOLQ-I is not available.

4. Income

For all case actions effective August 26, 2022, the applicant's attested income, including when the applicant attests to having zero ($0.00) income, is considered the verified income if the income attested to by the applicant is within *2*0% of the income reported by electronic data sources OR both sources are below the applicable income limit.

If the attested income is under the income limit and the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return. If the applicant meets a MN covered group, verification of income **is required** to determine spenddown liability based on actual income received.

For individuals requesting long-term services and supports (LTSS), verification of income is required to calculate the patient pay. See M1470.

If the attested income is over the income limit and the individual does not meet a Medically Needy (MN) covered group, deny the application.

If the individual agrees that the discovered countable income was received, determine if the on-line information can be used to evaluate current/ongoing eligibility. If the discovered information is not sufficient to evaluate eligibility, send a written request for needed verifications and allow at least ten calendar days for the return of the verifications.

If the individual reports the income has stopped, ask when the income stopped to ensure all income needed to correctly determine prospective and retroactive eligibility (if appropriate) is evaluated. Note the date of termination of income (last pay received) in the record. If the income stopped during a month that is being evaluated for eligibility, the individual must provide verification of the termination of income.

M0130.500 Returned Mail

A. General Principle

This policy pertains to all information mailed to the applicant at intake, changes or renewals. Generally, there are three types of recipient mail that could be returned to the Medicaid agency:
(1) mail with an in-state forwarding address;
(2) mail with an out-of-state forwarding address; and
(3) mail that does not include a forwarding address.

Workers must confirm whether the address information on the piece of returned mail is complete and consistent with the address information the agency has on file. The front of the returned mail should be scanned into the case record and all actions to contact the client must be documented.

B. Returned Mail With Complete Information

Compare the address provided to existing records. If an error is discovered (i.e., missing or incorrect apartment number, etc.), make any necessary corrections and resend the information. If the subsequent mailing to the correct address is not returned, no additional contact is required. The address should be updated in VaCMS and no other action is required. If the subsequent mailing is returned, proceed as indicated below based on whether the returned mail has a forwarding address.

C. Returned Mail with no Forwarding Addr

The worker must attempt to contact the recipient through two other methods, including phone, *text,* email, or alternate addresses *[including attempting to contact the Authorized representative (AR)]*. If only one other method is available, a contact attempt must be made. If no other methods are available, the condition will be met if it has satisfied the up-to-date contact information.

D. Returned Mail with Forwarding Address

Sending the VCL or other mail to the new address will represent one contact method. One other method of contact, if available, is required to satisfy the returned mail condition. If mail is not returned from the forwarding address, the returned mail condition no longer applies because the original mailing has been completed and is no longer considered to be returned. The address should be updated in VaCMS and no other action is required.

E. *Mail Returned from Authorized Representative*

Returned mail from the AR should be treated the same way as mail from the client. If the address appears correct and no other methods (phone, text, email or alternate addresses) are successful, the client should be informed.

***F.* Lack of Alternative Contact Information**

If after complying with the conditions described above, the only contact information available is the address in the individual's case record, and the LDSS does not have or cannot find a phone number, email address or other means to contact the individual, no further efforts to contact the individual are necessary.

***G.* Documentation**

The case narrative must contain documentation of all methods used for contact attempts. To ensure applicants are able to complete the application process, the worker should ensure that if they successfully contact an individual after receiving returned mail, the recipient receives any necessary verification requests at their correct address and has sufficient time to return the information and complete the application process.

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 4, 4a, 4b and 20
TN #DMAS-33	10/1/24	Pages 14e, 22
TN #DMAS-32	7/1/24	Pages 1, 4-5, 6a; Appendix 1, page 5 Appendix 4, page 2 Appendix 5, page 1
TN #DMAS-30	1/1/24	Page 3; Appendix 4, page 1
TN #DMAS-27	4/1/23	Page 17 Appendix 4, page 1 Appendix 5, page 1
TN #DMAS-25	10/1/22	Table of Contents, Page 14d. Page 22 Appendix 4 added page 2.
TN #DMAS-24	7/1/22	Table of Contents Pages 1, 4a, 4b, 5, 6a, 8, 14d, 14e, 15, 17, 18, 21, 22, 23 Page 6b was added as a runover page. Appendix 9 was added. Pages 22a and 24-25 were removed.

(MMIS) and SSA for the documentation of C&I for individuals enrolled in the Medicaid and FAMIS programs. In order for this process to be used to verify citizenship and identity, the individual's SSN must be verified by SSA (see M0240).

For eligibility determinations processed through VaCMS, the Social Security data match takes place when the individual's information is sent through the Hub. For cases not processed in VaCMS, the SSA data match will take place after the individual has been enrolled in MMIS.

1. MMIS Data Matches SSA

If the information in the MMIS matches the information contained in the SSA files, the MMIS will be updated to reflect the verification of C&I. No further action is needed on the part of the eligibility worker, and the enrollee will not be required to provide any additional documentation, if the SSA match code in MMIS shows that SSA verified the individual's C&I.

2. MMIS Data Does Not Match SSA

If the information in the MMIS does not match the information in the SSA files, a discrepancy report will be generated monthly listing the inconsistent information. Eligibility staff is expected to review the report to see if the report lists any enrollees who were rejected because SSA could not verify the enrollee's citizenship and identity.

a. SSA Cannot Verify C&I

If the SSA data match result does not verify the individual's C&I, eligibility workers must review the information in the system to determine if a typographical or other clerical error occurred. If it is determined that the discrepancy was the result of an error, steps must be taken to correct the information in the system so that SSA can verify C&I when a new data match with SSA occurs in the future.

If the inconsistency is not the result of a typographical or other clerical error, the individual must be given a reasonable opportunity period of 90 days to either resolve the issue with SSA or provide verification of C&I. The eligibility worker must send a written notification to the enrollee that informs the enrollee of the discrepancy and gives him 90 calendar days from the date of the notice to either resolve the discrepancy with the SSA and to provide written verification of the correction, OR provide acceptable documentation of C&I to the LDSS.

The notice must specify the date of the 90th day, and must state that, if the requested information is not provided by the 90th day, the individual's Medicaid coverage will be canceled. Include with the notice the "Birth Certificates and Proof of Citizenship for Medicaid" Fact Sheet available on at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/References. Acceptable forms of documentation for C&I are also included in Appendix 1 to this subchapter.

b. Individual Does Not Provide Verification in 90 Days

If the individual does not respond to the request and does not provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage may be canceled. Send an advance notice and cancel coverage at the end of the month in which the 90th day occurs. If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period shall be provided. *The new reasonable opportunity period begins the day after the first period ended. No more than two reasonable opportunity periods should be granted within a certification period since the case cannot be successfully redetermined without the C&I documentation.*

c. Discrepancy Resolved With SSA Within 90 Days

If written verification is received that corrects the SSA discrepancy within the 90 days, update the system accordingly so that the enrollee's information will be included in a future data match for C&I verification. The individual continues to remain enrolled pending the results of the subsequent data match.

If this subsequent data match with SSA results in verified C&I, MMIS will automatically enter code "CV" in the Cit Lvl and Identity fields in the individual's MMIS record. No further match will be done with the SSA files for C&I verification.

d. Verification of C&I Provided Within 90 Days

If the individual provides acceptable verification of his C&I within the 90 days, update the appropriate demographic fields in MMIS with the appropriate codes. No further match will be done with the SSA files for C&I verification.

3. Subsequent Applications

If the individual who lost coverage for failure to provide C&I documentation files a subsequent application, *but still does not provide C&I documentation,* a new *90 day* reasonable opportunity period should be granted.

M0220.200 ALIEN IMMIGRATION STATUS

A. Introduction

An alien's immigration status is used to determine whether the alien meets the definition of a "full benefit" alien. All aliens who meet the state residency, covered group and all other nonfinancial eligibility requirements (except SSN for illegal aliens), and who meet all financial eligibility requirements are eligible for Medicaid coverage of emergency services. "Full benefit" aliens may be eligible for all Medicaid covered services. "Emergency services" aliens may be eligible for emergency services only.

B. Procedure

An alien's immigration status must be verified. Use the procedures in sections M0220.201 and 202 below to verify immigration status. After the alien's immigration status is verified, use the policy and procedures in section M0220.300 to determine if the alien is a full benefit alien. If the alien is a full benefit alien and is eligible for Medicaid, use the policy and procedures in section M0220.600 to enroll the alien in Medicaid.

If the alien is an emergency services alien who is eligible for Medicaid, use the policy and procedures in section M0220.600 D to enroll an eligible emergency services alien in Medicaid for emergency services only.

C. Changes in Immigration Status

If a "full benefit" alien who was admitted to the U.S with immigration status in one of the "seven-year" alien groups listed in M0220.313.A becomes a Lawful Permanent Resident, he is considered to have full benefit status for the purposes of Medicaid eligibility for the first seven years of residency in the U.S.

M0220.201 IMMIGRATION STATUS VERIFICATION

A. Verification Procedures

An alien's immigration status is verified by the official document issued by the United States Citizenship and Immigration Services (USCIS) and a comparison with the Systematic Alien Verification for Entitlements (SAVE) system. SAVE interfaces with the Federal Hub for applications processed in VaCMS. The EW does not need to obtain the alien status document when immigration status is verified through the Hub. If immigration status cannot be verified through the Hub, the EW must see the original document or a photocopy; submission of just an alien number is NOT sufficient verification.

If the alien has an alien number but no USCIS document, or has no alien number and no USCIS document, use the **secondary verification** SAVE procedure in M0220.202 below if the alien provides verification of his or her identity.

If the agency cannot promptly verify immigration status of an individual in the Hub/SAVE, the agency must provide a 90-calendar-day reasonable opportunity period for the individual's immigration status to be verified and may not delay, deny, reduce or terminate benefits for an individual whom the agency determines to be otherwise eligible for Medicaid during such reasonable the opportunity period.

If the individual does not respond to the request and does not provide the information necessary to meet the C&I documentation requirements by the 90th day, coverage may be canceled. Send an advance notice and cancel coverage at the end of the month in which the 90th day occurs. If the individual provides part of the information or is in the process of getting the information, a new reasonable opportunity period should be provided. *The new reasonable opportunity period begins the day after the first period ended. No more than two reasonable opportunity periods should be granted within a certification period since the case cannot be successfully redetermined without the C&I documentation.*

NOTE: If a noncitizen attests that they do not have a valid immigration status, do not use the verification procedures in this section or the SAVE procedures. Go to section M0220.400 below to determine the noncitizen's eligibility.

B. Documents That Verify Status

Appendix 7 to this subchapter contains a list of typical immigration documents used by lawfully present noncitizens.

Verify lawful permanent resident status by a Resident Alien Card or Permanent Resident Card (Form I-551), or for recent arrivals a temporary I-551 stamp in a foreign passport or on Form I-94.

Verify lawful admission by a Resident Alien Card (issued from August 1989 until December 1997) or Permanent Resident Card (Form I-551); a Re-entry Permit; or a Form I-688B with a provision of law section 274A.12(A)(1). Afghan and Iraqi immigrants admitted to the U.S. under a Special Immigrant Visa will have either (1) a Form I-551 or (2) a passport or I-94 form indicating categories SI1, SI2, SI3, SQ1, SQ2, or SQ3 and bearing the Department of Homeland Security stamp or notation.

Form I-151 (Alien Registration Receipt Card – the old aka "green card"), Form AR-3 and AR-3a are earlier versions of the Resident Alien Card (Form I-551). An alien with one of the older cards who does not have an I-551should be referred to USCIS to obtain the application forms for the I-551. The forms may be ordered by calling 1-800-375-5283. When an I-151 is presented, refer the alien to USCIS, but accept the document for further verification (see M0220.201.E below).

3.	**Assignment of Rights and Pursuit of Support from Absent Parents**	the assignment of rights to medical benefits requirements (M0250);
4.	**Institutional Status**	the institutional status requirements (M0280);
5.	**Covered Group**	the covered group requirements (chapter M03). *Individuals who are eligible for Medicaid payment of emergency services are enrolled into the emergency services aid categories, 112 and 113, to ensure proper benefit package assignment; emergency services are not covered for individuals in Plan First or the Medicare Savings Programs (Qualified Medicare Beneficiaries, Special Low Income Medicare Beneficiaries, Qualified Individuals).*

M0310 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 5 and 28, Appendix 1
TN #DMAS-33	10/1/24	Page 28
TN #DMAS-29	10/1/23	Page 5
TN #DMAS-26	1/1/23	Pages 2, 28b Appendix 1
TN #DMAS-24	7/1/22	Page 36 Page 37 is a runover page.
TN #DMAS-23	4/1/22	Pages 2, 5, 6, 6a
TN #DMAS-22	1/1/22	Page 28
TN #DMAS-20	7/1/21	Page 6 Pages 5 and 5a are runover pages.
TN #DMAS-18	1/1/21	Table of Contents, page ii Pages 26, 27 Appendix 1 was removed. Appendix 2 was renumbered to Appendix 1.
TN #DMAS-17	7/1/20	Page 7 Pages 8 and 9 are runover pages.
TN #DMAS-15	1/1/20	Pages 29, 30
TN #DMAS-14	10/1/19	Pages 24, 26, 27, 40
TN #DMAS-13	7/1/19	Pages 24 Page 24a is a runover page.
TN #DMAS-12	4/1/19	Pages 8, 9, 13
TN #DMAS-10	10/1/18	Table of Contents, page ii Pages 1-4 Page 40 was added.
TN #DMAS-9	7/1/18	Page 35 Appendix 2, Page 1
TN #DMAS-8	4/1/18	Page 9
TN #DMAS-7	1/1/18	Pages 34, Appendix 2, page 1
TN #DMAS-5	7/1/17	Pages 13, 37, 38
TN #DMAS-4	4/1/17	Pages 24, 30a Page 23 is a runover page. Page 24a was added as a runover page.

2. F&C Groups

a. Children under age 18

b. Children under age 1

c. Pregnant Women

d. Children with Special Needs for Medical or Rehabilitative Care

e. Individuals under age 21

E. Refugees

"Refugees" are a special group of individuals who have an alien status of "refugee" and are eligible for Medicaid under a different federal funding source. Virginia receives full federal funding with no state matching funds for the medical assistance provided to these individuals during the first *4* months they are in the U.S who entered as of 10/1/2021.

There are two aid categories (ACs) for this group. AC 078 is used for Refugee Other and Refugee Medicaid Other and AC 079 is used for Refugee Medicaid Unaccompanied Minors. The policy and procedures used to determine whether an individual is eligible in this group are found in the Refugee Resettlement Program Manual, Volume XVIII.

M0310.100 DEFINITION OF TERMS

A. Introduction

The terms used in the covered groups policy and procedures and the procedures for determining if an individual meets a definition are stated in sections M0310.101 through 131 below.

M0310.101 ABD

A. ABD Definition

"ABD" is the short name used to refer to aged, blind or disabled individuals.

B. Procedures

See the following sections for the procedures to use to determine if an individual meets an ABD definition:

- M0310.105 Age and Aged
- M0310.106 Blind
- M0310.112 Disabled

M0310.102 ADOPTION ASSISTANCE

A. Definition

Adoption Assistance is a Title XX of the Social Security Act social services program that provides cash assistance and/or social services to adoptive parents who adopt "hard to place" foster care children who were in the custody of a local department of social services or a child placing agency licensed by the state of Virginia.

***1.* Residing in Virginia**

Adoption assistance children are children who reside in Virginia who are adopted under a Title IV-E or Non-IV-E (state-local) adoption assistance agreement with a department of social services or in conjunction with a child-placing agency.

application is pending for the disability determination. DDS does NOT stop the disability determination when the individual has excess income because of possible spenddown eligibility

4. LDSS Responsibilities for Communication with DDS

The LDSS must make every effort to provide DDS with complete and accurate information and shall report all changes in address, medical condition, and earnings to the DDS on pending applications.

5. Evaluation for Plan First and Referral to Health Insurance Marketplace

While an individual's application is pending during the non-expedited disability determination process, evaluate his eligibility in non-ABD covered groups (e.g. MAGI Adults, and Plan First if requested). If the individual is not eligible for full Medicaid coverage, refer the individual to the Virginia Health Insurance Marketplace (VIM) for evaluation for the Advance Premium Tax Credit (APTC).

H. Notification of DDS Decision to LDSS

1. Hospitalized Individuals

The DDS will advise the agency of the applicant's disability status as soon as it is determined by either SSA or the DDS. For hospitalized individuals who meet the requirements for an expedited disability determination, DDS will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.

2. Individuals Not Hospitalized

For all other disability determinations, DDS will notify the LDSS responsible for processing the application and enrolling the eligible individual *will fax the outcome of the disability determination directly to the LDSS responsible for processing the application and enrolling the eligible individual.* If the claim is denied, DDS will also include a personalized denial notice to be sent to the applicant explaining the outcome of his disability determination.

3. Disability Cannot Be Determined Timely

A disability determination cannot be completed within the allotted time when there is missing or incomplete medical information. DDS will notify the applicant about 75 days from the application date of the delay. DDS will notify the LDSS *with a delay letter to the worker and the client. Upon receipt of the delay letter* the LDSS must send the applicant a Notice of Action to extend the pending application.

4. DDS Rescinds Disability Denial

DDS will notify the agency if it rescinds its denial of an applicant's disability to continue an evaluation of the individual's medical evidence. If the Medicaid application has been denied, the agency must reopen the application and notify the applicant of the action. The application continues to pend until notification is received from DDS of the disability determination. If an appeal has been filed with DMAS, the agency must notify the DMAS Appeals Division so that the appeal may be closed (see M1650.100).

I. LDSS Action & Notice to the Applicant

The eligibility worker must complete the Medicaid eligibility determination immediately after receiving notice of the applicant's disability status and send the applicant a Notice of Action regarding the disability determination and the

agency's decision on the Medicaid application.

Disability Determination Services (DDS) Contact Information

Send ALL expedited and non-expedited disability referrals to the DDS Central *District* Office.

DDS *District* Office	**Hearing Contacts**
Central *District* Office Disability Determination Services 9960 Mayland Drive. Suite 200 Richmond, Virginia 23233 Phone: 800-523-5007 or 804-367-4700 FAX: 804-*367-4523* Operations Manager: Talya Brown Professional Relations Officer: *Bonita Jones* District Director: Elliot Duncan	Primary Contact for Scheduling *a hearing*: *Bonita Jones* (804) 367-*4707* Backup: *Shawnelle Martin* 804-367-*3292*

M0320 Changes

Changed With	Effective Date	Sections Changed
TN #DMAS-35	7/1/25	M0320.400 M0320.500 (formatting only)

Section Revision Date July 2025

M0320.000 AGED, BLIND & DISABLED GROUPS

M0320.400 MEDICAID WORKS

A. Policy

The Appropriations Act of 2006 authorized an amendment to the Virginia State Plan for Medical Assistance that allows disabled (including blind) individuals to work and earn higher income while retaining Medicaid coverage. This program is called MEDICAID WORKS and includes individuals:

- at least age 16 and are under age 65, **and**
- who have countable income less than or equal to 138% FPL **and**
- who have countable resources less than or equal to $2,000 for an individual and $3,000 for a couple; **and**
- who are working or have a documented date for employment to begin in the future.
- Current participation in the Social Security Administration (SSA) programs Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) will satisfy the condition for disability. Any applicant without SSA documentation of disability should be evaluated by the state's Disability Determination Services program before eligibility can be established.

These individuals can retain Medicaid coverage as long as they remain employed, and their C*ountable* earned income is less than or equal to $6,250 per month. MEDICAID WORKS is Virginia's Medicaid Buy-In (MBI) program.

B. Relationship Between MEDICAID WORKS and 1619(b) Status

An individual with SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) must meet the 138% FPL income requirement for entry into MEDICAID WORKS and should not be discouraged from enrolling in MEDICAID WORKS. An individual who meets the criteria for 1619(b) status *and the 138% income limit* may choose to participate in MEDICAID WORKS because of the higher resource limit. SSI or eligible for Medicaid as a Qualified Severely Impaired Individual (QSII) (1619(b)) individuals are not automatically enrolled in Medicaid Works. They must be evaluated according to the non-financial and financial requirements used for all MEDICAID WORKS applicants and enrollees.

Individuals may have their Social Security payments stop when their earnings are above the SSI threshold or SGA level. If the client would otherwise be eligible for a cash benefit if not for their earnings and has not had a determination of medical improvement following a

Continuing Disability Review (CDR), they are still considered disabled for Medicaid Works purposes. Individuals receiving 1619(b) Medicaid protections who request enrollment in Medicaid Works are considered disabled but must have their income and resources evaluated according to the guidelines for initial eligibility.

C. Nonfinancial Eligibility

The individual must also meet the following additional non-financial criteria:

- The individual must be competitively employed in an integrated setting. Work must occur in a work setting in the community or in a personal business alongside people who do not have disabilities. Work performed in a *supervised* sheltered workshop *designed to provide employment opportunities for individuals with disabilities* or similar setting is not considered competitive employment in an integrated setting. Contact a Regional Medical Assistance Program Consultant if there is a question about whether the employment meets the criteria for MEDICAID WORKS.

- The individual must receive pay at the minimum wage or at the prevailing wage or "going rate" in the community, and the individual must provide documentation that payroll taxes are withheld. Self-employment must be documented according to the policy contained in S0820.210.

- The individual must establish a Work Incentive (WIN) Account at a bank or other financial institution, such as a checking or savings account which can be established prior to the application date. The individual must provide documentation for the case record designating the account(s) as a WIN Account. The account must either be a new account or an existing account with only earned income deposited into it. Increases in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR because of a COLA adjustment to the Social Security Disability benefits may also be deposited into the WIN account and will be excluded as described in M0320.400 D.3.b.3) if the increase is regularly deposited upon receipt into the WIN account. The WIN account cannot contain the individual's other Social Security benefits. The individual must provide statements from the institution where the account is held at application and renewal.

- *If there is only one disabled individual on a jointly held account, we presume that all the funds in the account belong to that individual.* A previously established ABLE account can be used as a WIN account.

- All individuals requesting enrollment in MEDICAID WORKS must also sign a MEDICAID WORKS agreement, available at Medical Assistance Forms or Medicaid Works Agreement. The agreement outlines the individual's responsibilities as an enrollee in the program.

D. Financial Eligibility

1. Assistance Unit

a. Initial eligibility determination

To qualify for MEDICAID WORKS, the individual must meet the assistance unit policy and procedures in chapter M05 that apply to ABD non-institutionalized individuals. Individuals receiving SSI or who have 1619(b) status must also meet the income requirement for entry into MEDICAID WORKS.

Income from a non-ABD spouse, non-applicant/member ABD spouse, or parents is not considered deemable income and is not counted for the initial eligibility determination for individuals requesting to participate in MEDICAID WORKS.

Resources from the individual's spouse with whom he lives or, if under age 21, the individual's parents with whom he lives, must be deemed available.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, **the individual is treated as an assistance unit of one**. Spousal and parental resources and income are disregarded for ongoing enrollee eligibility.

Note: Children and non-spouse dependents are not included in the assistance unit when determining eligibility for MEDICAID WORKS.

2. Resources

a. Initial eligibility determination

For the initial eligibility determination, the resource limit is $2,000 for an individual and $3,000 for a couple. Resources must be evaluated for all individuals, including SSI recipients and QSII/(1619(b) individuals, who wish to qualify for MEDICAID WORKS. The resource requirements in chapter S11 and Appendix 2 to chapter S11 apply for the initial eligibility determination. The individual's countable, nonexempt resources must be verified. All countable resources, must be added together to determine if the individual's countable resources are within the limit. WIN accounts and other non-countable resources are excluded from the resource determination.

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following resource policies apply:

1) For earnings accumulated after enrollment in MEDICAID WORKS, up to the current 1619(b) income threshold amount will be disregarded if deposited and retained in the WIN Account. The 2024 1619(b) threshold amount is $45,976 (decreased from the 2023 amount). *The 2025 1619(b) threshold amount is $59,755.*

2) Resources accumulated while in MEDICAID WORKS and held in Internal Revenue Service (IRS)-approved retirement accounts, medical or health savings accounts, medical reimbursement (flex) accounts, education accounts, independence accounts, and other similar State-approved accounts are excluded. Examples of these accounts include Archer Medical Savings Accounts, 401(k)/403(b)/457(b)/503(b) accounts, traditional Individual Retirement Accounts (IRAs), Roth IRAs, SEP-IRAs, SIMPLE IRAs, and Thrift Savings Plans. The account must be designated as a WIN Account to be excluded. Resources accumulated while in MEDICAID WORKS and held in IRS-approved accounts that have been designated as WIN Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) for the exclusion to continue. Resources can be spent however the individual chooses. *Transfer of assets policy does not apply to Medicaid Works*.
3) Resources can be spent however the individual chooses. Transfers will be evaluated to determine if a penalty should be calculated if the individual applies for (or is receiving) LTSS.
4) For all other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All of the individual's countable, nonexempt resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual. Accounts are also excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees. The account must be exclusively used to hold resources accumulated while in MEDICAID WORKS (including interest) in order for the exclusion to continue.
5) For all other resources, the resource requirements in chapter S11 and Appendix 2 to chapter S11 apply. All the individual's countable, nonexempt resources must be verified and evaluated. All nonexempt resources must be added together to determine if the individual meets the Medicaid resource requirements. The resource limit for resources not excluded in 1) or 2) above is $2,000 for an individual.

3. Income

a. Initial eligibility determination

For the initial eligibility determination on or after *January 15, 2025*, the limit for total countable income (unearned and earned) is less than or equal to 138% of the FPL (*$1,801* per month for an individual or *$2,434* when the applicant has an ABD spouse who is also applying for or covered by Medicaid). Use the rules in chapter M08 to determine income in the month of application. (see M0320.101).

b. Ongoing eligibility

Once the individual is enrolled in MEDICAID WORKS, the following income policies apply:
1) The income limit for earned income is $6,250 per month ($75,000 per year) (no change for *2025*) *if* the funds are deposited in a WIN Account. The policy for determining countable earned income is contained in subchapter M0820.
If the individual is self-employed, net earnings from self-employment (NESE) must be demonstrated through documentation of Internal Revenue Service (IRS) filings, quarterly estimated taxes, business records, and/or business plans. The individual's signed allegation of self-employment is acceptable if no other evidence of NESE can be obtained. Follow the policy in M0820.220 *to determine* NESE.

2) The income limit for unearned income remains less than or equal to 138% of the FPL. The policy for determining countable unearned income is contained in subchapter M0830.

3) Any increase in an enrollee's Social Security Disability benefits resulting from employment as a MEDICAID WORKS participant OR because of a COLA adjustment to the Social Security Disability benefits will not be counted as long as the increase is regularly deposited upon receipt into the individual's WIN account.

4. Income Exceeds 138% FPL at Eligibility Determination

Spenddown does not apply to the Medicaid Works covered group. Therefore, admission into MEDICAID WORKS is not available to individuals whose income exceeds 138% of the FPL. Evaluate the individual's eligibility in all other Medicaid covered groups.

G. Safety Net

Resources held in the WIN Account that are accumulated from the enrollee's earnings while in MEDICAID WORKS will be disregarded up to the 1619(b) threshold amount for this eligibility determination.

If found eligible and enrolled in another Medicaid covered group, the individual shall have a "safety-net" period of up to one year from MEDICAID WORKS termination and enrollment in another group to dispose of these excess resources before they are counted toward ongoing eligibility. If the individual resumes working within the safety-net period, he may be re-enrolled in MEDICAID WORKS provided that all eligibility requirements are met, except that the resources in the WIN Account are disregarded up to the 1619(b) threshold amount. If the individual wishes to be re-enrolled in MEDICAID WORKS after the one-year safety net period, any resources retained in the WIN Account remain exempt. **Resources accumulated while in MEDICAID WORKS and retained in an IRS approved account described in M0320.400 D. 2. b. 2) that has been designated as a WIN Account are excluded in all future Medicaid determinations for former MEDICAID WORKS enrollees.**

H. Benefit Package

Individuals enrolled in MEDICAID WORKS are entitled to the standard benefits available to full-benefit Medicaid enrollees (see Chapter M18). Medicaid Works members cannot be enrolled in Developmental Disabilities (DD) waivers *or CCC Plus waivers*, but the waiver slot will be held for up to six months if a DD Waiver recipient wants to try transitioning to Medicaid Works. *Waiver slots are not held for CCC Plus recipients since there is no waiting list for CCC Plus waiver services.* Participants can receive personal care services as a service provided by the assigned MCO plan. ***No medical screening is required, and*** **MEDICAID WORKS enrollees do not have a patient pay responsibility.** Intensive Behavioral Dietary Counseling is also covered for MEDICAID WORKS enrollees when a physician determines that the service is medically necessary.

I. Entitlement and Enrollment

Entitlement for MEDICAID WORKS is dependent upon meeting the requirements listed above. *All requests for Medicaid Works should be evaluated and documented even if a member is currently eligible for Medicaid under another full or limited coverage category.*

There is no retroactive coverage under MEDICAID WORKS. The application date in the Virginia Case Management System (VaCMS) *is the date the signed Medicaid WORKS agreement is received by the LDSS.* Coverage shall begin on the first day of the month following the month in which all requirements are met. If the applicant has a future start date for employment, the effective date of eligibility shall be no earlier than the first day of employment. However, unless employment begins on the first day of the month, MEDICAID WORKS enrollment will begin on the first of the following month. If the person is already enrolled Medicaid, a new application is not required. Appendix D should be completed to gather additional information on resources. If the person is not currently enrolled in Medicaid, a *full* application is necessary.

The *Aid Category* for MEDICAID WORKS is 059. Use the following procedures to enroll the individual in VaCMS:

<u>New Application – Applicant is Disabled and enrolled in Medicaid</u>

1. For the month of application and any retroactive months in which the person is eligible, enroll the individual in the appropriate AC in a closed period of coverage, beginning the first day of the month in which eligibility exists. The cancel date is the last day of the month in which the MEDICAID WORKS Agreement was signed. Use Cancel Code 042.
2. Reinstate the individual's coverage in MEDICAID WORKS using AC 059 beginning the first day of the following month (the first day of the month following the month in which the MEDICAID WORKS Agreement is *received*). Use the same application date (the actual date of the initial application) that was used for the month of application.

DMAS approval is not required for participation in MEDICAID WORKS; however, information must be sent to DMAS after the individual is enrolled for tracking purposes. Use the MEDICAID WORKS Email Cover Sheet available at Medical Assistance Forms, and **email** it together with the following information to DMAS at **MedicaidWorks@dmas.virginia.gov**:

- the signed MEDICAID WORKS Agreement,

- the Work Incentive Account (WIN) information (a bank account statement or verification from the bank that the account was opened), and
- a pay stub showing current employment or an employment letter with start date or self-employment document(s) to verify employment.

Current Enrollee

1. Cancel current coverage using Cancel Code 042.
2. Reinstate in AC 059 beginning the first day of the following month. **Use the date the MEDICAID WORKS Agreement was signed for the application date**.

Send a Notice of Action to the applicant/recipient advising him of his eligibility and acceptance into MEDICAID WORKS. Do not send the Advance Notice of Proposed Action when a recipient moves to MEDICAID WORKS, because his Medicaid coverage has not been reduced or terminated.

Eligibility for MEDICAID WORKS continues as long as the enrollee continues to:

- be employed,
- meet the definition of disability or blindness,
- meet the age limitation, and
- does not exceed the income and resource limits for MEDICAID WORKS.

The MEDICAID WORKS enrollee continues to meet the disability criteria *unless* SSA has completed a Continuing Disability Review and has determined that the individual no longer has a disabling condition. The fact that the MEDICAID WORKS enrollee is earning over the SSA substantial gainful activity amount has no bearing on whether the disability criteria *is met*. *In addition, an individual can still be considered disabled by SSA and not receive a monthly payment. After checking the disability status and termination date by electronic sources and* if the enrollee's disability status *remains* unclear, contact a Regional Medical Assistance Program Consultant for assistance.

The individual's continuing eligibility must be determined at least every 12 months.

If the individual is no longer eligible for MEDICAID WORKS, *evaluate the individual to determine if* the individual remains eligible in any other covered group. **The policy in M0320.400 G above must be reviewed to determine whether the resource exclusion safety net rules apply.** If the individual is not eligible for Medicaid in any other covered group, coverage shall be cancelled effective the first of the month following the expiration of the 10-day advance notice.

Section Revision Date July 2025

M0320.000 AGED, BLIND & DISABLED GROUPS

M0320.500 300% of SSI INCOME LIMIT GROUPS

A. Introduction

The 300% of SSI income limit groups are for individuals who meet the definition of an institutionalized individual or have been authorized for long-term *services and supports (LTSS)* services (see M1410. B. 2) and are not eligible in any other full-benefit Medicaid covered group.

B. Covered Groups

- M0320.501 ABD in a Medical Institution, Income < 300% of SSI
- M0320.502 ABD Receiving Medicaid Waiver Services (CBC)
- M0320.503 ABD Hospice

M0330 Changes
Page 1 of 2

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 1 and 9
TN #DMAS-33	10/1/24	Pages 1a, 24
TN #DMAS-32	7/1/24	Page 1a, 4
TN #DMAS-31	4/1/24	Pages 8, 26-28
TN #DMAS-30	1/1/24	Pages 1, 2, 4, 6, 8, 10, 12, 17, 20, 23, 34, 35, 38, 40
TN #DMAS-26	1/1/23	Page 10
TN #DMAS-24	7/1/22	Pages 1, 2, 15, 18, 29, 31, 32 Page 2a was added as a runover page.
TN #DMAS-23	4/1/22	Table of Contents Pages 1, 2, 5, 7, 8, 29, 37, 39, 40
TN #DMAS-20	7/1/21	Pages 1, 13, 14
TN #DMAS-19	4/1/21	Pages 14, 26
TN #DMAS-14	10/1/19	Pages 1, 2, 10a
TN #DMAS-12	4/1/19	Pages 26, 28
TN #DMAS-11	1/1/19	Pages 1, 2, 12, 14-16, 24, 25
TN #DMAS-10	10/1/18	Table of Contents Page 1-2, 30 Page 10a-b were added as runover pages.

M0330.000 FAMILIES & CHILDREN GROUPS

M0330.001 GENERAL POLICY PRINCIPLES

A. Overview

A State Plan for Medicaid must include the mandatory federal categorically needy (CN) groups of individuals as well as the optional groups a state has elected to cover. This subchapter divides the Families & Children (F&C) covered groups into categorically needy and medically needy (MN) groups.

Enroll children and adults who receive Supplemental Security Income (SSI) in the SSI Medicaid covered group (see M0320.101) *unless Foster Care, Adoption Assistance or Former Foster Care recipient.* Evaluate other disabled children and adults for eligibility in the F&C CN covered groups first because they do not have a resource requirement. **Individuals who are eligible for or entitled to Medicare cannot be eligible in the MAGI Adults covered group.**

A federal mandate requires that as of January 1, 2024, all children under 19 receive 12 months of continuous eligibility unless

- they reach age 19;
- are no longer Virginia residents;
- the child or child's representative requests eligibility be closed;
- the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or
- the child is deceased.

B. Procedure

Determine an individual's eligibility first in a CN covered group. If the individual is not eligible as CN or for the Family Access to Medical Insurance Security Plan (FAMIS), go to the MN groups.

A determination of eligibility for a F&C child should follow this hierarchy:

1. If the child meets the definition of a foster care child, adoption assistance child, adoption assistance child with special needs for medical or rehabilitative care, or an individual under age 21, evaluate in these groups first.
2. If the child meets the definition of a pregnant woman or newborn child, evaluate in the pregnant woman/newborn child group.
3. If the child is under age 18 or is an individual under age 21 who meets the adoption assistance or foster care definition or is under age 21 in an intermediate care facility (ICF) or facility for individuals with intellectual disabilities (ICF-ID), AND is in a medical institution or has been authorized for Home and Community Based Services (HCBS) or has elected hospice, evaluate in the appropriate F&C 300% of SSI covered group.
4. If a child is under the age of 19, evaluate in this group.
5. If a child is a former foster care child under age 26 years, evaluate for coverage in this group.
6. If a child has income in excess of limits individual, evaluate for the Family Access to Medical Insurance Security Plan (FAMIS) eligibility (chapter M21).

B. Nonfinancial Eligibility Requirements

The individual must meet all the nonfinancial eligibility requirements in chapter M02. If the individual is not a U.S. citizen, he must meet the alien status requirements. These requirements differ depending on the age and pregnancy status of the individual. See subchapter M0220.

C. Financial Eligibility Requirements

There are no resource or income tests for the Former Foster Care group.

D. Entitlement

Entitlement as a former foster care child begins the first day of the month following the month the child was no longer in the custody of a local department of social services or the URM Program if the child was enrolled in Medicaid during the month foster care ended.

Accept the individual's declaration of enrollment in foster care or the URM Program and enrollment in Medicaid at the time turned at least 18.

If Medicaid coverage of a former foster care child was previously discontinued when the child turned 18, he may reapply for coverage and be eligible in this covered group if he meets the requirements in this section. The policies regarding entitlement in M1510 apply.

Individuals in this covered group receive full Medicaid coverage, including long-term care (LTC) services. Do not move enrollees in this covered group who need LTC to the 300% of SSI covered group.

E. Enrollment

The AC for former foster care children is "070."

M0330.200 LOW INCOME FAMILIES WITH CHILDREN (LIFC)

A. Policy

Section 1931 of the Act - The federal Medicaid law requires the State Plan to cover (1) dependent children under age 18 or under the age of 19 and full-time students in a secondary school or in the equivalent level of vocational or technical training, or in a General Educational Development (GED) program IF they may be reasonably expected to complete the secondary school, training or program before or in the month they attain age 19; and (2) parents or caretaker-relatives of dependent children who meet the financial eligibility requirements of the July 16, 1996 AFDC state plan. This covered group is called "Low Income Families With Children" (LIFC).

Public Law 111-148 (The Affordable Care Act) requires that coverage for all children under the age of 19 be consolidated in the Child Under Age 19 (FAMIS Plus) covered group. Virginia has chosen to implement this coverage effective October 1, 2013. Children are not enrolled as LIFC except when the child meets the definition of a dependent child in M0310.111 and his parents are receiving LIFC Extended Medicaid coverage (see M1520.500). In these situations, if the child's household income exceeds the limit for coverage in the Child Under Age 19 group, the child must be evaluated for LIFC Extended Medicaid coverage with his family.

B. Nonfinancial Eligibility

The individual must meet all the non-financial eligibility requirements in chapter M02.

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 4, 14, 15, 20, 33; Appendices 3, 5, 8
TN #DMAS-34	1/1/25	Pages 16a and 16b, Appendix 1,2,6,7
TN #DMAS-33	10/1/24	Appendix 2
TN #DMAS-32	7/1/24	Pages 2, 4, 5, 8, 16, 16b2, 21, 33, 34, 34a Appendices 3, 5 and 8
TN #DMAS-31	4/1/24	Pages 15 and 16a; Appendices 1, 2, 6 and 7
TN #DMAS-30	1/1/24	Pages 1, 34 Page 34a is a runover page
TN #DMAS-28	7/1/23	Page 37 Appendices 1,2,3,5,6 and 7

- Individuals eligible in the following covered groups:
  - LIFC (parents and caretaker-relatives)
  - Pregnant Individuals
  - Adoption Assistance and Foster Care Children
  - Former Foster Care Children Under Age 26
  - BCCPTA

- Supplemental Security Income (SSI) recipients and protected individuals.

7. Psychiatric Residential Treatment Facilities (PRTFs)

Children residing in a PRTF (formerly called a Level C PRTF) are not temporarily absent from home. They are indefinitely absent from home and are not living with their parents or siblings for Medicaid purposes, if their stay in the facility has been 30 calendar days or longer. Long-term *Services and Supports* rules do not apply. See M0520.100 B.*4*.

M0420.100 Definitions

A. Introduction

The definitions below are used in this chapter. Some of the definitions are also in subchapter M0310. Some of the definitions are from the IRC.

B. Definitions

1. Advance Premium Tax Credit (APTC) is a tax credit that an individual or family with taxable income of at least 100% FPL but no more than 400% FPL can take in advance to lower their monthly health insurance premium. Eligibility for the APTC is determined by the federal HIM using MAGI rules for tax-filer households. Projected annual household income, rather than monthly income, is evaluated.

2. Attested Income means the agency must review income information attested by the applicant and utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and other verified income in the eligibility record or system. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months.

3. Caretaker Relative means a non-parent relative of a "dependent" child by blood, adoption, or marriage with whom the child lives, who assumes primary responsibility for the child's care. When a parent is in the home, no adult relative other than a stepparent can be eligible for Medicaid in the LIFC covered group.

4. Child means a natural, biological, adopted, or stepchild.

5. Childless Adult a childless adult is someone who does not meet the definition of an LIFC parent or caretaker-relative.

6. Coverage Gap and Gap-filling Rule occurs when the difference in eligibility rules between the APTC and Medicaid/FAMIS creates a situation in which an applicant may appear to be financially ineligible for both the APTC (household income is too low) and Medicaid or FAMIS (household income is too high). The gap-filling rule is applied in such cases to help mitigate the coverage gap.

A. Tax Filer, Her Son and Her Nephew

Daria lives with her son, Jack age 11, and her nephew Billy age 8. All applied for MA.

Daria is a tax filer who claims her son and nephew as dependents. Her MAGI household is the same as her tax household. Jack is a tax dependent and no exceptions exist; his MAGI household is the same as the tax household. Billy is a tax dependent claimed by a tax filer who is not his parent so an exception exists and non-filer rules are used. Billy's MAGI household consists of Billy only because he has no parents or siblings in the home. The following table shows each person's MAGI household:

Person	# - Household Composition	Reason
Daria	3 – Daria, Jack and Billy	Tax filer and dependents
Jack	3 – Daria, Jack and Billy	Tax filer and dependents
Billy	1 – Billy	Non filer rules; Daria is not his parent, Jack is not his sibling

B. Tax Filer, Spouse, Their Child, His Parent Not Living In the Home

Dave lives with his wife Jean and their child, Cathy age 8. Dave files taxes separately from his wife who files her own taxes each year. Dave claims their child Cathy and his mother, Becky, as his tax dependents. Dave, Jean and Cathy applied for MA.

Dave's MAGI household includes the individuals in his tax household and his wife, Jean because married spouses are always included in each other's MAGI household. Jean is also a tax filer with no additional dependents. Jean's MAGI household includes Dave because married spouses are always included in each other's MAGI household. Cathy is a tax dependent whose parents are not filing jointly so non-filer rules are used; her MAGI household includes herself and her parents. The following table shows each person's MAGI household

Person	# - Household Composition	Reason
Dave	4 – Dave, Jean, Cathy and Becky	Tax filer, spouse, dependent child and dependent parent
Jean	2 – Dave, Jean,	Tax filer and spouse
Cathy	3 – Cathy, Dave, Jean	Non filer rules; child and parents in home

M0440.100

HOUSEHOLD INCOME

A. General Rule

The income counted under MAGI rules is the income counted for federal tax purposes with few exceptions. All taxable income sources and some non-taxable income sources are counted for the MA eligibility determinations.

Whenever possible, income, including income from self-employment, reported on the application will be verified through available electronic data sources. The agency must utilize online systems that are available to the agency without requiring verifications from the individual or family. If no data sources exist to verify the attestation, and the attestation is below the medical assistance income level, documentation of income is required. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. The agency must include in each applicant's case record facts to support the agency's decision on the case.

The reported income of a child must be verified regardless of whether the attested income is above or below the tax-filing threshold amount.

If an income calculation must be made, use the information in subchapter M0710 for estimating income, subchapter M0720 for sources of earned income, and subchapter M0730 for sources of unearned income with the exceptions in B. below. The sources of income listed in this section are organized in table form in M04, Appendix *8*.

B. MAGI Income Rules

1. Income That is Counted

a. Gross earned income is counted. There are no earned income disregards.

b. Earnings and unearned income, including Social Security benefits, of everyone in the household are counted, except the income of

- a tax dependent of any age regardless of relation to the tax-filer who is not required to file taxes because the tax filing threshold is not met or
- a child under 19 in a non-filer household who is living with a parent or parents

For children and tax dependents, Social Security income only counts toward the total household income if the child or tax dependent is required to file their own federal tax return.

Tax dependents claimed by someone other than a parent have their MAGI household determined using non-filer rules. For these individuals, income excluded from the tax-filer's household income may still be included in the tax-dependent's household income.

c. Income of a tax dependent or of a child under 19 in a non-filer household living with a parent or parents is not countable as household income unless the tax dependent is required to file taxes because the tax-filing threshold is met (Social Security benefits received by the dependent individual do not count in determining whether the tax filing threshold is met).

Effective, January 1, 202*5*, the Tax Filing Threshold for MAGI income counting purposes for individuals under 65 is $*1,300* in unearned income and $*14,600* in earned income. Social Security benefits do not count as unearned income in determining whether the tax filing threshold is met. If the dependent is married, 65 or over or blind, please see 2024 Publication 501

d. Interest, including tax-exempt interest, is counted.

e. Foreign income is counted.

f. Stepparent income is counted

M0450.100 STEPS FOR DETERMINING MAGI-BASED ELIGIBILITY

A. Determine Household Composition

1. Does the individual expect to file taxes?

a. If No - Continue to Step 2

b. If Yes - Does the individual expect to be claimed as a tax dependent by anyone else?

1) If No - the household consists of the tax filer, a spouse living with the tax filer, and all persons whom the tax filer expects to claim as a tax dependent. For a tax filer under age 19, parents living in the home are also in the individual's household.

2) If Yes - Continue to Step 2

2. Does the Individual Expect to be Claimed As a Tax Dependent?

a. If No - Continue to Step 3

b. If Yes - Does the individual meet **any** of the following exceptions?

1) the individual expects to be claimed as a tax dependent of someone other than a spouse or a biological, adopted, or stepparent; **or**

2) the individual is a child (under age 19) living with both parents, but the parents do not expect to file a joint tax return; **or**

3) the individual is a child who expects to be claimed by a non-custodial parent; **or**

4) the child is an adoption assistance child with special needs for medical or rehabilitative care, or

5) the child has been residing in a PRTF for more than 30 days.

If No to 1) through *5*) above - the household is the household of the tax filer claiming her/him as a tax dependent.

If Yes to any of 1) through *5*) above - Continue to Step 3.

3. Individual Is Neither Tax Filer Nor Tax Dependent Or Meets An Exception In 2. b Above

For individuals, other than adoption assistance children with special needs for medical or rehabilitative care, who neither expect to file a tax return nor expect to be claimed as a tax dependent, as well as tax dependents who meet one of the exceptions in 2.b above, the household consists of the individual and, if living with the individual:

- the individual's spouse;
- the individual's natural, adopted and step children under the age 19; and
- In the case of individuals under age 19, the individual's natural, adopted and stepparents and natural, adoptive and stepsiblings under age 19.

The household of an adoption assistance child with special needs for medical or rehabilitative care consists only of the child.

B. Non-financial Requirements

The individual must meet a MAGI covered group (Children under 19, LIFC, Pregnant Individuals, Individuals Under Age 21, Adults age 19-64, Plan First).and all non-financial eligibility criteria for that covered group.

C. Household Income Calculation

Under the gap-filling rule, the individual's household income must be calculated according to the MAGI rules used for APTC purposes and compared to the APTC 100% FPL annual income limit for the household size in M04 listed in, Appendix 1. If the annual income at or below the APTC 100% FPL amount, the income is then compared to the Medicaid annual income limits for the individual's covered group or to the FAMIS or FAMIS MOMS income limits to determine the individual's eligibility.

Only tax-filer rules are used for determining household composition for gap-filling determinations. Neither the tax dependent exceptions used for Medicaid/FAMIS MAGI-specific household composition nor non-filer rules are applicable. For example, if a child lives with both parents, and the parents are unmarried, the child is in the tax-filer household of the parent who claims the child as a tax dependent.

Financial eligibility is based on income already received and projected income for the calendar year in which benefits are sought. If the local agency knows the determination of annual income made by the HIM, it may use that information for the purposes of applying the gap-filling rule. Otherwise, the worker must obtain income information from the individual or authorized representative.

1. Verification of Income

Income reported as received for the calendar year in which benefits are sought as well as current monthly income must be verified.

If the information provided is reasonably compatible with information obtained by the worker from electronic sources such as the VEC, or documentation is available from other social services program, such as TANF or SNAP, and the systems information is dated within the past *6* months, the agency must determine eligibility based upon the information available. If there is a discrepancy between what is stated on the application and the information obtained from online systems/agency knowledge, contact the enrollee to obtain clarification of reported income.

2. Countable Income

Income that is listed in M0440.100 B as countable for the Medicaid/FAMIS MAGI evaluation is also countable for the gap-filling evaluation. Additionally, the following income **is counted** for the gap-filling evaluation only if it is countable for taxes:

- Payments made to American Indian/Alaska Natives as described in M0440.100 B.5.
- Scholarships/Awards and fellowship income, regardless of its intended use
- Lump sum payments received in the calendar year for which benefits are sought are included in the annual income calculation only

3. Income Evaluation

If the annual income as determined by the HIM is not known, the eligibility worker must calculate the annual income. Do not convert this income

LIFC Income Limits Effective *7/1/2025*

Group I

Household Size	Monthly Amount	Annual Amount
1	*$329*	*$3,948*
2	*495*	*5,940*
3	*632*	*7,584*
4	*764*	*9,168*
5	*896*	*10,752*
6	*1010*	*12,120*
7	*1142*	*13,704*
8	*1276*	*15,312*
Additional	*139*	*1,668*

Group II

Household Size	Monthly Amount	Annual Amount
1	*$429*	*$5,148*
2	*609*	*7,308*
3	*767*	*9,204*
4	*913*	*10,956*
5	*1,075*	*12,900*
6	*1,209*	*14,508*
7	*1,355*	*16,260*
8	*1,510*	*18,120*
Additional	*155*	*1,860*

Group III

Household size	Monthly Amount	Annual Amount
1	*$642*	*$7,704*
2	*859*	*10,308*
3	*1,048*	*12,576*
4	*1,226*	*14,712*
5	*1,452*	*17,424*
6	*1,613*	*19,356*
7	*1,793*	*21,516*
8	*1,983*	*23,796*
Additional	*188*	*2,256*

INDIVIDUALS UNDER AGE 21 INCOME LIMITS

EFFECTIVE *7/1/25*

Group I

Household Size	Monthly Income Limit	Annual Income Limit
1	*$315*	*$3,780*
2	*481*	*5,772*
3	*618*	*7,416*
4	*747*	*8,964*
5	*880*	*10,560*
6	*986*	*11,832*
7	*1,114*	*13,368*
8	*1,253*	*15,036*
Each additional person add	*135*	*1,620*

Group II

Household Size	Monthly Income Limit	Annual Income Limit
1	*$424*	*$5,088*
2	*611*	*7,332*
3	*765*	*9,180*
4	*914*	*10,968*
5	*1,079*	*12,948*
6	*1,209*	*14,508*
7	*1,355*	*16,260*
8	*1,509*	*18,108*
Each additional person add	*153*	*1,836*

Group III

Household Size	Monthly Income Limit	Annual Income Limit
1	*$560*	*$6,720*
2	*752*	*9,024*
3	*907*	*10,884*
4	*1,062*	*12,744*
5	*1,256*	*15,072*
6	*1,383*	*16,596*
7	*1,534*	*18,408*
8	*1,689*	*20,268*
Each additional person add	*154*	*1,848*

TREATMENT OF INCOME FOR FAMILIES & CHILDREN COVERED GROUPS

INCOME	MAGI COVERED GROUPS	MEDICALLY NEEDY; 300% SSI; F&C COVERED GROUPS
Difficulty of Care Payments	*Not counted*	*Counted with appropriate earned income disregards*
Earnings	Counted with no disregards	Counted with appropriate earned income disregards
Social Security Benefits Adult's MAGI household	Benefits received by a parent or stepparent are counted for his eligibility determination, as well as the eligibility determinations of his spouse and children in the home.	Counted if anyone in the Family Unit/Budget Unit receives
Social Security Benefits Child's MAGI household	If the child lives with a parent, only counted if the child is required to file a federal tax return..	Counted if anyone in the Family Unit/Budget Unit receives
Child Support Received	Not counted	Counted – subject to $50 exclusion
Child Support Paid	Not deducted from income	Not deducted from income
Alimony Received	Counted if divorce agreement was finalized prior to January 1, 2019, and the agreement has not been modified.	Counted – subject to $50 exclusion if comingled with child support
Alimony Paid	Deducted from income if divorce agreement was finalized prior to January 1, 2019	Not deducted from income
Worker's Compensation	Not counted	Counted
Veteran's Benefits	Not counted if they are **not** taxable in IRS Publication 525	Counted
Scholarships, fellowships, grants and awards used for educational purposes	Not counted	Not counted
Student Loan Debt	Effective January 1, 2019, student loan debt forgiven due to death or disability of student is not counted as income	Not applicable
Foreign Income (whether or not excluded from taxes)	Counted	Counted
Interest	Counted	Counted
Lump Sums	Income in month of receipt	Income in month of receipt
Lottery & Gambling Winnings	Lottery and gambling winnings of $80,000 or greater, received in a single payout, are counted in the month received and over a period of up to 120 months. Income in month of receipt for other HH members.	Income in month of receipt
Gifts, inheritances, life insurance proceeds	Not counted	Counted as lump sum in month of receipt
Parsonage allowance	Not counted	Counted

Pandemic Unemployment Compensation Payments	Not counted (regular Unemployment Compensation is counted.)	Not counted (regular Unemployment Compensation is counted.)
Federal COVID-19 relief payments	Not counted	Not counted

M0710 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 2 ; Appendices 2 and 3
TN #DMAS-32	7/1/24	Appendices 2 and 3
TN #DMAS-25	10/1/22	Page 2
TN #DMAS-24	7/1/22	Appendices 2 and 3
TN #DMAS-20	7/1/21	Appendix 2 Appendix 3
TN #DMAS-17	7/1/20	Appendix 2 Appendix 3
TN #DMAS-14	10/1/19	Pages 1, 2, 7, 8 Page 2a was added as a runover page.
TN #DMAS-13	7/1/19	Appendix 2 Appendix 3
TN #DMAS-9	7/1/18	Appendix 2 Appendix 3
TN #DMAS-5	7/1/17	Appendix 1 Appendix 2 Appendix 3
TN #DMAS-2	10/1/16	Appendix 2 Appendix 3
UP #11	7/1/15	Appendix 5
TN #100	5/1/15	Table of Contents Pages 1-8 Pages 9-13 were deleted. Appendix 1 Appendix 2 Appendix 3 Appendices 4-7 were removed.
TN #98	10/1/13	pages 1-4, 8, 9 Page 1a was added. Appendix 1 Appendix 3 Appendix 5
UP #9	4/1/13	Appendix 6, pages 1, 2 Appendix 7
UP #7	7/1/12	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
UP #6	4/1/12	Appendix 6, pages 1, 2 Appendix 7
TN #96	10/01/11	Appendix 6, page 1
UP #5	7/1/11	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1
TN #95	3/1/11	Appendix 6, pages 1, 2 Appendix 7
Update (UP) #1	7/1/09	Appendix 1, page 1 Appendix 3, page 1 Appendix 5, page 1

C. Individual Income Eligibility

An individual's income eligibility is based on the total countable income available to his/her FU/BU.

Each source of income received by a member of the FU/BU is evaluated and the countable amount determined based on the policy in this chapter. The countable amount of each FU/BU member's income is added to the countable amount of the income of all other FU/BU members. That total is used to determine the income eligibility of each individual within that FU/BU. The FU/BU's total countable income is compared to the income limit that is applicable to the individual's classification and to the number of members in the FU/BU.

D. Policy Principles

1. Income

Everything an individual owns and all monies received are assets. Monies received are income in the month received when the monies are cash or its equivalent.

Income may be either earned or unearned. See M0720 for earned income and M0730 for unearned income.

2. Verification

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. See M0130.001.B.3.

For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

All income other than Workforce Investment Act and the earned income of a student under age 19 must be verified. When attempts to verify income are unsuccessful because the person or organization who is to provide the information cannot be located or refuses to provide the information to both the applicant/recipient and the eligibility worker, a third party statement, a collateral contact, or as a last resort, the applicant's/recipient's written statement can be used as verification and to determine the amount of income to be counted.

Failure of the applicant/enrollee to verify his income results in the agency's inability to determine Medicaid eligibility and the applicant/enrollee's Medicaid coverage must be denied or canceled.

F&C MEDICALLY NEEDY INCOME LIMITS

EFFECTIVE 7/1/25

GROUP 1			GROUP II		GROUP III	
# of Persons in Family/Budget Unit	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**	**Semi-Annual Income**	**Monthly Income**
1	*$2,460.34*	*$410.05*	*$2,838.87*	*$473.14*	*$3,690.53*	*$615.08*
2	*$3,132.06*	*$522.01*	*$3,495.33*	*$582.55*	*4,449.18*	*741.53*
3	*$3,690.53*	*$615.08*	*$4,069.08*	*$678.18*	*5,015.39*	*835.89*
4	*$4,163.71*	*$693.95*	*$4,542.24*	*$757.04*	*5,488.55*	*914.75*
5	*$4,636.86*	*$772.81*	*$5,015.39*	*$835.89*	*5,961.70*	*993.61*
6	*$5,110.01*	*$851.66*	*$5,488.55*	*$914.75*	*6,434.85*	*1,072.47*
7	*$5,583.16*	*$930.52*	*$5,961.70*	*$ 993.61*	*6,908.00*	*1,151.33*
8	*$6,150.95*	*$1,025.15*	*$6,529.48*	*1,088.24*	*7,381.18*	*1,230.19*
Each add'l person	*$635.84*	*$105.97*	*$635.84*	*$105.97*	*$635.84*	*$105.97*

F&C 100% STANDARD OF ASSISTANCE
EFFECTIVE 7/1/25
(Used as the F&C Deeming Standard)

Group I

Household Size	Income Limit
1	*$324*
2	*486*
3	*619*
4	*752*
5	*882*
6	*995*
7	*1,120*
8	*1,257*
Each additional person add	*137*

Group II

Household Size	Income Limit
1	*$422*
2	*599*
3	*755*
4	*897*
5	*1,055*
6	*1,191*
7	*1,334*
8	*1,485*
Each additional person add	*153*

Group III

Household Size	Income Limit
1	*$632*
2	*844*
3	*1,031*
4	*1,208*
5	*1,426*
6	*1,586*
7	*1,767*
8	*1,953*
Each additional person add	*185*

M0810 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 1, 2 and 25
TN #DMAS-34	1/1/25	Pages 1 and 2
TN #DMAS-32	7/1/24	Page 2
TN #DMAS-31	4/1/24	Pages TOC i, 1, 2
TN #DMAS-29	10/1/23	Pages 6, 9
TN #DMAS-28	7/1/23	Pages 2, 6
TN #DMAS-27	4/1/23	Page 2, 25, 27, 28 Page 25a is a runover page
TN #DMAS-25	1/1/23	Pages 1, 2
TN #DMAS-24	7/1/22	Page 2
TN #DMAS-23	4/1/22	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2, 3
TN #DMAS-20	7/1/21	Page 2
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-18	1/1/21	Pages 1, 2
TN #DMAS-17	7/1/20	Page 2
TN #DMAS-16	4/1/20	Page 2
TN #DMAS-15	1/1/20	Pages 1, 2
TN #DMAS-14	10/1/19	Pages 20, 25, 27 Page 28 is a runover page.
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Pages 1, 2
TN #DMAS-10	10/1/18	Page 2
TN #DMAS-9	7/1/18	Page 2
TN #DMAS-8	4/1/18	Page 2
TN #DMAS-7	1/1/18	Pages 1, 2
TN #DMAS-5	7/1/17	Page 2
TN #DMAS-4	4/1/17	Page 2
TN #DMAS-3	1/1/17	Pages 1, 2
TN #DMAS-2	10/1/16	Page 2
TN #DMAS-1	6/1/16	Pages 1, 2
UP #11	7/1/15	Page 2
TN #100	5/1/15	Pages 1, 2
UP #10	5/1/14	Page 2
TN #99	1/1/14	Pages 1, 2
TN #98	10/1/13	Page 2
UP #9	4/1/13	Pages 1, 2
UP #7	7/1/12	Page 2
UP #6	4/1/12	Pages 1, 2
TN #95	3/1/11	Pages 1, 2
TN #93	1/1/10	Pages 1, 2
Update (UP) #1	7/1/09	Page 2

GENERAL

M0810.001 INCOME AND ELIGIBILITY

A. Introduction

The following sections explain how to treat income to determine eligibility in the Aged, Blind and Disabled covered groups in the Medicaid program. Virginia Medicaid follows Social Security Administration rules from the SSI section of the Program Operations Manual System (POMS) SSA's Policy Information Site - POMS. Some of the rules are adapted due to state laws and regulations. We have noted in each section if the section follows SSA policy without deviation by adding "per POMS'. This chapter explains how we count income.

B. Policy Principles

1. Who is Eligible

An individual is eligible for Medicaid if the person:

- meets a covered group; and
- meets the nonfinancial requirements; and
- meets the covered group's resource limits; and
- meets the covered group's income limits.

2. General Income Rules

- Count income on a monthly basis.
- Not all income counts in determining eligibility.
- If an individual's countable income exceeds a classification's monthly limit, a medically needy spenddown may be established, if appropriate.

M0810.002 INCOME LIMITS

A. Income Limits

The Medicaid covered group determines which income limit to use to determine eligibility.

1. Categorically Needy

Supplemental Security Income (SSI) and State Supplement (Auxiliary Grant) recipient's money payments meet the income eligibility criteria in the ABD Categorically Needy covered group.

2. Categorically Needy Protected Cases Only

Categorically-Needy Protected Covered Groups Which Use SSI Income Limits		
Family Unit Size	2024 Monthly Amount	2025 Monthly Amount
1	$943	$967
2	1,415	$1,450
Individual or Couple Whose Total Food and Shelter Needs Are Contributed to Him or Them		
Family Unit Size	2024 Monthly Amount	*2025 Monthly Amount*
1	$629	*$645*
2	$944	*$967*

3. Categorically Needy 300% of SSI

For the covered groups that use the 300% of SSI income limit, all income is counted (even excluded income) when screening at 300% of SSI. Do not count any monies which are defined as "what is not income" in S0815.000.

Family Size Unit	2024 Monthly Amount	2025 Monthly Amount
1	$2,829	$2,901

4. ABD Medically Needy

a. Group I	*7/1/24-6/30/25*		*7/1/25*	
Family Unit Size	*Semi-annual*	*Monthly*	*Semi-annual*	*Monthly*
1	*$2,391.01*	*$398.50*	*$2,460.34*	*$410.05*
2	*3,043.80*	*507.30*	*3,132.06*	*522.01*

b. Group II	*7/1/24-6/30/25*		*7/1/25*	
Family Unit Size	*Semi-annual*	*Monthly*	*Semi-annual*	*Monthly*
1	*$ 2,758.87*	*$ 459.81*	*$ 2,838.87*	*$ 473.14*
2	*3,396.83*	*566.14*	*3,495.33*	*582.55*

c. Group III	*7/1/24-6/30/25*		*7/1/25*	
Family Unit Size	*Semi-annual*	*Monthly*	*Semi-annual*	*Monthly*
1	*$3,586.53*	*$597.76*	*$3,690.53*	*$615.08*
2	*4,323.80*	*720.63*	*4,449.18*	*741.53*

5. ABD Categorically Needy

For:

ABD 80% FPL, QMB, SLMB, & QI <u>without</u> Social Security income; all QDWI; effective *1/15/25*

ABD 80% FPL, QMB, SLMB, & QI <u>with</u> Social Security income; effective *3/1/25*

All Localities	2024		2025	
ABD 80% FPL	Annual	Monthly	Annual	Monthly
1	$12,048	$1,004	$12,520	$1,044
2	16,352	1,363	16,920	1,410
QMB 100% FPL	Annual	Monthly	Annual	Monthly
1	$15,060	$1,255	$15,650	$1,305
2	20,440	1,704	21,150	1,763
SLMB 120% of FPL	Annual	Monthly	Annual	Monthly
1	$18,072	$1,506	$18,780	$1,565
2	24,528	2,044	25,380	2,115
QI 135% FPL	Annual	Monthly	Annual	Monthly
1	$20,331	$1,695	$21,128	$1,761
2	27,594	2,300	28,553	2,380
QDWI 200% of FPL	Annual	Monthly	Annual	Monthly
1	$30,120	$2,510	$31,300	$2,609
2	40,880	3,407	42,300	3,525

VERIFYING AND ESTIMATING INCOME

S0810.500 INCOME VERIFICATION

A. Policy Principles

1. Why Verification is Necessary

Although Medicaid does not determine Medicaid eligibility solely on the basis of statements concerning eligibility factors by applicants and recipients, for all case actions as of October 26, 2019, attestation of income will be accepted absent evidence to the contrary. We verify relevant information from independent or collateral sources and obtain additional information as necessary to be sure that eligibility is determined correctly. The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, and information from SSA through SVES or SOLQ-I. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. See M0130.001.B.3.

For all case actions effective August 26, 2022, if the income attested to by the applicant is within 20% of the income information obtained from electronic sources OR both sources are below the applicable income limit, no additional verification is required. If the reasonable compatibility standard is not met, request verification of income and allow a minimum of 10 days to return.

2. All Situations

a. **Individual's Attestation**
Obtain a statement over the individual's signature concerning the type, amount, frequency, or predictability of income. The statement or similar information on the application or redetermination form, is sufficient documentation. Absent evidence to the contrary, accept the individual's attestation.

b. **Evidence Disagrees with Attestation**
If there is evidence which disagrees with the individual's attestations, develop and document under the appropriate income rules.

2. Applicants/ Recipient's Responsibility

A person applying for or receiving Medicaid must give the local Department of Social Services (LDSS) any requested information and show necessary documents or other evidence to establish the amount of the individual's income.

B. Operating Policy

1. Burden of Proof

Applicants and recipients (or their representative payees) are responsible for providing LDSS with proof of income if requested and for reporting any changes in income.

2. Additional Verification Requirements

See the instructions for the particular type of income involved for additional verification requirements.

M0815 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 12
TN #DMAS-31	4/1/24	TOC page i
TN #DMAS-20	7/1/21	Pages 11, 12
TN #DMAS-17	7/1/20	Table of Contents Pages 11, 12
Transmittal (TN) #DMAS-7	1/1/18	Page 1

S0815.270 INCOME TAX REFUNDS AND CREDITS

A. Policy

1. General — Any amount refunded on income taxes already paid is **not income**.

2. Tax Withheld Prior to Application Date — Income tax refunds are not income even if the income from which the tax was withheld or paid was received in a period prior to application for Medicaid.

3. Tax Refunds and Blind Work Expenses — Income tax refunds are **not income** even if the income taxes were included as work expenses of the blind. (See S0820.535 B.3.)

4. COVID-19 Relief Payments — COVID-19 relief payments provided under federal law are considered tax credits and are **not countable as income *OR* resources.** See M1130.675. Interest earned on the retained payments is countable as interest income.

S0815.300 CREDIT LIFE OR CREDIT DISABILITY INSURANCE PAYMENTS

A. Definition of Credit Life/Disability Insurance — Credit life and credit disability insurance policies are issued to or on behalf of borrowers, to cover payments on loans, mortgages, etc. in the event of death or disability. These insurance payments are made directly to loan or mortgage companies, etc. and are not available to the individual.

B. Policy

- Payments made under a credit life or credit disability insurance policy on behalf of an individual are **not income.**
- Food, clothing, or shelter received as the result of a credit life or credit disability payment is **not income.**

C. Example — Frank Fritz, a Medicaid recipient, purchased credit disability insurance when he bought his home. Subsequently Mr. Fritz was in a car accident and became totally disabled. Because of his disability, the insurance company pays off the home mortgage. Neither the payment nor the increased equity in the home is income to Mr. Fritz.

M0830 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 27 and 114
TN #DMAS-31	4/1/24	TOC pages i, ii
TN #DMAS-28	7/1/23	Table of Contents, pages i,iv. Pages 8, 9, 23, 83, 84, 86. 87, 124, 124a. Add Pages 32a, 123a, 123b, 124b.
TN #DMAS-27	4/1/23	Pages 7, 124a
TN #DMAS-25	1/1/23	Pages 24, 24a, 50
TN #DMAS-24	7/1/22	Page 114
TN #DMAS-23	4/1/22	Page 78
TN #DMAS-17	7/1/20	Page 29
TN #DMAS-12	4/1/19	Page 113
TN #DMAS-7	1/1/18	Table of Contents, page iii, iv. Pages 7-8, 17-18, 20, 29, 48, 79a, 82, 124a-124b, 125.
TN #DMAS-4	4/1/17	Table of Contents, page i Pages 24, 24c
TN #DMAS-2	10/1/16	On page 109, updated the format of the header. Neither the date nor the policy was changed.
TN #DMAS-1	3/23/16	Table of Contents, page iii Pages 18, 82
Update #7	7/1/12	Page 24
TN #94	9/1/10	Page 29
TN #93	1/1/10	Table of Contents, page iv Pages 28, 67, 119-120 Pages 122-125
TN #91	5/15/09	Table of Contents, page i Page 29

4. Contact with OPM

If the individual has no acceptable documents, write or telephone OPM. Provide the individual's name and civil service annuity claim identification number (a seven-digit number with a "CSA" or "CSF" prefix). If the claim number is not available, provide the individual's date of birth and Social Security number. *You will also be required to provide a written release from the individual to OPM in order for any information to be released.*

The OPM telephone number is (888) 767-6738. Direct written inquiries to:

U.S. Office Personnel Management
Retirement Operations Center
P.O. Box 45
Boyers, PA 16017

S0830.225 RAILROAD RETIREMENT PAYMENTS

A. Introduction

1. Categories of Payment

There are three basic categories of payments made by the Railroad Retirement Board (RRB):

- Life and survivor annuities
- Social Security benefits certified RRB
- Unemployment, sickness, and strike benefits

2. Life and Survivor Annuities

- Life annuities for retirement and disability are paid under the Railroad Retirement (RR) Act to the railroad employee and his/her spouse. Children of a living annuitant are not entitled to benefits.
- Survivor annuities are payable to widows, widowers, children, and dependent parents of railroad employees. A small number of widows receive two annuities, a regular widow's check and a check payable to them as designated survivors of retired railroad employees who elected to receive reduced benefits during their lifetimes.
- RR annuity payments are similar to Title II benefits in that a check for one month is paid the next month. Also, cost of living adjustments (COLA) for RR annuities are effective the same month as Title II COLA's.

3. Social Security Benefits Certified by RRB

SSA may authorize the payment of Social Security benefits for RR employees to RRB instead of directly to Treasury. In these situations, RRB is responsible for certifying Title II benefits to Treasury, but they remain Title II benefits.

RR benefits are not necessarily Title II benefits. Individuals entitled to this type of benefit receive two award notices. The first notice, from SSA, informs the beneficiary that RRB has responsibility for making Social Security payments. The final notice, from RRB, specifies the amount of the first check.

RR annuity payments and Social Security benefits certified by RRB may be paid as a single check. In these cases, RRB may issue an interim notice before the final notice which specifies the amount of the first check.

S0830.645 REFUGEE CASH ASSISTANCE, CUBAN AND HAITIAN ENTRANT CASH ASSISTANCE, AND FEDERALLY REIMBURSED GENERAL ASSISTANCE PAYMENTS TO REFUGEES

A. Background

Refugee Cash Assistance and Cuban Haitian Entrant Cash Assistance and federally funded programs which make ongoing needs-based payments to refugees during their first *4* months in the United States.

B. Policy Principles

1. Refugee Cash Assistance, Cuban and Haitian Entrant Cash Assistance and federally reimbursed general assistance payments to refugees are federally funded income based on need and, unless excluded under a PASS (S0810.430) are counted as income. The $20 general income exclusion (S0810.420) does not apply to this income.

2. A payment under one of these programs is always considered to be a cash payment.

C. Operating Procedures

If a payment is made under one of these programs to a family unit or a group of people, the amount of the grant attributable to one individual in the family is determined by the incremental method (i.e., the income is the difference between the amount paid and the amount which would have been paid had the individual not been included).

M1110 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 6
TN #DMAS-34	1/1/25	Page 2, 10a
TN #DMAS-32	7/1/24	Pages 1 and 18
TN #DMAS-31	4/1/24	TOC, Pages 1, 6, 7
TN #DMAS-30	1/1/24	Page 2
TN #DMAS-27	4/1/23	Pages 6, 7
TN #DMAS-26	1/1/23	Page 2
TN #DMAS-22	1/1/22	Pages 1, 2
TN #DMAS-20	7/1/21	Page 16
TN #DMAS-19	4/1/21	Page 16
TN #DMAS-18	1/1/21	Page 2
TN #DMAS-17	7/1/20	Page 1
TN #DMAS-15	1/1/20	Page 2
TN #DMAS-12	4/1/19	Pages 10-10a
TN #DMAS-11	1/1/19	Page 2
TN #DMAS-3	1/1/18	Page 2
TN #DMAS-4	4/1/17	Pages 10, 10a
TN #DMAS-3	1/1/17	Pages 2, 7, 10, 11 Page 10a was added as a runover page.
TN #100	5/1/15	Page 2
TN #99	1/1/14	Page 2
UP #9	4/1/13	Page 2
UP #6	4/1/12	Page 2
TN #96	10/1/11	Page 2
TN #95	3/1/11	Page 2
Update (UP) #3	3/2/10	Table of Contents page 2
TN #93	1/1/10	Page 2
TN #91	5/15/09	Pages 14-16

C. Example (cont.)

2. While in the hospital, the recipient received a check for $25 as a "get-well" gift from her neighbors. She was unaware of the gift. At the time, her affairs were being managed by her daughter, who put the check in a desk drawer and failed to tell the recipient anything about it.

   In the month the recipient learns of the existence of the check, the check is counted as her **income**. In the following month, the $25 is counted as her **resource.**

COUNTABLE VS. EXCLUDED RESOURCES

S1110.200 COUNTABLE RESOURCES

Policy

The value of any asset that meets the definition of a resource counts against the applicable resource limit to the extent that the instructions in S1130.100 do not provide for its exclusion.

M1110.210 EXCLUDED RESOURCES

A. Introduction

Once you have determined that an asset meets the definition of a resource, it is necessary to determine that resource's effect on eligibility. Certain resources do not count against the resource limit; i.e., they are excluded.

B. List of Resource Exclusions

Exclusion	Reference	No Limit on Value and/or Length of Time	Limit on Value and/or Length of Time
Home serving as the principal place of residence, including the land on which the home stands (*contiguous property exempt for QDWI, QMB, SLMB, QI and ABD 80% FPL).	M1130.100	* X	X
Funds from sale of a home if reinvested timely in a replacement home	M1130.110		X
Jointly-owned real property which cannot be sold without undue hardship (due to loss of housing) to the other owner(s)-For QMB, QDWI, SLMB, QI and ABD 80% FPL only	M1130.130 Appendix 1 Appendix 2	X	
Real property for as long as the owner's reasonable efforts to sell it are unsuccessful	M1130.140	X	
Restricted, allotted Indian land if the Indian/owner cannot dispose of the land without the permission of other individuals, his/her tribe, or an agency of the Federal Government	M1130.150	X	
Resources funded by needs-based programs such as TANF and Foster Care	*M1130.678* *M1130.679*	*X*	

M1130 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Table of Contents page ii, Pages 24, 26, 34, 74
TN #DMAS-31	4/1/24	Table of Contents pages i, ii, Page 59
TN #DMAS-28	7/1/23	Page 66 and 73
TN #DMAS-27	4/1/23	Table of Contents, page ii Pages 77, 78 Page 77b added
TN #DMAS-23	4/1/22	Table of Contents, pages i, ii Pages 47, 48, 79 Page 48a was added. Page 48b was added as a runover page Page 78 is a runover page.
TN #DMAS-20	7/1/21	Table of Contents, page ii Pages 5, 73, 74 Page 74a was added as a runover page.
TN #DMAS-18	1/1/21	Pages 31, 33, 34
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 73, 74 Page 5 is a runover page.
TN #DMAS-12	4/1/19	Page 13
TN #DMAS-9	7/1/18	Pages 1, 3
TN #DMAS-7	1/1/18	Pages 45,78-79 Appendix 1, pages 3,5
TN #DMAS-5	7/1/17	Pages 13, 15, 78, 79 Page 14 is a runover page.
TN #DMAS-3	1/1/17	Table of Contents, page ii Page 76 Page 77 is a runover page. Pages 78 and 79 were added.
TN #DMAS-1	6/1/16	Pages 4, 14, 15
TN #100	5/1/15	Pages 13, 15, 21, 31, 33, 34 Pages 16 and 32 are runover pages.
UP #9	4/1/13	Table of Contents, page ii Pages 5, 62 Pages 62a was added.
TN#97	9/1/12	Page 14
Update #7	7/1/12	Page 24
TN #96	10/1/11	Table of Contents, page ii Pages 4, 73, 74 Appendix 1, pages 1-14 Appendix 2, page 1 Appendix 4, pages 1-8 added
TN #95	3/1/11	Pages 28, 29, 33
TN #94	9/1/10	Pages 20, 20a, 28-29a
TN #93	1/1/10	Pages 63-65 Pages 70, 74, 75
TN #91	5/15/09	Page 13

M1130.000 ABD RESOURCES EXCLUSIONS

M1130.400 BURIAL SPACES

A. Policy –The Exclusion

1. General

A burial space or agreement which represents the purchase of a burial space held for the burial of the individual, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.

Cemetery plots are not counted as resources, regardless of the number owned, except when evaluating eligibility as QDWI. For QDWI, exclude one cemetery plot (see Appendix 1 to chapter S11). Accept declaration regarding ownership of cemetery plots. Verification is not required.

2. No Effect on Burial Funds Exclusion

The burial space exclusion is in addition to, and has no effect on, the burial funds exclusion (M1130.410).

3. Multiple Burial Spaces

When items other than cemetery plots serve the same purpose, exclude only one per person. For example, exclude a cemetery plot and a casket for the same person, but not a casket and an urn.

4. Burial Spaces After Approval

Burial spaces do not need to be re-verified after application approval unless the Medicaid recipient reports a change.

B. Definitions

1. Burial Space

A burial space is a(n).

- Gravesite (either an existing grave or a plot);
- crypt;
- mausoleum;
- casket;
- urn;
- niche; or
- other repository customarily and traditionally used for the deceased's bodily remains.

The term also includes necessary and reasonable improvements or additions to such spaces, including but not limited to:

- vaults;
- headstones, markers, or plaques;
- burial containers (e.g., for caskets); and
- arrangements for the opening and closing of the gravesite.

For example, a contract for care and maintenance of the gravesite, sometimes referred to as endowment or perpetual care, can be excluded as a burial space.

C. Procedure-- Development and Documentation

The following procedures do **not** apply to installment burial contracts or insurance funded burial contracts. For installment contracts, see **M1130.420**. For insurance funded contracts, see **M1130.425**.

1. General

a. If an individual alleges owning only one burial space, or an individual and spouse allege owning no more than two spaces, **assume** that the spaces are excluded.

b. If an individual or individual and spouse allege owning more than one or two spaces, respectively, obtain a signed statement showing;

- the name of the person for whose burial each space is intended; and
- the relationship of each such person to the individual. Exclude only those spaces that are alleged to be for the burial of the individual, the spouse, or a member of the immediate family.

c. *Burial spaces do not need to be reverified unless the Medicaid member reports a change.*

2. Agreements Which Represent the Purchase of a Burial Space

a. General

If the contract shows the purchase of a specified burial space at a specified price, determine whether such space is held for the individual or member of the individual's immediate family per B.4. above.

If the space is held for the individual, determine if the contract is irrevocable or revocable. If irrevocable, it is not a resource. If the contract is revocable, it is an excludable resource. (See **M1130.420** C.3. on single-purpose burial space contracts.)

b. Installment Contract

If the contract calls for installment payments, determine whether the value of the burial space has to be treated as burial funds (**M1130.420** C.5.c.).

D. References

Burial funds exclusion, M1130.410.
Prepaid burial contracts, **M1130.420**.
Interest earned on excluded burial space purchases agreements, S0830.501.

F. Procedures- Renewal or a Reported Change

1. Verify Funds Already Excluded

If the case record shows excluded burial funds, *the current value does not need to be re-verified unless the Medicaid recipient reports a change (such as using the funds for another purpose).* When $3,500 or less was initially designated as a burial fund, increases in the burial fund due to appreciation or accumulated interest are excluded even if they result in the total burial fund exclusion exceeding the $3,500 maximum.

If more than $3,500 was initially designated for burial funds exclusion, interest and appreciation that have subsequently accrued on the excluded portion of the burial fund are excluded. Interest and appreciation that have subsequently accrued on the countable portion are countable. To calculate the countable value of a burial fund at renewal or when a change is reported you may use the electronic "BFE Increased Value Determination Worksheet". The worksheet is located on the Virginia Department of Social Services Local Agency web site (SPARK) at: *https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Training-Documents*.

If the funds have decreased, see G. below.

2. Enrollee Wishes to Designate Funds

If an enrollee wishes to designate funds for burial, proceed as you would for an initial application. This applies whether no funds are currently excluded or less than $3,500 (excluding appreciation or accumulated interest) is currently excluded.

3. Apply Burial Funds-Related Income/ Resources Exclusions

See H. below.

G. Procedure-Burial Funds Are Used for Another Purpose

1. When to Evaluate Use for Another Purpose

Determine if excluded burial funds have been used for some other purpose only if:

- there is some indication that excluded funds may have been used for another purpose, and
- the sum of the excluded funds (including any that may have been spent) and countable resources exceeded the applicable (individual or couple) resources limit as of the month in which the excluded funds may have been used for another purpose, and
- the individual was eligible for the month in which the excluded burial funds may have been used for another purpose.

2. Development and Documentation

If an individual alleges that his or her resources include unspent EITC and/or COVID-19 relief refunds or payments:

- verify the source, date(s), and amount(s) of such refund(s) or payment(s) in accordance with S0820.400, and
- obtain a statement as to the date(s) and amount(s) of any account deposits corresponding to the EITC and/or CARES Act refunds or payments.

C. References

Commingled funds, S1130.700.

S1130.678 INDIVIDUAL DEVELOPMENT ACCOUNTS – TANF FUNDED

A. Background

The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 authorized states to use money from their Temporary Assistance for Needy Families (TANF) grant to fund Individual Development Accounts (IDAs). The Acts of Assembly of 2020, Special Session I allocated funding for the establishment of IDA accounts for Virginia TANF participants, effective July 1, 2021.

An IDA is a special bank account that helps an individual save for his/her education, the purchase of a first home, or to start a business. The individual uses earnings from their work to set up an approved bank account for an IDA and contributes money from their earnings to the IDA. The TANF program matches the contributions to the IDA. The matching money helps the individual reach his/her goal sooner.

B. Policy

1. Contributions

An individual's contributions that are deposited in a TANF IDA are excluded from resources.

2. Matching Funds

Any matching funds that are deposited in a TANF IDA are excluded from resources.

3. Interest

Any interest earned on the individual's contributions and matching funds that are deposited in a TANF IDA is excluded from resources.

C. Procedures

1. How To Verify TANF IDAs

Whenever possible, verify the individual's TANF IDA through available case records. If the TANF IDA cannot be verified through the case record, obtain verification from the individual that the account is a TANF IDA.

2. After TANF Eligibility Ends

The treatment of an IDA after an individual's TANF eligibility ends or after an individual moves from one state to another can vary from state to state. Check with the TANF Program in the appropriate state regarding whether an account stops being an IDA after TANF eligibility ends or an interstate move occurs, and how to treat funds that remain in the account and withdrawals from the account after TANF eligibility ends or an interstate move occurs.

S1130.679 Resources Funded by Needs-Based Programs such as TANF and Foster Care

Other resources funded by needs-based programs are also exempt resources.

M1420 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Page 5
TN #DMAS-33	10/1/24	Pages 2-5
TN #DMAS-30	1/1/24	Page 1
TN #DMAS-26	1/1/23	Pages 1 and 2
TN #DMAS-25	10/1/22	Table of Contents Pages 1-5
TN #DMAS-24	7/1/22	Table of Contents Pages 1-5 Appendix 1 Page 6 was removed. Appendix 1 was removed and Appendix 2 was renumbered to Appendix 1.
TN #DMAS-19	4/1/21	Page 2
TN #DMAS-17	7/1/20	Pages 1-6
TN #DMAS-12	4/1/19	Page 2
TN #DMAS-11	1/1/19	Entire subchapter
TN #DMAS-7	1/1/18	Table of Contents Pages 2, 5. Appendix 2.
TN #DMAS-5	7/1/17	Pages 2-6
TN #DMAS-1	1/1/17	Table of Contents Pages 3-6 Appendix 3 Appendices 4 and 5 were removed.
TN #DMAS-1	6/1/16	Pages 3-5 Page 6 is a runover page. Appendix 3, page 1
TN #99	1/1/14	Page 4
UP#7	7/1/12	Pages 3, 4
TN #94	09/01/10	Table of Contents Pages 3-5 Appendix 3
TN #93	01/01/10	Pages 2, 3, 5 Appendix 3, page 1 Appendix 4, page 1

M1420.300 COMMUNICATION PROCEDURES

A. Introduction

To ensure that nursing facility, PACE placement or receipt of Medicaid HCBS services are arranged as quickly as possible, there must be prompt communication between screeners and eligibility staff.

B. Procedures

1. LDSS Contact

The LDSS should designate an appropriate staff member for screeners to contact. Local social services, hospital staff, CBTs, Managed Care Organizations (MCOs) and nursing facilities should be given the name and contact information for that person to facilitate timely communication between screeners and eligibility staff.

2. Screeners

Screeners must inform the individual's eligibility worker when the screening process has been completed.

3. Eligibility Worker (EW) Action

The EW must inform the individual, the provider and the MCO once eligibility for Medicaid payment of LTSS has been determined. If the individual is found eligible for Medicaid and written assurance of approval by the screening team, DMAS, or the managed care plan has been received (DMAS-96, WaMS printout or the Minimum Data Survey [MDS]), the eligibility worker must give the LTSS provider the enrollee's Medicaid identification number.

M1420.400 LTSS SCREENING EXCLUSIONS (Special Circumstances)

A. Purpose

The screening certification authorizes the local DSS to determine financial eligibility using the more liberal rules for institutionalized individuals, including the 300% SSI covered group and the special rules for married institutionalized individuals with a community spouse. The Eligibility Worker does not need to see any screening authorization if the individual applying is already a resident of a nursing (or PACE) facility when the Medicaid application is filed.

B. Screening Special Circumstances

Screening for LTSS is NOT required when:

- the individual is a resident in a nursing facility, receiving CCC Plus Waiver services or in PACE at the time of application;
- the individual resides out of state (either in a community, hospital or nursing facility setting) and seeks direct admission to a nursing facility;
- the individual is an inpatient at an in-state owned/operated facility licensed by DBHDS, in-state or out of state Veterans hospital, military hospital or VA Medical Center, and seeks direct admission to a nursing facility;
- the individual enters a nursing facility directly from the CCC Plus Waiver or PACE services;
- *the individual is being enrolled in Medicaid Works;*
- the individual is being enrolled in Medicaid hospice.

M1450 Changes

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Table of Contents, Pages 37, 41, 42, 45, 46
TN #DMAS-31	4/1/24	Pages 42 and 46
TN #DMAS-29	10/1/23	Page 37
TN #DMAS-28	7/1/23	Page 35 and Appendix 2
TN #DMAS-27	4/1/23	Page 44
TN #DMAS-26	1/1/23	Page 46
TN #DMAS-25	10/1/22	Page 36
TN #DMAS-17	7/1/20	Page 45
TN #DMAS-15	1/1/20	Page 46
TN #DMAS-14	10/1/19	Pages 19, 41, 42, 46
TN #DMAS-10	10/1/18	Pages 1, 2 Appendix 3, page 2 Page 24a was added back; it was inadvertently removed in a previous transmittal. Page 2a was added as a runover page.
TN #DMAS-9	7/1/18	Page 35-36a, 37-38, 43
TN #DMAS-7	1/1/18	Page 4, 24, 36, 36a, 37, 41, 42 Appendix 1, Page 1.
TN #DMAS-5	7/1/17	Table of Contents Pages 13, 35, 41-44 Page 43a was renumbered. Pages 45 and 46 were added as runover pages.
TN #DMAS-3	1/1/17	Pages 30, 40-42, 44
TN #DMAS-1	6/1/16	Pages 13, 15, 35 Pages 14 and 16 are runover pages.
TN #100	5/1/15	Table of Contents Pages 17-19, 36, 37 Page 35 is a runover page.
TN #99	1/1/14	Page 7, 10, 21
UP #7	6/1/12	Table of Contents Pages 37-43 Page 43a was added.
TN #96	10/1/11	Table of Contents Pages 4-8 Pages 15, 16, 25, 26 Pages 31-38 Page 31a removed.
TN #95	3/1/11	Pages 4, 24, 32, 36, 37, 37a, Pages 39, 42, 43
TN #94	9/1/10	Table of Contents Pages 36-37a, 39-44
TN #93	1/1/10	Table of Contents Pages 3, 17-18, 29 Appendix 2, page 1
TN #91	5/15/09	Pages 41, 42

TABLE OF CONTENTS

M14 LONG-TERM CARE

M1450.000 TRANSFER OF ASSETS

Appendices

D. Average Monthly Nursing Facility Cost (Figures Provided by Virginia Health Information)

Average Monthly Private Nursing Facility Cost

Application Date	Northern Virginia*	All Other Localities
10-1-96 to 9-30-97	$2,564	$2,564
10-1-97 to 12-31-99	$3,315	$2,585
1-1-00 to 12-31-00	$3,275	$2,596
1-1-01 to 12-31-01	$4,502	$3,376
1-1-02 to 12-31-03	$4,684	$3,517
1-1-04 to 9-30-07	$5,403	$4,060
10-1-07 to 12-31-10	$6,654	$4,954
1-1-11 to 12-31-14	$7,734	$5,933
1-1-15 to 6-30-18	$8,367	$5,933
7-1-18 to 12-31-20	$9,032	$6,422
1-1-21 to *12-31-24*	$9,268	$7,023
1-1-25 to present	*$9,703*	*$7,324*

*The northern Virginia localities are: Alexandria, Arlington, Fairfax, Fairfax County, Falls Church, Loudoun County, Manassas, Manassas Park and Prince William County.

See M1450, Appendix 1 for amounts prior to October 1, 1996.

E. Partial Month Transfer

The following example shows how to compute a penalty period for an uncompensated transfer that occurred on or after July 1, 2018 and involves a partial month.

Example #19 (using July 2018 figures): An individual living outside Northern Virginia made an uncompensated asset transfer of $48,294 in July 2018, the same month he applies for Medicaid. The uncompensated value of $48,294 is divided by the average monthly rate of $6,422 which equals 7.52 months. The full 7-month penalty period runs from July 2018, the month of the transfer, through January 2019, with a partial month penalty calculated for February 2019. The partial month penalty is calculated by dividing the partial month penalty amount ($3,340.00) by the daily rate ($207.16, which is the monthly rate of $6,422 divided by 31). The calculations are as follows:

Step #1	$48,294.00	uncompensated value of transferred asset
	÷ 6,422.00	avg. monthly nursing facility rate at time of application
	= 7.52	penalty period (7 full months, plus a partial month)
Step #2	$ 6,422.00	avg. monthly nursing facility rate at time of application
	X 7	seven-month penalty period
	$44,954.00	penalty amount for seven full months

The eligibility worker must send a letter to the individual informing him of each asset transfer and the corresponding penalty period, as well as the right to claim an undue hardship. An Asset Transfer Undue Hardship Claim form, available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical- Assistance/Forms, must be included with the letter. The Asset Transfer Undue Hardship Claim Form serves as the request for an undue hardship evaluation.

a. Undue Hardship Claimed - Required Documentation

When requesting an undue hardship, the individual must provide the following documentation appropriate to the case situation:

- the reason(s) for the transfer;
- attempts made to recover the asset, including legal actions and the results of the attempts;
- notice of pending discharge from the facility, or discharge from PACE, hospice, or CBC services due to denial or cancellation of Medicaid payment for these services and include the actual date discharge will take place;
- medical provider's statement stating the inability to receive nursing facility or CBC services would result in the applicant/recipient's inability to obtain life-sustaining medical care;
- documentation that individual would not be able to obtain food, clothing, shelter, or other necessities of life;
- list of all assets owned and verification of their value at the time of the transfer if the individual claims he did not transfer resources to become Medicaid eligible; and
- documents such as deeds or wills if ownership of real property is an issue.

b. *15* Days to Return Undue Hardship Claim

The individual must be given at least *15* calendar days to return the completed form and documentation to the local agency. If the individual requests additional time to provide the form and documentation, the worker shall allow up to 30 calendar days from the date the checklist was sent. If the form and documentation are not returned within 30 calendar days, the penalty period must be imposed.

c. Documentation for DMAS

If an undue hardship is claimed, the eligibility worker must send to DMAS:

- a copy of the undue hardship claim form
- a description of each transfer:
    - what was transferred
    - parties involved and relationship
    - uncompensated amount
    - date of transfer

- calculation and duration of the penalty period(s) being imposed;
- a brief summary of the applicant/recipient's current eligibility status and living arrangements (nursing facility or community); and
- other documentation provided by the applicant/recipient.

Email the documentation to DMAS at DMASEvaluation@dmas.virginia.gov or mail to:

DMAS, Eligibility Policy and Outreach Division
600 East Broad Street, Suite 1300
Richmond, Virginia 23219

A copy of all documentation submitted with the undue hardship claim must be retained in the case record.

Any information the agency receives about the individual's subsequent receipt of compensation which shortens the penalty period must be sent to the DMAS at the above address.

d. When Applicant/Recipient Was Victim

If the applicant/recipient was a victim of an individual who is not the individual's attorney in fact, guardian, conservator or trustee and undue hardship is claimed, the **agency** must provide a statement documenting the facts and what actions were taken by the agency *regarding* their findings. If the transfer was by a court-appointed guardian or conservator, documentation of any bond insurance that would cover the loss must be provided.

e. Undue Hardship Not Claimed or Not Granted by DMAS

If undue hardship is not claimed or if a penalty period must be imposed per DMAS, follow the procedures in M1450.800 through M1450.830 for notifying the individual and DMAS of the action. The individual must be informed that a denial of a claim for undue hardship may be appealed in accordance with the provisions of 12 VAC 30-110. If the individual meets all other eligibility requirements, he is eligible for Medicaid payment of all covered services other than LTC.

2. DMAS

DMAS will review the documentation provided with the undue hardship claim to determine if an undue hardship may be granted and send written notification to the eligibility worker. If additional information is needed to clarify the documentation received with the Undue Hardship claim, DMAS will notify the agency and provide a time frame for submitting the documentation. A copy of the decision must be retained in the individual's case record.

3. Subsequent Claims

If DMAS is unable to approve an undue hardship request because sufficient supporting documentation was not submitted, the claim must be denied, and the penalty period must begin. Once a claim is denied, no further decision related to the same asset transfer will be made by DMAS unless the individual experiences a change in circumstances **while still in the penalty period**, such as receiving a discharge notice, that would result in the individual being removed from the institution or becoming unable to receive life-sustaining medical care, food, clothing, shelter or other necessities of life.

M1450.820 PROVIDER NOTICE

A. Introduction

Use the Medicaid LTSS Communication Form (DMAS-225) to notify the provider of the individual's Medicaid eligibility and ineligibility for Medicaid payment of long-term care services.

B. Medicaid LTC Communication Form (DMAS-225)

The DMAS-225 should include:

- the individual's full name, Medicaid and Social Security numbers;
- the individual's birth date;
- the patient's Medicaid coverage begin date; and
- that the patient is not eligible for Medicaid payment of nursing facility/CBC waiver services for the months (state the penalty period begin and end dates) because of an asset transfer(s).

If the individual reports a change in circumstances to the local DSS, he or his authorized representative must be offered the chance to submit an additional claim of undue hardship. Follow the procedures in M1450.700 B above.

If DMAS grants the claim of undue hardship, the portion of the asset transfer penalty remaining **as of the date of the undue hardship request** is nullified. **Medicaid cannot pay for long-term care services received during the penalty period prior to the undue hardship request.** Nursing facility charges incurred during a penalty period may be evaluated as a patient pay deduction using the policy and procedures in M1470.230.

Once the penalty period has expired, no additional claims of undue hardship may be made.

M1450.830 DMAS NOTICE *section removed 7/1/25*

Page removed 7/1/25

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 1 and 48
TN #DMAS-34	1/1/25	Pages 1, 2, 10, 11, 19, 20, 24
TN #DMAS-33	10/1/24	Pages 1, 2, 2a
TN #DMAS-32	7/1/24	Pages 1, 2, 5, 12, 15, 18-20, 28-30, 44, 54, and 55
TN #DMAS-31	4/1/24	Page 10, 12a, 14 and 14a
TN #DMAS-30	1/1/24	Page 20
TN #DMAS-29	10/1/23	Pages 46-48
TN #DMAS-28	7/1/23	Page 19, Appendix 1
TN #DMAS-27	4/1/23	Page 15
TN #DMAS-26	1/1/23	Pages 19, 20
TN #DMAS-25	10/1/22	Page 20
TN #DMAS-24	7/1/22	Pages 1, 15, 28a, 44, 48-50 Page 14a is a runover page.
TN #DMAS-22	1/1/22	Pages 19, 20
TN #DMAS-21	10/1/21	Page 17
TN #DMAS-20	7/1/21	Pages 11, 20, 26
TN #DMAS-19	4/1/21	Pages 7, 8, 22, 23
TN #DMAS-18	1/1/21	Pages 19, 20
TN #DMAS-17	7/1/20	Table of Contents, page ii Pages 1, 14, 28a, 47, 48, 50, 55 Appendix 1, page 1
TN #DMAS-15	1/1/20	Pages 19, 20

M1470.000 PATIENT PAY-POST-ELIGIBILITY TREATMENT OF INCOME

M1470.001 OVERVIEW

A. Introduction

"Patient pay" is the amount of the long-term care (LTC) patient's income which must be paid as the share of the LTC services cost. This subchapter provides basic rules regarding the post-eligibility determination of the amount of the LTC patient's income which must be paid toward the cost of care. **MAGI Adults, *Hospice recipients receiving services outside a facility and individuals participating in the Medicaid Works program* have no responsibility for patient pay *(see M03 for more information).*** If an individual receiving LTC, also called long-term services and supports (LTSS), loses eligibility in *one of these* covered group*s* and is eligible in *a different* full coverage group, patient pay policy will apply.

B. Policy

The state's Medicaid program must reduce its payment to the LTC provider by the amount of the eligible patient's monthly income, after allowable deductions. Patient pay is calculated using actual verified income after an individual has been determined eligible for Medicaid and for Medicaid LTC services. A *non-Medically Needy* Medicaid recipient who is admitted to a nursing facility, facility for individuals with intellectual disability (ICF-ID) or Medicaid waiver services for less than 30 calendar days must have a patient pay determined for the month(s) in which the recipient is in the facility or waiver services**.** *Medically Needy Medicaid does not cover services in ICF-ID or other facilities for less than 30 days. See M1470.320.* The provider collects the patient pay from the patient or the authorized representative. Patient pay information is fed to the Automated Response System (ARS) and the MediCall Systems for provider verification of patient pay. These systems report the amount of patient pay and the date of service to the provider responsible for collecting patient pay.

C. VaCMS Patient Pay Process

The patient pay calculation is completed in VaCMS. Refer to the VaCMS Help feature for information regarding data entry. The patient pay must be updated in the system whenever the patient pay changes, but at least once every 12 months. If VaCMS is not able to process required transactions, a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP- Home/Medical-Assistance/Forms, should be submitted to patientpay@dmas.virginia.gov. If attested income was used to determine eligibility, actual income must be verified to calculate patient pay. If actual income was not obtained while determining eligibility the worker must request income verification to calculate patient pay by adding a comment on the notice. If the verified income affects eligibility for the individual, process as a change. If no additional verification is received, the estimated patient pay remains a liability for the individual.

D. Patient Notification

The patient or the authorized representative is notified of the patient pay amount on the Notice of Patient Pay Responsibility. VaCMS will generate and send the Notice of Patient Pay Responsibility. M1470, Appendix 1 contains a sample Notice of Patient Pay Responsibility generated by VaCMS. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into the Medicaid Enterprise System (MES, formerly MMIS).

The provider is the only entity with the authority to take action when residents do not pay their patient pay amount. If a resident, or his authorized representative is negligent in paying his patient pay amount to the provider, the provider will provide written documentation regarding the requirement to pay the patient pay amount to the resident or authorized representative and follow the provider's collection procedures to collect the funds. The provider will report the resident's negligence in paying the patient pay amount to the LDSS.

The provider's failure to collect the patient pay, or the patient's failure to pay the patient pay, does not itself affect the patient's Medicaid eligibility. However, the

M1470.910 RETROACTIVE ADJUSTMENTS FOR PRIOR MONTHS

A. Retroactive Adjustment

If a change was reported timely and the patient pay for prior months is incorrect, adjust the patient pay for the prior months only in the following situations:

1. a deceased individual had health insurance premiums or noncovered medical expenses that should have reduced patient pay; or

2. a community spouse is owed money for a spousal allowance and the institutionalized spouse is deceased or no longer in long-term care. However, if the community spouse had decreased income and did not report the change in a timely manner, do not adjust the patient pay.

3. *Patient pay may be reduced in the past when there is no other way to make the member whole (e.g. ongoing patient pay is zero). The reduction must be for the most recent months and must be approved and completed by DMAS. Send the Patient Pay Correction form to patientpay@dmas.virginia.gov.*

4. If an individual has moved from NF to CBC, adjust the patient pay effective the month after the change.

In these situations, adjust the patient pay retroactively using the VaCMS Patient Pay process for the prior months in which the patient pay was incorrect. **In all other situations when a change is reported timely, do not adjust the patient pay retroactively.** If VaCMS is not able to process required transactions, submit a Patient Pay Correction form (DMAS 9PP), available at https://fusion.dss.virginia.gov/bp/BP-Home/Medical-Assistance/Forms, to patientpay@dmas.virginia.gov.

B. Notification Requirements

VaCMS automatically generates and sends the Notice of Patient Pay Responsibility. DMAS will generate and mail a Notice of Patient Pay Responsibility for any changes input directly into *MES.*

M1470.920 LTC PROVIDER CHANGE WITHIN A MONTH

A. Policy

A change in LTC providers requires a review of the type of provider and living arrangements to determine the correct personal needs allowance and new patient pay, if applicable.

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 1 and 66
TN #DMAS-34	1/1/25	Pages 7, 18c, 66, 69, 70
TN #DMAS-33	10/1/24	Pages 16, 66
TN #DMAS-32	7/1/24	Pages 6, 8a, 8b, 15, 17, 18, 18a, 18c, 21, 30, 31, 47, 52, 52a, 55, 56, 60, 65, 66, 68, 73, 74, 77, 78, 82, 86, 87, 91
TN #DMAS-31	4/1/24	Page 8a, 17
TN #DMAS-30	1/1/24	Pages 3, 7, 18c, 66, 69, 70
TN #DMAS-29	10/1/23	Page 66
TN #DMAS-26	1/1/23	Pages 7, 18c, 66, 69, 70
TN #DMAS-25	10/1/22	Page 66
TN #DMAS-24	7/1/22	Pages 8a, 8b, 13, 50b, 51, 55, 57, 66, 87, 89, 91
TN #DMAS-22	1/1/22	Pages 7, 18c, 66, 69, 70
TN #DMAS-21	10/1/21	Page 66
TN #DMAS-20	7/1/21	Pages 66, 70
TN #DMAS-18	1/1/21	Page 7, 18c, 66, 69, 70, 92
TN #DMAS-17	7/1/20	Pages 8b, 9, 14, 66, 77, 92
TN #DMAS-15	1/1/20	Pages 1, 7, 18c, 66, 69, 70

M1480 MARRIED INSTITUTIONALIZED INDIVIDUALS' ELIGIBILITY & PATIENT PAY

M1480.000 GENERAL

A. Introduction

Section 1924 of the Social Security Act contains special eligibility rules that apply ONLY to married institutionalized individuals whose first continuous period of institutionalization began on or after September 30, 1989. These rules are intended to prevent the impoverishment of a spouse living in the community when the other spouse enters long-term care. **For resource assessment and eligibility determination, the resource value is its value as of the first moment of the first day of a calendar month.**

Section 1924 supersedes all other sections of Medicaid law when determining countable resources and income of a married institutionalized individual who has a community spouse. Therefore, the usual Medicaid eligibility rules do not apply to an institutionalized individual with a community spouse whenever the usual Medicaid rules conflict with the law in section 1924.

An institutionalized spouse is an individual who is in a medical institution, who is receiving Medicaid waiver services or who has elected hospice services, and who is married to a spouse who is not in a medical institution or nursing facility. The term "community spouse" means the spouse of an institutionalized spouse. The community spouse can be living outside an institution or in a residential institution such as an adult care residence.

B. Applicability

1. MAGI Adult

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid if the individual is eligible in the MAGI Adult covered group. If a *married* individual who has been determined eligible for LTSS in the MAGI Adult covered group *is no longer eligible in a MAGI group (turns 65 or begins receiving Medicare), eligibility must be redetermined and a Resource Assessment completed as of the first day of the first month the individual began their first continuous period of institutionalization (receiving LTSS services for more than 30 days). If an individual* subsequently marries and is no longer financially eligible in the MAGI Adults covered group, use the policy in M1480 to determine continuing financial eligibility for LTSS. The resource assessment is completed based on resources owned by the couple as of the first moment of the first day of the month in which the marriage took place (see M1480.220).

2. Admitted Before 9-30-89

DO NOT use this subchapter to determine the individual's financial eligibility for Medicaid when the married institutionalized individual was admitted to long-term care **prior to** September 30, 1989 and has been continuously institutionalized since admission. Use subchapters M1410 - M1460 to determine the individual's financial eligibility for Medicaid.

3. Admitted On/ After 9-30-89

Use this subchapter in determining Medicaid eligibility for an institutionalized spouse who

- was admitted to long-term care **on or after** September 30, 1989 and has been continuously institutionalized since admission, and
- has a community spouse.

M1480.400 PATIENT PAY

A. Introduction This section contains the policy and procedures for determining an institutionalized spouse's (as defined in section M1480.010 above) patient pay in all covered groups.

B. Married With Institutionalized Spouse in a Facility For a married long-term services and support (LTSS) patient with an institutionalized spouse in a facility, **NO** amount of the patient's income is deducted for the spouse's needs in the patient pay calculation.

M1480.410 MAINTENANCE STANDARDS & ALLOWANCES

A. Introduction This subsection contains the standards and their effective dates that are used to determine the community spouse's and other family members' income allowances. The income allowances are deducted from the institutionalized spouse's gross monthly income when determining the monthly patient pay amount. Definitions of these terms are in section M1480.010 above.

B. Monthly Maintenance Needs Allowance	$2,288.75	7-1-22
	$2,465	7-1-23
	$2,555	7-1-24
	$2,643.75	*7-1-25*
C. Maximum Monthly Maintenance Needs Allowance	$3,435.00	1-1-22
	$3,715.50	1-1-23
	$3,853.50	1-1-24
	$3,948.00	1-1-25
D. Excess Shelter Standard	$686.63	7-1-22
	$739.50	7-1-23
	$766.50	7-1-24
	$793.13	*7-1-25*

E. Utility Standard Deduction (SNAP)	$414.00	1 - 3 household members	10-1-23
	$524.00	4 or more household members	10-1-23
	$369.00	1 - 3 household members	10-1-24
	$467.00	4 or more household members	10-1-24

M1480.420 PATIENT PAY FOR ABD 80% FPL AND 300% SSI INSTITUTIONALIZED SPOUSE

A. Policy After a 300% SSI or ABD 80% FPL institutionalized spouse has been found eligible for Medicaid, determine patient pay (post-eligibility treatment of income).

Changed With	Effective Date	Pages Changed
TN #DMAS-35	7/1/25	Pages 7 and 18
TN #DMAS-33	1/1/25	Page 9
TN #DMAS-33	10/1/24	Change List; Pages 1, 2a, 4a – 6, 10 – 11, 12a

B. Renewal Procedures

Renewals may be completed in one of the following ways:

- ex parte,
- using a paper form,
- online,
- telephonically by calling the Cover Virginia Call Center.

1. Ex Parte Renewals

An ex parte renewal is an internal review of eligibility based on information available to the agency. Conduct renewals of ongoing Medicaid eligibility through the ex parte renewal process for all covered groups, including covered groups with a resource test and individuals receiving LTSS. If an automated ex parte renewal cannot be attempted, a manual ex parte renewal must be attempted and documented in VaCMS UNLESS the automated process leaves an ex parte attempt date.

a. MAGI-based *and Non-MAGI* Cases

For *all* cases an ex parte renewal should be completed when income verification is available through the federal Hub. An individual may authorize the use of Internal Revenue Services (IRS) data for up to five years on the application form and at each renewal. In order for the federal Hub to be used for income, there must be a valid authorization in the electronic or paper case record.

The agency must utilize online systems information verifications that are available to the agency without requiring verifications from the individual or family, and must make efforts to align renewal dates for all programs. The agency has ready access to Supplemental Nutrition Assistance Program (SNAP) and TANF records, some wage and payment information, information from SSA through SVES or SOLQ-I and information from child support and childcare files. Verification of income from available sources, including the VEC, may be used if it is dated within the previous *6* months. See M0130.001.B.3.

The eligibility worker is to take every opportunity to renew Medicaid eligibility when information is reported/verified that will allow a renewal of eligibility to be completed. For example, when an ongoing Medicaid enrollee applies for SNAP or TANF or reports a change in income, use the income information obtained to complete an early ex parte Medicaid renewal and extend the Medicaid renewal for another 12 months.

The agency must include in each applicant's case record facts to support the agency's decision on the case. The eligibility worker must document the date and method used to obtain the verification information (viewed pay stub dated xx/xx/xxxx, telephone call on xx/xx/xxxx date, etc.), the type of verification, the source and a description of the information. If the renewal is not processed and documented electronically, the documentation must be placed and maintained in the case record.

1. Received LIFC Medicaid in Three of Six Months

The family received LIFC Medicaid in at least three of the six months immediately before the month in which the *change occurred making the* family ineligible for LIFC. A family who received Medicaid erroneously during three or more of the six months before the month of ineligibility does **not** qualify for the Medicaid extension. Months during which the family received Extended Medicaid are not considered months in which the family received LIFC Medicaid, and the family must be evaluated for eligibility in other covered groups.

2. Cancel Reason

LIFC Medicaid was canceled solely because of:

- the parent's or caretaker/relative's new employment,
- the parent's or caretaker/relative's increased hours of employment, or

the parent's or caretaker/relative's increased wages of employment.

3. Has A Child Living in Home

There continues to be at least one child under age 18 or if in school, a child who is expected to graduate before or in the month he turns 19, living in the home with the parent or caretaker/relative.

4. No Fraud

The family has not been determined to be ineligible for LIFC Medicaid at any time during the last six months in which the family received LIFC Medicaid because of fraud.

A. Entitlement & Enrollment

The AC for enrollees in the family receiving the twelve-month extension is "081" for an LIFC family with one parent or caretaker-relative or "083" for a two-parent family. Entitlement does not continue for any member of the family who moves to another state.

If a parent becomes eligible for extended Medicaid, the child(ren) remains in the current Aid Category until the end of the previous 12 month continuous eligibility period. Then, if no longer eligible, they are moved into extended Medicaid for the remainder of the extended period. Children under 19 remain eligible for 12 months unless a child reaches age 19; is no longer a Virginia resident; the child or child's representative requests eligibility be closed; the agency determines that eligibility was incorrectly approved because of agency error or fraud, abuse, or perjury attributed to the child or the child's representative; or the child is deceased.

1. Determining Extension Period

a. Establishing Initial Month of Eligibility
Medicaid coverage will continue for six months beginning with the first month following the month in which the *change occurred making the* family no longer eligible for LIFC Medicaid because of excess income due to the increased earnings of the parent or caretaker/relative AND the Benefits Worker can give 10 days notice prior to taking action.

b. Extension for an additional six-month period is possible if the reporting and financial requirements below are met.

For example, if the increased earnings were received in April, but were not reported or discovered until a review of eligibility in June, the 12-month extension period begins with July if the Benefits Worker takes action prior to June 20. The screening period to determine if the family received LIFC Medicaid in at least three of the six months immediately preceding the month in which the *change occurred making the* family ineligible for LIFC Medicaid is November through April.