STATE OF MICHIGAN

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Bridges Eligibility Policy Manuals

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STATE OF MICHIGAN

DEPARTMENT OF HEALTH & HUMAN SERVICES

OVERVIEW

Family Independence Program (FIP)

Temporary Assistance to Needy Families (TANF), called the Family Independence Program (FIP) in Michigan, is a block grant that was established by the Social Security Act. Public Act (P.A.) 223 of 1995 amended P.A. 280 of 1939 and provides a state legal base for FIP. FIP policies are also authorized by the Code of Federal Regulations (CFR), Michigan Compiled Laws (MCL), Michigan Administrative Code (MAC), and federal court orders. Amendments to the Social Security Act by the U.S. Congress affect the administration and scope of the FIP program. The U.S. Department of Health and Human Services (HHS) administers the Social Security Act. Within HHS, the Administration for Children and Families has specific responsibility for the administration of the FIP program.

Each state must submit a state plan for FIP. State plans are located at http://www.michigan.gov. When federal statute or regulations provide for options, the state plan must indicate which optional provisions the state selects. In selecting optional provisions and developing policy, the Michigan Department of Health and Human Services (MDHHS) is governed primarily by state statutes. The state plan must be approved by HHS and the Governor's Clearinghouse for conformity to federal and state laws and regulations. A specific legal base is cited at the end of each program manual item.

Program Goal

The Family Independence Program (FIP) provides financial assistance to families with children. The goal of FIP is to help maintain and strengthen family life for children and the parent(s) or other caretaker(s) with whom they are living, and to help the family attain or retain capability for maximum self-support and personal independence.

Several nonfinancial and financial eligibility factors must be met for a family to be eligible for FIP.

Medical Assistance Program

The Medical Assistance Program was established by the Social Security Act. Amendments to the Social Security Act by the U.S. Congress affect the administration and scope of the MA program. The U.S. Department of Health and Human Services (HHS) administers the Social Security Act. Within HHS, the Center for Medicare and Medicaid Services (CMS) is responsible for the administration of the Medicaid (MA) program.

HHS develops and issues federal regulations that set the requirements and guidelines for states to follow in the determination of MA eligibility. Each state must submit a state plan for MA. When federal statute or regulations provide for options, the state plan must indicate which optional provisions the state selects. In selecting optional provisions and developing policy, the Michigan Department of Health and Human Services (MDHHS) is governed primarily by state statutes. The state plan must be approved by HHS and the governor's clearinghouse for conformity to the Code of Federal Regulations (CFR), Michigan Compiled Laws (MCL), and federal court orders. Legal bases are provided at the end of each program manual item.

Program Goal

MA provides medical assistance to individuals and families who meet the MA financial and nonfinancial eligibility factors. The goal of the MA program is to ensure that essential health care services are made available to those who otherwise would not have financial resources to purchase them.

Disability related Medicaid and Group 2 Medicaid eligibility can be obtained through several individual categories that are listed in BEM 105. MAGI Medicaid and Healthy Michigan Plan policy is available at www.michigan.gov/MDHHS and BEM, Bridges Eligibility Manual.

Food Assistance Program (FAP)

The Food Assistance Program (FAP) was established by the Federal Food and Nutrition Act of 2008. The Act places responsibility for the administration of the Food Assistance program with the U.S. Department of Agriculture (USDA) at the national

level. Within USDA, the Food and Nutrition Service (FNS) has specific responsibility for the administration of FAP. FNS, in turn, delegates actual day-to-day administration of the program to state agencies. Michigan participates in the program in accordance with a State Plan of Operations. This serves as an agreement with FNS to administer the program in accordance with the Code of Federal Regulations (CFR), Michigan Compiled Laws (MCL), Michigan Administrative Code (MAC) and federal court orders. These sources are the legal base for all policies and procedures. These are cited at the end of each manual item.

Program Goal

The purpose of the Food Assistance Program (FAP) is to raise the food purchasing power of low-income persons because limited food purchasing power contributes to hunger and malnutrition. Persons eligible for FAP, receive benefits based on net income and the size of the group, to increase the food purchasing power of the eligible household who apply for participation.

FAP benefits are not considered income or assets for Cash, MA or CDC. Therefore, any other assistance for which a Food Assistance group qualifies must not be reduced because of the group's receipt of food assistance benefits.

Authorized Purchases

Food assistance benefits can be used to buy eligible food at any FNS authorized retail food store or approved meal provider.

Eligible food includes:

- Any food or food product intended for human consumption except alcoholic beverages, tobacco, and hot food prepared for immediate consumption.
- Seeds and plants to grow food for personal consumption.
- Meals prepared by organizations approved by FNS as specified below.
- Meals prepared and served to eligible residents by a Substance Abuse Treatment Center, a Shelter for Battered Women and Children or an Adult Foster Care (AFC) Home.

Retail food stores include:

- Recognized grocery stores.
- House-to-house grocery vendors, such as milk and milk product deliverers, but not ice cream vendors.
- Nonprofit food purchasing ventures - private nonprofit associations of consumers whose members pool their resources to buy food.

Approved meal providers may include:

- Communal dining facilities for elderly and disabled individuals.
- Restaurants which provide low-cost meals.
- Meal delivery services - public or private nonprofit organizations which prepare and deliver meals to elderly persons (60 years of age or over), physically or mentally impaired persons, and their spouses, who are unable to adequately prepare all of their meals.

REFUGEE ASSISTANCE PROGRAMS

The refugee assistance programs were established by the U.S. Congress. The Office of Refugee Resettlement (ORR) in HHS has specific responsibility for the administration of Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA). The Michigan Department of Labor and Economic Opportunity's (LEO) Office of Global Michigan administers the programs and sets payment rates and eligibility criteria.

Program Goal

The refugee assistance programs provide financial assistance and medical aid to persons admitted into the U.S. as refugees. Eligibility is also available to certain other non-U.S. citizens with specified immigration statuses, identified in the section *refugees* in BEM 630.

The Immigration and Nationality Act, the Code of Federal Regulations (CFR), and federal court orders are the legal base for policies and procedures for RCA and RMA and are cited in the applicable manual item.

Child Development and Care (CDC)

The Child Development and Care (CDC) program was established by authority of the Social Security Act and the Child Care and Development Block Grant Act. The Michigan Department of Education (MDE) administers the program and sets subsidy payment rates and eligibility criteria. The U.S. Department of Health and Human Services (HHS), Administration for Children and Families (ACF) administers the program on the federal level.

The Michigan Department of Health and Human Services (MDHHS) is responsible for eligibility determination for the CDC program.

ACF develops and issues federal regulations that set the requirements and guidelines for states to follow in the administration of the Child Care and Development Fund (CCDF). Each state must submit a state plan describing the CCDF program to be conducted by the state for providing child care subsidies to low-income families and for increasing the quality of child care. The state plan must be approved by ACF for conformity to federal laws and regulations.

Program Goal

The Child Development and Care (CDC) program provides financial assistance with child care expenses to qualifying families.

The goal of the CDC program is to support low-income families by providing access to high-quality, affordable, and accessible early learning and development opportunities and to assist the family in achieving economic independence and self-sufficiency.

State Disability Assistance (SDA)

The State Disability Assistance (SDA) program was initially established by Michigan Public Act 111 of 1991 and has been reauthorized each year in the MDHHS appropriations act. The MDHHS administers the program.

Program Goal

State Disability Assistance (SDA) provides financial assistance to disabled adults who are not eligible for FIP. The goal of the SDA program is to provide financial assistance to meet a disabled person's basic personal and shelter needs.

POLICY MANUALS

All Programs

The Bridges Eligibility Manual (BEM), Bridges Administrative Manual (BAM), Bridges Policy Glossary (BPG), and the Reference Manuals (RF) contain all the policies and procedures needed by specialists to administer the FIP, MA, FAP, SDA, RCA/RMA and CDC programs. Each employee involved in the eligibility determination for these programs must have online access to the manuals.

Bridges Eligibility Manual (BEM)

BEM contains policies and procedures related to determining program eligibility and the level of program benefits, such as nonfinancial eligibility factors, financial eligibility factors and budgeting policy. A single item contains subjects applicable to all programs (for example, citizenship). Programmatic differences that exist are clearly identified in the item. Subjects that are unique to one program (for example, blindness or disability as it relates to MA) appear in separate items.

Bridges Administrative Manual (BAM)

BAM contains policies and procedures related to activities such as administrative hearings, voter registration services, over and under issuances and supplemental program benefits.

Bridges Glossary (BPG)

BPG contains definitions that assist with understanding the meaning of terminology used in other manuals rather than include definitions for the same terminology in each item. Many items contain cross-reference links to the glossary definitions.

Reference Manuals

The Reference Manuals include the following:

- **RFS** Schedules.
- **RFT** Tables.

REVISIONS

The upper right-hand corner of each page lists revision and effective dates.

Bulletins

Bulletins contain a summary of all policy changes and include:

- A list of the updated items.
- A brief summary of the policy change(s).
- The reason for the change.
- New policy implementation steps.

Manual maintenance instructions automatically list every item changed, added or deleted at the end of the bulletin.

Change Bars

Revised manual pages contain vertical lines in the right margin (change bars) to call attention to the particular areas that have been revised, except when an entire item is new.

Special Policy Bulletins

A special policy bulletin does not summarize an item update instead it announces policy; for example, when the children's clothing allowance is allocated in the MDHHS budget and is issued once yearly.

Public Access to Manuals

The MDHHS policy manuals are available to the public at the Michigan Department of Health and Human Services internet site under MDHHS Policy Manuals; see BAM 310, Confidentiality, regarding the release of specific information pertaining to clients.

POLICY EXCEPTIONS

MDHHS and MDE policy is primarily the policy contained in the manuals and numbered bulletins. However, policy releases **cannot** handle every conceivable situation.

Policy exceptions may be issued in case specific situations not covered by published policy. They may also be granted as overrides of

eligibility results in the automated eligibility system, Bridges, in any of the situations that follow:

- The eligibility results are incorrect or are inconsistent with published policy.
- Eligibility must be manually determined and applied in Bridges due to an unusual combination of circumstances.
- Manual adjustments to federal or state FIP time clock counters are necessary.
- The department has been overturned in a hearing or court decision and an override is necessary to implement the decision because it is outside the normal eligibility rules in Bridges or is contrary to correct policy rules implemented in Bridges.

Policy exception decisions for case specific problems not covered by published policy may be issued on form DHS-1785, Policy Decision, or an MSA notice by either of the following:

- The Medical Services Administration within the Michigan Department of Health and Human Services (MDHHS) central office for Medicaid.
- The Department of Education, Office of Great Start, Child Development and Care for CDC.
- The Economic Stability Administration, in the MDHHS central office for all other programs.

Policy issued on the DHS-1785 is official policy, but only for the case specified on the form.

There are three situations for which policy exceptions may be approved and issued on the policy decision form by the MDHHS and/or MSA central offices for case specific situations:

- There is no existing policy in manuals or numbered bulletins that applies in a specific case.
- A policy exception is needed for use in a specific case due to a new legal decision or a new law or regulation that is not yet official MDHHS policy.

- **FIP, SDA, RCA, CDC, MA, and RMA Only**
  A policy exception is needed based on unique and rare circumstances in a specific case to avoid extreme and unusual hardship on the client.

  Note: For some programs, central office must determine whether the Federal Financial Participation (FFP) will be affected. When FFP cannot be claimed, MDHHS central office must notify their central office accounting and the MDHHS local office.

Policy Exceptions Overrides

There are three situations in Bridges for which policy exceptions overrides may be approved and certified.

- The automated determination in Bridges has produced eligibility results inconsistent with existing policy for a specific case that needs to be corrected. Bridges eligibility results in the affected area are normally consistent with policy. Policy must review the individual case, determine the correct application of existing policy, and may need to manually determine eligibility and calculate benefits to apply the override.
- Policy must be published and made effective before the policy rules or logic can be updated in Bridges. Policy exceptions overrides must be made to affect the official published policy until the policy rules and logic can be implemented in Bridges.
- The published policy requires the use of an exceptions process in Bridges.

Note: For some programs, central office must also determine the correct funding source when a manual eligibility determination has been made. This is because eligibility determinations made outside of the automated processes do not set the funding source required based on the combinations of characteristics in a specific case.

EXCEPTION REQUESTS

Exceptions Not Covered by Published Policy

FIP, SDA, RCA/RMA, CDC and FAP only

Requests for a policy exception for a situation not covered by published policy may be initiated by any staff member but must be in writing and go through regular administrative channels. Requests may be sent to:

CDC

Department of Education
Office of Great Start
Child Development and Care
PO Box 30008
Lansing, MI 48909
Fax: 517-241-8679

Email: Policy-CDC@michigan.gov

FIP, SDA, and FAP

Department of Health and Human Services
Economic Stability Administration
Suite 1415, Grand Tower
235 South Grand Avenue
Lansing, MI 48933

Email: Policy-FIP-SDA@michigan.gov,
Policy-FAP@michigan.gov.

RCA/RMA

Department of Labor and Economic Opportunity
Office of Global Michigan
210 N Washington Square
Suite 150
Lansing, MI 48933

Email: LEO-RefugeeServices@michigan.gov

For the complete list of program policy email boxes, see *policy interpretations* in this item.

Policy exception requests must include:

- Case name (group member needing exception).
- Case number.
- Name and phone number of local office contact person.
- A detailed description as to why the exception is being requested.
- What steps the local office has taken to resolve the issue.
- How the case fits into one of the three allowable situations above.
- Copies of all related material.

Medicaid only

Medicaid policy exception requests may be sent ID mail, fax or email to:

Department of Health and Human Services
Bureau of Medicaid Policy, Operations and Actuarial Services
Eligibility Policy Section
PO Box 30479
Lansing, MI 48909

Medicaid exception requests may be faxed to: 517-241-8969.

Medicaid exceptions may be requested at eligibilitypolicy@michigan.gov

Policy exception requests must include:

- Beneficiary name.
- Case number and beneficiary ID number.
- Name and phone number of local office contact person. This should include a secure fax or email in which protected health information may be shared.
- A detailed description as to why the exception is being requested, including the BEM policy item.
- What steps the local office has taken to resolve the issue.

- Explanation of how the case fits into one of the three allowable situations above.
- Copies of all pertinent information.

Exceptions to provider or service policy, or prior authorization cannot be granted through this process; see BAM 402.

Medicaid policy exceptions are an internal process. Exception requests must come from a department employee.

Exception requests are not accepted from beneficiaries, attorneys or family members.

Policy exceptions do not determine eligibility. An exception denial does not grant hearing rights to the beneficiary.

Policy Exception Override Requests

All Programs except Medicaid

Policy exceptions override requests are generated using one of the following procedures:

- A request is called in through administrative channels to Bridges Resource Center (BRC), for resolution who coordinates between program policy units, based on the programs affected. The ticket must include all of the following information:
  - The specialist's name and contact information.
  - The case number.
  - The Head of Household's name.
  - The program(s) affected.
  - The name and individual ID of the member(s) affected.
  - The eligibility determination group (EDG) number(s).
  - A detailed description of the issue.
  - What steps the local office took to try to resolve the issue.
  - The expected resolution.
  - Copies of all supporting documentation, including a copy of the Hearing Decision and Order or Court Order for situations involving a hearing decision.
- A request is sent to the appropriate program policy email box for review. The request must include:

- The case number.
- The Head of Household's name.
- The name and number of a local office contact person.
- A detailed description regarding why the exception is needed.
- What steps the local office has taken to handle the issue.
- Copies of all related materials.

If a request for a policy exceptions override is denied, the program policy office will respond with the reason(s) for the denial as part of the BRC ticket resolution or as an email response from the policy email box.

Policy exceptions for Medicaid are not processed in Bridges.

Policy Exception Decisions

FIP, SDA, RCA/RMA, CDC, MA, and FAP only

When a policy exception is requested by a local office, MDHHS CDC Policy, and LEO Office of Global Michigan will use the DHS-1785 to issue policy decisions.

MDHHS/MSA will issue policy exceptions via a fax or email notice.

Each DHS-1785 or MSA notice will be issued for a specific case and will be identified by case name and number. The DHS-1785 will be signed by the individual responsible for the decision.

The DHS-1785 or MSA notice will be sent to the appropriate local office and must be filed in the case record.

State Emergency Relief (SER) Only

See ERM 104, Exceptions to Official SER Policy.

POLICY INTERPRETATIONS

All Programs

Implementation of existing policies in manuals, bulletins and numbered letters for use in specific cases is the responsibility of the local office staff. If assistance is needed, the local office may contact the policy mailbox in the MDHHS central office. Policy interpretation requests must be sent by email. Questions are accepted from:

- Up to three designated staff persons from each local office.
- Program managers.
- Partnership. Accountability. Training. Hope. (PATH) coordinators.
- Food assistance management evaluators, (FAME).
- AP specialists.

Program specific policy email box addresses are as follows:

- Policy-CDC@michigan.gov - Child Development and Care Policy.
- Policy-Employment@michigan.gov - FIP Employment and Training Policy.
- MDHHS-Policy-FAPemployment@michigan.gov - FAP Employment and Training Policy.
- Policy-FAP@michigan.gov - Food Assistance Program Policy.
- Policy-FIP-SDA@michigan.gov - FIP and SDA Assistance Programs.
- LEO-RefugeeServices@michigan.gov - RCA, RCA Employment and Training, and RMA Policy.
- EligibilityPolicy@michigan.gov (Medicaid related questions & exception requests).
- Policy-SER@michigan.gov - State Emergency Relief Policy.
- MDHHS-EBT-Policy@michigan.gov - EBT Policy.

- MDHHS-MA-FAP-Trusts_Annuities@michigan.gov - Medicaid and FAP Trusts.
- MDHHS-Medicaid-Hearing-Reconsideration-Requests@michigan.gov - Medicaid hearing reconsideration requests.
- MDHHS-Policy-Recoupment@michigan.gov - Recoupment Policy.
- Policy-Time-Limits@michigan.gov - TANF Out of State Time Limit Policy.
- MDHHS-Provider-Management@michigan.gov - Provider Management Unit.
- MDHHSVotes@michigan.gov.

Persons requesting policy clarifications are asked to provide:

- Their name, telephone number and job title.
- Programs needing clarification.
- Manual item needing clarification.
- Case name and number.
- Specific question.

ADMINISTRATIVE HEARING DECISIONS

All Programs

Rulings and orders in a hearing decision are applied only to the particular case in question. A hearing decision does not apply to other cases; see BAM 600.

QUALITY ASSURANCE ERRORS

All Programs

The Office of Quality Assurance and Internal Control (OQAIC) will accept DHS-1785 (or emergency policy communication) as official policy statement and will not consider it an error when a local office follows such policy. Also, decisions of administrative law judges will be accepted as policy for the specific case for which they are issued.

If OQAIC determines that an official policy is in error, the error in the affected cases will be cited as a central office error.

BAM 320, Department Audits, contains information and procedures to follow to request a reconsideration of an OQAIC exception.

SUSPECTED CHILD ABUSE/NEGLECT

All Programs

MDHHS employees must report suspected child abuse and/or neglect. An employee who has reasonable cause to suspect child abuse or neglect must immediately make report of suspected child abuse or neglect by one of the two following methods:

1. By phone to the MDHHS Centralized Intake Unit at 855-444-3911.
2. Through MI Bridges for Mandatory Reporters. More information for registration is available at https://www.michigan.gov/documents/mdhhs/MORS_Registration_Guide_for_SOM_Users_657121_7.pdf

If making an oral report by telephone, within 72 hours a written report must be filed with the MDHHS Children's Protective Services (CPS) unit to Centralized Intake. Use a DHS-3200, Report of Actual or Suspected Child Abuse or Neglect, to file the written report. The DHS-3200 should be either faxed to 616-977-1154 or 616-977-1158 or emailed to DHS-CPS-CIGroup@michigan.gov.

The written report made online should contain the names and addresses of the child's parent, the child's guardian, the persons with whom the child resides, and the child's age. The report should contain other information available to the reporting person that might establish the cause of the abuse or neglect, and the manner in which the abuse or neglect occurred.

For more information on mandatory reporting of child abuse/neglect; see Administrative Policy Human Resources (APR) 200, Mandated Reporter - Child.

SUSPECTED ADULT ABUSE/NEGLECT

All MDHHS employees must report suspected adult abuse, neglect, or exploitation.

See Administrative Policy Human Resources (APR) 201, Mandated Reporter - Adult, for information on how to report suspected adult abuse, neglect, and exploitation.

LEGAL BASE

FIP

Social Security Act, Title IV, Part A, as amended
P.A. 280 of 1939, as amended
Mich Admin code, R 400.3101 - 400.3131

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 - 400.3180

RCA/RMA

45 CFR 400.45 - 400.69 and 400.90 - 400.107

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

MA

Social Security Act, Sections 1902 and 1905
42 CFR 435
MCL 400.106

FAP

7 CFR 271.1.3(a)
7 CFR 272.1(d)
Food and Nutrition Act of 2008, as amended

All Programs

MCL 722.623(1), (2)

PSF

Adoption Assistance and Child Welfare Act of 1980
P.L. 104-193 of 1996 (8 USC 1157)

EXHIBIT I - LIST OF SSI-RELATED MA CATEGORIES

MA Category	BEM Item	Unique Nonfinancial Eligibility Factor	Program Code	Financial Eligibility Group	Automatic MA Eligibility
SSI Recipients	150	Aged, blind or disabled	A, B, E	1	Yes
Appealing SSI Termination	150	Appealing SSI termination	M, O, P	1	No
503 Individuals	155	Aged, blind or disabled	M, O, P	1	No
Early Widow(er)s	157	Blind or disabled	O, P	1	No
DAC	158	Aged, blind or disabled	M, O, P	1	No
AD-Care	163	Aged or disabled	M, P	1	No
Extended-Care	164	Aged, blind or disabled	M, O, P	1	No
Medicare Savings Programs	165	Medicare Part A	M, O, P	-	No
Group 2 Aged, Blind and Disabled	166	Aged, blind or disabled	M, O, P	2	No
QDWI	169	Type of Medicare	P	-	No
Home Care Children	170	Disabled	P	1	No
Children's Waiver	171	Disabled	P	1	No
Breast and Cervical Cancer Prevention and Treatment Program	173	Health department cancer screening	O	1	No

EXHIBIT II - SSI-RELATED MA CODING

Eligible for:			Case PT *	SC *	Recipient PT *	ES *
Regular MA	BEM	MSP				
AD-Care	163	Full QMB	0	1F	4	4
AD-Care	163	None	0	1F/1E	5	4
Extended-Care	164	Full QMB	8	1F	0	4
Extended-Care	164	Limited QMB (SLMB)	1	1F	1	4
Extended-Care	164	None	1	1F/1E	0	4
Group 2	166	Full QMB	9	2F	0	3
Group 2	166	Limited QMB (SLMB)	0	2F	2	3

Eligible for:			Case		Recipient	
Regular MA	BEM	MSP	PT *	SC *	PT *	ES *
Group 2	166	None	0	2F/2E	0	3
Active Deductible	545	Full QMB	9	2B	0	7
Active Deductible	545	Limited QMB (SLMB)	0	2C	2	7
Active Deductible	545	None	0	20	0	7
Active Deductible	545	Full ALMB	0	2H	0	7
None	**NA**	**Full QMB**	**9**	**2B**	**0**	**3**
None	**NA**	**Limited QMB** (SLMB)	**0**	**2C**	**2**	**3**
Appealing SSI termination	150	**	0	1F	0	4
503 Individual	**155**	**	**5**	**1F**	**0**	**4**
Early Widow(er)	**157**	**None**	**7**	**1F**	**0**	**4**
DAC	**158**	**	**4**	**1F**	**0**	**4**
Home Care Child	**170**	**	**0**	**1F**	**0**	**4**
Children's Waiver	**171**	**	**0**	**1F**	**0**	**4**
QDWI	**169**	**None**	**0**	**1Q**	**0**	**4**
Freedom to Work (FTW)	174	None	0	1D	0	4
Freedom to Work (FTW)	174	Full QMB	8	1D	0	4
Freedom to Work (FTW)	174	Limited QMB (SLMB)	0	1D	2	4
Freedom to Work (FTW) premium level	174	None	0	1K	0	4
None	NA	Full ALMB	0	2H	0	3

DATA ELEMENT KEY

- **Case level Program Type (PT) on format page one.**
- **Scope/Coverage (SC).**
- **Recipient level Program Type (PT) starting on format page two.**
- **Eligibility Status (ES).**

Note: When adding coverage to an active deductible case, the ES remains 7.

EXHIBIT III - QMB DESK AID

There are four categories of assistance available to help people pay their Medicare premiums. These categories are referred to by a variety of names.

Full Name	Also Known As	BEM	Benefit	Key Nonfinancial Test
Qualified Medicare Beneficiaries	• QMB • Full-QMB • Medicare Assistance Programs • Medicare Savings Programs	165	Pays Medicare: • Premiums (Part A and B) • Coinsurance • Deductibles	• Receiving Medicare Part A* **or** • Refused free Part A (claim number suffix is M1) **or** • Entitled to buy Part A. Social Security calls this Premium HI. *(claim number suffix is M)
Specified-Low Income Medicare Beneficiaries	• SLMB/SLM • Limited-QMB • Medicare Assistance Programs • Medicare Savings Programs	165	Pays Medicare Part B premiums	Receiving Medicare Part A free (claim number suffix is not M1 or M)
Additional Low-Income Medicare Beneficiaries Type 1	• ALMB • Q1 (Type 1) • Medicare Assistance Programs • Medicare Savings Programs	165	Type Q1 pays Medicare Part B premiums	Receiving Medicare Part A free (claim number suffix is not M1 or M)

* See BEM 169, Qualified Disabled Working Individual, if the person is under age 65 and paying a premium for Part A

Situation	Medicare Part A Code
Person is **not** entitled to Medicare Part A.	4
Part A premium being charged and person is under age 65.	4*
Claim number suffix is M and person age 65 or older.	3
Claim number suffix is M1.	2
Claim number suffix is **not** M or M1/ no Part A premium being charged.	1

EXHIBIT IV - CODES

Name	BEM	Program Group Type	BEM Program Code	Scope Coverage Code	Eligibility Status Code
BEM 150 Recipients A/B/E Recipients A/B/E Transferred to M/O/P MA While Appealing SSI Termination LOCAL OFFICE M, O AND P OPEN-INGS"	150	SSI TSO TSI TSI	A,B,E M,O,P M,O,P M,O,P	1F 1F 1F 1F	4 4 4 4
503 Individuals	155	503	M, O, P	See EXHIBIT II, SSI-Related MA coding	
Early Widow(er)s	157	EW	O,P	See EXHIBIT II, SSI-Related MA coding	
Disabled Adult Child	158	DAC	O,P	See EXHIBIT II, SSI-Related MA coding	
AD-Care	163	AD	M, P	See EXHIBIT II, SSI-Related MA coding	
Extended Care	164	EC	M,O,P	See EXHIBIT II, SSI-Related MA coding	
Medicare Savings Programs (MSP)	165	QMB SLMB ALMB1	See EXHIBIT II, SSI-Related MA coding		
Group 2 Aged, Blind and Disabled	166	G2S	M,O,P	See EXHIBIT II, SSI-Related MA coding	
Qualified Disabled Working Individual (QDWI)	169	QDWI	P	1Q	4
Home Care Child	170	HCC	P	1F, 1E[1]	4
Children's Waiver	171	CHW	P	1F, 1E[1]	4
SED Waiver	172		P	1F, 1E	4
Breast and Cervical Cancer Prevention and Treatment Program	173	BCCP	O	1F, 1E[1]	4
Refugee Assistance Program - Medical (Refugee Assistance, not Medicaid)	630	RAPM	I	20[2], 1F, 2F	4, 3, 7[3]

1. Coverage code E identifies coverage limited to emergency services due to alien status (BEM 225).
2. Scope/coverage 20 indicates that the person is in deductible status. If the person was in deductible status and eligible for a Medicare Savings Program (MSP) the scope/coverage would show MSP eligibility;0see Exhibit III in BEM 105.
3. ES code 7 is used for deductible status. It tells Bridges to switch scope/coverage 2F/2E back to the previous codes for the month after the deductible was met.

Note: PG Category types for SSI-related MA are AG (aged), BL (blind) and DI (disabled). However, BL and DI do not necessarily mean blind or disabled per BEM 260.

EXHIBIT V OTHER INSURANCE CODES

Codes	Description
90 - 96	Medicare
89	HMO/PPO
05	Blue Cross/Blue Shield (BCBS)
87	Pharmacy Only
88	Dental Only
83	Long-Term Care
84	Indemnity
78	Recipient Monitoring

Medical Insurance	
Code	**Description**
00	None Known (initial Value)
01	Aetna US Healthcare
02	American Association of Retired Persons (AARP)
03	American Community Mutual
04	Bankers
05	Blue Cross/Blue Shield of Michigan, Blue Cross/Blue Shield Federal and Blue Cross/Blue Shield - Other States
06	Benefit Services
07	Connecticut General Life and Equitable Life (aka CIGNA or Equicor)
08	CAN
09	General American
10	Wausau Insurance
11	Benefit Source
12	Reserved for future use
13	Great West Life/The New England
14	American Medical Security
15	Pyramid Life Insurance Company/The One Benefit Source
16	Unicare (aka John Hancock Mutual Life and Massachusetts Mutual)

Medical Insurance	
Code	**Description**
17	Harrington Benefit Services
18	Reserved for future use
19	Michigan Education Special Services Association (MESSA)
20	Group Benefit
1	Regency Medical Administration
22	Mutual of Omaha
23	John Alden Life Insurance Company
24	United Teachers Associates
25	Golden Rule Insurance
26	HRM Claim Management
27	Federated Mutual Insurance Company
28	NGS American, Inc
29	Physicians Mutual
30	Cigna Healthcare
31	Prudential Insurance Company
32	Reserved for future use
33	Teamsters

Medical Insurance	
Code	**Description**
34	United HealthCare/Benesight (aka Travelers and Metropolitan)
35	Automated Benefit Service
36	Ameraplan
37	Reserved for future use
38	Other Carriers Not Listed
39	First Health
40	Number not assigned
41	Federal Employee Health Insurance Programs
42	Activa Benefit
43	Weyco Incorporated
44	Trustmark
45	Principal Financial Group
46	Reserved for futre use
47	Central States
48	United American Insurance Co.
49	JFP Benefit Management
51	Reserved for furture use
Medical Insurance	

Medical Insurance	
Code	**Description**
Code	**Description**
512	Reserved for future use
53	United Furniture Workers
54	Mutual Protective Medico Life
54	Employee Benefit
56	Strategic Resource Company (SRC Services, Inc.)
57	State Farm Insurance
58	Group Health Managers, Inc.
59	Pioneer Life Insurance Co of Illinois
60	Reserved for future use
61	Reserved for future use
62	Humana
63	Reserved for future use
64	United Food & Commercial Workers (includes Michigan United Food & Commercial Workers)
65	Mid America Associates
66	Administration System Research (ASR
67	Trades, Services & Union Carriers/Plans (except United Food & Commercial Workers)

Medical Insurance	
Code	**Description**
Medical Insurance	
Code	**Code**
68	Self-Funded Administration/Group/Plans
69	Fortis Benefits Insurance Company
70	Group Marketing
71	United Medical Resources
72	Corporate Benefit Services
73	Secure One Benefit Admin., Inc.
74	SET/SEG
75	Claim Management Services
76	Core Source/Cambridge
77	Reserved for future use
78	Medicaid Recipient Monitoring
79	Guardian
80 - 82	Reserved for future use
83	Long-Term Care
84	Indemnity (fixed price paid per day/stay for outpatient, inpatient, home health and nursing homes, such as., AARP, Connecticut General, Physicians Mutual)

Laboratory Only Plans Code	
Code	**Description**
85	Laboratory Only Plans Code

Vision Only Plans	
Code	**Description**
86	Vision Only Plans
Pharmacy Only Plans	
Code	**Description**
87	Pharmacy Only Plans
Dental Only Plans	
Code	**Description**
88	Dental Only Plans Code (includes Delta Dental Plan of Michigan)

Private Enrollments Only - Managed Care Plans/HMOs	
Code	**Description**
	Do **not** use for Medicaid enrollments. **Private enrollments only** - **Managed Care Plans/Health Maintenance Organizations** (includes HMO, PPO and POS plans). Carriers assigned this code include, but are not limited to: • Aetna Health Plans of Northern California • Advantage Health Plan • Alliance Health & Life Insurance • Alternative Health • Anthem BCBS - Canton Region • Beech Street PPO • Blue Care Network • Blue Choice Network • Care Choices • CHAMPUS (aka CHAMPVA and Tricare) • Choice Care • CNA Health Partners • Community Blue • DayMed HMP, Inc. • Electronic Data Systems Corp (aka EDS) • Fallon Community Health Plan

89	Do **not** use for Medicaid enrollments. **Private enrollments only** - **Managed Care Plans/Health Maintenance Organizations** (includes HMO, PPO and POS plans). Carriers assigned this code include, but are not limited to: • Family Health Care Plan of Ohio • FHP Health Care • Grand Valley Health • Health Alliance Plan (aka HAP) • Health America • Health Maintenance Plan • Health Plan of Nevada • Health Plus of Michigan • HMO Health Ohio • HMO Illinois • Humana Health Care Plan • IBA Self-Funded Group • Maxicare Indiana, Inc. • MCARE • McAuley Health Plan (HMO) • MetraHealth Care Plan of Texas • Multiplan WPPN • Mutually Preferred HMO • NGS American • OmniCare, Inc. • Paramount Health Care • Partners National Health Plans • PHP Plus, Inc. • Physicians Health Plans (aka PHP) • Physicians Plus HMO • Planned Administrators, Inc. • PPOM Claims Department • Preferred Choices • Principal Health Care of Florida • Principal Health Care of Illinois • Principal Health Care of Indiana

Private Enrollments Only - Managed Care Plans/HMOs	
Code	**Description**
89	Do **not** use for Medicaid enrollments. **Private enrollments only** - **Managed Care Plans/Health Maintenance Organizations** (includes HMO, PPO and POS plans). Carriers assigned this code include, but are not limited to: • Priority Health • Prudential Health Care • Qual Med • Security Health Plan • SelectCare • Select Health Plan • Share Health Plan of Illinois • Total Health Care • Tricare Champus • Tuft Associated Health Plan • United Health Care • Wellness Plan • Wisconsin Health Organization

Medicare	
Code	**Description**
50	Medicare Excluded Alien (entered only by the Medicare Buy-In Unit)
90	Eligible for Medicare, but not confirmed. Indicates that a beneficiary has reached age of 65 and needs to be referred to SSA to apply for Medicare, or the beneficiary's Medicare coverage has not been confirmed by CMS.
91	Enrolled in Medicare Part A, B or D, - anyone or a combination.
95	Enrolled or eligible for Medicare plus any commercial insurance.
96	Enrolled in Medicare Advantage Plan (Part C) (to be identified by TPL staff and updated by the Medicare Buy-In Unit).

DEPARTMENT POLICY

MA Only

The goal of the Medicaid program is to ensure that essential health care services are made available to those who otherwise could not afford them. Medicaid is also known as Medical Assistance (MA).The Medicaid program comprise several sub-programs or categories. To receive MA under an SSI-related category, the person must be aged (65 or older), blind, disabled, entitled to Medicare or formerly blind or disabled.

Medicaid eligibility for children under 19, parents or caretakers of children, pregnant or recently pregnant women, former foster children, MOMS, MIChild, Flint Water Group and Healthy Michigan Plan is based on Modified Adjusted Gross Income (MAGI) methodology.

GROUP 1 AND GROUP 2

In general, the terms Group 1 and Group 2 relate to financial eligibility factors. For Group 1, net income (countable income minus allowable income deductions) must be at or below a certain income limit for eligibility to exist. The income limit, which varies by category, is for nonmedical needs such as food and shelter. Medical expenses are not used when determining eligibility for MAGI-related and SSI-related Group 1 categories.

For Group 2, eligibility is possible even when net income exceeds the income limit. This is because incurred medical expenses are used when determining eligibility for Group 2 categories. Group 2 categories are considered a limited benefit because a deductible is possible.

BEM 110 THROUGH 174

BEM 110 through 174 describe all of the MA categories and the eligibility factors for each category. BEM 110 through 148 describe the MAGI-related and Group 2 categories.

BEM 150 is for SSI recipients and certain former SSI recipients. BEM 155 through 174 describe SSI-related categories. EXHIBIT I - LIST OF ALL SSI-Related MA CATEGORIES.

Note: Certain non-Medicaid medical programs are described in various BEM 600 series items. Some of these programs are administered by MDHHS local offices and some are administered by MDHHS/Medical Services Administration (MSA).

MONTHLY DETERMINATIONS

Medicaid eligibility is determined on a calendar month basis. Unless policy specifies otherwise, circumstances that existed, or are expected to exist, during the calendar month being tested are used to determine eligibility for that month.

When determining eligibility for a future month, assume circumstances as of the processing date will continue unchanged unless you have information that indicates otherwise.

Children Under 19

Do not shorten a beneficiary's 12-month eligibility period.

Once eligible, children Under 19 years of age will remain eligible until the next redetermination unless any of the following occurs:

- Reaches age 19-aged out
- Moves out of state
- Death
- Requests closure
- Eligibility was based on erroneous information

A member may be added to an existing case even though the redetermination date is less than 12 months in the future.

Note: If a child on CHIP (MIChild) becomes eligible for and transfers to a Medicaid program, they must remain on Medicaid for the duration of the 12-month period.

Exceptions: Continuous Eligibility does not apply to the following;

Children in TMA

Children in Presumptive Eligibility

Children in a Group 2 Medically needy category (spend-down)

CHOICE OF CATEGORY

Persons may qualify under more than one MA category. Federal law gives them the right to the most beneficial category. The most beneficial category is the one that results in eligibility, the least amount of excess income or the lowest cost share.

Note: Persons may receive both Medicare Savings Program benefits (BEM 165) and coverage under another MA category; see **Medicare Savings Program** in this item.

However, clients are not expected to know such things as:

- Ineligibility for a cash grant does not mean MA coverage must end.
- The LIF category is usually the most beneficial category for families because families who become ineligible for LIF may qualify for TMA or Special N/Support.
- The most beneficial category may change when a client's circumstances change.

Therefore, you must consider all the MA category options in order for the client's right of choice to be meaningful.

Medicare Savings Program

A person entitled to Medicare Part A, Hospital Insurance, may be eligible for a Medicare Savings Program described in BEM 165. The person may be eligible for just a Medicare Savings Program or a Medicare Savings Program in addition to regular MA benefits.

See BEM 165 about when to do an eligibility determination for Medicare Savings Programs.

APPLICATION/ RENEWAL FORMS

The DCH-1426, Application for Health Coverage & Help Paying Costs, is used for all Medicaid categories.

- The DHS-4574, Medicaid Application (Patient of Nursing Facility), is completed by LTC patients. This application is used to determine MA eligibility for the LTC patient only.

- The MDHHS-1010, Redetermination is a Bridges generated form that is sent at the time of an annual renewal.
- The DHS-1004, Health Care Coverage Supplemental Questionnaire, is used to gather additional information when an applicant is not found eligible for any MAGI-related eligibility group or indicates a disability on the DCH-1426.

To apply online see the Michigan Department of Health and Human Services (MDHHS) website/Online Services/MI Bridges Apply for Assistance & Manage Your Account.

MAGI-Related Medicaid

The following categories are considered MAGI related groups.

- Pregnant Women (PW, MOMS).
- Infants and Children under age 19 (LIF, Newborn, HK1, OHK HKE, MIChild).
- Parents and caretaker relatives (PCR, LIF).
- Adult Group age 19-64 (HMP).
- Former Foster Care Children (FCTM).
- Flint Water Group (FWG).
- Plan First.

Non-MAGI Medicaid

Full Coverage

- Transitional Medicaid Assistance (TMA).
- Special N Support (SNS).
- Refugee Medical Assistance (RMA).

Non-MAGI Medicaid

Limited Coverage

- Group 2 Pregnant Women (G2P).
- Group 2 Under 21 (G2U).

- Group 2 Caretaker Relative (G2C, G2S).

SSI-RELATED MA PRIORITY

1. BEM 150 addresses MA for SSI recipients and persons appealing an SSI disability termination. The other SSI-related categories must be considered in the following order: BEM 154, Special Disabled Children
2. Special categories:
   - BEM 157, Early Widow(er)s.
   - BEM 158, Disabled Adult Children (DAC)
3. BEM 155, 503 Individuals.
4. BEM 170, 171, or 172 Home Care or Children's Waiver, SED Waiver. BEM 163, AD-Care.
5. BEM 164, Extended-Care and BEM 165, Medicare Savings Programs (QMB, SLMB).
6. BEM 166, Group 2 Aged, Blind and Disabled and BEM 165, Medicare Savings Programs (QMB, SLMB).
7. BEM 169, Qualified Disabled Working Individuals.
8. BEM 165, Additional Low-Income Medicare Beneficiaries (ALMB).
9. BEM 174, Freedom to Work.

The determinations for Medicare Savings Programs and Extended-Care or Group 2 are separate; see BEM 165.

Note: BEM 173, Breast and Cervical Cancer Prevention and Treatment Program, is not listed because MDHHS local office does not determine eligibility for this program. BCCPTP eligibility is determined by MDHHS/MSA.

FIP AND SSI TERMINATIONS

Most terminations of cash assistance or SSI benefits must include an evaluation of MA eligibility. See BEM 110, Low Income Family (LIF) for cash assistance terminations and BEM 150 for SSI terminations.

MA-ONLY TERMINATIONS

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

Consider eligibility under all other MA-only categories before terminating benefits under a specific category. In addition, when Group 1 eligibility does not exist but all eligibility factors except income are met for a Group 2 category, activate deductible status; see BEM 545.

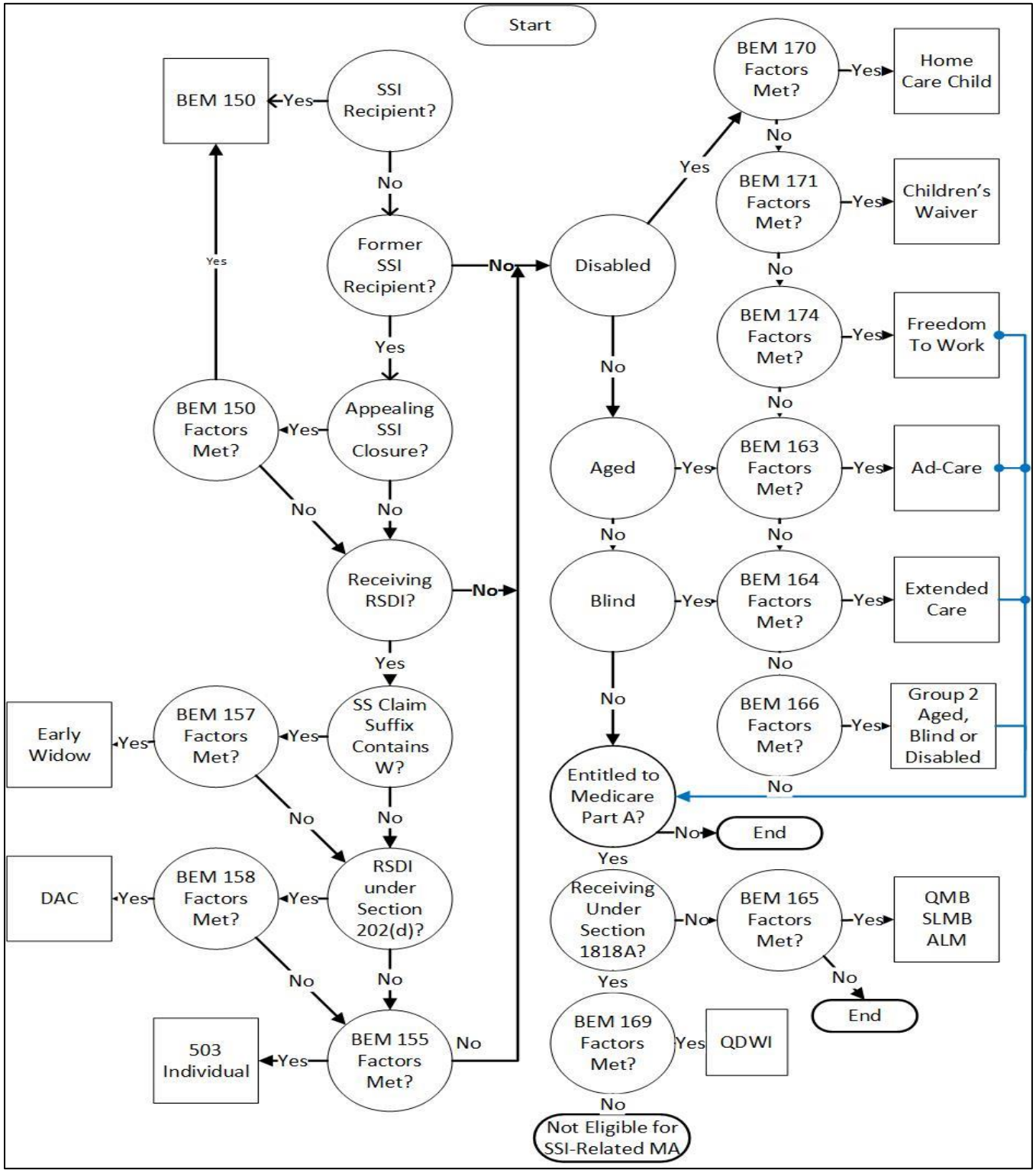
Exception: Close the case when benefits are terminating:

- For Medicare Savings Programs-only (BEM 165).
- For QDWIs (BEM 169).

MA-Only Lock-Out

To address beneficiary fraud and consistent with federal law, the Michigan Department of Health and Human Services (MDHHS) will pursue restrictions on Medicaid eligibility for individuals who are convicted of certain crimes related to the Medicaid program. Specifically, MDHHS may limit, restrict or suspend, for a period not exceeding one year, the Medicaid eligibility of any beneficiary who is convicted of an offense related to false statements or representations in connection with the Medicaid program, as described §1128B of the Social Security Act.

EXHIBIT I - SSI-RELATED MA CATEGORIES



LEGAL BASE

MA

Social Security Act, Sections 1128, 1902, and 1905
42 CFR Part 435

MCL 400.106

The Affordable Care Act of 2010 is the collective term for the Patient Protection and affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

DEPARTMENT POLICY

MA Only

This waiver is called the MI Choice Waiver Program. This waiver program provides home and community-based services for aged and disabled persons who, if they did not receive such services, would require care in a nursing home.

Services provided under this waiver program must be less costly for Medicaid (MA) than the cost of nursing home services for the total number of waiver participants, not per person.

The MI Choice waiver is **not an MA category**, but there are special eligibility rules for people approved for the waiver.

TARGETED GROUP

Waiver services are covered for MA recipients who:

- Are age 65 or over, or
- at least age 18 years and disabled.
- Medically qualify, and
- Have needs that cannot be met by the Home Help program and may be addressed with MI Choice services.
- Seek or have an expanded Home Help Program exception grant of $1000 or more per month.

WAIVER ADMINISTRATION

The Medical Services Administration (MSA) administers the waiver through contracts with Pre-paid Ambulatory Health Plans. See *Exhibit I* in this item for a list of these waiver agencies. The agency's functions are described below.

Assisting Participants

The agent will assist prospective waiver participants in applying for MA and for initial asset assessments. The agent will also help the person obtain requested information and verification.

WAIVER PROCESS

The waiver process includes:

Assessment

The agent completes an assessment to verify medical eligibility for the waiver.

Plan of Service

A written plan of services is developed by the agency and the waiver participant if the assessment confirms medical eligibility for the waiver. The participant may choose to receive home and community-based services from the waiver agency.

At a minimum, the plan includes:

- Types of services to be furnished; and
- The amount, frequency, and duration of each service; and
- The type of provider to furnish each service and
- Participant goals, preferences, and outcomes: and
- Participant approval of the plan; and
- The signature of the supports coordinator assisting with developing the plan.

Supports Coordination

The agent is responsible for arranging for planned services to be provided.

APPROVED FOR THE WAIVER

Approved for the waiver means:

- The agent conducted the assessment, **and**
- There is an available wavier slot for the individual's placement **and**

- A waiver agent has developed a person-centered plan of service **and**
- The participant has already received appropriate waiver services for more than 30 consecutive days or is currently receiving appropriate waiver services that are expected to continue more than 30 consecutive days, or expects to receive appropriate waiver services from the agent for at least 30 consecutive days.

Approval and Termination Dates

The agent determines the waiver approval date and termination date. The agent is responsible for advising the appropriate local Michigan Department of Health and Human Services (MDHHS) office of these dates. The agent is responsible for advising the appropriate local MDHHS office the dates of enrollment and disenrollment information in CHAMPS.

Waiver enrollment automatically terminates when the participant enters an LTC facility; see BEM 547 for instructions.

MDHHS LOCAL OFFICE RESPONSIBILITIES

The local MDHHS office is responsible for completing an initial asset assessment and determining MA eligibility for potential waiver participants.

Waiver Participant Defined

A waiver participant is a person who is approved to receive or receives waiver services in the month being tested for Medicaid eligibility.

Waiver Month Defined

A waiver month is a calendar month containing at least one day that the participant is (was) approved for the waiver. The agent determines the waiver approval date.

NONFINANCIAL ELIGIBILITY FACTORS

The eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Use special MA policies in the MA eligibility determination:

- A waiver participant is a group of one even when he lives with his spouse; see BEM 211.
- The Special MA Asset Rules in BEM 402 apply when completing the Initial Asset Assessment. See *special initial asset assessment rules for waiver applicants* in this item for rules on determining the first period of continuous care.
- The MA divestment policy in BEM 405 applies to waiver participants.
- The extended-care category is available to waiver participants; see BEM 164.
- Gross income must be at or below 300 percent of the SSI Federal Benefit Rate. An individual cannot spenddown income to waiver eligibility; see BEM 500.

A waiver participant may no longer qualify for waiver services; however, they may still qualify for MA.

Note: An ex-parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex-parte review should begin at least

90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

Initial Asset Assessment for Waiver Applicants

An Initial Asset Assessment (IAA) may be needed for potential waiver participants with a spouse. The IAA is used to protect a certain amount of the couple's combined resources for the community spouse. It does not determine the start of Medicaid eligibility. Use policy in BEM 402 to determine if an IAA is appropriate.

An IAA uses a first day of continuous care (See BEM 402 for a definition). The first period of continuous care is a period of at least 30 consecutive days where the institutionalized spouse/applicant has been or is expected to be:

- In a hospital and/or LTC facility and/or
- Approved for the waiver.
- The period is no longer continuous when none of the above is true for 30 or more consecutive days; see BEM 402 for examples.
- The first period of continuous care may have occurred in the past; however, the applicant must be currently receiving services to complete an IAA.
- If there is no past period of continuous care, then the IAA date must start on the first day that meets the definition of continuous care in BEM 402.

Start of a Divestment Penalty Period

The penalty period begins on the date which all the criteria listed under the a*pproved for the waiver* section in this item has been confirmed.

Notices

Waiver activities are performed by agents who meet the federal definition of administering the MA program. Therefore, you can share the following information with the agents without a signed release from the participant:

- A copy of the DHS-3503, Verification Checklist.
- A copy of the DHS-4588, Initial Asset Assessment Notice.

The original DHS-3503, and DHS-4588 must be sent to the participant or the guardian, court or agency that is legally responsible for the participant.

Do not enter waiver agencies in Bridges as a third-party type. Only the participant's legal guardian, court, or agency legally responsible for the participant can be entered as a third-party type.

HOSPICE SERVICES

Waiver participants may receive hospice services and waiver services simultaneously.

The waiver agency and the hospice coordinate their plans of care to avoid overlapping services. MSA is responsible for assuring correct payments are made.

MANAGED CARE PLANS

MA recipients must choose either waiver services or enrollment in a health maintenance organization (HMO). They cannot receive both waiver services and be enrolled in an HMO. Recipients cannot be enrolled in more than one program (MI Choice, PACE, MI Health Link, or Home Help) at the same time.

LIST OF SOME HOME AND COMMUNITY BASED SERVICES

- Adult Day Health
- Chore Services
- Community Health Worker

- Community Living Supports
- Community Transportation
- Counseling
- Environmental Accessibility Adaptations
- Fiscal Intermediary
- Goods and Services
- Home Delivered Meals
- Nursing Services
- Personal Emergency Response System
- Private Duty Nursing/Respiratory Care
- Respite
- Specialized Medical Equipment and Supplies
- Supports Coordination
- Training

MSA WAIVER SERVICE AGENTS

WAIVER AGENCIES	COUNTIES SERVED
Detroit Area Agency on Aging 1333 Brewery Park Blvd, Suite 200 Detroit, MI 48207 Phone: 313-446-4444 Fax: 313-446-4446 Web: www:daaa1a.org	Cities of: Detroit, Hamtramck, Highland Park, Grosse Pointe, Grosse Pointe Park, Grosse Pointe Shores, Grosse Pointe Woods, Grosse Pointe Farms, Harper Woods
The Senior Alliance 5454 Venoy Road Wayne, MI 48184 Phone: 734-722-2830 1-800-815-1112 Fax: 734-722-2836 Web: www.aaa1c.org	All of Wayne County excluding those areas served by the Detroit Area Agency on Aging
The Information Center, Inc. 20400 Superior Road Taylor, MI 48180 Phone: 734-282-7171 Fax: 734-282-7105 Web: www.theinfocenter.info	All of Wayne County excluding those areas served by the Detroit Area Agency on Aging
Area Agency on Aging 1B 29100 Northwestern Hwy, Suite 400 Southfield, MI 48034 Phone: 248-357-2255 1-800-852-7795 Fax: 248-948-9691 Web: www.aaa1b.org	Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw

WAIVER AGENCIES	COUNTIES SERVED
Macomb-Oakland Regional Center, Inc. 16200 Nineteen Mile Road PO Box 380710 Clinton Township, MI 48038-0070 Phone:586-263-8700 Fax: 586-228-7029 Web: www.MORChomecare.org	Livingston, Macomb, Monroe, Oakland, St. Clair, Washtenaw
Region 2 Area Agency on Aging 102 North Main Street PO Box 189 Brooklyn, MI 49230 Phone: 517-592-1974 Fax: 517-592-1975 Web: www.r2aaa.net	Jackson Hillsdale Lenawee
Senior Services, Inc. 918 Jasper Street Kalamazoo, MI 49001 Phone: 269-382-0515 Fax: 269-382-3189 Web:www.seniorservices1.org	Barry, Branch, Calhoun, Kalamazoo, St. Joseph
Region 3B Area Agency on Aging/Care Well Services 200 West Michigan Avenue Suite 102 Battle Creek, MI 49017 Phone: 269-966-2450 1-800-626-6719 Fax: 269-966-2493 Web: www.region3b.org	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren
Region IV Area Agency on Aging 2900 Lakeview Avenue St. Joseph, MI 49085 Phone: 269-983-0177 1-800-442-2803 Fax: 269-983-5218 Web: www.areaagencyonaging.org	Berrien Cass Van Buren
Valley Area Agency on Aging 225 E. Fifth Street, Flint, MI 48502 Phone: 810-239-7671 1-800-978-6275 Fax: 810-239-8869 Web: www.valleyaaa.org	Genesee Lapeer Shiawassee

WAIVER AGENCIES	COUNTIES SERVED
Tri-County Office on Aging 5303 South Cedar Street Lansing, MI 48911-3800 Phone: 517-887-1440 1-800-405-9141 Fax: 517-887-8071 Web: www.tcoa.org	Clinton Eaton Ingham
Area Agency on Aging of Western Michigan, Inc. 3215 Eaglecrest Dr. NE Grand Rapids, MI 49525 Phone: 616-456-5664 1-888-456-5664 Fax: 616-456-5692 Web: www.aaawm.org	Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Newaygo, Osceola
Reliance Community Care Partners 2100 Raybrook SE Suite 203 Grand Rapids, MI 49546 Phone: 616-956-9440 1-800-447-3007 Fax: 616-954-1520 Web: www.relianceccp.org	Allegan, Ionia, Kent, Lake, Mason, Mecosta, Montcalm, Muskegon, Newaygo, Oceana, Osceola, Ottawa
Region VII Area Agency on Aging 1615 S. Euclid Ave. Bay City, MI 48706 Phone: 989-893-4506 1-800-858-1637 Fax: 989-893-3770 Web: www.region7aaa.org	Bay, Clare, Gladwin, Gratiot, Huron, Isabella, Midland, Saginaw, Sanilac, Tuscola
A&D Home Health Care, Inc. 3150 Enterprise, Suite 200 Saginaw, MI 48603 Phone: 989-249-0929 1-800-884-3335 Fax: 989-249-1147 Web: www.a-dhomecare.com	Bay, Clare, Gladwin, Gratiot, Huron, Isabella, Midland, Saginaw, Sanilac, Tuscola
Northeast Mich Comm. Service Agency, Inc. Region IX Area Agency on Aging 2375 Gordon Road Alpena, MI 49707 Phone: 989-356-3474 1-800-219-2273 Fax: 517-354-5909 Web: www.nemcsa.org	Alcona, Alpena, Arenac, Cheboygan, Crawford, Iosco, Montmorency, Ogemaw, Otsego, Presque Isle, Roscommon

WAIVER AGENCIES	COUNTIES SERVED
Area Agency on Aging of Northwest Michigan 1609 Park Drive PO Box 5946 Traverse City, MI 49696-5946 Phone: 231-947-8920 1-800-442-1713 Fax: 231-947-6401 Web: www.aaanm.org	Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
Northern Lakes Community Mental Health/ Northern Health Care Management 105 Hall Street, Suite D Traverse City, MI 49684 Phone: 231-933-4917 or 800-640-7478Fax: 231-995-7900 Web: www.northernlakescmh.org	Antrim, Benzie, Charlevoix, Emmet, Grand Traverse, Kalkaska, Leelanau, Manistee, Missaukee, Wexford
Senior Resources 560 Seminole Rd. Muskegon, MI 49444 Phone: 231-739-5858 1-800-442-0054 Fax: 231-739-4452 Web: www.seniorresourceswmi.org	Muskegon Oceana Ottawa
U.P. Area Agency on Aging (UPCAP) 2501 14th Avenue South PO Box 606 Escanaba, MI 49829 Phone: 906-786-4701 1-800-338-7227 Fax: 906-786-5853 Web: www.upcap.org	Alger, Baraga, Chippewa, Delta, Dickinson, Gogebic, Houghton, Iron, Keweenaw, Luce, Mackinac, Marquette, Menominee, Ontonagon, Schoolcraft

LEGAL BASE

MA

Social Security Act, Section 1915
42 CFR Part 435.217, 441.350,.400

DEPARTMENT POLICY

MA Only

This is a MAGI-related MA category.

Low Income Family (LIF) eligibility under the ACA will be a MAGI-related eligibility subgroup. Eligibility for LIF will be derived after a successful MAGI-related eligibility determination for either Parent/Caretaker Relative or Children Under 19.

Adults with a dependent child and income under 54 pecent of the Federal Poverty Level will be considered LIF eligible.

Children with Income under 54 percent of the federal poverty level will be considered LIF eligible.

LIF LEGAL BASE

Social Security Act, Sections 1902(a) (63), 1931

The Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Reconciliation Act (Publication L. 111-152).

DEPARTMENT POLICY

Medicaid (MA) Only

Transitional Medical Assistance (TMA) is an automatic coverage group. Transitional Medical Assistance (TMA) eligibility is only considered after Low Income Family (LIF) MA.

Individuals may receive TMA for up to 12 months when ineligibility for LIF relates to income from employment of a caretaker relative.

TMA starts the month in which LIF ineligibility began regardless of when the LIF eligibility actually ended.

A new or updated application for healthcare coverage is not required to transfer to Transitional Medical Assistance (TMA).

INITIAL TMA ELIGIBILITY

LIF must be transferred to TMA when **all** of the requirements below are met.

1. At least one LIF qualified group member was eligible for and received LIF for three of the six calendar months immediately preceding the month of LIF ineligibility.
2. LIF ineligibility resulted from excess earned income **only**.
3. Earnings of the caretaker relative, caretaker relative's spouse or a dependent child's parent in the LIF ineligibility determination are greater than zero.

TMA Group

The TMA group is those individuals who were in the LIF group at the time of transfer to TMA.

Note: Newborns eligible under BEM 145 may be added to the TMA case, but are not TMA group members.

CONTINUED ELIGIBILITY

TMA eligibility continues until the end of the 12-month TMA period unless:

- A change is reported, such as decreased earned income, and the family is eligible for LIF; or

Note: The family might qualify for TMA or Special N/Support if they again become ineligible for LIF.

- For individual members, information is reported indicating that a member does not meet the MA requirements in:

  - BEM 220, Residence.
  - BEM 257,Third Party Resource Liability.
  - BEM 265, Institutional Status.

If a member loses TMA eligibility during the 12-month period based on BEM 220, 257 or 265, but the reason for ineligibility ceases, TMA eligibility exists again.

Eligibility restarts the month ineligibility ceased and continues for the remainder of the 12-month period. The beneficiary is responsible for reporting the change that re-establishes eligibility.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1925, 1931

DEPARTMENT POLICY

Medicaid Only

Special N/Support (SNS) is an automatic coverage group.When ineligibility for LIF results wholly or in part from spousal support payments, the individual may continue eligible for Medicaid for four months.

Individuals receiving Medicaid on this basis are referred to as Special N/Support beneficiaries.

Special N/Support eligibility can be considered only after Low Income Family (LIF) MA.

Divorce or separation agreements executed or modified after December 31, 2018, exclude spousal support as countable income in a MAGI Medicaid eligibility determination.

INITIAL SPECIAL N/ SUPPORT ELIGIBILITY

LIF must be transferred to Special N/Support when all of the following criteria are met.

- The LIF group is **not** eligible for continued Medicaid as Transitional MA.
- At least one LIF group member was a LIF beneficiary in three of the six calendar months before the month in which LIF will terminate.
- LIF ineligibility resulted from excess earned income and countable spousal support income.

A new or updated application for healthcare coverage is not required to transfer to Special N/Support.

Special N/Support Group

The Special N/Support group is those persons who were in the LIF group at the time of transfer to Special N/Support.

Four-Month Period

The four-month period begins with the calendar month following the month in which LIF terminates. For example, coverage begins August 1 if LIF terminates in July. In this example, the four-month period would end November 30.

CONTINUED ELIGIBILITY

During the four-month period, each Special N/Support group member remains eligible unless it is reported that a member does not meet the Medicaid requirements in :

- BEM 220, Residence.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.

If Special N/Support eligibility is lost during the four-month period based on BEM 220, 257, or 265, but the reason for ineligibility ceases, SNS eligibility exists again. Eligibility restarts the month ineligibility ceased and continues for the remainder of the 4 month period. The individual is responsible for reporting the change that re-establishes eligibility.

Note: Newborns eligible under BEM 145 may be added to the Special N/Support case but are **not** Special N/Support recipients.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)(A)(i)(I), 1931

DEPARTMENT POLICY

Medicaid (MA) Only

As explained in detail below, the following persons are automatically eligible for Group 1 MA.

- Department wards.
- Social Security Act title IV-E foster care (FC) recipients.
- Children with title IV-E adoption assistance agreements.
- Special needs children with adoption assistance agreements.

Adoption assistance agreements are also called adoption support subsidy agreements.

Other children,for example court wards, may be eligible under other MA categories such as Healthy Kids U-19; see BEM 105. MA coverage for court wards is not automatic. Local office specialists are responsible for opening and maintaining these cases.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

DEPARTMENT WARDS

Department wards are automatically eligible for Group 1 MA. A department ward is any child who:

- Has been committed to, or placed with, the department by a court order; and
- Does not live with his parent(s); and
- Is not a title IV-E recipient; or
- Is a former permanent court ward or state (MCI) ward, placed for adoption, but not finalized (adoption supervision period), and who is not receiving an adoption support subsidy.

- Does not have a special needs adoption assistance agreement.

Authorizing MA

The local office children's services workers will open and maintain current MA for a department ward; see FOM 803, Medicaid Foster Care. Current MA eligibility begins with the first day of the month the court order was received by the agency. Applications are not required for department wards for current MA.

Local office specialists are responsible for retro MA determinations. Applications are required for retro MA.

TITLE IV-E FOSTER CARE

Any child for whom FC maintenance payments are made under title IV-E of the Social Security Act is eligible for Group 1 MA. A title IV-E FC maintenance payment is ADC-FC. The child is eligible for Group 1 MA in the state where he is physically present even if the ADC-FC payments are made by another state.

Authorizing MA

Local office children's services workers will open and maintain current MA for children receiving title IV-E FC who are physically present in Michigan; see FOM 803. Applications are not required for children receiving title IV-E foster care for current MA.

Specialists are responsible for retro MA determinations. Applications are required for retro MA.

ADOPTION ASSISTANCE AGREEMENTS

There are federally-funded adoption agreements and state-funded adoption agreements. These arrangements are also called adoption support subsidy agreements.

Federally-funded adoption agreements are agreements under title IV-E of the Social Security Act.

Title IV-E Adoption Assistance Agreements

Any child for whom there is an adoption assistance agreement in effect under title IV-E of the Social Security Act is eligible for Group 1 MA. The child is eligible for MA in the state where he/she is physically present even if the adoption assistance agreement is with another state. The adoption assistance agreement need not provide for an actual adoption assistance payment.

Special Needs Adoption Assistance Agreement

A child for whom there is a special needs adoption assistance agreement in effect is eligible for Group 1 MA. A special needs adoption assistance agreement means a state-funded adoption assistance agreement for a child who:

- Has special needs for medical, mental health or rehabilitative care, and
- Cannot be placed without medical assistance.

The child is eligible for MA in the state where he/she is physically present even if the adoption assistance agreement is with another state. The adoption assistance agreement need not provide for an actual adoption assistance payment.

Authorizing MA

The MDHHS Adoption and Guardianship Assistance Offrice in central office authorizes and maintains current MA for a child with an adoption assistance agreement. An application is not required for DAS to authorize current MA.

Local office specialists are responsible for retro MA determinations. An application is required for retro MA.

OUT-OF-STATE ADOPTION ASSISTANCE AGREEMENTS

A child with an adoption assistance agreement with another state who moves to Michigan may contact the local office requesting MA. In that situation use the following procedure.

1. Follow the policies in BAM 110, Application Filing and Registration.

   The purpose of obtaining an application is to protect the application date in case it is determined that the child does not have a qualified adoption assistance agreement.

   A complete application for MA for a child eligible based on an adoption assistance agreement is an application containing:

   - Family's address and telephone number.
   - Parent's name and birthdate.
   - Child's name, social security number (if he has one), birthdate and sex.
   - Name of any health insurance for the child.
   - Signature.

2. Obtain the date the child came to Michigan.

3. Follow the procedure in BEM 257 to identify any third party resource liability and complete the DCH-0078.

4. Obtain a copy of the adoption assistance agreement.

5. Send a memo requesting an MA eligibility determination to the Adoption Subsidy Program in central office. The memo should include:

   - The date the child came to Michigan.
   - The name, address and telephone number of the child's parents.
   - The adopted child's name, social security number (if he has one), date of birth and sex.

- The name, address and telephone number of the out-of-state agency who is a party to the adoption assistance agreement.
- A copy of the adoption assistance agreement.
- All copies of the DCH-0078.The **EXHIBIT** in this item shows a format for the memo.

Send the memo via ID mail to:

Department of Health and Human Services
Adoption Subsidy Program
Division of Adoption Services
235 S Grand Avenue
PO Box 30037
Lansing, MI 48909

LEGAL BASE

MA

P.L. 99-272, Sections 9529 and 12305
42 CFR 435.115; .227; .403

EXHIBIT

STATE OF MICHIGAN

DEPARTMENT OF HUMAN SERVICES

==========

---------- MEMORANDUM ----------

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TO: **DATE:**

FROM:

SUBJECT: Adoption Assistance Agreement
(Case Number)

Medicaid has been requested for the child named below. A copy of his adoption assistance agreement is attached. All copies of any MSA-1354 or MSA-1354A are also attached.

Child:

(Name)
(Date of Birth)
(Social Security Number)
(Sex)
(Date Came to Michigan)

Parents:

(Name)
(Street)
(City)
(State) (Zip Code)
(Area Code) (Telephone Number)

Out-of-State
Agency:

(Name)
(Street)
(City)
(State) (Zip Code)
(Area Code) (Telephone Number)

DEPARTMENT POLICY

Medicaid (MA) Only

Individuals in this category are transitioning from foster care to adulthood. Children aging out of foster care on their 18th birthday are eligible for Foster Care Transition Medicaid (FCTMA) from age 18 until their 26th birthday.

Note: These cases must remain open regardless of changes in non-financial eligibility, income or assets.

NON-FINANCIAL ELIGIBILITY FACTORS

The MA eligibility factors in the following items must be met:

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

Note: Cases in this category **must** not close if it is discovered that one of these eligibility factors was not met.

Eligibility Criteria

Youth who age out of foster care are eligible for FCTMA if they meet both of the following criteria:

- In a foster care placement in any state on the individual's 18th birthday and receiving Medicaid at the time of aging out.
- Under 26 years of age.

Continued Eligibility

Eligibility must continue unless one of the following occurs:

- Death.
- Reaches age 26.

- Moves out-of-state.
- Case closure is requested.
- Another MA program is more beneficial.

Individuals may contact 800-343-7320 for change of address, etc., or fax a copy of the change to 517-346-9888.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

Annual Redetermination

Annual redeterminations are conducted through a centralized unit for this group. Contact:

Department of Human Services
PO Box 30037
235 S. Grand Ave., Suite 1406
Lansing, MI 48909

Or

Email: fctma@michigan.gov

FINANCIAL ELIGIBILITY FACTORS

Groups

An individual eligible under the Foster Care Transition Group category is a fiscal and asset group of one.

Assets

No asset test.

Income Eligibility

No income test.

LEGAL BASE

MA

Foster Care Independence Act of 1999, HR 3443.

DEPARTMENT POLICY

Medicaid Only

Plan First Medicaid (MA) is a MAGI-related limited coverage Medicaid group available to any United States citizen or individual with an immigration status entitling them to full Medicaid coverage residing in Michigan.

All eligibility factors in this item must be met. The fiscal group's net income cannot exceed 195 percent of the federal poverty level. All nonfinancial eligibility factors must be met in the calendar month being tested.

NONFINANCIAL ELIGIBILITY FACTORS

There are no gender or age requirements to be eligible for Plan First. Only United States citizens or individuals with an immigration status that entitles them to full Medicaid coverage are eligible for this group. There is no emergency services only (ESO) benefit plan available for this group.

Note: If an individual reports a pregnancy while enrolled in Plan First, rerun eligibility to ensure that they are moved to the most beneficial group.

The eligibility factors in the following items must be met:

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizen/Alien Status.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.

FINANCIAL ELIGIBILITY FACTORS

Household Composition

Household composition follows tax filing rules; see BEM 211.

Assets

There is no asset test.

Income Eligibility

Income eligibility exists when net income does not exceed 195 percent of the federal poverty level; see BEM 500 to determine net income.

Ex Parte Review

An ex parte review (see glossary) is required before Medicaid closures where there is an actual or anticipated change. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)(A)(ii)(XXI),1920.

The Affordable Care Act of 2010 is the collective term for the Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Recovery Act (Publication L. 111-152).

DEPARTMENT POLICY

Medicaid Only

Pregnant Women (PW) Medicaid (MA) is a MAGI-related Medicaid category.

Medicaid is available to a woman while she is pregnant, the month her pregnancy ends, and during the twelve calendar postpartum months following the month her pregnancy ended regardless of the reason (for example, live birth, miscarriage, stillborn).

Medicaid cannot be terminated during pregnancy or postpartum period unless the woman requests the closure, moves out of state or dies.

If initial eligibility was granted based on incorrect or fraudulent information, continuous eligibility may be interrupted.

All eligibility factors in this item must be met. Her fiscal group's net income cannot exceed 195 percent of the federal poverty level. All nonfinancial eligibility factors must be met in the calendar month being tested.

If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

Presumptive Eligibility

Refer to BEM 136 for presumptive eligibility policy.

Nonfinancial Eligibility Factors

The woman must be pregnant. The MA eligibility factors in the following items must be met:

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.

FINANCIAL ELIGIBILITY FACTORS

Household Composition

Household composition follows tax filing rules see BEM 211.

Assets

There is no asset test.

Divestment

Policy in BEM 405 applies because income can be divested.

Income Eligibility

Income eligibility exists when net income does not exceed 195 percent of the federal poverty level.

Refer to BEM 500 and 536 to determine net income.

Applications for Pregnant Women

A woman who is income eligible for one calendar month based on the income limit is automatically income eligible for each following calendar month through the twelfth calendar month after the month her pregnancy ends.

Category Transfer

An income test is not required when determining continuing eligibility for a pregnant woman whose eligibility under another MA category is terminating. This includes a woman who is Group 2 eligible for only a portion of a month due to incurred medical expenses; see BEM 545.

The woman who is eligible for and receiving under another MA category is automatically income eligible for Pregnant Women through the twelfth calendar month after the month her pregnancy ends

Note: Pursue eligibility for other MA categories when a beneficiary's coverage based on pregnancy is ending.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)(A)(i)(IV),1920. Deficit Reduction Act of 2005.

The Affordable Care Act of 2010 is the collective term for the Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Reconciliation Act (Publication L. 111-152).

American Rescue Plan Act of 2021 Sections 9812 and 9822, (ARP) (Pub. L. 117-2)

DEPARTMENT POLICY

Medicaid Only

This is a Group 2 Medicaid (MA) category.

Medicaid is available to a pregnant woman who meets the nonfinancial and financial eligibility factors in this item.

A woman who is eligible for, and receiving, Medicaid when her pregnancy ends and remains otherwise eligible may continue receiving Medicaid benefits for the twelve calendar postpartum months following the month her pregnancy ended.

The postpartum extension is available when the pregnancy ends for any reason (for example, live birth, miscarriage, stillborn). The eligibility requirements for the postpartum extension of Medicaid eligibility are discussed later in this item.

All eligibility factors must be met in the calendar month being tested.

If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

NONFINANCIAL ELIGIBILITY FACTORS

The woman must be pregnant. The Medicaid eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use the fiscal group policies for Group 2 Medicaid in BEM 211.

Assets

There is no asset test.

Divestment

Policy in BEM 405 applies because income can be divested.

Income Eligibility

Income eligibility exists when net income does not exceed Group 2 needs in BEM 544. Apply the Medicaid policies in BEM 500, 530 and 536 to determine net income.

If the net income exceeds Group 2 needs, Medicaid eligibility is still possible. The deductible for a pregnant woman is usually met at the first office visit because the woman incurs the full cost of the obstetric (OB) services (including labor and delivery) at her first OB visit. Her coverage should then be updated to MAGI-related Pregnant Women (PW) for the remainder of the pregnancy and twelve months post-partum; see BEM 545.

POSTPARTUM EXTENSION

The postpartum extension period is the twelve calendar months following the month a pregnancy ends. The postpartum extension of Medicaid eligibility is available to a woman who:

- Was eligible for, and receiving, Medicaid on the day her pregnancy ended; **and**
- Meets the nonfinancial eligibility factors in this item except pregnancy; **and**
- Is not currently eligible for Medicaid under any category other than postpartum extension.

Note: The woman who is eligible for and receiving under another Medicaid category is automatically income eligible for Pregnant

Women (PW) through the twelfth calendar month after the month her pregnancy ends.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all Medicaid categories; see BAM 115 and 220.

LEGAL BASE

MA

42 CFR 435.301.
Deficit Reduction Act of 2005.

American Rescue Plan Act of 2021 Sections 9812 and 9822, (ARP) (Pub. L. 117-2)

POLICY

Medicaid (MA) Only hi

Medicaid for children under age one (HK1) is part of the U-19 Medicaid Expansion program. It is a MAGI related Medicaid category.

HK1 Medicaid is available to children under one year of age whose household income is between 143-195 % of the Federal Poverty Level (FPL). All eligibility factors must be met in the calendar month being tested.

However, only certain eligibility factors apply before annual renewal. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

Note: Safe Delivery Babies do not need to meet any of the non-financial eligibility factors listed in this item.

Presumptive Eligibility

Refer to BEM 136 for presumptive eligibility policy.

NONFINANCIAL ELIGIBILITY FACTORS

The child must be under age one; see BEM 240. See CHILD IN HOSPITAL OR LTC in this item for an exception to the age limit.

The MA eligibility factors in the following items must be met:

BEM 220, Residence.
BEM 223, Social Security Numbers.
BEM 225, Citizenship/Alien Status.
BEM 255, Child Support.
BEM 257, Third Party Resource Liability.
BEM 265, Institutional Status.
BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Household Composition

Household composition follows tax filing rules refer to BEM 211, Medicaid Group Composition.

Assets

There is no asset test.

Divestment

Policy in BEM 405 applies because income can be divested.

Income Eligibility

Income eligibility exists when net income does not exceed 195% of the federal poverty level.

Refer to BEM 500 to determine income.

ONGOING ELIGIBILITY

Once eligible, a beneficiary's eligibility continues until annual renewal unless the child:

- Moves out of state.
- Is ineligible due to institutional status; see BEM 265.
- Is eligible for Foster Care Department Ward (FCDW) coverage.
- Dies.

Note: If eligibility was granted based on incorrect or fraudulent information, continuous eligibility may be interrupted.

Continue using Under Age 1 income eligibility at renewal when a child is:

- Currently eligible for and receiving Under Age 1 MA.
- An inpatient in a hospital or in long term care (LTC) facility and attained age one while in the facility.

Note: The stay in the facility must be uninterrupted since age one.

An ex parte review is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid.

When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

CHILD IN HOSPITAL OR LTC

A child eligible for, and receiving, MA under this category who is a hospital inpatient or in LTC on his or her first birthday remains eligible for the duration of the inpatient stay provided all eligibility factors except age are met. The stay must be uninterrupted.

Eligibility under this category no longer exists when a child stops receiving inpatient hospital or LTC services. Transfers between hospitals and/or LTC facilities are not considered interruptions of a stay.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)(A)(i)(IV), 1905(u)(2)(B)

Social Security Act XXI,

42 CFR 457.320(A)(2) and (3).

42 CFR 435.229 and 435.4

The Affordable Care Act of 2010 is the collective term for the Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Reconciliation Act (Publication L. 111-152).

OVERVIEW

MIChild is a MAGI-related Medicaid Expansion program for children who are under 19 years of age and who are not enrolled in comprehensive health insurance. Children who get enrolled in comprehensive health insurance during their 12 continuous month eligibility period, cannot be closed until redetermination, with limited exceptions.

Other eligibility criteria for MIChis the same as Children under 19 (U19) with the exception that MIChild beneficiaries are responsible for making monthly premium payments; see *premiums* in this item.

Eligibility begins the first day of the month of application. The 3-month retroactive period applies unless the beneficiary was enrolled in other comprehensive medical insurance during that time. Retroactive MIChild coverage is not available prior to January 1, 2016.

INCOME ELIGIBILITY

- Age zero to age one is 196 percent to 212 percent of the federal poverty level (FPL).
- Age one to age 19 is 161 percent to 212 percent of the FPL.

PRESUMPTIVE ELIGIBILITY

Refer to BEM 136 for presumptive eligibility policy.

PREMIUMS

Beginning January 1, 2024 MIChild beneficiaries are no longer required to pay premiums.

NONFINANCIAL ELIGIBILITY FACTORS

The person must be under age 19. The MA eligibility factors in the following items must be met:

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.

- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 257, Third Party Resource Liability.EM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Household Composition

Household composition follows tax rules, refer to BEM 211.

Assets

There is no asset test for MIChild.

Divestment

Policy in BEM 405 applies regarding divestment of income in order to obtain MIChild eligibility.

Income

Income eligibility is determined according to MAGI rules. Countable income as determined by MAGI rules cannot exceed 212% of the federal poverty level (FPL).

ONGOING ELIGIBILITY

Beneficiaries remain eligible for 12 months of continuous eligibility for MIChild unless the person meets one of the following criteria:

- Reaches age 19.
- Moves out of state.
- Is ineligible due to Institutional Status; see BEM 265.
- Death.
- Requests closure.

Note: If eligibility was granted based on incorrect or fraudulent information, continuous eligibility may be interrupted.

BEM 546 gives instruction on how to determine the post-eligibility patient-pay amount if the month being tested is an L/H month and eligibility exists.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The ex parte review includes consideration of all MA categories; see BAM 115 and 220.

HEARINGS

MIChild applicants and beneficiaries are entitled to full hearing rights. Individuals have the right to contest a department decision affecting Medicaid eligibility whenever they believe the decision is incorrect, or when their application is not acted upon with reasonable promptness; see BAM 600, Hearings.

LEGAL BASE

MA

Social Security Act XXI, 1905(u)(2)(B)
42 CFR 457.320(A)(2) and (3). 1902(a)(10)(A)(ii)(XIV)
42 CFR 435.229 and 435.4

DEPARTMENT POLICY

Medicaid (MA) Only

Other Healthy Kids (OHK) and the Healthy Kids Expansion (HKE) are two programs in the MAGI U-19 Medicaid category. OHK and HKE are available to children under the age of 19 whose household income does not exceed 160 percent of the Federal Poverty Level (FPL). Both programs are defined by age, household income, and whether the child has other comprehensive insurance. The MAGI U-19 income limits for Other Healthy Kids and the Healthy Kids Expansion are:

Program	Age	Income (% of FPL)	Has other comprehensive insurance?
MAGI U-19 OHK	>=1 and <=5	>54% and <144%	N/A
	>=1 and <=5	>=144% and <=160%	Yes
	>=6 and <=18	>54% and <110%	N/A
	>=6 and <=18	>=110% and <=160%	Yes
MAGI U-19 HKE	>=1 and <=5	>=144% and <=160%	No
	>=6 and <=18	>=110% and <=160%	No

All eligibility factors must be met in the calendar month being tested. However, only certain eligibility factors apply before annual renewal.

If the month being tested is a Long-Term Care or Hospital (L/H) month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

Presumptive Eligibility

Refer to BEM 136 for presumptive eligibility policy.

NONFINANCIAL ELIGIBILITY FACTORS

The child must be under age 19. The MA eligibility factors in the following items must be met.

BEM 220, Residence.
BEM 223, Social Security Numbers.
BEM 225, Citizenship/Alien Status.
BEM 255, Child Support.
BEM 257, Third Party Resource Liability.
BEM 265, Institutional Status.
BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Household Composition

Household composition follows tax filing rules refer to BEM 211, Medicaid Group Composition.

Assets

There is no asset test.

Divestment

Policy in BEM 405 applies because income can be divested.

Income Eligibility

Income eligibility exists when net income does not exceed 160% of the federal poverty level.

Refer to BEM 500, Income Overview to determine net income.

ONGOING ELIGIBILITY

Children under 19 (U-19) beneficiaries remain eligible for 12 months of continuous eligibility, unless the beneficiary:

- Reaches age 19.
- Moves out of state.
- Is ineligible due to Institutional Status; see BEM 265.
- Is eligible for Foster Care Department Ward (FCDW) coverage.
- Dies.

Note: If eligibility was granted based on incorrect or fraudulent information, continuous eligibility may be interrupted.

Note: An ex parte review is required before Medicaid closures when there is an actual or anticipated change unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)(A)(i)(IV), Social Security Act XXI,

42 CFR 457.320(A)(2) and (3). 1902(a)(10)(A)(ii)(XIV)

42 CFR 435.229 and 435.4

1905(u)(2)(B)

The Affordable Care Act of 2010 is the collective term for the Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Reconciliation Act (Publication L. 111-152).

DEPARTMENT POLICY

This is a Group 2 Medicaid (MA) category.

Medicaid is available to a person who is under age 21 and meets the eligibility factors in this item. All eligibility factors must be met in the calendar month being tested.

If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

NONFINANCIAL ELIGIBILITY FACTORS

The person must be under age 21 (BEM 240, Age). The Medicaid eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

AGE

Consider eligibility for all other Medicaid categories when a person reaches age 21 or otherwise becomes ineligible for this category.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid.When possible, an ex parte reivew should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use the fiscal group policies for Group 2 Medicaid in BEM 211.

Assets

Countable assets cannot exceed the asset limit in BEM 400. Countable assets are determined using BEM 400 and BEM 401.

Divestment

Policy in BEM 405 applies because income may be divested.

Income Eligibility

Income eligibility exists when net income does not exceed the Group 2 needs in BEM 544. Apply the Medicaid policies in BEM 500, 530 and 536 to determine net income.

If the net income exceeds Group 2 needs, Medicaid eligibility is still possible; see BEM 545.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

LEGAL BASE

MA

42 CFR 435.308.
MCL 400.106.
Deficit Reduction Act of 2005.

DEPARTMENT POLICY

MA Only

This is a Group 2 MA category.

MA is available to parents and other caretaker relatives who meet the eligibility factors in this item. All eligibility factors must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

NONFINANCIAL ELIGIBILITY FACTORS

A caretaker relative is a person who meets all of the following requirements:

- Except for temporary absences, the person lives with a dependent child. Use “CARETAKER RELATIVE NONFINANCIAL TEMPORARY ABSENCE” below. Dependent child is defined later in this item.
- The person is:
  - The parent of the dependent child; **or**
  - The core relative (other than a parent) who acts as parent for the dependent child. Core relative is defined later in this item. Acts as parent means provides physical care and/or supervision.
- The **MA** eligibility factors in the following items must be met.
  - BEM 220, Residence.
  - BEM 221, Identity.
  - BEM 223, Social Security Numbers.
  - BEM 225, Citizenship/Alien Status.
  - BEM 255, Child Support.
  - BEM 256, Spousal/Parental Support.
  - BEM 257, Third Party Resource Liability.
  - BEM 265, Institutional Status.
  - BEM 270, Pursuit of Benefits.

When a dependent child lives with both parents, both parents may be caretaker relatives.

Occasionally, a core relative (other than a parent) who claims to act as parent for the dependent child and the child's parent both live with the child. The client's statement regarding who acts as parent must be accepted. If both the parent and other core relative claim to act as parent, assume the parent is the caretaker relative. When only the other core relative claims to act as parent, both the other core relative and the parent(s) may be caretaker relatives.

Except as explained in the two preceding paragraphs, a child can have only one caretaker relative. This means that if a person is an Medicaid applicant or beneficiary based on being a caretaker relative, no other person can apply for or receive Medicaid based on being a caretaker relative for the same dependent child.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories. See BAM 115 and 220.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use the fiscal group policies for Group 2 Medicaid in BEM 211.

Assets

Countable assets cannot exceed the asset limit in BEM 400. Countable assets are determined using BEM 400 and BEM 401.

Divestment

Policy in BEM 405 applies because income can be divested.

Income Eligibility

Income eligibility exists when net income does not exceed the Group 2 needs in BEM 544. Apply the Medicaid policies in BEM 500, 530 and 536 to determine net income.

If the net income exceeds Group 2 needs, Medicaid eligibility is still possible. See BEM 545.

DEPENDENT CHILD DEFINED

A child is a dependent child when he meets all of the following conditions:

- The child is born.
- The child meets the **FIP** eligibility factors in the following items:
  - BEM 223, Social Security Numbers.
  - BEM 225, Citizenship/Alien Status.
  - BEM 270, Pursuit of Benefits.
- The child is a resident using Medicaid policy in BEM 220.
- The child meets the following age or age and school attendance requirement:
  - He must be under age 18; **or**
  - He must be age 18 and a full-time student in a high school or in the equivalent level of vocational or technical training as defined in FIP policy in BEM 245. He must be expected to complete his educational or training program before age 19.
- The child is:
  - A FIP recipient.
  - A SSI recipient.
  - A Medicaid applicant.
  - Active Medicaid deductible.
  - A Medicaid beneficiary.
  - A MIChild beneficiary.

CARETAKER RELATIVE NONFINANCIAL TEMPORARY ABSENCE

Living together or **living with** others means sharing a home, where family members usually sleep, except for temporary absences. A temporarily absent person is considered in the home.

A person's absence is temporary if:

- His location is known; **and**

- There is a definite plan for his return; **and**
- He lived with the group before the absence;

  Note: Newborns and unborn are considered to have lived with the group; **and**

- The absence has lasted, or is expected to last, 30 days or less.

Exceptions:

- **"Joint Custody"** below.
- A person in a medical hospital is considered in the home.
- A person is considered in the home when absent for training or education.
- A **dependent child** (defined above) in a psychiatric hospital is considered in the home for up to 12 calendar months after the admission date.

Presume that a placement in a residential facility (other than a medical hospital) will last over 30 days. The absence begins with the admission date and ends with a discharge to the person's home. It is not interrupted by home visits or admission to a medical hospital.

Consider the stay temporary **only** if the facility provides a signed statement that includes an expected discharge within 30 days after the admission.

Residential facilities provide 24-hour care, maintenance and supervision. Examples:

- Long-term care facilities.
- Homes for the aged.
- Licensed child foster care homes.
- Child caring institutions.
- Mental health facilities.

Joint Custody

Sometimes a court awards custody of children to both parents jointly. Separated parents may practice joint custody informally in the absence of a court order. A child is considered to be living with only one parent in a joint custody arrangement. This person is the primary caretaker. This is the person who provides the home where the child sleeps more than half of the days in a month, averaged over a twelve month period. The twelve month period begins at the

time the determination is being made. This is the parent who is responsible for the child's day-to-day care and supervision.

In a joint custody arrangement, one parent must be the primary caretaker. The other parent is considered absent from the home. For purposes of determining a primary caretaker accept the client's statement unless questionable or disputed by the other parent.

When parenting time is disputed or questionable, base your determination on a court order that addresses custody or visitation, if one is available. In the absence of a court order, give each parent an opportunity to present evidence of their claim. See Verification Sources in this item.

CORE RELATIVE DEFINED

A core relative is any of the following:

- Parent.
- Aunt or uncle.
- Niece or nephew.
- Any of the above relationships prefixed by grand, great or great-great.
- Stepparent.
- Sister or brother.
- Stepsister or stepbrother.
- First cousin.
- First cousin once removed (i.e., a first cousin's child).
- The spouse of any person above, **even** after marriage is ended by death or divorce.

The above includes relationships established by adoption.

Note: Termination of parental rights is a court order that ends a parent's rights and responsibilities to the child.

A person whose parental rights are terminated by a court is not a core relative. The child's relationships to **other** core relatives are not affected.

VERIFICATION REQUIREMENTS

The client's statements regarding relationship, primary caretaker, presence in the home and school attendance for the dependent child (ren) may be accepted. Verification is required only if the individual's statements are inadequate or inconsistent with other information.

Verification requirements for all other eligibility factors are in the appropriate manual items.

Verification Sources

Relationship

- Birth certificate.
- Hospital certificate of birth.
- Official records containing relationship information. **Examples:** court, school, church or medical records; marriage certificate; insurance policy.
- Newspaper account containing relationship information.
- Written statements by at least two persons with direct knowledge of the relationship.

Presence in the Home

- Home call.
- Written statements by at least two persons who do not live with the group but have direct knowledge of the living arrangement.
- School contact confirming where and with whom the child lives. DHS-3380, School Enrollment Verification, may be used.
- Court, medical or other official records confirming the child's presence in the home.

- Written statement from the landlord **if** the individual has direct knowledge of the living arrangement.

Primary Caretaker:

- School records indicating who enrolled the child in school, first person called in an emergency, who arranges for the child's transportation to and from school.
- Child care records showing who makes and pays for the child care arrangements and who drops off and picks up the child.
- Medical records showing where the child lives and who generally takes the child to medical appointments.

LEGAL BASE

MA

42 CFR 435.310, .510.
Deficit Reduction Act of 2005.

Presumptive Eligibility

Medicaid Only hi

Presumptive eligibility is temporary Medicaid eligibility as determined by a trained qualified entity. This allows individuals to receive needed health coverage and providers to receive payment for services provided before a full Medicaid determination is completed.

Qualified entities include but are not limited to local health departments, hospitals, and tribal health facilities operated by the Indian Health Services. These entities are trained and authorized by the Michigan Department of Health and Human Services (MDHHS).

To be considered a qualified entity, under the regulation at 42 CFR 435.1110(b) (1), the provider must agree to make presumptive eligibility determinations consistent with state policies and procedures.

Application

A streamlined application is used to determine eligibility. Information on the presumptive eligibility application will be self-attested, without the need for verification.

The application consists of a few simple questions such as name, household size and estimated monthly income.

Presumptive eligibility is determined based on gross income reported at the time of the application. Eligibility is determined for an individual whose application is filed online, by a trained qualified entity.

Eligibility Groups

The eligibility groups for which qualified entities determine eligibility presumptively are:

- Pregnant Women.
- Infants and children under age 19.
- Parents and caretaker relatives.
- Adult Group age 19-64.
- Former Foster Care Children.

- Certain individuals needing treatment for breast and cervical cancer.

Eligibility Period

The presumptive eligibility period begins on the date the determination is made by the qualified entity. The end date of the presumptive period is the earlier of:

- The date the eligibility determination for ongoing Medicaid is made, if an application for Medicaid is filed by the last day of the month following the month in which the determination of presumptive eligibility is made: or

- The last day of the month following the month in which the determination of presumptive eligibility is made, if no application for Medicaid is filed by that date.

The beneficiary must complete a health care coverage application and receive a determination to avoid losing coverage when the temporary eligibility period ends. This must be completed within 60 days of the date of the presumptive eligibility determination.

Presumptive eligibility is limited to one period of eligibility during any consecutive 12-month period. Pregnant women are limited to one presumptive eligibility period per pregnancy.

Covered Services

Presumptive eligibility benefits for infants, children and adults are the same as those provided under the Medicaid category for which the individual is determined to be presumptively eligible.

Coverage for a pregnant woman is limited to ambulatory prenatal care services only. Covered services include physician visits for prenatal care, prescription drugs related to pregnancy and prenatal laboratory tests.

Legal Base

The Affordable Care Act of 2010 is the collective term for the Patient Protection and Affordable Care Act (P.L. 111-148) and the Health Care and Education Reconciliation Act (P. L. 111-152).

42 CFR 435.1110(b) (1).

OVERVIEW

Medicaid (MA) Only

The Healthy Michigan Plan (HMP) is based on Modified Adjusted Gross Income (MAGI) methodology.

The Healthy Michigan Plan provides health care coverage for a category of eligibility authorized under the Patient Protection and Affordable Care Act and Michigan Public Act 107 of 2013 effective April 1, 2014.

Targeted Population

The Healthy Michigan Plan (HMP) provides health care coverage for individuals who:

- Are 19-64 years of age.
- Do not qualify for or are not enrolled in Medicare.
- Do not qualify for or are not enrolled in other Medicaid programs.
- Are not pregnant at the time of application.
- Meet Michigan residency requirements.
- Meet Medicaid citizenship requirements.
- Have income at or below 133 percent Federal Poverty Level (FPL).

Fee for Service Beneficiaries

For Healthy Michigan Plan beneficiaries who are exempt from enrollment in managed care plans or who have yet to enroll in a managed care plan, copayments for services may apply. Fee-For-Service (FFS) beneficiaries will not be assigned a MI Health Account.

Copayments may be required and due at the point of service for office visits, pharmacy, inpatient hospital stays, outpatient hospital

visits, and non-emergency visits to the emergency department for beneficiaries age 21 years and older.

Health Risk Assessment

The Michigan Department of Health and Human Services (MDHHS) has developed a Healthy Michigan Plan Health Risk Assessment that encompasses a broad range of health issues and behaviors including, but not limited to:

- Physical activity.
- Nutrition.
- Alcohol, tobacco, and substance use.
- Mental health.
- Influenza vaccination.
- Chronic conditions.
- Recommended cancer or other preventative screenings.

The DCH-1315, Health Risk Assessment form, is available through the health plans or at www.michigan.gov/Assistance Programs/Health Care Coverage/ Healthy Michigan Plan.

NONFINANCIAL ELIGIBILITY FACTORS

The Medicaid eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

Credible Coverage

Parents requesting health care coverage for themselves must provide proof that their children have credible coverage, even if not applying for the children.

Credible coverage is health insurance coverage under any of the following:

- Group health plan, individual or student health insurance.
- Medicare or Medicaid.
- TRICARE/CHAMPUS.
- CHIP (MIChild in Michigan).
- Federal Employees Health Benefit Program.
- Indian Health Service.
- Peace Corps.
- Public Health Plan (any plan established or maintained by a State, the U.S. government, or a foreign country).
- A state health insurance high-risk pool.

Assets

The Healthy Michigan Plan does not have an asset test.

Income

Modified adjusted gross income must be at or below 133 percent of the Federal Poverty Level (FPL).

REFERENCES

Patient Protection and Affordable Care Act 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

Michigan Public Act 107 of 2013.

Michigan Public Act 208 of 2018.

DEPARTMENT POLICY

Medicaid Only

This is a MAGI related Medicaid category.

Newborns who meet the eligibility factors in this item are automatically eligible for Medicaid from birth to age one.

AUTOMATIC ELIGIBILITY

A newborn is automatically eligible for MA the month of birth if, **for** his date of birth, his mother receives Medicaid coverage, regardless of when that coverage is authorized.

Eligibility continues through the month of the newborn's first birthday if he meets the MA eligibility factors in **all** of the following items:

- BEM 220, Residence.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.

If eligibility was granted based on incorrect or fraudulent information, continuous eligibility may be interrupted.

A newborn who meets the above criteria is eligible for MA **without** an application or eligibility determination.

Authorize MA as soon as the minimum information needed to activate the newborn is received.

A child born to a MA beneficiary is considered a U.S. citizen. No further documentation is required.

Do **not** delay authorizing MA for newborns.

Medical providers may send local offices MSA-2565C, Hospital Newborn Notice, when they are unable to submit notice of the birth through the Michigan Birth Registry system.

Consider an MSA-2565-C received for a newborn as a report of the child's birth.

Use the information on the form to authorize MA for the child. Contact the mother if the form has insufficient information to activate the newborn in Bridges.

MDHHS AUTHORIZATIONS

Medical Services Administration (MSA) within the Michigan Department of Health and Human Services (MDHHS) will authorize MA for a child born to an MA beneficiary when:

- The child's mother is enrolled in a managed care health plan, and
- MSA is notified of the birth, and
- The child is **not** already receiving MA.

Note: Do **not** wait for MSA to authorize MA when notified of the birth.

Local Office Responsibilities

Eligibility specialists are responsible for taking appropriate case action even if MSA has added newborn coverage when changes, such as an address change are reported.

RENEWAL

Determine eligibility for all other MA categories no later than the month of the child's first birthday. Proof of U.S. citizenship is not required at annual renewal.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1902(e)(4)

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.

EFFECTIVE

May 9, 2016.

DEPARTMENT POLICY

Medicaid (MA) Only

The Flint Water Group is a MAGI-related MA category.

Flint Water Group coverage is available to any individual under the age of 21, pregnant women, and children born to pregnant women who have been served by the Flint water system from April 2014 to the time the water is deemed safe by the proper authorities.

An individual was served by the Flint water system if he or she consumed water drawn from the Flint water system and:

- resided in a dwelling connected to the Flint water system,
- had employment by an entity served by the Flint water system,
- received child care or education in a dwelling/structure connected to the Flint water system.

Household income cannot exceed 400% of Federal Poverty Level (FPL).

MAGI-based income methodologies are used in calculating household income.

Individuals in this group cannot be otherwise eligible for or enrolled in any other Medicaid group.

There are no premiums associated with the Flint Water Group.

All eligibility factors must be met in the calendar month being tested.

Presumptive Eligibility

Refer to BEM 136 for presumptive eligibility policy.

NONFINANCIAL ELIGIBILITY FACTORS

Children must be under age 21 and women must be currently pregnant or within 2 months post-partum.

The MA eligibility factors in the following items must be met.

BEM 220, Residence.
BEM 223, Social Security Numbers.
BEM 225, Citizenship/Alien Status.
BEM 255, Child Support.
BEM 257, Third Party Resource Liability.
BEM 265, Institutional Status.
BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Household Composition

Use household group composition policy for MAGI-related children and pregnant women in BEM 211.

Assets

There is no asset test.

Divestment

Policy in BEM 405 applies because income can be divested.

Income Eligibility

Income eligibility exists when net income does not exceed 400% of the federal poverty level.

Apply MAGI methodology policies in BEM 500 to determine income.

ONGOING ELIGIBILITY

Once eligible, a beneficiary's eligibility continues until annual renewal unless the individual:

- Reaches age 21.
- Moves out of state.
- Is ineligible due to Institutional Status; see BEM 265.
- Dies.
- Requests voluntary case closure.

If eligibility was granted based on incorrect or fraudulent information, continuous eligibility may be interrupted.

Note: An ex parte review is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid.

When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)(A)(ii)(XX)

Social Security Act 1902(hh)

42 CFR 435.218

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DEPARTMENT POLICY

Medicaid (MA) Only

Supplemental Security Income (SSI) is a cash benefit for needy individuals who are aged (at least 65), blind or disabled. The Social Security Administration (SSA) determines SSI eligibility.

In Michigan, the Michigan Department of Health and Human Services (MDHHS) supplements federal SSI payments based on the client's living arrangement. Thus, in this item **SSI recipient** means a Michigan resident who receives the basic federal payment, the state supplement, or both.

To be **automatically** eligible for Medicaid (MA) an SSI recipient must both:

- Be a Michigan resident.
- Cooperate with third-party resource liability requirements.

MDHHS administers MA for SSI recipients, including a continued MA eligibility determination when SSI benefits end.

Ongoing MA eligibility begins the first day of the month of SSI entitlement. Some clients also qualify for **retroactive** (retro) MA coverage for up to three calendar months prior to SSI entitlement; see BAM 115.

The following individuals are considered SSI recipients for MA purposes even though they do **not** receive an SSI cash grant:

- Individuals appealing termination of SSI because SSA has determined they are no longer disabled or blind. MDHHS local offices are responsible for determining initial and continuing eligibility; see *MA while appealing disability termination* in this item.

- 1619 Recipients - Certain blind or disabled SSI recipients who work and have too much income for an SSI cash grant may be eligible for continued MA coverage. SSA determines eligibility. These recipients are the same as other SSI recipients in Bridges.

DATA EXCHANGE SYSTEM

Central office receives SSI client information daily from SSA through the State Data Exchange (SDX), which lists SSI:

- Applications.
- Denials.
- Appeals.
- Openings and re-openings.
- Closures.
- Address and other changes.

This information is available in Bridges through the SDX Individual Inquiry, located under Interfaces in left navigation; see BAM 800, Data Exchanges.

MA-SSI OPENINGS/ TRANSFERS

Central Office SDX Actions

An automated process tries to match new SSI recipients on the SDX file with persons active in other programs on Bridges. What happens next depends on what type of match is found.

- Exact match found:
  - If the individual is receiving MA in Bridges, EDBC is run in mass update to close MA under the current case and open ongoing SSI under a new case number.
- Possible match found:
  - The case is reported to the SSI Coordination Unit for manual processing.
  - The SSI Coordination Unit completes the manual SSI opening and transfers the SSI case to the appropriate local office.
- No possible match:
  - Bridges opens a new SSI case and assigns it to a specialist in the appropriate local office based on the individual's residence.

LOCAL OFFICE TRANSITIONAL SSI OPENINGS

An SSI recipient may come to the local office asking for MA coverage before the SDX process opens SSI in Bridges. Local offices should open AD-Care when:

- The SSI recipient is **not** currently active for full coverage MA, **or**
- The SSI recipient is receiving MA under another Type of Assistance (TOA.)

See *opening AD-Care* in this item.

Note: It is the local office responsibility to complete the AD-Care opening. The SSI Coordination Unit is unable to process manual SSI opening requests timely due to the limited resources available.

Opening AD-Care

Do **all** of the following **before** opening AD-Care for an SSI recipient:

- Obtain a signed DCH-1426, Application for Health Coverage & Help Paying Cost, with all of the following minimum information:
  - Recipient's name.
  - Recipient's birth date.
  - Recipient's address (unless homeless).
  - Recipient's/authorized representative's signature.

Note: Do **not** require the completion of the entire DCH-1426. Only the DCH-1426 with all of the minimum information listed above is needed.

- If there are other family members receiving Medicaid in the SSI recipient’s household and the applicant is a responsible relative (for example, spouse, parent) of the SSI Recipient, change the SSI Recipient’s individual program status to requested to apply for MA on the family’s case.
- If the SSI recipient is receiving other programs but not MA, use the *program request* screen in the existing case to apply for MA.

- If there are no active cases into which the SSI Recipient's MA request can be added, register an application for Medicaid in Bridges.

- Determine the SSI Recipient's state of residence. See BEM 220 if the SSI Recipient does **not** receive a state supplement from Michigan.

- Verify current receipt of SSI and/or state supplement and most recent entitlement date. Acceptable verification includes a current award letter from SSA (showing SSI eligibility for the current and ongoing month), information on a DHS-3471, DHS/SSA Referral, or contact with SSA.

To ensure transfer of AD-Care Medicaid to SSI Medicaid:

Email: SSI-Bridges-Coord@michigan.gov

Note: All communication with SSI Coordination must include:

- Client's name.
- Client's individual ID.
- Client's case number.
- Explanation of the issue or problem.
- Your name, title, location, and your telephone number or email address.

LOCAL OFFICE RESPONSIBILITIES

Central office does **not** automatically update Bridges when SSA reports an address and county code change. You must:

- Update Bridges and transfer the case; see BAM 305, **or**
- Notify SSA via DHS-3471 if the address and county code do **not** agree.

You also have the following case responsibilities based on information you receive from all sources:

- Update any address, residence county code, and residence district changes in Bridges.

- Send a copy of the current Bridges individual demographics screen and supporting documentation (for example, birth certificate, SSN card) to the SSI Coordination Unit when a name, date of birth or social security number is incorrect.

- Enter LTC facility (see *definition* in the glossary) and living arrangement changes for LTC and waiver patients. Transfer the case, if necessary; see BAM 305.

- Notify SSA via DHS-3471 of changes or corrections to:

  - Name.
  - Birthdate.
  - Marital status.
  - Address.
  - County code.
  - Living arrangement.

SSA Follow-ups

If case information you sent to SSA does **not** appear on the HR-070 within **45 days**, send copies of the DHS-3471 and documentation to the SSI Coordination Unit; see *local office transitional SSI openings* in this item. Clearly mark your request **Follow-up Report of Change**.

The SSI Coordinator contacts SSA and, after verifying that the information is acted on, responds to you.

Redeterminations

SSI recipients who are Michigan residents receive MA-SSI in Bridges for the duration of SSI eligibility. You do **not** have to conduct redeterminations. However, if SSI stops, you may have to determine continued MA eligibility; see SSI *terminations* in this item.

ELIGIBILITY FOR OTHER SERVICES

SSI recipients may qualify for food benefits, state emergency relief or other benefits. Make referrals as appropriate.

Note: SSI recipients may apply for FAP at SSA **or** the MDHHS local office. BAM 116 explains joint application processing.

Categorically eligible FAP groups automatically meet FAP **asset and income** limits. See BEM 213 for a definition of categorically eligible FAP groups.

SSA may refer SSI recipients with prepaid funeral contracts to MDHHS. BAM 805 explains how to certify the contract as irrevocable.

SSI TERMINATIONS

When SSI benefits stop, central office evaluates the reason based on SSA's negative action code, then does one of the following:

- **SSI Closure**. MA-SSI is closed in Bridges **if** SSI stopped for a reason that prevents continued MA eligibility (for example, death, moved out of state). Bridges sends the recipient a DHS-1605.
- **Transfer to** MA-Terminated SSI Medicaid. SSI cases **not** closed due to the policy above are transferred to the MA Termination SSI Medicaid Type of Assistance. A redetermination date is set for the second month after transfer to allow for an ex parte review; see glossary.

Local Office Responsibilities for Cases Transferred to SSIT

Based on current circumstances, determine whether the client qualifies for MA under:

- **MA While Appealing Disability Termination** in this item, or
- Any other MA category; see BEM 105.

Note: A redetermination/ex parte review (see *glossary* and BAM 210) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, a redetermination/ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115, 210 and 220.

When an MA Terminated SSI Medicaid EDG is set in Bridges, the new automated process will run. See SSI-Terminated (SSI-T) Redetermination/Ex Parte Review Process job aid for the full breakdown of the automated process and specialist responsibilities.

MA While Appealing Disability Termination

MA eligibility continues for an individual who:

- Has been terminated from SSI because he is no longer considered disabled or blind, and

  Note: See BEM 260 about SSI denial codes.

- Has filed an appeal of the termination with SSA within SSA's 60-day time limit, and

  Note: See BEM 260 for information about the SSA appeal process and appeal codes.

- Is a Michigan resident.

Other eligibility factors such as income, assets and third-party resource liability are **not** an issue.

MA eligibility continues until the person:

- Exhausts his SSA appeal rights, or
- Fails to file an appeal at any step within SSA's 60-day time limit, or
- Is no longer a Michigan resident.

When you run EDBC, Bridges will determine whether the individual qualifies under other MA categories (BEM 105) when eligibility ends based on this policy.

Administrative Case Closures

SSI cases with **PAY STAT code N20** on SOLQ are closed due to administrative reasons and might reopen within three weeks. Consider this in deciding when to begin evaluating continued MA eligibility and watch for an SSI reopening during the evaluation process.

SSI Closures

E-mail or fax the SSI Coordination Unit to **close an SSI case if** the client is:

- Deceased.
- No longer a Michigan resident.

When reporting a death, include a copy of the client's death certificate, obituary or other proof the client is deceased with the e-mail or fax.

VERIFICATION REQUIREMENTS

Verify current receipt of SSI and/or state supplement and the most recent entitlement date before authorizing AD-Care for an SSI recipient.

Verify the following for MA based on the **MA While Appealing Disability Termination** policy.

- SSI was terminated because the person was no longer considered disabled or blind.
- Timely appeal filed at SSA.

VERIFICATION SOURCES

Current Receipt of SSI

- Copy of a current SSI award letter from SSA.
- DHS-3471, DHS/SSA Referral.
- Contact with SSA.
- SOLQ.
  Note: See BEM 260 for a list of appropriate codes.

SSI Termination Reason

- SOLQ.
  Note: See BEM 260 for a list of appropriate codes.
- Contact with SSA.
- Copy of SSI Termination Notice.

Timely Appeal at SSA

Note: See BEM 260 for a list of appeal codes.

- SOLQ
- Copy of the SSI appeal form (SSA-561 or HA-501).
- Correspondence from SSA.
- Legal document indicating appeal filed.

LEGAL BASE

MA

42 CFR 435.120,.230
MCL 400.106

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

MA is available to former SSI recipients who receive RSDI benefits and would now be eligible for SSI if RSDI cost-of-living increases paid since SSI eligibility ended were excluded. The reason for SSI ineligibility does **not** matter.

All eligibility factors must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

503 individuals eligible for Medicare are covered by the Buy-In Program (see BAM 810) and are considered eligible for QMB (BEM 165).

Nationally, this MA category is referred to as Medicaid under the Pickle Amendment.

NONFINANCIAL ELIGIBILITY FACTORS

- The person must:
  - Currently receive RSDI benefits, **and**
  - Have stopped receiving SSI benefits after April 1977, **and**
  - Have been entitled to RSDI benefits in the last month he was eligible for and received SSI.

  Note: RSDI benefits paid retroactively can be considered. An SSI recipient who receives retroactive RSDI benefits does **not** become retroactively ineligible for SSI even when the retroactive RSDI monthly benefit was more than his SSI benefit.

- The person must be:
  - Age 65 or older (BEM 240), or
  - Blind (BEM 260), or
  - Disabled (BEM 260).

- The MA eligibility factors in the following items must be met:

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

Note: An ex parte reivew (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories. See BAM 115 and 220.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211.

Assets

Countable assets **cannot** exceed the asset limit in BEM 400. Countable assets are determined based on the MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies.

Income Eligibility

Income eligibility exists when net income does **not** exceed the special protected income level in RFT 245. Income eligibility **cannot** be established with a patient-pay amount or by meeting a deductible.

Determine countable income according to MA policies in BEM 500 and BEM 530, except as explained in **"503 COUNTABLE RSDI"** below. Apply the deductions in BEM 540 (for children) or BEM 541 (for adults) to countable income to determine net income.

503 COUNTABLE RSDI

Bridges does this calculation. Enter current RSDI in Bridges.

RSDI cost-of-living allowances are called COLAs. For all persons whose income is considered, do **not** count COLAs received since the 503 individual's last month of concurrent RSDI/SSI.

Exception: If the client objects to the amount used, request a COLA history from the SSA district office. Send a DHS-3471, DHS/SSA Referral to the SSA district office with the following request:

- Client objects to our determination of Medicaid eligibility under the Pickle Amendment. Please supply each amount of Title II COLA paid since * .

*Enter month and year of the last concurrent RSDI/SSI benefit.

If a fiscal group contains more than one potential 503 individual and their last month of concurrent RSDI/SSI differs, do separate budgets for each 503 individual.

VERIFICATION REQUIREMENTS

Verify current RSDI. Verify the last month of concurrent RSDI entitlement and SSI eligibility and receipt. BENDEX has such information.

The verification requirements for all other eligibility factors are specified in the appropriate manual items.

LEGAL BASE

MA

42 CFR 435.135
Deficit Reduction Act (2005), Social Security Act 1903(x) PL 109-171.

JOINT POLICY DEVELOPMENT

Medicaid, Adult Medical Program (AMP) also known as Adult Benefit Waiver (ABW), Transitional Medical Assistance (TMA/TMA-Plus), and Maternity Outpatient Medical Services (MOMS) policy has been developed jointly by the Department of Community Health (DCH) and the Department of Human Services (DHS).

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

MA is available to any person who:

1. Is **not** entitled to Medicare Part A (hospital insurance), and
2. Receives RSDI benefits some or all of which are early widow(er)'s benefits under section 202(e) or (f) of the Social Security Act, or under any other provision of section 202 if they are also eligible under subsections (e) or (f), and

   Note: Sections 202(e) and (f) provide the same benefits; (e) is for widows and (f) is for widowers.
3. Was terminated from SSI because of RSDI received under section 202 of the Act, and
4. Received SSI in the month before the month he began receiving RSDI under section 202 of the Act, and
5. Would be eligible for SSI if all RSDI under section 202 of the Act were excluded.

The Social Security Administration notifies central office when SSI terminates for a person meeting the criteria in 1-4 above. Notification is via a code on State Data Exchange (SDX) tapes.

All eligibility factors must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

This category is also referred to as “Kennelly Widows.”

NONFINANCIAL ELIGIBILITY FACTORS

The person must meet all the following:

- Is **not** entitled to Medicare Part A, Hospital Insurance.
- Receives:

- Early widow(er)'s RSDI under section 202(e) or (f) of the Social Security Act, or
- RSDI under another provision of section 202 but is also eligible under section 202(e) or (f)

- Was terminated from SSI because of RSDI received under section 202 of the Act.
- Received SSI in the month before the month he began receiving RSDI under section 202 of the Act.
- Is blind or disabled (BEM 260).Receipt of RSDI will **not** always verify blindness or disability. A widow(er) who is at least age 60 may be entitled to RSDI without being blind or disabled.
- Meets the MA eligibility factors in the following items:
  - BEM 220, Residence.
  - BEM 221, Identity.
  - BEM 223, Social Security Numbers.
  - BEM 225, Citizenship/Alien Status.
  - BEM 255, Child Support.
  - BEM 256, Spousal/Parental Support.
  - BEM 257, Third Party Resource Liability.
  - BEM 265, Institutional Status.
  - BEM 270, Pursuit of Benefits.

IDENTIFICATION

Persons receiving early widow(er)'s RSDI have a social security claim number suffix of W, W1-W9, WB, WC, WF, WG, WJ, WR or WT.

In addition, the SSI termination notice indicate potential MA eligibility; see **EXHIBIT**.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211.

Assets

Countable assets **cannot** exceed the asset limit in BEM 400. Countable assets are determined based on the MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies.

Income Eligibility

Income eligibility exists when net income does **not** exceed the special protected income level in RFT 245. Income eligibility **cannot** be established with a patient-pay amount or by meeting the deductible.

Determine countable income according to MA policies in BEM 500 and 530 **except** as explained in **COUNTABLE RSDI** below. Apply the deductions in BEM 541 to countable income to determine net income.

COUNTABLE RSDI

Exclude all RSDI benefits for the early widow(er).

For all other persons, countable RSDI is the person's gross RSDI for the month being tested. Gross RSDI means the amount before any deductions such as Medicare.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

VERIFICATION REQUIREMENTS

Verification of the following factors unique to this category is required at application, redetermination and whenever there is a change in RSDI benefits:

- Receipt of (or eligibility for) benefits under section 202(e) or (f) of the Social Security Act.
- **Not** entitled to Medicare Part A.

Verification policies for other eligibility factors are in the appropriate manual items.

Verification Sources

Receipt of (or eligibility for) RSDI benefits under section 202(e) or (f) of the Social Security Act:

- Social security claim number suffix from BENDEX, SOLQ, or other Social Security Administration document; see **Identification.**
- Memo or other communication from central office.
- Social Security Administration.Medicare Part A eligibility:
- BENDEX.
- SOLQ.
- SSA-1610-U2.
- Social Security Administration.

EXHIBIT - SSI NOTICE

This is the information about Medicaid which appears on SSI denial/termination notices when SSI ineligibility resulted from early widow(er)'s RSDI benefits.

You may be receiving Medicaid from your state. If you are, you may be able to keep Medicaid even though your SSI payments are stopping. You may receive Medicaid under special rules if all the following are true.

- You are a widow (widower) age 50 through 64;
- You no longer receive SSI because of Social Security payments;
- You do not have hospital insurance under Medicare; AND
- You meet the other state rules for Medicaid.

If these are not true about you, you may still be able to receive Medicaid under other state rules.

To apply for Medicaid, call or visit the Department of Human Services. If you visit, please bring this letter. If you call, tell them you received a widow's or widower's Medicaid letter. That will help them answer your questions.

LEGAL BASE

MA

Social Security Act, Section 1634(d)
Deficit Reduction Act 2005, Social Security Act 1903(x), PL 109-171

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

MA is available to a person receiving disabled adult children's (DAC) (also called Childhood Disability Beneficiaries' or CDBs') RSDI benefits under section 202(d) of the Social Security Act if he or she:

1. Is age 18 or older; and
2. Received SSI; and
3. Ceased to be eligible for SSI on or after July 1, 1987, because he became entitled to DAC RSDI benefits under section 202(d) of the Act or an increase in such RSDI benefits; and
4. Is currently receiving DAC RSDI benefits under section 202(d) of the Act; and

   Note: To receive DAC RSDI a person must have a disability or blindness that began before age 22.
5. Would be eligible for SSI without such RSDI benefits.

The Social Security Administration notifies central office when SSI terminates for a person meeting the criteria in 1-4 above. Notification is via a code on State Data Exchange (SDX) tapes. Central office sends a memo (see EXHIBIT I) to the appropriate local office. See SSI TERMINATIONS in BEM 150.

All eligibility factors must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

DAC MA recipients eligible for Medicare are covered by the Buy-In Program (see BAM 810) and are considered eligible for QMB (BEM 165).

NONFINANCIAL ELIGIBILITY FACTORS

1. The person must be age 18 or older.

2. The person must have:

   - Received SSI; and
   - Ceased to be eligible for SSI on or after July 1, 1987, because the person became entitled to DAC RSDI benefits under section 202(d) of the Act or an increase in such benefits.

Note: DAC RSDI is also called Childhood Disability Benefits (CDB).

3. The person is currently receiving DAC RSDI benefits.

   Note: When SSA employees say someone is a "DAC" they mean he receives DAC RSDI.

4. The MA eligibility factors in the following items must be met.

   - BEM 220, Residence.
   - BEM 221, Identity.
   - BEM 223, Social Security Numbers.
   - BEM 225, Citizenship/Alien Status.
   - BEM 255, Child Support.
   - BEM 256, Spousal/Parental Support.
   - BEM 257, Third Party Resource Liability.
   - BEM 265, Institutional Status.
   - BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211.

Assets

Countable assets **cannot** exceed the asset limit in BEM 400. Countable assets are determined based on the MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies.

Income Eligibility

Income eligibility exists when net income does **not** exceed the special protected income level in RFT 245. Income eligibility **cannot** be established with a patient-pay amount or by meeting a deductible.

Determine countable income according to MA policies in BEM 500 and 530 **except** as explained in **COUNTABLE RSDI** below. Apply the deductions in BEM 541 to countable income to determine net income.

COUNTABLE RSDI

Exclude all DAC related RSDI benefits for the person whose DAC eligibility is being determined. Count any RSDI benefits that are not related to DAC.

For all other persons, countable RSDI is the person's gross RSDI for the month being tested. Gross RSDI means the amount before any deductions such as Medicare.

IDENTIFYING DACS

An individual may be receiving DAC RSDI benefits if one of the following descriptions applies:

- He has been identified as a DAC by central office or an SSI letter and his social security claim number suffix contains the letter C. The C may be followed by another letter or number (CA, CB, C1, etc.).
- He is more than 19 years 2 months old and his social security claim number suffix contains the letter C. The C may be followed by another letter or number (CA, CB, C1, etc.).
- He is age 18 or older, **not** a full-time student in elementary or secondary school and his social security claim number contains the letter C. The C may be followed by another letter or number (CA, CB, C1, etc.).

Note: When an individual meets a bullet listed you must request a screening for DAC eligibility from central office unless a determination has already been completed by central office. After you receive verification of DAC RSDI from central office you still need to determine all other factors for MA eligibility (income and asset etc., listed on page 1 of this item) are met. You should retain

the copy of the verification from central office as you only need to verify DAC eligibility once.

Requests must be made through your management or central specialized staff (include titles). Send requests to:

DHS-DAC-Determination-Mailbox@michigan.gov and include the beneficiary's name, case number, SSN, SS claim number and any other information pertaining to the request.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories. See BAM 115 and 220.

VERIFICATION REQUIREMENTS

Verification of the following factors unique to DAC eligibility is required prior to authorizing DAC MA eligibility:

- Receipt of SSI on the basis of blindness or a disability.
- Termination of SSI on or after July 1, 1987 because of entitlement to DAC RSDI benefits or an increase in such benefits.

Verification of receipt of DAC RSDI benefits under section 202(d) of the Act is required prior to authorizing DAC MA eligibility and at redetermination.

Verification policies for other eligibility factors are in the appropriate manual items.

Verification Sources

Receipt of SSI on the basis of blindness or a disability.

- Memo or other communication from central office.
- SSI letter.
- Social Security Administration.

Termination of SSI on or after July 1, 1987 because of entitlement to DAC RSDI benefits or an increase in such benefits:

- Memo or other communication from central office.
- SSI letter.
- Social Security Administration.

Current receipt of DAC RSDI benefits:

- Social security claim number suffix from BENDEX, SOLQ or other Social Security Administration document. See “Identifying DACs.”
- SSI letter.
- Social Security Administration.

EXHIBIT I - CENTRAL OFFICE MEMO

STATE OF MICHIGAN
Department of Human Services

Memo

Outstate Operations
235 S Grand Ave
Lansing, MI 48909
www.michigan.gov

Department of Human Services

Tel: 517 373 2035

To: County DHS
From: DHS-DAC-Determination
Subject: Disabled Adult Child(DAC) Determination – BEM 158

Date: 06/25/2013

Case Name:
Social Security Number: XXX-XX-0000

A review of potential eligibility for Medicaid based on BEM 158, Disabled Adult Children (DAC), has been completed. We find that this customer is:

☐ **Not Eligible** for MA as a DAC because: .

☐ **Potentially Eligible** for MA as a DAC. When determining this client's continued MA eligibility, please give first consideration to eligibility based on BEM 158. SSI benefits have been terminated for this client, and Social Security Administration records identify this client as potentially eligible for continued MA as a DAC.

*SSI eligibility end date: mm/dd/yyyy
*Disability Onset Date: mm/dd/yyyy

DO NOT REMOVE - THIS LETTER FROM CASE RECORD

LEGAL BASE

MA

Social Security Act, Section 1634(c)
Deficit Reduction Act 2005, Social Security Act 1903(x), PL 109-171

JOINT POLICY DEVELOPMENT

Medicaid, Adult Medical Program (AMP), Transitional Medical Assistance (TMA/TMA-Plus), and Maternity Outpatient Medical Services (MOMS) policy has been developed jointly by the Department of Community Health (DCH) and the Department of Human Services (DHS).

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

Consider eligibility under this category only if eligibility does not exist under BEM 154 through 158. Use this category before using Extended-Care (BEM 164) or any Group 2 MA category.

This category is available to persons who are aged or disabled (AD).Net income cannot exceed 100% of the poverty level.

All eligibility factors in this item must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

NONFINANCIAL ELIGIBILITY FACTORS

1. The person must not be eligible for MA under BEM 154 through 158.

2. The person must be aged (BEM 240, Age) or disabled (BEM 260, MA Disability/Blindness).

   Note: Blindness is not a basis of eligibility. However, a blind person who is also aged or disabled meets this eligibility factor.

3. The MA eligibility factors in the following items must be met.

   - BEM 220, Residence.
   - BEM 221, Identity.
   - BEM 223, Social Security Numbers
   - BEM 225, Citizenship/Alien Status
   - BEM 255, Child Support.
   - BEM 256, Spousal/Parental Support.
   - BEM 257, Third Party Resource Liability.
   - BEM 265, Institutional Status.
   - BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211.

Assets

Countable assets cannot exceed the asset limit in BEM 400. Countable assets are determined based on MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies.

Income Eligibility

Net income cannot exceed one hundred percent of the federal poverty level. The net income limit can be determined by subtracting twenty dollars from the income limits listed in table one of RFT 242. Income eligibility cannot be established with a patient-pay amount or by meeting a deductible.

Determine countable income according to SSI-related MA policies in BEM 500, 501, 502, 503, 504 and 530 ***except*** as explained in **COUNTABLE RSDI** in this item. Apply the deductions in BEM 540 (for children) or 541 (for adults) to countable income to determine net income.

COUNTABLE RSDI

Gross amount means the amount of RSDI before any deduction such as Medicare.

Countable RSDI for fiscal group members is the gross amount for the previous December when the month being tested is January, February or March. Federal law requires that the cost-of-living increase received in January be disregarded for these three months. For all other months, countable RSDI is the gross amount for the month being tested.

For all other persons whose income must be considered, countable RSDI is always the gross amount for the month being tested.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

LEGAL BASE

MA

Social Security Act, Section 1902(m), 1902(r)(2)
Deficit Reduction Act 2005, Social Security Act 1903(x), PL 109-171

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

Consider eligibility under this category only if eligibility does **not** exist under BEM 154 through 163. Use this category before using a Group 2 category.

Consider Medicare Savings Program eligibility in addition to this category; see BEM 165.

This category is available only to L/H and waiver clients who are aged (65 or older), blind or disabled. See Bridges Glossary for the definition of L/H patients. See BEM 106 for the definition of waiver clients. Gross income **cannot** exceed 300 percent of the SSI federal benefit rate; see RFT 248.

All eligibility factors in this item must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, see BEM 546 to determine the post-eligibility patient-pay amount.

NONFINANCIAL ELIGIBILITY FACTORS

- The person must **not** be eligible for MA under BEM 154 through 163 but may be eligible for a Medicare Savings Program under BEM 165.
- The person must be an L/H or waiver client.
- The person must be aged, blind or disabled; see BEM 240, Age, or BEM 260, MA Disability/Blindness. The MA eligibility factors in the following items must be met:
  - BEM 220, Residence.
  - BEM 221, Identity.
  - BEM 223, Social Security Numbers.
  - BEM 225, Citizenship/Alien Status.
  - BEM 255, Child Support.
  - BEM 256, Spousal/Parental Support.
  - BEM 257, Third Party Resource Liability.
  - BEM 265, Institutional Status.

- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related MA groups in BEM 211.

Assets

Countable assets **cannot** exceed the asset limit in BEM 400. Countable assets are determined based on MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies.

Income Eligibility

Income eligibility exists when **gross** countable income does **not** exceed 300 percent of the SSI benefit rate.

Apply the MA policies in BEM 500, 501, 502, 503, 504 and 530 to determine gross income. Do not apply the deductions in BEM 540 and 541.

Income eligibility **cannot** be established with a patient-pay amount or by meeting a deductible.

Third Party Liability

Complete MSA-1354 for clients with other insurance including long term care/nursing home insurance and submit with a copy of insurance card if available.

Patient Pay Offsets

If an LTC applicant requests an offset of their patient pay to cover old medical bills, see Pre-Eligibility Medical Expense (PEME) in glossary and BEM 546.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

LEGAL BASE

MA

42 CFR 435.217 and .236
Deficit Reduction Act 2005, Social Security Act 1903(x), PL 109-171

DEPARTMENT POLICY

MA Only

Medicare Savings Programs (MSP) are SSI-related MA categories. They are neither Group 1 nor Group 2.

This item describes the categories that make up the Medicare Savings Programs. The categories are:

1. Qualified Medicare Beneficiaries (QMB).

   This is also called full-coverage QMB and just QMB. Program group type is QMB.

2. Specified Low-Income Medicare Beneficiaries (SLMB).

   This is also called limited-coverage QMB and SLMB. Program group type is SLMB.

3. QI Additional Low-Income Medicare Beneficiaries (ALMB).

   This is also referred to as ALMB and as just Q1. Program group type is ALMB.

4. Non-Categorically Eligible Michigan Beneficiaries (NMB).

There are both similarities and differences between eligibility policies for the categories. Benefits among the categories also differ.

Income is the major determiner of category.

QMB	Net income cannot exceed 100% of poverty.
SLMB	Net income is over 100% of poverty, but not over 120% of poverty.
ALMB (QI)	Net income is over 120% of poverty, but not over 135% of poverty.
NMB	Income and assets above allowed ALMB limits but have full coverage Medicaid with Medicare part A/B entitlement.

A person who is eligible for one of these categories cannot choose to receive a different Medicare Savings Program category. For example, a person eligible for QMB cannot choose SLMB instead.

All eligibility factors must be met in the calendar month being tested.

MEDICARE SAVINGS PROGRAMS BENEFITS

QMB Benefits

QMB pays:

- Medicare premiums, and

  Note: QMB pays Medicare Part B premiums and Part A premiums for those few people that have them.

- Medicare coinsurances, and
- Medicare deductibles.

SLMB Benefits

SLMB pays Medicare Part B premiums.

ALMB Benefits

ALMB pays Medicare Part B premiums provided funding is available.

NMB Benefits

NMB pays the Medicare Part B premiums (and the part A premiums for the few who have them) for full coverage Medicaid beneficiaries not otherwise eligible for MSP.

MEDICARE AND BUY-IN INFORMATION

See BAM 810 for general information about Medicare and information about the Buy-In program.

WHEN TO DO MEDICARE SAVINGS PROGRAMS DETERMINATIONS

Separate Medicare Savings Programs Determination

Some Medicaid programs do not have automatic MSP coverage. Complete a Medicare Savings Program determination for any individual entitled to Medicare Part A. This includes individuals who are also eligible for Medicaid in the following categories:

- Medicare Savings Programs-only.
- Group 2 MA (MAGI-related and SSI-related).
- Extended Care (BEM 164).
- Healthy Kids.
- Any other full coverage Medicaid program under MAGI or SSI-Related categories.

Note: The individual who is eligible for MA under any of these categories does not have to request a determination of MSP eligibility or re-apply for MA in order to be reviewed for MSP eligibility by the department.

Automatic QMB

Person's receiving MA under the following categories and entitled to Medicare Part A are considered QMB eligible without a separate QMB determination:

- BEM 150, SSI Recipients.
- BEM 155, 503 Individuals.
- BEM 158, DAC.
- BEM 163, AD-Care.
- BEM 110, LIF.
- BEM 111, TMA.

MSP Determinations When Requested by CMS

The Centers for Medicare and Medicaid Services (CMS) may ask MDHHS to review eligibility for, and addition of, MSP coverage for a timeframe when there was no Medicare Cost Share approved. The

central office Buy-In Unit at MSA will contact the field office to ask that a determination of the recipient's eligibility for MSP during that timeframe be completed and to update the case record to add the MSP coverage if the recipient is eligible.

MEDICARE SAVINGS PROGRAMS COVERAGE BEGIN DATES

QMB Begin Date

Begin QMB coverage the calendar month after the processing month. The processing month is the month during which an eligibility determination is made. QMB is not available for past months or the processing month.

SLMB Begin Date

SLMB coverage is available for retro MA months and later months.

Note: SLMB is only available for months income exceeds the QMB limit. A person cannot choose SLMB in place of QMB in order for coverage to start sooner (example, to get retro MA).

ALMB Begin Date

ALMB coverage is available for retro MA months and later months; however, not for time in a previous calendar year.

ALMB and Previous Year Limit

Do not approve ALMB for any month that is in a previous calendar year, even if application was made in the previous calendar year.

Application was made December 27, 2015. Eligibility was determined on January 3, 2016. ALMB cannot be approved for any time before January 1, 2016.

NMB Begin Date

NMB coverage is available for retro MA months and later months.

MEDICARE SAVINGS PROGRAMS INQUIRY

A person may wish to know whether MA will pay Medicare premiums before enrolling in Medicare. The person may even contact the department before reaching age 65 (example, during the three months before the person's 65th birthday).

Advise persons listed under Automatic QMB above that MA will pay their Medicare premium.

Do a determination of eligibility for all other persons. In doing this determination:

- Explain the nonfinancial eligibility factors. Assume they will be met.
- Use current information to determine financial eligibility. Do not ask for verification.
- Explain that changes may affect the actual determination of eligibility. Be sure to discuss asset policy thoroughly if the person's assets exceed the limit.
- There is no need for a person to make a separate application or a re-application for an MSP determination. A Health Care Coverage application is used for an MSP only determination.

NONFINANCIAL ELIGIBILITY FACTORS

Entitled to Medicare Part A

The person must be entitled to Medicare Part A. That means something different for QMB than it does for SLMB and ALMB.

Entitled to Medicare Part A for QMB

For QMB, entitled to Medicare Part A means the person meets condition 1, 2 or 3:

1. Is receiving Medicare Part A with no premium being charged.

Note: A premium is being charged even when it is being paid by the Buy-In program.

BENDEX and State Online Query (SOLQ) indicate whether a Medicare Part A premium is being charged.

2. Refused premium-free Medicare Part A.

   Suffix. Claim number suffix is always M1.

3. Is eligible for, or receiving, Premium HI (Hospital Insurance).

   Premium HI is what the Social Security Administration calls Medicare Part A when it is not free of charge.

   Suffix. Claim number suffix is M.

Exception: Medicare Part A under section 1818A of the Social Security Act does not meet this eligibility factor; see Part A Identification in this item.

Entitled to Medicare Part A for SLMB and ALMB

For SLMB and ALMB, entitled to Medicare Part A means the person is receiving Medicare Part A with no premium being charged.

BENDEX and SOLQ indicate whether a Medicare Part A premium is being charged.

A premium is being charged even when it is being paid by the Buy-In program.

Exception: Medicare Part A under section 1818A of the Social Security Act does not meet this eligibility factor; see Part A Identification in this item.

ALMB and Other MA

A person is not eligible for ALMB if the person is eligible for and receiving MA under another category. However, for deductible clients:

- Persons in active deductible status are not considered eligible for another MA category, and

- Persons identified as ALMB eligible at the time they report meeting their deductible remain ALMB eligible.
- Persons who change to a nursing home status, Freedom to Work, or a waiver are not eligible for ALMB.

Persons who are eligible for MA benefits under another category, but do not want such assistance can be eligible for ALMB. Persons can receive QMB or SLMB and full Medicaid benefits under another category.

Other Nonfinancial Factors

The MA eligibility factors in the following items must be met:

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

Part A Identification

Absent evidence to the contrary (example, SSA document), use the following guidelines to distinguish between Medicare for Medicare Savings Programs and Medicare under section 1818A of the Social Security Act.

- There is no charge for the person's Medicare Part A - Medicare Savings Program.
- The person is at least age 65 - Medicare Savings Programs
- The person is under age 65 and there is a premium charged for Medicare Part A -not Medicare Savings Programs; see BEM 169, Qualified Disabled Working Individuals.

Note: BENDEX and SOLQ indicate whether a Medicare Part A premium is being charged. Even if the BENDEX or SOLQ only indicate there may be entitlement for part A, a determination of

MSP eligibility should be completed; see Part B Eligibility in this item.

Part B Eligibility

Individuals who receive Medicare part A (free or with a premium) but do not show receipt of part B, may not show part B coverage in Bridges because they refused it.

Note: Because it is advantageous for the state to enroll every person who is entitled to Medicare part B (even if they have refused the coverage) into the MSP program, a determination of eligibility should be made even if a person shows only entitlement for Medicare part A.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211.

Assets

Countable assets cannot exceed the limit in BEM 400. Countable assets are determined based on MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies to MSP because there could be a Medicare coinsurance or deductible for LTC or home and community-based services.

Income Eligibility

Income eligibility exists when net income is within the limits in RFT 242 or 247. Income eligibility cannot be established with a patient-pay amount or by meeting a deductible.

Determine countable income according to the SSI-related MA policies in BEM 500, 501, 502, 503, 504 and 530, except as explained in COUNTABLE RSDI in this item. Apply the deductions in BEM 540 (for children) and 541 (for adults) to countable income to determine net income.

COUNTABLE RSDI

Federal law requires that for January, February and March:

- The RSDI cost-of-living increase received starting in January be disregarded for fiscal group members, and
- The income limits for the preceding December be used.

For all other months, countable RSDI means the countable amount for the month being tested.

For all other persons whose income must be considered, the RSDI cost-of-living increase is not disregarded.

Countable RSDI

Enter countable RSDI for the month being tested. When the month being tested is January, February or March Bridges will automatically:

- Compute and deduct the RSDI cost-of-living increase for fiscal group members, and
- Use the limits for the preceding December.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

Annual Redetermination

A redetermination of ALMB eligibility must be completed before the end of each calendar year. Set the ALMB redetermination date as September, October, November or December. ALMB cannot have a 24-month certification.

MEDICARE PART A

Answer the Medicare Part A question on SSI-related MA in Bridges based on the following:

- 1- Receiving Medicare Part A with no premium being charged.
- 2- Refused premium-free Medicare Part A. Claim number suffix is M1.
- 3- Entitled to buy Medicare Part A. The Social Security Administration calls this Premium HI. Claim number suffix is M.

Enter countable RSDI for the month being tested. The RSDI cost-of-living increase for fiscal group members will be deducted automatically if the month being tested is January, February or March.

Enter the person's claim number on the Recipient Information Screen when it is requested. It will then be printed on any memo generated for the Buy-In coordinator.

APPLICATION FOR MEDICARE

Verification of application for Medicare is by self-attestation.

NOTIFICATION

Email the beneficiary information to the Buy-in Coordinator at Buyinunit@michigan.gov when retro buy-in has been approved and indicate retro buy-in in the subject line.

LEGAL BASE

Social Security Act sections:

- 1902(a)(10)(E)(i) for QMB.
- 1902(a)(10)(E)(iii) for SLMB.
- 1902(a)(10)(E)(iv) for ALMB.
- 1902(r)(2).
- 1905(a) for retro MA.
- 1933 for ALMB funding.

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 2 MA category.

Consider eligibility under this category only when eligibility does **not** exist under BEM 155 through 164, 170 or 171.

Consider Medicare Savings Program eligibility (BEM 165) in addition to Group 2 MA.

MA is available to a person who is aged (65 or older), blind or disabled. All eligibility factors must be met in the calendar month being tested. If the month being tested is an L/H month and eligibility exists, go to BEM 546 to determine the post-eligibility patient-pay amount.

NONFINANCIAL ELIGIBILITY FACTORS

1. The person must not be eligible for MA under BEM 155 through 164, 170 or 171, but may be eligible for a Medicare Savings Program under BEM 165.

2. The person must be aged, blind or disabled (BEM 240, Age, or BEM 260, MA Disability/Blindness). The MA eligibility factors in the following items must be met.

    - BEM 220, Residence.
    - BEM 221, Identity.
    - BEM 223, Social Security Numbers.
    - BEM 225, Citizenship/Alien Status.
    - BEM 255, Child Support.
    - BEM 256, Spousal/Parental Support.
    - BEM 257, Third Party Resource Liability.
    - BEM 265, Institutional Status.
    - BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211.

Assets

Countable assets **cannot** exceed the asset limit in BEM 400. Countable assets are determined based on MA policies in BEM 400, 401 and 402.

Divestment

Policy in BEM 405 applies.

Income Eligibility

Income eligibility exists when net income does **not** exceed the Group 2 needs in BEM 544. Apply the MA policies in BEM 500, 530, 540 (for children) or 541 (for adults), and 544 to determine net income.

If the net income exceeds Group 2 needs, MA eligibility is still possible per BEM 545.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte reivew should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories. See BAM 115 and 220.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

LEGAL BASE

MA

42 CFR 435.320, .322 and .324
MCL 400.106

Deficit Reduction Act 2005, Social Security Act 1903(x), PL 109-171

DEPARTMENT POLICY

MA Only

The Program of All Inclusive Care for the Elderly (PACE) is a managed care program designed for the frail, elderly population. PACE enrollment is always prospective. The Medicaid Services Administration (MSA) administers the program through contracts with PACE organizations.

The PACE organization receives referrals from medical providers in the community who believe a person meets both the PACE program and Medicaid eligibility factors in this item as well as the nursing facility level of care criteria. PACE is currently operating in several counties in southern Michigan.

The PACE program is not a Medicaid category, but there are special eligibility rules for clients approved for PACE services.

TARGETED GROUP

The person must meet all the following:

- Be medically qualified.
- Be 55 years of age or older.
- Live within an approved geographic area of the PACE provider.
- Not reside in a nursing facility at the time of enrollment.
- Not enrolled in the MIChoice Waiver.
- Not enrolled in an HMO.

NONFINANCIAL ELIGIBILITY FACTORS

The eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211. A PACE participant is a group of one even when living with a spouse. Individuals covered under the Extended Care eligibility group can be enrolled in PACE.

Assets

Countable assets cannot exceed the asset limit for SSI-related MA categories in BEM 400. Countable assets are determined based on MA policies in BEM 400, 401, and 402.

Initial Asset Assessment (IAA) Date

The special MA asset rules in BEM 402 apply when completing the *initial asset assessment*.

The date of the medical assessment and approval for PACE enrollment is completed by the PACE agency is the first day of continuous care for the purpose of determining the IAA; unless there is a previous period of care which meets the definition of a first day of continuous care found in BEM 402.

Approval means the participant expects to receive appropriate waiver services for at least 30 consecutive days.

Divestment

The MA divestment policy in BEM 405 apply to PACE waiver applicants and participants.

Income

Income eligibility exists when gross income does not exceed 300 percent of the federal benefit rate. Income eligibility cannot be established with a patient-pay amount or by meeting a deductible.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

PATIENT-PAY AMOUNT

A patient-pay amount will be calculated if a PACE enrollee is admitted to a nursing facility or hospital. The PACE organization is responsible for collecting the patient-pay amount. Notice of the start, effective date, and any changes to the amount must be sent to the PACE organization.

NOTICES

PACE organizations have received federal and state approval for administering the program. Therefore, the following information may be shared without a signed release from the client:

- A copy of the DHS-3503, Verification Checklist.
- A copy of the DHS-4598, Medical Program Eligibility Notice, or the system equivalent.
- A copy of the DHS-1606, MA Determination Notice.

The original DHS-3503, DHS-4598, DHS-1606 must be sent to the client or the guardian, court or agency who is legally responsible for the client.

PACE PROVIDERS

CareResources
1471 Grace St. S.E.
Grand Rapids, MI 49506
616-913-2006 or 1-800-610-6299

LifeCircles- PACE Muskegon
560 Seminole Rd.
Muskegon, MI 49444
231-733-8686 or 1-888-204-8626

LifeCircles-PACE Holland
12330 James St.

Holland, MI 48424
616-582-3100

CentraCare
200 West Michigan Ave.
Battle Creek, MI 49017
269-441-9300 or 877-284-4071

CentraCare
445 W. Michigan Ave.
Kalamazoo, MI 49001
269-488-5460 or 1-800-488-5860

PACE of Southwest Michigan
2900 Lakeview Ave.
St. Joseph, MI 49085
855-483-8876

PACE Southeast Michigan
24463 W. 10 Mile
Southfield, MI 48033
855-445-4554

PACE Southeast Michigan
Dearborn Center
15401 N. Commerce Dr.
Dearborn, MI 48120
855-445-4554

PACE Southeast Michigan
Thome Rivertown PACE Center
250 McDougall St.
Detroit, MI 48207
855-455-4554

PACE Southeast Michigan
Warren
30713 Schoenherr
Warren, MI 48088
855-455-4554

Thome PACE
2282 Springport Rd.
Jackson, MI 49202
517-768-9791

Huron Valley PACE
2940 Ellsworth Rd.
Ypsilanti, MI 48197
855-483-7223

Genesys PACE of Genesee County
412 E. First Street
Flint, MI 48502
810-236-7500

Great Lakes PACE
3378 Fashion Square Blvd.
Saginaw, MI 48603
989-272-7610

VOANS Senior Community Care of Michigan
1321 E. Miller Road
Lansing, MI 48911
517-319-0700

Community at PACE, Inc.
231 West Pine Lake Drive
Newaygo, MI 49337
1-800-689-6675

LEGAL BASE

MA

Title XIX of the Social Security Act. 42 CFR 460.

INTRODUCTION

Effective March 1, 2015, the Michigan Department of Health and Human Services (MDHHS), in partnership with the Centers for Medicare and Medicaid Services (CMS), implemented a new capitated managed care program called MI Health Link (MHL). This program integrates, into a single coordinated delivery system, all physical health care, pharmacy, long-term supports and services and Medicare behavioral health care, and Medicaid Mild-to-Moderate behavioral health care for individuals who are dually eligible for full Medicare and full Medicaid. (Specialty Medicaid behavioral health care services are carved out of the program and delivered by the Regional Pre-paid Inpatient Health Plans (PIHPs).

The goals of the program are to improve coordination of supports and services offered through Medicare and Medicaid, enhance quality of life, improve quality of care, and align financial incentives. The program is a demonstration project ending December 31, 2025.

INTERGRATED CARE ORGANIZATIONS (ICO)

MDHHS and Center for Medicaid and Medicare Services (CMS) contracts with managed care entities called Integrated Care Organizations (ICOs) to provide Medicare and Medicaid covered acute and primary health care, pharmacy, dental and Long Term Supports and Services (nursing facility and home and community-based services). In addition to all Medicare Parts A, B, and D, and Medicaid State-plan services (except those covered through contracts between the State and the Michigan Pre-Paid Inpatient Health Plans), ICOs are required to provide supplemental benefits and other supports and services as defined in the approved 1915(b) and 1915(c) waivers and other supporting documentation, or rules, provided by CMS or MDHHS. See Exhibit I in this item for a list of ICO names and service areas.

The PIHPs are responsible for managing Medicaid Specialty Services and Supports in specified geographic regions, under contract with the Michigan Department of Health and Human Services (MDHHS) consistent with the Michigan Mental Health Code (MMHC). The ICOs and PIHPs coordinate and manage care for jointly served enrollees.

ELIGIBILITY

Individuals eligible for the MI Health Link Program are:

- Age 21 or older at the time of enrollment.
- Entitled to or enrolled in Medicare Part A, enrolled in Part B, eligible to enroll in a Part D plan as of the effective date of coverage under the MMP; and receiving full Medicaid benefits. (Note: This includes individuals who are eligible for Medicaid through expanded financial eligibility limits under a 1915(c) waiver or who reside in a nursing facility and have a monthly patient pay amount. See Financial Eligibility Factors later in this item.); and
- In one of the following counties of residence. These areas are grouped into four demonstration regions:
    - Region 1 - All counties in the Upper Peninsula.
    - Region 4 - Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, and Van Buren Counties.
    - Region 7 - Wayne County.
    - Region 9 - Macomb County.

Note: It is allowable for an Enrollee residing in a MI Health Link demonstration region to be admitted to a Nursing Facility outside the demonstration region for a service that cannot be obtained in the demonstration region (and replacement is not based on the family or social situation of the Enrollee). This is allowable for up to 6 months.

Populations ineligible for the MI Health Link Program are:

- Individuals under the age of 21.
- Individuals who do not live in the demonstration region.
- Individuals with Additional Low-Income Medicare Beneficiary (ALMB), Qualified Individual (QI), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Medicare Beneficiary (QMB) Medicaid coverage.
- Individuals without full Medicaid coverage (including those with spenddowns or deductibles).

- Individuals with Medicaid who reside in a State psychiatric hospital.
- Individuals with commercial HMO coverage.
- Individuals with elected hospital services prior to MHL enrollment.
- Individuals 21 years of age or older being served by the Children's Specialized Health Care Services program.
- Individuals who are incarcerated.
- Individuals with presumptive eligibility.
- Individuals not eligible for Medicaid due to divestment; and
- Individuals residing in designated State sanction Veterans' Homes.

Note: Individuals enrolled in MI Choice, PACE, MI Care Team, Independence at Home, and CSHCS are eligible but must leave their programs before joining MI Health Link. MI Health Link members cannot be simultaneously enrolled in MI Choice, PACE, or Home Help; see ASM 126 for information on Home Help referrals from MI Health Link.

MI HEALTH LINK ENROLLMENT PROCESS

Enrollment in the MI Health Link program occurs in two ways:

1. Voluntary enrollment.
2. Passive enrollment.

Voluntary Enrollment

For voluntary enrollment, the eligible individual must call the enrollment broker contracted by the state for Medicaid managed care programs. The individual selects the ICO in which they wish to enroll, using the ICO provider networks and drug formularies to assist in making choices.

Passive (Automatic) Enrollment

Eligible individuals who do not voluntarily enroll in the program receive a notification letter from the Enrollment Broker, Michigan

ENROLLS, at least 60 days prior to the enrollment effective date informing them they will be passively (automatically) enrolled in an assigned ICO. Eligible individuals will have a period of 60-days prior to the enrollment effective date to cancel their passive enrollment in the program if they choose to do so.

Enrolling, Disenrolling, or Cancelling Automatic Enrollment

Individuals eligible for MI Health Link may request to enroll, disenroll, or cancel passive (automatic) enrollment by contacting the Enrollment Broker, Michigan ENROLLS at 1-800-975-7630. The hours of operation are Monday through Friday 8 AM to 7 PM.

Note: Enrollment and disenrollment elections will be active the first day of the month following the request.

MI HEALTH LINK INFORMATION AND SUPPORT

To learn more about MI Health Link, individuals should contact the following:

- The Michigan Medicare Assistance Program (MMAP):

  MMAP provides resources to help individuals navigate Medicare options. To contact MMAP, individuals may call 1-800-803-7174. Office hours vary by location. Open Monday through Friday.

- Michigan ENROLLS:

  The State's Enrollment Broker, Michigan ENROLLS, may assist in answering questions or processing requests to enroll, disenroll, or cancel passive (automatic) enrollment in MI Health Link. The Michigan ENROLLS toll-free telephone number is 1-800-975-7630. Office hours are 8 AM through 7 PM, Monday through Friday.

Individuals actively enrolled in MI Health Link with questions or concerns related to their care may contact the following:

- The MI Health Link Ombudsman (MHLO):

  MHLO is an independent program that serves as an advocate and problem-solver for beneficiaries enrolled in MI Health Link. All services are free and confidential. To contact MHLO,

members may call toll-free at 1-888-746-6456 Monday through Friday 8 AM to 5 PM.

MI HEALTH LINK 1915 (B) AND (C) WAIVERS

The Behavioral and Physical Health and Aging Services Administration (BPHASA) MI Health Link Program offers comprehensive Medicare and Medicaid managed care, as well as a Home and Community Based Services (HCBS) Waiver through a single managed care organization called an Integrated Care Organization (ICO). The MI Health Link 1915(b) Waiver program allows Michigan to passively (automatically) enroll individuals eligible for both full Medicare and full Medicaid into a contracted ICO on a monthly basis. Individuals enrolled in an ICO who are eligible for 1915(c) Home and Community Based Services (HCBS) can access them through their ICO without being disenrolled from MI Health Link. Individuals receiving HCBS in MI Health Link's 1915(c) waiver would, absent the waiver, require services in a nursing facility.

This means an individual enrolled in MI Health Link is receiving comprehensive managed care and HCBS concurrently through their ICO.

Note: The MI Health Link Waiver is not an MA category, but there are special eligibility rules for people approved for the waiver; see *Financial Eligibility Factors* in this item.

1915 (C) WAIVER ADMINISTRATION

MI Health Link administers the HCBS Waiver through contracts with Integrated Care Organizations.

1915 (C) Waiver Eligibility

To be eligible for the MI Health Link HCBS Waiver, an individual must:

- Be enrolled in the MI Health Link program;
- Meet nursing facility level of care as determined by Michigan's Medicaid Nursing Facility Level of Care Determination tool;

- Have a need for one or more of the Waiver services listed in the MI Health Link Minimum Operating Standards.

Enrollee must receive at least one waiver service each month to remain enrolled in the MI Health Link HCBS Waiver.

1915(C) Waiver Enrollment Process

The HCBS waiver enrollment process includes:

Assessment

The ICO and/or the ICO's contracted vendor is responsible for completing an assessment to verify a member's medical and functional eligibility for the Waiver. Once all Waiver enrollment materials are complete, the ICO must enter the HCBS Waiver enrollment in CHAMPS and upload an enrollment packet for MDHHS to review. Additionally, ICOs must complete new Waiver assessments and submit to MDHHS at least annually.

Note: The MDHHS local office is still responsible for financial eligibility determination.

Plan of Service

A written plan of services, also known as an "Individualized Integrated Care and Supports Plan (IICSP)" or simply "Care Plan" is developed by the ICO and the Waiver participant if the assessment confirms medical and functional eligibility for the HCBS Waiver. The participant may choose to receive home and community-based services from the ICO.

At a minimum, the plan of services includes:

- Types of services to be furnished; and
- The amount, frequency, and duration of each service; and
- The type of provider to furnish each service; and
- Participant goals, preferences, and outcomes; and
- Participant approval of the plan; and
- The signature of the care coordinator assisting with developing the plan.

Care Coordination

Through care coordination, a person employed by the ICO, (known as a *care coordinator*) or a team, (known as an *integrated care team*), assists MI Health Link Enrollees in accessing Medicare and Medicaid services, including medical services and supplies, behavioral health, substance use disorder and/or intellectual developmental disabilities, pharmacy, and Long Term Supports and Services (LTSS), to promote quality, effectiveness, and integration of care.

The Enrollee's ICO is responsible for arranging for planned services to be provided. In addition to coordinating with MDHHS-contracted PIHPs for the delivery of Medicaid behavioral health services, ICOs may contract with downstream providers for delivery of covered services.

APPROVED FOR THE 1915 (C) WAIVER

Approved for the HCBS waiver means:

- The ICO conducted the assessment, and
- A person-centered plan of service has been developed; and
- The ICO submitted an assessment, a care plan, and other required documentation to MDHHS.
- The ICO reviewed documentation and determined medical and functional Waiver eligibility and enrolled into the HCBS Waiver.

  The participant's Waiver documentation has not been deemed incomplete or deficient through ongoing MDHHS monitoring and auditing processes.
- The participant has been approved for an available Waiver slot.
- The participant has at least one ongoing service need per month and is receiving at least one service from the ICO per month to remain on the Waiver.

Approval and Termination Dates

The ICO determines the Waiver effective date and termination date based on the participants' needs. The ICO is responsible for advising the appropriate local Michigan Department of Health and Human Services (MDHHS) office of these dates by entering the information into CHAMPS.

Waiver enrollment automatically terminates when the participant enters a Long-Term Care (LTC) facility; see BEM 547 for instructions.

Note: An HCBS Waiver Notice is sent from CHAMPS to Bridges to notify caseworkers when an individual is newly enrolled in the Waiver, which qualifies them for expanded financial eligibility. The HCBS Waiver Notice appears as an Admission/Discharge Notice in Bridges and is sometimes misinterpreted as a Nursing Facility Admission. Page one of the notice specifies in the SMA Approval Type field that the individual is in an ICO, meets Nursing Facility Level of Care Determination, and is in the community (formerly LOC 03 now ICO-HCBS or ICO-HOSW).

MDHHS LOCAL OFFICE RESPONSIBILITIES

The local MDHHS office is responsible for completing an initial asset assessment and determining MA eligibility for potential Waiver participants.

Waiver Participant Defined

A Waiver participant is a person who is approved to receive or receives Waiver services based on medical and functional and financial eligibility.

Waiver Month Defined

A waiver month is a calendar month containing at least one day that the participant is (or was) receiving Waiver services. ICOs enter Waiver enrollment into CHAMPS for either the current or the following month, dependent on service start date. The enrollment would be effective the first of the month.

For purposes of MA eligibility, a month remains a Waiver month even if the Waiver participant enters an LTC facility and/or hospital (L/H) in the same calendar month. A Waiver month does not become an L/H month; Example: A member is approved for the waiver and becomes a waiver participant in June. That same month, the member enters an LTC facility and/or hospital. June would still be considered a waiver month and not an L/H month because the member was approved for the waiver for at least one day of the calendar month. See Bridges Glossary for definitions of Waiver Month and L/H Month. NOTE: MHL HCBS Waiver months start on the first day of the month and end on the last day of the month. There are no mid-month start dates or end dates other than upon admission or discharge to/from a Nursing Facility.

NONFINANCIAL ELIGIBILTY FACTORS

The eligibility factors in the following items must be met.

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Non-Citizen Status.
- BEM 255, Child Support.
- BEM 256, Spousal/Parental Support.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Use special MA policies in the MA eligibility determination:

- A waiver participant is a group of one even when he/she lives with a spouse; see BEM 211.

- The Special MA Asset Rules in BEM 402 apply when completing the *Initial Asset Assessment*; see special initial asset assessment rules for waiver applicants in this item for rules on determining the first period of continuous care.
- The extended-care category is available to waiver participants; see BEM 164.
- Gross income must be at or below 300 percent of the SSI Federal Benefit Rate. An individual cannot spenddown income to waiver eligibility; see BEM 500.

A waiver participant may no longer qualify for waiver services; however, they may still qualify for MA.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

Initial Asset Assessment for 1915 (C) Waiver Applicants

An Initial Asset Assessment (IAA) may be needed for potential Waiver participants with a spouse. The IAA is used to protect a certain amount of the couple's combined resources for the community spouse. It does not determine the start of Medicaid eligibility. Use policy in BEM 402 to determine if an IAA is appropriate.

An IAA uses a first day of continuous care; see BEM 402 for definition. The first period of continuous care is a period of at least 30-consecutive days where the institutionalized spouse/applicant has been or is expected to be:

- In a hospital and/or LTC facility; and/or
- Approved for the Waiver.

Note: The period is no longer continuous when none of the above is true for 30 or more consecutive days; see BEM 402 for examples. The first period or continuous care may have occurred in the past; however, the applicant must be currently receiving

services to complete an IAA. If there is no past period of continuous care, then the IAA date must start on the first day that meets the definition of continuous care in BEM 402.

Notices

MI Health Link waiver activities are performed by ICOs who meet the federal definition of administering the MA program. Therefore, you can share the following information with the ICO without a signed release from the participant:

- A copy of the DHS-3503, Verification Checklist.
- A copy of the DHS-4588, Initial Asset Assessment Notice.

The original DHS-3503, and DHS-4588 must be sent to the participant or the guardian, court or agency that is legally responsible for the participant.

Do not enter ICOs in Bridges as a third-party type. Only the participant's legal guardian, court or agency legally responsible for the participant can be entered as a third-party type.

HOSPICE SERVICES

In MI Health Link, HCBS Waiver participants may receive hospice services and Waiver services simultaneously. However, individuals with elected hospice services prior to enrolling in MI Health Link are ineligible for the program. If an existing MHL participant elects hospice services, the participant may remain enrolled in the demonstration and obtain the hospice service through the Medicare FFS benefit.

MI HEALTH LINK COVERED SERVICES

The MI Health Link program offers an array of services to dually eligible individuals enrolled in the program. Covered services include all health care services covered by Medicare and Medicaid:

- Dental and vision services.
- Diagnostic testing and lab services.
- Emergency and urgent care.
- Equipment and medical supplies.

- Home health services.
- Hospitalizations and surgeries.
- Medications (without co-payments).
- Nursing home services.
- Hospice (if elected while enrolled).
- Primary care and specialty services.
- Transportation for medical emergencies and medical appointments.
- Care Coordination.

Services for long-term supports and services include:

- Adult day program.
- Chore services.
- Community transition services.
- Equipment to help with activities of daily living.
- Fiscal intermediary services.
- Home delivered meals.
- Home modifications.
- Non-medical transportation.
- Nursing home care.
- Personal care.
- Personal Emergency Response System (PERS).
- Preventive nursing services.
- Private duty nursing.
- Respite.

Home and Community Based services available through the MHL 1915(c) Waiver include:

- Adaptive Medical Equipment and Supplies.
- Adult Day Program.
- Assistive Technology.
- Care Coordination.
- Chore Services.
- Environmental Modifications.
- Expanded Community Living Supports.
- Fiscal Intermediary.

- Home Delivered Meals.
- Non-Medical Transportation.
- Personal Emergency Response Systems (PERS).
- Preventative Nursing Services.
- Private Duty Nursing.
- Respite.

MI HEALTH LINK MDHHS LOCAL OFFICE RESPONSIBILITIES

Caseworkers must check for Medicare enrollment or eligibility at time of MA application and redetermination/renewal to avoid placement in Health Michigan Plan (HMP) when the individual could be eligible for MI Health Link through an ICO. At the time of MA application and redetermination/renewal, the caseworker should review the State Online Query (SOLQ) and Consolidated Inquiry to ensure the individual is not enrolled in Medicare. If the individual is enrolled in Medicare, they are not eligible for HMP, but may qualify for MI Health Link/ICO; see BAM 801, SSA Data Exchanges.

VERIFICATRION REQUIREMENTS

Home and Community based services listed in this item are used to determine the first day of continuous care for the IAA must be verified.

VERIFICATION SOURCES

Review SMA screen in Bridges for enrollment dates.

EXHIBIT I MHL INTEGRATED CARE ORGANIZATIONS

ICO Name	COUNTIES SERVED
Aetna Better Health of Michigan, Inc. 855-676-5772 www.AetnaBetterHealth.com/Michigan	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren (Region 4) Wayne (Region 7), Macomb (Region 9)
AmeriHealth Michigan, Inc. 888-667-0318 www.amerihealthcaritasvipcareplus.com	Wayne (Region 7) Macomb (Region 9)
HAP CareSource 833-230-2159 www.caresource.com/plans/mihealthlink	Wayne (Region 7) Macomb (Region 9)
Meridian Complete Health Plan 888-437-0606 www.mmp.mimeridian.com	Barry, Berrien, Branch, Calhoun, Cass, Kalamazoo, St. Joseph, Van Buren (Region 4) Wayne (Region 7) Macomb (Region 9)
Molina Healthcare, Inc. 855-735-5604 www.MolinaHealthcare.come/Duals	Wayne (Region 7) Macomb (Region 9)
Upper Peninsula Health Plan 877-349-9324 www.uphp.com/medicare	All counties in the Upper Peninsula (Region 1)

LEGAL

MA

Social Security Act, Section 1915
42 CFR Part 435.217, 441.350,.400

DEPARTMENT POLICY

MA Only

This is an SSI-related MA category. It is neither a Group 1 nor a Group 2 MA category. MA pays only the recipient's Medicare Part A premium.

A person eligible under this category is called a Qualified Disabled Working Individual (QDWI). A QDWI is a person who:

- Receives, or is eligible to enroll in, Medicare Part A under section 1818A of the Social Security Act, and
- Is **not** eligible for MA under any other category, and
- Meets the eligibility factors specified in this item.

All eligibility factors must be met in the calendar month being tested. BEM 546, Post-Eligibility Patient-Pay Amounts, does **not** apply.

INQUIRY

A person may wish to know whether MA will pay Medicare Part A premiums before enrolling. If the person is **not** an MA, FIP or SSI recipient, do a determination of QDWI eligibility. Advise the person whether he might be eligible. In doing this determination:

- Explain the nonfinancial eligibility factors. Assume they will be met.
- Determine financial eligibility using current information. Verification is **not** required.
- Explain that changes may affect the actual determination of eligibility. Be sure to discuss asset policies thoroughly if the person's current assets exceed the limit.

NONFINANCIAL ELIGIBILITY FACTORS

1. The person must receive or be eligible to enroll in Medicare Part A under section 1818A of the Social Security Act (Act). See **"1818A Identification"** below.

2. The MA eligibility factors in the following items must be met.

   - BEM 220, Residence.
   - BEM 223, Social Security Numbers.
   - BEM 265, Institutional Status.

3. The person must **not** be eligible for any other MA category.

   Presume a person eligible for Medicare Part A under section 1818A of the Social Security Act is **not** disabled for purposes of BEM 260 unless the person reports a change and claims he is again unable to perform a substantial gainful activity.

1818A Identification

BAM 810 describes eligibility factors for Medicare Part A under section 1818A of the Act. The Social Security Administration is responsible for determining eligibility for Medicare and authorizing Medicare coverage.

Assume a person who is eligible for Medicare Part A is eligible under section 1818A if he is:

- Under age 65, and
- Charged a premium for his Medicare Part A, Hospital Insurance.

  BENDEX, Wire Third Party and TPQY indicate whether a Medicare Part A, Hospital Insurance, premium is being charged.

Other sources of identification include correspondence from, or contact with, the Social Security Administration.

FINANCIAL ELIGIBILITY FACTORS

Groups

Use fiscal and asset group policies for SSI-related groups in BEM 211.

Assets

Countable assets **cannot** exceed the asset limit in BEM 400. Countable assets are determined based on the MA policies in BEM 400 and 401.

Divestment

Do **not** apply policy in BEM 405.

Income Eligibility

Income eligibility exists when net income does **not** exceed the income limit in RFT 246. Income eligibility **cannot** be established with a patient-pay amount or by spending-down.

Apply the MA policies in BEM 500, 530, 540 (for children) and 541 (for adults) to determine net income.

COVERAGE

The only MA benefit is payment of Medicare Part A premiums. The mi health card, is **not** issued.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories. See BAM 115 and 220.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

Verification of Medicare Part A eligibility and premium is required.

The following are accepted as verification of Medicare Part A or Hospital Insurance premiums being charged:

- SOLQ.
- Correspondence from SSA.
- Contact with SSA.

LEGAL BASE

MA

Social Security Act, Sections 1902(a)(10)(E), 1905(p)(3), 1905(s)

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

MA is available to a child who requires institutional care but can be cared for at home for less cost.

The child must be under age 18, unmarried and disabled. The income and assets of the child's parents are **not** considered when determining the child's eligibility.

Children's Special Health Care Services (CSHCS) and the local MDHHS office share responsibility for determining eligibility for Home Care Children. All eligibility factors must be met in the calendar month being tested.

NONFINANCIAL ELIGIBILITY FACTORS

CSHCS Responsibilities

CSHCS determines if medical eligibility exists. That is:

- The child requires a level of care provided in a medical institution (for example the hospital, skilled nursing facility or an intermediate care facility); and
- It is appropriate to provide such care for the child at home; and
- The estimated MA cost of caring for the child at home does **not** exceed the estimated MA cost for the child's care in a medical institution.

CSHCS also obtains necessary information to determine whether the child is disabled and forwards it to the Disability Determination Service DDS. If the criterion in BEM 260 are met, disability will be certified on a DHS-49-A, Medical-Social Eligibility Certification, by DDS.

Communication to the Local Office

If the child is disabled and requirements above are met, CSHCS sends a MSA-1785, Policy Decision, and the medical packet to the appropriate MDHHS local office. The MSA-1785 certifies that the medical requirements in **CSHCS Responsibilities** in this item are met.

CSHCS will also notify the MDHHS local office when this category can no longer be used for a child. Pursue eligibility for other MA categories when a child is no longer eligible for this category. A child determined medically eligible for this category does not need a determination of Medicaid eligibility under a MAGI category first.

Local Office Responsibilities

Do not authorize MA under this category without a MSA-1785 certifying medical eligibility for this category**. Use this category when the child is *not* an SSI or FIP recipient. Use this category before using a Group 2 category.**

If a MSA -1785 is received for a child who is **not** an MA applicant or recipient, treat the MSA -1785 as a request for assistance. Contact the child's parents concerning an MA application for the child.

Determine if the child meets the MA eligibility factors in the following items:

- BEM 220, Residence.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 270, Pursuit of Benefits.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

INQUIRIES

Inquiries from medical providers or parents concerning medical eligibility (requirements in **CSHCS Responsibilities** in this item) under this category should be directed to a nurse consultant at:

Michigan Department of Health and Human Services
Public Health Administration
Bureau of Family, Maternal & Child Health, Children's Special Health Care Services
Lewis Cass Building, 6th Floor
320 S. Walnut Street
Lansing, MI 48913
Phone: 1-800-359-3722

FINANCIAL ELIGIBILITY FACTORS

Financial eligibility is determined by the MDHHS local office. Only the child's own income and assets are counted. Do **not** deem income and assets from the child's parents to the child.

Groups

The child is a fiscal and asset group of one.

Assets

The child's countable assets cannot exceed the asset limit in BEM 400. Countable assets are determined based on MA policies in BEM 400 and BEM 401.

Divestment

Do **not** apply policy in BEM 405.

Income Eligibility

Apply the MA policies in BEM 500, 501, 502, 503, 504, and 530 to determine net income. Income eligibility exists when the child's net income is equal to or less than 100 percent of the SSI federal benefit rate; see RFT 248:

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

LEGAL BASE

MA

Tax Equity and Fiscal Responsibility Act of 1982 (P.L. 97-248), Section 134

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

MA is available to a child who requires care in an Intermediate Care Facility for Individuals with Intellectual Disability (ICF/ID), but can be cared for at home for less cost.

The child must be under age 18, unmarried and disabled.

Exception: Children medically approved by the Department of Community Health (DCH) before 10/1/96 must be under age 26.

The income and assets of the child's parents are **not** considered when determining the child's eligibility.

The DCH and MDHHS share responsibility for determining eligibility for the Children's Waiver. All eligibility factors must be met in the calendar month being tested.

NONFINANCIAL ELIGIBILITY FACTORS

DCH Responsibilities

DCH determines if medical eligibility exists. That is:

- The child requires a level of care provided in an ICF/ID, and
- It is appropriate to provide such care for the child at home, and
- The average estimated MA cost of caring for the child at home does **not** exceed the average estimated MA cost for the child's care in an ICF/ID.

Mental Health Services to Children and Families in DCH is responsible for the following at application and medical review:

- Obtaining medical evidence of the disability.
- Certifying disability on the DHS-49-A, Medical-Social Eligibility Certification.

DCH certifies that the requirements above are met on an MSA-1785, Policy Decision.

If the child is **not** receiving MA, DCH will send the family:

- A copy of the MSA-1785 and
- A DCH-1426 with the address of the local office to mail the completed application.

Communication to the Local Office

DCH will send the MSA-1785 and the DHS-49A to the local MDHHS office when:

- A child is an MA recipient, or
- A child is **not** an MA recipient. DCH will also notify the local MDHHS office when this category can no longer be used for a child. Pursue eligibility for other MA categories when a child is no longer eligible for this category.

Local Office Responsibilities

Do *not* authorize MA under this category without a DHS-49-A and MSA-1785 authorizing MA in this category. Use this category when the child is *not* an SSI or FIP recipient. Use this category before using a Group 2 category.

Treat the MSA-1785 as a request for assistance, if it is received for a child who is **not** an MA applicant or recipient.

Determine if the child meets the MA eligibility factors in the following items:

- BEM 220, Residence.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 260, MA Disability/Blindness.
- BEM 270, Pursuit of Benefits.

  Note: DCH is responsible for obtaining medical evidence and certifying disability on the DHS-49-A; see DCH Responsibilities.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case

closure. The review includes consideration of all MA categories; see Bridges Administrative Manual (BAM) 115 and 220.

INQUIRIES

Inquiries from medical providers or parents concerning medical eligibility (requirements (a) through (c) above) under this category should be directed to your local Community Mental Health Services Program, Developmental Disabilities Division.

FINANCIAL ELIGIBILITY FACTORS

Financial eligibility is determined by the MDHHS local office. **Count only the child's own income and assets.** Do **not** deem income and assets from the child's parents to the child.

Groups

The child is a fiscal and asset group of one.

Assets

The child's countable assets **cannot** exceed the asset limit in Bridges Eligibility Manual (BEM) 400. Countable assets are determined based on MA policies in BEM 400 and 401.

Divestment

Do not apply policy in BEM 405.

Income Eligibility

Income eligibility exists when the child's **gross** income is equal to or less than 300% of the federal SSI benefit rate; see RFT 248.

Gross income is the amount determined after applying the MA policies in BEM 500, 501, 502, 503, 504 and 530. Do not apply the deductions in BEM 540 and 541.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

LEGAL BASE

MA

Social Security Act, Section 1915 (c)

DEPARTMENT POLICY

Medicaid (MA) ONLY

This is an SSI-related Group 1 MA category.

MA is available to a child who meets the criteria for admission to a state psychiatric hospital and/or who are at risk of hospitalization without wavier services.

The child must be under age 18 when approved for the waiver, unmarried, a current patient in a psychiatric hospital or at risk of such placement; must demonstrate serious functional limitations that impair ability to function in the community; and must have a completed MichiCANS Comprehensive that indicates SED waiver eligibility and meets Medicaid Provider manual eligibility criteria as determined by the local Community Mental Health Services Program (CMHSP). If a child on the SEDW turns 18, continues to meet all non-age-related eligibility criteria (see below in this item), and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.

The income and assets of the child's parents are not considered when determining the child's eligibility.

The Bureau of Children's Coordinated Health Policy and Supports (BCCHPS) and local MDHHS office share responsibility for determining eligibility for the SED Waiver. BCCHPS, in cooperation with the local CMHSP, has responsibility for determining non-financial eligibility factors for the SED Waiver. Financial eligibility is determined by MDHHS.

All eligibility factors must be met in the calendar month being tested.

NONFINANCIAL ELIGIBILITY FACTORS

BHDDA Responsibilities

BCCHPS determines that clinical eligibility exists. That is:

- The child meets the criteria for admission to a state inpatient psychiatric hospital; and

- It is appropriate to provide such care for the child in the community; and
- The average estimated cost to Medicaid of caring for the child in the community does not exceed the average estimated cost to Medicaid for the child's care in the state psychiatric hospital.

Mental Health Services to Children and Families within BCCHPS is responsible for the following at application and medical review:

- Obtaining and reviewing clinical evidence of the child's serious emotional disturbance and functional limitations from the local CMHSP, and
- Certifying disability on the DHS-49-A, Medical-Social Eligibility Certification.

The Behavioral and Physical Health and Aging Services Administration (BPHASA) certifies on the MSA-1785, Policy Decision, that the requirements in **BCCHPS Responsibilities** in this item are met.

If the child is not receiving MA, BPHASA will send the family:

- A copy of the MSA-1785, and
- A DCH- 1426, Assistance Application, with the address of the local office to mail the completed application.

Communication to the Local Office

BPHASA will send the MSA-1785 and the DHS-49-A to the local MDHHS and CMHSP offices whether or not a child is an MA recipient. BPHASA will send a letter of termination when a child is no longer eligible for this category. Pursue eligibility for other MA categories when a child is no longer eligible for the waiver.

Local Office Responsibilities

Do not authorize MA under this category without a MSA-1785 and DHS-49-A authorizing MA in this category. Use this category when the child is not an SSI or FIP recipient. Use this category before using a Group 2 category.

Treat the receipt of the MSA-1785 as a request for assistance if it is received for a child who is not an MA applicant or recipient.

Determine if the child meets the MA eligibility factors in the following items:

- BEM 220, Residence.
- BEM 223, Social Security Numbers.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 260, MA Disability/Blindness.
- BEM 270, Pursuit of Benefits.

Note: The **State Hospital Administration (SHA)** is responsible for obtaining clinical evidence and for certifying disability on the DHS-49-A; **see BCCHPS Responsibilities in this item.**

If a child on the SEDW turns 18 and continues to meet all the non-age related eligibility criteria, and continues to need waiver services, the child can remain on the waiver up to their 21st birthday.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

INQUIRIES

Inquiries from medical providers or parents concerning clinical eligibility under this category should be directed to the local CMHSP.

FINANCIAL ELIGIBILITY FACTORS

Financial eligibility is determined by the local office. **Count only the child's own income and assets.** Do not deem income and assets from the child's parents to the child.

Groups

The child is a fiscal and asset group of one.

Assets

The child's countable assets cannot exceed the asset limit in BEM 400. Countable assets are determined based on MA policies in BEM 400 and 401.

Divestment

Do not apply policy in BEM 405.

Income Eligibility

Income eligibility exists when the child's gross income is equal to or less than 300 percent of the federal SSI benefit rate, see RFT 248.

Gross income is the amount determined after applying MA policies in BEM 500 and 530. Do not apply the deductions in BEM 540 and 541.

VERIFICATION REQUIREMENTS

Verification requirements for all eligibility factors are in the appropriate manual items.

LEGAL BASE

MA

Social Security Act, Section 1915 (c)

DEPARTMENT POLICY

MA

The Breast and Cervical Cancer Prevention and Treatment Program (BCCPTP) is a Group 1 Medicaid category for women.

The Department of Health Health and Human Services/ Medical Services Administration (MSA)is responsible for establishing Medicaid under this category.

This category is **not** included on the priority lists in BEM 105 because MDHHS does **not** determine eligibility.

Eligibility is related to screening through a health department program called the Breast and Cervical Cancer Control Program.

Breast and Cervical Cancer Control Program

The Breast and Cervical Cancer Control Program is a health department program.The program may be more commonly known as the breast and cervical screening program. People seeking screening should refer to the name Breast and Cervical Cancer Control Program or the Breast and Cervical Screening Program.

Do not use the Medicaid category name to refer to the health department program, even though this program provides complete Medicaid coverage to the client.

Not all local heath departments participate and there are sites enrolled in the program that are **not** local health departments.

A woman may request screening from a participating agency if her local health department does **not** participate.

More information about the health department program through the MDHHS website. Use the link on the MDHHS Authorized Internet Sites on the MDHHS-Net, or:

- Go to www.michigan.gov/mdch.
- Type bcccp in the Search box.
- That will give you a link to the BCCCP page. Scroll down on that page for a link to the agency list.

The health department program has its own financial test for BCCCP. Income **cannot** exceed 250 percent of the federal poverty level. However, that determination is **not** an MDHHS responsibility.

BCCPTP APPLICATION AND ELIGIBILITY DETERMINATION

A simplified application form (DCH-1088, Medicaid Breast and Cervical Cancer Prevention and Treatment Program) has been created for this Medicaid category. It will be completed by a health department program coordinator or case manager and sent to MSA. MSA will register the application.

MSA will determine Medicaid eligibility for this Medicaid category at application (including any retro Medicaid eligibility), redetermination and when a change is reported.

BCCPTP is the only Medicaid category considered when the DCH-1088 is used.

BCCPTP AND OTHER MEDICAL ASSISTANCE

A woman who is already receiving Medicaid will **not** be approved for BCCPTP.

If a woman receiving BCCPTP is found eligible for FIP, notify MSA by calling the BCCPTP coordinator, Michele Barton at 517- 241-8164.

If a woman found eligible under BCCPTP is in Medicaid deductible status, MSA will end the Medicaid deductible status, open BCCPTP and notify the local office.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte reivew should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all Medicaid categories; see BAM 115 and 220.

BCCPTP REPORTS RECEIVED AT LOCAL OFFICE

The MDHHS local office in the county of residence will receive system generated reports (example, RD-093) which include BCCPTP recipients. The local office may also happen to receive change of address information for these recipients (example, woman is also receiving Food Assistance Program).

Send reports (or copies) for unit 78/specialist 88 and address changes to MSA.

Department of Health and Human Services
BCCPTP Coordinator
P.O. Box 30479
Lansing, MI 48909-7979

Telephone: 517- 241-8164

Fax: 517- 373-9305

BCCPTP HEARINGS

All hearing requests for BCCPTP applicants and recipients will be handled by MSA. If received by MDHHS, such hearing requests must be faxed, then mailed, to MSA's Administrative Tribunal; see Role of MDHHS Staff in BAM 600,Hearings.

BCCPTP NONFINANCIAL ELIGIBILITY FACTORS

MSA determines eligibility.

The person must:

- Be female, and
- Be age 18 through 64, and
- Have been screened for breast or cervical cancer under the Centers for Disease Control and Prevention's Breast and Cervical Cancer Early Detection program established under Title XV of the Public Health Services Act, and

Note: This is a health department program called the Breast and Cervical Cancer Control Program.

- Have been diagnosed with breast or cervical cancer or a precancerous condition through that health department screening program, and

  Note: A finding by a woman's doctor that she has breast or cervical cancer is not a substitute for a diagnosis through the screening program.

- **Not** have credible health insurance coverage [as the term is used under 42 U.S.C. 300gg(c)] that covers breast or cervical cancer or precancerous conditions.

  Examples of credible health insurance are Medicare, Armed Forces insurance, group health plan, state health risk pool, medical care under a hospital or medical services policy or certificate, hospital or medical service plan or contract, and health maintenance organization contract.

  Being in MA deductible status is not credible coverage. However, someone already receiving MA (coverage F or E) is **not** eligible under the BCCPTP category.

  A woman who has Medicare **cannot** receive MA under BCCPTP because Medicare is credible health insurance. Therefore, a woman eligible under BEM 165, Medicare Savings Programs, **cannot** be BCCPTP eligible.

The woman must also meet the eligibility requirements in the following items:

- BEM 220, Residence.
- BEM 221, Identity.
- BEM 223, Social Security Number.
- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.

FINANCIAL ELIGIBILITY FACTORS

There are no financial eligibility factors for the BCCPTP Medicaid category.

Note: There is a financial test for the health department's Breast and Cervical Cancer Control Program. Income cannot exceed 250 percent of the federal poverty level. However, that determination is not an MDHHS responsibility.

LEGAL BASE

Social Security Act, Sections 1902(a)(10)(ii)(XVIII) and 1902(aa)
DCH Appropriations Act.
Deficit Reduction Act 2005, Social Security Act 1903 (x), PL 109-171

DEPARTMENT POLICY

MA Only

This is an SSI-related Group 1 MA category.

FTW is available to a client with disabilities age 16 through 64 who has earned income.

Eligibility begins the first day of the calendar month in which all eligibility criteria are met. All eligibility factors must be met in the calendar month being tested.

Note: SSI recipients whose SSI eligibility has ended due to financial factors are among those who should be considered for this program.

NON-FINANCIAL ELIGIBILITY FACTORS

1. The client must be disabled according to the disability standards of the Social Security Administration, except employment, earnings, and substantial gainful activity (SGA) cannot be considered in the disability determination.

   Note: FTW applicants who do not already have a disability established with Social Security Administration require a disability determination from Disability Determination Service (DDS). The medical packet must clearly indicate the client is applying for FTW by checking the other Program box and writing “Freedom to Work” or “FTW”on the cover sheet.

2. The client must be employed. FTW coverage is retained when a participant is relocated due to employment.

   Note: A client may have temporary breaks in employment up to 24 months if the break is the result of an involuntary layoff or is determined to be medically necessary and retain FTW eligibility. Use client statements to verify.

3. The MA eligibility factors in the following items must be met:

   - BEM 220, Residence.
   - BEM 221, Identity.
   - BEM 223, Social Security Numbers.

- BEM 225, Citizenship/Alien Status.
- BEM 257, Third Party Resource Liability.
- BEM 265, Institutional Status.
- BEM 270, Pursuit of Benefits.

FINANCIAL ELIGIBILITY FACTORS

Groups

A client eligible under the FTW category is a fiscal and asset group of one.

Assets

Initial Eligibility

The asset limit for the initial eligibility determination is set to the Medicare Savings Program asset limit for an individual in that calendar year.

Ongoing Eligibility

Once eligibility for FTW is established, countable assets cannot exceed the asset limit for FTW in BEM 400.

Accumulated assets that are excluded (not countable) while the participant is enrolled in the FTW program will continue to be excluded if the beneficiary loses eligibility for the FTW program and has a determination of eligibility in another SSI-related Medicaid category.

Example: Additions made to a 401(k) account while the participant is working and in the FTW program are excluded from the ongoing FTW asset test and from the eligibility determination for any SSI related MA category such as AD Care, if eligibility for the FTW program is lost.

See BEM 400 for jointly owned assets.

Divestment

Do not apply policy in BEM 405.

Income Eligibility

Initial and Ongoing Eligibility

Initial income eligibility exists when the client's countable income does not exceed 250 percent of the Federal Poverty Level (FPL). Ongoing eligibility exists when the client's unearned income does not exceed 250 percent of the FPL

Determine countable earned and unearned income according to SSI-related MA policies in BEM 500, 501, 502, 503, 504, and 530. Determine income deductions using BEM 540 (for children) or 541 (for adults). Unemployment compensation benefits are not countable income for FTW.

PREMIUM PAYMENT

There are no premiums for individuals with MAGI (Modified Adjusted Gross Income) income less than 138 percent of the federal poverty level (FPL).

- A premium of 2.5 percent of their income will be charged for an individual with MAGI income between 138 percent of the FPL and $75,000 annually.
- A premium of 100 percent of the average FTW participant cost will be assessed for an enrolled individual with MAGI income over $75,000.

Bridges will automatically notify the premium coordinator when premiums for a FTW participant start/change/end. The premium coordinator has final determination over actual premium begin or amount change dates, as well as premium exclusions.

Nonpayment of premium is automatically sent to Bridges and mass update will close the Freedom to Work category.

Note: An ex parte review (see glossary) is required before Medicaid closures when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

MEDICARE SAVINGS PROGRAM (MSP)

MSP and FTW have different group composition, income and asset limits. A separate determination must be done when there is a spouse.

Reminder: A client eligible for MA under FTW is not eligible for ALMB.

LEGAL BASE

MA

Title XIX of the Social Security Act
Public Act 32 of 2003
Public Act 518 of 2014

PHILOSOPHY OF FIP PROGRAM

FIP

The department goal is to assist families towards self-sufficiency. Self-sufficiency is best accomplished by:

- Adults being employed,
- Securing court-ordered child support for each child where appropriate,
- Providing life skills training for those needing it including minor and teen parents, and
- Ensuring that all children have access to medical care.

As families become self-sufficient, we will meet the legal mandates such as work participation rates, reducing subsequent out of wed-lock pregnancies, ensuring that teens are completing secondary education, and ensuring that minor parents are living in appropriate settings.

Role of the FIS

The Family Independence Specialist (FIS) uses a Strength Based Solution Focused Approach and will:

- Identify goals with the client and develop plans for self-sufficiency, expressed in the client's own words, when possible. This will occur through the interactive solution focused process. When setting goals with the client, keep in mind that the goals should be clear, simple, specific, measurable, realistic, positive and important to the client. Clients must see their role in these goals for themselves to change concrete behavior. Monitor progress toward meeting the goals identified in the Family Self Sufficiency Plan (FSSP).
- Modify or add to the plan, when there is a change in circumstances; or upon discovery of a challenge or concern.
- Determine eligibility for financial and medical programs.
- Identify and or authorize support services to help families carry out their plan.

- Provide direct services such as counseling and problem solving when needed. This is especially helpful for clients who are in noncompliance.
- Identify resources and initiate referrals for community services, including employment and training, and domestic violence counseling.
- Explore options and authorize child care.

Case managers should focus on building a trusting relationship with families using the solution-focused interviewing skills. This is best accomplished by doing an interview. Building trust requires accepting clients for who they are, and understanding they are key in identifying their own needs and strengths in moving toward self-sufficiency. Case managers will help clients discover their needs and build on their strengths, recognizing that open and frequent communication is necessary to build the family's trust.

Use all available means in facilitating communications and trust. Such contact and communication are effective in developing and monitoring plans/contracts while reducing negative consequences. However, consequences will be used to reinforce the concept that clients are responsible for their own lives. Whenever possible, discretion has been left to staff to work with families. Discretion includes the frequency and types of contact beyond mandatory client contacts.

As the relationship with the client begins to build, the client may begin to disclose other barriers to self-sufficiency, such as domestic violence. The Michigan Department of Health and Human Services (MDHHS) believes all individuals have a right to be safe from violence. Domestic violence is a critical issue for many people. Victims of domestic violence need services that enhance their safety and self-sufficiency.

If there is a disclosure of domestic violence, and the client is not receiving services, the FIS must refer the family to the appropriate community services. Determine if domestic violence presents a barrier to cooperation with agency requirements, such as pursuit of child support (BEM 255), participation in employment and training activities (BEM 230A), and third-party liability (BEM 257).

Interviews

Interviews provide the best opportunity to interact with a client. Interviews help establish a trusting relationship which will open the door to an increased level of participation and willingness to discuss the family concerns.

While doing the interview, you can celebrate successes and identify challenges the family faces. Review and monitor the FSSP goals and activities and help the clients make a plan for removing any obstacles they perceive.

Topics for Discussion

When talking with a client, there are numerous topics for you to discuss, such as:

- The successes each adult has had since the previous contact for example, a plan for employment and, if they are employed, what progress have they made toward a raise, promotion, increased hours, or the results of any evaluations? This discussion will also give you an opportunity to make sure the correct earned income is in the benefit budgets.
- Any concerns or challenges that have come up which slowed down or hindered the family's movement to self-sufficiency. To meet those challenges, develop a plan. Compliment the family on any successes they had in dealing with the challenges or concerns. If a challenge or concern continues to exist, discuss and create a plan using the Solution Focused Approach to help the family meet these challenges.
- Discuss goals that the adults have for themselves which they believe will lead to self-sufficiency, what steps they need to take to achieve these goals, and how confident and motivated they are in achieving these goals (scaling questions).
- Involve the family in a discussion of the children and the importance of education. Ask the adult and the children, if present, how each child is doing in school, what their interests are and what extra-curricular activities they are participating in. Together with the family, talk about resources or opportunities for the children in their areas of interest.

This discussion will provide an opportunity for you to provide positive feedback and compliments. It will increase participation and involve the entire family in the plan to support each other. Inform them of the Tuition Incentive Program and other educational opportunities that are available for children to attend college if applicable.

- Ask what personal and community resources they know of that may be available to help the family remove their challenges and concerns, meet their goals, and move toward self-sufficiency. If the client does not know about community resources, help them develop a plan that will teach them to find these resources.

- Discuss child care arrangements that the parent has made for care of the children while the parent is employed, child care arrangements during school breaks, and back-up plans for child care if the provider is ill or otherwise unable to care for the children.

- Explain the Federal Earned Income Tax Credit and how receiving this credit throughout the year can increase monthly income. Help them find out how to apply for the credit.

- Discuss how to access the advanced education and training opportunities that are available for persons meeting the participation requirements.

- Discuss support services that are available while persons are participating in employment-related activities.

- Discuss the children and their adjustment to having the parent employed or otherwise out of the home and participating in employment-related activities.

- The children and their relationship to a stepparent or other adult living in the home can also be a topic of discussion and planning with the parent.

- Let clients know there are family and/or community support groups that are available in cases of emergencies.

For ineligible grantee cases, the focus of the interview should be a discussion about the children and resources that may be available to the family and/or the ineligible grantee, for example,

support groups that are available to grandparents who are raising grandchildren.

In absent parent situations, discuss the importance of parenting time and the involvement of both parents in a child's life. Discuss the relationship between the absent parent and child. Include steps in the plan to make it better. This discussion is also important for ineligible grantee cases. Does the child visit the parent? Are there custody issues? Is the relative interested in securing guardianship of the child, if appropriate?

In all interviews, including ineligible grantee situations, be alert to key indicators that signal problems in the home which may indicate a need for preventive services or require intervention by protective services. Be alert to situations of domestic violence, substance abuse by any family member, and behavioral problems of children or conflicts between family members.

Ask for the client's explanation of events but if you believe that the home environment requires preventive or protective services involvement, a referral must be made.

DEPARTMENT PHILOSOPHY

Minor parents and their children should live under adult supervision to ensure that they are in a safe, nurturing environment. Adult parents should act as the caretakers of their minor children and provide maintenance, physical care, and guidance, even after a minor child has become a parent. When living with a parent, stepparent, or legal guardian is not possible, the minor parent and child should live in another adult-supervised living arrangement.

DEPARTMENT POLICY

FIP

All minor parents must live in an adult-supervised living arrangement as a condition of eligibility. A minor parent and the dependent child in his or her care must live with the minor parent's parent, stepparent, or legal guardian or have good cause to live elsewhere. A minor parent who has good cause for not living with a parent, stepparent, or legal guardian must live in an acceptable adult-supervised living arrangement.

A minor parent living in a parent's or stepparent's home may not receive assistance on his/her own behalf, but must be treated as the dependent child of the parent or stepparent. A minor parent living in an adult relative's or legal guardian's home must be included as a dependent child in the relative's/legal guardian's group if the relative/legal guardian also receives benefits under the Family Independence Program (FIP); see BEM 210, Multi-Generation and Combined Groups.

DEFINITIONS

Minor Parent: a person under age 18 who is not emancipated and is either the parent of a dependent child living with him/her or is pregnant.

A person under age 18 is emancipated if:

- Ever validly married.
- Emancipated by court order.
- On active duty with the Armed Forces of the United States.

Acceptable Adult-Supervised Living Arrangement: a Michigan Department of Health and Human Services (MDHHS) -approved

living arrangement, other than the home of the parent, stepparent, or legal guardian, in which the minor parent and child live with an adult who acts as a parent to the minor parent. See Acceptable Living Arrangements in this item for specific criteria.

Adult Relative: a person age 18 or over who is related to the minor parent as grandparent (including great and great-great), aunt or uncle (including great and great-great), sibling or stepsibling, nephew or niece, first cousin, first cousin once removed, or the parent of the putative (alleged) father.

Supervising Adult: a person who accepts responsibility for the supervision of a minor parent, and is an adult relative of the minor parent or is an unrelated person age 21 or over.

INFORMING CLIENTS

When a minor parent applies for assistance, inform them of all of the following:

- The requirement to live under adult supervision.
- The circumstances under which there is good cause for permitting the minor parent to live in an adult-supervised setting other than the home of a parent, stepparent, or legal guardian.
- The requirement to attend school if the minor parent has not completed high school.

When a minor parent who is not living with a parent, stepparent, or legal guardian applies for assistance, inform him/her that MDHHS will determine good cause. Do not approve assistance, except for MA and FAP.

REFERRALS

Record information about the minor parent's circumstances in Bridges.

Bridges will generate a task/reminder when a CPS referral is needed. See the Administrative Policy Manual Human Resources (APR) - Mandated Reporters Child, for information regarding how to report suspected child abuse and neglect.

Protective Services Complaint

A complaint to Children's Protective Services (CPS) is required if any of the following are true:

- There is reason to suspect that either the minor parent or the child is endangered, abused, or neglected.
- The financial needs, safety, and security of the minor parent and child cannot be assured during the period of eligibility determination for FIP.
- The minor parent became pregnant when she was under the age of 12.
- The parent, stepparent, or legal guardian will not allow the minor parent to live in his/her home.

Law Enforcement

A referral to local law enforcement is required if:

The minor parent became pregnant when she was between the ages of 12 and 16. The purpose of this referral is so local law enforcement can determine if the situation should be investigated or referred to the prosecuting attorney if the minor parent is a victim of criminal sexual conduct. Local offices must develop guidelines for such referrals with the local prosecuting attorney. Use the DHS-1266, Law Enforcement Referral, form to initiate this referral.

Minor Parent Coordinator

Local offices must designate a minor parent coordinator to coordinate the delivery of services to minor parents. Refer all minor parents who refuse to comply with the requirements of this policy or withdraw their request for assistance to the minor parent coordinator. The department offers services to minor parents whether eligible for assistance benefits or not.

GOOD CAUSE REASONS - LIVING ARRANGEMENT

The good cause reasons for not requiring a minor parent and his/her child to live with a parent, stepparent, or legal guardian are:

- The minor parent is living with another adult relative with parental consent.
- The minor parent has no living parent, stepparent, or legal guardian whose whereabouts is known. At a minimum, do a Bridges Individual Inquiry on the parent's/stepparent's/legal guardian's name(s) to attempt to locate them.
- The parent, stepparent, or legal guardian will not allow the minor parent to live in his/her home. A CPS complaint is required because of neglect. Do not delay other actions or the eligibility determination awaiting the CPS determination.
- The physical or emotional health or safety of the minor parent or dependent child would be jeopardized if they lived with the minor parent's parent, stepparent, or legal guardian because:
  - An investigated CPS complaint (confirmed or unconfirmed) indicates that the minor parent or other children in the household did not receive adequate food, clothing, medical care or other necessities or were physically, emotionally, or sexually abused. An unconfirmed complaint must have indicated that there was risk to the children although the allegations could not be substantiated.
  - The return of the minor parent and child to the parent's, stepparent's, or legal guardian's home would result in violation of the terms of a lease or violation of local health or safety standards.
  - Law enforcement officers have verbally verified that there is probable cause to believe that the home of the parent, stepparent, or legal guardian is the scene of illegal activity.
- The minor parent is participating in a licensed substance abuse treatment program which would no longer be available if he/she returned to the parent's, stepparent's or legal guardian's home.

- The minor parent's parent, stepparent or legal guardian lives in another state.

Reevaluate good cause if it is discovered that circumstances regarding the good cause reason have changed.

Local Office Exception

The local office director may grant an exception to this policy and allow the minor parent to live independently when all of the following are true:

- Attending school full-time.
- Participating in a MDHHS or Teen Parent services plan.
- Moving would require the minor parent to change schools.
- The independent living arrangement will provide adequate structure and safety for the minor parent and child.

Follow local office procedure for requesting such exceptions. Local offices must maintain a record of these exceptions for annual reporting to the legislature.

DETERMINING GOOD CAUSE - LIVING ARRANGEMENT

The standard of promptness is 30 calendar days to determine if the minor parent has good cause for not living in the home of the parent, stepparent, or legal guardian. The client must move into the home of the parent, stepparent, or legal guardian unless he/she has good cause for refusing. Document good cause determinations in the case record.

At local office discretion, determinations of good cause and evaluations and supervision of acceptable living arrangements may be assigned to children's services staff instead of the specialist.

No Good Cause

If the minor parent does not have good cause, do all of the following:

- Record the fact that there is no good cause in Bridges.
- Run EDBC and certify the FIP denial in Bridges.

- Offer services to assist the minor parent to return home.
- Make a referral to a teen parent contractor or other community services to work with the minor parent, if appropriate.
- Make a referral to the local office minor parent coordinator if the client refuses to comply with the requirements.

Good Cause Granted

If the minor parent has good cause:

- Inform the minor parent that:
  - He/she must live in an adult-supervised living arrangement approved by the department.
  - The department will assist him/her in locating an acceptable adult-supervised arrangement if necessary.
  - FIP cannot be opened until the minor parent is living in an acceptable adult-supervised living arrangement.
- Determine if the minor parent's current living arrangement is acceptable.
- Help the minor parent to select an acceptable living arrangement, if necessary.

Minor parents age 16 and over have primary responsibility for finding and selecting an acceptable adult-supervised living arrangement. Assist the minor parent if necessary.

Notify your area service center if the minor parent, with the department's assistance, is unable to locate an acceptable adult-supervised living arrangement within 30 calendar days.

ACCEPTABLE LIVING ARRANGEMENTS

A minor parent cannot live with the child's other parent, regardless of the other parent's age, unless both reside in an acceptable adult-supervised living arrangement. The child's adult parent may not function as the supervising adult to the minor parent.

Acceptable adult-supervised living arrangements are:

- The home of an adult relative.
- The home of an unrelated adult age 21 or over. These arrangements include private homes and cooperative and congregate living facilities.
- A licensed foster family home or foster family group home.

  Supervision of a minor parent in family foster care may be purchased from a licensed private child placing agency.
- A child welfare-licensed residential facility.

If placement in a foster home or residential facility is selected, a DHS-3813, Voluntary Placement Agreement, must be signed by the minor parent's parent or legal guardian. If the only acceptable living arrangement is in a foster home or residential facility and if the parent/legal guardian refuses to sign an agreement, make a referral to CPS for a petition for court jurisdiction.

DETERMINING ACCEPTABLE LIVING ARRANGEMENT

Determine if the minor parent's living arrangement is acceptable. The living arrangement must be one of those described in **ACCEPTABLE LIVING ARRANGEMENTS** in this item and must do all of the following:

- Support the minor parent's efforts to complete a high school education or participate in employment and training opportunities.
- Support the minor parent's efforts to learn parenting skills and enhance decision-making skills.
- Provide a safe environment which supports the minor parent's responsibilities to provide food, clothing, and medical care to the child.

Use the guidelines under **Safety Assessment** and **Supportive Environment Assessment** in this item to determine if the living arrangement meets the above criteria.

Safety Assessment

The living arrangement must not include individuals (other than parents, stepparents, or legal guardians when reunification is appropriate) who are listed as perpetrators on the CPS Central Registry. Request a check of all individuals over age 18 in the home against the CPS Central Registry.

If it is suspected at any time that either the minor parent or the child is endangered, abused, or neglected, make an immediate referral to CPS. Some indications that a CPS referral should be made are:

- The child or minor parent has marks or bruises which appear suspicious.
- The child is fearful of the parent or other people living in or having access to the home.
- The living conditions are hazardous or present a public health threat.
- The minor parent or child appear malnourished.
- The minor parent or another person living in or having access to the home exhibits violent behavior.
- The minor parent describes or acts toward the child in predominately negative terms or has unrealistic expectations, or the supervising adult or another person in the household exhibits similar behavior to the minor parent.
- Family members or household members refuse access to the minor parent or child, or there is reason to believe that the minor parent is about to flee, or the minor parent's child's whereabouts cannot be ascertained.
- The minor parent is unwilling or unable to meet his/her own or the child's needs for food, clothing, shelter, or medical care.
- The minor parent's use of alcohol or drugs seriously affects his/her ability to supervise, protect, or care for the child.
- The minor parent fails to protect himself/herself or the child from physical harm or threatened physical harm, neglect, or sexual abuse by other family or household members or others having access to the child.

- The minor parent does not provide the supervision needed to protect the child from potential harm:
  - The minor parent does not attend to the child to the extent that the child's need for care goes unnoticed or unmet (for example, allows the child to wander outdoors alone, play with dangerous objects, or be exposed to other serious hazards).
  - The minor parent leaves the child alone in the home.
  - The minor parent makes inadequate/inappropriate child care arrangements or demonstrates very poor planning for the child's care.
- The minor parent has experienced incidents of domestic violence.

Supportive Environment Assessment

Determine if the living arrangement is a supportive environment for the minor parent. A supportive environment is one in which:

- The minor parent has a support person, such as the supervising adult, family members, neighbors, or other people in the community who are available to support and help the minor parent.
- The supervising adult discusses issues of concern with the minor parent and solutions are identified and pursued.
- The supervising adult does not take over parenting of the minor parent's child but demonstrates and discusses appropriate parenting techniques and skills.
- The supervising adult establishes reasonable house rules regarding visitors, curfews, phone usage, and care of the minor parent's child.
- The supervising adult is available to the minor parent when the minor parent experiences a problem.
- The minor parent has child care and transportation resources to enable attendance at school or work.

RESPONSIBILITIES OF THE SUPERVISING ADULT

By agreeing to be the supervising adult, a person assumes certain responsibilities. These must be explained to and accepted by the supervising adult. These responsibilities include:

- The supervising adult agrees to be the protective payee of the minor parent's FIP grant. As protective payee, the supervising adult must manage the minor parent's grant and help the minor parent learn to manage money.
- The supervising adult agrees to report any suspicion of abuse or neglect of the minor parent or his/her child to CPS.
- The supervising adult agrees to assist and facilitate the minor parent's school attendance and participation in other activities required by MDHHS. At a minimum, the supervising adult will not place any expectations on the minor parent which will impede attendance at school or negatively affect the minor parent's ability to care for his/her child.
- The supervising adult must acknowledge that the MDHHS is not responsible for any payments or expenses beyond those specifically included in the minor parent's FIP grant.
- The supervising adult has the authority and responsibility to set reasonable house rules regarding visitors, curfews, phone usage, and other issues necessary to maintain a safe and stable home. If the minor parent refuses to comply with the rules or if other disputes arise, the supervising adult or the minor parent may request the intervention of the specialist. If they are unable to resolve the issue, the supervising adult may request the minor parent to move to another appropriate setting.
- The supervising adult is not responsible for providing child care. The minor parent may be eligible for child care payments according to policies of the Child Development and Care program.

Obtain a signed, written agreement specifying the responsibilities and expectations for the minor parent, the supervising adult, and the department.

PAYMENTS

The minor parent's FIP grant must be paid to a protective payee. The supervising adult should be the protective payee; see BAM 420.

SCHOOL ATTENDANCE

As a condition of eligibility, a minor parent must attend high school full-time. See BEM 245 for the definition of high school and full-time.

Minor parents who have graduated from high school must participate in Partnership. Accountability. Training. Hope. (PATH).

Failure to meet the above requirements causes ineligibility for the minor parent and his/her child. This requirement applies to all minor parents, including those who are living with a parent, stepparent, legal guardian, or other adult relative and are not the grantee.

If an applicant minor parent will not agree to attend school deny or close the FIP Eligibility Determination Group (EDG). A minor parent whose FIP is closed for this reason must reapply and enroll in school before assistance can be granted; see BEM 245, Regaining FIP Eligibility After Previously Failing Student Enrollment/Attendance Requirement.

VERIFICATION REQUIREMENTS

Verify good cause for living arrangement reasons as needed.

Verify school enrollment and attendance at application, redetermination, and at each birthday.

VERIFICATION SOURCES

- DHS-3380, Verification of Student Information.
- Telephone contact with the school.

School Attendance

See BEM 245.

LEGAL BASE

FIP

42 USC 608(a)(4)
42 USC 608(a)(5)
MCL 380.10
MCL 380.1561
MCL 400.57 et seq.
Mich Admin Code, R400.3112
45 CFR 233.107

DEPARTMENT POLICY

FIP Only

Each eligible child under age six must receive all immunizations recommended by the Michigan Department of Health and Human Services (MDHHS). The group is in compliance when immunizations have **begun** for all children subject to this requirement.

The group's payment standard is reduced by $25 for each month in which the following apply:

- One or more eligible children under age six are **not** immunized, **and**
- The group has no unresolved barriers to immunizations.

Consider a child to be age six for the full month in which he/she reaches age six.

Child Development and Care (CDC) Only

Each non-exempt, eligible child for whom CDC is requested must receive all immunizations recommended by the Michigan Department of Health and Human Services (MDHHS), as verified by self-certification. The child is in compliance when immunizations have **begun**.

Note: A licensed child care provider may require documentation related to immunizations, and may allow less time to comply with immunization requirements than the CDC program. These licensing requirements do not impact a child's eligibility for the CDC benefit. Clients (parents) should discuss these requirements with their licensed provider.

EXEMPTIONS

FIP and CDC

A child is exempt from the immunization requirement if:

- He/she is under two months of age.
- Immunizations are medically inappropriate for the child.
- Immunizations are contrary to the family's religious beliefs.

GRACE PERIOD

CDC Only

A child who has not met the immunization requirement will have a grace period that extends until the next eligibility determination. If the child fails to meet the immunization requirement at the next eligibility determination, the child will not be eligible to receive the CDC benefit.

IMMUNIZATION PENALTY

FIP Only

At redetermination, Bridges reduces the group's payment standard by $25 for each month in which:

- One or more non-exempt eligible children under age six are **not** immunized, **and**
- The group has no unresolved barriers to immunization.

The penalty is **not** initiated at case opening.

Related FAP

The unreduced FIP payment standard is budgeted in related FAP cases when an immunization penalty is imposed on the FIP group.

CDC Only

At redetermination, CDC eligibility will end for a child who does not meet the immunization requirement and did not meet the immunization requirement at or since the previous eligibility determination, according to the grantee’s self-certification.

At reapplication/member add, CDC will be denied for a child who does not meet the immunization requirement and did not meet the immunization requirement at or since the most recent application or redetermination eligibility period, according to the grantee’s self-certification.

A denial will only impact the child who has not met the requirement.

Compliance

FIP Only

The group is in compliance when immunizations have **begun** for all non-exempt children. When the group begins immunizations, enter the date the group begins as the *Circumstances Start Change Date* and *Cooperation Begin* D*ate* on the *Immunizations* screen. Do **not**:

- Wait until immunizations are complete, **or**
- Require written verification.

The group is in compliance for the whole month in which immunizations are begun. Bridges will remove the penalty and issue a supplement to affect the full month of compliance when the regular monthly issuance cannot be affected.

CDC Only

The child is in compliance when immunizations have **begun**. If the child begins immunizations after being out of compliance, enter the date the child begins as the *Circumstance Start Change Date* on the *Immunization* screen. Do **not** do either of the following:

- Wait until immunizations are complete.
- Require written verification.

Bridges will allow CDC eligibility to be approved for the child.

Assisting Clients

FIP Only

Assist clients to resolve problems which hinder compliance with the immunization requirement prior to imposing the penalty. This might include:

- Assistance with transportation; see BAM 825, **and**
- Referral to the group's health provider or to the local health department.

Document these efforts in the physical case record or in *Case Comments* on Bridges.

APPLICATION PROCEDURES

FIP Only

At application, do the following:

- Inform the FIP group with a non-exempt child under the age of six of the following:
  - Immunization requirement.
  - Penalty for failure to immunize, which might be initiated at redetermination.
- Review the information titled Immunize Your Children (FIP only) from the Cash Assistance section of the MDHHS-1171-INFO, Information Booklet, with the client to ensure full understanding of this requirement.
- Refer the group to its health provider or to the local Health Department for more information on immunizations, as needed.

CDC Only

At application, do the following:

- Inform the CDC client with a non-exempt child for whom CDC has been requested of the following:
  - Immunization requirement.
  - Penalty for failure to immunize, which might be initiated at redetermination.
- Refer the group to its health provider or to the local Health Department for more information on immunizations, as needed.

Reapplication

FIP Only

At reapplication, ask if a formerly penalized group is now willing to comply. The penalty continues at reopening if the:

- FIP EDG closed while being penalized, or because the penalty was initiated, **and**

- Group is unwilling to comply at reopening, **and**
- Group has no unresolved barriers to immunization.

CDC Only

At reapplication, CDC will be denied for a child who does not meet the immunization requirement and did not meet the immunization requirement at the most recent eligibility determination, according to the grantee's self-certification.

A denial will only impact the child who has not met the requirement.

REDETERMINATION PROCEDURES

FIP Only

At redetermination, ask the client if there are any children under age six who are not up-to-date on their immunizations (shots) in the FIP EDG. If any non-exempt eligible child is not up-to-date on immunizations, the group might be subject to the penalty.

Ask why the child has **not** been immunized. If a problem such as lack of transportation hinders compliance, do all of the following:

- Assist the client to resolve the problem through appropriate referrals or other actions.
- Document all actions in the physical case record or in *Case Comments* in Bridges.
- Follow up with the group at the next annual redetermination.

Do **not** enter a non-cooperation date on the *Immunizations - Details* screen in Bridges if a group has an unresolved problem that hinders compliance. If the client is uncertain whether immunizations are up to date for a child under six, treat that as a problem which hinders compliance. Refer the group to its health provider or to the local health department and document your actions in the physical case record or in C*ase* C*omments* in Bridges.

If the group is not cooperating, use the date the group became non-compliant as the *Circumstances Start/Change Date* and the *Non-Cooperation Date* on the Bridges *Immunization - Details screen*.

Bridges will give the group timely notice of this action and affect the next possible month. If imposing the penalty results in a grant amount under $10, the FIP EDG will close.

CDC Only

At redetermination, eligibility will end for a child who does not meet the immunization requirement and did not meet the immunization requirement within the previous grace period, according to the grantee's self-certification.

A denial will only impact the child who has not met the requirement.

VERIFICATION REQUIREMENTS

FIP and CDC

Accept the client's statement, or declaration on an application, redetermination or change document that one of the following applies:

- All children in the FIP group, or children(ren) for whom CDC has been requested, have met the immunization requirement.
- Immunizations are contrary to the family's religious beliefs.
- Immunizations are medically inappropriate for a child.

Use the client's response on the current or most recent application, redetermination, change document, or the client's verbal statement. Do **not** require written verification. Document verbal statements and resulting eligibility decisions in the case record or in *Case Comments* in Bridges.

Document all actions taken to assist the group with compliance prior to imposing the penalty in the case record or Case Comments in Bridges.

LEGAL BASE

FIP

42 USC 608(b)(2)(A)(ii)
MCL 400.57g
Mich Admin Code, R 400.3115

FAP

7 USC 2017(d)

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

POLICY

Family Independence Program (FIP), Refugee Cash Assistance (RCA) State Disability Assistance (SDA) and Food Assistance Program (FAP)

People who have been convicted of certain crimes and probation or parole violators are not eligible for assistance.

Policy to establish intentional program violations (IPV) disqualifications and overissuances is found in Bridges Administrative Manual (BAM) 700, Benefit Overissuances and BAM 720, Intentional Program Violation.

DUPLICATE RECEIPT OF ASSISTANCE

FIP

A person is disqualified for a period of 10 years beginning with the date of conviction if convicted in court of having made a fraudulent statement or representation regarding their residence in order to receive assistance simultaneously from two or more states under any of the following programs:

- State programs funded under Title IV-A of the Social Security Act (known as Temporary Assistance for Needy Families (TANF) in the Social Security Act; known as FIP in Michigan).
- Medical Assistance (MA), FAP, or Social Security Income (SSI).

FAP

A person is disqualified for a period of 10 years if found guilty through the administrative hearing process, convicted in court or by signing a repayment and disqualification agreement (such as a DHS-826, Request for Waiver of Disqualification Hearing, or DHS-830, Disqualification Consent Agreement,) of having made a fraudulent statement or representation regarding their identity or residence in order to receive multiple FAP benefits simultaneously.

PROBATION AND PAROLE VIOLATORS

FIP, RCA, SDA

A person who is violating a condition of probation or parole imposed under a federal or state law is disqualified.

The person is disqualified as long as the violation occurs.

A person is considered to be violating probation or parole if the Michigan Department of Health and Human Services (MDHHS) is made aware through a quarterly data match with the Michigan Department of Corrections that the individual is in violation of a condition of probation or parole imposed under federal or state law.

FAP

A person is disqualified because of a probation or parole violation if all the following conditions are met:

- MDHHS verifies with law enforcement, the courts or the MDOC that the individual is found to be violating a condition of probation or parole imposed under federal or state law.
- The individual is absconding from supervision; see BPG Glossary for definition of absconding.
- Federal, state, or local law enforcement, or Michigan Department of Corrections authorities are actively seeking the individual to enforce the conditions of the probation or parole.

Actively seeking means one of the following:

- A Federal State, or local law enforcement agency informs MDHHS that it intends to enforce an outstanding felony warrant or to arrest an individual for a probation or parole violation within 20 days of submitting a request for information about the individual to MDHHS.
- A Federal, State or local law enforcement agency presents a felony arrest warrant or to arrest an individual for a probation or parole violation within 20 days.
- A Federal, state, or local law enforcement agency states that it intends to arrest an individual for a probation or

parole violation within 30 days of the date of a request from MDHHS about a specific probation or parole violation.

If the law enforcement agency indicates it does intend to arrest the individual for the probation or parole violation within 20 days of the contact with MDHHS or 30 days of the date of the MDHH's request for information, MDHHS will postpone taking any action on the case until the appropriate 20 or 30-day period has expired.

Once the 20 or 30-day period has expired, MDHHS shall verify with the law enforcement agency whether it has attempted to arrest the probation or parole violator. If it has, MDHHS shall take appropriate action to deny an applicant or terminate an individual who has been determined to be a probation or parole violator. If the law enforcement agency has not taken any action within 20 or 30 days, MDHHS will not consider the individual a probation or parole violator.

The person is disqualified as long as the violation occurs and until the Michigan Department of Corrections notifies MDHHS the individual is no longer absconding or until Federal, State or local law enforcement is no longer actively seeking the individual.

Central office staff enters any disqualification.

FLEEING FELONS

FIP SDA and FAP

A fleeing felon is an individual who is intentionally fleeing to evade prosecution, custody, or confinement for a felony and is actively being pursued by federal, state or local law enforcement.

For FIP, SDA, and FAP purposes, an individual can only be considered a fleeing felon if they meet all of the criteria below and have been determined to be a fleeing felon by Office of Inspector General (OIG) and MDHHS central office review.

An individual's fleeing felon status must be evaluated only when the following occurs for an individual receiving or applying for FIP/SDA and/or FAP:

- A federal, state or local law enforcement officer acting in their official capacity, presents to MDHHS an outstanding felony arrest warrant that conforms to one of the following offense descriptors and/or their corresponding Uniform Offense

Classification Codes, as published by the National Crime Information Center, to obtain information on the location of and other information about the individual named in the warrant:
- Escape (4901);
- Flight to Avoid (prosecution, confinement, etc.) (4902); or
- Flight-Escape (4999).

If a felony warrant is presented, notify a supervisor, and send the following to: MDHHS-Policy-Criminal-Justice@michigan.gov:

- Local office requestor's name, telephone number and job title.
- Individual or geo group email address where a response should be sent.
- Law enforcement requestor's name, email, telephone number and job title and law enforcement agency (for example, ___ City Policy Department, ___ County Sheriff's Department).
- MDHHS case name and number.
- Name of individual who may be a fleeing felon.
- Above individual's ID, date of birth, race, sex and SSN.
- How the individual was reported to the department as a fleeing felon.
- Scanned copy of warrant.
- Written documentation that law enforcement:
  - Initiated the presentment of the warrant and
  - Requested location information regarding the individual.
- Date the felony warrant was presented to MDHHS.

MDHHS central office will log and forward to OIG to evaluate the individual's information and determine if they meet the department's definition of fleeing felon.

Benefits must be processed as normal during the evaluation period. Benefit determination must not be delayed while waiting for OIG's determination.

OIG Process

Referrals received from MDHHS central office will be loaded, processed, and tracked in MIGS.

The Enforcement Division manager will screen the referral and assign the status determination. The agent will review the warrant to verify if the warrant is a felony and whether it conforms to the above NCIC codes or comparable MCL. After confirming, the agent will verify that the individual on the warrant matches the individual in Bridges.

When both the felony warrant and individual are confirmed, OIG must contact the law enforcement agency to inquire whether law enforcement intends to enforce the warrant within 20 days of OIG's contact. If law enforcement intends to enforce the warrant, OIG will recontact after 20 days to determine whether or not the law enforcement agency has attempted to arrest the individual.

An individual is able to be disqualified as a fleeing felon if OIG is able to:

- Verify the individual is the person with the warrant.
- Verify that the law enforcement agency intends to enforce the warrant in the next 20 days from OIG's initial contact.
- Verify that law enforcement unsuccessfully attempted to enforce the warrant within 20 days from OIG's initial contact.
- Verify that the warrant is still outstanding after the 20 days from OIG's contact.
- Verify the warrant conforms to offense descriptors and/or their corresponding Uniform Offense Classification Codes, as published by the NCIC.

If OIG is unable to verify any of the items listed above, the individual cannot be disqualified as a fleeing felon.

After the above review, the OIG agent is to contact policy (MDHHS-Policy-Criminal-Justice@michigan.gov) indicating whether or not the individual is to be disqualified due to fleeing felon status.

Adding a Fleeing Felon Disqualification to Bridges

If the individual is not considered a fleeing felon, central office staff will update Bridges case comments and notify the local office via email.

If the individual is considered a fleeing felon, central office staff will complete a manual budget to remove the individual from the group, add an override, add case comments in Bridges, send the DHS-1605 to the group and notify the local office via email.

Removing a Fleeing Felon Disqualification

A fleeing felon disqualification must be removed at application, redetermination, or if the individual reports that the warrant is resolved or that law enforcement is no longer actively seeking them.

Removing a Fleeing Felon Disqualification from Bridges

At application, redetermination or reported change, immediately send the following to: MDHHS-Policy-Criminal-Justice@michigan.gov:

- Local office requestor's name, telephone number and job title.
- Individual or geo group email address where a response should be sent.
- Case name and number.
- Individual's name and individual ID that must have a fleeing felon disqualification removed.
- Reason for removal (application, redetermination or reported change).

Central Office staff will update Bridges, add case comments, and notify the local office via email of the disqualification removal.

Evaluating a Disqualification

When a group with a disqualified fleeing felon is receiving FAP and applies for FIP or SDA or is receiving FIP or SDA and applies for FAP, the fleeing felon disqualification must be reevaluated. Notify a supervisor, and send the following to: MDHHS-Policy-Criminal-Justice@michigan.gov:

- Local office requestor's name, telephone number and job title.
- Individual or geo group email address where a response should be sent.
- MDHHS case name and number.
- Name of individual who needs to be reevaluated for fleeing felon disqualification.
- Above individual's ID, date of birth, race, sex and SSN.
- Reason for reevaluation.

Releasing Information

Do not release information to law enforcement unless and until central office approves the release; see BAM 310, Confidentiality and Public Access to Case Records.

INTENTIONAL PROGRAM VIOLATION

FIP and FAP

A person is disqualified from receiving benefits for the duration of their penalty period when any of the following have occurred:

- An administrative hearing decision has determined the person was found to have committed an IPV.
- A disqualification agreement has been signed agreeing to an IPV disqualification.
- A court decision has found the person to be guilty of an IPV.

See, BAM 700, Benefit Overissuances and BAM 720, Intentional Program Violation, for definitions (including trafficking) and for standard and non-standard disqualification penalty periods.

LEGAL BASE

FIP

42 USC 608 (a)(8) and (9)
PA 280 of 1939, as amended
PA 109 of 1997

21 USC 862a(1)
Section 619 of the Michigan Appropriations Act

SDA

MDHHS Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

FAP

Food and Nutrition Act of 2008, as amended
PA 294 of 1998, sect. 621
7 CFR 273.11 (c)(1), (n)(1), (2) and (3)
21 USC 862a(1)
Section 619 of the Michigan Appropriations Act

DEPARTMENT POLICY

CDC

Group composition is the determination of which persons living together are included in the Child Development and Care (CDC) program group. Use the definitions in this item to determine CDC group composition.

DEFINITIONS

Program group means those persons living together whose income and assets must be counted in determining eligibility; see BEM 703, Eligibility Groups.

Living together means sharing a home except for temporary absences.

Temporary absence: A person's absence is temporary if:

- The person's location is known.
- The person plans to return.
- The person lived with the group before the absence.

  Note: A person in the U.S. Military whose absence exists solely due to military service is considered to be living in the home.

A temporarily absent person is considered to be living in the home.

See BEM 702 for required verifications.

DETERMINING THE PROGRAM GROUP

When CDC is requested for a child, each of the following persons who **live together** must be in the program group:

- Each child for whom care is requested.
- Each child's legal and/or biological parent(s) or stepparent.
- Each child's unmarried, under age 18, sibling(s), stepsiblings or half sibling(s).

- The parent(s) or stepparent of any of the above sibling(s).
- Any other unmarried child(ren) under age 18 whose parent, stepparent or legal guardian is a member of the program group.

Note: In some circumstances, when you determine who is in the program group, the applicant is not included; see **Applicant** in this item. For example, if a legal guardian requests care for a child, the legal guardian is not included in the program group if there are no other children for whom care is requested.

APPLICANT

The **applicant/client** is the person who signs the application and who serves as primary contact with the Michigan Department of Health and Human Services (MDHHS). This person must live with the child(ren) for whom care is requested, and be one of the following in relation to the child(ren) needing care:

- Parent, stepparent or foster parent of the child.
- Another related person acting as caretaker to the child.
- Legal guardian of the child.
- An unrelated adult who is at least age 21 and whose petition for legal guardianship of the child is pending.
- An unrelated adult with whom MDHHS Children's Services has placed a child, subsequent to a court order identifying MDHHS as responsible for the child's care and supervision.
- The FIP grantee for the child.

A minor parent (unmarried and under age 18) may be the applicant **only** if his/her parent or legal guardian does **not** live in the home. If the minor parent's parent or legal guardian lives in the home, he/she must be the applicant.

Exception: If the child needing care receives FIP, the FIP grantee must be the applicant.

When an application is received and it is determined that another CDC household member must be the applicant, send or give a new

application to that person. If the signed, completed application is returned within 10 calendar days of the date the specialist requested the new application, use the date of the original application as the receipt date. The original application must be filed and kept in the correct applicant's case record.

SHARED/JOINT CUSTODY

If a child's parents do not live together but have shared/joint custody of the child, authorize care only for the time periods when the parent who is applying has physical custody of the child.

The parent's statement of shared/joint custody is acceptable.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

DEPARTMENT POLICY

FIP, RCA and SDA

The Family Independence Program (FIP), Refugee Cash Assistance (RCA) and State Disability Assistance (SDA) are cash assistance programs designed to help individuals and families become self-sufficient.

When an individual applies for cash assistance, Bridges determines group composition and builds an eligibility determination group (EDG) for these programs in the following order: FIP, RCA and SDA. Cash assistance is available to eligibility determination groups who meet all of the non-financial and financial requirements that are needed to determine eligibility and calculate benefit amounts.

FIP GROUP COMPOSITION

In order to evaluate FIP eligibility, a FIP EDG must exist, based on the rules in BEM 210, FIP Group Composition.

FIP NON-FINANCIAL ELIGIBILITY FACTORS

Non-financial eligibility factors in the following Bridges Eligibility Manual (BEM) items must be met:

- 201, Minor Parents
- 202, Immunizations
- 203, Criminal Justice Disqualifications
- 220, Residence
- 221, Identity
- 222, Concurrent Receipt of Benefits
- 223, Social Security Numbers
- 225, Citizenship/Non-Citizenship Status
- 227, Strikers

- 228, Family Automated Screening Tool and Family Self-Sufficiency Plan
- 229, Orientation
- 230A, Employment and/or Self-Sufficiency-related Activities
- 233A, Failure to Meet Employment and/or Self-Sufficiency-Related Requirements
- 234, FIP Time Limits
- 240, Age
- 245, School Attendance and Student Status
- 255, Child Support
- 256, Spousal/Parental Support
- 257, Third Party Resource Liability
- 265, Institutional Status
- 270, Pursuit of Benefits

FIP FINANCIAL ELIGIBILITY FACTORS

Financial eligibility factors in the following BEM items must be met:

- 400, Assets
- 500, Income Overview
- 501, Income From Employment
- 502, Income From Self-Employment
- 503, Income, Unearned
- 504, Income From Rental/Room and Board
- 505, Prospective Budgeting/Income Change Processing
- 515, FIP/RCA/SDA Needs Budgeting
- 518, FIP/RCA/SDA Income Budgeting
- 520, Computing the FIP/RCA/SDA Budget

RCA GROUP COMPOSITION

In order to evaluate RCA eligibility, a RCA EDG must exist, based on the rules in BEM 215, RCA Group Composition.

RCA NON-FINANCIAL ELIGIBILITY FACTORS

Non-financial eligibility factors in the following items must be met.

- 203, Criminal Justice Disqualifications
- 220, Residence
- 221, Identity
- 222, Concurrent Receipt of Benefits
- 223, Social Security Numbers
- 225, Citizenship/Non-Citizenship Status
- 228, Family Automated Screening Tool and Family Self-Sufficiency Plan
- 230C, Employment and/or Self-Sufficiency-related Activities: RCA
- 233C, Failure to Meet Employment and/or Self-Sufficiency-Related Requirements: RCA
- 240, Age
- 245, School Attendance and Student Status
- 256, Spousal/Parental Support
- 265, Institutional Status
- 270, Pursuit of Benefits
- 630, Refugee Assistance Program

RCA FINANCIAL ELIGIBILITY FACTORS

Financial eligibility factors in the following items must be met:

- 400, Assets
- 500, Income Overview

- 501, Income From Employment
- 502, Income From Self-Employment
- 503, Income, Unearned
- 504, Income From Rental/Room and Board
- 505, Prospective Budgeting/Income Change Processing
- 515, FIP/RCA/SDA Needs Budgeting
- 518, FIP/RCA/SDA Income Budgeting
- 520, Computing the FIP/RCA/SDA Budget

SDA GROUP COMPOSITION

In order to evaluate SDA eligibility, an SDA EDG must exist, based on the rules in BEM 214, SDA/AMP Group Composition.

SDA NON-FINANCIAL ELIGIBILITY FACTORS

Non-financial eligibility factors in the following items must be met:

- 203, Criminal Justice Disqualifications
- 220, Residence
- 221, Identity
- 222, Concurrent Receipt of Benefits
- 223, Social Security Numbers
- 225, Citizenship/Non-Citizenship Status **or** 225A Special Immigration Status
- 240, Age
- 256, Spousal/Parental Support
- 261, Disability - SDA
- 265, Institutional Status
- 270, Pursuit of Benefits
- 271, SSI Referral, Application, Denial and Appeal
- 272, SDA Repay Agreements

SDA FINANCIAL ELIGIBILITY FACTORS

Financial eligibility factors in the following items must be met:

- 400, Assets
- 500, Income Overview
- 501, Income From Employment
- 502, Income From Self-Employment

- 503, Income, Unearned
- 504, Income From Rental/Room and Board
- 505, Prospective Budgeting/Income Change Processing
- 515, FIP/RCA/SDA Needs Budgeting
- 518, FIP/RCA/SDA Income Budgeting
- 520, Computing the FIP/RCA/SDA Budget

LEGAL BASE

FIP

42 USC 603 - 608
MCL 400.57 - 400.57(z)
Mich Admin Code, R 400.3101 - 400.3131

RCA

45 CFR 400
45 CFR 401

SDA

Annual MDHHS Appropriations Act
Mich Admin Code, R 400.3151 - 400.3180

DEPARTMENT PHILOSOPHY

The Michigan Department of Health and Human Services (MDHHS) believes that children are best served by living in supportive family settings. The mutual responsibility of family members for each other and their commitment to caring for each other are key to building strong families. Parents are responsible for the care and support of their minor children. In the absence of parents, children may be cared for by other adults having specific relationships to the children. Spouses are responsible for each other. All needy family members living together are expected to share income, assets, and expenses. The limited nature of the Family Independence Program is essential to meeting the goals of the program.

DEPARTMENT POLICY

FIP

Group composition is the determination of which individuals living together are included in the FIP eligibility determination group/program group and the FIP certified group. To be eligible for FIP both of the following must be true:

- The group must include a dependent child who lives with a legal parent, stepparent or other qualifying caretaker.
- The group cannot include an adult who has accumulated more than 60 TANF funded months, beginning October 1, 1996 or any other time limits in the Family Independence Program; see BEM 234.

DEFINITIONS

Caretaker

A caretaker is a legal parent or stepparent living in the home, or when no legal parent or stepparent lives in the home, another adult who acts as a parent to a dependent child by providing physical care and supervision. See *Who May Be a FIP Caretaker?* in this item.

Certified Group

The certified group means those individuals in the FIP EDG who meet all non-financial FIP eligibility factors. Countable income and assets of certified group members are considered in determining FIP eligibility. Certified group members have a FIP EDG participation status of Eligible Child or Eligible Adult.

Dependent Child

A dependent child is an unemancipated child who lives with a caretaker and is one of the following:

- Under age 18.
- Age 18 and a full-time high school student. See BEM 245, for definition of high school.

Note: See definition of Emancipated, later in this item.

Eligibility Determination Group (EDG)/ Program Group

The EDG means those individuals living together whose information is needed to determine FIP eligibility. Based on data entry, and rules programmed into the system, Bridges assigns an EDG participation status to each member of the household.

EDG Participation Status

The FIP EDG participation status explains the role the individual plays in the FIP eligibility determination. Individuals having a FIP EDG participation status other than Excluded Adult or Excluded Child, are included in the FIP EDG. The countable income and assets of individuals having an Eligible or Disqualified FIP EDG participation status are considered in determining FIP eligibility.

Note: The FIP payment standard is based on the grantee's EDG participation status and the FIP certified group size; see RFT 210.

Emancipated

A child is emancipated if any of the following:

- Ever validly married.

- Emancipated by court order.
- On active duty with the armed forces of the United States.

Joint Physical Custody

Joint physical custody occurs when parents or other caretakers alternate taking responsibility for the child's day-to-day care and supervision in separate homes. It may be included in a court order or may be an informal arrangement between parents or other caretakers.

Living Together

Living together means sharing a home where family members usually sleep except for temporary absences.

Primary Caretaker

The primary caretaker is the caretaker who is primarily responsible for the child's day-to-day care and supervision in the home where the child sleeps more than half of the days in a month, when averaged over a twelve-month period. The twelve-month period begins at the time the determination is being made.

Absent Caretaker

Once a caretaker is determined to be the primary caretaker, the child's other caretakers are considered absent caretakers.

Temporary Absence

A temporarily absent person is considered to be living in the home when **all** of the following are true:

- Individual's location is known.
- There is a definite plan to return.
- The individual lived with the FIP EDG before the absence (newborns are considered to have lived with the FIP EDG).
- The absence has lasted or is expected to last 30 days or less.

  Exception: An individual is still considered to be living in the home, even after 30 days if the absence reason is any of the following:

- In the hospital (including a psychiatric hospital).
- In a residential substance abuse treatment center.
- Absent for school or training.
- Absent due solely to active duty in the uniformed services of the U.S.
- A child who is living apart from a parent due solely to the parent residing in a domestic violence shelter.

Note: A dependent child who is temporarily absent, can be considered living with only one caretaker. When a child sleeps in the home of multiple caretakers who do not live together, Bridges makes a primary caretaker determination; see Determining Primary Caretaker in this item.

Exception: A court ward is under the care and supervision of the court. Even if they meet the temporary absence requirements above, the child is **not** considered to be living in the parent's home.

FAILURE TO REPORT CHILD'S ABSENCE

A parent or other FIP caretaker, must notify the department of a child's absence from the home within five days of the date it becomes clear to the caretaker that the child will be absent for 30 days or more. If the child's absence does not meet temporary absence requirements to be considered in the home, the caretaker who fails to notify the department within five days is disqualified for one month.

WHO IS IN THE FIP EDG?

The FIP EDG includes all household members whose information is needed to determine FIP eligibility. Based on data entered in the system, Bridges determines all of the following:

- Each household member's FIP EDG participation status.
- Which individuals' income and assets are considered.
- Which individuals' needs are considered.
- Which individuals' relationship(s) to other members are considered.

These determinations are made based on the individual's:

- Age.
- School attendance.
- Relationship(s) to other household members.
- Program Request status.
- Receipt of other program benefits such as SSI, child foster care payments or Independent Living Stipend.
- Criminal justice disqualifications.
- FIP time limit.

Mandatory FIP EDG Members

When cash assistance is requested for a dependent child, or a dependent child is a mandatory FIP EDG member, all of the following individuals who live together are in the FIP EDG:

- Dependent child.
- Child's legal parent(s).
- Child's legal siblings who meet the definition of a dependent child (siblings have at least one legal parent in common).
- Legal parent(s) of the child's siblings.
- Child's legal stepparent, even after death of or divorce from the parent.
- Child's legal stepsiblings, who meet the definition of a dependent child, even after death of or divorce from the parent.
- Child's child.

Example: Sally is 18 and attends high school full-time. Sally and her one-year-old daughter live with her mother and 13-year-old brother. Sally applies for cash assistance for herself and her daughter. Everyone in the household is a mandatory FIP EDG member because Sally has requested cash for her dependent child, making Sally a mandatory EDG member; and Sally meets the

definition of a dependent child, making her brother and mother mandatory FIP EDG members.

Exception: The client has the option to exclude a new spouse from the FIP Certified Group for up to 18 months after the month the marriage took place. See the *marriage exemption* section of this policy item.

Refusal of any FIP EDG member to provide information needed to determine FIP eligibility causes ineligibility for the entire FIP EDG.

Exception: Failure to cooperate with the following eligibility requirements have specific penalties, not always FIP denial or closure:

- Employment and/or family self-sufficiency requirements.
- Social Security Numbers.
- Child Support.
- Third Party Liability.
- Caretaker's failure to report a child's absence timely.
- School attendance.
- Criminal justice requirements.

See Failure to Report Child's Absence in this item and BEM 223, 228, 230A-233B, 255 and 257 for penalties for failure to meet these requirements.

There are circumstances in which a FIP certified group contains no dependent child; see *FIP Certified Groups with No Child* in this item.

Who May be a FIP Caretaker?

A legal parent or stepparent living with a dependent child is always the child's caretaker, unless the parent is a minor. See *Multi-Generation and Combined Groups* in this item for exceptions regarding minor parents.

A person other than a legal parent or stepparent may be a caretaker only when the dependent child has no legal parent or stepparent in the home. A caretaker in the child's home, other than a parent or stepparent must be one of the following:

1. A relative who is at least age 18 and legally related to the child by blood, marriage or adoption, as any of the following:

- Grandparent (including great or great-great).
- Aunt or uncle (including great or great-great).
- Sibling.
- Stepsibling.
- Nephew or niece.
- First cousin or first cousin once removed.
- The spouse of any of the above, even after the marriage is ended by death or divorce.
- The parent of the child's putative (alleged) father.

Note: When a court order has terminated parental rights, the parent and child are no longer legally related. However, the child's relationship to other relatives is not affected.

2. The child's legal guardian(s).
3. An adult(s) who is at least age 21 and whose petition for legal guardianship of the child is pending.
4. An adult, having none of the qualifying relationships above, with whom MDHHS children's services has placed a child, subsequent to a court order identifying MDHHS as responsible for the child's care and supervision. This relationship is known as unrelated caregiver, formerly fictive kin. Occasionally, a child is included in a FIP EDG when there is not a qualifying relationship to the caretaker due to mandatory EDG member policy.

Example: Anthony applies for cash assistance for his son Tony and Tony's half-sister Angela. Anthony was never married to Tony's mother and she is not in the home. Because Tony and Angela are half siblings, Angela is a mandatory FIP EDG member, even though there is no qualifying relationship between Angela and Anthony.

Receipt of Other Program Benefits

Receipt of the following types of other program benefits or services affects an individual's FIP EDG participation status.

- Children's Services Independent Living Stipend.
- SSI.
- Child foster care payments.
- MDHHS children's services for a child in an out-of-home foster care placement due to abuse or neglect, when there is a plan to return the child to the parent's home.

Independent Living Stipend

A FIP EDG member who is a recipient of an Independent Living Stipend has an EDG participation status of Other Adult. The income, assets and needs of this individual are not considered in determining eligibility for FIP, however, their relationship to other FIP EDG members is considered.

Example: Linda, a foster child, lives independently and receives an Independent Living Stipend. Linda has a baby daughter in the home. There is no allowance for the child in the Independent Living Stipend. Even though Linda cannot receive FIP for herself, she can receive ineligible grantee FIP for the child because she is the dependent child's caretaker.

SSI Recipients

A FIP EDG member, who receives SSI, has a FIP EDG participation status of Other Adult or Other Child. The income, assets and needs of an SSI recipient are not considered in determining eligibility for the FIP EDG. However, their relationships to other EDG members are considered.

Example: An unmarried couple has one child in common. Paternity has been established. The child receives SSI. The child's relationship to the parents forms a valid FIP EDG, even though the SSI recipient cannot be in the FIP certified group. The SSI recipient's relationship to the parents makes them mandatory FIP EDG members.

Example: SSI recipient has one child. The SSI recipient cannot be in the FIP certified group; however, the SSI parent's relationship to the dependent child forms a valid FIP EDG.

Note: Request cash assistance for the SSI child, even though the child will not be in the FIP certified group.

Children's Foster Care Payment Recipient

A recipient of children's foster care payments has a FIP EDG participation status of Excluded Child. The income, assets, needs and relationships to other household members are not considered. This child has no effect on FIP eligibility determination.

Parent of Child in Out-of-Home Foster Care Placement

The legal parent and/or stepparent of a child in an out-of-home foster care placement due to abuse or neglect forms a valid FIP EDG, as long as there is a plan to return the child to the parent/stepparent's home up to twelve months from the date of removal. When there is no basis for FIP eligibility except for the parent's relationship to the child in out-of-home foster care placement, the child has a FIP EDG participation status of Other Child on the parent's case. If the foster care plan is to return the child to the parents' home, the parent/stepparent may be eligible for FIP based on the relationship to the child in foster care; see FIP Certified Groups with No Child in this item.

Note: Request cash assistance for the foster care child on the parent's case even though the child will not be in the FIP certified group.

OPTIONAL CERTIFIED GROUP MEMBERS

A needy caretaker other than a parent or stepparent may request cash assistance and be included in the FIP certified group. The caretaker's spouse and dependent children living in the home must also be included in the FIP certified group when the caretaker is included. When FIP eligibility is based solely on the presence of a child placed in the home by children's services, the adult is in the FIP EDG for relationship purposes, but cannot be in the FIP certified group. FIP for court-ordered unrelated caregivers is limited to the ineligible grantee payment standard. If there are other children in the home who have different relationships to this caretaker; see Multi-Generation and Combined Groups in this item.

Marriage Exemption

The marriage exemption option applies to all marriages that occur on or after 1/1/2020.

The client has the option to exclude a new spouse from the FIP certified group for up to 18 months after the month of the marriage when **all** the following non-financial and financial criteria are met:

- The group is already active FIP.
- Marriage occurred on or after 1/1/2020.
- The new spouse was not already a FIP Group member.
- The new spouse meets all other non-financial eligibility criteria.
- The total assets of the program group, including the new members as a result of the marriage, are equal to or less than double the FIP asset limits; see BEM 400.
- The budgetable income (result of the qualifying issuance test) of the Program Group, including the new members as a result of the marriage, is less than twice the FIP Monthly Payment Standard for the group size; see RFT 210.

Note: If a group qualifies for the marriage exemption and chooses to include the new spouse in the FIP group, the marriage exemption would no longer be an option for that spouse. Additionally, if a family uses the exemption, a child or sibling/half-sibling to an active member would be considered a mandatory group member. Any child that joined the group only as a result of the marriage, would not be part of the mandatory group.

Example 1: Leighton and her daughter Lizzy receive FIP. Leighton marries Luke in January 2020 and Luke moves into the home. Luke and Leighton's total liquid assets equal $4,000. The only income for the family is $1,100 per month of earned income.

($1,100 earned income - $200 earned income disregard - $180 additional 20% of the remaining earnings = $720)

The budgetable income (after the qualifying income deductions) is $720 per month. Twice the payment standard for the FIP group of 3 is $984 per month. Leighton has the option to exclude Luke from

the FIP group. If the family chooses to use the exemption, Luke's assets and income will not count in the FIP budget for up to 18 months. The group is potentially eligible for the exemption through July 2021. Luke becomes a mandatory group member effective August 2021.

(January 2020 + 18 months = July 2021)

Example 2: Brook and her son Chase receive FIP. Brook marries John and John moves into the home. Brook and John's total liquid assets equal $4,000. The only income for the family is $4,300 per month of unearned income.

The budgetable income is $4,300 per month, the household did not qualify for any of the income deductions. Twice the payment standard for the FIP group of 3 is $984 per month. Brook and John do not qualify for the exemption. John is a mandatory group member. John's assets and income will count in the FIP budget.

Example 3: Bill and his son Matt receive FIP. Jane marries Bill and moves into the home. Jane also has a child that moves into the home. If the family qualifies for the exemption and chooses to use the exemption, Jane and her child will remain out of the FIP certified group.

Example 4: Amy and her son Mike receive FIP. Tom lives with his son Jack at a different address. Amy is Jack's mother. Tom and Amy get married and all four of them move in together. The family qualifies for the exemption and chooses to use the exemption. The FIP certified group consists of Amy, Mike, and Jack. Tom is excluded.

Complete the DHS-1172-M, FIP Marriage Exemption Worksheet, for all groups that meet the non-financial requirements of the marriage exemption. Required verifications must be received prior to determining if the group meets the financial requirements of the exemption. If the group does not meet the exemption requirements, proceed with regular case processing.

If the group does meet the exemption requirements, once all information has been verified and scanned into the electronic case file, submit the DHS-1172-M to Policy-FIP-SDA@michigan.gov for final approval. The specialist will be notified of the results via email. Upon approval policy will complete the exception override in Bridges. The override can only be modified by the Cash Policy unit.

Note: Notify the Cash Policy unit of all changes that may impact eligibility results. Email the following to Policy-FIP-SDA@michigan.gov: case name, case number, and details of the change.

Example 5: Kenton and his son Zack are receiving FIP. Kenton marries Kristin in February of 2020 and reports that Kristin is in the home. The group qualified and chose to use the marriage exemption. Kristin is not in the FIP group. The Cash Policy unit has completed the override, only Kenton and Zack are included in the FIP group. May 2020, Kenton reports the only income for the household is $5,000 per month of earned income.

($5,000 earned income - $200 earned income disregard - $960 additional 20% of the remaining earnings = $3,840)

The budgetable income (after the qualifying income deductions) is $3840 per month. Twice the payment standard for the FIP group is $984 per month. Kenton and Kristin no longer qualify for the exemption. Kristin is now a mandatory group member. Kristin's assets and income will now count in the FIP budget.

Determining Primary Caretaker

The primary caretaker is the person who is primarily responsible for the child's day-to-day care and supervision in the home where the child sleeps more than half the days in a month, when averaged over a twelve-month period. The twelve-month period begins at the time the determination is being made.

When a child spends time in the home of multiple caretakers who do not live together (such as joint physical custody or parent/grandparent), Bridges determines the primary caretaker based on the number of days per month a child sleeps in the home.

Accept the client's statement regarding number of days the child sleeps in the caretaker's home unless questionable or disputed by another caretaker.

Child's Normal Sleep Time

When a caretaker works during a child's normal sleep hours, include the nights the child sleeps away from home when due

solely to the caretaker's employment, as nights slept in the home of the caretaker.

Vacations/Other Absences

Vacations or other time a child spends away from the primary caretaker does not change the result of the primary caretaker determination, unless the child is away, or expected to be away from the home for more than 30 consecutive days.

Once a caretaker is established as primary, the child's other caretakers are considered absent caretakers.

Only the primary caretaker can receive FIP for a child.

Absent Caretakers

Exception: If otherwise eligible, an absent caretaker may receive FIP for a child when **both** of the following are true:

- The child lives with the absent caretaker for more than 30 consecutive days.
- The child does not meet temporary absent requirements to be considered living with the primary caretaker.

Caretaking Time Shared Equally

If the child sleeps in the home of multiple caretakers an equal number of days in a month, when averaged over a twelve-month period, such as every other week, the caretaker who applies and is certified eligible first is the primary caretaker for that program.

Note: It is possible to have a different primary caretaker for different programs

Caretaking Time Disputed

When the number of days per month a child sleeps in the home of multiple caretakers is questionable or disputed, give each caretaker the opportunity to provide evidence of their claim. Base primary caretaker determination upon best available information and evidence supplied by the caretakers; see Verification Sources in this item.

Example 1: Joey is seven years old and lives with Mom during the school year. He spends eight weeks each summer with Dad. Joey returns to Mom's home two days per week during this time with Dad. Joey sleeps in Mom's home more than half the days in a month, when averaged over the next twelve months. Mom is the primary caretaker and continues to receive assistance for Joey through the summer.

Note: If Joey does **not** return to Mom's home at least once every 30 days, he is no longer considered to be living with Mom. If Joey is in Dad's home for more than 30 consecutive days, Dad could apply and receive assistance for Joey.

Example 2: Eric is ten years old. His mom works during the week. Eric's mom drops him off at his grandmother's house on Sunday evening and picks him up on Friday evening. Eric's grandmother is primarily responsible for his care and supervision in the home where he sleeps more than half the days in a month when averaged over the next twelve months. Eric's grandmother is the primary caretaker. His mom is an absent caretaker.

Note: If Mom works during Eric's normal sleep hours, and he is only at Grandma's to sleep while mom works, he is not there all week. Mom is the primary caretaker. Grandma is providing child care.

Changes in Primary Caretaker

Re-evaluate primary caretaker status when any of the following occur:

- There is a change in the number of days per month the child sleeps in a caretaker's home.
- A second caretaker disputes the first caretaker's claim of the number of days the child sleeps in his/her home.
- A second caretaker applies for assistance for the same child.

Example 1: Tommy has lived in his Mom's home except for weekends for the past several years. He is now fourteen and has become a discipline problem. Mom and Dad agree that it would be better for Tommy to live with Dad except weekends. Dad is now the primary caretaker. Mom is now an absent caretaker.

Example 2: Mom is receiving FIP for her six-year-old son, Austin. At application, Austin sleeps in her home more than half the days in a month, when averaged over the next twelve months. Dad is contacted by Friend of the Court regarding his ability to pay child support. Dad states that Austin sleeps in his home all week and spends weekends only with Mom. Determine the number of days per month Austin stays in each parent's home based on best available information and evidence supplied by both parents.

Legal Guardian

Whenever a FIP Eligible Child has a legal guardian, the legal guardian must be the protective payee for the FIP grant; see BAM 420. This applies whether or not the guardian resides with the FIP group and continues until guardianship is terminated. Verify termination of legal guardianship prior to terminating the protective payee; see Verification Sources in this item.

Note: When a legal guardian is receiving FIP for a child, and the parent of the only eligible child returns to the home, enter the parent's data on the legal guardian's Bridges case and run eligibility. The legal guardian's FIP will be terminated. If the parent applies and is found eligible for FIP, the legal guardian must be made the protective payee for the parent's FIP.

MULTI-GENERATION AND COMBINED GROUPS

When an unemancipated minor parent and the parent's child (see BEM 201) live with a legal parent(s) or stepparent, all three generations compose the group. The unemancipated minor parent may not be the grantee for FIP when living with a parent(s) or stepparent; the unemancipated minor parent is the dependent child of the parent(s) or stepparent.

When a minor parent lives with a qualifying FIP caretaker other than a parent or stepparent, and the caretaker requests cash assistance for themselves, the minor parent is a dependent child. If the minor parent's non-parent caretaker does not request cash assistance, or is ineligible for FIP, the minor parent may apply, be treated as an adult and be the FIP grantee; see BEM 201.

When a person is caring for two or more dependent children who are not legally related to each other as siblings or stepsiblings, all children for whom the caretaker requests cash assistance are in a

single FIP EDG and certified group. The caretaker, however, is not required to request assistance for all children who are not related to each other as siblings or stepsiblings.

FIP Certified Groups with No Child

A FIP certified group may be composed of only adults under specified circumstances. Groups with no eligible child may consist of the following:

- A pregnant woman and if married, her spouse.

  Note: If the pregnant woman is not a member of the certified group, such as an SSI recipient, there is no FIP eligibility based on the pregnancy.

- The caretaker(s) of a dependent child who would be eligible for FIP except for the child's receipt of SSI.

- A legal parent(s) and/or stepparent of a dependent child in an out-of-home foster care placement due to abuse and/or neglect when there is a plan to return the child to the parent's home. Eligibility based on this policy is allowed for up to 12 months from the date the child(ren) were removed.

Children's services or the Services Inquiry screens will verify that there is a plan for reunification with the parent, at application and redetermination; see Verification Sources in this item.

DETERMINING THE FIP CERTIFIED GROUP

Bridges determines which members of the FIP EDG are included in the FIP certified group. A FIP EDG member, who does not meet a nonfinancial eligibility factor or is disqualified for any reason, is not in the FIP certified group.

Note: An immunization penalty is not a disqualification.

VERIFICATION REQUIREMENTS

Relationship

Relationship must be verified for each dependent child on the FIP EDG. Verification must establish the relationship of each dependent child to the child's legal parent, stepparent or other qualifying caretaker.

When a child lives with the natural father, but paternity has not been legally established, the father may voluntarily complete the DHC-0682, Affidavit of Parentage; see BEM 255, Child Support, Voluntary Paternity Acknowledgement.

Marriage Exemption

Verification of date of marriage is required when applying the marriage exemption.

Primary Caretaker

Accept the client’s statement regarding the number of days per month a child sleeps in the home. If questionable or disputed by another caretaker, request verification from both caretakers.

Pregnancy

Verification of pregnancy is required when FIP eligibility is based solely on the pregnancy.

Guardianship Termination

Verify termination of legal guardianship before terminating the protective payee.

Reunification Plan

Verify at reported change, application and redetermination, that there is a plan for a child in foster care to be returned to a parent’s home.

Unrelated Caregiver Placement

Verify that a court has ordered MDHHS responsible for the care and supervision of a child(ren), and that MDHHS children’s services

staff have placed the child(ren) with an unrelated caregiver at application and redetermination.

Emancipated

Verify emancipation of a child under age 18.

VERIFICATION SOURCES

Relationship

- Birth certificates.
- Michigan Birth Registry.
- Adoption records.
- Marriage license/certificate.
- School records.
- Separation records.
- Divorce records.
- Hospital birth records.
- Affidavit of Parentage.
- Child support records.
- Court orders.
- Baptismal records.
- Immigration records.
- Any legal document that traces the child's relationship to the parent, stepparent or other qualifying caretaker.
- Other government or local agency records, newspaper records, or local histories that specify the relationship.
- Consecutively numbered I-94 cards do not prove relationship of a caregiver to a child.

Marriage

- Marriage License/Certificate.

Primary Caretaker

When caretaking time of a dependent child is disputed or questionable, examples of proof to consider include, but are not limited to:

- The most recent court order that addresses custody and/or visitation.
- School contact or records indicating who enrolled the child in school, first person called in case of emergency, and/or who arranges for the child's transportation to and from school.
- Child care provider contact or records showing who makes and pays for child care arrangements, and who drops off and picks up the child.
- Medical providers contact or records showing where the child lives and who usually brings the child to medical appointments.
- Other documents or collateral contacts that support/contradicts the caretaker's claim.

Pregnancy

Statement, including expected date of delivery, from one of the following:

- Doctor of Medicine (MD).
- Doctor of Osteopathy (DO).
- Physician's Assistant (PA).
- Ob-gyn Nurse Practitioner (NP).
- Ob-gyn Clinical Nurse Specialist (NS).
- Certified Nurse-Midwife.
- Registered Nurse (RN).
- DHS-49, Medical Examination Report; DHS-54A, Medical Needs; DHS-54E, Medical Needs-PATH or other written statement may be used.

Guardianship Termination

Guardianship or other documents showing legal guardianship has been terminated.

Reunification Plan

Any document or collateral contact that verifies the services plan is to return the child to the parent's home.

When a child in out-of-home foster care placement is active Children's Protective Services only, assume there is a plan to return the child to the parent's home when the field on the Services Inquiry screen Petition Filed for Termination of Parental Rights is not yes.

When the child in out-of-home foster care placement is active Children's Foster Care, there is a plan to return the child to a parent's home when the Services Inquiry screen shows 'MI goal of return home' and the 'parent cooperation' switch is not 'no'.

Unrelated Placement

Verify that a court has ordered MDHHS responsible for the care and supervision of a child(ren), and that the child has been placed with the unrelated caregiver by MDHHS children's services staff with one of the following:

- A DHS-498, Caregiver Assistance Application Cover Letter, completed by MDHHS children's services staff.
- A copy of court documents.
- Contact with or statement from the MDHHS children's services staff that provides the same information.

Emancipated

- Marriage certificate.
- Court order.
- Armed forces documentation.

LEGAL BASE

FIP

42 USC 608
42 USC 619
Mich Admin Code, R 400.3112, .3114, .3122
MCL 400.57 *et seq*.
MCL 400.6(3) and (4)
2018 P.A. 574

DEPARTMENT POLICY

MAGI-Related

Group composition for MAGI-related categories follows tax filer and tax dependent rules.

The MAGI related groups are:

- Children (U19). The income limit for children birth to age 1 is 195 percent of the federal poverty level (FPL). The income limit for a child age 1-19 is 160 percent FPL.
- Pregnant Women (PW). The income limit for pregnant women of any age is 195 percent FPL.
- Parents and caretakers (PCR). The income limit for parents and caretakers is 54 percent FPL.
- Healthy Michigan Plan (HMP). The income limit for adults age 19-64 is 133 percent FPL.
- Former foster children (FCTM). There is no income test for individuals' ages 18-26 who were in foster care in Michigan at age 18.
- MOMS. The income limit for pregnant women of any age is 195 percent FPL.
- MIChild. The income limit for children birth to age 19 is 212 percent FPL.
- Plan First. The income limit is 195 percent FPL.

More information regarding income limits is available at www.medicaid.gov.

FAMILY SIZE

The size of the household will be determined by the principles of tax dependency in the majority of cases. Parents, children and siblings are included in the same household. Parents and stepparents are treated the same. Individual family members may be eligible under different categories.

TAX FILERS AND NON- TAX FILERS

The household for a tax filer, who is not claimed as a tax dependent, consists of:

- Individual.
- Individual's spouse.
- Tax dependents.

The household for a non-tax filer who is not claimed as a tax dependent, consists of the individual and, if living with the individual:

- Individual's spouse.
- The individual's natural, adopted and step children under the age of 19 or under the age of 21 if a full time student.
- If the individual is under the age of 19 (or under 21 if a full time student), the group consists of individual's natural, adopted and step parents and natural, adoptive and step siblings under the age of 19 (or under 21 if a full time student).

The household for an individual who is a tax dependent of someone else, consists of:

- The household of the tax filer claiming the individual as a tax dependent, except that the individual's group must be considered as non-filer/non-dependent if:
- The individual is not the spouse or a biological, adopted, or step child of the taxpayer claiming them; or
- The individual is under the age of 19 (or under 21 if a full time student) and expects to be claimed by one parent as a tax dependent and are living with both parents but the parents do not expect to file a joint tax return; or
- The individual is under the age of 19 (or under 21 if a full time student) and expects to be claimed as a tax dependent by a non-custodial parent,
- The individual's group consists of the parent who has a court order or binding separation, divorce, or custody agreement establishing physical custody controls, or

- If there is no such order or agreement or in the event of a shared custody agreement, the custodial parent is the parent with whom the child spends most nights.

Core Relative

Core relatives include any of the following:

- Parent.
- Aunt or uncle.
- Niece or nephew.
- Any of the above relationships prefixed by grand, great or great-great.
- Stepparent.
- Sister or brother.
- Stepsister or stepbrother.
- First cousin.
- First cousin once removed (for example, a first cousin's child).

A core relative may also include the spouse of any individual above, even after the marriage is ended by death or divorce. Core relatives include relationships established by adoption.

The individual's statement regarding relationship, presence in the home and tax dependency is acceptable.

HOUSEHOLD COMPOSITION EXAMPLES

Kayla is a grandmother who claims her 20 year old daughter, Samantha and 2 year old granddaughter, Joy as tax dependents. Samantha is a full-time student. Kayla is the tax filer.

- Tax rules apply to all.
- Kayla's group is 3. Kayla, Samantha and Joy.
- Samantha's group is 3. Samantha, Kayla and Joy.
- Joy's group is 2, Samantha and Joy.

Bob and Mary are married. Mary is the mother of Jane, age 22. Jane attends college in Ohio. Bob is the tax filer and claims Mary and Jane as tax dependents.

- Tax rules apply to all.
- Group is 3 for all individuals.

SSI-Related Medicaid (MA), Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

Use fiscal groups and, for SSI-related MA, Group 2 Persons Under Age 21 and Group 2 Caretaker Relative, asset groups to determine the financial eligibility of a person who requests Medicaid and meets all the nonfinancial eligibility factors for an Medicaid category.

Individual family members may be eligible under different Medicaid categories.

All categories of Medicaid must be explored for each person who requests Medicaid; see *choice of category* in BEM 105.

REFUSING INFORMATION

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

A person about whom information necessary to determine eligibility is refused and that person's spouse and children, if living with the person, are not eligible for MA. Therefore, no fiscal or asset group is set up for them.

Failure to cooperate with SSN, support or third party resource liability requirements (BEM 223, 255, 256 and 257) may result in MA ineligibility for a person, but is not refusing information necessary to determine eligibility.

DEFINITIONS

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

Child means an unmarried person under age 18.

Adult means a person who is married or age 18 or older.

RULES FOR GROUPS

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

Determine the fiscal and asset groups separately for each person requesting MA. When referring to the group listings, remember:

- Only persons living with one another can be in the same group; see *living with* in this item.
- Certain persons cannot be fiscal or asset group members in SSI-related MA; see *excluded persons* in this item.
- There is no asset test for Group 2 Pregnant Women.

For all Group 2 MA categories, when a child lives with both parents who do not live with each other (for example, child lives with his mother two weeks each month and his father the other two weeks), only one parent, the primary caretaker, is in the fiscal group. Determine a primary caretaker.

The primary caretaker is the parent who is primarily responsible for the child's day-to-day care and supervision in the home where the child sleeps more than half the days in a month, when averaged over a twelve month period. The twelve month period begins at the time the determination is being made. Vacations and visitation with the absent parent do not interrupt primary caretaker status.

Joint physical custody occurs when parents alternate taking responsibility for the child's day-to-day care and supervision. It may be included in a court order or may be an informal arrangement between parents. A child is considered to be living with only one parent in a joint custody arrangement. This parent is the primary caretaker.

Pregnancy

Count a pregnant woman as at least two members. If multiples are expected count the woman as three, etc.

LIVING WITH

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

Living with others means sharing a home where family members usually sleep, **except** for temporary absences. A temporarily absent person is considered in the home.

Temporary Absence

SSI-Related MA, Group 2 Pregnant Women, Group 2 Persons Under Age 21, Group 2 Caretaker Relative

A person's absence is temporary if for the month being tested:

- His/her location is known; **and**
- There is a definite plan for him/her to return home; **and**
- He/she lived with the group before the absence (**Note:** newborns and unborns are considered to have lived with their mothers); **and**
- The absence did not last, or is not expected to last, the entire month being tested unless the absence is for education, training, or active duty in the uniformed services of the U.S.

Exception: An absence is never temporary when:

- The month being tested is an L/H month (see BPG) for the absent person; or
- The absent person is in one of the following on the last day of a past month or on the processing date for current and future months:
  - Long-term care (LTC) facility.
  - Adult foster care facility.
  - Home for the aged.
  - Licensed child foster care home.
  - Child caring institution.

Therefore, the above persons (including spouses residing in the same facility) are never considered to be living with others. A child who has resided in a hospital for 30 or more days is not considered

to be living with others and is a fiscal group of one. Certify for 12 months before re-determining eligibility for the child.

RULES FOR DEPENDENT CHILDREN

A dependent child can be temporarily absent from only one home. When a child spends time with two parents who do not live together, a primary caretaker must be determined. Scheduled vacations and visitation do not interrupt primary caretaker status.

EXCLUDED PERSONS FOR SSI-RELATED

SSI-Related MA

The following cannot be fiscal or asset group members:

- FIP recipients.
- SSI recipients.
- Title IV-E recipients.
- Department wards.
- A person about whom information necessary to determine eligibility is refused.

SSI-RELATED FISCAL GROUPS

SSI-Related MA

Determine the fiscal group for each person who is requesting MA. The fiscal group must be determined separately for each person.

SSI-Related Child

SSI-Related MA

A **child** is a fiscal and asset group of one.

For a child living with his parent(s), BEM 400 and 540 explain whether the parent(s) must deem assets or income to the child. Also, see BEM 540 to determine budgetable income for the fiscal group.

SSI-Related Adult

SSI-Related MA

When an adult is applying for L/H, waivers (BEM 106 and 167) or FTW (BEM 174) the fiscal and asset group is the adult, even if the individual lives with a spouse, and the spouse is not **also** an L/H, waiver, or Freedom to Work client.

When the adult is applying for any other program (including the Medicare Savings Program) the fiscal and asset group is the adult applicant and the spouse.

See BEM 400 to determine the asset group's countable assets and BEM 541 to determine budgetable income for each person in the fiscal group.

Exception: When BEM 402 instructs you to determine a couple's countable assets for an **INITIAL ASSET ASSESSMENT** or **Initial Eligibility**, the L/H or waiver patient and the community spouse are considered an asset group.

Note: Transfers of income and/or assets are allowed between spouses regardless of each's eligibility for program benefits. Transfers between spouses may cause program ineligibility for one or both spouses. This includes transfers of income from an L/H spouse to the spouse in the home who may be a waiver client.

Group 2 Fiscal Groups

Determine the fiscal and asset groups separately for each person requesting Medicaid. The fiscal group must be determined separately for each person. In determining a person's eligibility, the only income that may be considered is the person's own income and the income of the following persons who live with the individual:

- The individual's spouse, and
- The individual's parent(s) if the individual is a child.

Group 2 Under Age 21

A child's fiscal group is the child and the child's parents.

Group 2 Caretaker Relative

An adult's fiscal group is the adult and the adult's spouse.

VERIFICATION REQUIREMENTS

Group 2 Medicaid

Verify the primary caretaker when questioned or disputed.

Verification Sources

Primary Caretaker

Court order that addresses custody or visitation.

School records indicating who enrolled the child and who is called in an emergency situation.

Medical records stating where the child lives, who is responsible for the child's medical care.

Child care records showing where the child lives and who makes and pays for the child care arrangements.

LEGAL BASE

MA

Social Security Act, Sections 1902(a) (10), (17)
MCL 400.106

The Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

DEPARTMENT POLICY

Bridges will help determine who must be included in the Food Assistance Program (FAP) group prior to evaluating the non-financial and financial eligibility of everyone in the group.

Food Assistance Program group composition is established by determining all of the following:

1. Who lives together.
2. The relationship(s) of the people who live together.
3. Whether the people living together purchase and prepare food together or separately.
4. Whether the person(s) resides in an eligible living situation; see *Living Situations* in this item.

RELATIONSHIPS

The relationship(s) of the people who live together affects whether they must be included or excluded from the group. First, determine if they **must** be included in the group. If they are **not** mandatory group members, then determine if they purchase and prepare food together or separately.

Spouses

Spouses who are legally married and live together **must** be in the same group.

Parents and Children

Children include natural, step and adopted children.

Parents and their children **under** 22 years of age who live together **must** be in the same group regardless of whether the child(ren) have their own spouse or child who lives with the group.

Note: For ongoing and intake applications where the child(ren) are not yet 22, they are potentially eligible for their own case, the month after turning 22.

Primary Caretaker

The primary caretaker is the person who is primarily responsible for the child's day-to-day care and supervision in the home where the child sleeps more than half of the days in a calendar month, on average, in a twelve-month period.

Caretaker

A caretaker is a related or unrelated person who provides care or supervision to a child(ren) **under** 18 who lives with the caretaker but who is **not** a natural, step or adopted child. This policy does **not** apply to foster children (see below). A person acting as a parent and the child(ren) for whom he acts as a parent who live with him **must** be in the same group.

Example: Emma's grandson Pete (age 15) lives with her and she receives FIP for him as an ineligible grantee. She provides for his care by giving him a place to live, clothing, etc. Emma and Pete must be in the same group.

Example: Polly's niece Peggy (age 17) lives with her. Peggy has a full-time job, pays room rent and buys her own food. Polly states that she has just provided a place to live in exchange for the room rent; she does not supervise Peggy's activities. Polly and Peggy are separate groups. Either may apply with separate group status.

Foster Children

The FAP group may choose to include or exclude a foster child whose foster parent is a group member. If excluded, the foster child is **not** eligible for FAP as a separate group, and the foster care payment is **not** income to the group.

Foster Adults

The FAP group may choose to include or exclude a foster adult who lives with the group. If excluded, the foster adult is **not** eligible for FAP as a separate group, and the foster care payment is **not** income to the group.

Exception: This policy does **not** apply to residents of Adult Foster Care (AFC)/Community Living Facility (CLF) homes which are nonprofit and licensed for 16 or fewer residents. Policy in Bridges Eligibility Manual (BEM) 615, Group Living Facilities and BEM 617, FAP in Nonprofit Group Living Facilities applies to these residents.

LIVING WITH

Living with means sharing a home where family members usually sleep and share **any** common living quarters such as a kitchen, bathroom, bedroom or living room. Persons who share **only** an access area such as an entrance or hallway or non-living area such as a laundry room are **not** considered living together.

For policy regarding persons in other group living situations; see BEM 617.

Temporary Absence

A person who is temporarily absent from the group is considered living with the group.

A person's absence is temporary if all of the following are true:

- The person's location is known.
- The person lived with the group before an absence (newborns are considered to have lived with the group).
- There is a definite plan for return.
- The absence has lasted or is expected to last 30 days or less.

  Exception: The absence may last longer than 30 days if the absent person is in a hospital and there is a plan for him to return to the home.

DETERMINING PRIMARY CARETAKER

When a child spends time with multiple caretakers who do not live together such as joint physical custody, parent/grandparent, etc., determine a primary caretaker. Only one person can be the primary caretaker and the other caretaker(s) is considered the absent caretaker(s). The child is **always** in the FAP group of the primary caretaker. If the child's parent(s) is living in the home, they must be included in the FAP group.

Exception: If otherwise eligible, the absent caretaker may receive FAP benefits for the child when the child is visiting the absent

caretaker for more than 30 days (not temporarily absent from the primary caretaker's home.)

Determine primary caretaker by using a twelve-month period. The twelve-month period begins when a primary caretaker determination is made. To determine the primary caretaker:

- Ask the client how many days the child sleeps at their home in a calendar month.
- Accept the client's statement unless questionable or disputed by another caretaker.

  Note: When a caretaker works during a child's normal sleep hours, include the nights the child sleeps away from home when due solely to the caretaker's employment as nights slept in the home of the caretaker; see Example 3.

- If primary caretaker status is questionable or disputed, verification is needed.
- Allow both caretakers to provide evidence supporting his/her claim.

Base your determination on the evidence provided by the caretakers; see *Verification Sources* in this item.

- Document who the primary caretaker is in the case.

If the child spends virtually half of the days in each month, averaged over a twelve-month period with each caretaker, the caretaker who applies and is found eligible first, is the primary caretaker. The other caretaker(s) is considered the absent caretaker(s).

Example 1: Patty normally lives with Mom and they receive FAP benefits. Dad has scheduled visitation every other weekend, two weeks at Christmas, two weeks at Easter and eight weeks in the summer. When Patty is gone for the eight weeks in the summer, Dad (absent caretaker) could apply and receive FAP benefits with Patty in his group, if otherwise eligible. Patty would have to be removed from Mom's case because she **no** longer meets the definition of temporary absence.

Note: If in the example above, Patty returns every other weekend to visit with Mom during the summer visitation with Dad, she remains on Mom's case (she is temporarily absent).

Example 2: Eric is ten years old. His mom works during the week. Eric's mom drops him off at his grandmother's house on Sunday evening and picks him up on Friday evening. Eric's grandmother is primarily responsible for his care and supervision in the home where he sleeps more than half the days in a month when averaged over the next twelve months. Eric's grandmother is the primary caretaker. His mom is considered an absent caretaker.

Example 3: Mom works during Eric's normal sleep hours, and Eric is only at Grandma's house to sleep while mom works (he is not there all week). Mom is the primary caretaker. Grandma is providing child care.

Changes in Primary Caretaker

Re-evaluate primary caretaker status when any of the following occur:

- A new or revised court order changing custody or visitation is provided.
- There is a change in the number of days the child sleeps in another caretaker's home and the change is expected to continue, on average, for the next twelve months.
- A second caretaker disputes the first caretaker's claim that the child(ren) sleeps in their home more than half the nights in a month, when averaged over the next 12 months.
- A second caretaker applies for assistance for the same child.

Example: Martin has lived in Mom's home more than half the days in a month on average over the past several years. He is now a teenager and becoming a problem for Mom. There is a change in the custody arrangement. Mom and Dad agree that it would be better for Martin to live with Dad. They now expect him to stay at Dad's home more than half the days in a month, when averaged over the next twelve months. Dad is now the primary caretaker. Mom is considered the absent caretaker.

FOOD PURCHASE AND PREPARATION

The phrase, purchase and prepare together, is meant to describe persons who usually share food in common.

Persons usually share food in common if any of the following conditions exist:

- They each contribute to the purchase of food.
- They share the preparation of food, regardless of who paid for it.
- They eat from the same food supply, regardless of who paid for it.

In general, persons who live together and purchase and prepare food together are members of the FAP group.

Example: Sue, age 26 and her sister Mary, age 29 live in the same home. They purchase and prepare their food together. They are one FAP group.

Example: Betty and her two children move in with Sara, Betty's friend. Sara purchases and prepares food separately from Betty and her two children. They are two groups for FAP purposes.

Persons who normally purchase and prepare separately maintain that distinction even when they are temporarily sharing food with others.

Persons are temporarily sharing food if both of the following are true:

- They had previously purchased and prepared separately.
- Others are sharing their food until the person:
  - Is approved for FAP.
  - Qualifies for other cash assistance.
  - Secures some other source of income.

The purchase and prepare question on the MDHHS-1171, Assistance Application, is addressed as buy and fix food together.

Senior Impaired Group

A person at least 60 years old, his spouse and their children under 22 years of age may choose to be a separate group from those they live with, even if they purchase and prepare together if both of the following are true:

- The person cannot purchase and prepare meals due to a permanent disability as determined by Social Security Administration (SSA) or a non-disease-related permanent, severe disability.

- The countable income of all the other people the senior impaired group lives with does **not** exceed 165 percent of the poverty level; see Reference Tables Manuals (RFT) 250.

LIVING SITUATIONS

The following policies describe living situations which create ineligibility for FAP or which must meet specific requirements to allow eligibility.

Boarder

A boarder is a person residing in either of the following:

- In a commercial boarding house.
- With the FAP group and paying reasonable monthly compensation for meals.

A commercial boarding house is an establishment which provides room and board for compensation. It may or may **not** be licensed; it is **not** IRS tax exempt.

Persons residing in a commercial boarding house are **not** eligible for FAP.

Reasonable monthly compensation is:

- The amount of the maximum monthly FAP benefits for the number of persons making the board payment if the payment is for at least three meals a day.

- Two-thirds of the maximum monthly FAP benefits for the number of persons making the board payment if the payment is for less than three meals per day.

Note: Spouses, parents and children, and children under parental control of a person acting as a parent living together are never boarders, regardless of any payments made to one another.

The group providing the board in a noncommercial board situation may choose to include or exclude the boarder(s) from the group. If excluded, the boarder is **not** eligible for FAP.

Persons paying less than reasonable monthly compensation for board **must** be included in the group providing the board.

Residents of Institutions

A person is a resident of an institution when the institution provides the majority of his meals as part of its normal services.

Residents of institutions are **not** eligible for FAP unless one of the following is true:

- The facility is authorized by the Food and Nutrition Service (FNS) to accept FAP benefits.
- The facility is an eligible group living facility; see BEM 615, Group Living Facilities.
- The facility is a medical hospital and there is a plan for the person's return home; see *Temporary Absence* in this item.

DISQUALIFIED PERSONS

A disqualified person is one who is ineligible for FAP because the person refuses or fails to cooperate in meeting an eligibility factor.

Disqualified members are determined based on questions in Bridges.

Individuals are disqualified for the following reasons:

- Failure to meet citizenship/non-citizen status; see BEM 225, Citizen/Non-citizen.
- Failure to provide a social security number; see BEM 223, Social Security Numbers.
- Failure to comply with employment-related activities; see BEM 233B, Intentional Program Violation.
- Intentional program violation; see Bridges Administrative Manual (BAM) 720.
- Voluntary quit; see BEM 233B, Failure to Meet Employment Requirements: FAP.

- Failure to comply with a Quality Control review; see BAM 105, Rights and Responsibilities.
- Traffickers; see BEM 203, Criminal Justice Disqualifications.
- Parole and Probation Violators; see BEM 203.
- Divestment; see BEM 406, FAP Divestment.
- Time Limited; see BEM 620, Time Limited Food Assistance.
- Fleeing Felons; see BEM 203.

MEMBER ADDS/ DELETES

A member add that increases benefits is effective the month after it is reported **or**, if the new member left another group, the month after the member delete. In determining the potential FAP benefit increase, Bridges assumes the FIP/SDA supplement and new grant amount have been authorized.

When a member leaves a group to apply on his own or to join another group, a member delete should be completed in the month the local office learns of the application/member add. Initiate recoupment if necessary. If the member delete decreases benefits, adequate notice is allowed.

NON-GROUP MEMBERS

Persons might live with the FAP group or applicant group who are **not** group members. Do **not** consider their income and assets (for non-categorically eligible groups) when determining the group's eligibility.

Furloughed Prisoner

A furloughed prisoner is a person on leave from a correctional institution. The Department of Corrections provides meals or meal money to such persons.

A furloughed prisoner is **not** eligible.

Ineligible Student

A person who is in student status and does not meet the criteria in BEM 245, School Attendance and Student Status is a non-group member.

Live-in Attendant

A live-in attendant lives in the group's home to provide housekeeping, medical or child care, or similar personal services. Persons who take someone into their own home to provide such services are **not** live-in attendants.

The live-in attendant may apply for FAP as a separate group.

Note: Spouses, parents and children, and persons acting as a parent and the children they care for **cannot** be live-in attendants for one another, regardless of the actual situation.

Roomer

A roomer is a person to whom the group furnishes lodging, but **not** meals, for compensation.

The roomer(s) may apply for FAP as a separate group.

Persons Who Have Already Received FAP Benefits

A person must not participate as a member of more than one FAP group in any given month; see BEM 222, Concurrent Receipt of Benefits.

Exception: Residents of shelters for battered women and children; see BEM 617.

If the person is a mandatory group member, action must be taken as soon as possible to remove him from his former group and add him to the new group.

CATEGORICALLY ELIGIBLE GROUP

After determining who is in the FAP group, Bridges determines if this group is categorically eligible for FAP benefits; see BEM 213, Food Assistance Program Group Compensation.

VERIFICATION REQUIREMENTS

Verify group composition factors if the information given is questionable. Such factors might include boarder status, age or senior members, and inability to purchase and prepare meals separately.

Primary Caretaker

Accept the client's statement regarding the number of days per month (on average) a child sleeps in their home. Verify only if questionable or disputed by the other parent.

Senior Impaired Status

A person's impaired status **must** be verified if it is not obvious and it affects the FAP group composition.

VERIFICATION SOURCES

Verify the factors below using one of the listed sources.

Boarder Status

Written statement from the board provider that indicates the amount paid for board.

Impaired (Disability Considered Permanent Under SSA)

The following is a partial list of disabilities considered permanent under the SSA:

- Permanent loss of the use of both hands, both feet, or one hand and one foot.
- Amputation of a leg at the hip.
- Amputation of a leg or foot because of diabetes mellitus or a peripheral vascular disease.
- Total deafness, not correctable by surgery or a hearing aid.

- Statutory (legal) blindness, except if due to cataracts or a detached retina.
- IQ of 59 or less, established after age 16.
- Paraplegia or quadriplegia.
- Multiple sclerosis that is severe, recurring, and includes muscle weakness, paralysis, or interference of vision or speech.
- Muscular dystrophy with a significant effect on the use of the arms or legs.
- Chronic renal disease (documented by persistent, adverse objective findings) resulting in severely reduced kidney function.

Age

Birth Certificate.

Hospital certificate of birth.

Other official records containing birth information such as school records, medical records, baptismal record, marriage certificate, or insurance policy.

Identification containing birth information such as driver's license or state-issued ID.

Newspaper clipping containing the date of birth.

Written statements from two or more individuals who know the person's age.

Inability to Purchase and Prepare Meals

Statement from physician or psychologist.

Primary Caretaker

When primary caretaker status is questionable or disputed, base the determination on the evidence provided by the caretakers. Give each caretaker the opportunity to provide evidence supporting his/her claim. Suggested verifications include:

- The most recent court order that addresses custody and/or visitation.
- School records indicating who enrolled the child in school, first person contacted in case of emergency, and/or who arranges for child's transportation to and from school.
- Child care records showing who makes and pays for child care arrangements, and who drops off and picks up the child(ren).
- Medical providers' records showing where the child lives and who generally takes the child to medical appointments.

LEGAL

7 CFR 273.1

7 CFR 273.8(h)

Mich Admin Code, R 400.3006

DEPARTMENT POLICY

Food Assistance Program (FAP) Only

Categorically eligible groups automatically meet the asset and income limits for the Food Assistance Program (FAP). Categorically eligibility applies to groups, not individuals. Bridges determines group composition prior to determining categorical eligibility.

Categorially Eligible Groups

FAP groups are categorically eligible based on enhanced authorization for Domestic Violence Prevention Services (DVPS). If their gross income is at or below 200 percent of the federal poverty level, they are also categorically eligible.

Determination of categorical eligibility will be made at application, reported change and redetermination.

Note: Categorical eligibility does not mean applicants automatically receive FAP as clients must still meet all of the other program requirements.

Exception: All FAP groups are required to report and must close if they receive a single lottery or gambling winning of $4,500 or more. All FAP groups that close for lottery or gambling winnings, will be required to verify assets if they reapply.

Non-Categorically Eligible Groups

The following groups are **not** categorically eligible but are authorized to receive DVPS. They must meet income, asset and all other program requirements to receive FAP benefits.

Senior/Disabled/Disabled Veteran (SDV)

Groups which contain an SDV member and whose gross income is above 200 percent are **not** categorically eligible. They may still be eligible for benefits if their net income is below 100 percent of the poverty level, and they meet the asset limit; see Bridges Eligibility Manual (BEM) 400, Assets, and BEM 550, FAP Income Budgeting.

Disqualified Member

A group is **not** categorically eligible for FAP if **any** member of the group is FAP disqualified for:

- Intentional program violation (IPV).
- Fleeing Felon.
- Employment-related activity **only** when the disqualified person is the head of household.

Excess Income Denial

Categorically Eligible and Non-Categorically Eligible Groups Excess Income Denial

FAP groups, must verify all countable income before an application can be denied for exceeding the income limit. A VCL must be sent giving the group 10 calendar days to provide the income verification. If the group does not provide income verification by the VCL due date, the application must be denied for failure to provide verification. If income verification is provided, the application can be denied for exceeding the income limit, if applicable.

APPLICATION PROCESSING

Verification

If questionable, verify that the group:

- Meets all the group composition requirements; see BEM 212, Food Assistance Program Group Composition.
- Includes all persons who purchase and prepare food together in one FAP group, **and**
- Includes **no** persons who have been FAP **disqualified** for IPV, and/or fleeing felon, and/or employment-related activity (only when the disqualified person is the head of household).

If categorically eligible, do **not** verify for FAP purposes:

- That the group's income is within the gross income limit (130 percent) and net income limit (100 percent); see RFT 250, FAP Income Limits.
- Social Security numbers.
- Sponsored alien information.
- Residency.

Note: Although the above eligibility factors are not verified for categorically eligible households, they must be verified if they are not verified by another program.

Postponing Denial

Postpone the denial of benefits for a potential categorically eligible group until the **30th day** if it is likely that the group will be categorically eligible.

ISSUING BENEFITS

Bridges will compute net income for all categorically eligible groups.

One and two member categorical FAP groups that exceed the gross and/or 100 percent net income limit, but whose gross income is at or below 200 percent of the poverty level, and all other FAP eligibility requirements are automatically eligible for the minimum benefit amount.

Three or more member categorical FAP groups that exceed the gross and/or 100 percent net income limit, but whose gross income is at or below 200 percent of the poverty level and who meet all other FAP eligibility requirements may be eligible for benefits as low as $1 as determined by RFT 260, Food Assistance Issuance Table.

Exception: Benefits are prorated in the initial month of application and benefits will not be issued if the issuance is less than $10.

A case with zero benefits **will not** be opened in Bridges. Therefore, categorically eligible FAP groups with three or more members **will** be denied or closed **if** net income results in a zero benefit amount based on the Food Assistance Issuance Table.

TERMINATION OF CATEGORICAL ELIGIBILITY

When the group is **no** longer categorically eligible due to imposing a FAP disqualification for IPV, and/or fleeing felon, and/or employment-related activity (**only** when the disqualified person is the head or household), **all** FAP eligibility requirements are reviewed to determine whether the group remains eligible. Bridges will send a DHS-1605 to inform the client of any change in eligibility or benefit level.

LEGAL BASE

FAP

7 CFR 273.2(j)

7 CFR 273.8

Food and Nutrition Act of 2008, as amended

DEPARTMENT PHILOSOPHY

Spouses are responsible for each other. Needy spouses living together are expected to share income, assets, and expenses.

DEPARTMENT POLICY

SDA

SDA is a cash program for individuals who are not eligible for FIP and are disabled or the caretaker of a disabled person. An SDA eligibility determination group (EDG) consists of either a single adult or adult and spouses living together. See BEM 261 for disability criteria.

DEFINITIONS

Adult

An individual is considered an **adult** for SDA when he or she is age 18 or older or has been emancipated.

Emancipated

An individual under the age of 18 is **emancipated** if any of the following:

- Ever validly married.
- Emancipated by court order.
- On active duty with the armed forces of the United States.

An emancipated individual is considered an **adult**.

Eligibility Determination Group

The **eligibility determination group (EDG)** means those adults living together whose information is needed to determine SDA Eligibility. Only an adult individual and his or her spouse who live together are included in an SDA EDG.

Certified Group

The **certified group (CG)** means those persons in the EDG who meet all non-financial SDA eligibility factors. Countable income and assets of CG members are always considered in determining SDA eligibility.

Living Together

Living together means sharing a home except for temporary absences.

Temporary Absence

A temporarily absent person is considered to be living in the home when **all** of the following are true:

- His location is known.
- He plans to return.
- He lived with the group before the absence.
- The absence has lasted or is expected to last 30 days or less.

Exception: A person is considered living in the home, even after 30 days, when absence is due to hospitalization, education or training.

DETERMINING THE ELIGIBILITY DETERMINATION GROUP

SDA

The EDG consists of both:

- The individual.

The individual's spouse who lives with the individual and does not receive FIP, Refugee Cash Assistance, or a refugee matching grant.

Bridges determines the members of the SDA EDG based on information reported by the individual and entered in the system.

DETERMINING THE CERTIFIED GROUP

The CG includes only the eligible members of the SDA EDG. A spouse in the home may fail eligibility and be excluded from the CG but remains a mandatory EDG member. A spouse who fails to meet a nonfinancial eligibility factor or is disqualified for any reason is excluded from the CG.

Bridges determines the members of the SDA CG based on information reported by the individual and entered in the system.

LEGAL BASE

SDA

Annual Appropriations Act
Michigan Administrative Code R 400.3151 - 400.3180

DEPARTMENT PHILOSOPHY

Refugee Cash Assistance (RCA) is a federal program that helps refugees become self-sufficient after their arrival in the U.S.

RCA is a cash program for refugees who are not eligible for FIP.

DEPARTMENT POLICY

RCA

Group composition is the determination of which individuals living together are included in the eligibility determination group (EDG) and certified group (CG). Spouses are responsible for each other. Needy spouses living together are expected to share income, assets, and expenses.

To be considered for RCA all of the following must apply:

- An individual must be a refugee as defined in the REFUGEES section in BEM 630 or 225A.
- The months for which eligibility is being determined must be within the RCA eligibility period as defined in BEM 630 and BEM 225A.
- When there is potential FIP eligibility, the group must take all actions available to obtain FIP. Failure to do so results in group RCA ineligibility.

DEFINITIONS

Adult

An individual is considered an **adult** for RCA when the individual is 18 years of age or older or has been legally emancipated.

Exception: An individual who meets the definition of a dependent child is **not** considered an adult for RCA eligibility purposes; see BEM 210.

Certified Group

The RCA certified group means those individuals in the RCA EDG who meet all non-financial eligibility factors. Countable income and assets of CG members are always considered in determining eligi-

bility. CG members have a RCA EDG participation status of eligible adult.

Note: The RCA payment standard is based on the CG size.

EDG Participation Status

The RCA EDG participation status explains the role the individual plays in the RCA eligibility determination. The countable income and assets of individuals having an eligible or disqualified RCA EDG participation status are considered in determining RCA eligibility.

Eligibility Determination Group

The RCA EDG means those individuals living together whose information is needed to determine eligibility for RCA.

Note: Individuals with an EDG participation status of disqualified adult remain in the RCA EDG. Disqualified individuals must meet all program requirements. Bridges considers their income and assets.

Emancipated

An individual under the age of 18 is **emancipated** if any of the following apply:

- Ever validly married.
- Emancipated by court order.
- On active duty with the armed forces of the United States.

Living Together

Living together means sharing a home, where individuals usually sleep, except for temporary absences.

Refugee

A refugee is an individual who meets the criteria under the **REFUGEES** section in BEM 630 or BEM 225A.

Temporary Absence

A temporarily absent individual is considered to be living in the home when **all** of the following are true:

- Individual's location is known.
- There is a definite plan to return.
- The absence has lasted or is expected to last 30 days or less.
- The individual lived with the RCA EDG before the absence.

Exception: An individual is considered living in the home, even after 30 days, when absence is due to any of the following:

- In-patient hospitalization (including a psychiatric hospital).
- Absence for training or education.
- Absence due solely to active duty in the armed forces of the U.S.

GROUP COMPOSITION

RCA

Based on data entered in the system, Bridges determines all of the following:

- Each household member's RCA EDG participation status.
- Which individuals' income and assets are considered.
- Which individuals needs are considered.
- Which individuals relationship(s) to other members are considered.

These determinations are made based on the individual's:

- Age.
- Relationship(s) to other household members.
- Receipt of other program benefits such as SSI or Refugee Matching Grant payments.

Mandatory RCA EDG Members

RCA

The following individuals who live together are mandatory RCA EDG members:

- The individual.
- The individual's spouse who lives with the individual.

Exception: A special living arrangement (SLA) resident's spouse has an EDG participation status of excluded even if they would otherwise live together; see BEM 616 for SLA policy.

Excluded RCA EDG Members

The following individuals have an EDG participation status of other adult. They have no effect on the eligibility determination:

- SSI Recipients.
- Refugee matching grant recipients.

Refusal of a RCA EDG member to provide information needed to determine eligibility causes group ineligibility.

LEGAL BASE

RCA

45 CFR 400
P.L. 106-386 of 2000, Section 107

DEPARTMENT PHILOSOPHY

Refugee Medical Assistance (RMA) is a federal program that helps refugees become self-sufficient after their arrival in the U.S.

RMA is a medical assistance program for refugees who are not eligible for other Medical Assistance (MA) or MIChild programs. Eligibility for these categories must be determined prior to making an RMA eligibility determination.

DEPARTMENT POLICY

Group Composition is the determination of which individuals living together are included in the eligibility determination group (EDG). Use fiscal groups and asset groups to determine the financial eligibility of an individual who requests MA and meets all the nonfinancial eligibility factors for a MA category.

Individual family members may be eligible under different MA categories. Explore all categories for each individual who requests MA; see CHOICE OF CATEGORY in BEM 105.

Example: A refugee family, consisting of a mother and father and two children, is approved LIF for all members. After initial MA approval, the father begins employment and the income exceeds the income limit for LIF. The two children are approved for Children under 19 and the parents are approved for RMA.

Example: A refugee family, consisting of a mother and father and two children, is approved LIF for all members. The mother and father begin employment and the income exceeds the income limit for LIF and for all full-coverage MA. The children are determined ineligible for MI Child. The family of 4 are approved RMA.

DEFINITIONS

Child means an unmarried person under age 18.

Adult means a person who is married or age 18 or older.

REFUSING INFORMATION

Refusal of any information needed to determine eligibility for an individual causes ineligibility for the individual's spouse and/or child living in the home. There is no fiscal or asset group for them. Failure to cooperate with social security number, support or third party resource liability requirements (BEM 223, 255, 256 and 257) may result in MA ineligibility for an individual, but it is not considered refusing information necessary to determine eligibility for the individual.

RULES FOR GROUPS

Determine the fiscal and asset groups separately for each individual requesting MA.

When referring to the EDG, remember:

- Only individuals living with one another can be in the same EDG; see Living With in this item.
- Count a pregnant woman as at least two members. If twins are verified, count the woman as three, etc.

LIVING WITH

Living with others means sharing a home where family members usually sleep, except for temporary absences. A temporarily absent individual is considered in the home; see Temporary Absence in this item.

When a child lives with both parents who do not live with each other (for example, child lives with his mother two weeks each month and his father the other two weeks), only one parent, the primary caretaker, is in the fiscal group. Make a determination of the primary caretaker.

The primary caretaker is the parent who is primarily responsible for the child's day-to-day care and supervision in the home where the child sleeps more than half the days in a month, when averaged over a 12 month period. The 12 month period begins at the time the determination is being made. Vacations and visitation with the absent parent do not interrupt primary caretaker status. See rules in BEM 255 concerning support from the other parent.

Joint physical custody occurs when parents alternate taking responsibility for the child's day-to-day care and supervision. Joint custody may be outlined in a court order or may be an informal arrangement between parents. For RMA purposes, a child is considered to be living with only one parent in a joint custody arrangement. This parent is the primary caretaker.

TEMPORARY ABSENCE

An individual's absence is temporary for the month being tested if:

- The individual's location is known; **and**
- There is a definite plan for the individual to return home; **and**
- The individual lived with the group before the absence; **and**

Note: newborns and unborns are considered to have lived with their mothers

- The absence did not last, or is not expected to last, the entire month being tested unless the absence is for education, training, or active duty in the uniformed services of the U.S.

Exception: An absence is never temporary when:

- The month being tested is an L/H month (see BPG manual) for the absent individual; or
- The absent individual is in one of the following on the last day of a past month or on the processing date for current and future months:
  - Long-term care (LTC) facility.
  - Adult foster care facility.
  - Home for the aged.
  - Licensed child foster care home.
  - Child caring institution.

The above individuals (including spouses residing in the same facility) are never considered to be living with others. A child who has resided in a hospital for 30 or more days is not considered to be living with others and is a fiscal group of one. Certify for 12 months before redetermining eligibility for the child.

RULES FOR CHILDREN

A child can be temporarily absent from only one home. When a child spends time with two parents who do not live together, a determination of primary caretaker must be made; see Living With in this item.

Example: Amanda normally lives with mom. Dad has scheduled visitation every other weekend, two weeks at Christmas, two weeks at Easter and two weeks in the summer. Mom is the primary caretaker.

Example: Emily's mother works during the week. She drops Emily off at her grandmother's house on Sunday evening and picks her up on Friday evening. Emily's grandmother is primarily responsible for her care and supervision in the home where she sleeps more than half the days in a month when averaged over the next twelve months. Emily's grandmother is the primary caretaker.

Example: Emily's mother works during Emily's normal sleep hours. Emily is only at her grandmother's to sleep while mom works and is not there all week. Mom is the primary caretaker. Grandmother is considered to be providing child care.

FISCAL GROUP

Determine the fiscal group for each individual who is requesting MA. The fiscal group must be determined separately for each individual.

In determining an individual's eligibility, the only income that is considered is the individuals own income and the income of the following persons who live with the individual:

- The individual's spouse, **and**
- The individual's parent(s) if the individual is a child.

For example:

- A child's income cannot be used to determine a parent's eligibility.
- A stepparent's income cannot be used to determine a stepchild's eligibility.

- A grandparent's income cannot be used to determine a grandchild's eligibility.
- A parent's income is considered in determining his/her child's eligibility.
- Each spouse's income is considered in determining the other spouse's eligibility.

In addition to establishing a fiscal group for each individual requesting MA, use policy in BEM 536 to prorate an individual's income among the individual's dependents and him/herself.

Child Fiscal Group

A child's fiscal group is:

- The child, **and**
- The child's parents.

See BEM 400 to determine the asset group's countable assets.
See BEM 536 to determine budgetable income of the fiscal group.

Adult Fiscal Group

An adult's fiscal group is:

- The adult, **and**
- The adult's spouse.

See BEM 400 to determine the asset group's countable assets.
See BEM 536 to determine budgetable income of the fiscal group.

VERIFICATION REQUIREMENTS

Pregnancy and Number of Unborns

Verify the number of unborns when:

- A pregnant woman claims to be expecting more than one child, **and**

- Multiple unborns are necessary to establish income eligibility.

Primary Caretaker

Verify the primary caretaker when questioned or disputed.

VERIFICATION SOURCES

Pregnancy and Number of Unborns

DHS-49, Medical Examination Report, DHS-54A, Medical Needs.

Written statement from any of the following:

- M.D.
- D.O.
- Physician's assistant (PA).
- Ob-gyn nurse practitioner (NP).
- Ob-gyn clinical nurse specialist (NS).
- Certified nurse midwife.
- Registered nurse (RN).

Primary Caretaker

Court order that addresses custody or visitation.

School records indicating who enrolled the child and who is called in an emergency situation.

Medical records stating where the child lives, who is responsible for the child’s medical care.

Child care records showing where the child lives and who makes and pays for the child care arrangements.

LEGAL BASE

Social Security Act, Sections 1902(a)(10),(17) MCL 400.106

45 CFR 400.90 - 104

POLICY

Family Independence Program (FIP), Refugee Cash Assistance (RCA), State Disability Assistance (SDA), Child Development and Care (CDC), Medicaid (MA), Food Assistance (FAP), State SSI Payment (SSP)

To be eligible, a person must be a Michigan resident. Bridges uses the requirements in the Residence section in this item to determine if a person is a Michigan resident.

See BAM 110, where to apply/process applications.

Medicaid Only

Bridges uses the requirements in the Institutionalized Persons section in this item when the fiscal group consists of **only** a person in, or expected to be in, an institution the entire calendar month being evaluated and certified.

In all other situations, it uses the requirements in the **Residence** section, based on circumstances for the calendar month being evaluated and certified.

RESIDENCE

FIP, SDA

A person is a resident if **all** of the following apply:

- Is not receiving assistance from another state.
- Is living in Michigan, except for a temporary absence.
- Intends to remain in the state permanently or indefinitely.

CDC and FAP

A person is considered a resident while living in Michigan for any purpose **other than a vacation**, even if there is no intent to remain in the state permanently or indefinitely. Eligible persons may include:

- Persons who entered the state with a job commitment or to seek employment; and
- Students (for FAP **only**, this includes students living at home during a school break.)

Medicaid

A Michigan resident is an individual who is living in Michigan except for a temporary absence.

Residency continues for an individual who is temporarily absent from Michigan or intends to return to Michigan when the purpose of the absence has been accomplished.

Example: Individuals who spend the winter months in a warmer climate and return to their home in the spring. They remain MI residents during the winter months.

Example: College students who attend school out of state but return home during semester breaks or for the summer can remain MI residents.

State SSI Payment (SSP)

Interface coding received from the Social Security Administration (SSA) validates Michigan residency on a month-by-month basis.

HOMELESS PERSONS

FIP, SDA, RCA, MA, and FAP

A **homeless person** is an individual who lacks a fixed and regular nighttime dwelling **or** whose temporary night time dwelling is one of the following:

- Supervised private or public shelter for the homeless.
- Halfway house or similar facility to accommodate persons released from institutions.
- Home of another person.
- Place not designed or ordinarily used as a dwelling (for example, a building entrance or hallway, bus station, park, campsite, vehicle).

Lack of a permanent dwelling or fixed mailing address does not affect an individual's state residence status. Assistance cannot be denied **solely** because the individual has no permanent dwelling or fixed address.

Use the local office address or another location agreeable to the individual as the mailing address in Bridges. Do not designate a temporary mailing address as the individual's physical address.

CDC Only

Homeless policy can be found in BEM 703.

INSTITUTONALIZED PERSONS

FIP, SDA, and Medicaid

An **institution** is an establishment that furnishes food, shelter and some treatment or services to more than three people unrelated to the proprietor. For SDA clients, this also includes group living facilities; see BEM 615.

Medicaid Only

In this section only, **institution** includes an out-of-state foster care home licensed by that state that provides food, shelter and supportive services to at least **one** person unrelated to the proprietor.

OUT-OF-STATE PLACEMENTS

FIP and SDA

Incompetent adults and dependent children are sometimes placed in another state by a person or agency legally responsible for their care. The individual remains a Michigan resident **unless** the move is to establish a permanent out-of-state home.

Note: An incompetent adult or dependent child placed in Michigan from another state is not a Michigan resident **unless** the move is to establish a permanent home in Michigan.

Medicaid Only

An individual is a Michigan resident if placed in an out-of-state institution by a Michigan agency (for example, MDHHS, juvenile court). An individual is not a Michigan resident if placed in a Michigan institution by another state's agency.

DETERMINATION OF CAPABILITY

Medicaid Only

If the individual is institutionalized, first determine whether they are capable or incapable of indicating their intent to remain in the state.

Exception: This does not apply to out-of-state placements (see above) **or** to unmarried persons under age 18.

Consider an individual capable of indicating intent **unless** one of the following factors is documented:

- IQ under 50.
- Mental age under 8.
- Judgment of incompetence by a court.
- In a psychiatric facility by court order.
- Determined incapable by the medical review team.

CAPABLE PERSONS AT LEAST AGE 18 OR MARRIED

Medicaid Only

An institutionalized, capable individual at least age 18 or married has Michigan residence **if** the individual lives in Michigan **and** intends to remain in the state permanently or indefinitely.

Exception: An individual remains a Michigan resident if the individual:

- Is currently in an out-of-state LTC facility, **and**
- Was a Michigan resident immediately prior to entering the LTC facility.

Note: A Michigan resident who voluntarily enters an out-of-state long-term care facility on or after October 1, 2007 is not considered a Michigan resident for Medicaid purposes.

UNDER AGE 18 AND UNMARRIED; OR INCAPABLE BEFORE AGE 21

Medicaid Only

An individual who (1) is under age 18 and unmarried, or (2) became incapable of indicating intent before age 21, has Michigan residence in **any** of the following circumstances:

- One of his legal parents lives in Michigan **or** did so at the time of the institutional placement.
- Parental rights of his parents were terminated; the court appointed a legal guardian for him; and the guardian lives in Michigan **or** did so at the time of the institutional placement.
- He was abandoned by his parents **and** he does not have a court-appointed legal guardian, **but** a person who lives in Michigan completed the most recent application for him.

INCAPABLE AT OR AFTER AGE 21

Medicaid Only

An institutionalized individual who became incapable at or after age 21 has Michigan residence **if** physically present in Michigan and not placed by an out-of-state agency.

Note: A Michigan resident who voluntarily enters an out-of-state long-term care facility on or after October 1, 2007 is not considered a Michigan resident for Medicaid purposes.

VERIFICATION REQUIREMENTS

Record the verification source in Bridges for all items below that have a verification source field. Bridges will list them on a DHS-3503, Verification Checklist, if they are not verified or if the verification source is not valid for the program(s) on the case.

Assistance from Another State

FIP and SDA only

Verify receipt of assistance from another state; see BEM 222.

Address

FIP, SDA, CDC

Verify the individual's address, unless homeless.

FAP only

Verify that the individual lives in the area your office serves. However, do not deny benefits to an individual with no permanent address (such as a new arrival, migrant, homeless) **solely** for lack of a verified address. The lack of this verification and reason for it must be documented.

Intent to Remain in Michigan

FIP and SDA

Accept an individual’s statement of intent to remain in Michigan **unless** the statement is inconsistent or conflicts with known facts.

Intent to Return to Michigan

FIP and SDA

If an individual is temporarily absent from Michigan, verify the intent to return; see v**erification** s**ources** in this item.

Job Commitment/ Seeking Employment

CDC only

Accept an individual’s statement of entering the state with a job commitment or to seek employment **unless** it is inconsistent or conflicts with known facts.

Incapability to Indicate Intent

Medicaid Only

Verify an institutionalized individual's incapability to indicate intent **unless** he is:

- An out-of-state placement, as defined in this item, **or**
- Under age 18 and unmarried.

VERIFICATION SOURCES

Address

FIP, SDA, FAP and CDC

- Driver's license.
- Other ID which provides a name **and** address.
- Mortgage or rent receipt.
- Utility bill.
- Collateral contact with a person who knows the individual's living arrangement.

FAP only

Exception: Verification of residence is not needed for categorically eligible groups; see BEM 213.

Medicaid Only

Verification of residence is not needed.

State SSI Payment (SSP)

SDX interface as well as SOLQ, display the State Code under the heading State and County Jurisdiction. The code for the State of Michigan is 23.

Intent to Return to Michigan

FIP and SDA

- Evidence that rent, property taxes, utilities or house payments in Michigan are being paid.
- Evidence that a local job is being held for the individual.

- Evidence that the reason for the absence implies intent to remain a Michigan resident.

Incapability to Indicate Intent

Medicaid Only

- Medical evidence of an IQ under 50 or mental age under 8. Use a DHS-49D, Psychiatric Examination Report, or other professional medical certification.
- Legal evidence of a court judgment of incompetence or court-ordered placement in a psychiatric facility. Use copies of court documents or other official legal evidence.
- Follow the procedures in BAM 815 to obtain medical evidence or make a referral to the medical review team.

LEGAL BASE

FIP

42 USC 602(a) (1) (A) (i)
MCL 400.32
Annual Appropriations Act

MA

42 CFR 435.403
Section 11005 of P.L. 99-570
Social Security Act, Sections 1902(a) (48), 1902(b)(2)
MCL 400.32
The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

FAP

7 CFR 273.2 (f)(1)(vi), .3
7 CFR 271.2
7 U.S.C. 2012(m)

SDA

DHS Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

DEPARTMENT POLICY

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance (RCA), Child Development and Care (CDC) and Food Assistance Program (FAP)

Identity of head of household (grantee) must be verified.

If an authorized representative (AR) applies on behalf of a group, the AR must verify his own and the identity of the head of household.

Failure of the head of household (grantee) to verify identity results in group ineligibility.

Failure or inability to verify identity when required results in member disqualification of the individual for whom acceptable verification is not provided.

FIP, SDA, RCA

If an individual presents identification issued by another state, verify that person is not receiving benefits from that state; see Bridges Eligibility Manual (BEM) 220 and BEM 222.

Medicaid

Applicants and beneficiaries of Medicaid are not required to verify identity.

FIP, SDA, RCA

Non-U.S. citizens are not required to verify identity unless questionable.

Note: The Secretary of State will waive the fees on state IDs for individuals who receive FIP or SDA. The individual must present a DHS- 1605, Notice of Case Action, from MDHHS indicating the applicant is **currently** eligible to receive FIP or SDA. The notice must contain the approved benefit period for FIP or SDA.

VERIFICATION REQUIREMENTS

Record the verification source for identity in Bridges. If an individual's verification source is not valid for the individual's program(s),

Bridges will list the verification of identity needed on a DHS-3503, Verification Checklist, for each individual whose identity must be verified.

VERIFICATION SOURCES

FIP, SDA, and FAP

The data match with Social Security Administration (SSA) is sufficient to verify identity. Examples of acceptable verification of identity include but are not limited to:

- Driver's license.
- State-issued identification.
- School-issued identification.
- Federal or local government issued identification card.
- Document indicating an individual’s receipt of benefits under a program that requires verification of identity (for example, Supplemental Security Income (SSI), Retirement Survivors and Disability Insurance (RSDI).
- Identification for health benefits.
- Voter registration card.
- Wage stub.
- Birth certificate/record.
- Cross match with SSA that validates the Social Security number.

Documents listed under CDC are also acceptable for FIP, SDA, and FAP. Any documents which reasonably establish the applicant’s identity must be accepted. If documentary evidence is not readily available, use a collateral contact to verify identity.

CDC

The data match with SSA is sufficient to verify identity and should be completed prior to requesting verification from a recipient; see BAM 130. Other acceptable verifications include:

- Current, valid driver's license with a photograph of the individual.
- Federal, state, or local government issued identification card with the same information included on a driver's license.
- School-issued identification with a photograph.
- U.S. military card or draft record.
- Benefit award letter or other document indicating an individual's receipt of benefits under a program that requires verification of identity (for example, SSI, RSDI).
- A cross match with a federal or state governmental, public assistance, law enforcement, or correction agency's data system (for example, the SSA cross match in Bridges).
- A U.S. passport.
- A Certification of Naturalization (Department of Homeland Security, (DHS) Forms N-550 or N-570).
- A Certificate of U.S. Citizenship (DHS Forms N-560 or N-561).
- Military dependent's identification card.
- Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document.
- U.S. Coast Guard Merchant Mariner card.
- School records, such as report cards, are acceptable for children age 16-18.
- Three or more corroborating documents such as marriage licenses, divorce decrees, high school diplomas, college degrees, or employer ID cards. This option is only available to individuals who submitted second or third tier proof of U.S. citizenship, **not** fourth tier; see BEM 225 for citizenship tiers. When this is used for proof of identity, choose **other acceptable** as the verification source on citizenship/residency screen in the individual demographics logical unit of work (LUW).
- Disabled individuals in residential care facilities may have their identity attested to by the facility director or administrator when

the individual does not have or cannot get any document from the preceding list. The affidavit is signed under penalty of perjury but does not need to be notarized.

Note: Recently expired (30 days) identity documents are acceptable as long as there is no reason to believe the document does not match the individual.

FIP, SDA, RAP, CDC

Examples of acceptable verification of identity when questionable for non-US citizens include:

- Immigration document.
- Refugee resettlement agency document.
- Passport/VISA.

LEGAL BASE

FIP

P.A. 280 of 1939, as amended, MCL 400.1 et seq.R 400.3116 (MAC)

SDA

MDHHS Annual Appropriations Act
Michigan Administrative Code; R 400.3151 – 400.3180

RCA

45 CFR 400.53(a)(2)

CDC

Child Care and Development Block Grant Act of 1990 45 CFR Parts 98 and 99
Social Security Act, as amended
R 400.5001 - 400.5020

MA

MCL 400.105

Subsection 1903(x) of the Social Security Act
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.

The Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Reconciliation Act (Publication L. 111-152).

FAP

7CFR 273.2(f)(1)(vii)

DEPARTMENT POLICY

All Programs

Concurrent receipt of benefits means assistance received from **multiple** programs to cover a person's needs for the same time period. Certain restrictions apply, as specified in this item.

Benefit duplication means assistance received from the **same** (or same **type** of) program to cover a person's needs for the same month. For example, FIP from Michigan and similar benefits from another state's cash assistance program. Benefit duplication is prohibited **except** for Medicaid and FAP in limited circumstances (see **Medicaid Benefits** and **FAP Benefits** in this item). See BEM 203, Criminal Justice Disqualifications, for penalties for individuals found to have received duplicate assistance.

Bridges is programmed to apply the requirements in this item.

Cash Assistance Benefits

Family Independence Program (FIP), Refugee Assistance Program Cash (RCA) and State Disability Assistance (SDA) Only

A recipient of cash assistance from another state is **not** eligible for FIP, RCA or SDA in Michigan for the **same** month.

A recipient of FIP in Michigan is not eligible for SDA or RCA for the same month.

A recipient of SDA in Michigan is not eligible for FIP or RCA for the same month.

A recipient of RCA in Michigan is not eligible for FIP or SDA for the same month.

To prevent benefit duplication, send an DHS-3782, Out-of-State Inquiry, to another state's agency when either of the following:

- The individual arrived from that state within 30 days before FIP/SDA/RCA application.
- Any evidence suggests receipt of assistance from that state for the current month.
- The individual presents current out-of-state identification.

If the applicant arrived here from a state other than his home state, you might have to contact both states.

Pending the other state's response, authorize FIP/SDA/RCA for an otherwise eligible individual **if** no evidence suggests benefit duplication. If such evidence does exist, wait for the response before certifying eligibility in Bridges.

When the other state's response indicates benefit duplication, benefits should only continue in the state where the client resides. Enter out-of-state benefits in Bridges, run EDBC and an Over Payment (OP) referral will be generated if you approved benefits pending the other state's response.

Refugee Matching Grant

FIP, RCA and SDA Only

A person **cannot** receive both Refugee Matching Grant and FIP, RCA or SDA for the **same** month.

SSI Benefits

FIP and RCA Only

A person **cannot** receive both SSI and FIP or RCA for the **same** month.

Children's Foster Care Payments

FIP and RCA Only

Children's foster care payments are cash payments for the care of a minor child, that are paid to a relative or a licensed foster care provider. A child for whom foster care payments are received, is not eligible for FIP or RCA for the **same** month.

Medicaid Benefits

Medicaid

Assume an Medicaid applicant is **not** receiving medical benefits from another state unless evidence suggests otherwise. Do **not** delay the Medicaid determination. Upon approval, notify the other state's agency of the effective date of the client's medical coverage in Michigan.

FAP Benefits

FAP Only

A person **cannot** be a member of more than one FAP Certified Group (CG) in any month.

A person **cannot** receive FAP in more than one state for any month.

Exception: A resident of a shelter for victims of domestic violence may temporarily be a member of two FAP groups; see BEM 617.

Nutrition Assistance Program (NAP)

NAP benefits from Puerto Rico, American Samoa and the Northern Marianna Islands are not counted when determining eligibility and benefits.

Food Distribution Program Benefits

FAP Only

A person **cannot** receive both FAP and Indian Tribal Food Distribution benefits for the same month. To prevent benefit duplication, check the lists of food distribution participants provided by the tribes. If duplication has occurred, the recoupment policy in BAM 700, 705 and 720 applies.

VERIFICATION REQUIREMENTS

FIP, RCA, SDA and FAP

Make an out-of-state inquiry when an applicant arrived from another state within 30 days before application and/or presents current identification from another state. Use a DHS-3782, Out-of-State Inquiry.

FIP, SDA and RCA Only

Verify the receipt and/or termination of SSI benefits and Refugee Matching Grant from another state.

VERIFICATION SOURCES

Out-of-State Benefits

FIP, RCA, SDA and FAP

Out-of-state benefit receipt or termination may be verified by one of the following:

- DHS-3782, Out-of-State Inquiry.
- Letter or document from other state.
- Collateral contact with the state.

Receipt or Termination of SSI

FIP, SDA and RCA Only

Receipt or termination of SSI can be verified by one of the following:

- Current SSI check.
- SSI award letter.
- SSA-1610-U2, Public Assistance Agency Information Request; see BAM 800.
- SOLQ (State Online Query) response; see BAM 800.
- Recent SSA correspondence which clearly indicates the client's SSI status.

Receipt or Termination of Refugee Matching Grant

FIP, SDA and RCA Only

Verify receipt or termination of Refugee Matching Grant by contact with the refugee resettlement agency administering the grant.

LEGAL BASE

FIP

Mich Admin Code, R 400.3122
MCL 400.57a(12)(a) & (b)

SDA

Mich Admin Code, R 400.3174

FAP

7 CFR 273.3; 7 CFR 281.1

DEPARTMENT POLICY

All Programs

Family Independence Program (FIP), Refugee Cash Assistance (RCA), State Disability Assistance (SDA), Child Development and Care (CDC), Medicaid (MA), Food Assistance (FAP)

SSN refers to a Social Security number.

SSA refers to the Social Security Administration.

As a condition of eligibility, individuals, including individuals being added to an active case, must:

- Supply their SSN.
- Cooperate in obtaining an SSN.
- Be excused from supplying and obtaining an SSN. See *excused from providing and obtaining an SSN*.

Note: This condition of eligibility does **not** apply to individuals who are only applying for benefits on behalf of someone else (example, parents who want MA just for their children).

Exception: For **FAP only**, expedited service recipients must cooperate in providing or obtaining an SSN before the first issuance **after** the expedited benefit.

Exception: For **CDC only**, obtain the Social Security number (SSN) of the CDC grantee. Do **not** deny eligibility solely when unable to obtain the SSN.

Verification of an SSN is **not** initially required. Therefore, do **not** delay processing an application for verification of an SSN.

SSNs are checked with SSA for accuracy. If SSA is unable to confirm the SSN, a Bridges enumeration task will be generated; see Enumeration Tasks in this item. The client must cooperate in resolving any errors.

FAILURE TO COMPLY

All Programs Except CDC

Disqualify family members for whom the grantee **refuses** to supply an SSN, cooperate in obtaining an SSN or cooperate in resolving any errors.

Note: Providing an SSN is **not** a condition of eligibility for CDC clients.

Note: This condition of eligibility does **not** apply to individuals who are only applying for benefits on behalf of someone else (example, parents who want MA just for their children).

SUPPLYING AN SSN

All Programs

The requirement to supply an SSN is met by any of the following:

- Previously verified SSN. Bridges displays a check in the protected Validated by SSA field on the **individual information** screen.

  Note: Use the validated SSN already on Bridges even if the individual provides a different SSN.

- Providing an SSN.

  Note: See MORE THAN ONE SSN if the client has more than one SSN.

COOPERATE IN OBTAINING AN SSN

All Programs Except CDC

The requirement to cooperate in obtaining an SSN is met by any of the following:

- Completing an SS-5, Application for a Social Security Card. See APPLYING FOR A SOCIAL SECURITY CARD VIA SS-5.

- A refugee or, for **FAP only,** any individual provides an SSA-5028, Receipt for Application for a Social Security number, to verify his SSN application at SSA.

- A newborn is assigned an SSN via the Enumeration At Birth process, and the parent provides any of the following documents:
  - A DHS-4557, Information About Your Baby's Social Security Card.
  - SSA-2853, Information About When You Will Receive Your Baby's Social Security Card.
  - A copy of a signed State of Michigan Certificate of Live Birth indicating that a Social Security card was requested.
  - A modified birth document, indicating a Social Security card was requested. See Verification Sources in this item.

Note: Inform clients who provide an SSA-5028 or proof of Enumeration at Birth that they must report the SSN upon receipt. SSNs issued through these processes are **not** tape matched onto Bridges. Failure to report these SSNs within six months of receipt or by the next redetermination, whichever is later, results in an overissuance.

EXCUSED FROM PROVIDING AND OBTAINING AN SSN

All Programs

An individual excused by court order is excused from providing and obtaining an SSN.

FAP and MA Only

An individual is excused from providing and obtaining an SSN based on religious grounds. If an SSN already exists, it may be used.

MA Only

The following individuals are excused from providing and obtaining an SSN:

- Newborns automatically eligible per BEM 145.
- Deceased individuals.
- Safe Delivery babies.

Specialists are **not** responsible for the enumeration of individuals receiving foster care MA (such as department wards or title IV-E recipients whose MA eligibility is determined in MISACWIS).

MA Only

The following non-citizens whose medical coverage is limited to emergency services are excused from providing and obtaining an SSN:

- Illegally present in the U.S.
- Nonimmigrant status (for example, non-citizen with a student visa).

  Note: This does **not** include parolees, permanent residents and other legal non-citizens whose medical coverage is limited to emergency services; see BEM 225.

APPLYING FOR A SOCIAL SECURITY CARD VIA SS-5

All Programs

A client meets the requirement of applying for an SSN by completing an SS-5, Application for a Social Security Card, at the local office. **Help the client complete the form and the client must sign it**.

Assist and advise the client, as needed, to provide verification of age, identity and citizenship/non-citizen status required by SSA. Inform the client that SSA determines whether the submitted documents are acceptable. See the verification requirements on the SS-5.

SS-5 Instructions

All Programs

An SS-5 must be completed, signed and dated for each individual who needs a Social Security number. Place a photocopy of the SS-5 in the case record to document that the client has applied for an SSN.

Mail or deliver the original SS-5 to the local SSA office. Attach age, identity and citizenship documents **unless** any of the following are true:

- The client will be interviewed in person at the SSA office.

  Note: Non-Citizens and individuals 18 or older who have never had a Social Security number must be interviewed in person at the SSA office.

- The document(s) **cannot** be obtained before the application is otherwise ready for processing.

- The client should **not**, or chooses **not**, to give up possession of the document(s), for example a driver's license.

  Note: SSA requires original documents or copies certified by the issuing agency.

In these situations, tell the client to go to the SSA office and give him a photocopy of the SS-5 to take along so that SSA has the Bridges case number. Tell the client to comply with SSA requirements.

SS-5 Follow-Up

All Programs

Follow up at each redetermination for each client whose SSN is **not** on Bridges:

- If the client received an SSN, he must provide his SSN.
- If the client did **not** receive an SSN, a current SS-5 is required, and the SS-5 Instructions above must be followed.

Exception: Wait until the **next** redetermination to have a duplicate SS-5 processed **if** it is for a child under six months old **and** the SSN was applied for via birth certificate.

MORE THAN ONE SSN

All Programs

Client Presents Multiple SSNs

If a client presents multiple SSNs do all of the following:

- Enter one of them on the Bridges in the SSN field on the *individual information* screen.

- Refer the client to the local SSA office.
- Send a letter of explanation to that office. See the sample letter in Exhibit of this item.

SSA will notify the client which SSN to use and cross reference the multiple numbers in the SSA files.

The client must provide the SSN he/she is instructed to use. Enter that number on the Individual Information screen. Enter the originally recorded SSN, if different, in the reported SSN field on the Individual Information screen.

SSA Verifies Multiple SSNs

If SSA verifies multiple SSNs for the same individual, Bridges will generate an enumeration task: SSA has assigned multiple SSNs to client. Refer client to SSA to verify number client is to use.

It may be necessary to request verification of the client's SSN in this situation.

BRIDGES INSTRUCTIONS

All Programs

Bridges receives **all** SSN-related input by specialists. It also performs some SSN tape match functions and generates enumeration error tasks.

Bridges performs some SSN tape match functions and generates the DHS-4639, Important Notice About Social Security Numbers.

Where to Input SSN Information

All Programs

Social Security numbers are entered and verified on the Individual Information screen.

Information about an individual's application for an SSN is recorded in Bridges on the *Individual Demographics - SSN Application/Armed Services* screen. The information includes:

- SS-5 completion date.

- Verification of SSN application.
- Willingness to apply for an SSN.
- Reason unwilling to apply for an SSN.

DHS-4639, Important Notice About Social Security Numbers

All Programs

Bridges generate form letter DHS-4639, Important Notice About Social Security numbers, every three months **until** a SSN is entered in Bridges. The letter asks the grantee to write the SSN on the letter for the recipients indicated and to return the letter to you.

Enumeration Tasks

All Programs

Bridges produces an enumeration task when:

- Bridges and SSA records differ on the name, sex or birthdate of the individual.
- The individual has more than one SSN.

Note: Request verification of the individual's SSN when the individual has more than one SSN.

Erroneous SSN on Bridges

All Programs

Use the Individual Information screen to correct any SSN discovered to be erroneous. A duplicate SSN error message means another individual on the system is using the SSN.

Complete an Individual Inquiry on the SSN to determine if your client and the client using the SSN are the same individual.

- **Same Individual.** If both clients are the same individual, do the following:
  - Explore the possibility of fraud if the client is active in another case.

- Request deletion of the duplicate individual ID if the client is inactive in another case.

- **Different Individuals**. If your client and the client using the SSN are different individuals, do the following:
  - Request verification of the SSN from your client.
  - If the SSN verified by your client is still the same SSN, blank out your client's SSN.
  - Have your client complete an SS-5 using procedures in this item.

A check in the Validated by SSA box on Bridges means SSA has verified that SSN for that individual. Contact the Bridges Application Support Unit at (517) 241-9700 for resolution if the verified SSN conflicts with the SSN verified by the client.

VERIFICATION REQUIREMENTS

Record the SSN verification source in Bridges for each SSN for which the Validated by SSA box is not checked. If an individual's SSN is not verified or the source is not valid for the individual's program(s), Bridges will list verification of SSN is needed on a DHS-3503, Verification Checklist, for each individual whose SSN must be verified.

All Programs

Verify cooperation in obtaining an SSN at application and member add.

File a photocopy of the client's verification of SSN application or SS-5 in the physical case record.

Verification of an SSN may be needed to resolve an enumeration task or when two people claim the same SSN.

Verification Sources

MA Only

The following may be used in place of an SSN application:

- A valid Social Security card.

- A FDSH (federal data source) validation.

All Programs

The following sources in the SSN Application Verification field in Bridges are valid verification of an SSN application.

- SS-5, Application for a Social Security Card.
- SSA-5028, Receipt for Application for a Social Security number (allowed only for refugees for FIP, SDA, RAP, or MA; allowed for all individuals for FAP).
- DHS-4557, Information About Your Baby's Social Security Card.
- SSA-2853, Enumeration at Birth (EAB) Receipt.
- Michigan birth certificate with box 10b marked that an SSN and card were requested.
- Modified birth document that includes the minimum required information.

The minimum required information on a modified birth document is:

- Child's name.
- Child's date of birth.
- Parent(s) name(s).
- Name of hospital where child was born.
- Signature of hospital representative.
- Dated and check-marked annotation that SSN was requested.

EXHIBIT - MULTIPLE SSNS FOR THE SAME CLIENT

Use this letter as a guide when drafting a letter to the Social Security Administration to resolve multiple SSNs for a client.

Note: Address the letter to the SSA district or branch office serving the area of the client's residence. That address is in the telephone directory or available by entering the client's zip code in the online *Social Security Office Locator* located within the Social Security online Web site.

January 01, 2006

Social Security Administration
5210 Perry Robinson
Lansing, MI 48911

Re: John S. Doe, Our Client ID #33434343

SSN 373-40-0001 &

SSN 363-40-8088

Dear Sir or Madam:

We have received verification which indicates that our client, John Sylvester Doe, born 8/31/42, has been assigned two different Social Security numbers (SSN). Attached are copies of our verification documents for each SSN.

In order to update our records correctly, we need to know which SSN Mr. Doe should use. Please advise both Mr. Doe and the specialist named below of your decision.

Thank you for your assistance in this matter.

Sincerely,

_____, Eligibility Specialist
Ingham County Department of Human Services
5303 South Cedar
Lansing, MI 48910
Telephone (517) 887-9400

cc: Mr. John S. Doe
2120 W. Willow
Lansing, MI 48917

Attachments

LEGAL BASE

FIP

Social Security Act, Sections
409(a)(4) and 1137(a)(1),(b),(f)

SDA

DHS Annual Appropriations Act

Mich Admin Code,;\ R 400.3151 – 400.3180

MA

42 CFR 435.910

FAP

7 CFR 273.6

RAP

45 CFR 400.62
45 CFR 401

CDC

45 CFR 98.71

DEPARTMENT POLICY

In this item:

- INA refers to the Immigration and Nationality Act.
- USCIS refers to the U.S. Citizenship and Immigration Services, formerly the Bureau of Citizenship and Immigration or Immigration and Naturalization Service.
- SSA refers to the Social Security Administration.

All Programs

Determine the status of each non-citizen requesting benefits at application, member addition, redetermination and when a change is reported.

Note: For Child Development & Care (CDC), only determine the non-citizen status of each child for whom care is requested, not other family members.

Exception: RSDI and SSI recipients, Medicare recipients, newborns (BEM 145), safe delivery babies, and children receiving Title IV-B services or Title IV-E adoption assistance, or foster care payments are not required to verify U.S. citizenship.

FIP, SDA, CDC and FAP

If a group member is identified on the application as a U.S. citizen, do **not** require verification unless the statement about citizenship is inconsistent, in conflict with known facts or is questionable. The following are not sufficient reasons to question citizenship:

- General appearance of the applicant.
- Accent.
- English is not first language.
- Employment as a migrant farmworker.
- Unique sounding name.

A person must be a U.S. citizen or have an acceptable non-citizen status for the designated programs; see *citizenship/non-citizenship status* in this item. Persons who do not meet this requirement, **or who refuse to indicate their status,** are disqualified.

Others living with a person disqualified by this requirement can qualify for program benefits. However, the disqualified person's assets and income might have to be considered based on the program(s) requested; see BEM 210, 212 and 550.

Example: Fred and Sadie complete an MDHHS-1171, Assistance Application, to request FIP and FAP for **only** their two children born in the United States. Fred and Sadie are **not** applying for benefits for themselves and refuse to indicate their status, so they are disqualified. Do **not** require the parents to provide proof of their status or Social Security numbers. Fred and Sadie have no assets; however, since they are both working, they must provide proof of their income to determine eligibility for the children.

Non-immigrants (for example, students, tourists, etc.) and undocumented non-citizens are **not** eligible. A non-immigrant temporarily enters the U.S. for a specific purpose such as business, study, temporary employment, or pleasure. When a person is admitted to the United States, a USCIS official will assign a non-immigrant category according to the purpose of the visit.

CDC

Each child receiving child care paid through CDC must be a U.S. citizen or have an acceptable non-citizen status; see *citizenship/non-citizenship status* in this item. Exclude a child's day care need if that child fails the requirement. Deny the application or close the case if all children needing care on the case fail the requirement.

MA

Citizenship/non-citizen status is not an eligibility factor for emergency services only (ESO) MA. However, the person must meet all other eligibility factors, including residency; see BEM 220.

To be eligible for full MA coverage a person must be a U.S. citizen, or a non-citizen admitted to the U.S. under a specific immigration status.

U.S. citizenship must be verified with an acceptable document to continue to receive Medicaid; see BAM 130.

A person claiming U.S. citizenship is not eligible for ESO coverage.

The status of each non-citizen must be verified to be eligible for full MA coverage; see *citizenship/non-citizenship status* in this item.

A child born to a woman receiving Medicaid is considered a U.S. citizen. No further documentation of the child's citizenship is required.

Exception: RSDI and SSI recipients, Medicare recipients, newborns (BEM 145), safe delivery babies, and children receiving Title IV-B services or Title IV-E adoption assistance, or foster care payments are not required to verify U.S. citizenship.

MA coverage is limited to emergency services for any:

- Persons with certain non-citizen statuses or U.S. entry dates as specified in policy; see *citizenship/non-citizenship status* in this item.
- Persons refusing to provide citizenship/non-citizen status information on the application.
- Persons unable or refusing to provide satisfactory verification of non-citizen information.

Note: All other eligibility requirements including residency **must** be met even when MA coverage is limited to emergency services; see BEM 220.

CITIZENSHIP/ NON-CITIZENSHIP STATUS

All Programs

Persons listed under the program designations in Acceptable Status meet the requirement of citizenship/non-citizen status. Eligibility may depend on whether the person meets the definition of Qualified Non-citizen.

QUALIFIED NON-CITIZEN

All Programs

The definition of qualified non-citizen includes specific non-citizen statuses, but **not** all non-citizen statuses. This definition is used in several of the acceptable non-citizen statuses, in conjunction with other criteria. Not all acceptable non-citizen statuses require that the person be a qualified non-citizen

Qualified non-citizen means a non-citizen who is:

- Lawfully admitted for permanent residence under the INA.
- Granted asylum under Section 208 of the INA.
- A refugee who is admitted to the U.S. under Section 207 of the INA; this includes Iraqi and Afghan special immigrants.
- Paroled into the U.S. under Section 212(d)(5) of the INA for a period of at least one year.
- A non-citizen whose deportation is being withheld under Section 241(b)(3) or 243(h) of the INA.
- Granted conditional entry pursuant to Section 203(a)(7) of the INA.
- A Cuban/Haitian entrant.
- A non-citizen who has been battered or subjected to extreme cruelty in the U.S. by a U.S. citizen or legal permanent resident spouse or parent, or by a member of the spouse's or parent's family living in the same household or is the parent or child of a battered person.

FIP, SDA, MA, CDC and FAP

- A compact of Free Association (COFA) citizens of Federated States of Micronesia, the Republic of Marshall Islands, and the Republic of Palau entrant.

ACCEPTABLE STATUS

FIP and FAP

- U.S. citizen (including persons born in Puerto Rico).

  Children of U.S. citizens born abroad must meet the following criteria:

  - Two U.S. citizen parents in wedlock: One of the parents MUST have resided in the U.S. prior to the child's birth.
  - Child of one U.S. citizen and one non-citizen parent in wedlock: the U.S. citizen was physically present in the

U.S. for time period required by law at the time of the child's birth:

- Birth on or after 11/14/1986: U.S. citizen's required time period is five years; two of the years must be after the age of 14.
- Birth between 12/24/1952 and 11/13/1986: U.S. citizen's required time period is 10 years; five of the years must be after the age of 14.

- Child of only U.S. citizen father out of wedlock must meet each of the following criteria:
  - A blood relationship between the applicant and the father is established by clear and convincing evidence.
  - The father had the nationality of the U.S. at the time of the applicant's birth.
  - The father (unless deceased) had agreed in writing to provide financial support for the person until the applicant reached the age of 18.
  - While the person is under the age of 18:
    - Applicants are legitimated under the law of their residence or domicile.
    - Father acknowledges paternity of the person in writing under oath.
    - The paternity of the applicant is established by adjudication court.
- Child of U.S. citizen mother out of wedlock: the mother was a U.S. citizen at the time of the child's birth and the mother had previously been physically present in the U.S. or one of its outlying possessions for a continuous period of one year.

All Programs

- U.S. citizens (including persons born in Puerto Rico).
- See Exhibit IV, HOW TO BECOME A UNITED STATES CITIZEN, in this item.

- Persons born in Canada who are at least 50 percent American Indian.
- Member of a federally acknowledged American Indian tribe.
- **Qualified military** non-citizen--a qualified non-citizen on active duty in, or veteran honorably discharged from, the U.S. armed forces.

  Active duty must **not** be for training, such as two weeks of active-duty training for National Guard. Discharge must **not** have been due to non-citizen status.

  Veteran means a person who either:

  - Served in the active military, naval or air service for the shorter of 24 months of continuous active duty or the full period for which he or she was called to active duty.
  - Died while in the active military, naval or air service.
  - Served in the military forces of the Commonwealth of the Philippines while such forces were in the service of the armed forces of the U.S. during the period from July 26, 1941, through June 30, 1946.
  - Served in the Philippine Scouts under Section 14 of the Armed Forces Voluntary Recruitment Act of 1945.
- A qualified non-citizen spouse and unmarried qualified non-citizen dependent child of a qualified military non-citizen.

  Note: Dependent child is a child claimed as a dependent on the qualified military non-citizen's federal tax return and under 18, or under age 22 and a student regularly attending school.

  Spouse includes the unremarried surviving spouse of a deceased qualified military non-citizen. The marriage must fulfill one of the following:

  - The spouse was married to the veteran for one year or more.
  - A child was born to the spouse and veteran during or before the marriage.

- The spouse was married to the veteran within the 15-year period following the end of the period of service in which an injury or disease causing the death of the veteran was incurred or aggravated.

- Holder of one of the following immigration statuses:

  - Lawful permanent resident with class code RE, AS, SI or SQ on the I-551 (former refugee or asylee).

    Note: For FAP, clients who enter the U.S. with one of the following categories are eligible for the first seven years. If they adjust to another category which requires them to meet the five-year requirement, they are still eligible for the first seven years.

  - Refugee admitted under INA Section 207.

  - Granted asylum under INA Section 208.

  - Cuban/Haitian entrant.

  - Amerasian under P.L. 100-202 (class code AM on the I-551).

  - Victim of trafficking under P.L. 106-386 of 2000; see VICTIMS OF TRAFFICKING in this item.

  - Non-citizen whose deportation (removal) is being withheld under INA Sections 241(b)(3) or 243(h).

  - **For FIP**, eligibility is limited to five years following the date of the withholding order unless the non-citizen is a qualified military non-citizen or the spouse or dependent child of a qualified military non-citizen.

FIP, SDA, MA, CDC and FAP

  - Compact of Free Association (COFA) citizens of the Federated States of Micronesia, the Republic of Marshall Islands and the Republic of Palau entrant.

FIP, SDA and MA

- Non-citizen admitted into the U.S. with one of the following immigration statuses:

- Lawful Permanent Resident with a class code on the I-551 other than RE, AM or AS.
- Non-citizen paroled into the U.S. for at least one year under INA Section 212(d)(5).

Exception (both statuses above): The eligibility of a non-citizen admitted into the U.S. on or after August 22, 1996, with one of these statuses is restricted as follows unless the non-citizen is a qualified military non-citizen or the spouse or dependent child of a qualified military non-citizen:

- **For FIP,** an individual is disqualified for the first five years in the U.S.
- **For SDA,** an individual is disqualified.
- **For MA** an individual is limited to emergency services for the first five years in the U.S.

- Non-citizen granted conditional entry under INA section 203(a)(7).
- Lawful Permanent Resident with an I-151, Alien Registration Receipt Card. (not acceptable for MA verification)

FIP, MA and FAP

- A non-citizen who has been battered or subjected to extreme cruelty in the United States or whose child or parent has been battered or subjected to extreme cruelty in the United States.

  Exception: The eligibility of a battered alien admitted into the U.S. on or after August 22, 1996, is restricted as follows:

  - **For FIP**, clients are disqualified for the first five years in the U.S.
  - **For MA,** clients are limited to emergency services for the first five years in the U.S.
  - **For FAP**, clients are disqualified unless they meet one of the applicable footnotes listed in Exhibit II-CITIZENSHIP/NON-CITIZEN STATUS TABLE at the end of this item.

  A non-citizen is considered a battered alien if all the following conditions are met:

- The USCIS or the Executive Office of Immigration Review (EOIR) has granted a petition or found that a pending petition sets forth a prima facie case that the non-citizen is eligible for legal permanent resident status (LPR) by way of being one of the following:
  - A spouse or child of a U.S. citizen or LPR.
  - The widow or widower or a U.S. citizen to whom the non-citizen had been married for at least two years before the citizen's death.
  - A battered alien, or the non-citizen parent of a battered child, or the non-citizen child of a battered parent.
- The abuse was committed by the non-citizen's spouse or parent, or by a member of the spouse or parent's family residing in the same household as the non-citizen, and the spouse or parent consented to such battery or cruelty (and if the victim was the non-citizen's child, the non-citizen did not participate in or condone the abuse).
- There is a substantial connection between the battery or extreme cruelty and the need for assistance.
- The battered alien, child or parent no longer lives in the same household as the abuser.

CDC

- Lawful Permanent Resident (regardless of class code).
- Non-citizen paroled into the U.S. under INA Section 212(d)(5)8USC for at least one year.
- Non-citizen granted conditional entry under INA Section 203(a)(7).

MA

- Non-citizen paroled into the U.S. for less than one year under INA Section 212(d)(5). Coverage is limited to emergency services only.
- Non-immigrant--a non-citizen temporarily in the U.S. for a specific purpose (for example, student, tourist). The non-citizen

must not have exceeded the time period authorized by USCIS. For MA, coverage is limited to emergency services only.

- Person who does not meet any of the MA citizenship/non-citizen statuses above--limited to coverage of emergency services only. This includes, for example, undocumented non-citizens and non-immigrants who have stayed beyond the period authorized by USCIS.

SDA and FAP

- Lawful Permanent Resident (regardless of class code) meeting the Social Security Credits (SSC) requirement; see SOCIAL SECURITY CREDITS in this item.

  Note: A qualified military non-citizen, spouse or dependent child, regardless of date of entry or class code, need not meet the SSC requirement.

  Note: For FAP, a qualified non-citizen who has been in the U.S. for five years need not meet the SSC requirement.

SDA

- A qualified non-citizen who was receiving SSI on August 22, 1996.
- A qualified non-citizen who was lawfully residing in the U.S. (see below) on August 22,1996 and is now blind or disabled according to SSI standards.

FAP

- A qualified non-citizen who was lawfully residing in the U.S. on August 22, 1996, and was 65 years of age or older on August 22, 1996.

- A person who is lawfully residing in the U.S. and was a member of a Hmong or Highland Laotian tribe at the time that the tribe assisted U.S. personnel by taking part in a military or rescue operation during the Vietnam era beginning August 5, 1964, and ending May 7, 1975, or is either:

  - The unmarried dependent child of such Hmong or Highland Laotian who is under the age of 18 or if a full-time student under the age of 22; an unmarried child under the age of 18 or if a full-time student under the age of 22 of such a deceased Hmong or Highland Laotian

provided the child was dependent upon them at the time of their death; or an unmarried disabled child age 18 or older if the child was disabled and dependent on the person prior to the child's 18th birthday.

- The spouse or surviving spouse of such a person who is deceased.

- A person lawfully residing in the U.S. and disabled now. Disabled means:
  - Receives SSI, RSDI, MA, or Railroad Retirement benefits based on disability or blindness.
  - Is a veteran with a disability rated or paid as total by the Veterans Administration (VA).
  - Is a veteran or the surviving spouse of a veteran and considered by the VA to be in need of regular aid and attendance or permanently housebound.
  - Is a surviving child of a veteran and considered by the VA to be permanently incapable of self-support.
  - Is a surviving spouse or child of a veteran and considered by the VA to be entitled to compensation for a service-connected death or pension benefits for a non-service-connected death and has a permanent disability.
- Persons who have lived in the U.S. as a qualified non-citizen for at least five years since their date of entry.

  Note: A non-citizen who is eligible for FAP under a status that doesn't require five years U.S. residence who later adjusts to a status that is subject to the five-year limit continues to be eligible.
- A qualified non-citizen who is under 18 years of age.

LAWFULLY RESIDING IN THE U.S.

A person is (or was) lawfully residing in the U.S. if he or she meets (or met) one of the following criteria:

- Is a **qualified** non-citizen.

- Has been inspected and admitted to the U.S. and has not violated the terms of the status under which the individual was admitted or to which he or she has changed after admission.
- Has been paroled into the U.S. pursuant to Section 212(d)(5) of the INA for at least one year or was either:
  - Paroled for deferred inspection or pending exclusion proceedings under 236(a) of the INA.
  - Paroled into the U.S. for prosecution under 8 CFR 212.5(a)(3).
- Is in temporary resident status under Section 210 or 245A of the INA.
- Is under temporary protected status under Section 244A of the INA.
- Is a family unity beneficiary under Section 301 of P.L. 101-649, as amended.
- Is under deferred enforced departure pursuant to a decision made by the president of the United States.
- Is in deferred action status pursuant to service operations instructions at OI 242.1(a)(22).
- Is the spouse or child of a U.S. citizen whose visa petition has been approved and who has a pending application for adjustment of status.
- Is an applicant for asylum under Section 208(a) of the INA.
- Is an applicant for withholding of deportation under Section 243(h) of the INA who has been granted employment authorization.
- Is an applicant for asylum or withholding of deportation who is under the age of 14 and has had an application pending for at least 180 days.

NOTIFICATION TO USCIS

FIP and FAP

The local office must complete a USCIS referral after determining that a member of the applicant or recipient group is ineligible because their presence in the U.S. is unlawful.

A person is in the U.S. unlawfully **only** if either:

- A final order of deportation is presented during the eligibility or redetermination process.
- A determination of ineligibility based on immigration status was made **and** the action by MDHHS was upheld in an administrative hearing, **and** the hearing determination of unlawful presence is supported by a determination by the USCIS or the executive office of immigration review, such as a formal order of deportation.

Note: The absence of proof of legal residence, a determination of a person's ineligibility, or a group member's statement regarding illegal residence does not meet the conditions of unlawful residence in the U.S. and does not require notification to USCIS.

The USCIS referral must contain:

- The information which led to the referral, **and**
- The person's:
  - Full name.
  - Date of birth.
  - Place of birth.
  - Current residence.
  - Place of employment (if any).
  - USCIS file number (if known).
  - Place of entry into the U.S. (if known).

Do not release any other information to USCIS.

Send referrals to:

US Citizenship and Immigration Services (USCIS)
Detroit District
333 Mt. Elliott Street
Detroit, MI 48207

Document the basis for the USCIS referral in the case record.

VICTIMS OF TRAFFICKING

All Programs

The Office of Refugee Resettlement (ORR) within the U.S. Department of Health and Human Services issues letters of certification to persons it determines are victims of trafficking. Children under age 18 are issued eligibility letters instead of certification letters. **Persons with the original certification and/or eligibility letters are not required to provide any other immigration documents to receive benefits.**

When a victim of trafficking applies for assistance:

- Accept the original certification and/or eligibility letter. Copy the letter for the case record and return the original to the client.
- Telephone the ORR trafficking verification line at 1-866-401-5510 to confirm the validity of the certification and/or eligibility letter and inform ORR of the benefits for which the person has applied. Document the phone call in the case record.

See sample ORR letters in BEM 630, Exhibits II and III.

Note: Victims of trafficking are sometimes issued T visas and eligible relatives of the trafficking victims are entitled to visas designated as T-2, T-3, T-4 or T-5 (collectively referred to as Derivative T Visas). The eligible relative(s) with a Derivative T Visa is eligible for the same program(s) as the victim of trafficking, providing they meet other eligibility criteria (for example, asset or income limits).

SOCIAL SECURITY CREDITS (SSC)

SDA and FAP

Social Security credits (SSC) are earned by working at a job covered by Social Security and/or Medicare. The Social Security Administration (SSA) decides how many SSCs a person has earned. A person can earn up to four SSCs per year, depending on the amount of their gross earned income.

SSCs do not represent earnings in a particular calendar quarter. However, SSA attributes SSCs to calendar quarters to assist in determining non-citizen program eligibility.

SSCs are posted to the earner's Social Security earnings file by September of the taxable year following the year in which they were

earned. For example, SSCs earned in 1996 are posted by September 1997. SSCs which have been earned but not yet posted are lag SSCs; see Lag SSCs in this section.

SSC Requirement

Some lawful permanent residents must meet the SSC requirement to be eligible; see CITIZENSHIP/NON-CITIZEN STATUS and EXHIBIT II in this item.

To meet the SSC requirement, a lawful permanent resident must have at least 40 countable SSCs; see Determining Countable SSCs in this section. A non-citizen must meet this requirement only once.

Each lawful permanent resident whose eligibility depends upon SSCs must complete and sign a DHS-4784, Permanent Resident Alien Declaration, at application (including member addition) unless there is proof that the SSC requirement has already been met.

Review at redetermination the eligibility of any group members disqualified for failing the SSC requirement.

Whose SSCs to Count

Count towards the non-citizen's SSC requirement all SSCs earned by:

- The lawful permanent resident.
- The non-citizen's spouse and one or more deceased spouses, while married to the non-citizen.

  Note: Do not count any SSCs of annon-citizen’s ex-spouse. Determine the non-citizen's eligibility without the ex-spouse’s quarters at the next redetermination following the report of a divorce.

- The non-citizen's parent(s) while the non-citizen was under age 18 (including SSCs earned prior to the non-citizen's birth).
- The non-citizen's stepparent(s) while the non-citizen was under age 18 (including SSCs earned prior to the non-citizen's birth), provided the step relationship has not terminated by divorce.

Exception: SSCs earned after December 31, 1996, might not be countable; see Uncountable SSCs in this section.

SSCs of Nongroup Members

Obtain a completed and signed DHS-4757, Social Security Credits Release, from each living nongroup member whose SSCs are used in the eligibility determination. The completed form must be on file before inquiring with SSA about the person's SSCs.

Note: No release is required to inquire about a deceased person's SSCs.

If a nongroup member cannot be located or refuses to provide the completed and signed release, document the circumstances in the case record. Determine that person's countable SSCs using available information; see Determining Countable SSCs.

Determining Countable SSCs

Determine countable SSCs using the numbered steps below. Some SSCs might be uncountable; see Uncountable SSCs in this section.

Before the determination, examine the non-citizen's DHS-4784. If at least seven years of U.S. employment are declared on line 4, complete the Wire Third Party 40 quarters process in Bridges for each person whose work contributed to that total; see SSCs of Nongroup Members about restrictions.

Refer to the Wire Third Party 40 quarters report, if applicable, and the DHS-4784 in the following steps.

Note: Each person can earn a maximum of only four SSCs per year. However, more than four SSCs per year might be countable towards the non-citizen's SSC requirement (for example, four from each parent).

1. Determine the number of countable SSCs, including lag SSCs earned by the non-citizen; see Lag SSCs in this item. If 40 or more, the SSC requirement is met. If fewer than 40, go to step 2.

2. Determine the number of countable SSCs, including **Lag SSCs**, earned by the non-citizen's spouse since their marriage.

Include in your calculation the SSC attributed to the calendar quarter containing the date of marriage.

Add these SSCs to those from step 1. If the total is 40 or more, the SSC requirement is met. If the total is less than 40, go to step 3.

3. Determine the number of countable SSCs, including **Lag SSCs**, earned by the (step)parent(s) while the non-citizen was under age 18. Include in your calculation the SSC attributed to the calendar quarter containing the 18th birthday.

   Add these SSCs to the total from step 2. If the total is 40 or more, the SSC requirement is met. If the total is less than 40, the non-citizen fails the requirement.

Lag SSCs

Due to the lag in SSA's posting process, SSCs earned this year and last year might not be posted to a person's earnings file until September of the year after they were earned. These lag SSCs are counted toward a non-citizen's eligibility if they meet all other requirements in this item.

Lag SSCs might exist when the non-citizen enters current year or last year gross earnings for the non-citizen, spouse and/or (step)parent(s) on the DHS-4784. Determine the number of lag SSCs earned by an individual using the following steps:

- Determine that current year and last year wages are covered by Social Security or Medicare. Wages are covered if FICA or Medicare was withheld.
- Total the gross covered wages earned by **each** person in **each** calendar year.
- Divide each person's yearly total by the minimum amount needed to earn an SSC in that year. Those minimums are:
  - $1,360 for 2019.
  - $1,320 for 2018.
  - $1,300 for 2017.
  - $1,260 for 2016.
  - $1,220 for 2015.
  - $1,200 for 2014.
  - $1,160 for 2013.
  - $1,130 for 2012.

- $1,120 for 2010 and 2011.
- $1,090 for 2009.
- $1,050 for 2008.
- $1,000 for 2007.
- $970 for 2006.
- $920 for 2005.
- $900 for 2004.
- $890 for 2003.
- $870 for 2002.
- $830 for 2001.
- $780 for 2000.
- $744 for 1999.
- $700 for 1998.
- $670 for 1997.
- $640 for 1996.

Round the answer down to the nearest whole number. That number, up to a maximum of four, is the number of lag SSCs earned by the person in that calendar year.

Uncountable SSCs

Special restrictions apply to SSCs earned starting January 1, 1997. An SSC attributed by SSA to a particular calendar quarter is uncountable if any time during that quarter either the non-citizen or the person earning the SSC (if other than the non-citizen) received any of the following benefits anywhere in the U.S.:

- Aid to Families with Dependent Children, or its equivalent (called Family Independence Program, or FIP, in Michigan).
- Food Assistance benefits.
- Medical Assistance (but not MA for emergency services only).
- Supplemental Security Income (SSI).

Exception: Because lag SSCs have not been attributed by SSA to a particular calendar quarter, a different determination is used. One lag SSC earned during a calendar year becomes uncountable for each calendar quarter (January 1 - March 31, April 1 - June 30, etc.) during that year in which either the non-citizen or the person earning the SSC (if other than the non-citizen) received the above benefits anywhere in the U.S; see Lag SSCs in this section.

Eligibility While Disputing Earnings File

Your inquiry to SSA on non-citizen's earnings files might verify fewer SSCs than they claimed on Line 1 of the DHS-4784 (for example, they believe their SSA earnings files are in error); see VERIFICATION SOURCES in this item.

Non-citizens who believe they have earned at least 40 countable SSCs (including lag SSCs) are eligible while disputing their earnings file with SSA if all the following conditions exist:

- The non-citizen's signed DHS-4784 claims that they have worked at least 10 years in the U.S. (estimated 40 SSCs).
- It is determined that at least 40 of the non-citizen's estimated SSCs claimed on the DHS-4784 are countable; see Uncountable SSCs in this section.
- The non-citizen's request SSA to review their earnings file and provides proof of this request; see SSA Referral in this section.

  Note: SSA will not accept a request to review lag credits.

Eligibility based on disputed earnings ends six months after the date of the Wire Third Party 40 quarters process, which verified fewer SSCs than the non-citizen claimed. File a follow-up to review the non-citizen's SSC requirement at that time.

Redetermine the non-citizen's countable SSCs using clarified earnings file information from SSA, if available. If the SSC requirement is not met, disqualify the non-citizen and recoup any benefits issued while the earnings file was being disputed.

SSA Referral

Refer a non-citizen to SSA with a copy of each person's Wire Third Party 40 quarters report from Bridges when one of the following occurs:

- The non-citizen believes there is an error in the SSA earnings file of:
  - The non-citizen**.**
  - The non-citizen's deceased spouse or (step)parent(s)**.**

- Questionable SSCs needed to meet the non-citizen's requirement appear on the Wire Third Party 40 quarters report from Bridges for both:
  - The non-citizen.
  - The non-citizen's deceased spouse or (step)parent(s).

Inform the non-citizen that the earnings file or questionable SSCs of a living spouse or (step)parent must be clarified with SSA by the spouse or (step)parent. Give the non-citizen a copy of each person's Wire Third Party 40 quarters report from Bridges to assist in the SSA clarification process.

VERIFICATION REQUIREMENTS

U.S. Citizenship

FIP, SDA, FAP and CDC

Do not request verification from a person claiming U.S. citizenship **unless** the client's statements are questionable.

MA

U.S. citizenship must be verified.

Non-Citizen Status

All Programs

The non-citizen status of each non-citizen requesting benefits **MUST** be verified.

Exception: See MA Emergency Services Only in this item.

For victims of trafficking, verify the validity of the ORR certification and/or eligibility letter; see VERIFICATION SOURCES in this item.

Verify each of the following dates **if** they affect a non-citizen's eligibility:

- Date of entry into the U.S.
- Date asylum was granted under INA Section 208.
- Date deportation (removal) was withheld under INA Section 241(b)(3) or 243(h).

- ORR certification/eligibility date for victims of trafficking.

Note: The client's statement about a date is verification in certain circumstances; see Dates Affecting Non-Citizen Eligibility in this item.

FIP, SDA, and FAP

Disqualify a person who is unable to obtain verification or refuses to cooperate in obtaining it.

MA Emergency Services Only

The coverage of a person who is unable to obtain verification of non-citizen status or refuses to cooperate in obtaining it is limited to emergency services until verification is obtained.

A person claiming to be a U.S. citizen is not eligible for ESO coverage.

Verify all other eligibility requirements, including residency, before authorizing emergency services coverage; see BEM 220.

Exception: As of August 1, 2024, any pregnant individual or individual under the age of 21 that is lawfully residing in the United States in any immigration status is eligible to receive full coverage. In the case of a pregnant individual, full coverage should continue through the end of the pregnancy and postpartum period. For individuals under 21, full coverage should continue until they reach age 21.

Note: Pregnant individuals need to either apply or report their pregnancy while they are currently pregnant or within two calendar months of it ending in order to be assessed for a full coverage Medicaid group.

Social Security Credits

SDA and FAP

Verify Social Security credits when the non-citizen does one of the following:

- Requests verification.
- Disputes your SSC determination.

- Declares a total of seven or more years of U.S. employment on line 4 of the DHS-4784.

Verify the following elements of the SSC requirement:

- The non-citizens relationship to the spouse or (step)parent(s), but **only** when it is questionable.
- Covered wages used to calculate lag SSCs.
- The non-citizen's statement that SSA is reviewing their disputed earnings file.
- Clarified SSA earnings file information used to redetermine the non-citizen's countable SSCs when eligibility based on disputed earnings ends.

Accept the non-citizen's written statement on DHS-4784, regarding receipt of benefits unless it conflicts with other information (such as SSI receipt on SOLQ).

File copies of all SSC-related verification documents in the case record.

VERIFICATION SOURCES

Citizenship

All Programs

Primary evidence of citizenship is documentary evidence of the highest reliability that conclusively establishes that the person is a U.S. citizen. In general, obtain primary evidence of citizenship before using secondary evidence.

The data match with the SSA is sufficient to verify citizenship and should be completed prior to requesting verification from a recipient; see BAM 130.

See EXHIBIT III in this item for document titles and descriptions.

- Birth certificate or other birth record.
- U.S. passport.
- Voter registration card.
- Naturalization papers or USCIS identification card.

FAP

A client might offer good reasons why none of the verifications above can be obtained. In that situation, accept a U.S. citizen's signed statement under penalty of perjury that the person in question is a U.S. citizen. See EXHIBIT I in this item for information required on the statement.

Primary Evidence

Primary evidence of citizenship is:

- A U.S. passport.
- A U.S. passport card.
- A Certificate of Naturalization (N-550 or N-570).
- A Certificate of Citizenship (N-560 or N-561).

Secondary Evidence

Secondary evidence of citizenship is documentary evidence of satisfactory reliability that is used when primary evidence is not available. Secondary evidence is:

- A U.S. public birth record showing birth in one of the 50 States, District of Columbia, American Samoa, Swain's Island Puerto Rico (if born on or after January 13,1941), Virgin Island of the U.S. (if born on or after January 17, 1917), Northern Mariana Islands (if born on or after November 4, 1986) or Guam (if born on or after April 10, 1899).

- A Michigan enhanced driver's license or enhanced state ID.

- Certification of Report of Birth (DS-1350). The Department of State issues a DS-1350 to U.S. citizens in the U.S. who were born outside the U.S. and acquired U.S. citizenship at birth based on the information shown on the FS-240.

- Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240). Children born outside the U.S. to U.S. military personnel usually have one of these.

- Certification of Birth Abroad (FS-545). Before November 1, 1990 Department of State consulates also issued Form FS-545 along with prior version of the FS-240. In 1990, U.S. consulates ceased to issue Form FS-545. Treat an FS-545 the same as the DS-1350.

- United States Citizen Identification Card (I-197 or I-179). INS issued Form I-179 and I-197 to naturalized U.S. citizens living near the Canadian or Mexican borders who needed it for frequent border crossings. Although neither form is currently issued, either form that was previously issued is still valid.

- American Indian Card (I-872). The Department of Homeland Security issues this card to identify a member of the Texas Band of Kickapoos living near the U.S./Mexican border. A classification code KIC and a statement on the back denote U.S. citizenship.

- Northern Mariana Card (I-873). INS issued this form to a collectively naturalized citizen of the U.S. who was born in the Northern Mariana Islands before November 4, 1986. The card is no longer issued, but those previously issued are still valid.

- Final adoption decree. The decree must show the child's name and U.S. place of birth. In situations in which an adoption is not finalized and the state in which the child was born will not release a birth certificate prior to final adoption, a statement from a state-approved adoption agency that shows the child's name and U.S. place of birth is acceptable. The adoption agency must state in the certification that the source of the place of birth information is an original birth certificate.

- Evidence of civil service employment by the U.S. government. The document must show employment by the U.S. government prior to June 1, 1976.

- Official military record of service. The document must show a U.S. place of birth, (a DD-214 or similar official document showing a U.S. place of birth).

- A verification with the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) database.

- Evidence of meeting the automatic criteria for U.S. citizenship outlined in the Child Citizenship Act of 2000.

The Child Citizenship Act of 2000 allows certain foreign-born, biological and adopted children of American citizens to acquire American citizenship at birth, but they are granted citizenship when they enter the United States as lawful permanent residents.

The child must meet **all** the following requirements:

- Have at least one American citizen parent by birth or naturalization.
- Be under 18 years of age.
- Live in the legal and physical custody of the American citizen parent.
- Be admitted as an immigrant for lawful permanent residence.

If the child is adopted, the adoption must be full and final.

Third Level Evidence

Third level evidence of U.S. citizenship is documentary evidence that is used when neither primary nor secondary evidence is available. Third level evidence may be used **only** when primary evidence cannot be obtained within a reasonable length of time, secondary evidence does not exist or cannot be obtained, **and** the applicant or recipient alleges being born in the U.S. Third level evidence is usually a non-government document established for a reason other than to establish U.S. citizenship and showing a U.S. place of birth. The place of birth on the non-government document and the application must agree.

Third level evidence is:

- An extract of a hospital record on hospital letterhead, established at the time of birth that was created at least five years before the initial application date (or near the time of birth for children) that indicates a U.S. place of birth. Do not accept a souvenir birth certificate.
- Life, health or other insurance record showing a U.S. place of birth that was created at least five years before the initial application date.
- Religious record recorded in the U.S. within three months of birth showing the birth occurred in the U.S. and showing either the date of the birth or the individual's age at the time the record was made. The record must be an official record recorded with the religious organization. Entries in a family bible are **not** considered religious records.

- Early school record showing a U.S. place of birth. The school record must show the name of the child, the date of admission to the school, the date of birth, a U.S. place of birth, and the name(s) and place(s) of birth of the applicant's parents.

Fourth Level Evidence

Fourth level evidence should **only** be used in the rarest of circumstances and includes:

- Federal or state census record showing U.S. citizenship or a U.S. place of birth, generally for persons born 1900 through 1950. The census record must show the person's age. To secure this information the applicant, recipient or state should complete a Form BC-600, Application for Search of Census Records for Proof of Age. Add in the remarks section "U.S. citizenship data requested". Also indicate that the purpose is for Medicaid eligibility. This form requires a fee.
- Seneca Indian tribal census record.
- Bureau of Indian Affairs tribal census records of the Navajo Indians.
- Bureau of Indian Affairs Roll of Alaskan Natives.
- U.S. State Vital Statistics official notification of birth that is amended more than five years after the person's birth.
- Statement signed by the physician or midwife who was in attendance at the time of birth.
- Institutional admission papers from a nursing facility or other institution or medical records from a hospital, doctor or clinic that was created at least five years before the initial application date and indicates a U.S. place of birth. Admission papers generally show biographical information including a place of birth. An immunization record is **not** considered a medical record for purposes of establishing U.S. citizenship.
- A written affidavit should only be used in rare circumstances. It must be completed by the applicant or recipient and at least two additional individuals of whom one is not related to the applicant/recipient and who have personal knowledge of the event(s) establishing the person's claim of citizenship. Individuals making the affidavit must be able to provide proof of their own citizenship and identity. The affidavit is signed under

penalty of perjury by the person making the affidavit but need not be notarized. The affidavit should include information explaining why other documentary evidence establishing the applicant's claim of citizenship does not exist or cannot be obtained.

Non-Citizen Status

All Programs

See EXHIBIT III in this item for document titles and descriptions.

- Lawful permanent resident status is indicated on one of the following:
  - I-151 issued before June 1978 or I-551(I-151 is not acceptable for MA, must be replaced with I-551).
  - I-327 (unexpired).
  - I-94 stamped "Processed for I-551."
  - Passport stamped "Processed for I-551 Temporary Evidence of Lawful Admission for Permanent Residence."
- American Indian who enters the U.S. from Canada is indicated on one of the following:
  - I-151 issued before June 1978 or I-551.(I-151 is not acceptable for MA, must be replaced with I-551).
  - I-181.
  - Other USCIS documentation.
  - Birth record or affidavit from a tribal official indicating the person is at least 50 percent American Indian.

  Note: Such persons are not required to register with USCIS.
- Refugee, asylee or parolee status is indicated on an I-94 annotated with INA section 203(a)(7) (prior to April 1, 1980), 207, 208 or 212(d)(5).
- Derivative Asylee.
  - I-730 Asylee Relative Petition.

- Parolee.
  - I-94 annotated with INA section 212(d)(5) which has a parole end date (duration) at least one year later than the date of entry.
- Afghan aliens admitted under Section 101(a)(27) of the INA is indicated on either:
  - Passport with Visa IV category SI or SQ.
  - An I-94 with date of entry.
  - I-551 with category SI or SQ.
- Iraqi aliens admitted under Section 101(a)(27) of the INA is indicated on either:
  - Passport with Visa IV category SI or SQ.
  - An I-94 with date of entry.
  - I-551 with category SI or SQ.
- Amerasian status is indicated on one of the following documents annotated with class code AM:
  - I-94.
  - I-327 (unexpired).
  - I-551.
  - U.S. or Vietnamese passport.
  - Vietnamese Exit Visa (“Laissez Passer”).
- Cuban/Haitian entrant status is indicated on one of the following:
  - I-94 indicating admission into the U.S. from Cuba or Haiti, annotated with “Cuban/Haitian entrant (Status Pending),” “parole,” including public interest or humanitarian, “212(d)(5)” or “Form I-589 Filed.”
  - I-94 indicating admission into the U.S. from Cuba or Haiti and letter or notice from USCIS indicating ongoing (not final) deportation, exclusion or removal proceedings.
  - I-551 with adjustment code CH6 or CU6.
  - I-766 with A4 or C11.
  - I-688B annotated with 274a.12(a)(4), 274a.12(c)(11), or 274a.12(c)(8).

- A national of Cuba or Haiti who is the subject of removal, deportation, or exclusion proceedings under the INA and with respect to whom a final, non-appealable, and legally enforceable order of removal, deportation, or exclusion has not been entered.
  - DHS form I-221, Order to Show Cause and Notice of Hearing.
  - DHS form I-862, Notice to Appear.
  - DHS form I-220A, Order of release on Recognizance.
  - DHS form I-122, Notice to Applicant Detained for a Hearing Before an Immigration Judge.
  - DHS form I-221S, Order to Show Cause, Notice of Hearing and Warrant for Arrest.
  - DHS form I-589 date stamped by the Executive Office for Immigration Review (EOIR), Application for Asylum and Withholding of Removal Subject of Removal, Deportation or Exclusion Proceedings.
  - DHS form I-485 date stamped by EOIR, Application to Register Permanent Residence or to Adjust Status; Individual is Subject of Removal, Exclusion or Deportation Proceedings.
  - EOIR-26, Notice of Appeal, date stamped by the Office of the Immigration Judge.
  - I-766 Employment Authorization Document with the code C10.
  - I-688B, Employment Authorization Document with the provision of law 274a.12(c)(10).
  - Other documentation pertaining to an applicant's removal, exclusion or deportation proceedings.
- A national of Cuba or Haiti who has an application for asylum pending and with respect to whom a final, non-appealable, and legally enforceable order of removal, deportation or exclusion has not been entered.
  - Department of Homeland Security receipt for filing form I-589.

- I-766, Employment Authorization Document with C08.
- I-688B, Employment Authorization Document with the provision of law 274a.12(c)(8).

Note: Contact the EIOR Hotline at 1-800-898-7180 to verify if a Cuban or Haitian Entrant has a final, non-appealable, and legally enforceable order of removal, deportation, or exclusion, entered. Client confidentiality must be maintained when contacting this number and MDHHS case information should not be shared with the EIOR hotline, other than what is needed for confirmation of their status.

- Status as a non-citizen whose deportation (removal) is withheld is indicated on a court order or letter from an immigration judge stating that deportation (removal) is withheld per INA section 241(b)(3) or 243(h).
- Victim of trafficking status is confirmed with both:
  - Original ORR certification and/or eligibility letter, or for victims under age 18, an original eligibility letter from ORR (See EXIBITS II and III).
  - Telephone contact with the ORR trafficking verification line (1-866-401-5510) to verify the validity of the letters.

Note: Victims of trafficking may also be identified with adjustment code ST6 on the I-551.

- Any non-citizen status:
  - G-641 annotated at the bottom by a USCIS representative.
  - Information from the USCIS Records Section, 333 Mt. Elliott, Detroit, Michigan 48207.

FIP, SDA, MA, CDC and FAP

- Compact of Free Association (COFA) citizens of the Federated States of Micronesia, the Republic of Marshall Islands, and the Republic of Palau entrant.

MA

- Nonimmigrant status:

- I-94, visa, passport or other USCIS correspondence granting non-immigrant status.
- Form I-20 ID (Student) Copy with a future D/S date verifies unexpired non-immigrant student status.

Dates Affecting Non-Citizen Eligibility

All Programs

Verify date of entry as required, using the sources listed below.

- Refugees under Section 207, date of entry is on an I-94 which has been endorsed with INA Section 207.
- Former refugees (class code RE on the I-551), accept the client's statement regarding date of entry if the stated date:
  - Is *at least one year earlier* than the Date of Adjustment/Admission on the I-551;
  - Does not conflict with other information.
- Lawful permanent residents with class codes other than RE, AM, AS, SI or SQ date of entry is the Date of Adjustment/Admission on the I-551.

  Exception: If the client disputes this date, accept the client's statement regarding date of entry if the stated date is *earlier than* the date of adjustment admission on the I-551, **and** does not conflict with other information.

  Note: Date of entry is not an eligibility factor for Lawful permanent residents presenting an I-151. (I-151 is not acceptable for MA, must be replaced with I-551).
- For parolees under Section 212(d)(5), date of entry is on an I-94 which has been endorsed with INA section number 212(d)(5). The end date (duration) of parole is also on the I-94. For Cuban Parolees, the date of entry is the date of grant of parole, or first parole if more than one parole was granted.
- For Cuban/Haitian entrants, date of entry is the date they first entered Cuban/Haitian Entrant status. For entrants in

possession of an I-94, date of entry is on a properly endorsed I-94.

- For Cuban/Haitian entrants, date of entry is on a properly endorsed I-94; see Non-Citizen Status in this section.
- For victims of trafficking, date of entry is the date of certification on the ORR certification/eligibility letter; see EXHIBITS II and III in BEM 630.

For asylees, the date of entry is the date asylum was granted. Verify date asylum was granted, as required, using the sources listed below.

- For asylees under Section 208, the date asylum was granted appears on an I-94 which has also been endorsed with INA Section 208.
- For former asylees (class code AS on the I-551), accept the client's statement regarding the date asylum was granted if the stated date:
  - Is *at least one year earlier* than the date of adjustment/admission on the I-551) **and** does not conflict with other information.

Verify date deportation (removal) was withheld under section 241(b)(3) or 243(h) using the court order or letter from an immigration judge granting the withholding of deportation (removal).

Social Security Credits

SDA and FAP

Use 40 Quarters functionality in Bridges Inquiry.

For lag SSCs, use the following documents showing FICA or Medicare withholding to verify covered earnings:

- Employer-prepared wage statements.
- Forms W-2 and/or W-2c.
- Copy of the earner's tax return.

Disputed Earnings File

SDA and FAP

An SSA document stating that the clients have requested a review of their earnings file is verification that they have requested this review.

Non-Citizens Limited to Emergency MA Coverage During a Five-Year Bar

MA

A non-citizen limited to emergency services only (ESO) coverage during the five-year bar means a non-citizen whose immigration status does not entitle them to full Medicaid coverage without first lawfully residing in the United States for five years.

For example, a lawful permanent resident with an I-551 with a class code other than RE, AM, AS, SI, or SQ will receive ESO coverage for the first five years they reside in the United States after their date of entry or the date on which they switched to this immigration status.

Exception: As of August 1, 2024, children under age 21 and pregnant individuals (including through the entirety of their postpartum period) are no longer subject to the five-year bar. They should be approved for full coverage even if their immigration status would normally require them to first reside in the United States lawfully for five years.

When a pregnant individual's postpartum period ends, or an individual reaches age 21, they will revert to ESO coverage if they have not met the five-year bar and are still in an immigration status that is subject to it.

Note: Pregnant individuals need to either apply or report their pregnancy while they are currently pregnant or within two calendar months of it ending in order to be assessed for a full coverage Medicaid group.

EXHIBIT I - CITIZENSHIP STATEMENT

CITIZENSHIP STATEMENT

Case Name:

_____

Case Number:
_____

County/Workload No:
_____

I certify that I am a United States citizen and that
_____
is a United States citizen.

I understand that if I intentionally give false information to help
_____
get Food Assistance benefits, I may be prosecuted and may be fined, imprisoned, or both.

_____
Signature Date

EXHIBIT II - CITIZENSHIP/NON-CITIZEN STATUS TABLE

	FIP	SDA	CDC	FAP	MA
U.S. Citizen (include person born in Puerto Rico)	Yes	Yes	Yes	Yes	Yes
Person born in Canada, at least 50% American Indian	Yes	Yes	Yes	Yes	Yes
Member of American Indian tribe	Yes	Yes	Yes	Yes	Yes
Qualified Military Non-Citizen	Yes	Yes	Yes	Yes	Yes
Spouse or Dependent Child of Qualified Military Non-Citizen	Yes	Yes	Yes	Yes	Yes
Refugee under Section 207; including Iraqi and Afghan special immigrants.	Yes	Yes	Yes	Yes	Yes
Asylee under Section 208	Yes	Yes	Yes	Yes	Yes
Cuban/Haitian Entrant	Yes	Yes	Yes	Yes	Yes
Compact of Free Association (COFA) citizens*	Yes	Yes	Yes	Yes	Yes

	FIP	SDA	CDC	FAP	MA
Amerasian (I-551 has class code AM)	Yes	Yes	Yes	Yes	Yes
Victim of Trafficking	Yes	Yes	Yes	Yes	Yes
Lawful Permanent Resident, I-551 has class code RE, AM, AS, SI or SQ	Yes	Yes	Yes	Yes	Yes
Lawful Permanent Resident, I-551 class code is OTHER THAN RE, AM, AS, SI or SQ					
• U.S. entry before 8/22/96	Yes	Yes	Yes	Yes	Yes
• U.S. entry on or after 8/22/96					
•• First five years in U.S.	No a	No a,b,d	Yes	No a,b,c, f, g	E a
•• More than five years in U.S.	Yes	No a,b,d	Yes	Yes	Yes
Lawful Permanent Resident, has I-151	Yes	Yes	Yes	Yes	No
Deportation (Removal) Withheld under Section 241(b)(3) or 243(h)					
• First five years after withholding order	Yes	Yes	Yes	Yes	Yes
• Sixth and seventh years after withholding order	No	Yes	Yes	Yes	Yes
• More than seven years after withholding order	No a	Yes	Yes	Yes	Yes
Granted Conditional Entry under Section 203(a)(7)	Yes	Yes	Yes	Yes	Yes
Paroled under Section 212(d)(5) for at least one year					
• U.S. entry before 8/22/96	Yes	Yes	Yes	Yes	Yes
• U.S. entry on or after 8/22/96					
•• First five years in U.S.	No a	No a,d	Yes	No a,c,f, g	E a
•• More than five years in U.S.	Yes	No a,d	Yes	Yes	Yes

	FIP	SDA	CDC	FAP	MA
Battered Aliens					
• U.S. entry before 8/22/96	Yes	No a,d	No	Yes	Yes
• U.S. entry on or after 8/22/96					
•• First five years in U.S.	No	No a,d	No	No a,b,c, f, g	E a
•• More than five years in U.S.	Yes	No a,d	No	Yes	Yes
Paroled under Section 212(d)(5) for less than one year	No	No	No	No	E
Non-immigrant (student, tourist)	No	No	No	No	E
Pregnant individual or individual under age 21 that is lawfully residing in the US in any immigration status	N/A	N/A	N/A	N/A	Yes
Non-Citizens not described above undocumented non-citizens)	No	No	No	No	E

[a] Unless a qualified military non-citizen, or the spouse or dependent child of a qualified military non-citizen.

[b] Unless permanent resident has at least 40 countable Social Security Credits.

[c] Unless lawfully residing in U.S. on 8/22/96 and age 65 or older on 8/22/96; or a Hmong or Highland Laotian tribe member that rendered assistance to U.S. personnel by taking part in a military or rescue operation during Vietnam era (August 5, 1964 - May 7, 1975) lawfully residing in U.S., their spouse, unmarried dependent child under age 18 now, or unremarried surviving spouse.

[d] Unless lawfully residing in the U.S. now and was receiving SSI on 8/22/96 or was lawfully residing in the U.S. on 8/22/96 and is blind or disabled now.

[e] Means medical coverage is limited to emergency services.

[f] Unless lawfully residing in the U.S. and blind or disabled now.

[g] Unless under age 18 now.

*Citizens of the Federated States of Micronesia, the Republic of Marshall Islands, and the Republic of Palau.

EXHIBIT III - DOCUMENTS

U.S. State Department

U.S. State Department documents regarding citizenship include:

- United States passport. It is issued to U.S. citizens and nationals. The expiration date is on the document face. A U.S. passport does not have to be currently valid to be accepted as evidence of citizenship, as long as it was originally issued without limitation.
- United States passport card. This card cannot be used for air travel; otherwise, it carries the same rights and privileges of the U.S. passport book.
- DS-1350, Certification of Report of Birth or FS-545, Certification of Birth Abroad. Issued to U.S. citizens born in another country. The FS-545 was last issued in 1990.
- FS-240, Consular Report of Birth Abroad of a Citizen of the U.S. It is issued to U.S. citizens born in another country, often children of U.S. military personnel.

U.S. Citizenship and Immigration Services (USCIS)

USCIS documents regarding citizenship/non-citizen status include, but are not limited to:

Note: Information about forms and fees is available on the USCIS website. Some forms may be filled out online and some are available for electronic filing. The website is http://www.uscis.gov/portal/site/uscis.

- G-641, Application for Verification of Information from U.S. Citizenship and Immigration Services Records.
- I-20 ID (Student) Copy is issued to non-immigrant students authorized to study in the U.S. The D/S date (duration of status) indicates expiration of student status.
- I-94, Arrival-Departure Record. It is usually attached to the unexpired foreign passport of non-immigrant non-citizens. The expiration date is on the document face. As of 5/1/13, the I-94

will begin to be automated at certain airports in the U.S. Some of the I-94 information will be stamped on the unexpired foreign passport. Refugees, derivative asylees and parolees will continue to receive a paper I-94.

- I-151, Alien Registration Receipt Card. It was issued prior to June 1978 to lawful permanent residents and is commonly referred to as a green card. The I-151 became obsolete on 3/20/96, and individuals should have requested the I-551 replacement. (Cannot use the I-151 card as verification for MA eligibility, must have replaced with the I-551).
- I-327, Permit to Reenter the United States. It is issued to lawful permanent residents before leaving the U.S. for one to two years. The expiration is on page 2.
- I-485, Application to Register Permanent Residence or to Adjust Status.
- I-539 Application to Extend/Change Non-immigrant Status.
- I-551, Permanent Resident Card (PRC). It is a revised edition of the I-151, issued for a renewable 10-year period to lawful permanent residents. The expiration date is on the document face.
- I-551, Permanent Resident Card (Conditional Permanent Resident). It is issued for a two-year period (expiration date on the back) to conditional permanent residents such as non-citizen spouses of U.S. citizens/permanent residents.
- I-571, Refugee Travel Document. It is issued to non-citizens granted refugee status who intend to travel abroad. The expiration date is on page 4.
- I-698, Application to Adjust Status From Temporary to Permanent Resident.
- I-765, Application for Employment Authorization.
- I-766, Employment Authorization Document.
- I-797, Notice of Action. It is issued to applicants/petitioners to acknowledge receipt of applications, convey statuses, etc. It verifies lawful permanent resident status when it acknowledges both receipt of application for a replacement I-551 and receipt of the old I-551.

- N-550 or N-570, Certificate of Naturalization. It is issued to naturalized U.S. citizens.
- N-560, Certificate of United States Citizenship. It is issued to persons with citizenship acquired through naturalization of a parent, birth by a U.S. citizen in another country, or application by adoptive parents.

USCIS Non-Immigrant Classifications

These classifications indicate temporary or time-limited status. They include but are not limited to the following:

A. Foreign government representatives on official business and their families and servants (A1-3).

B. Visitors for business or pleasure, including exchange visitors (B1, 2).

C. Non-Citizens in travel status while traveling directly through the U.S. (C1-4).

D. Crewman on shore leave (D1,2).

E. Treaty traders and investors and their families (E1,2).

F. Foreign students (F1,2).

G. International organization representation and personnel and their families and servants (G1-5).

H. Temporary workers including agricultural contract workers (H1-4).

I. Members of foreign press, radio, film or other information media and their families (I).

EXHIBIT IVV - HOW TO BECOME A UNITED STATES CITIZEN

Most people become U.S. citizens in one of two ways: by birth, either within the territory of the United States or to U.S. citizen parents, or by naturalization.

For information about becoming a U.S. citizen go to the U.S. Citizenship and Immigration Services (USCIS) website at

http://www.uscis.gov/portal/site/uscis. Click on the Learn about U.S. Citizenship button on the left navigation.

LEGAL BASE

All Programs

Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA)
P.L. 104-193 of 1996, as amended
P.L. 106-386 of 2000, Victims of Trafficking and Violence Protection Act of 2000
P.L. 110-457 of 2008, William Wilberforce Trafficking Victims Protection Reauthorization Act of 2008
P.L. 114.22, Justice for Victims of Trafficking Act of 2015
65 FR 58301

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

FIP

P.A. 280 of 1939, as amended, MCL 400.1 et seq.
INA: Act 301- Sec. 301(8 U.S.C. 1401)(g)

MA

42 CFR 435.403, 406, 407, Public Law 109-171
Deficit Reduction Act 2005, Social Security Act 1903(x), PL 109-171
Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), Public Law 111-3.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

FAP

Federal Supplemental Nutrition Assistance Program

7 U.S.C. 2011-2036
7 CFR 273.2(b)(1)(iii)
7 CFR 273.2(f)(1)(ii)
7 CFR 273.4(a)(4),(5),(6) and (b)
38 U.S.C 5303(b)
38 U.S.C 107
INA: Act 301- Sec. 301(8 U.S.C. 1401)(g)

DEPARTMENT POLICY

The Michigan Department of Health and Human Services (MDHHS) routinely utilizes data exchanges for verification of certain eligibility factors. Information provided with MDHHS and MDE applications (MDHHS-1171, MDHHS-1010, DHS-4574, DHS-4574B, and DCH 1426) informs individuals of the data exchange process.

OVERVIEW

The Systematic Alien Verification for Entitlements (SAVE) Program enables federal, state, local government agencies and licensing bureaus to obtain immigration status information needed to determine a noncitizen applicant's eligibility for many public benefits. The SAVE Program is an intergovernmental information-sharing initiative designed to aid specialists in determining a noncitizen applicant's immigration status. This will ensure that only eligible noncitizen applicants receive federal, state, or local public benefits. The SAVE Program is an information service which benefits issuing agencies, institutions, licensing bureaus, and other entities. The SAVE Program does not make a determination on noncitizen applicant's eligibility for a specific benefit or license.

All Programs

Determine the status of noncitizens according to policy outlined in BEM 225. Apply the SAVE process at intake, add a member, and if a change in immigration status occurs. When the SAVE box is not checked, additional screens are required to complete the SAVE process.

PROCESS

The SAVE process is prompted in Bridges when the specialist completes the Alien Details screen.

Record all non-citizen details in Bridges that are reported by the individual and/or are supported by documentation. The data that is required is determined by the selection of the status, document type, and verification; see Verification Sources in BEM 225.

Benefits may be approved while SAVE is pending. However, if the final response from SAVE does not validate the individual’s status as reported, the specialist must contact the individual to clarify the discrepancy.

SAVE Response

The SAVE response screen begins with the display of the Individual information as entered on the Alien-Details screen. Validation of the information is obtained from SAVE at three levels. The Level 1 process should resolve ninety percent of all requests within 3-5 seconds. The Level 2 process may be required when further information is needed and may take 3-5 federal working days. Few inquiries require the Level 3 process which takes 10-20 federal working days to resolve. The three levels of SAVE are enabled as needed in the process.

Level 1

The specialist must submit initial verification at Level 1.

Within 3-5 seconds the SAVE response fills the data fields to complete Level 1. See table for possible responses and necessary action:

RESPONSE to LEVEL 1	ACTION
Eligibility status is confirmed	SAVE indicator is checked. No further action needed by specialist.
Submitted verification requires correction	Correct document, number or additional verification and submit corrected verification.
Institute Additional Verification	Proceed to Level 2.

Note: When the Class of Admission code found for the noncitizen indicates a student or exchange visitor the individual alien type/document is automatically changed to non-immigrant and SAVE is not applied.

Level 2

When the initial verification cannot conclusively determine the noncitizen status electronically, the secondary verification prompts SAVE to perform a manual search of the individual's status. The specialist must request secondary verification when indicated by the Level 1 response. See table for possible responses and necessary action:

RESPONSE to LEVEL 2	ACTION
Eligibility status is confirmed with major code other than 15.	SAVE indicator is checked. No further action needed by specialist.
Major code is 15.	Task/reminder is generated for specialist to proceed to Level 3.

Level 3

When Level 2 verification cannot conclusively determine the individual's non-citizen status, the Level 3 process is required. The specialist must submit the Level 3 verification when indicated by the Level 2 response.

See table for possible responses and necessary action:

RESPONSE to LEVEL 3	ACTION
Eligibility status is confirmed with major code 1, 2, 4, 5, 6, 7, 8, 9, 11, 19, or 20.	SAVE indicator is checked. No further action needed by specialist.
Major code is anything other than 1, 2, 4, 5, 6, 7, 8, 9, 11, 19, or 20.	Task/reminder is generated for specialist to review the SAVE response and change the alien type to undocumented alien. Complete verification.

SAVE Completion

The process may be complete at any level of the SAVE process. Once complete, one of the following will occur:

- The individual's status is confirmed, the SAVE indicator is checked and eligibility status is sustained.
- The specialist changes the individual's alien status to undocumented alien and proceeds with case processing.
- The SAVE response indicates non-immigrant status and SAVE is not applicable.

LEGAL BASE

Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Pub. L. No. 104-193, 100 Stat. 2105, as amended.

Immigration Reform and Control Act of 1986, Pub. L. No 99-603, 100 Stat 3359 as amended (see, e.g., 8USC 1101).

Illegal Immigration Reform and Immigrant Responsibility Act of 1996 (IIRAIRA), P.L. 104-208, 110 Stat. 3009-546.

7 CFR 272.11

DEPARTMENT POLICY

FAP Only

This item applies only to non-categorically eligible FAP groups that have a member who is FAP disqualified, see BEM 213.

Definitions

Indigent Alien

A sponsored alien who is unable to obtain food and shelter because the sum of the sponsored alien's income and that of the sponsor's income and contributions are less than 130 percent of the poverty income guideline for the household size; see "Determining Deemed Amounts" in this item.

INA

The Immigration and Nationality Act.

USCIS refers to the U.S. Citizenship and Immigration Services, formerly Bureau of Citizenship and Immigration Services (BCIS) or Immigration and Naturalization Service (INS).

A **sponsor** is a person and the person's spouse who has executed USCIS form I-864, I-864A or I-864EZ on or after December 19, 1997, agreeing to financially support an non-citizen as a condition of the non-citizen's entry into the U.S. for permanent residence.

A **sponsored alien** is an non-citizen for whom the above agreement of financial support is made.

Date of entry, established by USCIS, is the date the sponsored alien was admitted into the U.S. for permanent residence.

Deemed income means a financial resource that is considered available to the sponsored alien without proof of an actual contribution.

Note: Sponsors' assets will be deemed only to non-categorically eligible households.

Overview

The income and assets of both the sponsor and their spouse must be considered in determining eligibility and benefit level until:

- The non-citizen gains U.S. citizenship.
- Has earned 40 qualifying work quarters.
- A portion of the sponsor's income might be deemed available to the non-citizen; see Determining Deemed Amounts in this item.

Consider the deemed amounts available to the sponsored alien even if the sponsor:

- Does **not** make an actual contribution to the non-citizen.
- Gives up sponsorship responsibilities.

Exception: Indigent Aliens; see Income Test.

If the non-citizen changes sponsors, evaluate the new sponsor's income and assets. Deeming ceases for the earlier sponsor.

The names of all non-citizens a sponsor is responsible for must be provided at application and redetermination. If the sponsored aliens are in separate FAP groups, divide the total deemable income equally among the groups. If no other names are provided, attribute the total deemable amounts to the non-citizen applicant.

Exempt Aliens

The income and assets of the non-citizen sponsor must be evaluated for all sponsored aliens **except** the following:

- Any non-citizen who is under age 18.
- Battered alien spouse or alien parent of a battered child for 12 months after battery is determined by USCIS or the state agency. The battered alien must not live with the batterer.
- Non-citizens admitted into the U.S. as refugees under INA section 212(d)(5) or 207.
- Non-citizens granted political asylum under INA section 208.
- Non-citizens granted withholding of deportation per INA section 243(h).
- Non-citizens admitted as conditional entrant refugees before April 1, 1980 under INA section 203(a)(7).

- Non-citizens granted permanent resident status under INA section 245A or 210 (class code S16, S26, W16, W26 or W36 on the I-551).
- An indigent alien.
- Non-citizens whose sponsor signed the agreement of support before December 19, 1997.
- Non-citizens who are a member of their sponsor's FAP household.
- Disqualified sponsored alien.

Determining Deemed Amounts

Evaluate the income and assets of the sponsor **and** their spouse if they live together. This applies even if they were not married when the agreement was signed.

Use a DHS-2411, Statement of Sponsor's Resources, to obtain information about a sponsor.

To determine deemed income**,** see BEM 550.

Deeming ceases if the sponsor dies, regardless of a surviving spouse and/or estate.

Income Test

The sponsor's income deemed to be available to the sponsored alien is counted as income to the non-citizen's group.

If the sponsored alien has been determined to be indigent; see Definitions, deem only that amount of income that is actually provided. Continue to deem this amount for 12 months. Determine indigence every 12 months. Send indigence determinations to the U.S. Attorney General's Office at:

U.S. Department of Justice
950 Pennsylvania Ave. NW
Washington, D.C. 20530-0001

Provide the sponsor's name and the sponsored alien's name.

Note: The sponsored alien must provide written consent before any information is released to the Attorney General or the non-

citizen's sponsor. However, the specialist must notify the sponsored alien of the consequences of refusing to provide consent; see Refusing Information below.

Reporting Changes

All sponsored aliens must report sponsor information at the following times:

- At application and redetermination.
- At a change in sponsor.
- When income of the sponsor or sponsor's spouse changes, including loss of employment.
- Upon death of the sponsor or sponsor's spouse.

Refusing Information

If requested information about a sponsor is **not** provided, one of the following applies:

- If the sponsored alien is cooperating, treat him as disqualified.
- If the sponsored alien is **not** cooperating, another adult group member must cooperate. If none do, **all** group members are ineligible, even if they are U.S. citizens.

Overissuance

The sponsor and non-citizen are jointly responsible for a benefit overissuance due to inaccurate or incomplete information regarding the sponsor's income or assets.

Exception: The non-citizen is solely responsible **if** the sponsor had good cause or was without fault.

BAM 715 explains recoupment procedures for active and closed cases.

Initiate recoupment from the group which received the overissuance. However, repayment can be made by the group, the sponsor, or both.

If both parties repay **and** the total exceeds the overissuance, the excess must be refunded in proportion to the amount paid by each party.

VERIFICATION REQUIREMENTS

The sponsored alien must provide, or assure that the sponsor provides, necessary information and verification.

The non-citizen must report any change in the sponsor's circumstances.

Verify a sponsor's claim of sponsoring aliens in different FAP groups.

Record the non-citizen's place of birth and alien registration number in the case.

LEGAL BASE

FAP

7 CFR 273.4(c)
7 CFR 273.11(h)
7 USC 2014

DEPARTMENT POLICY

FIP and FAP Only

A **striker** is a person involved in an employee strike, concerted stoppage, slowdown or interruption of work activities or employment operations. This includes a stoppage when a collective bargaining agreement expires.

Persons are **not** considered strikers **if** they:

- Are locked out of the workplace by the employer, **or**
- Are not part of the bargaining unit on strike, **or**
- Are non-strikers who fear reprisal if they cross a picket line, **or**
- For **FAP only**, were exempt from employment-related activities on the day before the strike for any reason **other than** being employed.

FIP Only

Exclude from the group a person on strike on the **last day of a calendar month**. Also exclude:

- The striker's spouse, **if** they live together, **and**
- The striker's children living with him.

APPLICATION

FIP Only

At application, assume a striker will be on strike on the last day of the month **unless** it is verified that he will not be.

FAP Only

Groups with strikers are eligible **only if** they were eligible for, or receiving FAP before the strike **and** continue to be eligible. If pre-strike **ineligibility** is established, you do **not** have to determine current eligibility.

Pre- and post-strike eligibility is determined as follows:

- Evaluate the group's nonfinancial eligibility on the **day before the strike**. If those factors were met, evaluate **current** nonfinancial eligibility.

- Calculate the fiscal group's countable **pre-strike** income. If the group was income eligible, combine
  - The striker's **pre-strike or current** countable income, whichever is higher, **plus**
  - Current countable income of other fiscal group members.

See the "**STRIKERS**" section in BEM 550.

The group is eligible **if** it meets **all** of the above conditions. Both pre-strike and current circumstances must be verified.

Document the case record including both the pre-strike and current circumstances.

Use of Union or Company Facilities

FAP Only

Do **not** complete FAP certifications using services or facilities of organizations or individuals involved in a strike/lockout. However, you may use union or company officials to verify applicant information.

ONGOING

FIP Only

If a group member was on strike on the last day of the report month, remove the striker from the group for **two pay periods or until the strike ends**, whichever is longer. Remove his/her spouse, if they live together, and his/her natural/adopted children who live with him/her.

FAP Only

Refer to the "**APPLICATION**" section above to determine whether a group with a striker continues to be eligible.

LEGAL BASE

FIP

R400.3117

FAP

7 CFR 273.1

DEPARTMENTAL PHILOSOPHY

The Family Independence Program (FIP) is a temporary cash assistance program to support a family's movement to self-sufficiency. The Family Self-Sufficiency Plan (FSSP) was created to allow Michigan Department of Health and Human Services (MDHHS) and other MDHHS client service providers to document and share information about mutual participants for optimal case management. The department's goal of assisting families to achieve self-sufficiency whenever possible can only be achieved if barriers are properly identified and overcome.

Use the Family Automated Screening Tool (FAST) and the FSSP described below to serve the FIP assistance recipients.

DEPARTMENTAL POLICY

Federal and state laws require each family receiving FIP to develop a plan and participate in activities that will strengthen the family and/or help them reach self-sufficiency. Users of the FSSP include MDHHS and the Partnership. Accountability. Training. Hope. (PATH)/one-stop service centers.

Note: Recipients of Refugee Cash Assistance (RCA) are not required to complete the FAST or FSSP issued from Bridges. These individuals are required to complete a Refugee Family Self-Sufficiency Plan (RFSSP) with the refugee contractor (RC).

Michigan's success in meeting federal work participation requirements is measured by the participant's actual hours of participation in work related activities as documented on the FSSP.

The FSSP identifies compliance goals and responsibilities to be met by members of the FIP group, MDHHS, and PATH. The FSSP plan reflects the individual needs and abilities of the particular family, and includes the following:

- The obligation of each adult to participate (an adult who is not working 40 hours a week) in PATH and to meet federal guidelines for work participation unless verified as deferred.
- The obligation of each minor parent who has not completed secondary school to attend school.

- The obligation to cooperate in the establishment of paternity and to assign child and spousal support to MDHHS and to cooperate in the procurement of child support.
- The obligation of the recipient who fails to comply with compliance goals due to substance abuse to participate in substance abuse treatment and submit to any periodic drug testing required by the treatment program.
- Notification to the recipient of the individual 48-month lifetime cumulative total for receiving FIP assistance.
- Notification to recipient regarding employment and self-sufficiency related noncompliance that may be imposed.
- Prohibition against use of FIP to purchase lottery tickets, alcohol, or tobacco. Cash assistance grants cannot be used for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, cruise ships or other nonessential items.
- The Family Automated Screening Tool (FAST) is a Web-based initial screening to identify the strengths and needs of FIP families. Completing a FAST is one of the FIP participant's first required work related activities and establishes a foundation for the development of a successful FSSP.

All Work Eligible Individuals (WEIs) and non WEI's as defined below are required to complete the FAST within 30 days and participate in the development of the FSSP within 90 days of the FAST/FSSP notice.

Compliance with the FSSP is a required activity for all WEIs. These requirements apply to FIP participants who are referred to PATH as well as those who are temporarily deferred. Non-compliance with the FSSP without good cause may result in penalties outlined in BEM 233A, 233B and 233C.

Exception: RCA recipients have a requirement to complete a Refugee Family Self-Sufficiency Plan (RFSSP) with the refugee contractor (RC).

WHEN TO COMPLETE

Explain the purpose of the FAST and FSSP during the initial in-person or phone interview and determine whether the participant

needs a paper copy of the DHS-595, FAST, or additional help to complete the FAST. A FAST/FSSP notice, DHS-1535 or 1536 is automatically sent to applicants the night after the first run of eligibility (EDBC) for FIP. All participants listed on the notice are required to complete the FAST within 30 days and the FSSP within 90 days of the notice. The DHS-1535 is for deferred WEIs and the DHS-1536 is for referred WEIs.

The completion of the FAST is required once for each episode of FIP assistance. The FSSP is complete when the participant, department and other service providers have agreed to the activities and the agreement date is entered in the Contract Agreement under the Contracts tab of the FSSP.

The FAST is required for the determination of good cause. When a participant is noncompliant with work related activities and a FAST has not been completed during the same episode of assistance, a FAST must also be completed, in order to determine good cause.

Send a DHS-2442, Notice of Employment-Related Appointment/Assignment or Home call, to the participant after the submission of the FAST and before the 90th day from the date the FAST/FSSP notice to arrange for the development of an FSSP for those not served by PATH.

Note: The completion of the FSSP requires action by all agencies involved in the case management of the participant. The participant cannot be considered noncompliant for the FSSP, if the agency fails to complete the FSSP mapping process.

WHO MUST COMPLETE

All FIP WEIs and non-WEIs must complete a FAST and develop a FSSP.

Work Eligible Individuals (WEIs)

Work Eligible Individuals (WEIs) are FIP participants who count in the state and/or federal work participation rate. All WEIs are required to participate in work related activities (core or non-core) for a minimum number of hours based on case circumstances unless reasonable accommodations are required and other activities are planned; see BEM 230A. WEIs include all FIP applicants and participants, except those listed under Non-Work

Eligible Individuals, below. For more information about the work participation role, see Exhibit I.

Non-Work Eligible Individuals

Non-WEIs are FIP recipients who do not count in the state and/or federal work participation rate. Non-WEIs are not required to participate in work related activities for a minimum number of hours but may volunteer for core or non-core activities. Instead, non-WEIs engage in other activities to strengthen the family or improve self-sufficiency skills. For more information about PATH, see Exhibit I.

Non-WEIs include all the following:

- An adult FIP client who is disqualified due to being a non-citizen.

  Note: All other disqualified adults are WEIs.

- Ineligible Grantees.The person who acts as grantee but who is not an eligible group member.

- An adult FIP participant providing care for a spouse who is disabled and living in the home.

  Note: Verification of the disability and that the care is needed on a full time basis must be supported by medical documentation; see BEM 230A, Care of a Disabled Spouse or Disabled Child.

- An adult FIP participant providing care for a child who is disabled and living in the home.

  Note: Verification of the disability and that the care is needed must be supported by medical documentation; see BEM 230A, Care of a Disabled Spouse or Disabled Child.

The following types of dependent children are not WEIs and are the only individuals who do not have to complete a FAST or FSSP.

- Dependent children who are either:
  - Under age 16.
  - Age 16 through 18 who are full-time students in high school.

See BEM 245 for a definition of high school and an explanation of full time enrollment and attendance.

FAMILY AUTOMATED SCREENING TOOL

The Family Automated Screening Tool (FAST) is a 50-question, Web-based survey designed to identify an individual's strengths, needs and barriers to family functioning and/or successful employment. The framework of information about the family that is gathered from the FAST will pre-fill various sections of the FSSP.

Participants complete the FAST from any computer with Internet access. This could occur in the participant's home, through public Internet access, at the local PATH office, or from a PC available in the local MDHHS office. The address to the FAST is www.michigan.gov/fast. The client recipient ID, the name of the service county and the last four digits of the participant’s Social Security number are entered to complete a FAST. (Instruct participant to enter four zeros when participant has no Social Security number.)

Completion of the FAST will take approximately 30 minutes depending on the individual's reading and computer skills. The participant must select an answer to every question even if it is skip. When the participant submits final answers to complete the FAST, the participant will be given a confirmation number to print or write down as verification that the FAST was completed.

Individuals with disabilities, no Internet access or literacy skills that prevent successful completion of the FAST may complete the DHS-595, Family Screening Tool. MDHHS specialists and PATH case managers must assist.

The participant's answers from the paper FAST must be entered on the electronic FAST to pre-fill information on the participant's FSSP. MDHHS staff may enter this information for deferred participants.

FAMILY SELF-SUFFICIENCY PLAN

The Family Self-Sufficiency Plan (FSSP) is a Web-based service plan developed by the department, employment service provider and, most importantly, the participant. It allows agencies to share information about mutual participants to eliminate the participant's need to comply with multiple plans. It is used to collect, document,

and report participant activities that promote self-sufficiency and meet federal reporting requirements. Information is entered on the FSSP from the following sources:

- As a result of FAST completion.
- Directly by MDHHS specialist.
  Directly by the PATH case manager.

MDHHS specialists access the FSSP from Bridges. The one-stop service center case workers access the FSSP (read only) from OSMIS.

Create or Update FSSP

Open the FSSP at the in-person interview (new episode) or when completing a changeto enter strengths and/or barriers that are identified during the interview. Enter the case number of a pending or active FIP case in Bridges to view the FSSP.

GENERAL INFORMATION ABOUT THE FSSP

Each summary page in the FSSP displays a header that includes identifying information about the specific participant for quick reference: Name, client ID, case number. Required and planned hours are displayed for the benefit of serving FIP recipients.

The sources of information are automatically entered on the FSSP. The sources may be the FAST (participant), FSSP, or OSMIS.

Access information for various sections of the FSSP by clicking the edit pencil box to the far right of a goal, activity, strength, etc page. Enter comments by clicking the comment icon at the top of a barrier, strength, etc page. Click save and continue prior to leaving a section to save your entry. Add case comments to clarify and changes or errors. Previously saved comments cannot be deleted. Items entered and comments saved for those items from the FAST cannot be deleted.

CLIENT INFORMATION

Information in these sections are either pre-filled by systems or saved by the case manager. Information saved by the case manager will remain on this FSSP despite the status of the FIP assistance. There are six sections under this tab:

- **Client Information- Contact**- The page will be auto populated by the information found on the Data collection pages in Bridges. .
- **Employment Information**- The Employment pages will auto populate by the information found on the Data Collection pages (Employment-Details and Employment-Summary).
- **Skills Information-** The Specialist will evaluate and measure individual skill levels and enter information on the Skills page.
- **Education Information-** The Specialist will evaluate and measure individual education level and educational goals and enter information on the Education page.
- **Testing Information-** The Specialist will evaluate and measure the need for testing and enter testing information on the Testing page.

  Family Strengths Information- Individual or Family goals will appear on the Strengths page.

Participation

These fields are automatically pre-filled and are read only.

Required Hours are the minimum of hours per week, on average, that a participate must participate in work related activities to meet the federal work participant requirement.

Planned Hours are the hours per week, on average, that a participant will participate in work-related or other activities which are documented under the Goals and Activities tab. Activities assigned by the PATH in the OSMIS system are included in this calculation.

STRENGTHS AND ABILITIES.

Start with this section when you interview the participant to complete the FSSP. Compliment the participant on strengths identified at application, interviews or by completion of the FAST. A confident participant will be a more active participant in developing the FSSP.

Strengths are identified by type: employment, education and training or family strengthening for quick reference by the worker assigned from each agency. Some strengths will be pre-filled based on how the participant answered the FAST questions. Comments may be entered for items collected from the FAST; however, the item cannot be deleted. Enter comments to strength when necessary as you discuss them with the participant.

Help the participant identify resources the participant already has available to move toward success without MDHHS. The following technique is recommended:

Tell me about a success you have had in the past. Which of your qualities contributed to your success? Have you always had this quality or did you have to learn it?

Often concerns can translate to strengths. For instance:

- Children who have no history of truancy or expulsion from school..
- An individual successfully completed inpatient or outpatient rehabilitation..
- Successfully completed Employment and Training programs under the Job Training Parternership Act (JTPA).
- An individul who have litte ornever worked, however very knowledgeable in life experiences, andbonded with their children.

BARRIERS & RESOURCES

Barriers

Identify, document and address barriers to self-sufficiency in this section as in the Strengths and Abilities section.

Based on how the participant answered the FAST, explore the need to address specific potential barriers. Discuss these items with the individual and document results discussion in the comments section associated when necessary. When the FAST results suggest a barrier that the participant has already addressed or does not recognize, document this in the comments and focus on addressing barriers which the participant recognizes and is ready to work on. Consider activities that could be planned that will address the barriers the participant is willing and able to address.

Resources

After discussing strengths and abilities, complete the resource section. FAST results in this section will report needs for which the participant specifically requested help or services. Participants are more likely to be successful in activities related to these items because they are self-identified. Help the participant choose activities related to these items.

Add potential referrals to this section for needs that are identified but an activity cannot be entered to address that need, or the participant does not yet recognize the need.

GOALS & ACTIVITIES

Enter goal and activity information agreed upon with the participant in these sections. Remember to ask about and enter activities in which the participant is already participating.

Goal

Help the participant identify family goals. Use the miracle question to allow him/her to dream or create an alternative future. When using the miracle question, ask the participant: “When you wake up tomorrow morning and your world is exactly how you want it to be, what would be different from today?” If the participant’s goals are too vague, broad, or far in the future, assist by asking for more detail so the participant will be motivated toward short term goals and a plan can be developed. To be meaningful, the goals must be achievable, clear, simple, and measurable.

Participant complaints about their current situation can be rephrased as goals to change something in their lives. For example, if the participant complains that s/he does not have enough money, the goal could be to get more money. Get details on what s/he would buy with the money to make the goal more

concrete. Compliment the participant as s/he works through this process.

Activities

Activities are specific actions the participant will take to reach the goal(s) and meet PATH requirements. Activities are divided into three categories: core, non-core and other.

Note: PATH workers enter activities in OSMIS when the WEI is referred there. Necessary comments that pertain to PATH activities must be entered in OSMIS.

Core Activities

Core activities are recorded by PATH for the WEI referred to the PATH. They include the following activities:

- Unsubsidized employment.
- Subsidized private and public sector employment.
- Work experience.
- On-the-job training.
- Job search/job readiness.
- Community service programs.
- Vocational educational training, including condensed vocational training.
- Providing child care for a community service participant.

Unless a WEI is planning to participate in a minimum of 20-hour core activities and the remaining required hours in non-core activities, none of the hours will meet federal participation requirements and thereby reduce the state's participation rate.

Fair Labor Standards Act (FLSA)

As a **core** activity, when a participant is assigned to or participating in unpaid work activity that includes community service or work experience, the total number of required hours of participation in the unpaid work cannot exceed the FIP grant amount divided by state minimum wage per month.

Combined FIP/FAP Waiver

In order to comply federal FLSA requirements, a participant must engage in another core activity if the maximum unpaid work hours are not enough to meet the minimum federal participation requirements. With the combined FIP/FAP waiver, the FIP and FAP grants are combined and divided by the state minimum wage, in most cases, allowing the participant increased hours for which they can participate in community service and/or unpaid work experience to meet federal work participation requirements. Furthermore, if a participant is assigned the maximum hours allowed by the FLSA calculation, but this maximum is not enough to meet their core hour requirement, the remaining core hours may be "deemed." Deeming gives the participant credit for completing **core (**for community service or unpaid work experience **only)** hours when they have not actually met their required hours, due to the FLSA restriction. By deeming, the participant meets WPR requirements for the month.

Note: Bridges interfaces to OSMIS the combined FIP/FAP grant amount on a monthly basis.

Example: FIP and FAP grant amount combined for a family of two (consisting of one adult and one child) is $803. Divide $803 by state minimum wage ($9.25). The total of 86.81 hours per month is rounded to the lower whole number. 86 hours per month is the maximum number of community service/unpaid work hours that may be required of the participant. This participant has a 30 hour per week minimum federal requirement, multiplied by four weeks, totaling 120 hours per month. In this example, there is a shortfall of 34 required hours, as the FIP and FAP combined grant amounts limits the participant to 86 hours maximum in community service and/or unpaid work experience. The participant will be deemed as meeting his/her entire work requirement for that month.

A participant with a 30 hour requirement must complete their 20 required hours in the core activities and may complete the additional 10 required hours in non-core activities. If the participant is able to deem their 20 hour requirement based on the combined FIP/FAP waiver, but does not meet their additional 10 hour non-core requirement, that participant will not meet their work participation requirement for the month.

Non-Core Activities

Non-core activities are only countable when the minimum number of core activities have been met. Non-core activities include the following:

- Job skills training directly related to employment.
- Education directly related to employment.
- High school completion/GED.

Other Activities

Other activities are family strengthening activities that may support efforts made toward self-sufficiency and are not counted toward federal participation requirements. These include self-improvement or other activities that will assist the participant to overcome barriers so they may participate in employment services or otherwise strengthen the family. Other activities include but are not limited to the following:

- Parenting programs or classes.
- Counseling, including mental health, substance abuse, marital, family.
- Life skills programs or classes .
- Conflict resolution programs or classes.
- Arranging child care or home care for a family member with disabilities.
- Attendance in a support group.
- Any other activity that would assist the participant in achieving self-sufficiency.

Any activities that are part of the FSSP must be appropriate to the individual's and family's needs and circumstances, including disability-related needs or limitations.

Note: Counseling contractors are paid directly from the DSS allocation. Contractors that serve your county are listed in the MDHHS-Net by selecting the Department Site, Central Office, Financial and Administrative Service, Logistics and Rate Setting, Counseling Contracts. Select the county and type of counseling desired.

REQUIRED HOURS OF PARTICIPATION FOR WEIS

Required hours are the minimum number of hours per week on average the WEI is to participate in work-related activities to meet the federal work participation requirement. Required hours will appear in the Required Hours field on the FSSP and OSMIS for every WEI. Required hours are automatically determined by the group composition when the FSSP is opened/edited as follows:

Single Parent Households

20-Hour Requirement

A FIP group containing only one WEI when the youngest child in the group is less than six years old.

Exception: A WEI who is temporarily deferred from a referral to employment services due to being a caregiver of a child less than two months old or a caretaker of a child less than six years old is temporarily disregarded from participation when appropriate, adequate or affordable child care is not available and unavailability is verified in writing by the Great Start Connect contractor. (Required hours are zero).

30-Hour Requirement

A FIP group containing only one WEI parent when the youngest child in the group is six years old or greater.

Note 1: A FIP household containing two parents, where only one parent is a FIP group member/WEI due to the marriage exemption, will follow the single parent household hour requirements.

Note 2: A FIP household containing two parents has a 30 hour requirement, regardless of the age of the youngest child, when only one parent is a FIP group member/WEI due to receipt of SSI by the second parent.

Two-Parent Households

In a two-parent family, the required hours apply to the couple as opposed to the individual; however, the entire required hours

appear only on the grantee's FSSP. The second adult will show zero required hours.

Exception: A two-parent household is considered a single-parent household when one parent:

- Receives SSI.
- Is needed in the home to care for a child/spouse who is disabled.
- Is disqualified due to being a non-citizen.

Combined 35-Hour Requirement

A FIP group containing two WEIs when the group is not active for the Child Development and Care (CDC) Program or CDC payment has not been authorized. One WEI can complete combined 35 hour requirement.

Combined 55-Hour Requirement

A FIP group containing two WEIs when the group is active for the CDC Program and CDC payment has been authorized. Both WEIs must complete combined 55 hour requirement.

18 And 19 Year Old Adults

18 and 19 year old adults who are active at the one-stop service center may be deemed as meeting their required hours if they are participating in high school completion or GED to satisfactory attendance as determined by the educational institution. This deeming is determined by the PATH case manager.

REQUIRED HOURS OF PARTICIPATION FOR NON-WEIS

Non-WEIs are not required to participate in work related activities for a minimum number of hours. Instead, they should be encouraged to engage in activities to strengthen the family or improve self-sufficiency skills. Notice the difference in verification requirements for the WEI and non-WEI.

DRAWING ACTIVITIES FROM YOUR CLIENT

Employment service providers take the lead in planning activities when the participant is referred for employment services.

MDHHS must plan and monitor other activities appropriate to the needs, strengths and circumstances of a family when the participant is referred to the employment service provider for a reduced number of hours due to a partial deferral, accommodation for disabilities or special needs and/or limitations.

MDHHS takes the lead in planning activities when the participant is not referred to an employment service provider.

Explore situations from the participant's past to find success. Ask, "Was there ever a time in the past when you were in a similar situation? Do you know of anyone who has been in a similar situation? How was that handled?" Get details.

Allow the participant time to think. Compliment the participant as s/he thinks of solutions. Write down all options the participant comes up with, then discuss the possible consequences after a few options have been listed. Do not offer solutions. Let the participant suggest his/her own ideas.

Help the participant identify the activities s/he needs to take, the date to start the activities, and the expected result. Ask the participant, "What is the very first small step? Before that? Before that? What else?" until the participant identifies specific activities s/he can begin now. Ask, "How will you do that?" "How will you know when you achieve it?" and "What would you like to see happen as a result?"

Consider the participant's circumstances and local resources in helping them choose the best activity. Keep these suggestions in mind when assisting the participant to identify options they can choose to meet goals.

Avoid using phrases such as "you should," "why don't you?" or "you must."

Ineligible grantees are more likely to engage in activities that promote family strengthening such as volunteering at their childrens' school or visiting the library on a regular basis.

Entering Goals/ Activities on the FSSP

Click Add to enter the participant's long and/or short-term goal statements or an activity. Select the type from education & training, employment, or family strengthening for a goal. The activity selected determines the fields used to describe specifics about the activity. You may enter other details about the activity in the Description area.

Statuses include

- **Planned:** The participant has agreed to participate in the goal/activity.
- **In Progress:** The participant is currently participating in the goal/activity.
- **Complete:** The participant completed the goal/activity. Enter an end date. This goal/activity will be stored in the History section of the activities screen. A completed goal will also appear as a strength.
- **Abandoned:** The participant is no longer participating in this goal/activity. This activity will automatically move to the History section of that screen for future consideration.

Other Fields

Other fields that may appear in a goal/activity are as follows:

- **Begin Date:** Enter the expected begin date or actual begin date. There are time limits on some activities so it is most advantageous to begin an activity early in the week that starts with Sunday.
- **Target Date:** The target date for a GOAL is the anticipated date of completion. The target date for an ACTIVITY is the next date the actual hours must be entered on the FSSP**.**
- **End Date:** Enter the last date the participant participated in the goal or activity.
- **Planned Hours/wk:** Enter the average number of hours per week the participant expects to participate in the activity. This must be a whole number.

- **Actual Hours/wk:** The Status of an activity must be saved as In Progress to enter Actual Hours/wk. Enter the number of hours per Verifications later in this item.

  Note: Actual hours must be entered for all WEIs for their participation in work related activities to be counted in the federal participation rate.

  Verification of wage earning activities must be entered in the Actual Hours at least every six months. Project the actual hours by taking the average from at least two consecutive pay stubs that represent hours worked. Actual hours may be projected for up to six months or one week at a time.

  Verification of unpaid activities must be entered in the Actual Hours of that activity aweekly for the WEI. The DHS-630, Weekly Activity Log, is completed and submitted by the WEI participant weekly to the worker who is monitoring that activity. The worker must enter the actual hours within two weeks of receipt.

  Note: Set the activity target date to the next date actual hours must be entered for each activity.

PATH case managers continue to enter activities and actual hours on the OSMIS system. Activities documented in OSMIS will appear in the FSSP fields the day after they are saved on OSMIS.

For any of a participant's hours of work related activity to count towards the federal requirements, they must participate in at least 20 hours of core activities in addition to the remaining number of required hours in non-core activities per week.

In a two-parent home that has a 35 hour/week work related participation requirement, the group must participate in at least 30 hours of core activities in addition to the remaining number of required hours in non-core activities per week for their participation to count toward the federal requirement.

In a two-parent home that has a 55 hour/week work related participation requirement, the group must participate in at least 50 hours of core activities in addition to the remaining number of required hours in non-core activities per week for the their participation to count toward the federal requirement.

PERSONAL CONTRACT

The Personal Contract page of the FSSP is used to display activities agreed to, target dates,changes made to the FSSP, and document the participant's agreement to the plan.

Initial development of the FSSP is considered complete when a date is entered on the Contract Agreements section for the first time of the current episode of cash assistance. This is documentation of the participant's agreement to the goals and activities entered. Complete the Personal Contract when the FSSP is initially developed, and each time changes are made to the activities within the FSSP. Give or send a printed copy of the contract to the participant each time it is completed. The printed version of the Personal Contract includes a notification to the participant that s/he must contact the MDHHS/PATH worker if anything interferes with the completion of an agreed upon activity.

A clear and accurate Personal Contract is important when it is developed as part of the triage or good cause determination. When the participant is available and willing, obtain the participant's signature on the printed version of the Personal Contract. However, if the FSSP is completed or updated over the telephone, acknowledge the participant's agreement in the comments section and mail a copy of the updated personal contract to the participant.

FOLLOW-UP

Participation in an activity entered on the FSSP is monitored by the agency that entered the activity. The target date entered for an activity is either the next time actual hours are to be entered for WEI's activities or follow-up to non-WEI's activities.

The next target date entered for each completed FSSP appears on the FSSP Target Dates report for MDHHS to view the dates to follow up.

Example: The PATH case manager assigned the participant to spend 20 hours per week developing a resume and seeking employment and the PATH case manager referred the participant to engage in parenting classes 10 hours per week. PATH monitors compliance with the hours of activity.

The FSSP is a work in progress while the FIP case is active. Review the goals and activities frequently in the process of case management.

- Ask the participant how s/he is coming along with the activities. The previous contact's narrative may assist in this process. Ask the participant, "What's better?"
- Using strength-based interviewing, address concerns related to meeting participation requirement if the participant is not participating.
- Update the dates activities were accomplished, comments and outcomes. Add new activities as appropriate.
- Document new individual and family abilities and skills as they are developed or identified.

FAILURE TO COMPLY

The WEIs failure to submit the FAST within 30 days of the notice date is failure to meet eligibility requirements. A task/reminder is sent to the specialist to deny the pending application for FIP.

The participant's failure to participate (can not be local office fault) in the development of the FSSP within 90 days of the notice date creates a record of noncooperation and a task/reminder is sent to the case manager to determine good cause for the noncooperation ion the active FIP EDG.

Policy Questions

Questions regarding this policy may be submitted by authorized users to the Employment & Training policy email box at: Policy-Employment@Michigan.gov.

VERIFICATION REQUIREMENTS

Wage Earning Activity

Document actual hours of participation in wage earning activities that are not monitored by PATH when earnings start and every six months thereafter. Take the average of verified hours from one of the following sources:

- MDHHS-38, Verification of Employment.

- Minimum of two consecutive pay check stubs that represent expected hours of participation.
- Collateral contact with employer or other person who has knowledge of the position and wages earned.

Non-Wage Earning Activity

Verification of the WEIs participation in core, non-core, and other activities that do not pay wages must be documented in the Actual Hours section of that activity at least biweekly. The only acceptable source of verification is the DHS-630, Weekly Activity Log.

Monitor the non-WEIs participation in activities during any contact with the family. Verification is not required.

VERIFICATION SOURCES

Wage Earning Activity

- MDHHS-38, Verification of Employment.
- Minimum of two consecutive pay check stubs that represent expected hours of participation.
- Collateral contact with employer or other person who has knowledge of the position and wages earned.

Non-Wage Earning Activity

Monitor the non-WEIs participation in activities during any contact with the family. Verification is not required.

LEGAL BASE

FIP

MCL 400.57e

EXHIBIT I - PATH ROLE

PATH ROLE				
Employment Code	**Required Hours**	**In Federal WPR**	**In State WPR**	**3 month, 6 month lifetime Sanction Eligible**
Work Eligible Individual (WEI): FIP recipients required to participate in employment-related activities. S/he counts in either the Federal or State WPR. S/he complete the FAST and participate in the development of an FSSP in conjunction with an employment service provider and MDHHS.				
WD/WL/WF (single)	Y	Y	Y	Y
WD/WL/WF (two-parent)	Y	N	Y	Y
VV	Y	Y	Y	Y
TC	Y	Y	Y	Y
WU (FIP)	Y	Y	Y	Y
OL	N	Y	Y	Y
SE (grantee)	Y	Y	Y	Y
SE (not grantee)	N	Y	N	N
VN	Y	Y	Y	Y
EI	Y	N	Y	Y
IN	Y	N	Y	Y
DV	Y	Y	Y	Y
DC	Y	Y	Y	N

PATH ROLE				
Employment Code	**Required Hours**	**In Federal WPR**	**In State WPR**	**3 month, 6 month lifetime Sanction Eligible**
TE	Y	Y	Y	Y
CA (2-month limit)	N	N	Y	Y
PG	Y	Y	Y	Y
OM* (WF)	Y	Y	Y	Y
Non-WEI: FIP member and/or grantee not required to participate in employment-related activities but is required to complete a FAST and assist in the development of an FSSP in conjunction with MDHHS that may include family strengthening activities (such as, other in FSSP).				
00	N	N	N	N
NC	N	N	N	Y
NS	N	N	N	Y
*** New with Bridges.**				

DEPARTMENT PHILOSOPHY

Clients must be made aware that public assistance is limited to 48 months to meet their family's needs and they must take personal responsibility to achieve self-sufficiency. This message, along with information on ways to achieve independence, direct support services, non-compliance penalties, and good cause reasons, is initially shared by Michigan Department of Health and Human Services (MDHHS) when the client applies for cash assistance. The Partnership. Accountability Training. Hope. (PATH) program requirements, education and training opportunities, and assessments will be covered by PATH when a mandatory PATH participant is referred at application.

DEPARTMENT POLICY

PATH Application Eligibility Period

Completion of the 10-day PATH application eligibility period (AEP) part of orientation which is an eligibility requirement for approval of the FIP application. PATH participants must complete all of the following in order for their FIP application to be approved:

- Begin the AEP by the last date to attend as indicated on the DHS-4785, PATH Appointment Notice.
- Complete PATH AEP requirements.
- Continue to participate in PATH after completion of the 10-day AEP.

Deny the FIP application if an applicant does not complete all of the above three components of the AEP.

Jobs and Self-Sufficiency Survey

At application, the registration support staff must provide clients with a DHS-619, Jobs and Self-Sufficiency Survey. For applications received from MI Bridges, the questions from the DHS-619 have been incorporated into the screens. Specialists must do all of the following:

- Review the survey or the PDF copy of the application from MI Bridges, and other information in the case record and Bridges

during the intake interview to make a preliminary barrier assessment to determine the client's readiness for PATH referral.

Note: Be alert to indicators that the client or family members suffer from undisclosed or undiagnosed disabilities. Some disabilities diminish the individual's ability to recognize or articulate his/her needs or limitations. Temporarily defer clients who need further screening or assessment.

- Identify and provide direct support services as needed. Child care and transportation barriers are common. MDHHS is responsible and must assist clients who present with child care or transportation barriers before requiring PATH attendance; see BEM 232 Direct Support Services.
- Open/edit the Family Self-Sufficiency Plan (FSSP) and enter strength and barrier information identified and addressed during the intake process.
- Temporarily defer an applicant with identified barriers until the barrier is removed.
- Temporarily defer an applicant who has identified barriers that require further assessment or verification before a decision about a lengthier deferral is made, such as clients with serious medical problems or disabilities or clients caring for a spouse or child with disabilities.

Note: Clients should not be referred to orientation and AEP until it is certain that barriers to participation such as lack of child care or transportation have been removed, possible reasons for deferral have been assessed and considered, and disabilities have been accommodated.

Work and Self-Sufficiency Rules

Use the DHS-1538, Work and Self-Sufficiency Rules, to explain all of the following to clients at FIP application for each episode of assistance:

- Direct support services opportunities, including transportation and child care required to attend AEP orientation.
- Work requirements and reasons why a person may be deferred from PATH and work requirements.

- Self-sufficiency requirements.
- Penalties for non-compliance, the triage, hearing processes and good cause.
- Earnings or activity reporting and verification requirements, including the semi-annual reporting requirement for families with earnings.
- Domestic violence.
- FIP is limited to a 48-month lifetime limit per individual; see BEM 234, FIP Time Limit.
- Prohibited use of FIP to purchase lottery tickets, alcohol, or tobacco. It is also prohibited for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, cruise ships or other nonessential items.

Ensure the client understands his/her responsibility to participate in employment-related activities including, but not limited to, calling before they are unable to attend a meeting or appointment and before they become noncompliant.

The DHS-1538 must be reviewed and signed by all of the following applicants and member adds:

- Adult members.
- Minor parent grantees.
- Deferred and potentially deferred adults.
- Ineligible grantees.

File the original signed copy of the DHS-1538, Work and Self-Sufficiency Rules, in the case record; a photocopy is given to the client at the in-person interview or is mailed to the client following a phone interview.

Timing of PATH Referral

Mandatory PATH clients are referred to PATH upon application for FIP, when a client's reason for deferral ends, or a member add is requested. Do not send any others to PATH at application, unless a deferred client volunteers to participate. All PATH referrals are sent by Bridges. Bridges will generate an automated PATH referral to the one-stop service centers' One Stop Management Information System (OSMIS), as well as generating an DHS-4785, PATH

Appointment Notice, which is sent to the participant, when the specialist does all of the following:

- Completes data collection.
- Eligibility determination/benefit calculation (EDBC) is completed for applicants.
- EDBC is completed and ongoing benefits are certified for member adds and ongoing active cases.

Note: Do not use the following manual processes:

- Call the one-stop service center to have them terminate a referral on OSMIS.
- Enter a new referral that was not included on the interface between Bridges and MIS.
- Manually generate a DHS-4785 when Bridges has indicated that it has created a referral to PATH and a corresponding DHS-4785.
- Manually enter denials prior to the 17th day after a PATH referral is sent. It is critical that both MDHHS and the PATH staff wait for interfaces to function. Manual entries on either side will cause a client to disconnect from both systems.

Clients Losing Deferral

When a client no longer qualifies for a deferral, Bridges sends a task/reminder to the specialist ten days before the end of the month the deferral ends. This task/reminder alerts the specialist to run eligibility and certify in order for the PATH referral and the DHS-4785 to be automatically generated by Bridges. Bridges sends the PATH referral and the DHS-4785 the first business day of the calendar month after the deferral ends.

Referrals Already Active on MIS

In most instances, OSMIS will accept a referral for a client who is already active on OSMIS. The new referral is accepted, and a flag is sent to the one-stop service center advising a new referral is pending. Clients are identified as active and attended PATH in Bridges. Activation of the new referral is handled by the one-stop service center.

Rejected Referrals

The following PATH referrals are rejected and need further action as indicated by a task/reminder or via email:

- Address mismatches. When Postal Soft in Bridges is not used to verify address accuracy, a rejection may occur. Check address using Postal Soft in Bridges and re-refer the client.
- SSN/Customer ID Mismatch. An email will be sent to the specialist of record with instructions.

Monitoring Pending PATH Referrals

The specialist can monitor PATH referral status in Bridges through Inquiry/DLEG referral history.

Bridges automatically denies FIP applicants still pending or creates a record of noncompliance when a member is added or client whose deferral is ending when attendance at PATH is not entered by the one-stop service center by the 17th day after the day the PATH referral is made. Bridges also automatically denies FIP when a client fails to continue to participate while the FIP application is pending. Clients can reapply for FIP at any time after their application is denied for failing to appear or participate with PATH.

PATH coordinators should monitor engagement using the QG report series.

FAST and FSSP Notice

Bridges issues a FAST FSSP notice (DHS-1535, FAST Referral Notice or DHS-1536, FAST Mandatory Notice) to all work eligible and non-work eligible individuals upon completion of the intake interview and after worker runs EDBC in Bridges; see BEM 228, Family Automated Screening Tool and Family Self-Sufficiency Plan.

PATH Appointment Notice and Attendance Requirements

Bridges will automatically issue a DHS-4785, PATH Program Appointment Notice, from Bridges at application, member add, or

when a client loses a deferral to schedule an appointment for each mandatory PATH participant. The DHS-4785 will be generated overnight and can be viewed the next day in Correspondence History.

In generating a PATH referral and the DHS-4785, Bridges will allow 6 days for the PATH referral to be processed through Central Print before requiring the client to attend PATH. The one-stop service centers have been advised not to serve clients who appear for AEP or PATH without a system-generated referral as client may not be eligible for PATH services. Bridges will include the date, time and location to appear for their PATH assignment on the automated DHS-4785.

When assigned, clients must engage in and comply with all PATH assignments while the FIP application is pending. PATH engagement is a condition of FIP eligibility. Failure by a client to participate fully in assigned activities while the FIP application is pending will result in denial of FIP benefits. Bridges automatically denies FIP benefits for noncompliance while the application is pending.

Bridges will not penalize Food Assistance when a client fails to attend PATH as a condition of eligibility when the noncompliant individual is not active FIP on the date of the noncompliance. Clients must be active FIP and FAP on the date of FIP noncompliance to apply a FIP penalty to the FAP case.

Bridges will generate an alert when active FIP recipients, including clients losing deferral or member adds do not attend PATH. See BEM 233A for further policy related to noncompliance with employment-related activities.

Note: Do not manually deny FIP or manually enter a noncompliance for failing to attend PATH. Wait for the Bridges interfaces to create the record. Task and reminders are sent to workers when Bridges takes action or receives an attendance through the interface process.

Extending the Last Date to Attend Orientation

Either MDHHS or the one-stop service center may extend the last day the client has to attend AEP/orientation when necessary. Extend this date directly on OSMIS before the 15th day passes. To extend the last date to attend PATH:

- Use applicant search to locate a client.
- Choose the welfare registration screen.

- Select work first program.
- Select welfare registration.
- Scroll down to last date to attend orientation.
- Extend the date.

LEGAL BASE

FIP

MCL 400.57

DEPARTMENT PHILOSOPHY

The Family Independence Program (FIP) is temporary cash assistance to support a family's movement to self-sufficiency. The recipients of FIP engage in employment and self-sufficiency related activities so they can become self-supporting.

DEPARTMENT POLICY

Federal and state laws require each work eligible individual (WEI) in the FIP group to participate in Partnership. Accountability. Training. Hope. (PATH) or other employment-related activity unless temporarily deferred or engaged in activities that meet participation requirements. These clients must participate in employment and/or self-sufficiency related activities to increase their employability and obtain employment. PATH is administered by the Talent and Economic Development (TED), State of Michigan through the Michigan one-stop service centers. PATH serves employers and job seekers for employers to have skilled workers and job seekers to obtain jobs that provide economic self-sufficiency. PATH case managers use the One-Stop Management Information System (OSMIS) to record the clients' assigned activities and participation.

WEIs not referred to PATH will participate in other activities to overcome barriers so they may eventually be referred to PATH or other employment service provider. Michigan Department of Health & Human Services (MDHHS) must monitor these activities and record the client's participation in the Family Self-Sufficiency Plan (FSSP).

A WEI who refuses, without good cause, to participate in assigned employment and/or other self-sufficiency related activities is subject to penalties. For more about penalties; see BEM 233A. See BEM 230B and BEM 233B for FAP employment requirements.

INFORMING CLIENTS

The MDHHS-1171 Info, Information Booklet, provides each applicant with information about the work requirements. The same information about work requirements is provided in the MI Bridges online application. Review information found in the Information Booklet, or direct the client to review his/her MI Bridges online application and the DHS-1538, Work and Self-Sufficiency Rules, with clients at application, redetermination and when a change in

circumstances might affect the person's required hours of participation. Review all the following information:

- Work requirements and reasons why a person may be deferred from work participation.
- Rights and responsibilities.
- Self-sufficiency requirements.
- Penalties for non-compliance, good cause, the triage and hearing processes and good cause.
- Right of deferred persons to participate.
- Reporting requirements, including income verification and the DHS-630, Weekly Activity Log, in this item.
- FIP time limit restrictions.
- Prohibited use of FIP to purchase lottery tickets, alcohol or tobacco. It is also prohibited for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, cruise ships or other nonessential items.

REASONABLE ACCOMMODATION

Disability Definition

Section 504 of the Americans with Disabilities Act (ADA) defines a disability as a physical or mental impairment that substantially limits one or more major life activities; or a history of such an impairment; or being regarded as having such an impairment. Examples of major life activities include: thinking, learning, taking care of oneself, maintaining social relationships, sleeping, communicating, etc.

Many FIP clients have disabilities or live with a spouse or child(ren) with disabilities that may need accommodations to participate in assigned activities. The needs of persons with disabilities are highly individual and must be considered on a case-by-case basis. MDHHS must make reasonable efforts to ensure that persons with disability-related needs or limitations will have an effective and meaningful opportunity to benefit from MDHHS programs and services to the same extent as persons without disabilities. Efforts

to accommodate persons with disabilities may include modifications to program requirements, or extra help, as explained below. Failure to recognize and accommodate disabilities undermines efforts to assist families in achieving self-sufficiency.

When a client requests reasonable accommodation in order to participate, MDHHS and the employment service providers will consider the need for applying the above requirements.

A disability as defined above that requires reasonable accommodation must be verified by an appropriate source, such as a doctor, psychologist, therapist, educator, etc. A client may disclose a disability at any time. Failure to disclose at an earlier time does not prevent the client from claiming a disability or requesting an accommodation in the future.

Screening and Assessment

Be alert to undisclosed or unrecognized disabilities and offer screening and assessment as appropriate. Help clients understand that MDHHS can only offer accommodations if a disability is verified. Clients are screened for disabilities on the DHS-619, Jobs and Self-Sufficiency Survey and the Family Automated Screening Tool (FAST), which ask questions about medical problems, special education and symptoms of mental illness.

Inform clients requesting accommodation or deferral that they may be required to attend appointments with doctors, psychologists, or others to ensure that appropriate accommodations or deferrals are made. Explain that assessment is voluntary but failure to cooperate with assessment may prevent MDHHS from providing a deferral or accommodation. Also inform the client of the requirement to engage in self-sufficiency and family strengthening activities even if they are deferred from PATH or work activities and may be subject to penalties if they do not participate as required.

Accommodation

When information provided by an appropriate source indicates the need for reasonable accommodation, do the following:

- Obtain a DHS-54A, Medical Needs, or the DHS-54E, Medical Needs-PATH, from a qualified medical professional listed on the form.

- Consult Michigan Rehabilitation Services (MRS) if additional information about appropriate accommodations is needed or when you need advice.
- Document the accommodation in the Other MWA referral comments section of the Employment Services - Details screen, and on the Family Self-Sufficiency Plan (FSSP).

Modifications or extra help may include, but are not limited to, the following:

- Reduced hours of required participation.
- Extended education allowances including more than 12 months allowed for vocational education.
- Extended job search/job readiness time limit.

Justification for a plan including reasonable accommodation is documented in the client's FSSP and the Individual Service Strategy (ISS) with the one-stop service center.

When clients with verified disabilities are fully participating to their capability, they are counted as fully engaged in meeting work participation requirements regardless of the hours in which they are engaged, even if they do not meet federal work requirements.

MANDATORY PARTICIPATION IN EMPLOYMENT SERVICES

All WEIs, unless temporarily deferred, must engage in employment that pays at least state minimum wage or participate in employment services. WEIs who are temporarily deferred are required to participate in activities that will help them overcome barriers and prepare them for employment or referral to an employment service provider.

PATH

Most WEIs are referred to PATH provided by the one-stop service center serving the client's area when one of the following exists:

- A WEI applies for FIP.
- A WEI applies to be a member added to a FIP group.
- A WEI is no longer temporarily deferred from employment services.

Note: An 18-year-old **adult** group member is considered a WEI and must attend PATH, regardless of school attendance; see BEM 228, Required Hours for Participation of WEIs.

The last date for a client to attend PATH is 15 calendar days from the date of the PATH referral and the DHS-4785, PATH Appointment Notice, are sent. If the client calls to reschedule before the 15th day, extend the Last Date for Client Contact on OSMIS. Either MDHHS or the one-stop service center have the capability of extending this date.

Note: A task and reminder is sent to the worker when a participant did not appear at PATH within the 15 day period. A pending application is automatically denied.

MDHHS workers indicate the minimum number of hours a client must participate in employment and/or self-sufficiency-related activities on the Employment Services - Details screen in Bridges. Clients may have limitations that support the need for special accommodations, which may include a reduction in the number of hours they are able to participate. In this instance, refer to policy outlined above under Reasonable Accommodations.

The one-stop service centers use the minimum required hours indicated in the FSSP to initially assign clients to activities that meet federal minimum participation requirements, up to 40 hours per week, unless reasonable accommodation policy applies and is documented.

Other Service Providers

The following groups must be referred to other service providers (not PATH) when applicable:

Tribal Agencies

Tribal agencies serve some clients under the Native Employment Works Program. Refer those who may be served by a tribal agency.

Special Needs Participants

Determine appropriate participation and types of supports for the following groups considering Reasonable Accommodations earlier in the item. Reasonable accommodations are selected from the

verification for the deferral reason on the Employment Services Details screen in Bridges.

Minor Parent

A minor parent, aged 16 or 17, who has graduated from high school must participate in PATH or other service provider. See BEM 201, for the definition of minor parent and BEM 245 for the definition of high school.

Clients in Treatment Plans

Certain clients have circumstances which may make their participation in employment and/or self-sufficiency related activities problematic. Unless otherwise deferred, they must be referred to PATH. Indicate the appropriate Additional Information from the drop-down list on the Employment Services-Details screen in Bridges.

Examples of these circumstances include:

- Prescribed medication to control mental illness.
- Ongoing substance abuse treatment.

Former Recipients

A client whose benefits are terminated continues to be eligible for contracted employment and/or self-sufficiency related activities (for example, counseling) until the contractual obligations have been met or the contract has been terminated, whichever occurs first.

Refugees are eligible for refugee-specific employment services for the first five years they are in the country, regardless of whether they receive assistance from MDHHS; see BEM 630, Refugee Assistance Program.

MANDATORY PARTICIPANTS DELAYED REFERRAL (DEFERRED) TO EMPLOYMENT SERVICES

WEIs meeting one of the following criteria are only temporarily not referred to an employment service provider because they may continue to count in Michigan's federal work participation rate. They are required to participate in activities that will increase their full potential, help them overcome barriers and prepare them for employment or referral to an employment services provider as soon as possible. Enter the specialist assigned activities into the FSSP to track participation of temporarily deferred WEIs; see BEM 228.

If the WEI refuses or fails to provide verification of a deferral when required, refer him/her to PATH.

Notify PATH service provider immediately by phone or email when a client who was previously referred is granted a temporary deferral.

Information entered in Bridges data collection will create the following participation/deferral reasons.

Meeting Participation Through Education

Minor Parent Grantees

Minor parent grantees who attend high school full-time are regarded as fully engaged in required activities even though his/her education does not meet the federal requirements. Enter the education activity on the FSSP under the Goal and Activities tab, Non-Core Activities, High School Completion/GED. Enter 30 hours per week of actual participation upon receipt of verification the student is attending.

Working 40 Hours Per Week

Applicants and members added to the FIP group who are working a minimum of 40 hours per week at the state minimum wage are not

referred to PATH. This client's participation in employment is meeting requirements.

Care of a Child or Post-Partum Recovery

Disregard one parent of a child under the age of two months up to two months when the newborn is in the home. Disregard a mother for post-partum recovery up to two months.

Lack of Child Care

In the Employment Services - Detail screen in Bridges, select the *No Child Care for Child Under Six* deferral reason and reply to questions regarding child care when a single parent personally provides care for a child under age six in the FIP EDG and adequate child care is unavailable. Adequate child care meets all the following:

- Appropriate. The care is appropriate to the child's age, disabilities and other conditions.
- Reasonable distance. The total commuting time to and from work and child care facilities does not exceed three hours per day.
- Suitable provider. The provider meets applicable state and local standards. License exempt providers who are not licensed by the Michigan Department of Licensing and Regulatory Affairs (LARA) Child Care Licensing Bureau (CCLB) must meet Child Development and Care (CDC) enrollment requirements.
- Affordable. The child care is provided at the rate of payment or reimbursement offered by the CDC program.

Clients who need assistance in finding a licensed provider should be referred to Great Start to Quality, the online early learning resource site, at www.greatstarttoquality.org. All active licensed providers in good standing are searchable. If additional assistance is needed, clients can be referred to 877-614-7328 to reach the Great Start to Quality Resource Center serving their county. Resource centers can provide personal consultation for families in need of child care. If a provider cannot be located, the client needs to provide verification.

If a provider is located within 10 calendar days, end the deferral on the Employment Services Detail screen in Bridges. Bridges will generate a referral to PATH as well as generate the DHS-4785 once the specialist runs and certifies eligibility.

If the client is unable to obtain child care that meets the conditions above within 10 calendar days, the client may be deferred from referral to PATH for 90 days or until the child turns age six, or until appropriate care is available, whichever is sooner. Bridges will change the deferral code to mandatory participant at the end of the deferral period. Once the specialist runs and certifies eligibility, Bridges will generate the referral to PATH and the DHS-4785 will be generated. Document the referrals and results in the case record. The Deferral/Participation Reason is identified as *No Child Care Available.*

Pregnancy Complications

Clients requesting a deferral from PATH due to pregnancy complications must provide medical verification that indicates that they are unable to participate. An individual requesting deferral greater than 90 days for pregnancy complications is not subject to the requirements for establishing long-term incapacity later in this item.

Domestic Violence

Domestic violence means one or more threats or acts against any family member concerning any of the following:

- Physical injury.
- Sexual abuse.
- Sexual involvement of a dependent child.
- Mental/emotional abuse.
- Neglect or deprivation of medical care.

Defer parents and caretakers with a documented claim of threatened or actual domestic violence, against themselves or their dependent children, that can reasonably be expected to interfere with work requirements.

Assist the client to develop a plan intended to overcome domestic violence as a barrier to self-sufficiency. The plan may include participation in services for domestic violence victims or receipt of related professional care. Specific activities which might reasonably

be expected to endanger the client should be avoided. Document the clients' agreement in the FSSP.

The maximum deferral period is three months. Bridges will change the deferral code to mandatory participant at the end of the deferral period. Bridges will generate a referral to PATH as well as the DHS-4785.

With documented supervisor approval, extensions are permitted in three-month increments.

Use the client's written statement as documentation unless there is sufficient reason to question it. If the statement is questionable, request further documentation, including any of the following:

- Service from a domestic violence provider.
- Medical records.
- Court records, such as personal protection order or petition.
- Police records (for example, domestic disturbance response).
- School records (for example, statement by a school counselor).
- Statement by a licensed therapist or counselor.
- Other case record information (including children's services).

Note: All information concerning domestic violence is confidential; see BAM 310, Confidentiality and Public Access to Case Records.

VISTA, Job Corps, AmeriCorps

Participants in VISTA, Job Corps or AmeriCorps meet participation requirements if the client is participating in this activity for at least the minimum number of required hours. These clients are not referred to PATH unless they wish to participate in the one-stop service center education and training program.

Note: When a participant in VISTA, Job Corps or AmeriCorps participates less than the minimum number of required hours, refer the client to PATH as a mandatory participant.

Use OSMIS case notes to inform PATH of the client's participation in VISTA, Job Corps or AmeriCorps.

Disability

Information recorded in Bridges will defer the following:

- Recipients of RSDI based on disability or blindness.

- Persons found eligible for RSDI based on disability or blindness who are in non-pay status.

FSSP Data Entry

Assign clients to self-sufficiency or barrier removal activities as medically permissible. Enter these activities on the FSSP in the Other activity category listed under the Goals and Activities tab.

Short-Term Incapacity

Persons with a mental or physical illness, limitation, or incapacity expected to last less than three months and which prevents participation may be deferred for up to three months.

Verify the short-term incapacity and the length of the incapacity using a DHS-54A, Medical Needs, or DHS-54E(an N.P. or P.A. can complete the DHS 54E), Medical Needs - PATH, or other written statement from an M.D./D.O./P.A./N.P Set the medical review date accordingly, but not to exceed three months.

Do not advise clients with a short-term incapacity to apply for SSI.

Long-Term Incapacity

At intake, redetermination or anytime during an ongoing benefit period, when an individual claims to be disabled or indicates an inability to participate in work or PATH for more than 90 days because of a mental or physical condition, the client should be deferred in Bridges. Conditions include medical problems such as mental or physical injury, illness, impairment or learning disabilities. This may include those who have applied for RSDI/SSI.

For FIP applicants already receiving MA based on their own disability and/or blindness, meet the medical deferral requirements for incapacitated up to the medical review date stated on the DHS-49-A, as determined by the DDS 7/1/2015 and after.

Note: A person with a condition or impairment that is pregnancy-related must be deferred for a problem pregnancy. These individuals should **not** be referred to the DDS or to an SSI Advocate if the **only** conditions or impairments are due to pregnancy: see Pregnancy Complications in this item.

Step One: Establishment of Disability

Once a client claims a disability, he/she must provide MDHHS with verification of the disability when requested. The verification must indicate that the disability will last longer than 90 calendar days. If the verification is not returned, a disability is not established. The client will be required to fully participate in PATH as a mandatory participant; see Verification Sources in this item.

In Bridges, the Deferral/Participation Reason is *Establishing Incapacity* while awaiting the verification that indicates the disability will last longer than 90 days.

At application, once the client has verified the disability will last longer than 90 days, the application may be approved, assuming all other eligibility requirements have been met.

If the returned verification indicates that the disability will last 90 days or less; see Short-Term Incapacity in this item.

Step Two: Defining the Disability

For verified disabilities over 90 days, see BAM 815, Medical Determination and Disability Determination Service, for the policy requirements in obtaining a medical certification from DDS. If the client does not provide the requested verifications, the FIP should be placed into closure for failure to provide needed documentation.

For verified disabilities over 90 days, the client must apply for benefits through the Social Security Administration (SSA) before step three. See BAM 815, Medical Determination and Disability Determination Service and BEM 270, Pursuit of Benefits.

In Bridges, the Deferral/Participation Reason is *Establishing Incapacity* while awaiting the DDS decision.

Step Three: Referral to DDS

Send the completed required forms along with any medical evidence provided, to the DDS to begin the medical development process.

The Deferral/Participation Reason in Bridges remains *Establishing Incapacity*.

Manually set a reminder in Bridges for a three-month follow-up.

DDS DECISION

Upon the receipt of the DDS decision, review the determination and information provided by DDS. Establish the accommodations the recipient needs to participate in PATH or to complete self-sufficiency-related activities. Follow the procedure for accommodating disabilities; see Reasonable Accommodation in this item.

Work Ready

Recipients determined by DDS to be work ready are able to fully engage in PATH without any accommodation. To engage the recipient in PATH, end the Disability Details record in Bridges. On the CASH-EDG Summary, the Deferral/Participation Reason will be *MWA Activity* or PATH and Bridges will generate a referral to PATH as well as the DHS-4785.

Work Ready with Limitations

Recipients determined as work ready with limitations are required to participate in PATH as defined by DDS. To engage the recipient in PATH, take the following actions:

- End the Disability Details record in Bridges.
- Update the Disability Determination-MRT and Employment Services- Details screens in Bridges to indicate the recipient is *work ready with limitations*.
- On the Employment Services- Detail screen, use the Other MWA Referral Comments to identify the recipient's limitations as defined by DDS.
- On the CASH-EDG Summary the Deferral/Participation Reason will be *Work Ready with Limitations*.
- Bridges will generate a referral to PATH as well as the DHS-4785 once the specialist runs and certifies eligibility.

Do not require the recipient to apply for RSDI/SSI.

Work Ready with Limitations served by MDHHS

MDHHS must serve recipients, who are determined work ready with limitations by DDS, when the recipient cannot be served by PATH. These recipients are considered mandatory participants and must engage in activities monitored by the department. The specialist is responsible for assigning self-sufficiency activities up to the medically permissible limit of the recipient.

Note: When PATH states they are no longer able to serve the work ready with limitations recipient based on verification of new or increased medical condition, MDHHS may determine that the department will best serve the recipient. Document in Bridges case notes the outcome of the discussion between PATH case worker and the MDHHS specialist regarding the requirement for the recipient to be served by the department.

Ask the one-stop service center to provide any test results or other documentation about the client's limitations at the time the client is referred to MDHHS.

For the participation requirement to transfer from PATH to MDHHS, update the Employment Service- Details screen, Employment Participation Special Circumstances to *Work Ready with Limitations at DHS*. The CASH-EDG Summary will have a Deferral/Participation Reason of *Work Ready with Limitations at DHS*.

Disabled-Potentially Eligible for RSDI/SSI

After DDS determines a recipient meets the established disability criteria, verify the following:

- Update the Disability Determination- MRT and Employment Services screen to indicate the recipient is *Incapacitated Greater than 90 Days*.
- The CASH-EDG Summary will show the Deferral/Participation Reason of *Incapacitated more than 90 days*.

When to Request a New DDS Decision

After a DDS decision and/or SSA medical determination has been denied and the client states their existing condition has worsened or states they have a new condition resulting in disability greater than 90 days, verify the new information using a DHS-54-A or a DHS-54E. When an individual presents a doctor's note after the DDS decision but does not have new medical evidence or a new condition, send the DHS-518, Assessment for FIP Participation, to the doctor and request supporting medical evidence.

If the returned verification confirms the above, follow policy in BAM 815 to make a new referral to DDS.

The specialist must assign and maintain FSSP activities to ensure continued pursuit of self-sufficiency.

If new medical evidence is not provided, do not send the case back to the DDS. The previous DDS decision stands.

NONCOMPLIANCE

When a client determined by DDS to be work ready with limitations becomes noncompliant with PATH or his/her FSSP assigned activities, follow instructions outlined in BEM 233A.

Voluntary Participants

Clients who meet the criteria for a deferral may request a referral to PATH. Deferred clients should be encouraged to participate. If the client is volunteering for PATH, generate a PATH referral and the DHS-4785 by indicating on Employment Services Detail screen in Bridges the client is requesting voluntary participation with PATH.

Noncompliance penalties apply to all voluntary participants when the client is noncompliant with activities agreed to on the FSSP or assigned by PATH. Explain to clients who volunteer that if they try to participate and discover they do not have the capacity to fulfill

their requirements, they must immediately inform the specialist or PATH worker before becoming noncompliant.

Note: Clients identified as volunteers are eligible to volunteer only if the original deferral lasts. When the deferral time limit associated with the voluntary code expires, the specialist should make a new determination based on current case circumstances and update Bridges to reflect the change.

PERSONS NOT REQUIRED TO PARTICIPATE IN EMPLOYMENT SERVICES

Work Eligible Individual (WEI)

Aged 65 or Older

Recipients age 65 and over are not required to participate in employment related activities except for completion of the FAST and FSSP. However, they continue to count in Michigan's Work Participation Rate and may be referred to PATH as volunteers.

Non-WEI

Non-WEIs are FIP clients who do not count in the state's work participation rate. Non-WEIs do not have required hours. Non-WEIs are not required to participate in work related activities for a minimum number of hours but must complete a FAST and FSSP. Instead, non-WEIs should engage in other activities to strengthen the family or improve self-sufficiency skills. Non-WEIs include the following:

Disqualified Non-Citizens

A person who is not eligible for cash assistance due to being a non-citizen is not a WEI and is not referred to employment services and is not required to engage in PATH.

Failure to complete the FAST or FSSP by the due date may result in case closure for failure to provide the department with needed information. BEM 233A and BEM 233C do not apply.

Note: All other disqualified members, including Intentional Program Violations, are WEIs and must be referred to PATH unless temporarily deferred.

Ineligible Caretakers

Ineligible caretakers are not recipients of FIP, although the family is receiving FIP benefits for the children. They are not WEIs and are not referred to PATH. Ineligible caretakers must complete a FAST and develop a FSSP for the family to reach self-sufficiency. Failure to complete the FAST or FSSP by the due date may result in case closure for failure to provide the department with needed information. BEM 233A and BEM 233C do not apply.

Care of a Spouse or Child with Disabilities

A spouse or parent who provides care for a spouse or child with disabilities living in the home is not a WEI and is not referred to PATH if:

- The spouse/child with disabilities lives with the spouse/parent providing care.
- A doctor/physician's assistant (P.A.) verifies all the following in writing or by using a DHS-54A, Medical Needs, form or DHS-54E, Medical Needs-PATH (the DHS 54E can be completed by a N.P. or P.A.:
  - The spouse/child with disabilities requires a caretaker due to the extent of the disability.
  - The spouse/parent is needed in the home to provide care.
  - The spouse/parent cannot engage in an employment-related activity due to the extent of care required.

REQUEST FOR TEMPORARY DEFERRAL FROM PATH

Deferral Not Granted

Do all the following when a request for deferral is not granted:

- Document the basis of the decision including any limitations or restrictions in the FSSP under the Barriers and Referrals tab**.**
- Inform the individual that he/she did not meet the criteria for the deferral and that he/she will be required to participate in PATH.
- Refer the client to PATH as outlined in BEM 228, providing information on any limitations to full participation using Other MWA Referral Comments on the Employment Services Detail Screen.

Advise the client of his/her right to:

- Discuss the deferral decision with a supervisor**.**
- File a grievance with the one-stop service center if he/she disagrees with the activities assigned at PATH**.**
- File a hearing regarding denial of support services such as transportation assistance, child care assistance, decrease in benefits.

Note: When a deferral is not granted, it is not a loss of benefits, termination or negative action. When a client requests a hearing based on not being granted a deferral, be sure to advise the client at the pre-hearing conference and use the DHS-3050, Hearing Summary, to inform the administrative law judge the action did not result in a loss of benefits or services. Be sure the client understands the time to file a hearing is once he/she receives a Notice of Case Action for noncompliance.

Deferral Granted

When a request for deferral is granted:

- Enter the supporting information in Bridges**.**
- Determine the length of the deferral**.**
- Notify the client of the decision and length of deferral**.** Bridges nightly interface file will notify OSMIS of the deferral.
- Document the decision in the FSSP under the Barriers and Referrals tab**.**

A Bridges task and reminder is sent to the worker for follow-up to review the deferral ten calendar days before the end of the month before it is to expire.

TIME LIMITS

Time limits apply to Job Search/Job Readiness and Vocational Educational activities. Excused absences and holiday hours may only be applied when they occur during of participation in unpaid work activities. Enter actual hours on the FSSP as noted below. Use caution when entering any of these hours as the time limits apply even if the client does not meet participation requirements for a given month. Do not enter excused absence hours or Job Search/Job Readiness hours if the client's FSSP planned hours will not meet federal participation requirements. Hours entered that do not meet participation requirements are applied to the limits.

Job Search/Job Readiness (JS/JR)

The limit for each WEI assigned to JS/JR is a week of federally required hours times 12 weeks. No more than four consecutive weeks are allowed without a one-week break (Sunday through Saturday) in a preceding 12-month period beginning September 28, 2008 or it is not countable.

Example: Client has a 30-hour requirement and is assigned to JS/JR. The JS/JR limit for this client is 360 hours. Client is assigned to JS/JR for 30 hours each week for six consecutive weeks and completes the assignment each week and actual hours are entered on the FSSP. The 360-hour limit is now reduced to 210 hours (360-180+30). Weeks one through four are countable for the 30 hours each week; week five is not countable and the FSSP will automatically store this week under **other work activity** and not reduce the 30 hours of participation for that week; week six is countable and reduces the total allowable hours. This client cannot

get the 150 hours added back to his/her JS/JR limit until the corresponding report months drop off 12 months in the future.

Vocational Educational Training

This activity continues to have a lifetime limit of 12 months. The limit began January 1, 1997. Clients who participated any day in a given month since the limit began will have a count of 1 applied on the FSSP. Participation in this activity exceeding the 12 month limitation is not counted in the work participation rate.

HOLIDAYS AND EXCUSED ABSENCES

Holiday hours and excused absence hours may be applied for unpaid work activities only. The FSSP will not allow entry of these hours for paid work activities. Clients in paid work receive holiday and excused hours from their employer.

Holidays

Holidays are now considered participation when a client in an unpaid work activity has previously been assigned to a planned activity and is scheduled to participate. The following holidays are allowed:

- New Year’s Day.
- Martin Luther King Jr. day.
- Memorial Day.
- Fourth of July.
- Labor Day.
- Veterans Day.
- Thanksgiving.
- Day after Thanksgiving.
- Christmas Eve.
- Christmas day.

The countable holiday hours are limited to an average of eight hours per holiday.

Record the hours that a client is scheduled to participate in the activity under that activity in the FSSP when:

- Participation is monitored by MDHHS.
- The client was scheduled to participate.
- The date is one in the list of holidays.
- The hours are required to meet the federally required minimum hours.

Excused Absences

A client's participation in an unpaid work activity may be interrupted by occasional illness or unavoidable event. A WEI's absence may be excused up to 16 hours in a month but no more than 80 hours in a 12-month period.

Record the hours that a client is scheduled to participate in the activity under that activity in the FSSP when:

- Participation is monitored by MDHHS.
- The client was scheduled to participate.
- The hours are required to meet the federally required minimum hours.

FSSP ENTRY

MDHHS must record the activities the client will participate in and the client's actual participation in activities monitored by MDHHS directly in the FSSP. Activities may address barriers to employment services or core activities that count in the work participation rate.

PATH case managers record and monitor the activities the client will participate in and the client's actual participation in activities in OSMIS. The records in OSMIS are displayed on the FSSP the next day.

Michigan's work participation is based on the recipient's participation in required activities as captured from the records displayed in the FSSP.

VERIFICATION REQUIREMENTS

Paid Work Activities

The client's actual hours of participation in paid work activities must be verified. The specialist may use two consecutive paycheck stubs or wage statements that reflect the average number of hours worked by the client. Paycheck stubs or a collateral contact with the client's manager or supervisor meet the requirement to project the

client's hours for six months. Determine the average number of hours worked per week and document the actual hours on the FSSP.

Example: Amber submits three consecutive paycheck stubs for pay dates of January 5, 12 and 19. One paycheck stub shows 25 hours worked, one paycheck stub shows 30 hours worked and one pay check stub shows 32 hours worked. The average of the three paycheck stubs is 29 hours per week on average.

Example: Jordan submits two consecutive paycheck stubs for pay dates of January 5 and January 19. The client is paid bi-weekly. One paycheck stub states 60 hours worked and one paycheck stub states 55 hours worked. The average of the two paycheck stubs is 28 hours per week, dropping the fraction (60+55 divided by four weeks) to obtain the weekly average.

Project hours for the next six months by using the week begin date and the weekend date on the FSSP on the Activity screen. The FSSP will not allow entries greater than six months. Set the target date to allow collection of new verification in time to project the next six-month projection.

The specialist must monitor clients working 40 hours per week at or above state minimum wage who are not participating in PATH and deferred volunteers who may be working.

Change in hours of Work Activity

When a client reports a change in the number of hours of employment during the six-month projection, the specialist must gather actual paycheck stubs that reflect the change. Change the actual hours previously recorded in the FSSP to the actual participation as verified. Use a minimum of two new consecutive paycheck stubs, wage statements or the collateral contact to project the new six-month period that begins the month after the month with the change.

Non-Paid Activities

Activities assigned to a MDHHS-served client on the FSSP must be verified using a DHS-630, Weekly Activity Log, when monitoring is required. Report weeks are always Sunday through Saturday. The activity log due date is always the Friday after the weekend date. Use the target date on the FSSP Activity screen as a follow-up date for receipt of the activity log. Run the Target Date report available

through the FSSP Main Menu and follow-up accordingly with clients who must return a DHS-630, Activity Log. Enter actual hours of participation at least monthly for each client with assigned activities.

This client is advised of this requirement on the DHS-1538, Work and Self-Sufficiency Rules, at application.

If the client does not return the activity log by the due date, it is treated as a noncompliance; see BEM 233A, Failure to Meet Employment Related Requirements.

Validity of activity logs should be monitored, and best practice is to check one entry for each client once per month.

Deferrals

See Verification Sources in this item for more information.

Verify the following reasons for deferral:

- **Temporary Incapacity.** Obtain medical evidence if the client claims a disabling condition expected to last 90 days or less. If needed, authorize a general medical exam or payment for a medical report; see BAM 815.

- **Disability.** If the client claims a disabling condition expected to last more than 90 days, it must be verified by one of the following:

  - Note from client's doctor.
  - DHS-49.
  - DHS-54A.
  - DHS-54E (the DHS 54E can be completed by a P.A. or N.P.)

- **Problem Pregnancy**. If the client claims an inability to participate in PATH based on pregnancy complications, it must be verified by one of the following:

  - Note from client's doctor.
  - DHS-49.
  - DHS-54A.
  - DHS-54E (the DHS 54E can be completed by a P.A. or N.P.).

- **Care of a Spouse/Child with Disabilities.** A doctor/ physician's assistant must verify all of the following in writing

using a DHS-54A, Medical Needs or DHS-54E Medical Needs-PATH, form:

- The disability of the spouse/child needing care and the extent and duration of the disability.
- The spouse/parent is needed in the home to provide care.
- The spouse/parent cannot engage in an employment-related activity due to the extent of care required.

- **Lack of Child Care**. Documentation that child care is not attainable from the Great Start Regional Child Care Resource Center serving their county.
- **Domestic Violence**. Document the case file with a written statement. Use other sources of verification listed in this item if questionable.

Verify other deferral reasons as needed.

VERIFICATION SOURCES

Paid Work Activities

The specialist requires verification of hours in a wage earning activity when the client does not participate in PATH. Use one of the following:

- Two consecutive paycheck stubs that reflect hours worked.
- Collateral contact with the client's manager, supervisor, or authorized representative of the employer who is able to verify the hours worked.
- Semi-annual simplified reporting verification.
- Equifax Verification Services (formerly known as the TALX Work Number).

Non-Paid Activities

Use the DHS-630, Activity Log, to collect verification of non-paid activities as noted above.

Age and School Attendance

See BEM 240, Age, and BEM 245, School Attendance and Student Status.

SSI/RSDI Based on Disability/ Blindness

To verify information regarding SSI or RSDI based on disability or blindness, use one of the following:

- Document from the Social Security Administration.
- DHS-1552, Verification of Application or Appeal for SSI/RSDI.
- Third Party Single Online Query (SOLQ) ED-030.
- Consolidated Inquiry.

Lack of Child Care

Correspondence or telephone contact with the Great Start to Quality Resource Center confirming the client's inability to secure child care that meets the deferral criteria.

Domestic Violence

See Deferral for Domestic Violence in this item.

Temporary Incapacity

Statement from an M.D./D.O./P.A./N.P. that the person is unable to work, including diagnosis, limitations on activities and expected duration.

The DHS-54A, Medical Needs, or the DHS 54E Medical Needs (the DHS 54E can be completed by a P.A. or N.P.) - PATH; DHS-49, Medical Examination Report; or other written statement is acceptable.

For SSI/RSDI application or denial due to duration, use one of the sources listed above for Care of a Spouse/Child with a Disability.

LEGAL BASE

FIP

MCL 400.57
Rehabilitation Act of 1973 (Section 504),

Americans with Disabilities Act of 1990
Michigan Persons with Disabilities Civil Rights Act 1976 PA 220, MCL 37.1101-.1607

DEPARTMENT PHILOSOPHY

Michigan Department of Health and Human Services (MDHHS) has a unique opportunity to assist families in becoming strong, viable, participative members of the community. By involving the adult members of the household in employment-related activities, we help restore self-confidence and a sense of self-worth. These are cornerstones to building strong, self-reliant families.

The goal of the Food Assistance Program (FAP) is to ensure sound nutrition among children and adults. In addition, the goal of our employment-related policies for FAP households is to assist applicants and recipients toward self-sufficiency by providing them with opportunities to pursue employment and/or education and training.

DEPARTMENT POLICY

Use this item to determine work-related activities and deferrals for FAP clients.

Also use this item when Family Independence Program (FIP) or Refugee Cash Assistance (RCA) closes for any reason other than a penalty or disqualification.

The items listed below must be used when FIP or RCA closes due to noncompliance and a penalty or disqualification is imposed.

If the noncompliant client:

- Received FIP and FAP on the date of noncompliance; see Bridges Eligibility Manual (BEM) 233A, Failure To Meet Employment And/Or Self-Sufficiency-Related Requirements :FIP.
- Received RCA and FAP on the date of noncompliance; see BEM 233C Failure To Meet Employment Requirements: RCA.
- Did not receive FIP or RCA on the date of noncompliance; see BEM 233B, Failure To Meet Employment Requirements: FAP.

See BEM 620 Time Limited Food Assistance (TLFA) for more specific work requirements that apply to TLFA recipients.

WORK REQUIREMENTS

Non-deferred adult members of FAP households must comply with certain work-related requirements in order to receive food assistance.

However, unlike cash benefits, which are tied to participation in Partnership. Accountability. Training. Hope. (PATH), there are no hourly requirements for the Food Assistance Program. In order to receive FAP benefits, non-deferred adults must comply with the following work requirements:

Non-deferred adults must be registered for work and be informed of work requirements.

Non-deferred adults who are already working may not do any of the following:

- Voluntarily quit a job of 30 hours or more per week without good cause.
- Voluntarily reduce hours of employment below 30 hours per week without good cause.

Note: If the job quit or reduction in hours occurred more than 30 days prior to the application date, no penalty applies.

Non-deferred adults who are not working or are working less than 30 hours per week must:

- Provide the State agency or it's designee with sufficient information regarding employment status or availability for work.
- Accept a valid offer of employment.
- Participate in activities required to receive unemployment benefits if the client has applied for or is receiving unemployment benefits.

  Note: If a client is an applicant or recipient of unemployment benefits, they must follow through with the unemployment benefits program’s procedures and requirements. This work requirement does not apply to a client who is clearly not eligible for unemployment benefits. Do not require a client to apply for unemployment benefits in order to receive FAP.

Disqualify FAP clients for noncompliance if the applicant or recipient is neither deferred (see deferrals in this item) or non-compliant with one of the FAP work requirements listed in this item.

In order to provide all FAP adults with the opportunity to pursue employment and/or education and training that will lead to self-sufficiency, encourage FAP applicants and recipients to pursue employment services such as job search, employment counseling, education and training, etc.

Workforce Innovation and Opportunity Act (WIOA) services may be available to all adults in FAP households. Other programs, such as the non-cash recipient program may be available to employed, underemployed, or recently employed adults residing in a household with a child under 18. Every local Michigan Works! Agency throughout Michigan operates both of these programs and may provide additional employment and training services. Local variations, restrictions and/or policies may apply. Check with a local Michigan Works! Agency to determine what employment and education/training services are available in the area.

Do not disqualify FAP program applicants or recipients for failing to comply with WIOA services or any other suggested employment and training component.

Determine each group member's participation requirement at:

- Application.
- Redetermination.
- Change in circumstance that might affect the person's participation requirement; see Bridges Administrative Manual (BAM) 105, Rights and Responsibilities for changes in circumstances that are required to be reported for the FAP.

INFORMING CLIENTS Explain all of the following to FAP clients at Application, Redetermination, Member Add and When an individual becomes subject to the work rules:

- FAP work requirements.
- Rights and responsibilities of non-deferred adults in FAP households.
- Consequences of their failure to comply.
- Right of deferred persons to participate.

- Reporting requirements. What constitutes good cause for noncompliance; see BEM 233B.

Note: All individuals subject to the FAP work-related requirements will receive the MDHHS-6015 Consolidated Work Notice, at application, redetermination, member add and when an individual becomes subject to the work rules outlining the FAP related work requirements.

SCREENING

All individuals must be screened for any deferral they may qualify for at application, redetermination and when an individual becomes subject to the General Work Requirements.

DEFFERALS

Clients meeting one of the criteria below are temporarily deferred from employment-related activities and work registration.

Age

Defer a person who is:

- Under age 16 or at least age 60.
- A 16- or 17-year-old who is not the grantee.
- A grantee age 16 or 17 who:
  - Lives with a parent or person in that role.
  - Attends school at least half time.
  - Is enrolled in an employment/training program at least half time.

See BEM 240, Age and BEM 245, School Attendance And Student Status for verification requirements.

Care of a Child

Defer one person who personally provides care for a child under age six, even if the child is not a member of the FAP group, nor resides with the caregiver.

Care of Disabled Individual

Defer one person who personally provides care for a disabled individual, even if the disabled individual is not a member of the

FAP group, nor resides with the caregiver. A statement indicating care is needed in the home is acceptable.

To verify, use a statement from an M.D./D.O./P. A that the client's presence is needed to assist the household member with minimum daily activities of living.

Disability

Defer persons incapacitated due to injury, pregnancy complication, physical illness, or mental illness.

Verify a reason for deferral only if it is not obvious and the information provided is questionable (unclear, inconsistent or incomplete).

Sources that may be used to verify questionable information are:

- SSI/RSDI/MA approval or receipt based on disability or blindness. For SSI and RSDI, use one of the sources referenced in FIP policy, Care of Disabled Spouse or Disabled Child, in BEM 230A.
- An evaluation signed by a fully licensed psychologist that the client has an IQ of 59 or less.
- Statement from an M.D./D.O./ P.A that the person is unable to work.
- The DHS-54A, Medical Needs; DHS-49, Medical Examination Report; DHS-49-D, Psychiatric/Psychological Examination Report; or another written statement is acceptable.
- A medically documented pregnancy complication confirmation by an M.D./D.O./P. A, certified nurse-midwife, ob-gyn nurse practitioner or ob-gyn clinical nurse specialist, which must include an expected date of delivery.

Education

A person enrolled in a post-secondary education program may be in student status, as defined in BEM 245, Student Status.

Employment

Persons employed, self-employed or in work study an average of 30 hours or more per week over the benefit period **or** earning on average the federal minimum wage times 30 hours per week are **not** required to participate in any further employment-related

activities. This includes migrant or seasonal farm workers with an employer or crew chief contract/agreement to begin work within 30 days.

Note: Refugee Cash Assistance (RCA) and Refugee Matching Grant (MG) applicants and/or recipients who are meeting participation requirements, as determined by the Refugee Contractor (RC) are not required to participate in any further employment-related activities.

See Verification Sources in BEM 501, Income From Employment, BEM 503, Income, Unearned, to verify income.

SSI/FAP Applicants

Defer applicants who apply for both SSI and FAP through the Social Security Administration. The application for SSI and FAP must be made at the same time.

Note: The deferral must be re-evaluated if it is later determined the individual is ineligible for SSI.

Substance Abuse Treatment Center Participant

Defer active participants in inpatient or outpatient programs for substance abuse treatment and rehabilitation. This does not include AA or NA group meetings.

To verify, use a verbal or written statement from the center.

Unemployment Compensation (UC) Applicant or Recipient

Defer an applicant for or recipient of unemployment benefits. This includes a person whose unemployment benefits application denial is being appealed.

Use a DHS-32, UCB Claims Information Request, to verify.

FAE&T PROVIDER DETERMINATION

Participation in the FAP Employment and Training program (FAE&T) is a way for individuals subject to work registration requirements to volunteer at the MWA to learn valuable skills that will assist the individual with becoming employable.

A FAE&T provider determination is issued when a participant is not a good fit for an Employment and Training component when volunteering at the MWA.

If it is determined that the individual is not a good fit for the FAE&T program, the MWA will notify the DHHS Specialist within 10 days of the provider determination being made via the FAE&T provider determination interface in Bridges. The Specialist will receive a task and reminder notifying them to contact the client. The DHHS Specialist must contact the client within 10 days of the provider determination being issued.

The DHHS Specialist will discuss the reason for the provider determination and what the next steps will be for the individual. The DHHS Specialist must document in case comments that the client has been contacted about the provider determination and what was discussed during the call.

Note: Provider determinations apply to all TLFA and non-TLFA individuals subject to work registration.

For non-TLFA individuals, the DHHS Specialist will explain that there will be no negative impact on the individuals benefits as a result of the provider determination since participation is voluntary.

FAE&T Provider Determination options

If it is determined that an individual is not a good fit for an FAE&T component when volunteering at the Michigan Works! Association (MWA), one of the following options must be completed by the next redetermination:

Option 1: Refer the individual to an appropriate employment and training component.

- The MDHHS specialist should reassess the individual to determine if a referral back to the FAE&T program is

appropriate. The individual may be better suited for a deferral or referral to another FAE&T component.

- There is an appropriate and available component in the FAE&T program.
- The individual must also receive case management services.

Option 2: Reassess the individual for mental or physical fitness.

- If the individual is not mentally or physically fit, the individual will not be referred to the FAE&T program.
- The specialist must also choose to reassess the individual for other deferrals from the general work requirement as applicable.

Option 3: Coordinate with other federal, state, or local work force or assistance programs to identify work opportunities or assistance for the individual.

- Consider this option for individuals with needs that fall outside of the scope of the FAE&T program.

LEGAL BASE

FAP

Food Stamp Act of 1977, as amended
7CFR Parts 272 and 273
FNS Waiver 2040026

DEPARTMENT POLICY

The Refugee Cash Assistance program (RCA) is temporary cash assistance to support an individual's or a family's movement to self-sufficiency. The recipients of RCA engage in employment and self-sufficiency related activities so they can become self-supporting.

Federal and state laws require each mandatory participant in the RCA group to participate in the employment-related activities provided through a refugee contractor unless temporarily deferred. RCA recipients must participate in employment and/or self-sufficiency related activities to increase their employability and obtain employment. The refugee contractor must document these activities in the Refugee Family Self-Sufficiency Plan (RFSSP). The refugee contractor and Michigan Department of Health and Human Services (MDHHS) should ensure that the RFSSP assesses each individual member of the household that can benefit from refugee social services in order to facilitate economic self-sufficiency, family stability, and community integration for the household. MDHHS must also monitor these activities and maintain a record of the recipient's participation, as supplied by the refugee contractor. The refugee employment program as implemented by the refugee contractor is administered by the Michigan Department of Labor and Economic Opportunity (LEO), Office of Global Michigan Refugee Services.

Temporarily deferred RCA recipients not referred to employment-related activities may volunteer to participate in other activities to overcome barriers so they may eventually be referred to the refugee contractor. The refugee contractor must document these activities in the RFSSP. MDHHS must also monitor these activities and maintain a record of the recipient's participation, including the RFSSP, as supplied by the refugee contractor.

A mandatory participant who refuses, without good cause, to participate in assigned employment and/or other self-sufficiency related activities is subject to penalties; see *BEM 233C, Failure to Meet Employment Requirements: RCA*.

Do not delay approval of RCA benefits solely for employment and self-sufficiency activity requirements. Participation in self-sufficiency activities is not a condition of initial eligibility, however it is a condition of continued eligibility.

INFORMING CLIENTS

The MDHHS-1171-INFO, Information Booklet, provides each applicant with information about the participation requirements for RCA. The same information is provided in the MI Bridges online application. Review information found in the Information Booklet or direct the applicant to review his/her MI Bridges online application, with the recipients at application, redetermination and when a change in circumstances might affect the person's required participation. Review all the following information:

- Program requirements and reasons why an individual may be deferred from program participation.
- Rights and responsibilities.
- Self-sufficiency requirements.
- Penalties for noncompliance, good cause, and the triage and hearings process.

REASONABLE ACCOMMODATION

Disability Definition

Section 504 of the Americans with Disabilities Act defines a disability as a physical or mental impairment that substantially limits one or more major life activities; or a history of such an impairment; or being regarded as having such an impairment. Examples of major life activities include: thinking, learning, taking care of oneself, maintaining social relationships, sleeping and communicating.

A number of RCA recipients have disabilities or live with a spouse with disabilities that may need accommodations to participate in assigned activities. The needs of persons with disabilities are highly individual and must be considered on a case-by-case basis. MDHHS must make reasonable efforts to ensure that persons with disability-related needs or limitations will have an effective and meaningful opportunity to benefit from MDHHS programs and services to the same extent as persons without disabilities. Efforts to accommodate persons with disabilities may include modifications

to program requirements, or extra help as explained below. Failure to recognize and accommodate disabilities undermines efforts to assist families in achieving self-sufficiency.

When a client requests reasonable accommodation in order to participate, MDHHS and the refugee contractor will consider the need for applying the above requirements.

A disability as defined above that requires reasonable accommodation must be verified by an appropriate source such as a doctor, psychologist, therapist or educator. A client may disclose a disability at any time. Failure to disclose at an earlier time does not prevent the client from claiming a disability or requesting an accommodation in the future.

Screening and Assessment

Be alert to undisclosed or unrecognized disabilities and offer screening and assessment as appropriate. Help clients understand that MDHHS can only offer accommodations if a disability is verified. Clients are screened for disabilities on the MDHHS-DHS-1171, Assistance Application, and the MDHHS-1171-CASH, cash specific supplement form, which ask questions about medical problems and special education.

Inform clients requesting accommodation or deferral that they may be required to attend appointments with doctors, psychologists, or others to ensure that appropriate accommodations or deferrals are made. Explain that assessment is voluntary but failure to cooperate with assessment may prevent MDHHS from providing a deferral or accommodation. Also inform the client of the requirement to engage in self-sufficiency and family strengthening activities even if he/she is deferred from work participation program or work activities and may be subject to penalties if he/she does not participate as required.

Accommodation

When information provided by an appropriate source indicates the need for reasonable accommodation, do the following:

- Obtain a DHS-54A, Medical Needs, form from a qualified medical professional listed on the form.

- Consult Michigan Rehabilitation Services (MRS) if additional information about appropriate accommodations is needed or when you need advice.

- Document the accommodation on the *Additional Comments* section of the DHS-4785-R that is submitted to the refugee contractor.

Justification for a plan including reasonable accommodation is documented in the client's RFSSP by the refugee contractor or MDHHS specialist, as appropriate.

When clients with verified disabilities are fully participating to their capability, they are counted as fully engaged in meeting work participation requirements regardless of the hours in which they are engaged, even if they do not meet federal work requirements

MANDATORY PARTICIPATION IN EMPLOYMENT SERVICES

All mandatory participants, unless deferred, must engage in employment that pays at least the state minimum wage or participate in employment services provided through a refugee contractor.

Note: For RCA mandatory participants who reside in counties that do not have a primary refugee contractor, the individual will be automatically referred via the One Stop Management Information System (OSMIS) to the one-stop service center serving the client's area; see *BEM 229, PATH Program Referrals and the Application Eligibility Period*. However, these individuals are still required to meet employment and/or self-sufficiency related activities as outlined in this item. They should not be held to the same requirements as Family Independence Program (FIP) recipients.

The Refugee Employment Program

Most mandatory participants are referred to the refugee employment program provided by the refugee contractor serving that recipient's area when one of the following exists:

- A mandatory participant applies for RCA.

- A mandatory participant applies to be a member added to an RCA group.
- A mandatory participant is no longer temporarily deferred from work requirements.
- A participant that is deferred from work requirements volunteers to participate.

Referral to the Refugee Contractor

Mandatory participants are referred to the refugee contractor upon application for RCA, when a recipient's reason for deferral ends, or a member add is requested. When a referral to the refugee contractor is required, the specialist must manually generate the DHS-4785R.

The specialist must notify the refugee contractor of this referral via the process developed by the local office and the refugee contractor.

The last date for a client to make contact with the refugee contractor is 30 days from the date the DHS-4785R is sent. If a mandatory participant calls to indicate that he or she needs more time to attend orientation at the refugee contractor, the specialist will contact the refugee contractor provider to extend the deadline.

The DHS-4785R must be returned to the MDHHS local office with a date stamp from the refugee contractor to verify completion of the orientation.

RCA recipients may have limitations that support the need for special accommodations, which may include reduction in the employment-related activities in which they are able to participate; see *Reasonable Accommodations* in this item.

Special Needs Participants

Determine appropriate participation and types of supports for the following groups considering reasonable accommodations earlier in the item. Certain clients have particular circumstances which may make their participation in employment and/or self-sufficiency related activities problematic. Unless otherwise deferred, they must be referred to the refugee contractor. Reasonable accommodations

are to be entered in Bridges case comments as well as being communicated to the refugee contractor on the DHS-4785-R.

Examples of these circumstances include:

- Prescribed medication to control mental illness.
- Ongoing substance abuse treatment.

Former Recipients

Refugees are eligible for refugee-specific employment services for the first five years they are in the country, regardless of whether they receive assistance from MDHHS.

MANDATORY PARTICIPANTS DELAYED REFERRAL TO THE REFUGEE CONTRACTOR

Mandatory participants may request to be temporarily deferred from participation in employment services at the refugee contractor.

Working 40 Hours Per Week

Applicants and members added to the RCA group who are working a minimum of 40 hours per week at the state minimum wage are not referred to the refugee contractor. This client's participation in employment is meeting requirements.

Lack of Child Care

In the Employment Services - Detail screen in Bridges, select the *No Child Care for Child Under Six* deferral reason and reply to questions regarding child care when a guardian personally provides care for a child under age 6 and adequate child care is unavailable. Adequate child care meets all the following:

- Appropriate. The care is appropriate to the child's age, disabilities and other conditions.
- Reasonable distance. The total commuting time to and from work and child care facilities does not exceed three hours per day.
- Suitable provider. The provider meets applicable state and local standards. License exempt providers who are not licensed by the Michigan Department of Licensing and

Regulatory Affairs (LARA) Child Care Licensing Bureau (CCLB) must meet Child Development and Care (CDC) enrollment requirements.

- Affordable. The child care is provided at the rate of payment or reimbursement offered by the CDC program.

Clients who need assistance in finding a licensed provider should be referred to Great Start to Quality, the online early learning resource site, at www.greatstarttoquality.org. All active licensed providers in good standing are searchable. If additional assistance is needed, clients can be referred to 877-614-7328 to reach the Great Start to Quality Resource Center serving their county. Resource centers can provide personal consultation for families in need of child care. If a provider cannot be located, the client needs to provide verification.

If a provider is located within 10 calendar days, end the deferral on the Employment Services Detail screen in Bridges. The specialist must generate the DHS-4785-R and complete the referral to the refugee contractor.

If the client is unable to obtain child care that meets the conditions above within 10 calendar days, the client may be deferred from referral to the refugee contractor for 90 days or until the child turns age 6, or until appropriate care is available, whichever is sooner. Bridges will change the deferral code to mandatory participant at the end of the deferral period. The specialist must generate the DHS-4785-R and complete the referral to the refugee contractor. Document the referrals and results in the case record. The Deferral/Participation Reason is identified as No Child Care Available.

Domestic Violence

Domestic violence means one or more threats or acts against any family member concerning any of the following:

- Physical injury.
- Sexual abuse.
- Sexual involvement of a dependent child.
- Mental/emotional abuse.
- Neglect or deprivation of medical care.

Defer clients with a documented claim of threatened or actual domestic violence against themselves that can reasonably be expected to interfere with work requirements.

Assist the client to develop a plan intended to overcome domestic violence as a barrier to self-sufficiency. The plan may include participation in services for domestic violence victims or receipt of related professional care. Specific activities which might reasonably be expected to endanger the client should be avoided. Document the clients' agreement in the RFSSP.

The maximum deferral period is three months. Bridges will change the deferral code to mandatory participant at the end of the deferral period. The specialist must then manually generate the DHS-4785R and complete a referral to the refugee contractor.

With documented supervisor approval, extensions are permitted in three-month increments.

Use the client's written statement as documentation unless there is sufficient reason to question it. If the statement is questionable, request further documentation, including any of the following:

- Service from a domestic violence provider.
- Medical records.
- Court records, such as personal protection order or petition.
- Police records (for example, domestic disturbance response).
- Statement by a licensed therapist or counselor.
- Other case record information (including children's services).
- School records (for example, statement by a school counselor).

Note: All information concerning domestic violence is confidential; see *BAM 310, Confidentiality and Public Access to Case Records*.

Disability

Information recorded in Bridges will defer the following:

- Recipients of RSDI based on disability or blindness.
- Persons found eligible for RSDI based on disability or blindness who are in non-pay status.

RFSSP Data Entry

Assign clients to self-sufficiency or barrier removal activities as medically permissible. Enter these activities on the RFSSP.

Short-Term Incapacity

Persons with a mental or physical illness, limitation, or incapacity expected to last less than three months and which prevents participation may be deferred for up to three months.

Verify the short-term incapacity and the length of the incapacity using a DHS-54A, Medical Needs, or other written statement from an M.D./D.O./P.A. Set the medical review date accordingly, but not to exceed three months.

Do not advise clients with a short-term incapacity to apply for SSI.

Long-Term Incapacity

At intake, redetermination, or any time during an ongoing benefit period, when an individual claims to be disabled or indicates an inability to participate in work or with the refugee contractor for more than 90 days because of a mental or physical condition, the client should be deferred in Bridges. Conditions include medical problems such as mental or physical injury, illness, impairment or learning disabilities. This may include those who have applied for RSDI/SSI.

RCA applicants/recipients who are already receiving MA based on their own disability and/or blindness, meet the medical deferral requirements for incapacitated up to the medical review date stated on the DHS-49-A, as determined by the DDS 7/1/2015 and after.

Note: A person with a condition or impairment that is pregnancy-related must be deferred for a problem pregnancy. These individuals should not be referred to the DDS or to an SSI advocate if the **only** conditions or impairments are due to pregnancy; see *Pregnancy Complications* in this item.

Step One: Establishment of Disability

Once a client claims a disability, he/she must provide MDHHS with verification of the disability when requested. The verification must indicate that the disability will last longer than 90 calendar days. If the verification is not returned, a disability is not established. The client will be required to fully participate with the refugee contractor as a mandatory participant; see *Verification Sources* in this item.

In Bridges, the Deferral/Participation Reason is *Establishing Incapacity* while awaiting the verification that indicates the disability will last longer than 90 days.

At application, the RCA may be approved once the client has verified the disability will last longer than 90 days, assuming all other eligibility requirements have been met.

If the returned verification indicates that the disability will last 90 days or less; see Short-Term Incapacity in this item.

Step Two: Defining the Disability

For verified disabilities over 90 days, see *BAM 815, Medical Determination and Disability Determination Service*, for the policy requirements in obtaining a medical certification from DDS. If the client does not provide the requested verifications, the RCA should be placed into closure for failure to provide needed documentation.

For verified disabilities over 90 days, the client must apply for benefits through the Social Security Administration (SSA) before step three; see *BAM 815, Medical Determination and Disability Determination Service* and *BEM 270, Pursuit of Benefits*.

In Bridges, the Deferral/Participation Reason is *Establishing Incapacity* while awaiting the DDS decision.

Step Three: Referral to DDS

Send the completed required forms, along with any medical evidence provided, to the DDS to begin the medical development process.

The Deferral/Participation Reason in Bridges remains *Establishing Incapacity*.

Manually set a reminder in Bridges for a three-month follow-up.

DDS DECISION

Upon the receipt of the DDS decision, review the determination and information provided by DDS. Establish the accommodations the recipient needs to participate with the refugee contractor or to complete self-sufficiency-related activities. Follow the procedure for accommodating disabilities; see *Reasonable Accommodation* in this item.

Disabled-Potentially Eligible for RSDI/SSI

After DDS determines a recipient meets the established disability criteria, verify the following:

- Update the *Disability Determination- MRT and Employment Services* screen to indicate the recipient is *Incapacitated more than 90 Days*.
- The Cash-EDG Summary will show the Deferral/Participation Reason of *Incapacitated More Than 90 days*.

When to Request a New DDS Decision

After a DDS decision and/or SSA medical determination has been denied and the client states their existing condition has worsened or has a new condition resulting in disability greater than 90 days, verify the new information using a DHS-54-A. If the returned verification confirms the above, see BAM 815.

The specialist must assign and maintain RFSSP activities to ensure continued pursuit of self-sufficiency.

If new medical evidence is not provided, do not send the case back to the DDS. The previous DDS decision stands.

INDIVIDUALS NOT REQUIRED TO PARTICIPATE WITH THE REFUGEE CONTRACTOR

Aged 65 or Older

Recipients ages 65 and over are not required to participate in employment and/or family self-sufficiency plans. However, they may be referred to the refugee contractor as volunteers.

Disqualified Non-Citizens

An individual who is not eligible for RCA due to a non citizenship status is not referred to the refugee contractor; see *BEM 630, Refugee Assistance Program*.

REQUEST FOR TEMPORARY DEFERRAL FROM THE REFUGEE CONTRACTOR

Deferral Not Granted

Take the following actions when a request for deferral is not granted:

- Document in the case file and in Bridges the basis of the decision including any limitations or restrictions.
- Inform the recipient that the criteria for the deferral were not met and therefore participation with the refugee contractor is mandatory.
- Refer the recipient to the refugee contractor, using the manually generated DHS-4785R and the established process between the local office and the refugee contractor. Provide all information on any limitations to full participation when making this referral.

Advise the recipient of his/her right to:

- Discuss the deferral decision with a supervisor.
- File a grievance with the refugee contractor if he/she disagrees with the activities assigned at the refugee contractor.
- File a hearing regarding denial of support services such as transportation services, translation services, or a decrease in benefits.

Note: When a deferral is not granted, it is not a loss of benefits, termination or negative action. When a participant requests a

hearing based on not being granted a deferral, be sure to advise the recipient at the pre-hearing conference and use the DHS-3050, Hearing Summary, to inform the administrative law judge the action did not result in a loss of benefits or services. Be sure the participant understands the time to file a hearing is once he/she receives a Notice of Case Action for noncompliance.

Deferral Granted

When a request for deferral is granted, take the following actions:

- Enter the supporting information into Bridges.
- Determine the length of the deferral.
- Notify the recipient of the decision and length of deferral. Notify the refugee contractor of the deferral status via the established process between the local office and the refugee contractor.
- Document the decision in the case file and in Bridges case comments.

A Bridges task and reminder is sent to the worker for follow-up to review the deferral four calendar days before the end of the month before it is to expire.

PARTICIPATION AT THE REFUGEE CONTRACTOR

The mandatory participant must attend orientation and participate at the refugee contractor for employment and self-sufficiency activities. If the mandatory participant does not comply with these activities, he/she may face penalties and potential closure of his/her RCA; see *BEM 233C Failure to Meet Employment And/Or Self-Sufficiency Requirements: RCA*.

Participation in Refugee Contractor Activities

Mandatory participants in the RCA program must comply with certain work-related requirements in order to maintain RCA. However, unlike FIP benefits, there are no hourly work participation requirements. In order to maintain the RCA benefit, they do have to work or engage in activities leading to employment or self-sufficiency.

Refugee Family Self-Sufficiency Plan (RFSSP)

The mandatory participant is required to complete an RFSSP with the refugee contractor. The RFSSP is to be developed collaboratively with the mandatory participant and the refugee contractor case manager to address the goals and responsibilities to be met by the mandatory participant and the refugee contractor. The RFSSP should contain both the goals agreed to by the mandatory participant and the refugee contractor, as well as the specific activities the mandatory participant will take to reach the goals.

The RFSSP is to be completed within 30 days of the referral to the refugee contractor. The mandatory participant and refugee contractor case manager must agree to all goals and activities assigned in the RFSSP and both must sign and date the RFSSP. The refugee contractor must submit a copy of the signed RFSSP to the specialist via the process developed by the local office and the refugee contractor. If changes or updates are made to the RFSSP, the refugee contractor must submit a copy of the updated RFSSP to specialist.

Note: A new RFSSP is required for each new application period.

Employment and/or Self-Sufficiency Related Activities

As developed in the RFSSP, mandatory participants may be required to participate in the following activities:

- Register and participate with the refugee contractor for employment services.
- Create and sign the RFSSP, with the refugee contractor case manager.
- Comply with activities assigned to the mandatory participant on the RFSSP.
- Participate in employment and/or self-sufficiency related activities.
- Accept a job referral and/or offer of employment.
- Participate in any arranged job interview or scheduled appointment.

- Participate in any employability service program which provides job or language training, which is determined to be available and appropriate for the mandatory participant.
- Participate in any social service program if referred and as available in the area in which the mandatory participant resides.

VERIFICATION

Paid Work Activities

The recipient's actual hours of participation in paid work activities must be verified. The specialist may use two consecutive paycheck stubs or wage statements that reflect the average number of hours worked by the client. Paycheck stubs or a collateral contact with the client's manager or supervisor meet the requirement to project the client's hours for six months. Determine the average number of hours worked and document in Bridges *Case Comments*.

Example: Amber submits three consecutive paycheck stubs for pay dates of January 5, 12 and 19. One paycheck stub shows 25 hours worked, one paycheck stub shows 30 hours worked and one pay check stub shows 32 hours worked. The average of the three paycheck stubs is 29 hours per week on average.

Example: Jordan submits two consecutive paycheck stubs for pay dates of January 5 and January 19. The client is paid bi-weekly. One paycheck stub states 60 hours worked and one paycheck stub states 55 hours worked. The average of the two paycheck stubs is 28 hours per week, dropping the fraction (60+55 divided by four weeks) to obtain the weekly average.

Change in hours of Work Activity

When a recipient reports a change in the number of hours of employment during the six-month projection, the specialist must gather actual paycheck stubs that reflect the change. Use a minimum of two new consecutive paycheck stubs, wage statements or the collateral contact to project the new six-month period that begins the month after the month with the change. Document the change in Bridges *Case Comments.*

Non-Paid Activities

Mandatory participants temporarily deferred from participating at the refugee contractor are not required to complete any additional unpaid activities. Document any additional activities in which the individual may be voluntarily participating in Bridges *Case Comments.*

Deferrals

See *Family Independence Program Verification* criteria outlined in *BEM 230A, Employment And/Or Self-Sufficiency Related Activities*, for appropriate verifications for deferrals.

VERIFICATION SOURCES

Paid Work Activities

Verification of hours the recipient participates in a wage-earning activity is required by the specialist. Use one of the following:

- Two consecutive pay checks stubs that reflect hours worked.
- Collateral contact with the recipient's manager, supervisor, or authorized representative of the employer who is able to verify the hours worked.
- Equifax Verification Services (formerly known as the TALX Work Number).

SSI/RSDI Based on Disability / Blindness

To verify information regarding SSI or RSDI based on disability or blindness, use one of the following:

- Document from the Social Security Administration.
- DHS-1552, Verification of Application or Appeal for SSI/RSDI.
- Third Party Single Online Query (SOLQ) ED-030.
- Consolidated Inquiry.

EXHIBIT- REFUGEE CONTRACT PROVIDERS

Contractor	County of Service	Telephone Contact
Catholic Charities of Ingham, Eaton and Clinton Counties	Clinton, Ingham and Eaton counties.	517-323-4734
Samaritas	Calhoun and Kalamazoo counties.	269-345-5776
Samaritas	Kent County.	616-356-1934
Jewish Family Services of Washtenaw County	Jackson, Hillsdale, Lenawee, Livingston, and Washtenaw counties.	734-769-0209
Latin Americans United for Progress	Muskegon and Ottawa counties.	616-888-7225
Samaritas	Genesee, Macomb, and Oakland counties.	248-423-2790

Contractor	County of Service	Telephone Contact
International Institute of Metro Detroit	Wayne County	313-871-8600
Samaritas	Technical assistance provider for remote services and consultation only: Alcona, Alger, Allegan, Alpena, Antrim, Arenac, Baraga, Barry, Bay, Benzie, Berrien, Branch, Cass, Charlevoix, Cheboygan, Chippewa, Clare, Crawford, Delta, Dickinson, Emmet, Gladwin, Gogebic, Grand Traverse, Gratiot, Houghton, Huron, Ionia, Iosco, Iron, Isabella, , Kalkaska, Keweenaw, Lake, Lapeer, Leelanau, Luce, Mackinaw, Manistee, Marquette, Mason, Mecosta, Menominee, Midland, Missaukee, Monroe, Montcalm, Montmorency, Newaygo, Oceana, Ogemaw, Ontonagon, Osceola, Oscoda, Otsego, Presque Isle, Roscommon, Sanilac, Saginaw, Schoolcraft, St. Joseph, Tuscola, Shiawassee, St. Clair, Van Buren and Wexford.	248-423-2790

LEGAL BASE

45 CFR 400.75 - 400.81

DEPARTMENT PHILOSOPHY

Michigan Department of Health and Human Services (MDHHS) assists families to achieve self-sufficiency. The primary avenue to self-sufficiency is employment. MDHHS and Partnership. Accountability. Training. Hope. (PATH) provides Direct Support Services (DSS) to help families become self-sufficient.

DEPARTMENT POLICY

FIP, CDC, MA Family, FAP Family, FAP Non-Family

Definitions

Direct Support Services (DSS)

Goods and services provided to help families achieve self-sufficiency. DSS **includes** Employment Support Services (ESS) and Family Support Services (FSS) that directly correlates to removing an employment-related barrier.

There is no entitlement for DSS. The decision to authorize DSS is within the discretion of the MDHHS or PATH program, based on local office funding.

Employment Support Services (ESS)

Include, but are not limited to, transportation, special clothing, tools, physical exams, vehicle purchases, vehicle insurance and vehicle repair. ESS may be authorized by MDHHS or PATH program; *see availability and clients served by MDHHS* or *clients served by PATH* in this item.

Family Support Services (FSS)

Include, but are not limited to, classes and seminars, counseling services and commodities. FSS may only be authorized by the family independence specialist. FSS services are provided to clients when the primary reason for providing a service is to remove an employment-related barrier preventing the client from participating in activities leading to self-sufficiency. Clients experiencing barriers directly tied to other services such as children’s services or housing must be charged or funded by those funding sources.

FAP Family and FAP Non-Family

For purposes of this item, a distinction is made between FAP-Family and FAP-Non-Family.

- FAP Non-Family is an eligible group that does not include a child under age 18 or a pregnant person.
- A FAP Family is an eligible group that includes a pregnant person, a child under age 18, or a child aged 18 who is in high school full time.

Ineligible Grantees

An ineligible grantee (the person who acts as grantee but who is not an eligible group member) in a FIP family may be eligible for DSS if the ineligible grantee receives CDC, MA Family and/or FAP and otherwise meets DSS eligibility requirements and there are no other resources available.

Overview

Funds for direct support services for FIP, CDC, MA Family, and FAP Families, are allocated to local offices annually. Local offices must prioritize the services provided to assure expenditures do not exceed their allocation. This allocation is published each year for MDHHS staff.

Local offices in need of additional DSS funding during the year may request this funding through their Prosperity/Business Centers (BSC) at and carbon copy (Cc:) the DSS policy mailbox, Policy-Employment@michigan.gov. The decision to transfer DSS funding amongst counties is within the discretion of the BSC's, based on existing county funding. DSS allocation balances may be viewed in Bridges under **data collection, miscellaneous, DSS allocation.**

FAP employment and training reimbursements to FAP applicants and recipients and FSS provided under the statewide counseling contract are not included in the direct support services allocation since services are funded by another source. Payments issued for these reasons do not reduce the local office DSS allocation.

Any adult group member who has been found guilty of an Intentional Program Violation (IPV) for any program in the last five years is not eligible for DSS assistance. If a participant who is serving an IPV needs DSS funding for either transportation or child care assistance to attend orientation at PATH, a policy exception is

required. Email the DSS policy mailbox, at Policy-employment@michigan.gov with a detailed explanation of the exception request.

Refugees

Refugee families receiving FIP, CDC, MA Family, and/or FAP.

Refugee families receiving FIP and participating in PATH receive ESS from the PATH provider. Refugee families receiving CDC, MA Family, and/or FAP benefits and who are otherwise eligible for direct support services, receive DSS payments from MDHHS using local office DSS allocation funds.

Refugee non-families and refugee families not receiving FIP, CDC, MA Family or FAP.

Refugee non-families and refugee families not receiving FIP, CDC, MA Family or FAP who are requesting employment-related services, including support services must be served by a refugee contractor. See BEM 230C, Employment And/Or Self-Sufficiency Related Activities: RCA, for the Refugee Contractor Provider Table that identifies the Refugee Contractors for each county that provides consultation services either in person or by phone. Provide the client with the contact information for the contractor of service.

AVAILABILITY

FIP, CDC, MA Family, FAP Family, FAP Non-Family.

This section explains when services are provided by MDHHS and when services are provided by PATH.

CLIENTS SERVED BY MDHHS

FIP

MDHHS may authorize ESS and FSS to applicants and recipients. MDHHS may authorize services to clients who are:

- Referred to orientation.

  Note: It is critical for the specialist to evaluate DSS transportation and child care to a client who identifies a need for assistance with these services in order to participate in orientation requirements. Assistance will continue until local

PATH program policies allow them to provide transportation or until the specialist is able to approve Child Development and Care (CDC) services. Use the DHS-619, Jobs & Self-Sufficiency Survey, to evaluate client need for services.

- Completing a compliance activity assigned by MDHHS.
- Participating in a PATH program activity when both MDHHS and PATH agree that it is in the client's best interest to have MDHHS make the DSS payment. MDHHS and PATH program staff should locally determine when and under what circumstances this should occur. MDHHS and PATH may collaborate to jointly fund services to clients when necessary.
- Dependent children aged 16 to 18 who are full-time students in elementary or high school by policy exception.
- Teen parents who are attending high school full- time.
- Participants in Volunteers in Service to America (VISTA), Job Corps or Americorps who are not participating in a PATH approved education or training program but are meeting work participation requirements.

CDC, MA Family, FAP Family

Employment Support Services are available **only if** all these apply**:**

- No other resource is available.
- The family is applying for or receiving CDC, MA Family or FAP.
- The CDC, MA Family or FAP recipient did not receive DSS for more than four consecutive months.

Example: Client requests ongoing transportation funds to attend a specialist assigned FSS activity each week for five months. The specialist can approve transportation funds to support this activity for only four months in a row when the client is not active FIP.

The above example would also be true if the group requested any DSS service or combination of services each month for four months in a row.

Example: The specialist approves a single request for a vehicle repair, vehicle insurance and payment of a towing bill for one client in May. May counts as one month. Count months, not services.

FIP, CDC, MA Family, FAP Family Applicants

When providing DSS to an applicant of FIP, CDC, MA Family or FAP Family, use form DHS-3043, Temporary Assistance for Needy Families (TANF) Income Eligibility Declaration, to determine financial eligibility. There is no verification required. The DHS-3043 is a client declaration only. File the original copy of the declaration in the electronic case record.

FAP

FAP clients who are not applicants or recipients of FIP and do not qualify for DSS may be eligible for the FAP employment and training reimbursement as noted below. The purpose of this reimbursement is to provide support services to FAP clients who are in self-initiated job search or self-initiated community service, not related to meeting Time Limited Food Assistance (TLFA) work requirements Employment and Training (E&T) reimbursement services may not be provided to any client for the purpose of support services related to a job regardless if that job is in exchange for money, goods or services (in-kind).

The following type of support services may be provided at a combined maximum of $50 each month:

- Transportation/travel (for non-TLFA participation).
- Interview clothing for job interviews.
- Personal safety items: for example, safety glasses and welding glasses for the purpose of the education/training program assigned by PATH.
- Books or training manuals.
- Tools: for example, mechanic’s tools for the purpose of the education/training program assigned by PATH.
- Other necessary preparatory items.

CLIENTS SERVED BY PATH PROGRAM

FIP

PATH may authorize ESS to any mandatory or voluntary work participant program participant who is active on the One-Stop Management Information System (OSMIS). This includes clients who are deferred, but volunteering for PATH.

CDC, MA Family, FAP Family

PATH may authorize ESS to non-cash recipient (NCR) parents and caretakers in CDC, MA Family, and FAP Family cases when members are participating in PATH employment and training program.

FAP Non-Family, TLFA

PATH may authorize the FAP employment and training reimbursement to both Time Limited Food Assistance (TLFA) and non-TLFA recipients participating in a FAP employment and training program.

DOCUMENTING AUTHORIZATIONS

FIP, CDC, MA Family, FAP Family, FAP Non-Family

All support service payments are entered on Bridges. However, actual payments are recorded in Statewide Integrated Government Management Application (SIGMA). A nightly file is sent to MIS to ensure the payments do not exceed time limits or payment maximums.

PAYMENT AUTHORIZATIONS

FIP, CDC, MA Family, FAP Family, FAP Non-Family, TLFA

Follow the authorization procedures below for ESS, FSS, and the $50 FAP employment and training reimbursement payments.

Bridges Entries

MDHHS must enter all payments on Bridges, including the FAP $50 reimbursement.

Use Bridges to complete the MDHHS-5602, Payment Voucher. This will record the payments on Bridges and also track services that have time and payment limits. All Bridges entries must be input prior to sending the MDHHS-5602 to the accounting unit for payment. At this time, Bridges does not process DSS payments. Continue to enter payments through SIGMA. Accounting office's follow instructions outlined on the MDHHS-5602 completed by the specialist.

Note: Print a copy of the MDHHS-5602 for the local office fiscal unit to process the payment per instructions outlined by the specialist. The accounting office will request payment processing updates based on the outcome of purchase orders or bills once the authorization becomes final. The specialist updates the original authorization using left navigation, benefit issuance, pending DSS option. The specialist submits a new MDHHS-5602 to accounting for final processing.

Bridges sends a DHS-1605, Client Notice, informing the client of the outcome of his/her DSS request.

Payment Maximums

Payment maximums are the combined total of the payments made by MDHHS and PATH program.

Example: If MDHHS pays $1400 for a vehicle repair and PATH later pays $600 for the same client within the same calendar year, the payment maximum of $2000 has been reached. The specialist

must confirm that the payments made are not duplicate from those made by PATH.

Note: Bridges will pre-fill any data fields on the MDHHS-5602 known to the system. Bridges edits prohibit support service entries that exceed payment maximums, frequency limits, or local office allocation limits.

DSS payment maximums by service can be viewed under benefit issuance, DSS, payment caps. Specialist must review payment maximums prior to approving a new request for a capped service.

Overcap Payment Requests

When an overcap policy exception is required, an overcap approval is needed. The specialist should email the DSS policy mailbox, at Policy-Employment@michigan.gov with a detailed explanation regarding the over cap exception request. Upon approval the local office will contact the Bridges Resource Center (BRC) and request a payment override.

Actual Cost

For authorizations based on actual costs supported by an invoice, use the MDHHS-5602 in Bridges to direct the accounting office to issue a vendor payment.

Estimated Cost

For authorizations based on an estimated cost, use the MDHHS-5602 on Bridges to direct the accounting office to issue a DHS-2083, Purchase Order Invoice. The DHS-2083 authorizes the vendor to provide the service (for example, vehicle repair) and bill the local office. The accounting office will inform the specialist when the final bill or purchase order is received, if the amount is different. The specialist then re-processes the payment amount in Bridges.

BSC's and Local Office Procedures and Records

BSC's and Local offices should use standard accounting and internal control procedures to ensure that spending limits are not exceeded.

BSC's and Local offices must also maintain records of payment authorizations, and client Bridges records must reflect the payment authorizations.

Bulk Purchases

Bulk purchased items are managed by designated local office staff. An inventory of bulk items is maintained outside of the Bridges system. When purchasing bulk items, designated staff complete a MDHHS-5602, Payment Voucher, attaching the original bill. Designated staff or accounting staff should email the DSS policy mailbox or send a copy of the MDHHS-5602 to:

MDHHS Central Office
Program Policy Unit
Suite 1307
Lansing, MI 48909
Attention: Heidi Norfleet

Policy staff use the MDHHS- 5602 to reduce the local office DSS allocation in Bridges. It is not necessary for the specialist to enter individual bulk purchase items in Bridges as expenditures are recorded at the time of the bulk purchase. The specialist must enter a case comments indicating what bulk purchased item was given to a client and the reason. Accounting staff or other designated staff must maintain a sign-out process to ensure an item is associated to a client(s) for auditing purposes.

Contracts

When making FSS referrals, use local procedures to alert contractors to bill to DSS. Contractors must list DSS service units on a separate line when billing on the DHS-3469, Statement of Expenditures. Do not use the MDHHS-5602 or DHS-2083 for payment of contractual services.

When referring a client to a statewide counseling contract provider, send the Bridges DHS-839, Statewide Counseling Contract Referral, and a signed copy of the DHS-1555, Authorization to release Protected Health Information for Employment Services, both in Bridges. See *soft skills classes, seminars and counseling referrals*, in this item.

COVERED SERVICES

Child Care for Orientation, Compliance Activity, or to Attend FSS Activity

FIP, CDC, MA Family, FAP Families

Upon reviewing the DHS-619, Jobs and Self-Sufficiency Survey, local offices may use either CDC and/or DSS child care payments to complete:

- The first week of the assigned PATH program or tribal program.
- An employment-related compliance activity for FIP or FAP families See BEM 233A, Failure to Meet Employment Requirements: FIP, and BEM 233B, Failure to Meet Employment Requirements.
- Specialist-assigned FSS activities.

MDHHS must provide child care when a client identifies this barrier to attending PATH or other employment-related activity.

Note: Determine eligibility for the CDC program for assignments beyond the first week or for employment; see BEM 702, 703, 704, 705 and BEM 710.

Authorize DSS child care payments on a MDHHS-5602, Payment Voucher, through MIS.

Advise clients that to be eligible for DHS payment, they must use an eligible provider. Eligible providers are those monitored by the MDHHS Bureau of Children and Adult Licensing or enrolled by MDHHS; see BEM 704.

Medical Exams, Immunizations and Tests

FIP, CDC, MA Family, FAP Family

Certain services which are not defined as medical services may be needed to overcome barriers to employment or training. See *prohibited expenditures* in this item for the definition of medical services.

Pre-Employment and Training Medical Exams

Use the DHS-54A, Medical Needs, form or the DHS-54E, Medical Needs-PATH Program form, to obtain general physical examinations by an MD or DO statement to determine client's employment limitations.

Use a DHS-93A, Medical Services Authorization Invoice, to authorize payment. See RFT 285, Diagnostic Examination Fee Schedule, for employment-related activities payments.

Immunizations and Tests

When an immunization or test is required to obtain, maintain or enhance employment, and cannot be obtained free of charge, authorize payment via DHS-93A; see *fee schedules* in this item.

Note: Local office DSS allocations are not reduced by issuance of the payments listed below.

Coding The DHS-93A

Program Code	Reason Code	Service Code	MPS Provider Code	Service Code Description	Payment Maximum
C	D	01	45, 46	DSS - Photo Copies	$100
C	D	02	45	DSS - Existing Records	$12
C	D	21	45	DSS - Other	$00
C & NCR Family	D	22	45	DSS - Immunization & Lab Tests	$100
C	D	04	45, 46	DSS General Medical	

Dental Services

Dental services, not defined as medical services, may be needed to overcome barriers to employment or training. See *prohibited expenditures* in this item for the definition of medical services.

To access information about the types of dental services that are covered under Medicaid, contact a local Medicaid Provider or email-mail Kyle Norman the Medicaid dental policy specialist at the

Michigan Department of Health and Human Services, at Normank2@michigan.gov.

Relocation

FIP, CDC, MA Family, FAP Family

Relocation assistance may be available to FIP/CDC/MA Family and FAP families. Moving expense allowances may be provided to persons who obtain verified employment beyond commuting distance; see BEM 233A, Long Commute in Good Cause for Noncompliance or Refusing Employment.

Funds may be used for:

- Trailer or truck rental.
- Compensation for persons assisting in the move.
- Mileage allowance.
- Rental of moving equipment such as dollies.
- Security deposit and first month's rent at the new location.
- Other expenses of the move the local office determines necessary.

Expenses are limited to $1,500 per participant. In two-parent families, both parents may receive the service, simultaneously or on separate occasions, if they both obtain employment requiring relocation.

Clothing

FIP, CDC, MA Family, FAP Family

The following items may be authorized for work projects, training or employment.:

- Work gloves, work boots, work shoes and hard hats.
- Other protective/special clothing or personal safety items needed for training or employment.
- Clothing needed in training or to prepare for or accept employment.
- Appropriate clothing to successfully participate with PATH or other employment-related activity.

The total cost of clothing for FIP, CDC, MA Family, or FAP family clients may not exceed $250 per participant, including any clothing authorized in the previous 12-month period. In two-parent families, both parents may receive the service if both have a need.

Note: Individuals served by the MWA's via the PATH program may be eligible for clothing assistance up to $500 in a 12-month period, as determined by the MWA.

FAP Non-Family

See *clients served by MDHHS*, *FAP* in this item.

Transportation Allowance

FIP, CDC, MA Family, FAP Family

This allowance includes, but is not limited to, travel between the person's home and:

- Participation in PATH or other employment-related activity until PATH is able to provide transportation.
- Child care provider.
- Educational facility.
- Job club.
- Training site.
- Specific job interview.
- Community service site (except for TLFA recipients participating in a Food Assistance Community Service Program).
- Specialist-assigned FSS activity site or state-wide counseling contract assignment.
- Job site.

Note: Job site transportation is limited to three months. Before the three-month limit is reached, the MDHHS specialist, PATH case manager and client should address transportation issues to ensure the client can meet these expenses when the allowance ends.

Transportation Costs

MDHHS is responsible for transportation costs:

- To participate in PATH or other employment-related assignment until PATH is able to serve the client's transportation needs.
- To complete a compliance activity.
- For teen parents attending school full time if the client cannot use the school transportation system because of the need to arrange transportation to child care.

For FIP, CDC, MA Family or FAP family clients, compensation is actual cost for public transportation or based on the IRS standard mileage reimbursement (currently 58 cents a mile) for a private vehicle. In two-parent families, both parents may receive the service if both have a need.

A flat rate is allowed but must be based on public transit costs or actual miles. Local offices may use a formula to devise a method for issuing a bulk purchased flat rate method using, for example, gas cards in-town or out-of-town or rural approach to average the costs per issuance.

See *clients served by MDHHS*, FAP in this item.

Bus Tickets/ Tokens

FIP, CDC, MA Family, FAP FAMILY, FAP NON-FAMILY

Bus tickets/tokens are part of a bulk purchase already paid for by the local office designee. Bridges does not require entry of a dollar amount or unit amount, but a case comment should be entered on what was provided and the reason. Bus tickets/tokens are distributed in units that reduces the inventory of this bulk purchased item.

Bus tickets/tokens may be given for a client to transport children to child care facilities when the client is working or participating in employment-related activities.

Local offices must develop a sign-out method to track issuance of bulk purchased items (for audit purposes) to associate a particular

client to the service. PATH and TLFA bulk purchase requests must be completed on separate MDHHS-5602 payment request forms.

Payment Methods for Transportation

Local offices should develop the payment method(s) to best meet local needs and resources. Examples include:

- Payment directly to the participant.
- Payment to a provider for a specific participant.
- Payment to a provider for a number of participants.
- Bulk purchase of bus tickets/tokens or gas cards to be issued to individual participants but paid for or redeemed as a group.

If more than one payment method is used, the local office must ensure against duplicate assistance. Standard accounting procedures and security for vouchers and bus tickets/tokens must be in place.

Note: Care should be taken when purchasing bulk gas or gift-type cards that guarantees clients are not able to purchase prohibited items. Best practice is to work with a provider and obtain cards that only allow for the purchase of gas, clothing, or other expense intended by the card.

Vehicle Repair

FIP, CDC, MA Family, FAP Family

Authorize vehicle repairs for each participant for a vehicle that is the primary means of transportation for employment-related activities, even if public transit is available. The total MDHHS/PATH program cost of repairs may not exceed $2000 including any repairs done in the previous 12 months. Clients may contribute any amount over $2000 prior to MDHHS payment.

Prior approval is required MDHHS before authorizing a major repair, ensure that all of the following conditions are met:

- An eligible group member owns the vehicle.
- The client requesting the service has a valid driver's license.
- The repair is expected to make the vehicle safe and roadworthy including new tires, headlamps, batteries, etc.

  Note: If the client requesting the service does not have a valid driver’s license but has someone else use their vehicle to drive

them, document the name of the person driving the vehicle. Verify a valid driver's license for the individual that will be operating the vehicle.

A vehicle may be repaired for a currently employed client if the client needs a vehicle to accept a verified offer of a better job or needs a vehicle to retain current employment; and has a demonstrated ability to maintain a job.

A vehicle may be repaired for a client who is not currently employed if the client needs a vehicle to accept a verified job offer; or needs a vehicle to participate in family self-sufficiency activities that will prepare the client for employment

A lease vehicle may be repaired for a client when there is at least 12 months left in the lease agreement and the client is up-to-date with the lease payments.

An estimate of the vehicle repair is required and must be placed in the electronic case file.

Do not authorize any vehicle repair for a vehicle that has been purchased within the last 60 calendar days.

If the vehicle repair being approved is $500.00 or more, the specialist will be required to enter a comment on the **DSS Service Request - Additional Information** screen explaining the reason for the payment of $500.00 or over.

Note: Any payment authorized by MDHHS for estimates or towing are **not** included in the $2000 limit; see *other ESS* in this item.

Vehicle Purchase

FIP, CDC, MA Family, FAP Family

Authorize up to $5000 to purchase, not lease, a vehicle to be used as a participant's primary means of transportation for work or employment-related activities. For FIP recipients, *see clients served by PATH* in this item. Vehicle purchase is limited to once in a client's lifetime. Prior approval through Bridges is required for this service.

In a two-parent family, if both parents are required to participate and need separate vehicles, a policy exception must be requested prior to approving a vehicle purchase for a second parent.

A vehicle may be purchased for a currently employed client if the client needs a vehicle to accept a verified offer of a better job; or needs a vehicle to retain current employment; and has a demonstrated ability to maintain a job.

A vehicle may be purchased for a client who is not currently employed if the client:

- Has a demonstrated ability to maintain a job.
- Needs a vehicle to accept a verified job offer.
- Needs a vehicle to participate in family self-sufficiency activities that will prepare the client for employment.

In addition, ensure all of the following before authorizing the purchase:

- Public transportation is not reasonably available (such as, considering the location and hours of the employment, child care or long commute as defined as good cause in BEM 233A), and the person has no other means to reach the job site reliably.

- The client has the ability to afford any payments, insurance and other expenses associated with owning the vehicle.

- The client has a valid Michigan driver's license.

- Verify via the Secretary of State records that the client does not own an unusable vehicle

- The vehicle must be registered to an eligible group member and insured, at a minimum, for public liability and property damage (PLPD). Vehicle insurance, license plates, or vehicle registration are covered under *other ESS* in this item and do not reduce the $5000 lifetime limit.

A vehicle inspection by a licensed mechanic is required and must be placed into the case file.

Vehicle purchases made by MDHHS are not exempt from use and sales tax collected by the Secretary of State.

Note: Any payment authorized by MDHHS for the inspection or sales tax is not included in the $5,000 limit; see *other ESS* in this item.

Before approving a vehicle purchase, the specialist must ensure that any additional payments above the allocation from the department are affordable by the client and will in no way hinder the client's progress towards self-sufficiency and financial independence. Confirm co-pay by client prior to approval.

Michigan Department of Health and Human Services employees are prohibited from selling any vehicle to any program recipient for DSS funds.

Deceptive Motor Vehicle Dealer Practices

If MDHHS personnel become aware that a recipient is being victimized regarding deceptive motor vehicle dealer practices, advise the:

- Secretary of State's Bureau of Regulatory Services at (800) 292-4204.
- Attorney General's Consumer Protection Division at 877-765-8388.

Other ESS

FIP, CDC, MA Family, FAP Family

You may authorize other ESS directly needed to obtain, maintain, or enhance a person's employment when it has been verified that funds are **not** available from other sources.

Examples:

One-time work-related expenses such as:

- Payment for license fees (vehicle, trade certification).
- Purchase of professional tools.
- Business start-up expenses.
- Vehicle inspection, sales tax on vehicle purchases, estimate or towing.
- License plates.
- Driver's education, by policy exception only.

Vehicle Insurance

Limited up to a $2,000 maximum lifetime cap. Limit the vehicle insurance coverage for the time period in which the client is establishing income to allow for their ongoing payment of the insurance, up to 90 days at one time. If an additional 90 days is required, it can be allowed with manager's approval.

Note: Complete a DHS-110, DSS Repay Agreement, when authorizing vehicle insurance premiums. Send the original copy to the Accounting Office with the MDHHS-5602, Payment Voucher. Retain a copy in the case record.

Tools

FAP NON-FAMILY

See *clients served by MDHHS, FAP* in this item.

FAP EMPLOYMENT AND TRAINING REIMBURSEMENT

All FAP-only Clients

See *clients served by MDHHS*, FAP in this item.

Note: Do not use the FAP employment and training reimbursement if the family/recipient meets the requirements under *Clients Served by MDHHS, CDC/MA FAMILY/FAP Family* or *Clients served by PATH, CDC/MA FAMILY/FAP Family* in this item.

FAMILY SUPPORT SERVICES

FIP, CDC, MA Family, FAP Family

Family support services (FSS) may be used to address specific family barriers to self-sufficiency not otherwise covered by ESS for:

- FIP, CDC, MA Family, FAP families, regardless of whether they are served by PATH or MDHHS. These families must meet the **family** definition and resource requirement. There is no employment requirement for FSS. An FSS-participating FIP client’s significant other is eligible for these services, even if that person is not in the FIP eligible group. Determination of significant other status is by client declaration.

- FIP clients completing a compliance activity.
- Statewide counseling contract services.

Do not use FSS to provide specific services identified as *prohibited expenditures* in this item. Services provided under FSS must be primarily related to an employment-related barrier. If the primary reason for services is related to children's services, prevention, housing or other primary reason requiring service, other fund sources must be used. When a client is pending or active with children's services or prevention or the client has a housing emergency, DSS must not be used to fund the service.

To ensure coordination with PATH employment support services, when relevant, local offices should convey to PATH staff the specific FSS provided to FIP clients with whom they are working. Only a specialist may approve and process FSS payments.

There are no dollar maximums on these services. Local offices must follow MDHHS contract and purchasing guidelines when providing FSS services.

FSS EXAMPLES

FSS may include but are not limited to the services outlined below.

Child Care

ESS funds can be used to provide child care and transportation to participate in FSS activities. Do not use FSS to provide child care or transportation for education or training activities, other than FSS activities.

Soft Skills Classes, Seminars and Counseling Referrals

Soft skills are personal attributes that enhance an individual's interactions, job performance and career prospects. Unlike hard skills, which tend to be specific to a certain type of task or activity, soft skills are broadly applicable and a necessary part of a successful job interview or placement.

Soft skills have to do with how people relate to each other: communicating, listening, engaging in dialogue, giving feedback, cooperating as a team member, solving problems, contributing in meetings

and resolving conflict. Leaders at all levels rely heavily on people skills such as setting an example, team building, encouraging innovation, solving problems, making decisions, planning, delegating, observing, instructing and motivating.

When evaluating a client for referral to a service provider, consider soft skills and areas the client may need assistance in preparing for participation in an employment-related activity or referral to PATH. The specialist should review the results of a client's Family Automated Screening Tool (FAST) when coordinating services and completing a referral for service. Assignments should be recorded when completing Family Self-Sufficiency Plan (FSSP) with the client.

Counseling services may be used to provide strategies for addressing behaviors that may impede efforts to seek or maintain employment. When referring clients with barriers for counseling services either with a statewide counseling contract provider or through a locally developed DSS contract, consider the following when designing and referring clients for service.

State-Wide Counseling and Intervention Services Contract Referrals

Counseling services provide a brief intervention or treatment that is focused most upon behavior. It often targets a particular symptom or problematic situation and offers suggestions and advice for dealing with the problem. The service involves the application of clinical counseling principles, methods or procedures for the purpose of achieving social, personal, career and emotional development and with the goal of promoting and enhancing healthy self-actualizing and satisfying lifestyles.

Counseling contract services must be one of the following:

- **Clinical counseling**: A counselor meets with a referred client and/or family members or a person significant to the client (if specified in the MDHHS referral) at a confidential space in the counselor's usual place of business.
- **Outreach counseling**: A counselor meets with a referred client and/or family members or a person significant to the

client (if specified in the MDHHS referral) at the client's home or, with MDHHS approval, at a mutually agreed upon site.

- **Group counseling**: A counselor meets with a group of referred clients. In addition to the counselor, each group shall include not fewer than three or more than ten individual members and shall include not fewer than three unrelated family groups.

In order to achieve success and self-sufficiency related to employment and relationships, many MDHHS clients would benefit from personalized, one-on-one therapeutic and educational intervention aimed at addressing specific needs. Topics that address such issues as soft skills education, anger and impulsivity control, prospering in a work environment and developing a balance between work and personal life demands can all contribute to increased success and self-sufficiency.

The specialist should evaluate which type of counseling would best serve the client's needs. The type of counseling requested must be included on the Bridges DHS-839, DSS Counseling Contract Referral, located in Bridges, under correspondence in left navigation. Attach a signed DHS-1555 to the DHS-839 when referring clients for counseling services.

Employment and training coordinators or other local office staff may want to organize group counseling sessions, or the specialist should contact the provider of service to ensure that group counseling is available from the provider.

The contractor shall certify eligibility for counseling based on client declaration that a need exists for them to fill out the FAST. Client(s) must be willing to participate in case management activities as required by their FSSP or could be found in noncompliance as outlined in BEM 233A.

Counseling treatment may be used for active or pending FIP, CDC, MA or FAP families to provide the following types of services:

- Strengthen family systems, which are not related to children's services, in order to increase employability or stability.
- Reduce emotional instability and impulsivity and develop professional work skills and standards.
- Provide opportunities for self-exploration, adaptation and new functional behaviors for both the workplace and personal lives.

- Provide acceptable solutions to anger management-related barriers.

Referral Process

The specialist determines the client's eligibility for services, type of service needed and reason for referral. A counseling contract provider cannot accept DSS funded referrals from any source other than an Employment and Training coordinator or specialist. Providers can be located by accessing the MDHHS-Net, Department Site, Central Office, Financial Services Administration, Office of Contracts and Purchasing, Counseling Contractors. Select the county and type of counseling desired.

When it is determined that counseling services are necessary and the client is eligible, the specialist contacts the counselor by phone to discuss the referral. If the counselor agrees to see the client, a written referral must be sent to the counselor using the Bridges DHS-839, DSS Counseling Services Referral, in the Bridges application under the correspondence tab in left navigation. Counseling services cannot begin until the counselor receives the DHS 839 and the signed DHS-1555. The DHS-839 must be completed accurately and signed by a FIM before it is sent to the counselor. The case copy of the referral is stored in Bridges.

Upon receipt of the DHS-839 and the DHS-1555, the counselor must contact the referring specialist to discuss the client's circumstances and preliminary goals and objectives.

Maximum Number of Units

The period of eligibility and number of counseling units must be listed. The maximum number of units is 12. An extension above the maximum must be in writing, listing the number of counseling units authorized and the dates that the service is authorized. Extensions must be signed by the referring specialist, the manager and approved by the local office director.

Service Delivery

Within ten working days of receipt of a written referral from MDHHS, an initial session shall occur between the counselor and the client. This initial session shall assess the client's circumstances, developmental history, family structure, support system, physical health, employment, emotional and mental status and client's view on presenting concern.

Within ten working days of the initial session with the client, the counselor shall submit a Counseling Services Assessment and Treatment Plan Report, DHS-840, to the referring specialist. The DHS-840 should address:

- Record of client sessions kept and unkept appointments.
- Phone or other case contacts.
- Individual and/or family assessment.
- Diagnosis, identification of employment-related barriers.
- Identified concerns and client strengths.
- Specific objectives and time frames.

The objectives listed in the treatment plan should be behaviorally based and measurable. The objectives should reflect interventions and strategies employed to achieve the overall goals of the counseling treatment. For example, a client working toward employment stability may have an overall goal of addressing anger and impulse control in the workplace. A measurable objective for this goal may be to participate in anger management activities assigned by the counselor in the assigned time frame. By tracking the number of assigned anger management activities, the client completes the objective can be measured and a decision made about progress or lack of progress on the goal.

The DHS-840, Counseling Services Assessment and Treatment Plan Report, shall be completed monthly by the counselor and submitted to the specialist within ten working days following the end of a month. The monthly report shall also include progress made toward treatment objectives and indicate if any changes were made in the treatment plan. This monthly submission affords the specialist the opportunity to closely monitor the client's progress or lack of progress with the service.

Medical/Psychological Treatment Recommendations

When a counselor identifies the need for a Medicaid-covered service such as mental illness, the counselor and the specialist should work together to connect the client with the appropriate provider/service. When barriers are identified that result in the need for IQ or other outside testing, refer the client to a provider of service outlined under *medical exams, immunizations and tests* in this item when Medicaid does not cover the service.

Counseling Service Termination

When counseling services are terminated, the counselor must complete a DHS-841, Counseling Services Termination Summary, no later than ten working days following termination of services. The DHS-841 addresses the following:

- Diagnosis/employability determination at termination.
- Treatment summary.
- Objectives and progress toward objectives.
- Total number of sessions.
- Number of sessions attended.
- Cooperation in treatment.
- Reason for closure.
- Recommendation of employability and future self-sufficiency.

Monitoring Service Provisions

Ongoing communication between the specialist and the counselor provides the best assurance for a good working relationship and effective service for the referred client. The specialist needs to keep the counselor informed when there are changes in specialists, legal statuses, address changes or significant changes in the case plan. The counselor needs to be notified when the FIP case is closed or denied.

The specialist must review reports submitted by the counselor. The reports should include all of the information listed in the service delivery section. The reports should be specific to the client, reflecting updated information. There are other contract requirements that need to be monitored:

- Did the counselor contact the client within three working days of a missed appointment?

- Did the counselor notify the specialist by phone each time two consecutive appointments were missed?

  Note: Missed appointments are considered noncompliance. Follow policy outlined in BEM 233A when this occurs.

Contract Noncompliance

Each contractor signs a counseling services contract that outlines the counselor's responsibilities, including the services to be delivered and actions for failure to deliver services. If a counselor is not meeting the requirements, the following action(s) must be taken:

- The specialist contacts the counselor and discusses the concern(s) and documents the contact in the affected case record.
- If the counselor does not address the concern(s), the specialist notifies the manager, in writing, of the issue.
- The manager or designated local office contract monitor files a report, in writing, to the MDHHS Financial and Administrative Services Administration, Division of Contracts and Rate Setting, Grand Tower Building, Lansing. The report must include:
  - The name, address and phone number of the counselor.
  - A narrative explaining the specific contract violation and a chronology of attempts to work with the counselor to rectify the concern.

Contract Payment

The specialist approves payment for counseling services using the DHS-3469, Statement of Expenditure. The specialist signs and dates the form and submits the approved bill to central office for payment. These payments do not reduce the local office DSS allocation, as funding is held centrally.

Note: Do not record DHS-3469 payment authorizations in Bridges. Provide case comments in Bridges.

The counselor submits a MDHHS-3469 monthly. The MDHHS-3469 shall accurately represent the units of service delivered, the reimbursement rate by type of service delivered and the total amount being claimed. The total number of units (by service type) for each bill must be rounded down to the nearest whole or tenth of a unit. Billings shall be submitted to the specialist within 30 days from the end of the monthly billing period. The specialist shall not make payment to the counselor for billings submitted more than 90 days after the end of a billing period. The specialist shall authorize payment to the counselor within 45 days after receipt of the billing.

When outreach counseling units are billed, the counselor may bill for mileage (at the state's premium established rate) from the counselor's starting point to his/her return to the office or home, whichever is closer.

A counselor cannot bill for more than one unit per counseling session for clinical and group counseling. A counselor cannot bill for missed appointments.

DSS Contracts

Local offices may continue to design and develop DSS contracts using their DSS allocation. Services vary from location to location and state-wide counseling service providers may not be available in all locations. Local offices may encourage providers to sign up with the state as a COUN/counseling contract provider. Once providers are approved by the Division of Contracts and Rate Setting (DCRS), billings will no longer affect the local office's DSS allocation. Local offices should use the same guidelines outlined above for statewide counseling and intervention services contract referrals, when establishing a DSS-related contracted service.

Prohibitions Related to Contracted Services

Specialists may refer clients via the statewide or locally developed FSS/DSS contracts for counseling services provided the services are unrelated to a medical need or sexual abuse and not available through Medicaid or Community Mental Health (CMH).

FSS/DSS referrals for counseling must not be medically related or intended for diagnosis, treatment or prevention of any physical or mental illness, regardless of the cause. Clinical outreach, group and family counseling are appropriate if not medically related.

Do not use FSS/DSS for outreach, clinical or group counseling related to sexual abuse. Refer the client to a children's protective services unit.

All contracts using DSS funding (81117) must comply with the DSS program guidelines which are available on the DCRS website. The fact that a service can be associated with an employment and training barrier is not sufficient to qualify for DSS funding.

There needs to be a clear designation and a primary reason for a client's referral for services. If a DSS/TANF eligible client is pending or active with children's services, then that is the primary reason for the service referral and the referral should be funded using a PCA that identifies the other fund source such as Strong Families/Safe Children (SF/SC) or Child Safety and Permanency Planning (CSPP/CAN).

When evaluating funding associated with DSS contracts, distinguish between services that are primarily children's services or that are related to another fund source, and services that are employment and training related as the primary reason for referral or service.

Commingled Contracts

The Office of Contracts and Purchasing will no longer approve any new commingled contracts to be executed (PCA 81117). All contracts using DSS funds will require the DSS fund source designation. When two fund sources are used for the same provider, two separate contracts must be executed to enforce the financial requirements and limitations of each fund source.

Commodities

Household items may include calendars, alarm clocks, booklets and other articles which are directly tied to an employment-related barrier and support a family's goal of self-sufficiency.

Note: These items should not be purchased for a general resource room or for the purpose of volunteer services. Clients must be tied to a service provided with this fund source and must meet TANF eligibility in order to receive service.

Indirect FSS

Indirect services are services which cannot be attributed to specific clients. Examples include but are not limited to household items (tools, carpet cleaners), newspaper subscriptions, periodicals, instructional video tapes, motivational items (books, videos, cassettes) to be loaned, and equipment and supplies used for providing indirect client services. All indirect client service expenditures are subject to department purchase requirements. See Administrative Handbook Manual purchasing AHR 425, Purchasing - Purchase Authority Delegated to MDHHS Worksites.

Note: These items should not be purchased for a general resource room or for the purpose of volunteer services. Clients must be tied to a service provided with this fund source and must meet TANF eligibility in order to receive service.

PROHIBITED EXPENDITURES

FIP, CDC, MA Family, FAP Family, FAP Non-Family

DSS funds, including FSS and ESS, **cannot** be used for:

- Financial incentives (or the equivalent) to clients to participate in employment-related activities.
- Fines arising from charges against clients.
- Bail for clients who have been arrested.
- Fees to reinstate driver's licenses.
- Medical services.

  Note: Medical services are services to diagnose, treat or prevent disease. Disease refers to any condition of physical or mental ill health, regardless of the cause. Typically, medical services are covered by the Medicaid program, other health insurance plan or a community public health agency. DSS may be used for services not covered by Medicaid.
- Substance abuse counseling or urine screens.
- Children's Services related sexual abuse counseling (outreach, clinical or group). When a client is active or pending with children's services, this is considered the primary reason for referral for services. DSS funds must not be used to purchase services. Children's Services funding must be used when the primary reason for referral/service is related to Children's Services.
- Enrollment fees for ESS child care or CDC.
- Services provided under other funding sources such as state emergency relief (SER), emergency services (ES) funds, strong families/safe children (SF/SC), child safety and permanency planning (CSPP/CAN), volunteer services or any

other funding source. This includes housing related services that should be covered using SER or ES funds.

- Food related items.
- Gift or gas cards that are not restricted to specific purchases or services.
- Resource room or clothes closet items that do not restrict access to TANF-eligible clients only for the purpose of removing a barrier that is linked to an employment-related purchase or service.

PROPERTY LIABILITY FOR COMMUNITY SERVICE PROJECTS

FIP, CDC, MA Family, FAP Family, FAP Non-Family

MDHHS is **not** liable for property damages incurred while community service project (CSP) work crews perform assigned duties.

WORKERS COMPENSATION

FIP, CDC, MA Family, FAP Family, FAP Non-Family

In general, employers pay worker's compensation for persons they employ. The State of Michigan is the worker's compensation insurer for clients, while they are assigned to unpaid work-related activities through MDHHS or PATH, including compliance test activities. Former TLFA recipients participating in PATH employment and training program are covered by workers' compensation.

Workers' compensation is a benefit that pays for reasonable and necessary medical care for work-related injuries or illness; and compensates clients for work related injuries and illnesses that result in wage loss or more than 7 days. The State of Michigan has the right to choose who will provide the client's medical treatment for the first 28 days following initial treatment of the injury and is not required to pay for any medical bills from other providers during this time. After 28 days, the client has the right to choose any treating provider qualified to treat his or her injury or illness.

Former TLFA clients in self-initiated community service are **not** covered.

Persons participating in FSSP, and other non-work activities are **not** covered. Examples: ABE, high school completion, GED, post-secondary education, vocational education/training.

Using a State of Michigan Workers' Compensation Claim Form (Accident and Illness Report) from the Civil Service Commission, Disability Management Office website.

The MDHHS local office must report any injury from a client's unpaid work-related activity as described above, to the Civil Service Commission, Disability Management Office within twenty-four hours of becoming aware of the incident.

Michigan Civil Service Commission
Disability Management Office
Capital Commons Center
400 South Pine Street
P.O. Box 30002, Lansing, MI 48909
Phone; 877-766-6447, option 2
Facsimile:517-241-9926

All medical bills should also be sent to the Michigan Civil Service Commission Disability Management Office.

MDHHS

Staff responding to a request for case record information about an accident must apply confidentiality policy in BAM 310, especially as contained in **Access by Government Officials, Client Access to Case Records, and Court Proceedings.** Refer attorneys seeking information **not** contained in the case record to York Risk Services Group inc..

In representing MDHHS and PATH, staff of York Risk Services Group, Inc. may review the participant's client's case record and obtain copies of case materials. A signed DHS-27, Release of Information, is not needed.

OVERISSUANCE

FIP, CDC, MA Family, FAP Family, FAP Non-Family

Initiate a referral to the Office of Inspector General (OIG) when a suspected intentional program violation (IPV) results in an overissuance of MDHHS-authorized DSS, including FSS and ESS of $500 or more. Take no action to recoup the overissuance until notified by the OIG.

When the OIG indicates that an IPV caused the overissuance, initiate cash recoupment by notifying the local office fiscal unit, which has sole authority for the collection. DSS, including FSS and ESS overissuances are not recouped via the automated recoupment system.

When initiating cash recoupment, create case comments regarding the DSS overissuance details in the electronic case file and the DHS-1171 specifying the overissuance date/s, type/s, recipient/s and amount/s.

VERIFICATION REQUIREMENTS

FIP, CDC, MA Family, FAP Family, FAP Non-Family.

Verify participation in PATH, employment, job offer or other employment-related activity if questionable.

Verify receipt or application of FIP, MA Family, FAP or CDC.

Relocation

Verify out-of-town employment exists and requires relocation, by written statement from, or phone call to, the employer.

Verify all moving expenses by a written estimate or phone call.

Vehicle Repair or Purchase

Verify that the cost of the vehicle or repairs will not exceed the vehicle's retail value. Acceptable verifications are a written statement from, or phone call to, a vehicle dealer or via the NADA Appraisal Guide on the MDHHS-Net, internet sites. [The NADA Appraisal Guide for Older Cars may be purchased from ESS funds.]

For vehicle repair, verify that the repair is expected to make the vehicle safe and roadworthy. The client requesting the service has a valid driver's license. If the client requesting the service does not have a valid driver's license but has someone else use their vehicle to drive them, document the name of the person driving the vehicle. Verify a valid driver's license for the individual that will be operating the vehicle.

Verify the length of lease agreements when a vehicle repair is approved.

LEGAL BASE

FIP

MCL 400.57a et. seq.
R400.3603, MAC
42 USC 604(a)
P.A. 280 of 1939, Social Welfare Act

FAP-Only

R400.3603, MAC
7 CFR 273.7

RCA

45 CFR 400.154, 400.155

DEPARTMENT PHILOSOPHY

FIP

MDHHS requires clients to participate in employment and self-sufficiency-related activities and to accept employment when offered. The focus is to assist clients in removing barriers so they can participate in activities which lead to self-sufficiency. However, there are consequences for a client who refuses to participate without good cause.

The goal of the FIP penalty policy is to obtain client compliance with appropriate work and/or self-sufficiency related assignments and to ensure that barriers to such compliance have been identified and removed. The goal is to bring the client into compliance.

DEPARTMENT POLICY

FIP

A Work Eligible Individual (WEI) and non-WEIs (except ineligible grantees, clients deferred for lack of child care, and disqualified non-citizens), see BEM 228, who fails, without good cause, to participate in employment or self-sufficiency-related activities, must be penalized. Depending on the case situation, penalties include the following:

- Delay in eligibility at application.
- Ineligibility (denial or termination of FIP with no minimum penalty period).
- Case closure for a minimum of three months for the first episode of noncompliance, six months for the second episode of noncompliance and lifetime closure for the third episode of noncompliance.

See BEM 233B for the Food Assistance Program (FAP) policy when the FIP penalty is closure.

NONCOMPLIANCE WITH EMPLOYMENT AND/OR SELF-SUFFICIENCY-RELATED ACTIVITIES

As a condition of eligibility, all WEIs and non-WEIs must work or engage in employment and/or self-sufficiency-related activities. Noncompliance of applicants, recipients, or member adds means doing any of the following without good cause:

- Failing or refusing to:
  - Appear and participate with Partnership. Accountability. Training. Hope. (PATH) or other employment service provider.
  - Complete a Family Automated Screening Tool (FAST), as assigned as the first step in the Family Self-Sufficiency Plan (FSSP) process.

    Note: The specialist should clear any alerts in Bridges relating to rejected PATH referrals as well as any FAST confirmation information the client has obtained before considering a client noncompliant.
  - Develop a FSSP.

    Note: A FSSP completion appointment with the client must have been scheduled and the client failed to attend before considering a client noncompliant for FSSP completion.
  - Comply with activities assigned on the FSSP.
  - Provide legitimate documentation of work participation.
  - Appear for a scheduled appointment or meeting related to assigned activities.
  - Participate in employment and/or self-sufficiency-related activities.
  - Participate in required activity.
  - Accept a job referral.

- Complete a job application.
- Appear for a job interview (see the exception below).

- Stating orally or in writing a definite intent not to comply with program requirements.
- Threatening, physically abusing or otherwise behaving disruptively toward anyone conducting or participating in an employment and/or self-sufficiency-related activity.
- Refusing employment support services if the refusal prevents participation in an employment and/or self-sufficiency-related activity.

Exception: Do not apply the three month, six month or lifetime penalty to ineligible caretakers, clients deferred for lack of child care and disqualified non-citizens. Failure to complete a FAST or FSSP results in closure due to failure to provide requested verification. Clients can reapply at any time.

REFUSING SUITABLE EMPLOYMENT

Refusing suitable employment means doing **any** of the following:

- Voluntarily reducing hours or otherwise reducing earnings.
- Quitting a job (see exception below).

  Exception: This does not apply if:

  - PATH verifies the client changed jobs or reduced hours in order to participate in a PATH approved education and training program.

- Firing for misconduct or absenteeism (not for incompetence).

  Note: Misconduct sufficient to warrant firing includes any action by an employee or other adult group member that is harmful to the interest of the employer, and is done intentionally or in disregard of the employer's interest, or is due to gross negligence. It includes but is not limited to drug or alcohol influence at work, physical violence, and theft or

willful destruction of property connected with the individual's work.

- Refusing a bona fide offer of employment or additional hours up to 40 hours per week. A bona fide offer of employment means a definite offer paying wages of at least the applicable state minimum wage. The employment may be on a shift; full or part time up to 40 hours per week; and temporary, seasonal or permanent.

Exception: Meeting participation requirements is not good cause for refusing suitable employment, unless the employment would interfere with approved education and training.

See Benefit Delay for Refusing Employment in this item for applicants refusing employment within 30 days prior to the date of application or while the application is pending. See Noncompliance Penalties for Active FIP Cases and Member Add in this item for member adds refusing employment within 30 days prior to the date of application or while the application for the member add is pending.

Do not penalize applicants or member adds who refused employment more than 30 days prior to the date of application or date of member add.

GOOD CAUSE FOR NONCOMPLIANCE

Good cause is a valid reason for noncompliance with employment and/or self-sufficiency related activities that are based on factors that are beyond the control of the noncompliant person. A claim of good cause must be verified and documented for member adds and recipients. Document the good cause determination in Bridges on the noncooperation screen as well as in case comments.

If it is determined during triage the client has good cause, and good cause issues have been resolved, send the client back to PATH. There is no need for a new PATH referral, unless the good cause was determined after the negative action period.

Good cause includes the following:

Employed 40 Hours

The person is working at least 40 hours per week on average and earning at least state minimum wage.

Client Unfit

The client is physically or mentally unfit for the job or activity, as shown by medical evidence or other reliable information. This includes any disability-related limitations that preclude participation in a work and/or self-sufficiency-related activity. The disability-related needs or limitations may not have been identified or assessed prior to the noncompliance.

Illness or Injury

The client has a debilitating illness or injury, or a spouse or child's illness or injury requires in-home care by the client.

Reasonable Accommodation

The MDHHS, employment services provider, contractor, agency, or employer failed to make reasonable accommodations for the client's disability or the client's needs related to the disability.

No Child Care

The client requested child care services from MDHHS, PATH, or other employment services provider prior to case closure for noncompliance and child care is needed for an eligible child, but none is appropriate, suitable, affordable and within reasonable distance of the client's home or work site.

- **Appropriate**. The care is appropriate to the child's age, disabilities and other conditions.
- **Reasonable distance**. The total commuting time to and from work and the child care facility does not exceed three hours per day.
- **Suitable provider**. The provider meets applicable state and local standards. Also, license exempt providers who are not licensed by the Michigan Department of Licensing and Regulatory Affairs (LARA) Child Care Licensing Bureau

(CCLB) must meet Child Development and Care (CDC) enrollment requirements; see BEM 704.

- **Affordable**. The child care is provided at the rate of payment or reimbursement offered by CDC.

No Transportation

The client requested transportation services from MDHHS, PATH, or other employment services provider prior to case closure and reasonably priced transportation is not available to the client.

Illegal Activities

The employment involves illegal activities.

Discrimination

The client experiences discrimination on the basis of age, race, disability, gender, color, national origin or religious beliefs.

Unplanned Event or Factor

Credible information indicates an unplanned event or factor which likely prevents or significantly interferes with employment and/or self-sufficiency-related activities. Unplanned events or factors include, but are not limited to, the following:

- Domestic violence.
- Health or safety risk.
- Religion.
- Homelessness.
- Jail.
- Hospitalization.

Comparable Work

The client quits to assume employment comparable in salary and hours. The new hiring must occur before the quit.

Long Commute

Total commuting time exceeds:

- Two hours per day, not including time to and from child care facilities **or**

- Three hours per day, including time to and from child care facilities.

Clients Not Penalized

Ineligible caretakers, disqualified non-citizens, and single parents who cannot find appropriate child care for a child under age six are not required to participate; see BEM 230A for required verification.

NONCOMPLIANCE PENALTIES AT APPLICATION

Noncompliance by a WEI while the application is pending results in group ineligibility. A WEI applicant who refused employment without good cause, within 30 days prior to the date of application or while the application is pending, must have benefits delayed; see Benefit Delay for Refusing Employment in this item.

Benefit Delay for Refusing Employment

If a WEI applicant refuses suitable employment without good cause while the FIP application is pending (**or up to 30 days before the FIP application date**), approve FIP benefits no earlier than the pay period following the pay period containing the 30th day after the refusal of employment.

A good cause determination is not required for applicants who are noncompliant prior to FIP case opening.

For the definition of Refusing Suitable Employment see Noncompliance With Employment And/or Self-Sufficiency Related Activities in this item**.**

Example: Client applies for FIP on May 7. Client refuses work without good cause on May 21. The 30th day from the refusal date is June 20. FIP benefits may not be authorized for any pay period earlier than July 1, as long as all other eligibility requirements have been completed.

If a WEI member add refuses suitable employment without good cause while the FIP member add is pending, close the FIP EDG for the minimum number of penalty months; see Noncompliance Penalties For Active FIP Cases And Member Adds in this item.

NONCOMPLIANCE PENALTIES FOR ACTIVE FIP INDIVIDUALS AND MEMBER ADDS

The penalty for noncompliance without good cause is FIP EDG closure. Effective October 1, 2011, the following minimum penalties apply:

- For the individual's first occurrence of noncompliance, Bridges closes the FIP EDG for not less than three calendar months.
- For the individual's second occurrence of noncompliance, Bridges closes the FIP EDG for not less than six calendar months.
- For the individual's third occurrence of noncompliance, Bridges closes the FIP EDG for a lifetime sanction.

The individual penalty counter begins April 1, 2007. Individual penalties served after October 1, 2011 will be added to the individual's existing penalty count.

Example: In February 2011, Betty started serving her third noncompliance penalty of 12 months, which will end March 2012. After reapplication, if she is determined noncompliant for a fourth occurrence, Bridges will close the FIP EDG for a lifetime sanction.

The sanction period begins with the first pay period of a month. Penalties are automatically calculated by the entry of noncompliance without good cause in Bridges. This applies to active FIP cases, including those with a member add who is a WEI mandatory participant.

Note: Do not apply the three month, six month or lifetime penalty to ineligible caretakers, clients deferred for lack of child care and disqualified non-citizens. Failure to complete the FAST or FSSP results in closure due to failure to provide requested verification. Clients can reapply at any time.

Individual Penalty Counter

Bridges applies noncooperation penalties at an individual level.

Two parent families will have two individual penalty counters. The FIP EDG penalty is applied based on the individual penalty counter.

Example: Sally has a penalty count of one. Edward has a penalty count of two. If the next penalty results from Sally's noncompliance, the FIP EDG will close for six months. However, if the next penalty results from Edward's noncompliance, the FIP EDG will close for a lifetime sanction.

In a two parent family, one parent has to reach his/her individual penalty count of three for the case to close for a lifetime sanction.

In the first episode of assistance, Sally has a penalty count of one and Edward has a penalty count of one. Sally receives a second penalty count and the case closes for six months. After reapplication, in the second episode of assistance, the next penalty on the case is Edward's second penalty, which closes the case for six months. After reapplication, in the third episode of assistance, Edward receives his third penalty count, which closes the case for lifetime.An individual serving their first or second employment and training sanction is able to apply for FIP benefits only in the last month of their current sanction, in order to be determined eligible for FIP benefits the month after the current sanction ends.

Example: Lenny is serving a sanction that ends 1/31. He applies for assistance on 12/10. As he is applying for benefits effective in January, the application will be denied as he is ineligible in January due to serving a sanction.

Example: Carl is serving a sanction that ends 1/31. He applies for assistance on 1/01. If he meets all eligibility criteria, the application may be approved for February, as his sanction ends on 1/31.

triagePATH participants will not be terminated from PATH without first scheduling a triage meeting with the client to jointly discuss noncompliance and good cause. Locally coordinate a process to notify PATH case manager of triage day schedule, including scheduling guidelines.

Note: Do not schedule a triage for instances of noncompliance while the FIP application is pending.

Prior to the triage meeting, the specialist should review the following:

- The One-Stop Management Information System (OSMIS) case note and activities that correspond to Bridges noncompliance and sanction records.
- Case notes in the case file and on Bridges.
- Noncooperation records in Bridges reflect the appropriate penalty count.
- Documented triage results on the noncooperation records, to ensure they are consistent with client statements or possible documentation of good cause.

During the triage appointment, review the FAST and FSSP with the client to determine if any identified barriers were not addressed. Document the results in Bridges case notes.

Clients can either attend a meeting or participate in a conference call if attendance at the triage meeting is not possible. If a client calls to reschedule an already scheduled triage meeting, offer a phone conference at that time. If the client requests to have an in-person triage, reschedule for one additional triage appointment. Clients must comply with triage requirements and must provide good cause verification within the negative action period.

Determine good cause based on the best information available during the triage and prior to the negative action date. Good cause may be verified by information already on file with MDHHS or PATH. **Good cause must be considered even if the client does not attend**, with particular attention to possible disabilities (including disabilities that have not been diagnosed or identified by the client) and unmet needs for accommodation.

If the specialist or PATH case manager do not agree as to whether good cause exists for a noncompliance, the case must be forwarded to the immediate supervisors of each party involved to reach an agreement. The MDHHS supervisor makes the final determination of good cause.

MDHHS must be involved with all triage appointment/phone calls due to program requirements, documentation and tracking.

Document in the case file and on Bridges that the case noncompliance history was reviewed.

Note: Clients not under the supervision of PATH, but rather under the department's supervision, must be scheduled for a triage

meeting between the specialist and the client. This does not include applicants.

Note: When a client who is determined by Disability Determination Service (DDS) to be work ready with limitations becomes noncompliant with PATH, schedule a planning triage, which includes all of the following:

- Review the medical packet including the limitations identified by DDS on the DHS-49-A, Medical-Social Eligibility Certification.
- If necessary, revise the FSSP using the limitations identified on the DHS-49-A. Assign medically permissible activities.
- Enter good cause reason *Client unfit* in Bridges on the Noncooperation details screen, if the noncooperation was related to the identified limitation or is an additional identified limitation.

If an individual becomes noncompliant with his/her FSSP assigned activities, follow the instructions in this item, under Noncompliance Penalties For Active FIP Individuals and Member Add.

PROCESSING THE FIP CLOSURE

Follow the procedures outlined below for processing the FIP closure:

- On the night that the one-stop service center case manager places the participant into triage activity, OSMIS will interface to Bridges a noncooperation notice. Bridges will generate a triage appointment at the local office as well as generating the DHS-2444, Notice of Employment And/Or Self-Sufficiency Related Noncompliance, which is sent to the client. The following information will be populated on the DHS-2444:
  - The name of the noncompliant individual
  - The date of the initial noncompliance**.** (For individuals being served by PATH, this is the date the client was considered to be noncompliant by the one-stop service center and placed into the triage activity in OSMIS.)
  - All the dates, if addressing more than one incident of noncompliance.

- The reason the client was determined to be noncompliant**.**
- The penalty that will be imposed**.**
- The scheduled triage appointment, to be held within the negative action period.

- Determine good cause during triage and prior to the negative action effective date. Good cause must be verified and provided prior to the end of the negative action period and can be based on information already on file with the MDHHS or PATH. Document the good cause determination on the Noncooperation Detail Screen within 24 hours of determination.

Note: For manually entered noncooperations, the DHS-2444 will be generated upon the next EDBC run, which will schedule the triage appointment and will place the case into case closure pending the negative action period.

Entering and Tracking Penalty Periods for Active FIP Cases and Member Adds

Immediately following the triage meeting, enter all results at one time in Bridges. Enter the following penalty information for tracking purposes:

Date of the Noncompliance

This is the date the client was considered to be noncompliant by the one-stop service center and placed into the triage component in OSMIS or the date the MDHHS case worker enters a manual noncooperation for a client. This is the date that displays in Bridges as the non-cooperation date. This date will be populated by Bridges for cases that are being served by the one-stop service center, as well as for FAST/FSSP noncompliances and loss of employment noncompliances. The case worker will need to populate this date for manually entered noncooperations.

Type

This field describes the type of noncompliance. This will be populated by Bridges for cases that are being served by the one-stop service center, as well as for FAST/FSSP noncompliances and loss

of employment noncompliances. Case workers will need to select one of the options available from the drop-down list for manually entered noncooperations.

Noncooperation Description

This field describes how the client did not comply. This will be populated by Bridges for cases that are being served by the one-stop service center, as well as for FAST/FSSP noncooperations and loss of employment noncooperations. Case workers will need to select one of the options available from the drop-down list for manually entered noncooperations.

Date Triage Appointment Held

Date the triage appointment is scheduled or rescheduled.

Good Cause Status/Reason

Select the appropriate good cause reason from the drop-down list if the client verified a good cause reason for the noncompliance. Select the appropriate No Good Cause reason from the drop down list if the client does not have good cause for the noncompliance.

Date of Determination

Date good cause or no good cause determined.

Good Cause Established

If the client establishes good cause within the negative action period, reinstate benefits; see *Good Cause for Noncompliance* in this item. Send the client back to PATH, if applicable, after resolving transportation, CDC, or other factors which may have contributed to the good cause. Make any changes/corrections in Bridges to reflect the outcome of the noncompliance.

Good Cause NOT Established

If the client does not provide a good cause reason for the noncompliance, determine good cause based on the best information available.

For individuals who are active Food Assistance Program (FAP) at the time of the FIP noncompliances; see BEM 233B, Failure to Meet Employment Requirements; FAP.

Medicaid

Bridges determines eligibility for Medicaid as part of the closure process.

Overlapping Negative Actions and Client Requests

When FIP is expected to close for a reason unrelated to noncompliance (including verbal or written client request), use the following guidelines:

- If a DHS-2444, Notice of Employment and/or Self-Sufficiency-Related Noncompliance, is issued to a noncompliant person before his/her verbal or written request for case closure or for any other reason, proceed with the noncompliance determination. If the client does not have good cause for the noncompliance, follow procedures outlined in this item under Processing the FIP Closure.
- If a DHS-2444, Notice of Employment and/or Self-Sufficiency-Related Noncompliance, has not been issued before the verbal or written request for closure, or closure is initiated for any other reason, do not proceed with the noncompliance determination.

Noncompliant Member Leaves The Home

If the noncompliant member leaves the home before issuing a DHS-2444, Notice of Noncompliance, do not act on the closure. Enter a good cause reason for the pending noncompliance in Bridges.

If the noncompliant member leaves the home after Bridges closes the FIP EDG due to the noncompliance, the noncompliant member takes his/her individual penalty sanction and counter with him/her to a new group. The original group may reapply for FIP as there is no longer a noncompliant individual serving a current sanction in the group.

If it is reported to the department that the parent who affected the FIP EDG closure is out of the home and a new DHS-1171 is submitted, request a Front End Eligibility (FEE) investigation from the Office of Inspector General (OIG) to complete a home visit to verify the parent is out of the home. Do not determine eligibility on the pending FIP EDG until the FEE agent completes an investigation. Document the results of the home visit in the case file and in Bridges case comments.

If the noncompliant individual who is currently serving a sanction is eligible for FIP in a new group, the new group must serve the sanction.

Example: Bernard is serving a lifetime sanction and leaves Mary's home. Mary reapplies for FIP and reports that Bernard left the home. FEE verified this statement is true. Mary is approved for FIP. Sue reports Bernard has moved into her home and is a mandatory group member. Bridges will close Sue's FIP EDG for a lifetime sanction.

HEARINGS

Expedited Hearings

Staff must identify cases for the Michigan Office of Administrative Hearings and Rules (MOAHR) when a client files a hearing based on closure due to noncompliance with an employment and/or self-sufficiency related activity. MOAHR has agreed to expedite these hearing requests in an effort to engage clients in a timely manner and improve the state's overall work participation rate. Write "**Expedited Hearing E&T**" at the top of the hearing request so that it can be easily identified as a priority. Refer to BAM 600, Expedited Hearings, for additional instructions.

Hearing Decisions

When a hearing decision is upheld for noncompliance, impose the penalty for the first full month possible for three months, six months or a lifetime sanction. Do not recoup benefits.

LEGAL BASE

MCL 400.57
42 USC 607

DEPARTMENT PHILOSOPHY

Michigan Department of Health and Human Services (MDHHS) requires participation in employment and/or self-sufficiency-related activities associated with the Family Independence Program (FIP) or Refugee Cash Assistance (RCA). Applicants or recipients of Food Assistance Program (FAP) only must accept and maintain employment. There are consequences for a client who refuses to participate in FIP/RCA employment and/or self-sufficiency-related activities or refuses to accept or maintain employment without good cause.

DEPARTMENT POLICY

The policies in this item apply to all FAP applicants and recipients age 16 to 59 . Noncompliance without good cause, with employment requirements for FIP/RCA may affect FAP if both programs were active on the date of the FIP noncompliance; see BEM 233A.

Exception: See BEM 233C for FAILURE TO MEET EMPLOYMENT REQUIREMENTS: RCA. RCA clients do not have the Last RCA budgeted on their FAP benefits, but can be disqualified from FAP.

Michigan's FAP Employment and Training program is voluntary and penalties for noncompliance may only apply in the following two situations:

- Client is active FIP/RCA and FAP and becomes noncompliant with a cash program requirement without good cause
- Client is active RCA and becomes noncompliant with a RCA program requirement
- Client is pending or active FAP only and refuses employment (voluntarily quits a job or voluntarily reduces hours of employment) without good cause

At no other time is a client considered noncompliant with employment or self-sufficiency related requirements for FAP.

PROCESS FOR FIP/ RCA ASSOCIATED NONCOMPLIANCE

When a recipient of FIP/RCA and FAP is noncompliant, the following will occur:

- On the night that the One-Stop Service Center case manager places the participant into triage activity, the One-Stop Management Information System (OSMIS) will interface to Bridges a noncooperation notice. Bridges will generate a triage appointment at the local office as well as generating the DHS-2444, Notice of Employment And/Or Self-Sufficiency Related Noncompliance, which is sent to the client

- For manually entered noncooperations, the DHS-2444 will be generated upon the next EDBC run, which will schedule the triage appointment and place the case into case closure pending the negative action period

- If a participant is active FIP and FAP at the time of FIP noncompliance, determination of FAP good cause is based on the FIP good cause reasons outlined in BEM 233A. For the FAP determination, if the client does not meet one of the FIP good cause reasons, determine the FAP disqualification based on FIP deferral criteria only as outlined in BEM 230A, or the FAP deferral reason of care of a child under 6 or education. No other deferral reasons apply for participants active FIP and FAP

- Determine good cause during triage appointment/phone conference and prior to the negative action period. Good cause must be provided prior to the end of the negative action period. Document the good cause determination on the n*oncooperation detail screen* within 24 hours of determination. If the client does not participate in the triage meeting, determine good cause for FAP based on information known at the time of the determination. Good cause may be verified by information already on file with MDHHS, the Refugee Contractor (RC), or the Partnership. Accountability. Training. Hope. (PATH)

- Determine FAP good cause separately from the FIP/RCA based on FAP good cause reasons defined later in this item. If a good cause reason is selected for FIP/RCA it also applies to FAP. If the client does not meet one of the FIP/RCA good

cause reasons in the drop down list, but does meet one of the FAP only good cause reasons, select the FAP only good cause reason to avoid client disqualification on FAP. Bridges makes both determinations simultaneously

When To Disqualify

Disqualify a FAP group member for noncompliance when all the following exist:

- The client was active both FIP/RCA and FAP on the date of the FIP/RCA noncompliance
- The client did not comply with FIP/RCA employment requirements
- The client is subject to a penalty on the FIP/RCA program
- The client is **not** deferred from FAP work requirements; see DEFERRALS in BEM 230B
- The client did not have good cause for the noncompliance.

See *member disqualification* in this item.

Budgeting Last FIP

Bridges applies policies associated with a FIP related noncompliance and budgets the *Last FIP* grant amount into the FAP budget. The FIP grant is removed from the FAP budget at the end of the FIP penalty period. For individuals serving a lifetime sanction, Bridges will remove the FIP income from the FAP budget once the individual reaches their FIP lifetime time limit.

In instances in which the individual serving a FIP sanction leaves the group, the sanction follows that individual. When the client reapplies for FIP, Bridges will remove the FIP income from the FAP budget

Note: When the individual with the lifetime sanction enters a different FIP group, Bridges will close the FIP case for the lifetime sanction and budget the last FIP, for that sanctioned individual, into the FAP budget for the new group.

Bridges will not budget the Last RCA grant when imposing Refugee Assistance Program penalties. See BEM 233C for RCA penalties.

Overlapping Negative Actions

When a client is active both FIP and FAP on the date of a FIP non-compliance and FIP is closing for a reason unrelated to noncompliance (for example client request) take one of the following actions:

- If the client requests closure of both FIP and FAP during the good cause determination **and** before case closure, act on the unrelated FAP closure. Do not proceed with the FAP noncompliance penalties
- If the client requests closure of FIP benefits only, but not FAP, any time during the penalty process and after the noncompliance occurred, continue to process the FAP disqualification. A minimum one or six month penalty applies. If the FIP closure is not employment and/or self-sufficiency-related, Bridges will not budget the *Last FIP* grant amount

FAP ONLY NONCOMPLIANCE

Refusing Employment

Non-deferred adult members of FAP households must follow certain work-related requirements in order to receive food assistance program benefits.

Working

Disqualify non-deferred adults who were working when the person:

- Voluntarily quits a job of 30 hours (weekly earnings equal to or in excess of 30 hours times federal minimum wage) or more per week without good cause, or
- Voluntarily reduces hours of employment below 30 hours per week without good cause, and after the reduction, earnings are less than 30 hours times the federal minimum wage

  Note: If the job quit or reduction in hours occurred more than 30 days prior to the application date, no penalty applies.

Not Working

Non-deferred adults who are **not** working or are working less than 30 hours per week must:

- Accept a valid offer of employment

  Note: A valid offer of employment means a definite offer paying wages of at least the applicable state minimum wage

- Follow through and participate in activities required to receive unemployment benefits (UB) **if** the client has applied for or is receiving UB

Note: Determine good cause before implementing a disqualification.

FAP ONLY PENALTIES FOR REFUSING SUITABLE EMPLOYMENT

When a client has refused suitable employment as described above, do the following:

- Complete the noncompliance record by either completing the *Loss of Employment screen* for job quit or voluntary reduction of hours below 30 hours or by entering a noncooperation for refusal of employment on the *Noncooperation Summary screen*. The DHS-2444, Notice of Employment And/Or Self-Sufficiency Related Noncompliance will be generated upon the next run of EDBC, which will also schedule the triage appointment at the local office and place the individual into disqualification pending the negative action period

- The following information will be populated on the DHS-2444:

  - The name of the noncompliant individual
  - The date of noncompliance
  - All the dates, if addressing more than one incident of noncompliance
  - The reason the client was determined to be noncompliant
  - The disqualification that may be imposed

- The scheduled triage appointment, to be held in person or by phone, within the negative action period

- Hold the triage appointment/phone conference to determine good cause prior to the negative action period. Good cause must be verified and provided prior to the end of the negative action period and can be based on information already on file with MDHHS. Document good cause determination on the Noncooperation Detail screen within 24 hours of determination

- If the client does not participate in the triage meeting, determine good cause for FAP based on information known at the time of the determination

- An in-person meeting is not required for FAP only. A phone conference to determine good cause is acceptable

- Determine FAP good cause based on FAP good cause reasons defined later in this item

WIOA AND OTHER EMPLOYMENT & TRAINING PROGRAMS

Do **not** disqualify FAP applicants or recipients for failing to comply with Workforce Innovation Opportunity Act (WIOA) services or any other FAP employment and training components.

MEMBER DISQUALIFICATION

Disqualifications for failure to comply without good cause are the same for FAP applicants, recipients and member adds. Evaluate each client's work requirement before imposing a disqualification; see BEM 230B DEFERRALS.

- For the first occurrence, disqualify the person for one month or until compliance, whichever is longer

- For a second or subsequent occurrence, disqualify the person for six months or until compliance, whichever is longer

Bridges counts any previous FIP or RCA-related FAP penalty as a first or subsequent occurrence.

Applicants

For applicants, begin the disqualification the month after application, even if the failure occurred within the 30 days before the application. Bridges sends a client notice to inform the client.

Member Add

For a member add, the disqualification must begin the month after the new member was reported.

Recipients

For recipients, begin the disqualification the first month possible after determination or notification of the failure to comply. Provide the group timely notice**.**

Disqualification Begin Date

Begin the disqualification the first month after the negative action period ends. If the notice is not sent timely, impose the full disqualification period beginning the first month possible after discovering the error.

Once begun, the month(s) of disqualification proceed consecutively and cannot be interrupted, even if the noncompliant person or the group becomes ineligible for another reason.

Note: When a member in a FAP group becomes disqualified, Bridges budgets the member's income and expenses as they count toward the remaining eligible group members. See BEM 550 for budgeting instructions.

GOOD CAUSE FOR NONCOMPLIANCE

Good cause is a valid reason for failing to participate in employment and/or self-sufficiency-related activities or refusing suitable employment. Investigate and determine good cause before deciding whether to imposing a disqualification. Good cause includes the following:

Deferred

- The person meets one of the deferral criteria; see DEFERRALS in BEM 230B

Meets Participation Requirements

- The person meets participation requirements; see DEFERRALS in BEM 230B

Wage Under Minimum

- Except for sheltered workshops, the wage offered, including tips, is less than the applicable state minimum wage

Client Unfit

- The client is physically or mentally unfit for the job, as shown by medical evidence or other reliable information

Health or Safety Risk

- The degree of risk to health or safety is unreasonable

Illness or Injury

- The client has a debilitating illness or injury, or an immediate family member's illness or injury requires in-home care by the client

Religion

- The working hours or nature of the employment interferes with the client's religious observances, convictions or beliefs

Net Income Loss

- The employment causes the family a net loss of cash income

No Child Care

- Child Development and Care (CDC) is needed for a CDC-eligible child, but none is adequate, suitable, affordable and within reasonable distance of the client's home or work site; see BEM 703

No Transportation

- Reasonably priced transportation is not available to the client

Illegal Activities

- The employment involves illegal activities

Discrimination

- The client experiences discrimination on the basis of age, race, disability, gender, color, national origin or religious beliefs

Unplanned Event or Factor

- Credible information indicates an unplanned event or factor which likely prevents or significantly interferes with employment and/or self-sufficiency-related activities

Comparable Work, Job Quits

- The client obtains comparable employment in salary **or** hours to the job that was lost

  Note: When a client quits a job and during the negative action period secures employment, the penalty still applies unless the new job meets the definition of comparable work above.

Education or Training

- The employment interferes with enrollment at least half time in a recognized education or job training program

Long Commute

- Total commuting time exceeds either:
  - Two hours per day, not including time to and from child care facilities
  - Three hours per day, including time to and from child care facilities

Unreasonable Conditions

- The employer makes unreasonable demands or conditions (for example, working without being paid on schedule)

Forced Move

- The person must quit a job and move out of the county due to another group member's:
  - Employment
  - Employment and/or self-sufficiency-related activities
  - Enrollment at least half time in a recognized education or job training program

Retirement

- The employer recognizes the person's resignation as retirement

Unkept Promise of Work

- For reasons beyond the person's control, promised employment of at least 30 hours per week (or the state minimum wage times 30 hours) does not materialize or results in less than that minimum

Union Involvement

- The person must join, resign from, or refrain from joining a labor organization as an employment condition

Strike or Lockout

- The work is at a site subject to a strike or lockout (not enjoined by federal law) at the time of the offer

Work Not Familiar

- In the first 30 days after determined a mandatory FAP participant, the only employment offered is outside the person's major field of experience

REESTABLISHING FAP ELIGIBILITY

A noncompliant person must serve a minimum one-month or six-month disqualification period unless one of the criteria for ending a disqualification early exists.

End the disqualification early if the noncompliant person either:

- Complies with work assignments for a cash program

- Obtains comparable employment in salary **or** hours to the job which was lost
- Meets a deferral reason other than unemployment benefit (UB) application/recipient; see DEFERRALS in BEM 230B
- Leaves the group

If the person has met any of the criteria above after a disqualification has actually taken effect, restore benefits beginning the month after the noncompliant person reports meeting the criteria.

Example: A mandatory FAP recipient reports a job quit on March 28 without good cause. The adverse action to disqualify the noncompliant person takes effect on April 13. The noncompliant person reports getting a comparable job on April 25. Since the disqualification doesn't actually take effect until May 1, and the client has met one of the criteria for ending a disqualification early, she/he should receive FAP benefits for May. If the noncompliant person did not report a new job until May 1, the FAP benefits could not be restored until the 1st of June.

If the noncompliant person does not meet the criteria above for ending a disqualification early, a compliance test must be completed before eligibility is regained. In addition, the minimum disqualification period must be served.

If the disqualification caused FAP closure, and all eligibility criteria for FAP eligibility are met, open the case effective the latter of:

- The date the person agreed to comply
- The day after the disqualification ended
- The date of application

Compliance Test

After a one-month or six-month disqualification, the noncompliant person must complete a compliance test to become eligible for FAP, unless:

- Working 20 hours or more per week
- Meets FAP deferral criteria; see DEFERRALS in BEM 230B

When a disqualified client indicates a willingness to comply, provide an opportunity to test his/her compliance, provided it is no earlier than one month before a minimum disqualification period ends.

The test may consists of any of these activities for a total of 20 hours:

- Community Service -verify participation with community service agency
- Work Experience -verify participation with work experience site
- Applying for three jobs within 10 days. Use the DHS-402, FAP Compliance Letter, and Job Application Log or other acceptable verification
- Other employment and/or self-sufficiency-related activities for a total of 20 hours

If the person completes the test, recalculate the group's FAP benefit amount with him/her included.

LEGAL BASE

Food and Nutrition Act of 2008 (7 USC 2011 *et seq*.)
Mich Admin Code, R 400.3610
7CFR 272 and 273.7
Social Welfare Act

DEPARTMENT PHILOSOPHY

Michigan Department of Health and Human Services (MDHHS) requires clients to participate in employment and/or family self-sufficiency-related activities and to accept employment when offered. Refugee contractors work with families in removing barriers as well as surmounting challenges and concerns when recipients fail, without good cause, to comply with employment requirements. If these efforts to engage recipients in participation do not succeed, clients must experience the consequences of their decisions and actions.

The goal of the Refugee Cash Assistance (RCA) penalty policy is to obtain client compliance with appropriate work and/or self-sufficiency related assignments and to ensure that barriers to such compliance have been identified and removed. The goal is to bring the client into compliance.

DEPARTMENT POLICY

The policies in this item apply to failure to comply with work requirements in the Refugee Cash Assistance (RCA). This item only applies to FAP when the noncompliant person was active for both RCA and FAP on the date of the noncompliance.

Process FAP using policy in BEM 233B when RCA is closed for noncompliance or refusing suitable employment. If the noncompliant person is not a FAP recipient on the date of the RCA noncompliance, no FAP penalty applies.

When a RCA mandatory participant fails without good cause to comply with an employment and/or self-sufficiency-related activity or refuses suitable employment, a member disqualification must be imposed. The refugee contractor works with the family to gain compliance and lift the penalty in the shortest period required.

Both applicants and recipients are penalized for refusing suitable employment. Only RCA recipients are penalized for noncompliance with an employment and/or self-sufficiency-related activity.

This item only applies to FAP when the noncompliant person was active for both RCA and FAP on the date of the noncompliance.

Process FAP using policy in BEM 233B when RCA is closed for noncompliance or refusing suitable employment. If the

noncompliant person is not a FAP recipient on the date of the RCA noncompliance, no FAP penalty applies.

Noncompliance with Employment and/or Self-Sufficiency-Related Activities

As a condition of eligibility mandatory participants in the eligible group must work or engage in activities leading to employment. Persons failing to do so are disqualified from the eligible group. See BEM 230C, Employment and/or Self-Sufficiency Related Activities: RCA for mandatory participation requirements.

Noncompliance with an employment and/or self-sufficiency-related activity means any of the following:

- Failing or refusing to:
  - Comply with activities assigned to the mandatory participant on the Refugee Family Self-Sufficiency Plan (RFSSP) as created with the Refugee Contractor (RC).
  - Participate in employment and/or self-sufficiency-related activities.
  - Accept a job referral and/or offer of employment.
  - Register/participate with the RC for employment services.
  - Participate in any arranged job interview or scheduled appointment.
  - Participate in any employability service program which provides job or language training, which is determined to be available and appropriate for the client.
  - Participate in any social service or targeted assistance program if referred and as available in the area in which the refugee resides.
- Stating orally or in writing a definite intent not to comply with program requirements.

- Threats, physical abuse or other behavior disruptive toward anyone conducting or participating in an employment and/or self-sufficiency-related activity.
- Refusing employment support services if the refusal prevents participation in an employment and/or self-sufficiency-related activity.

Refusing Suitable Employment

As a condition of eligibility, eligible group members who are mandatory participants cannot refuse suitable employment up to 40 hours per week.

Refusing suitable employment means any of the following:

- Failing or refusing to appear for a job interview; see the exception in this item.
- Refusing a bona fide offer of employment or additional hours up to 40 hours per week, except for certain clients in post-secondary education. The employment may be on a shift; full or part time up to 40 hours per week; and temporary, seasonal or permanent.

  A bona fide offer of employment means a definite offer paying wages of at least the applicable federal or state minimum wage.
- Voluntarily reducing hours or otherwise reducing earnings.
- Quitting a job.

  Exception: This does not include quitting a seasonal job to return to an approved, self-initiated plan for obtainment of a high school diploma or equivalency.
- Firing for misconduct or absenteeism (not for incompetence).

RECORDING A NONCOMPLIANCE OCCURRENCE

When a client has been noncompliant as described above, do the following:

- Complete the noncompliance record by either completing the *Loss of Employment screen* for job quit or voluntarily reducing hours or by entering the noncooperation information on the *Noncooperation Summary screen*. The DHS-2444, Notice of Employment And/Or Self-Sufficiency Related Noncompliance, will be generated upon the next run of EDBC, which will also schedule the triage appointment at the local office and place the client into disqualification pending the negative action period.

- The following information will be populated on the DHS-2444:

  - The name of the noncompliant client.

  - The date of noncompliance.

  - All the dates, if addressing more than one incident of noncompliance.

  - The reason the client was determined to be noncompliant.

  - The disqualification that may be imposed.

  - The scheduled triage appointment, to be held in person or by phone, within the negative action period.

- Hold the triage appointment/phone conference to determine good cause prior to the negative action period. Good cause can be based on information already on file with MDHHS or the RC. If the client does not attend the triage meeting, determine good cause based on the information known at the time of determination. Good cause must be considered even if the client does not attend, with particular attention to possible disabilities (including disabilities that have not been diagnosed or identified by the client) and unmet needs for accommodation.

Note: The MDHHS specialist must inform the RC, either by phone or email of the triage appointment date and time so they may attend.

- Bridges will automatically apply and track member disqualification penalties based on the data you enter on the Non-Cooperation - Details screen.

GOOD CAUSE FOR NONCOMPLIANCE OR REFUSING EMPLOYMENT

Good cause is a valid reason for failing to participate in employment and/or self-sufficiency-related activities that are based on factors that are beyond the control of the noncompliant mandatory participant. A claim of good cause must be verified and documented for applicants, recipients and member adds.

Note: Good Cause - School Attendance in BEM 201 addresses minor parents not attending school.

Record the good cause reason on the Non-Cooperation - Details screen in Bridges by selecting the appropriate description from the Good Cause Reason drop down list. If you have not determined good cause exists, select:

- Determination pending if you are investigating good cause but have not completed the determination.
- None of the above if you have determined the client does not have good cause for non-compliance.

Bridges will automatically apply and track member disqualification penalties based on the data you enter on the Non-Cooperation - Details screen.

Good cause includes the following:

Client Unfit

The client is physically or mentally unfit for the job, as shown by medical evidence or other reliable information.

Illness or Injury

The client has a debilitating illness or injury, or an immediate family member's illness or injury requires in-home care by the client.

Reasonable Accommodation

The MDHHS, the RC, or employer fails to make reasonable accommodations for the client's disability or the client's needs related to the disability of a child or spouse.

No Child Care

The client requested child care services (CDC) from MDHHS or the RC prior to case closure for noncompliance and CDC is needed for a CDC-eligible child, but none is adequate, suitable, affordable and within reasonable distance of the client's home or work site; see BEM 704.

No Transportation

The client requested transportation services from MDHHS, or the RC prior to case closure and reasonably priced transportation is not available to the client.

Illegal Activities

The employment involves illegal activities.

Discrimination

The client experiences discrimination on the basis of age, race, disability, gender, color, national origin or religious beliefs.

Unplanned Event or Factor

Credible information indicates an unplanned event or factor which likely prevents or significantly interferes with employment and/or self-sufficiency-related activities. Unplanned events or factors include, but are not limited to the following:

- Domestic violence.
- Health or safety risk.
- Religion.
- Homelessness.

Comparable Work

The client quits to assume employment comparable in salary and hours. The new hiring must occur before the quit.

Long Commute

Total commuting time exceeds:

- Two hours per day, **not** including time to and from child care facilities, **or**

- Three hours per day, including time to and from child care facilities.

PENALTIES FOR FAILURE TO COMPLY

The policies in this section apply to both noncompliance with employment and/or self-sufficiency-related activities and refusing suitable employment. A mandatory participant who fails to meet either work requirement is disqualified from the eligible group.

Penalties for noncompliance with employment and/or self-sufficiency-related activities apply to RCA-FAP recipients only. Penalties for refusing employment apply to RCA-FAP recipients and RCA applicants (including work refusals up to 30 days before the application).

Note: A member add is considered an applicant.

Penalties for Recipient's Noncompliance or Employment Refusal

Disqualify a mandatory participant who fails without good cause to meet employment requirements by removing the person from the eligible group. See Good Cause for Noncompliance or Refusing Suitable Employment in this item.

Bridges automatically applies disqualification periods as follows:

- For the first failure, a minimum of three months, after which the person must participate to regain eligibility.
- For the second or subsequent failure, a minimum of six months, after which the person must participate to regain eligibility.

Bridges will begin the disqualification effective the first month possible after you certify the eligibility determination for the failure to comply.

Penalties for Employment Refusal - Applicant

An applicant is ineligible if s/he refuses suitable employment without good cause within 30 days before the application date **or** while the application is pending; see Good Cause for Noncompliance or Refusing Suitable Employment in this item.

Begin RCA benefits no earlier than the pay period following the pay period containing the 30th day after the refusal.

Examples:

1. Client applies October 5 after being fired for absenteeism on September 28. RCA cannot begin until November 1.

2. Client applies October 5 after quitting a job on October 3. RCA cannot begin until November 16.

3. Client applies October 5 and refuses a job on October 18. RCA cannot begin until December 1. Process FAP according to policy outlined in BEM 233B.

Upon certification, Bridges will generate a DHS-1605, Client Notice, explaining benefit denials or reductions.

Penalties for Employment Refusal - Member Add

If a member being added is a mandatory participant and refuses employment (including up to 30 days before the request to be added), add the person's needs no earlier than the first month after the month that includes the 30th day.

Examples:

1. The grantee requests a member add for a mandatory group member October 5. The member was fired for absenteeism on September 7. The member cannot be added to RCA until November 1.

2. The grantee requests a member add October 25 for a mandatory group member. Before the member add is

processed, the member being added quits a job on November 3. The member cannot be added to RCA until January 1.

Upon certification, Bridges will generate a DHS-1605, explaining benefit denials or reductions.

Restoring Benefits

In multiple-member RCA groups, after the minimum disqualification period is served, restore RCA benefits effective the first pay period in the month following the minimum disqualification period. For single-member RCA groups follow standard application procedures. Restore FAP benefits according to policy in BEM 233B.

RCA Closure Effects

When RCA closes for reasons unrelated to employment requirements, an ongoing disqualification may or may not be affected.

A three-month or six-month minimum disqualification period that has **not** expired continues during closure if:

- The period expires during the closure, the disqualification ends.
- The period has not expired when the case reopens.

To regain eligibility, the disqualified person must serve the remainder of the period and then comply.

Disqualifications are consecutive (not concurrent), despite case closing and reopening or transfer to a different RCA eligible group. Process FAP according to BEM 233B.

LEGAL BASE

45 CFR 400.82

DEPARTMENT POLICY

On Oct. 1, 1996, Michigan began the Family Independence Program.

The Family Independence Program (FIP) is not an entitlement.

FIP requires an individual to meet all eligibility criteria required for the receipt of federal or state funds or determined necessary by the department to accomplish the goals of the program.

Time limits are essential to establishing the temporary nature of aid as well as communicating the FIP philosophy to support a family's movement to self-sufficiency. The message that FIP is temporary is an important part of how Michigan helps parents take advantage of the opportunities for work as well as self-sufficiency and independence. Families receiving FIP are to engage in activities that will help them gain financial independence and increase self-sufficiency.

Michigan operates a single Family Independence Program whose budgeting and accounting methods use both federal and state funds. To execute the most efficient, fair and cost-effective administration of the program, the proportion of federal and state funding associated with a case is dependent upon the group composition and/or individual characteristics on a case by case basis, as determined by the department.

On Oct. 1, 1996, Michigan law reduced the cumulative total of FIP to 48 months during an individual's lifetime. Also, under the Family Independence Program, a family is not eligible for assistance beyond 60 consecutive or non-consecutive federally funded months. Federally funded countable months began to accrue for FIP on Oct. 1, 1996. Counts accrued for every month a family received FIP, including months that met hardship criteria. As of Oct. 1, 1996, no hardship criteria exists in Michigan.

FEDERAL TIME LIMIT

Temporary Assistance to Needy Families (TANF) is the federal grant that funds the overwhelming majority of FIP assistance issued by the Department. The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) established a five-year (60month) lifetime limit on assistance for adult-headed families. The begin date for the federal time limit counter is Oct. 1,

1996. In line with the goals of the Family Independence Program, any group that includes an individual who has received 60 months or more of FIP is not eligible for the FIP program.

Federal Countable Month

Each month an individual receives federally funded FIP, the individual receives a count of one month. A family is ineligible when a mandatory member of the FIP group reaches the 60 TANF-funded month federal time limit.

Federal Time Limit Exception

Michigan will provide an exception to the federal 60 month time limit eligibility criteria and state fund the FIP eligibility determination group (EDG) for individuals that met the following criteria on Jan. 9, 2013:

- An approved/active ongoing FIP EDG **and**
    - Who was exempt from participation in the Partnership. Accountability. Training. Hope. (PATH) program for:Domestic violence.
    - Age 65 or older.
    - Establishing incapacity.
    - Incapacitated more than 90 days.
    - Care of a spouse with disabilities.
    - Care of a child with disabilities.

The exception continues as long as:

- The individual's ongoing FIP EDG reaches 60 TANF federal months **and** the individual remains one of the above employment deferral reasons. In these instances, the FIP EDG will become state funded after the 60th month.

- The individual, at application, is approved as **any** of the above employment deferral reasons. In these instances, the FIP EDG will be state funded.

The exception ends once one of the above individuals **no** longer qualifies for one of the above employment deferral reasons or they **no** longer meet other standard eligibility criteria for FIP. The FIP EDG will close or the application will be denied.

Bridges will identify the above clients on the *Michigan/Federal Time Limits Search Summary* screen.

State Funded FIP

Any month that an individual's FIP assistance is state funded is **not** a countable month toward the federal time limit count. To meet the goals of the Family Independence Program, in a limited number of cases, the department has determined to state fund cases with one or more of the following characteristics:

- Two parent households.

  Note: Months prior to Oct. 1, 2006 were federally funded.

  Exception: If a parent in a two-parent household receives SSI, the group is considered a single-parent household and is federally funded.

- A FIP group that has a parent deferred from PATH due to a verified disability or long-term incapacity lasting longer than 90 days; see BEM 230A. This includes individuals deferred from PATH with a *Deferral/Participation* reason in Bridges of *Establishing Incapacity*.

  Note: Months prior to Oct. 1, 2006 were federally funded.

- Court-ordered, unrelated caregivers receiving FIP for a child placed in the home by Children's Protective Services; see BEM 210.

- The only dependent child in the FIP group is 19 years old and attending high school full-time. This applies to months **before** Oct. 1, 2011.

- A FIP group with no dependent child(ren). This applies only when the legal parent(s) and/or stepparent receives FIP when their dependent child(ren) is in an out-of-home foster care placement due to abuse and/or neglect when there is a plan to return the child(ren) to the parent's home; see BEM 210.

- A FIP group that includes an adult who has accumulated more than 60 months on their federal time limit counter but meets the federal time limit exception criteria.

STATE TIME LIMIT

The state time limit reflects the number of remaining months an individual may receive FIP in the state of Michigan. Michigan has a 48 month lifetime limit. This 48 month lifetime limit is more restrictive than the federal 60 month lifetime limit.

Each month an individual receives FIP, regardless of the funding source (federal or state), the individual receives a count of one month. A family is ineligible for FIP when a mandatory group member in the program group reaches the 48 month state time limit.

State Time Limit Exemptions

The state time limit allows exemption months in which an individual does not receive a count towards the individual's state time limit. However, the federal time limit continues, unless the exemption is state funded.

Effective Oct. 1, 2011, exemption months are months the individual is deferred from PATH for:

- Domestic violence.
- Age 65 and older.
- A verified disability or long-term incapacity lasting longer than 90 days.

  Note: This includes the deferral reason of establishing incapacity.

- A spouse or parent who provides care for a spouse or child with verified disabilities living in the home.

See BEM 230A for eligibility criteria for exemptions.

OUT-OF-STATE CASH ASSISTANCE MONTHS

Cash assistance (TANF) an individual received in other states counts towards the individual's FIP time limit. If an individual reports to the Department that he/she received cash assistance in another state, **do not** certify eligibility for FIP until those months are calculated by central office. Failure to allow central office to include the

correct out-of-state months may lead to the individual receiving FIP inappropriately.

Those months that an individual received assistance in another state(s) may be disclosed on the DHS-1171, Assistance Application. Or, if the individual provides an out-of-state driver's license, ask the individual if he/she received cash assistance in that or another state and for what months. Email the following to Policy-Time-Limits@Michigan.gov:

- Individual's name.
- Individual's client id.
- Individual's case number.
- Individual's social security number.
- Individual's date of birth.
- State(s) individual received cash assistance from.
- Months the individual received cash assistance. If received in multiple states, indicate which states, for which months.

Note: If an individual does not remember the months that he/she received cash assistance in another state, provide the state(s) name(s) and the individual's best estimate.

Central office will contact the other state(s) to get the individual's countable months. Central office will notify the specialist that the countable months have been added to the individual's FIP time limits. After the months are verified and recorded by central office, the specialist will need to determine eligibility for FIP.

Note: Member adds need to go through the same process.

Note: Be sure to check old DHS-1171's at redetermination to capture previously reported out-of-state assistance to add to individual FIP time limit counter.

Example: Sarah moves to Michigan and she received 40 months of cash assistance in Ohio. Once central office verifies and records the 40 months, Sarah will have a concurrent federal and state time limit count of 40 months for FIP. However, if Sarah moved to Michigan with 48 months of cash assistance from Ohio, she would not be eligible for FIP assistance.

SANCTIONED MONTHS

Each month an individual serves a sanction period, those months count toward their state time limit. Sanction months should be counted starting Oct. 1, 2007.

Sanctioned reasons that count towards the individual time limit are:

- Employment and training noncompliance.
- Family Automated Screening Tool (FAST) noncompliance.
- Family Self-Sufficiency Plan (FSSP) noncompliance.
- Family Strengthening Activities noncompliance.

Example: Penny has a state time limit of 10 months. Penny must serve a six month employment and training sanction. Once she has completed the sanction, her state time limit count will be 16 months. Her federal time limit will remain at 10 months.

INDIVIDUAL TIME LIMIT

The FIP time limits are applied at an individual level.

Individuals that receive a time limit count are:

- Adults age 18 and older who are eligible in the FIP group or disqualified due to a sanction listed in Sanctioned Months in this item.
- Minor parents who are the head-of-household.

Individuals who do **not** receive a FIP time limit count are:

- Dependent children age 18 and younger who are eligible in the FIP group.
- Ineligible grantees (for example, grandparents, SSI recipients.)
- Dependent children age 19 and in high school full-time who are eligible in the FIP group. (This applies only from Oct. 1, 2007 to Sept. 30, 2011.)

Two parent families will have individual FIP time limit counts. The parent with the highest FIP time limit count is applied to the FIP group's time limit. Once the parent with the highest count reaches the maximum time limit, FIP shall close.

If a two parent family closes due to a parent reaching the maximum FIP time limit and that parent leaves the home, the remaining parent may be eligible for FIP assistance until the remaining parent's maximum FIP time limit is reached.

If it is reported to the Department that the parent who affected the FIP closure is out of the home, and a new DHS-1171 is submitted, the specialist is to request a Front End Eligibility (FEE) investigation from the Office of Inspector General (OIG). A home visit shall be completed to verify the parent is out of the home. Do **not** determine eligibility on the pending FIP application until the FEE agent completes an investigation.

FIP APPLICATION AFTER A TIME LIMIT IS REACHED

Once an individual reaches a FIP time limit and the FIP closes, the individual is not eligible for FIP if the individual reapplies and meets any exemption criteria.

LEGAL BASE

42 USC 608

Michigan TANF State Plan

MCL 400.57 - 57u

MCL 400.6(3) and (4)

2011 P.A. 131 and 2011 P.A. 132, amending MCL 400.57 - 57u., MCL 400.6(3) and (4)

2012 P.A. 607

DEPARTMENT POLICY

FIP, SDA, RCA, CDC and MA

Age is an eligibility factor for FIP, SDA, RCA, CDC and certain MA types of assistance.

Bridges evaluates age as an eligibility factor at application, redetermination and whenever an individual reaches an age limit defined in this item.

FIP, SDA, RCA, and MA

An individual remains eligible with respect to age for the entire month in which they reach the maximum age.

CDC Only

A child remains eligible with respect to age for the remainder of the 12-month continuous eligibility period in which they reach the age of 13.

For a child whose eligibility continues beyond redetermination after age 13 (due to a physical/mental/psychological condition or a court order), the child remains eligible with respect to age for the entire pay period in which the child reaches the maximum age.

AGE AS AN ELIGIBILITY FACTOR

Age of a Child

FIP Only

A dependent child must meet the conditions described below:

- The dependent child is under age 6.
- The dependent child is age 6 through 17, attending school full-time.
- The dependent child is age 18 and attending high school full-time until either the dependent child graduates from high school or turns 19, whichever occurs first.

A FIP group that has a dependent child age 6 through 15 that is not attending school full-time is not eligible for FIP.

A dependent child age 16 or 17 who is not attending high school full-time is not eligible for FIP benefits. The dependent child will have a Disqualified FIP eligibility determination group (EDG) participation status in Bridges.

Note: A dependent child under the age of 18 who has graduated high school is eligible for FIP until the dependent child's 18th birthday.

See BEM 245 for the definition of high school, an explanation of full-time enrollment and attendance, and verification sources.

CDC Only

A child must meet one of the conditions or set of conditions described below:

- Under age 13 at application and redetermination.
- Age 13, under age 18 and requires constant care due to a physical/mental/psychological condition; or supervision has been ordered by the court.
- Age 18 and a full-time high school student expected to graduate before age 19, who requires constant care due to a physical/mental/psychological condition or court order.

Eligible children turning age 13 during a CDC 12-month continuous eligibility period are eligible until the end of the certification period.

For a child whose eligibility continues beyond redetermination after age 13 (due to a physical/mental/psychological condition or a court order), the child remains eligible with respect to age for the entire pay period in which the child reaches the maximum age.

Age of SDA/RCA Individuals

SDA and RCA

An individual must be age 18 or over or emancipated.

A child under age 18 is emancipated if any of the following:

- Ever validly married.

- Emancipated by court order.
- On active duty with the armed forces of the United States.

Age-Related MA Types of Assistance

MA Only

Age criteria exist for the following MA types of assistance:

- Low-Income Family MA (BEM 110): A child must meet one of the following:
  - Under age 18.
  - Age 18 or 19 and a full-time high school student who is expected to graduate by age 20.
- Newborns (BEM 145): The individual must be under age one.
- Medicaid under 1 (BEM 129): The individual must be under age one.
- Children under 19 (BEM 130, 131): The individual must be under age 19.
- Home Care Children (BEM 170): The individual must be under age 18.
- Childrens Waiver (BEM 171): The individual must be under age 18 (under age 26 for children medically approved by MDHHS before 10/1/96).
- Children with Serious Emotional Disturbance (SED) Waiver (BEM 172): The individual must under age 18.
- Group 2 Persons Under Age 21 (BEM 132): The individual must be under age 21.
- Disabled Adult Children (BEM 158): The individual must be age 18 or older.
- Healthy Michigan Plan (BEM 137): The individual must be age 19-64.
- Aged SSI-Related Persons (BEM 155, 163, 164, and 166): The individual must be age 65 or older.

Age is attained on the anniversary of birth.

Age requirements for the above categories must be met in the month being tested.

AGE NOTIFICATION

FIP

Bridges generates age-related tasks the month before an individual turns ages:

- Six years.
- 16 years.
- 17 years.
- 18 years.
- 19 years.

Age-Related Tasks

When specialist action is required before eligibility can be determined based on a change in age, Bridges generates a specialist task or reminder.

Automatic Mass Update

When specialist action is not required based on a change in age, Bridges triggers mass update, which causes EDBC to run, and certifies the eligibility result automatically. Client's notice of case action is also generated automatically if the type of assistance changes or ends due to an individual passing one of the above ages thresholds.

VERIFICATION REQUIREMENTS

FIP

Verify a dependent child's age.

SDA, RCA, CDC and MA

Accept the individual's statement regarding age. Require verification only if the individual's statement is inadequate or inconsistent.

SDA and RCA

Verify emancipation of a child under age 18.

VERIFICATION SOURCES

Age

All Programs

- Birth certificate.
- Birth registry verification.
- Hospital certificate of birth.
- Other official records which contain birth information, such as school records, medical records, baptismal records, marriage certificate, insurance policy, etc.
- Forms of identification which contain age or date of birth, such as driver's license, state-issued I.D. card, etc.
- Newspaper clippings which contain the date of birth.
- Written statements from two or more individuals who know the individual's age.

Emancipation

- Marriage certificate.
- Court order.

School Enrollment and Attendance

SDA and LIF Only

- Form DHS-3380, Verification of Student Information.
- Other written statement verifying school enrollment and attendance and signed by a school official.
- Telephone contact with school.

LEGAL BASE

FIP

42 USC 619 (1), (2)
MCL 380.10
MCL 380.1561
MCL 400.57(1)(c)
MCL 400.57 (c)

SDA

DHS Annual Appropriations Act
Michigan Administrative Code; R 400.3151 – 400.3180

RCA

45 CFR 400.76

MA

42 CFR 435.110-320, .520
MCL 400.106
Social Security Act Section 1920(a)(10)(A), (e)(4), 1931

The Patient Protection and Affordable Care Act (Publication L. 111-148) and the Health Care and Education Reconciliation Act (Publication L. 111-152).

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

DEPARTMENT POLICY

FIP Only

Dependent children are expected to attend school full-time, and graduate from high school or a high school equivalency program, in order to enhance their potential to obtain future employment leading to self-sufficiency.

Dependent children ages 6 through 17 must attend school full-time.

Age 6 to 15

A dependent child age 6 through 15 must attend school full-time. If a dependent child age 6 through 15 is not attending school full-time, the entire Family Independence Program (FIP) group is not eligible to receive FIP.

Note: A child may be 6 years old and not enrolled in school if the child's sixth birthday falls after the enrollment deadline for the current school year.

Age 16 or 17

A dependent child age 16 or 17 who is not attending high school full-time is disqualified from the FIP group in Bridges.

Note: A dependent child age 16 or 17 who has graduated from high school is **not** required to participate in the Partnership. Accountability. Training. Hope. (PATH) program; see Bridges Eligibility Manual (BEM) 230A.

Age 18

Dependent children age 18 must attend high school full-time until either the dependent child graduates from high school or turns 19, whichever occurs first.

Minor Parent

Minor parents under age 18 must attend high school full-time; see BEM 201. Refer a minor parent to PATH once he or she graduates high school; see BEM 230A.

FAP Only

A person enrolled in a post-secondary education program may be in student status, as defined in this item. A person in student status must meet certain criteria in order to be eligible for assistance.

DEFINITIONS

FIP Only

MDE

Michigan Department of Education.

ISD

Intermediate school district.

High school

A course of study leading to the attainment of a high school diploma, or its equivalency. The following programs are considered to meet the definition of high school equivalency:

- Adult basic education (ABE).
- Alternative education.
- Charter school.
- General education development (GED).
- Home school.
- Non-public school.
- Vocational or technical training.

FIP and FAP

School means a:

- Public school.
- Nonpublic school registered with the MDE.
- Home school.

SCHOOL ATTENDANCE

Dependent Children

FIP Only

Dependent children ages 6 through 18 must meet one of the conditions described below:

- A child age 6 through 17 must be a full-time student.
- A child age 18 must attend high school full-time until either the child graduates from high school or turns 19, whichever occurs first.

A dependent child must be enrolled in and attending a school as defined in this item. Courses which are not administered by a school do **not** meet the requirement of school attendance. Correspondence or web-based courses administered by a school or used as part of a home school curriculum are acceptable.

Consider a dependent child as still meeting the school attendance requirement during official school vacations or periods of extended illness, unless information is provided by the client that the dependent child does **not** intend to return to school.

Note: If a refugee or dependent child with equivalent immigration status has resettled in Michigan during a school year or a summer month and the school will not allow enrollment for the dependent child until the start of the next school term/year, email the FIP-SDA-RCA policy mailbox for a policy exception per Policy Exception policy in BEM 100. See Refugees in BEM 630 for equivalent immigration status.

Minor Parents

FIP Only

A minor parent must attend school full-time. If a minor parent fails to comply with this requirement, the minor parent and the minor parent's child(ren) are not eligible for FIP; see BEM 201.

STUDENT STATUS

RCA and RMA Only

A full-time student in post-secondary education is **not** eligible for Refugee Cash Assistance (RCA) or Refugee Medical Assistance (RMA). The school determines full-time enrollment and attendance.

FAP Only

A person is in student status if he is:

- Age 18 through 49 and
- Enrolled half-time or more in a:

- Vocational, trade, business, or technical school that normally requires a high school diploma or an equivalency certificate.

- Regular curriculum at a college or university that offers degree programs **regardless** of whether a diploma is required.

In order for a person in student status to be eligible, they must meet one of the following criteria:

- Receiving FIP.

- Enrolled in an institution of higher education as a result of participation in:

  - A Job Training Partnership Act (JTPA) program.

  - A program under section 236 of the Trade Readjustment Act of 1974 us 19 USC 2341, et. seq.

  - Enrolled in a FAE&T or FAE&T plus, in a component or components that are either:

    - Part of a program of career and technical education as defined under the Perkins Strengthening Career and Technical Education Act (Perkins V) and a course of study that will lead to employment.

    - Are limited to remedial courses, basic adult education, literacy, or English as a second language.

- An employment and training program for low-income households operated by state and local government where one or more of the components of such program is at least equivalent to an acceptable FAP employment and training program component. This includes a program under the Carl D. Perkins Career and Technical Education Improvement act of 2006, administered by one of the 35 participating colleges that will lead to employment.

  Note: Some examples of career and technical programs offering certificate or diploma that will lead to employment are data entry occupations, medical and health care careers, HVAC and refrigeration, hospitality and tourism management.

- Another state or local government employment and training program.
- Physically or mentally unfit for employment.
- Employed for at least an average of 20 hours per week and paid for such employment.
- Self-employed for at least an average of 20 hours per week and earning an average weekly income at least equivalent to the federal minimum wage multiplied by 20 hours.
- Participating in an on-the-job training program. A person is considered to be participating in an on-the-job training program only during the period of time the person is being trained by the employer.
- Participating in a state or federally-funded work study program (funded in full or in part under Title IV-C of the Higher Education Act of 1965, as amended) during the regular school year.

  To qualify under this provision the student must be approved for work study during the school term and anticipate actually working during that time. The exemption:

  - Starts the month the school term begins or the month work study is approved, whichever is later.
  - Continues until the end of the month in which the school term ends, or when the local office becomes aware that the student has refused a work-study assignment.
  - Remains between terms or semesters when the break is less than a full month, or the student is still participating in work study during the break.
- Providing more than half of the physical care of a group member under the age of six.
- Providing more than half of the physical care of a group member age six through eleven and the local office has determined adequate child care is not available to:
  - Enable the person to attend class and work at least 20 hours per week.

- Participate in a state or federally-financed work study program during the regular school year.

- A single parent enrolled full-time in an institution of higher education who cares for a dependent under age 12. This includes a person who does not live with his or her spouse, who has parental control over a child who does **not** live with his or her natural, adoptive or stepparent.

For the care of a child under age six, consider the student to be providing physical care as long as he or she claims primary responsibility for such care, even though another adult may be in the Food Assistance Program (FAP) group.

When determining the availability of adequate child care for a child six through 11, another person in the home, over 18, need not be a FAP group member to provide care.

The person remains in student status while attending classes regularly. Student status continues during official school vacations and periods of extended illness. Student status does not continue if the student is suspended or does not intend to register for the next school term (excluding summer term).

HOURS OF ENROLLMENT AND ATTENDANCE

FIP and FAP

Schools determine:

- The level of enrollment (such as full-time, half-time, or part-time).

- Attendance compliance.

- Suspensions (such as reasons for/duration).

Note: Consider dependent children attending half-day kindergarten as attending full-time.

HOME SCHOOLING

FIP and FAP

Parents and legal guardians must direct and oversee the home schooling of their dependent child in an *organized educational program*. The parent or legal guardian is responsible for assigning homework, giving tests and grading tests. If home schooling continues through grade 12, the parent or legal guardian issues a high school diploma to the graduate. The organized educational program must include the subject areas of reading, spelling, mathematics, science, history, civics, literature, writing, and English grammar. Home school families may purchase the textbooks and instructional material of their choice. Parents or legal guardians are encouraged to maintain student records of progress throughout the year. There are no required tests for a home school student, but the parent or legal guardian is responsible for administering tests based upon the curriculum they use.

The annual registration of a home school with the MDE is voluntary. It is not required unless the student has special needs and is requesting special education services from the local public school or intermediate school district. A list of registered home schools is provided to intermediate school district superintendents each year. A parent or legal guardian may register a home school with the MDE by using the SM-4325, Nonpublic School Membership Report. Completion of the form is important. A home school student may be eligible to receive auxiliary services through their local public school district or ISD.

It is not required that a parent or legal guardian inform their local school of the decision to home school. However, if the parent or legal guardian does not inform their local school, this may result in the student being marked absent and the involvement of the truancy officer. Notification may be a phone call or a written note to the district.

CHILDREN NOT ENROLLED IN SCHOOL/HOME SCHOOL

FIP Only

A referral must be made to the local Intermediate School District's attendance officer if it is verified a dependent child age 6 to 17 is

not enrolled/attending a public school or is not participating in an organized education program. Document in *Case Comments* in Bridges that a referral to the attendance officer has been made.

A referral may be made to Children's Protective Services if it is verified a dependent child age 6 to 17 is not enrolled/attending a public school or is not participating in an organized education program **and** the case worker suspects other forms of child abuse and neglect.

ATTENDANCE COMPLIANCE TEST

FIP Only

If verification is returned that a dependent child or minor parent **receiving** FIP is not attending school full-time, an attendance compliance test is required **before** taking appropriate action regarding the FIP group.

The attendance compliance test requires the dependent child or minor parent to attend **all** school days for 21 consecutive calendar days.

Initiating the Attendance Compliance Test

In order for a dependent child or minor parent to complete the attendance compliance test, do the following:

- Generate the MDHHS-5443, FIP Student Attendance Compliance Test, and send to the FIP group. The MDHHS-5443 explains to the head of household that a dependent child or minor parent has been verified as not enrolled or not attending school full-time. In order for the FIP group and/or dependent child age 16 or 17 to continue to receive FIP, the dependent child or minor parent must complete a 21 day attendance compliance test. In order for FIP benefits to continue, the DHS-3380, Verification of Student Information, must be returned in 31 days verifying full-time attendance.
- Generate the DHS-3380 and send to the FIP group with the 21 Day Compliance Test box checked. The DHS-3380 must be sent with the DHS-3503-F, Verification Checklist, to be returned in 31 days.

If any day in the mandatory 21 calendar day attendance compliance test is during summer break, verify the dependent child or minor parent's enrollment. Once the new school year has started, initiate the attendance compliance test. Create a manual task and reminder in Bridges to complete the attendance compliance test at the start of the new school year.

Results of the Attendance Compliance Test

If the DHS-3380 is returned stating the dependent child or minor parent has attended all the school days in the past 21 calendar days, FIP eligibility continues for the FIP group and/or the dependent child age 16 or 17.

If the DHS-3380 is returned stating the dependent child or minor parent has not attended all the school days in the past 21 calendar days, take appropriate action regarding the FIP group based on department policy in this item.

If the DHS-3380 is not returned; see BAM 130, Verification and Collateral Contact, and initiate FIP group closure for failure to return requested verification.

Client Assistance

If the client contacts the department and requests an interview to resolve school attendance issues and/or barriers, one must be provided before taking appropriate action on the FIP group. If the client requests assistance removing current barriers for their child(ren) to complete the attendance compliance test or to attend school full-time, assist the client with barrier removal if possible; see BEM 232, Direct Supportive Services.

Note: Any barriers identified should be added to the head of household's Family Self-Sufficiency Plan (FSSP). If barriers are identified and entered into the FSSP and a dependent child or minor parent does not complete the attendance compliance test, do **not** impose an additional employment and training/FSSP sanction. Only take action on the FIP group based on department policy in this item.

REGAINING FIP ELIGIBILITY AFTER PREVIOUSLY FAILING STUDENT ENROLLMENT/ ATTENDANCE REQUIREMENT

FIP Only

Full-time school attendance is mandatory for 21 consecutive calendar days **before** regaining FIP eligibility if any of the following occurred previously:

- A dependent child age 6 to 15 failed to attend school full-time and the FIP group lost eligibility.
- A dependent child age 16 or 17 failed to attend high school full-time and the child was disqualified from the FIP group.
- A minor parent failed to attend school full-time and was denied FIP benefits at application or was a disqualified dependent child on a FIP group.

Dependent children or a minor parent listed above must attend all school days in the 21 consecutive calendar days.

If any day in the mandatory 21 calendar day attendance requirement is during summer break, verify school enrollment for the following school year prior to certifying FIP eligibility during the summer break. Once the new school year has started, verify the dependent child is attending school full-time. Create a manual task and reminder in Bridges to verify full-time attendance after school starts. Once the school year has started and it is verified the minor parent or dependent child is **not** attending school full time, take appropriate action regarding the FIP group based on department policy in this item.

Example: Ted would start the mandatory 21 calendar day attendance requirement on May 28. Since summer break starts June 7, verify Ted is enrolled in school for the following school year for the application processing. Create a manual task and reminder in Bridges for the start of the new school year.

For a new FIP application, it is possible that a previously noncompliant child has attended the past 21 calendar days in school. The past 21 day attendance is sufficient verification to

satisfy the compliance requirement. Do not require the additional completion of 21 days from the application date.

Example: Mary's FIP closed in January for her daughter Jane not attending school full-time. Jane starts attending school full-time again in April. On Nov. 30, Mary applies for FIP. It is required to verify Jane's full-time attendance for 21 consecutive calendar days before FIP eligibility can be approved. It is verified Jane has been attending full-time since April, the 21 days before the Nov. 30 application date satisfies the 21 day attendance requirement at application.

VERIFICATION REQUIREMENTS

FIP Only

Accept the client's statement that a 6 year old is enrolled and attending school full-time unless questionable.

Verify school enrollment and attendance at application and redetermination beginning with age 7.

Verify school enrollment and attendance at application, redetermination and at each birthday beginning with age 16.

Verify school enrollment and attendance for minor parents at application, redetermination and at each birthday.

Verify the completion and results of the attendance compliance test for dependent children or minor parents receiving FIP.

Verify the completion and results of the 21 day attendance requirement for dependent children or minor parents at FIP application.

FAP Only

If a home school has not voluntarily registered with MDE, accept the client's statement.

FIP Only

School enrollment and attendance:

- DHS-3380, Verification of Student Information. At each birthday a child has beginning with age 16, Bridges automatically sends the DHS-3380.

- For home schools, verification of the organized educational program used, curriculum agenda, instruction materials or student records may be used. The SM-4325, Nonpublic School Membership Report, may also be used, but completion of this form is voluntary for home schools.

- Telephone contact with the school.

- Other acceptable documentation that is on official business letterhead.

Attendance compliance test or 21 day attendance requirement:

- DHS-3380, Verification of Student Information.
- Telephone contact with the school.
- Other acceptable documentation that is on official business letterhead.

FAP Only

Hours of employment:

- Pay check stubs.
- Written, signed statement from employer.

Self-Employment Earnings and Hours:

- Primary source - Income tax return provided:
    - The client hasn't started or ended self-employment, or received an increase/decrease in income, etc.
    - The tax return is still representative of future income.
    - The client filed a tax return.
- Secondary source - DHS-431, Self-Employment Statement, with all income receipts to support claimed income.
- Third Source - DHS-431, Self-Employment Statement, without receipts

Physically or Mentally Unfit for Employment:

- Award letter or other verification of eligibility for Retirement, Survivors, and Disability Insurance (RSDI) or Supplemental Security Income (SSI) on the basis of disability.

- Award letter or other verification of eligibility for disability benefits issued by government or private sources.
- Statement from an M.D. or D.O.
- Statement from a psychologist.

Perkins Program:

- Enrollment letter stating the individual is enrolled in the Perkins Program.
- DHHS-3380, Verification of Student Information.
- MDHHS - 5857, Michigan Community College Verification Form.
- Collateral contact with the community college via the Employment and Training mailbox: Policy-employment@michigan.gov

LEGAL BASE

FIP

42 USC 619
MCL 380.10
MCL 380.1561-1599
MCL 400.57 et seq.
MCL 712A.2 et seq.

RCA/RMA

45 CFR 400.53

FAP

7CFR 273.5

DEPARTMENT PHILOSOPHY

Families are strengthened when children's needs are met. Parents have a responsibility to meet their children's needs by providing support and/or cooperating with the department, including the Office of Child Support (OCS), the Friend of the Court (FOC) and the prosecuting attorney to establish paternity and/or obtain support from an absent parent.

POLICY

Child Development and Care (CDC) Only

Effective 2/25/2024, cooperation with OCS is no longer a requirement for the CDC program. Failure to cooperate will **not** have a negative impact on the CDC benefit at application, redetermination, or during the 12-month eligibility period.

Note: Policy related to the completion of the *Absent Parent Logical Unit of Work* and trio should still be completed to assist the parent/applicant with obtaining child support.

Family Independence Program (FIP) and Medicaid (MA)

The custodial parent or alternative caretaker of children must comply with all requests for action or information needed to establish paternity and/or obtain child support on behalf of children for whom they receive assistance, unless a claim of good cause for not cooperating has been granted or is pending.

Absent parents are required to support their children. Support includes **all** of the following:

- Child support.
- Medical support.
- Payment for medical care from any third party.

Note: For purposes of this item, a parent who does not live with the child due solely to the parent's active duty in a uniformed service of the U.S. is considered to be living in the child’s home.

Complete the *Absent Parent Logical Unit of Work* and trio for any group member who has been or is currently a recipient of public assistance as a dependent child and had an absent parent.

Complete a new trio when the custodial parent/caretaker changes.

The summary will include all trios created for individuals who had an absent parent during an episode of assistance. This may include parents who were previously absent for a period of time an individual received assistance. This may include individuals who are now adults but the history of having an absent parent is necessary for the OCS to determine disbursement of arrearage payments that may be received.

Failure to cooperate without good cause results in disqualification. Disqualification includes member removal, as well as denial or closure of program benefits, depending on the type of assistance (TOA); see *support disqualification* in this item.

Note: When OCS, FOC or a prosecuting attorney determines a client is in cooperation or noncooperation the determination is entered in Bridges via a systems interface. When the client is in noncooperation, Bridges will generate a notice closing the affected program(s) or reduce the client benefit amount in response to the determination. A copy of the details regarding the cooperation or noncooperation can be requested by contacting the primary worker noted in the Child Support (CS) icon on the Absent Parent Child Link page.

Note: A pregnant woman who fails to cooperate may still be eligible for MA; see *MA member disqualification* in this item.

FIP

All rights to current and future court-ordered child support paid for a period of time a child receives FIP must be assigned to the state as a condition of FIP eligibility. See Assignment in this item for the types of child support payments that a FIP recipient is entitled to keep.

Court-ordered child support paid for a child receiving FIP on or after 1/1/2023 will be paid to the payee as a child support client participation payment (CPP).

Note: Custodial parents cannot waive family owed arrears while receiving FIP.

Spousal support included in a child support order must also be assigned; see *support assignment and certification* in this item.

GOOD CAUSE FOR NOT COOPERATIONG

FIP and MA

Exceptions to the cooperation requirement are allowed for all child support actions except when the recipient fails to return assigned child support payments received after the support certification effective date; see *support certification effective date* in this item.

Informing Families about Good Cause

FIP and MA

Inform the individual of the right to claim good cause by giving them a DHS-2168, Claim of Good Cause - Child Support, at application, before adding a member and when a client claims good cause. The DHS-2168 explains all of the following:

- The department's mandate to seek child support.
- Cooperation requirements.
- The positive benefits of establishing paternity and obtaining support.
- Procedures for claiming and documenting good cause.
- Good cause reasons.
- Penalties for noncooperation.
- The right to a hearing.

Grant good cause **only** when both of the following are true:

- Requiring cooperation/support action is against the child's best interests.
- There is a specific good cause reason.

See the *good cause reasons* in this item.

Good Cause Reasons

FIP and MA

There are two types of good cause:

1. Cases in which establishing paternity/securing support would harm the child. Do **not** require cooperation/support action in any of the following circumstances:
   - The child was conceived due to incest or forcible rape.
   - Legal proceedings for the adoption of the child are pending before a court.
   - The individual is currently receiving counseling from a licensed social agency to decide if the child should be released for adoption, **and** the counseling has **not** gone on for more than three months.
2. Cases in which there is danger of physical or emotional harm to the child or client. Physical or emotional harm may result if the client or child has been subject to or is in danger of:
   - Physical acts that resulted in, or threatened to result in, physical injury.
   - Sexual abuse.
   - Sexual activity involving a dependent child.
   - Being forced as the caretaker relative of a dependent child to engage in non-consensual sexual acts or activities.
   - Threats of, or attempts at, physical or sexual abuse.
   - Mental abuse.
   - Neglect or deprivation of medical care.

Note: This second type of good cause may include instances where pursuit of child support may result in physical or emotional harm for a refugee family, or the absent parent of a refugee family,

when the family separation was the result of traumatic or dangerous circumstances. This may also apply to individuals who are treated to the same extent as a refugee, including asylees and victims of trafficking.

Claiming Good Cause

FIP and MA

If a client claims good cause, both the specialist and the client must sign the DHS-2168. The client must complete Section 2, specifying the type of good cause and the individual(s) affected. Give the client a copy of the completed DHS-2168.

To prevent any support action while the good cause claim is pending, enter good cause status and claim date in the absent parent logical unit of work and file the DHS-2168 in the case **within two working days of completion.** A claim may be made at any time. The FIS/ES specialist is responsible for determining if good cause exists. Do **not** deny an application or delay program benefits just because a good cause claim is pending.

A good cause claim must do all of the following:

- Specify the reason for good cause.
- Specify the individuals covered by it.
- Be supported by written evidence or documented as credible.

Evidence and Credibility of Good Cause

Request the client provide evidence of good cause within 20 calendar days of claim. Allow an extension of up to 25 calendar days if the client has difficulty obtaining the evidence.

Note: Change the Verification Check List (VCL) due date in Bridges manually, to extend the due date of verification.

Assist clients in obtaining written evidence if needed. Place any evidence in the case record. See *verification sources* in this item for examples of acceptable evidence.

If written evidence does **not** exist, document why none is available and determine if the claim is credible. Base credibility determination on available information, including client statement and/or collateral contacts with individuals who have direct knowledge of the client's situation.

Verification of good cause due to domestic violence is required only when questionable.

Determining Good Cause

FIP and MA

Make a good cause determination within 45 calendar days of receiving a signed DHS-2168 claiming good cause. The OCS can review and offer comment on the good cause claim before you make your determination. Exceed the 45-day limit **only if** all of the following apply:

- The client was already granted an additional 25-day extension to the original 20-day limit.
- More information is needed that **cannot** be obtained within the 45-day limit.
- Supervisory approval is needed.

Document extensions in the case record.

One of three findings is possible when making a determination:

- Approved - Continue with Child Support Action.

  Example: Court order is already established and client participation is no longer necessary to pursue support.

- Approved - Discontinue or do not initiate Child Support Action; this applies when there is a risk to the child or custodial parent/caretaker or there is an existing child support order.
- Denied - Good cause does not exist; this applies if the family does not present criteria that meets good cause or there was no convincing evidence of risk.

All good cause determinations must be:

- Approved by a specialist's supervisor.
- Reviewed at every redetermination if subject to change.
- Documented on the DHS-2169, Notice of Good Cause Decision **and** a copy must be placed in the case record.
- Entered in the absent parent logical unit of work to include status, claim date, and begin date when approved. End date is entered when applicable.

ROLE OF THE SUPPORT SPECIALIST

FIP and MA

Support Specialists work for the OCS to support families by:

- Accepting referrals/applications for child support services on behalf of public assistance recipients, as well as from the general public.
- Obtaining absent parent information from clients.
- Reviewing and offering comment on good cause claims.
- Attending pre-hearing conferences and administrative hearings in support of OCS actions.
- Determining cooperation and non-cooperation (entered in Bridges via the systems interface).
- Referring appropriate cases to the local prosecutor or the FOC.

Support Specialist Role in Good Cause

FIP and MA

Enter the good cause claim **within two workdays of the individual's claim**. No support action or contact with the client will be initiated while the good cause claim is pending.

Provide the support specialist with information if submitted when a recommendation is needed. Consider the OCS recommendation even though it is not binding. Consider the recommendation especially when determining if support action can proceed without the client's cooperation and without resulting in physical/emotional harm to the child or client.

CHILD SUPPORT REFERRAL REQUIREMENTS

FIP, CDC Income Eligible and MA

Refer unmarried children who have no legal father or who have a legal parent absent from the home to the OCS for child support action by completing the Absent Parent Logical Unit of Work and certifying eligibility of benefits.

Exception: The following children are not referred to OCS:

- Children whose absent parent is deceased.
- Children adopted by a single parent only.
- Teen and minor parents with an **adult** Eligibility Determination Group (EDG) participation status.

MA Only

The support specialist will **not** take action on deductible cases until after certification of the first period of MA coverage.

Children not living with a specified relative, as defined in BEM 135, are not referred to the OCS.

REPORTING CHANGES TO OCS

FIP, CDC Income Eligible and MA

Enter new information about the absent parent in the absent parent logical unit of work within two workdays of learning the following changes when there is an active EDG:

- Changes affecting cooperation or a good cause claim.
- New information about an absent parent.

Contact the primary worker noted in the Child Support (CS) icon on the Absent Parent Child Link page to resolve case-specific questions regarding collection action.

Note: The primary child support worker can be the support specialist or the prosecutor's office, which also determines cooperation and non-cooperation.

ESTABLISHING PATERNITY AND OBTAINING SUPPORT

Voluntary Paternity Acknowledgement

FIP, CDC Income Eligible and MA

Parents who wish to voluntarily establish paternity must complete form DCH-0682, Affidavit of Parentage. Give these clients the DCH-0682. Clients may complete the affidavit in the local office, may take it with them for completion, and/or may seek assistance from the support specialist.

It is critical that parents are provided with sufficient information on the paternity acknowledgement process. If assisting clients in completing the affidavit, be sure to review the consequences, rights and responsibilities of acknowledging paternity that are listed on the DCH-0682.

Refer parents with questions about paternity or child support to the support specialist 1-866-540-0008.

Signatures of both parents on the affidavit must be notarized. Provide each parent with a copy of the completed form.

A copy of the form is available to the public at https://www.michigan.gov/documents/Parentage_10872_7.pdf.

COOPERATION

FIP and MA

Cooperation is a condition of eligibility. The following individuals who receive assistance on behalf of a child are required to cooperate in establishing paternity and obtaining support, unless good cause has been granted or is pending:

- Grantee (head of household) and spouse.
- Specified relative/individual acting as a parent and spouse.
- Parent of the child for whom paternity and/or support action is required.

Cooperation is required in all phases of the process to establish paternity and obtain support. It includes **all** of the following:

- Contacting the support specialist when requested.
- Providing all known information about the absent parent.
- Appearing at the office of the prosecuting attorney when requested.
- Taking any actions needed to establish paternity and obtain child support (including but not limited to testifying at hearings or obtaining genetic tests).

FIP Only

Cooperation includes repaying to the department any assigned support payments received on or after the support certification effective date.

Exception: The following child support payment types should not be returned. The FIP recipient is entitled to keep:

- Child support collections attributed to a time period during which the child was not on FIP, when initial FIP eligibility was certified on or after October 1, 2009.
- Child support client participation payment.
- Child support refunds.
- Child support reimbursements.

MA

The support specialist will **not** take action on deductible cases until after authorization of the first period of MA coverage in Bridges.

Cooperation is required for an active deductible EDG once the first period of MA coverage is authorized. This requirement continues as long as the EDG is active and includes periods for which MA coverage is **not** authorized.

Support Specialist Determines Cooperation

FIP and MA

The support specialist determines cooperation for required support actions. The date client fails to cooperate will be populated in the absent parent logical unit of work and negative action is applied the same night automatically; see *support disqualification*.

Exception: Determine non-cooperation for failure to return assigned support payments received after the support certification effective date; see *FIS determines cooperation* in this item.

Cooperation is assumed until negative action is applied as a result of non-cooperation being entered. The non-cooperation continues until a comply date is entered by the primary support specialist or cooperation is no longer an eligibility factor. The comply date will be populated in the absent parent logical unit of work and the mandatory member will be added to active MA EDG the same night automatically; see *removing a support disqualification* in this item.

FIS Determines Cooperation

FIP Only

Determine non-cooperation for failure to return assigned support payments received after the support certification effective date; see *support certification effective date* in this item.

The individual is considered non-cooperative when they have received assigned support payments directly for a **second** calendar month after the certification effective date **and** failed to return them to the department.

Note: The two calendar months need not be consecutive.

Start the disqualification procedure; see *support disqualification* in this item.

Cooperation exists when the client returns subsequent assigned support payments or an overpayment claim has been established and certification of support has occurred; see *removing a support disqualification* in this item.

SUPPORT DISQUALIFICATION

FIP and MA

Bridges applies the support disqualification when a begin date of non-cooperation is entered and there is no pending or approved good cause. The disqualification is not imposed if any of the following occur on or before the timely hearing request date; see BAM 600, Hearings:

- OCS records the comply date.
- The case closes for another reason.
- The non-cooperative client leaves the group.
- Support/paternity action is no longer a factor in the child's eligibility (for example, the child leaves the group).

- Client cooperates with the requirement to return assigned support payments to MDHHS and the support is certified.
- Client requests administrative hearing.

Note: Reinstatement of FIP is necessary to prevent the disqualification from being applied when an administrative hearing is requested timely.

Support Disqualification At Application

FIP and MA

At application, the client has 10 days to cooperate with the OCS. Bridges informs the client to contact the OCS in the verification check list (VCL). The disqualification is imposed if client fails to cooperate on or before the VCL due date when all of the following are true:

- There is a begin date of non-cooperation in the absent parent logical unit of work.
- There is **not** a subsequent comply date.
- Support/paternity action is still a factor in the child's eligibility.
- Good cause has not been granted nor is a claim pending; see *good cause for not cooperating* in this item.

Note: If the client is cooperating at reapplication but has not served the minimum one-month penalty for FIP, Bridges determines eligibility for the month following the penalty month; see *FIP disqualification* in this item.

Do all of the following at the application interview:

- Inform the applicant that the disqualification will be imposed unless a comply date is received from the support specialist.
- Encourage the applicant to cooperate with the support specialist and discuss the consequences of the non-cooperation.

- Promptly refer persons who indicate a willingness to cooperate to the primary worker from the CS icon. A support specialist can be reached at 1-866-540-0008 to re-evaluate the individual's cooperation status; see *removing a support disqualification* in this item.

FIP Disqualification

FIP

Any individual required to cooperate who fails to cooperate without good cause causes group ineligibility for a minimum of one month.

Bridges will close FIP for a minimum of one calendar month when any member required to cooperate has been determined non-cooperative with child support. The disqualification is effective the first day of a month.

MA Member Disqualification

MA

Failure to cooperate without good cause results in member disqualification. The adult member who fails to cooperate is **not** eligible for MA when both of the following are true:

- The child for whom support/paternity action is required receives MA**.**
- The individual and child live together.

Exception: Bridges will not begin or continue a disqualification for failure to cooperate when any of the following are true:

- During pregnancy when a woman meets all other eligibility factors.
- Up to 12 months after the month the pregnancy ends.

Note: The child's MA eligibility is not affected by the adult member's disqualification. The adult member's MA must have an ex-parte review before closure because of a failure to cooperate.

Hearings

Notify the primary worker from the Child Support (CS) icon of hearing requests involving child support actions. Attempt to resolve the issue without going to a hearing. Involve the primary worker noted in the CS icon on the Absent Parent Child Link page in the pre-hearing conference.

REMOVING A SUPPORT DISQUALIFICATION

FIP and MA

Ask a disqualified client at application, redetermination or reinstatement if they are willing to cooperate. A disqualified member may indicate willingness to cooperate at any time. Immediately inform clients willing to cooperate to contact the primary worker from the CS icon or a support specialist can be reached by calling 1-866-540-0008.

Bridges will **not** restore or reopen benefits for a disqualified member until the client cooperates (as recorded on the child support non-cooperation record) or support/paternity action is no longer needed. Bridges will end the non-cooperation record if any of the following exist:

- OCS records the comply date.
- Support/paternity action is no longer a factor in the client's eligibility (for example, child leaves the group).
- For **FIP only,** the client cooperates with the requirement to return assigned support payments, or an overpayment is established and the support is certified.
- For **FIP only**, a one-month disqualification is served when conditions (mentioned above) to end the disqualification are not met prior to the negative action effective date.

FIP only

Client must reapply for program eligibility when the above did not exist before the negative action effective date of the closure.

MA only

Disqualified member is returned to the eligible group active for program in the month of cooperation.

SUPPORT ASSIGNMENT AND CERTIFICATION

Assignment

FIP

Assignment is the agreement of the head of household and parent to give to the state all rights to current and future court-ordered child support paid on behalf of a FIP recipient for the same time period. Assignment occurs when the individual completes and signs a MDHHS-1171, Assistance Application.

Note: Minor parents must also sign the MDHHS-1171 to confirm their understanding of the assignment of child support.

Exception: The following child support payment types are **not** assigned and should not be returned. The FIP recipient is entitled to keep:

- Child support collections attributed to a time period during which the client was not receiving FIP, when initial FIP eligibility is certified on or after October 1, 2009.
- Child support client participation payment.
- Child support refunds.
- Child support reimbursements.

FIP recipients also assign their spousal support if it is included in the same order as the child support.

Certification

FIP and MA

Child support is certified (sent to the state) when it is paid for a period of time an individual was a dependent receiving FIP or MA. This is reimbursement for the FIP or MA expenditures.

Support certification occurs automatically based on completion of an Absent Parent Logical Unit of Work for each child requiring a referral to the OCS when initial FIP and/or MA eligibility is certified in Bridges.

FIP recipients' spousal support that is included in the same order as child support is also certified.

Support Certification Effective Date

The support certification effective date is based on the initial FIP eligibility date and if direct child support was included in the initial eligibility determination in Bridges. When direct child support is not included in the initial eligibility determination, the certification is effective when eligibility begins. When direct child support is included in the initial eligibility determination, certification is effective the first of the original ongoing month.

Original Ongoing Month

FIP

The original ongoing month displayed in the FIP EDG summary is the date that child support will begin to be assigned to the state by OCS for the current episode of FIP. The original ongoing month is in the future, as indicated below.

When the initial FIP eligibility date is the first of a month, the original ongoing month is the first day of the month following the day initial FIP eligibility is certified in Bridges.

When the initial eligibility date is the 16th day of a month, the original ongoing month is the later of:

- The first day of the month following the initial eligibility date.
- The first day of the month following the day initial FIP eligibility is certified in Bridges.

Support Received by FIP Recipient

FIP

A FIP recipient may receive assigned support payments after the support certification effective date because of:

- Delays in processing the certification.
- Delays in processing out-of-state orders.
- An incomplete Absent Parent logical unit of work.

If one of these types of child support is paid to the FIP client, a task/reminder is received by the specialist.

The recipient must return or forward assigned support payments received after the support certification effective date to the local MDHHS fiscal unit. Accounting Manual item ACM 462 gives fiscal unit instructions for handling client-returned child support warrants.

Inform all clients of this requirement, whether support is established or pending, when FIP is approved or a member is added to a FIP EDG. See *assignment* section in this item for the types of child support payments the FIP recipient is entitled to keep.

See BEM 500 and BEM 518 for budgeting policies/procedures for support payments received after the support certification date that are retained by the FIP recipient.

Child Support Warrants Addressed to the Local Office

Child support warrants are mailed to the client's mailing address in Bridges. To minimize the number of warrants received in the local office, avoid entering the local office address as the client's mailing address in Bridges.

When the Local Office Liaison receives a child support warrant addressed to the client at the local office address, a DHS-2362,

State Treasurer's Warrants, Rewrite/Disposition Request, will also be received. Determine and notify the Local Office Liaison if the warrant should be returned to MiSDU or forwarded to the individual by completing the DHS-2362.

Note: The client need not return all child support payment types. See *assignment* section in this item for types of payments that FIP recipients are entitled to keep while receiving FIP.

VERIFICATION REQUIREMENTS

Good Cause

FIP and MA

A claim of good cause must be supported by written evidence or documented as credible. Assist clients in obtaining evidence if needed. See *verification sources* in this item for examples of acceptable evidence.

Verification of good cause due to domestic violence is required only when questionable.

VERIFICATION SOURCES

Good Cause

Pending Adoption

Court documents or records indicating that legal proceedings for adoption are pending.

Adoption Counseling

Written statement from a licensed social agency indicating **both** of the following:

- The individual is receiving counseling to decide whether the child should be released for adoption.
- The counseling has not gone on for more than three months.

Domestic Violence

- Documented receipt of domestic violence counseling or client is residing in a domestic violence shelter.
- Medical records.
- Court records (for example, personal protection order or petition).
- Police records (for example, domestic disturbance response).
- Other case record information (including Children's Services).

LEGAL BASE

FIP

42 USC 608, Social Security Act, Section 408
45 CFR 303.11(b)(9)
MCL 400.1 et seq.
MCL 552.23(2)
MCL 722.718
P.A. 67 of 2019

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

MA

42 USC 1386(K)
Social Security Act, Section 1912
42 CFR 433.146, .147
MCL 400.106

DEPARTMENT POLICY

FIP, SDA and MA Only

If a group member and his/her spouse do **not** live together, a referral to the local county prosecutor may be necessary to establish the absent spouse's responsibility for financial support.

If the absent spouse is also the parent of a group member under age 18, refer him/her to child support; see BEM 255.

FIP Only

Unmarried children under age 18 who act as adult case members **or** grantees may need to be referred to the county prosecutor for possible support action against their parents.

COUNTY PROSECUTOR REFERRALS

FIP, SDA and MA Only

Refer appropriate cases to the county prosecutor under locally established procedures when he has indicated he will take action under the Poor Law or Status of Minors Act.

Use the DHS-1171-ABS, Absent Spouse/Parent Referral Notice, to refer appropriate cases. Make the referral within 14 days of opening a case **or** whenever a referral is required.

Make a referral:

- When an eligible group member and spouse do **not** live together **and** the absent spouse is **not** the parent of a group member under age 18.
- For **FIP only**, when a minor parent resides away from a parent **and** is the grantee.

Do **not** make a referral when the absent spouse/parent:

- Is complying with a current probate court order for support**.**
- Is the parent of a group member under age 18 who has been referred for support action (see BEM 255).

- Currently receives FIP, RAP, SDA, MA or SSI.
- Is required to support the recipient spouse via a circuit court order.

Refer to BEM 402, Special MA asset rules, for information regarding absent spouse assets and income.

Take the following actions when a referral has been made:

- Assume court action is inadvisable and stop the process if there is no reply from the prosecutor's office after 30 days.
- Obtain any additional information about the absent spouse if requested.
- Initiate a Poor Person's petition in the county probate court if court action is recommended by the prosecutor's office.
- Budget any resulting court ordered spouse or child support received by the group as unearned income.

REFUSING INFORMATION

FIP, SDA and MA Only

The spouse/minor in the group is ineligible if he/she refuses to provide information about an absent spouse/parent **or** cooperate with the prosecutor.

VERIFICATION REQUIREMENTS

FIP, SDA and MA Only

The DHS-1171-ABS, may be used to gather information about an absent spouse when required under the local procedure with the prosecutor's office.

LEGAL BASE

FIP

P.L. 104-193 of 1996
P.A. 280 of 1939, as amended
MCL 400.1 - .9
MCL 722.3

SDA

Annual Appropriations Act
Michigan Administrative Code; R 400.3151 – 400.3180

MA

42 CFR 433.147
42 CFR 435.821-.822
MCL 400.106
MCL 401.1-.9

OVERVIEW

Family Independence Program (FIP)

As a condition of eligibility, the client must identify all third-party resources unless he/she has good cause for not cooperating. Failure, without good cause, to identify a third-party resource result in disqualification.

Medicaid (MA)

In addition to the requirements above, as a condition of eligibility for Medicaid an individual is required to apply for coverage under Medicare Part A, B and or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs.

A third-party resource is a person, entity or program that is, or might be, liable to pay all or part of a group member's medical expenses.

The Third-Party Liability Division, Bureau of Medicaid Policy, Operations and Actuarial Services, in the Department of Health and Human Services uses third-party resource information to reduce MA expenditures by both:

- Rejecting MA claims until liable third parties have paid.
- Seeking reimbursement from liable third parties after MA payment has been made.

The Social Security Administration determines client cooperation and reports third-party resources to the Third-Party Liability Division for individuals active Medicaid for Aged, Blind, or Disabled. Policy in this item does not apply to those MA groups.

RESOURCE TYPES

FIP, MA

Usually, the resource is Medicare or a health/casualty insurance company. Resources often exist in the following situations:

- A person has private health insurance.
- Work-related injury.
- An injury occurs outside the home (for example: an auto accident).

- Other accident/incident resulting in illness or injury (for example: crime, medical malpractice, slip and fall, faulty product).
- LTC insurance (for example: Cigna, John Hancock, AFLAC, Conseco).

RESOURCE LEADS

FIP, MA

When there is a potential third-party resource, contact the client; see *reporting resources* in this item. The following will help identify resources:

Age

Persons age 65 and over often have supplemental health insurance in addition to Medicare.

Employment

Many employers provide health insurance for the employee, spouse and (step)children. Separate policies might cover dental, vision or other health needs.

Medical Information

Medical reports or information (for example at application or redetermination) might indicate a third-party resource for an accident/illness or LTC services. The DCH-2565-C, Facility Admission Notice, frequently lists health insurance.

Military Service

Dependents of active, retired, deceased or totally disabled military service personnel are eligible for medical coverage through the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), Civilian Health and Medical Program of the Veterans Administration (CHAMPVA), or the TRICARE Program.

Monthly Expense Information

This might show payment of private insurance premiums. Medicare recipients often buy supplemental health insurance.

Retirement

Many employers provide health insurance for retirees.

School

Often the school's insurance covers injuries during school activities (for example sports).

Union Membership

Unions often have a group health plan for members and dependents. This might be in effect even if the member is not working.

COOPERATION

FIP, MA

The following persons are required to cooperate in identifying third-party resources unless they have good cause for not cooperating:

- An adult who has a third-party resource.
- A parent whose unmarried child under age 18 has a third-party resource.
- A legal guardian whose ward has a third-party resource.
- A caretaker or caretaker relative whose dependent child has a third-party resource.

GOOD CAUSE CLAIMS

FIP, MA

Give or send a DHS-4469, Claim of Good Cause-Third Party Resources, to clients who indicate any concern about identifying third-party resources. The DHS-4469 explains:

- The department's mandate to seek third-party resources.
- Cooperation requirements.
- Procedures for claiming and documenting good cause.
- Good cause reasons.
- Disqualification for noncooperation.
- The right to a hearing.

If the client claims good cause, both of the client and the eligibility specialist must sign section 1 of the DHS-4469. The client must complete section 2 specifying the type of good cause and person(s) affected. Give or send the client a copy of the DHS-4469 within two workdays after it is completed.

A claim of good cause may be made at any time. The eligibility specialist is responsible for determining good cause and making a finding.

To do so, follow all of the instructions in the *Good Cause Claims* section of BEM 255, Child Support, **except:**

- Use the DHS-4469 instead of the DHS-2168.
- Support specialists are not involved with third-party resource good cause claims.

Do not deny an application or delay benefits because a good cause claim is pending.

IMPOSING A DISQUALIFICATION

FIP, MA

Failure to cooperate without good cause results in disqualification. The following person who failed to cooperate is not eligible:

- The adult who fails to cooperate in identifying his/her own third-party resource.
- The parent who fails to cooperate in identifying a third-party resource of his unmarried child under age 18 who is a FIP or MA recipient.
- The legal guardian who fails to cooperate in identifying a third-party resource of his ward who is a FIP or MA recipient.
- The caretaker or caretaker relative who fails to cooperate in identifying a third-party resource of any dependent child on whom the relative's FIP, LIF or Caretaker Relative Medicaid eligibility is based.

FIP

Do not include a disqualified person's needs when determining group eligibility or benefits.

A disqualified person cannot serve as an ineligible grantee unless he is the only adult in the case **and** no suitable protective payee can be found.

REMOVING A DISQUALIFICATION

FIP, MA

End the disqualification when any of the following occurs:

- The disqualified person cooperates.
- Good cause is established for not cooperating.
- The resource no longer exists.
- Eligibility ends for the person on whose resource the disqualification is based.

REPORTING RESOURCES

MDHHS Reporting

FIP, MA

Report to the Third-Party Liability Division when a third-party resource is identified at application, redetermination or any time a resource becomes known.

Complete all required information and submit the DCH-0078, Request to Add, Terminate or Change Other Insurance to the Third-Party Liability Division as quickly as possible.

The DCH-0078 form can be submitted electronically at www.michigan.gov/reportTPL.

If available, attach copies (front/back) of insurance identification cards. Ensure copies of the cards are legible and that the policy number is entered correctly on the form.

Although the electronic submission is preferred, you can also fax the form to TPL Division at 517-346-9817.

The Third-Party Liability Division uses third party resource information, such as LTC insurance, to reduce Medicaid expenditures by rejecting Medicaid claims until liable third parties have paid **or** seeking reimbursement from third parties after Medicaid payments have been made. This coordination of benefits is vital to ensure claims are paid correctly.

MSA staff may send a completed DCH-0078 for clients in any of the following placements:

- MDHHS facilities.
- Community Living Facilities (CLF)
- Receiving Children's Special Health Care Services (CSHCS).

Upon receipt of either form, enter the basic identifying information (for example: Medicaid ID number) and forward the form to the Third-Party Liability Division.

The Third-Party Liability Division often learns of a resource independently. Cooperate with Third Party Liability Division staff by providing the information or clarification requested.

Bridges Coding

FIP, MA

When the Other Insurance (OI) code in Bridges is blank or zeroes, enter the appropriate code to reflect the client's Medicare and/or health insurance coverage.

Any further changes to the OI code must be initiated by the MSA Third Party Liability Division or Buy-In staff.

See *Change or Termination of a Resource* in this item.

When Resources Are Not Reported

FIP, MA

Do not report a third-party resource to the Third-Party Liability Division in any of the following circumstances:

- The resource is Medicare. **However, do report supplemental health insurance and long-term care insurance.**
- The resource is court-ordered medical, but no insurance information is provided.
- There is documented good cause for failure to cooperate on a DHS-2169, Notice of Good Cause Finding-Child Support/Third Party Resources, **and** reporting the resource would endanger the client or dependents. However, **do report** any resource not covered by good cause.

Note: When good cause has been approved **and** there is an OI code on the Insurance Policy Information screens or on the Medicare Claim screens in Bridges, send a copy of the DHS-2169 to notify the Third-Party Liability Division of the need to delete the OI code.

- A disqualification is imposed for failure to cooperate. Send a DCH-0078 when the disqualification ends.
- The case is reopened with no lapse in MA. However, if the resource has changed or was never reported, send a DCH-0078.

Change or Termination of a Resource

FIP, MA

Report a change to http://www.michigan.gov/reportTPL when:

- Health insurance changes or ends. Attach documentation from the employer or insurer indicating the date coverage changed or ended.
- The insurance information in Bridges was not provided by the client and he is unaware of the coverage. When the client contacts you, check the case record to determine if there is information about the resource. If not, note on the DCH-0078 that the case record does not indicate OI coverage. In the above situations, the Third-Party Liability Division staff must:
  - Verify the insurance.
  - Update the TPL coverage if appropriate. Bridges will be updated effective the following month.

Third-party resource information is stored in a computerized TPL coverage file maintained by the Third-Party Liability Division. It includes claim information such as health insurance company, policy number, benefit information, and coverage dates.

The TPL file updates the OI code monthly. The monthly update occurs the evening of the regular cut-off date and selects the OI code based on priority.

Claims are paid or rejected based on information on the TPL coverage file, not other insurance information in Bridges. It is imperative

that the corresponding DCH-0078 is received in the Third Party Liability Division so that the correct OI code is entered on the TPL coverage file.

Without the completed DCH-0078, even if an OI code is entered in Bridges, claims will continue to be paid by Medicaid.

INQUIRIES BY MAIL

Direct inquires or complaints about other insurance problems to:

Michigan Department of Health and Human Services
Third Party Liability Division
Bureau of Medicaid Policy, Operations & Actuarial Services
PO Box 30479
Lansing, MI 48909

PHONE INQUIRIES

Enrolled Providers

Provider Inquiry Helpline: 1-800-292-2550 or providersupport@michigan.gov.

Beneficiaries

Beneficiary Helpline: 1-800-642-3195.

VERIFICATION REQUIREMENTS

FIP, MA

For good cause claims, follow verification policy in BEM 255.

MA

Application for Medicare parts A/B is by self-attestation.

REFERENCES

FIP

P.A. 280 of 1939, as amended.

MA

42 CFR 433.135-153
MCL 400.106

DEPARTMENT POLICY

MA Only

This item explains the MA disability and blindness factors.

EXHIBIT I in this item contains definitions of disability, substantial gainful activity and blindness.

A person meets the disability or blindness factor for a month if he is determined disabled or blind for the month being tested.

In addition, a disabled person does **not** meet the disability requirement if he refuses treatment without good cause; see Treatment Requirement (Disability Only) in this item.

DISABILITY/ BLINDNESS ESTABLISHED

Death

Death establishes a person's disability for the month of his death.

503, Early Widow, DAC

SSA has established disability for 503, Early Widow, and DAC beneficiaries; see BEM 155, 157, 158 for other eligibility factors.

Eligible for SSI

See BEM 150 if a person is receiving Supplemental Security Income (SSI).

Recently Eligible for SSI

If SSI eligibility based on disability or blindness was terminated due to **financial** factors, continue medical eligibility for MA. Medical development and DDS certification are **not** initially required. Schedule a medical review 12 months from the date of SSI termination; see BAM 815.

Note: The client must meet all financial and other nonfinancial factors for SSI-related MA.

Eligible for RSDI

A person eligible for Retirement, Survivors and Disability Insurance (RSDI) benefits based on his disability or blindness meets the disability or blindness criteria. Disability or blindness starts from the RSDI disability onset date established by the Social Security Administration (SSA). This includes a person whose entire RSDI benefit is being withheld for recoupment. No other evidence is required.

RSDI Eligibility Established After MA Denial

Process a previously denied application as if it is a pending application when all of the following are true:

- The reason for denial was that the DDS determined the client was **not** disabled or blind, **and**
- The Social Security Administration (SSA) subsequently determined that the client is entitled to RSDI based on his disability/ blindness for some or all of the time covered by the denied MA application.

Follow MA policies including verification of income, assets and receipt of RSDI based on disability/blindness. All eligibility factors must be met for each month MA is authorized.

Note: If more than one MA denial notice was issued prior to the date the client informs DHS of the RSDI approval, determine eligibility beginning with the oldest application and its retro MA months.

Example:

April 2	Ms. G applied for MA including retro MA for January, February and March.
May 15	MA denied because the DDS determined Ms. G was **not** disabled.

August 4 Ms. G informs DHS that SSA approved her for RSDI based on disability. Ms. G's RSDI disability onset date is February 1.

Determine MA eligibility as if the April 2 application and associated retro application are still pending. Note that Ms. G. still does **not** meet the disability factor for January.

DISABILITY/ BLINDNESS DETERMINATIONS AND REFERRALS

Not Eligible For RSDI

If the client is **not** eligible for RSDI based on disability or blindness:

- The Disability Determination Service (DDS) certifies disability and blindness.

Exception: The Social Security Administration's (SSA's) final determination that the client is **not** disabled/blind for SSI, **not** RSDI, takes **precedence** over an DDS determination; see **Final SSI Disability Determination** in this item.

Final SSI Disability Determination

SSA's determination that disability or blindness does **not** exist for SSI is **final** for MA if:

- The determination was made after 1/1/90, **and**
- No further appeals may be made at SSA; see EXHIBIT II in this item, **or**
- The client failed to file an appeal at any step within SSA's 60 day limit, **and**
- The client is **not** claiming:
  - A totally different disabling condition than the condition SSA based its determination on, **or**
  - An additional impairment(s) or change or deterioration in his condition that SSA has **not** made a determination on.

Eligibility for MA based on disability or blindness does **not** exist once SSA's determination is **final**.

DDS

A client not eligible for RSDI based on disability or blindness must provide evidence of his disability or blindness.

Do **all** of the following to make a referral to the DDS:

- Obtain an DHS-49-F, Medical-Social Questionnaire, completed by the client.

Note: The DDS will determine disability/blindness for retro months even if retro MA is **not** requested by the client at application. If the client subsequently applies for retro MA, refer to the DHS-49-A, Medical/Social Certification, for the disability determination for those retro months.

BAM 815 contains the procedures to process the medical determination.

Do **not** refer the client for a medical determination if the case contains a valid DDS certification. **Valid** means **all** of the following:

- SSA's determination that the client is **not** disabled or blind for SSI purposes is **not final** as defined in this item.
- The medical review is **not** due or past due.
- The client continues to be unable to engage in substantial gainful activity.
- The client's condition is the same.

Client Cooperation

The client is responsible for providing evidence needed to prove disability or blindness. However, assist the customer when they request or need help to obtain it. Such help includes the following:

- Scheduling medical exam appointments.
- Paying for medical evidence and medical transportation.

See BAM 815 and BAM 825 for details.

A client who refuses or fails to submit to an exam necessary to determine disability or blindness **cannot** be determined disabled or

blind and you should deny the application or close the case. It is not necessary to return the medical evidence to DDS for another decision in this instance.

Hearings

Requests for administrative hearings regarding MDDHS determinations, such as MDDDS denials or the calculation of a deductible amount, are heard by DHS.

However, MDDHS **cannot** conduct hearings regarding the issue of disability or blindness when SSA made the determination. These requests must be filed at SSA.

If a client or authorized hearings representative (AHR) insists upon requesting a MDDHS hearing regarding the disability or blindness issue **and** SSA made the determination:

- Forward the request and completed hearing summary to Michigan Office of Administrative Hearings and Rules (MOAHR). Include a statement on the hearing summary indicating the hearing request should be denied because the disability or blindness denial was SSA's determination. MOAHR will deny the request.
    - Negative action must take effect and remain in effect if SSA's determination is **final** as defined under Final SSI Disability Determination in this item.

See **DEFINITIONS** in the Bridges Policy Glossary (BPG). Also see Denial of a Hearing Request in BAM 600 if the request includes an issue(s) in addition to disability/blindness.

Treatment Requirement (Disability Only)

The DDS evaluates each disability case for treatment.

Notify the client when the DDS orders treatment. The client **must** undergo the treatment, unless he has good cause **not** to. The DDS decides if the client has good cause to refuse treatment.

Exception: Do **not** apply the treatment requirement to clients eligible for RSDI based on disability.

Treatment is:

- Vocational rehabilitation, including basic education and job training attempts to alleviate the impairment(s), including physical therapy, diet, mental health services, substance abuse therapy and limited surgery.

Good cause to refuse treatment includes such things as:

- Conflict with religious belief.
- Unusual health risks.
- Lack of transportation.
- Inability to pay treatment costs.

Trial Work Period (Disability Only)

A trial work period of three months allows disabled clients to test their ability to work. Any work done during the trial work period may **not** be used as evidence the person can engage in substantial gainful activity. (EXHIBIT I in this item explains substantial gainful activity.)

Refer the case to the DDS when a disabled client starts working and claims they are still disabled.

The DDS determines if the client is still disabled and a trial work period applies.

DDS Review of Disability or Blindness

Refer the client to the DDS to determine continued disability or blindness when **any** of the following occurs:

- The client is no longer eligible for RSDI based on disability or blindness.
- An administrative law judge requires a review.
- The DDS requires a review.

  Note: The DDS records a review date on the DHS-49-A, Medical-Social Eligibility Certification, when they certify disability or blindness. Forward a client completed DHS-49-F, Medical-Social Questionnaire, to the DDS to complete the review. Allow enough time before the due date to enable the DDS to process the review.

- SSA determines the client is **not** disabled or blind for SSI purposes and the client claims either of the following:
  - A totally different disabling condition other than the one upon which SSA based its determination.
  - An additional impairment(s), change, or deterioration in his condition that SSA has **not** reviewed.

Also refer a disabled client to the DDS to determine continued disability when the client:

- Is working but claims to still be disabled.
- Completes treatment.
- Has improved health.
- Refuses treatment.

Describe what has happened in a memo to the DDS. Send the evidence of impairment in the case record. If a referred client refuses treatment, include an explanation of efforts made to involve them in treatment. The DDS will request any additional evidence needed.

VERIFICATION REQUIREMENTS

At application and redetermination, verify any of the following that apply to the case:

- Eligibility for RSDI based on disability or blindness
- Death
- DDS certification of disability or blindness when **all** of the following are true:
  - Client is **not** eligible for RSDI based on disability or blindness.
  - Client is **not** deceased.
  - SSA's determination that the client is **not** disabled or blind for SSI purposes is **not final**.

Verify filing of timely appeal when SSA has determined a client is **not** disabled or blind for SSI purposes.

Sources of Verification

Receipt of RSDI based on disability/blindness:

- Correspondence from SSA.
- SOLQ.
- Telephone contact with SSA.
- BENDEX (disability only). (Report coding does **not** distinguish blind from the disabled.)
- SSA-1610.

Death:

- Death certificate.
- Newspaper clipping.
- Funeral bill.
- Other document specifying date of death.

DDSSRT Certification:

- DHS-49-A, Medical-Social Eligibility Certification, based on:
  - DHS-49, Medical Examination Report.
  - DHS-49-D, Psychiatric/Psychological Examination Report.
  - DHS-49-E, Mental Residual Functional Capacity Assessment.
  - DHS-49-F, Medical-Social Questionnaire.
  - DHS-49-I, Eye Examination Report.
  - Other equivalent narrative reports.
- Medical evidence of disability must be based on the findings of an M.D. or D.O. or fully licensed psychologist.

  Note: Any medical evidence of disability submitted by a Physician's Assistant must be co-signed by an M.D. or D. O.
- Medical evidence of blindness must be based on the findings of a(n):

- Board-certified ophthalmologist.
- Licensed optometrist.
- M.D. or D.O. resident in ophthalmology.
- M.D. or D.O. eligible to pass board in ophthalmology.

Timely appeal at SSA:

- Copy of SSI appeal form (SSA-561 or HA-501).
- SOLQ.
- HR-070.
- Correspondence from SSA.
- Documented contact with SSA.
- Legal documents indicating appeal filed.

Bridges

Enter the medical review date (MRDT) set by the DDS or administrative law judge.

EXHIBIT I - DISABILITY, SUBSTANTIAL GAINFUL ACTIVITY AND BLINDNESS

Disability

A person is **disabled** when **all** of the following are true:

- They have a medically determined physical or mental impairment.
- Their impairment prevents them from engaging in any substantial gainful activity.
- Their impairment
  - Can be expected to result in death, or
  - Has lasted at least 12 consecutive months, or
  - Is expected to last at least 12 consecutive months.

Substantial gainful activity means a person does ALL of the following:

- Performs significant duties, and
- Does them for a reasonable length of time, and
- Does a job normally done for pay or profit.

Significant duties are duties used to do a job or run a business. They must also have a degree of economic value. The ability to run a household or take care of oneself does **not**, on its own, constitute substantial gainful activity.

A child under age 18 is **disabled** when they suffer from a medically determined impairment(s) of comparable severity. Significant duties for a child include age-related tasks and abilities.

Blindness

A person is determined **blind** when either:

- The visual acuity in his better eye can only be corrected to 20/200 or less, **or**
- The widest diameter of the visual field in his better eye is limited to an angle 20 degrees or less.

EXHIBIT II - GENERAL INFORMATION ABOUT THE SSA APPEALS PROCESS

When the Social Security Administration (SSA) determines that a client is **not** disabled/blind for SSI purposes, the client may appeal that determination at SSA.

The **SSA Appeals Process** consists of 3 steps:

1. Reconsideration (If initial application filed prior to October 1, 1999).
2. Hearing.
3. Appeals Council.

SSA has no time limits for making decisions on appeals.

The client, however, has **60 days** from the date he receives a denial notice to appeal each of the following SSA actions:

- Determinations.
- Reconsiderations.
- Hearings.

Reconsideration is filed at the Social Security Administration. A DDS employee, other than the one who decided the client was **not** disabled/blind, reviews the determination. Most reconsiderations uphold the original decision.

A reconsideration is **not** completed for SSI applications filed after October 1, 1999.

Hearings are conducted by an administrative law judge (ALJ). The ALJ renders a new decision based on a review of the material, questions asked at the hearing, testimony of witnesses and new evidence submitted.

Appeals Council can deny or dismiss an appeal from the hearings level, **or** grant the request by issuing a new decision or remanding the case back to an ALJ. Most appeals are denied or dismissed at this step.

If the Appeals Council upholds the ALJ's decision, there are no further appeals at SSA. The client may contest SSA's decision at the appropriate federal district court.

EXHIBIT III - SSI DENIAL AND APPEAL CODES ON THE HR-070

The HR-070, SSI Update Report, is produced at least once a week. Part 2 of the report contains SSI denial and appeal codes.

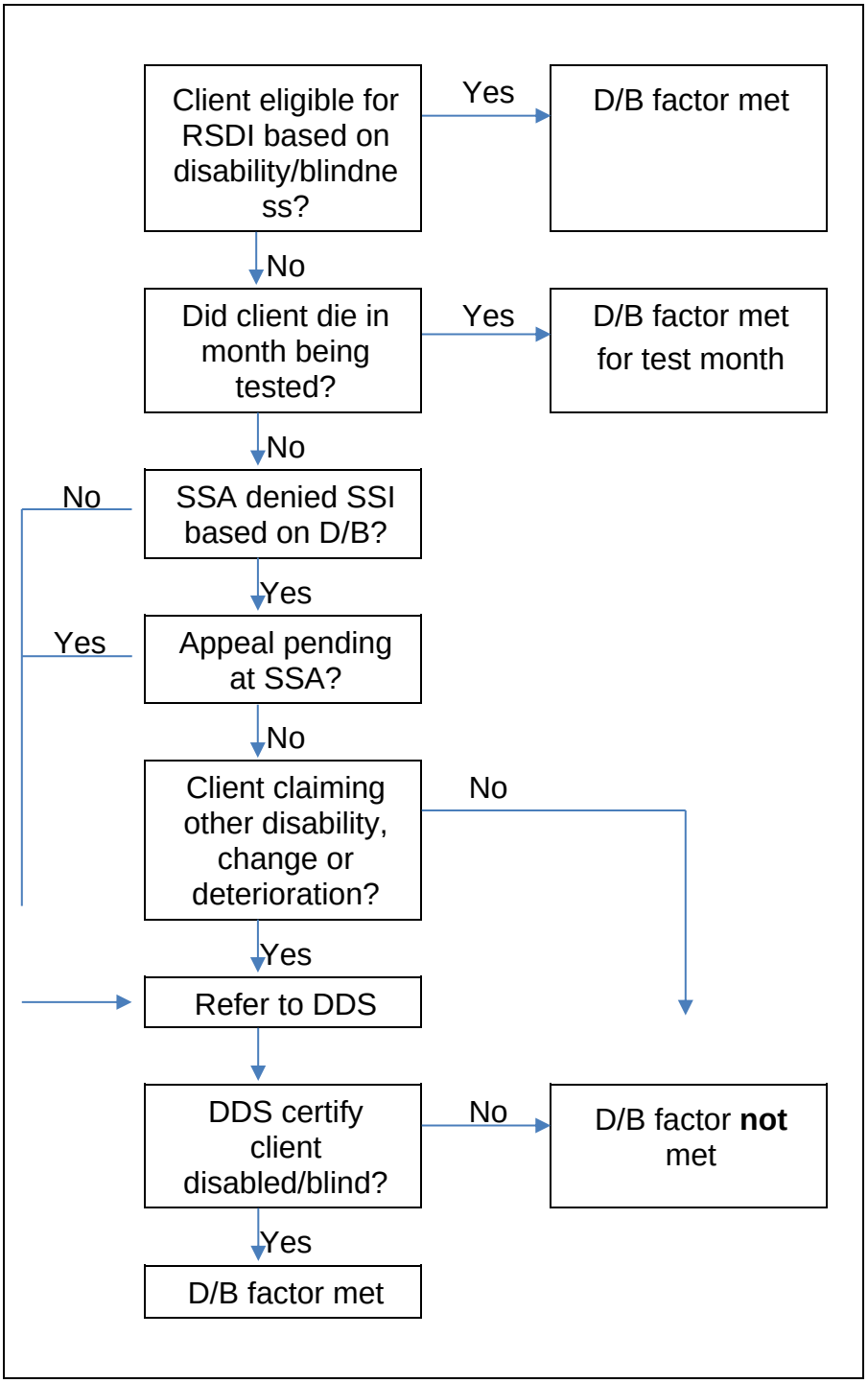
SSI disability/blindness **denial** codes are:

- N07
- N08
- N15
- N16
- N27
- N30
- N31
- N32
- N33
- N34
- N35
- N40
- N41
- N42
- N43
- N44
- N45
- N46
- N51

Relevant **appeal** codes are:

- **Appeal request filed**
  - A (reconsideration).
  - P (hearing).
  - W (appeals council).
- **Appeal dismissed, denied or withdrawn**
  - B - Dismissed or withdrawn (reconsideration).
  - C - Prior decision affirmed (reconsideration).
  - Q - Dismissed or withdrawn (hearing).
  - R - Prior hearing decision reaffirmed (hearing).
  - X - Withdrawn or dismissed (appeals council).
  - Y - Prior decision affirmed (appeals council).

EXHIBIT IV - MEETING THE MA DISABILITY/ BLINDNESS (D/B) FACTOR



LEGAL BASE

MA

Disability

42 CFR 435.540, .541
MCL 400.106

Blindness

42 CFR 435.530, .531
MCL 400.106

DEPARTMENT POLICY

State Disability Assistance (SDA)

To receive SDA, a person must be disabled, caring for a disabled person, or age 65 or older.

DEFINITIONS

Participation

Participation in a substance abuse/mental health treatment program which meets the requirements established by the treatment provider.

Material to the Determination of Disability

Used in reference to substance abuse, this phrase means that, if the person stopped using drugs or alcohol, his or her remaining physical or mental limitations would not be disabling.

Substance Abuse

The use of alcohol or drugs which results in a physical or mental impairment, as documented by objective medical findings.

Substance Abuse Treatment Program

Any program for the treatment of substance abuse, including self-help programs such as Alcoholics Anonymous.

DISABILITY

A person is disabled for SDA purposes if he or she meets any of the following criteria:

- Receives other specified disability-related benefits or services; see Other Benefits or Services in this item.
- Resides in a qualified Special Living Arrangement (SLA) facility.

- Is certified as unable to work due to mental or physical disability for at least 90 days from the onset of the disability.
- Is diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

Note: If the client's circumstances change so that the basis of his/her disability is no longer valid, determine if he/she meets any of the other disability criteria. Do **not** simply initiate case closure.

Other Benefits or Services

Persons receiving one of the following benefits or services meet the SDA disability criteria:

- Retirement, Survivors and Disability Insurance (RSDI), due to disability or blindness.
- Supplemental Security Income (SSI), due to disability or blindness.
- Medicaid (including deductible) as blind or disabled if the disability/blindness is based on:
  - A Disability Determination Service (DDS) determination, or
  - A hearing decision, or
  - Having SSI which was based on blindness or disability that was recently terminated (within the past 12 months) for financial reasons; see Recently Eligible for SSI in BEM 260.

    Medicaid received by former SSI recipients based on policies in BEM 150 under SSI TERMINATIONS, including MA While Appealing Disability Termination, does not qualify a person as disabled for SDA. Such persons must be certified as disabled or meet one of the other SDA qualifying criteria; see Medical Certification of Disability in this item.
- Michigan Rehabilitation Services (MRS). A person is receiving services if he has been determined eligible for MRS and has a signed active individual plan for employment (IPE) with MRS. Do **not** refer or advise applicants to apply for MRS for the purpose of qualifying for SDA.

- Michigan Bureau of Services for Blind Persons (BSBP), formally known as the Commission for the Blind. A person is receiving services if he has been determined eligible for BSBP and has an active BSBP case.

- Special education services from the local intermediate school district. To qualify, the person may be either of the following:

  - Attending school under a special education plan approved by the local Individual Educational Planning Committee (IEPC).

  - Not attending under an IEPC approved plan but has been certified as a special education student **and** is attending a school program leading to a high school diploma or its equivalent, **and** is under age 26. The program does not have to be designated as special education as long as the person has been certified as a special education student. Eligibility on this basis continues until the person completes the high school program or reaches age 26, whichever is earlier.

- Refugee or asylee who lost eligibility for SSI due to exceeding the maximum time limit.

Special Living Arrangements

Persons admitted to a qualified SLA facility meet the SDA disability criteria.

Qualified SLA facilities are:

- Homes for the aged.
- County infirmaries.
- Adult foster care homes.
- Substance abuse treatment centers (SATC).

See BEM 615 for descriptions of these facilities.

In addition, a person receiving post-residential substance abuse treatment meets SDA disability criteria for 30 days following discharge from the SATC. To qualify, the person must:

- Have received SDA while residing in the SATC, **and**
- Continue outpatient substance abuse treatment immediately following discharge.

Note: If a client states they have a plan and a scheduled date to continue outpatient substance abuse treatment, then they would be eligible for the 30 days post treatment SDA.

Medical Certification of Disability

When the person does not meet one of the criteria under Other Benefits or Services or Special Living Arrangements, follow the instructions in BAM 815, Medical Determination and Disability Determination Service (DDS), Steps for Medical Determination Applications. The DDS will gather and review the medical evidence and either certify or deny the disability claim based on the medical evidence.

The DDS will deny the disability claim if the medical evidence shows that substance abuse is a contributing factor material to the determination of disability. The DDS may approve the disability claim if the medical evidence shows that substance abuse is **not** material to the determination of the disability.

CARETAKER OF A DISABLED PERSON

A caretaker of a disabled person may receive SDA provided that the assistance of the caretaker is medically necessary for at least 90 days and the caretaker and the disabled person live together.

Assistance means personal care services and includes meal preparation, laundry, food shopping, errands, light cleaning, non-nursing personal care (bathing, dressing, etc.) and assistance with medication.

The disabled person does not have to be related to the caretaker or receive SDA.

AGE

Persons age 65 or older may receive SDA.

Refer persons age 65 or older to the Social Security Administration (SSA) to apply for SSI; see BEM 270 and BEM 271.

SPECIAL DIAGNOSIS

Person diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

VERIFICATION REQUIREMENTS

Verify the disability or the need for a caretaker at application, redetermination, when required by the DDS, or as needed when the client's circumstances change. Verify age only if the client's statement is inadequate or inconsistent.

Verify participation in substance abuse treatment at each medical review.

If the client's circumstances change so that the verification method used to establish eligibility is no longer valid, obtain new verification following policy in BAM 130. (For example, a client no longer participating in Special Education may now have to provide medical evidence.) Do **not** immediately send a negative action notice for case closure. First request verification according to policy in BAM 130.

VERIFICATION SOURCES

SSI or RSDI

- Correspondence from the SSA.
- ED-030, BENDEX Report.
- Single Online Query (SOLQ) Response.

Vocational Rehabilitation Services

MRS or BSBP

- DHS-4698, Verification of Vocational Rehabilitation Status.
- Other statement from MRS or BSBP.
- Current (within the last 12 months) signed copy of the client's individual plan for employment (IPE).

Special Education Services

Statement from the local or intermediate school district.

Special Living Arrangements

Confirmation from the facility.

Substance Abuse Treatment

- Form DHS-4762, Verification of Substance Abuse Treatment.
- Other statement from the treatment provider.

The verification must be signed by the treatment provider. Verification from self-help groups such as Alcoholics Anonymous or Narcotics Anonymous is acceptable.

Medical Certification

DHS-49-A, Medical-Social Eligibility Certification, showing DDS approval for SDA.

Caretaker of a Disabled Person

- DHS-54A, Medical Needs.
- Statement by a M.D. or D.O. that the client is needed in the home to provide personal care to the disabled household member for at least 90 days. The statement must include the diagnosis and the length of time care is needed.

LEGAL BASE

SDA

Annual Appropriations Act

Michigan Administrative Code R400.3115 - R400.3180

DEPARTMENT POLICY

All Programs

Residents of institutions can qualify for certain program benefits in limited circumstances. This item explains how institutional status affects eligibility.

DEFINITIONS

All Programs

- **Institution** means an establishment furnishing food, shelter and some treatment or services to more than three people unrelated to the proprietor.
- **Institution for Mental Diseases** means a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment or care of persons with mental diseases.
- **Government-operated facility** means a facility over which a governmental unit has responsibility or exercises administrative control. It includes a facility owned or leased by a governmental agency and administered through the agency's salaried staff.
- **Public nonmedical institution** means a government-operated facility that does not provide medical care (for example, jail or prison, juvenile detention or secure short-term detention). A community residence facility for fewer than 17 people or a school is not considered a public nonmedical institution.
- **Psychiatric facility** means a private or government-operated institution engaged primarily in diagnosing or caring for persons with mental disease. It does not include the psychiatric ward of a hospital **or** a facility for an individual with a developmental disability.
- **Entire calendar month** means a period that begins any time on the first day of a calendar month and ends any time on the last day of that month.

OVERVIEW

Family Independence Program (FIP)

A person in an institution other than a hospital, psychiatric hospital, or residential substance abuse treatment center for more than 30 days is not eligible. Presume that a person placed in an institution will remain there more than 30 days **unless** a shorter stay is verified.

State Disability Assistance (SDA)

A person in an institution other than those listed in the **Exceptions** below for more than 30 days is not eligible. Presume that a person placed in an institution will remain there more than 30 days unless a shorter stay is verified.

Exception: A person in one of the following institutions may be eligible, regardless of the length of stay:

- Hospital.
- Home for the Aged.
- County Infirmary.
- Adult Foster Care Home.
- Substance Abuse Treatment Center.
- Long Term Care (LTC) facility.
- Department of Corrections contract facility for probationers.
- Technical Institute and Rehabilitation Center operated by Michigan Rehabilitation Services.

FAP Only

A person in a facility which provides its residents a majority of their meals can qualify for FAP **if** the facility:

- Is authorized by the Food and Nutrition Service (FNS) to accept Food Assistance; **or**

- Is an eligible group living facility as defined in Bridges Eligibility Manual (BEM) 615.

The resident must also meet the criteria in the ELIGIBLE PERSONS section in BEM 617.

JAILS OR PRISONS (INCLUDING SECURED SHORT-TERM DETENTION)

Medicaid (MA)

An individual can remain eligible and an applicant can be determined eligible for Medicaid during a period of incarceration.

Medicaid coverage is limited to off-site inpatient hospitalization only.

The facility is responsible for all other medical services provided to these individuals. The case should be maintained in the local office in which the individual resided before the incarceration.

An individual is in jail, prison or detention until released:

- On bail, **or**
- As not guilty, **or**
- On parole, **or**
- On pardon, **or**
- Upon completing the sentence, or
- Under home detention (tethered), or
- Dismissal of court petition.

Update the living arrangement screen when notified of an individual's incarceration or release.

OTHER PUBLIC NONMEDICAL INSTITUTIONS

MA

A resident of a public nonmedical institution (other than a jail or prison, juvenile detention or secure short-term detention) can qualify for full MA coverage **if**:

- The individual was placed there on an **emergency** basis pending a suitable placement; **or**

- The individual was, or is expected to be, a resident for **less** than the entire calendar month being tested.

The individual is a resident of such an institution until he is away to receive medical care (for example hospital care) **or** leaves and is not expected to return.

Institution For Mental Diseases

MA

An individual between the ages of 21 and 65 who is a resident of an Institution for Mental Diseases (IMD) may be eligible for MA. Medicaid coverage is limited to off-site inpatient hospitalization only. If the individual is an inpatient of an IMD when the individual turns age 21, the individual is eligible to continue as an inpatient until age 22. (MA coverage would remain as full coverage until age 22).

Michigan IMDs

IMDs in Michigan are:

- Walter Reuther Psychiatric Hospital.
- Caro Psychiatric Hospital.
- Kalamazoo Psychiatric Hospital.
- Center For Forensic Psychiatry.
- Hawthorne Center (for children).

Psychiatric Facilities

MA

An individual aged 22 through 64 in a psychiatric facility can qualify for MA. Medicaid coverage is limited to off-site inpatient hospitalization only.

The individual is a resident of such a facility until discharged **or** absent for a convalescent leave to experience living outside the facility.

LEGAL BASE

FIP

Act 280 of 1939, as amended
P.L. 104-193 of 1996

MA

42 CFR 435.1008,1009, 440.150,155,160

FAP

7 CFR 273.11(e)

SDA

P.A. 368 of 1996

DEPARTMENT POLICY

FIP, SDA, and Medicaid

As a condition of eligibility individuals must apply for any state and/or federal benefits for which they may be eligible. This includes taking action to make the entire benefit amount available to the group.

Any action by the individual or other group members to restrict the amount of the benefit made available to the group causes ineligibility.

Exception: Receipt of reduced Veterans Administration benefits does not constitute a failure to pursue benefits.

Except for contractual care arrangements, the requirements in this item **do not** apply to a past month determination for MA when the applicant has taken action to apply for potential benefits.

FIP, SDA and RCA

Refusal of a program group member to pursue potential benefits result in group ineligibility.

Individuals applying for or receiving disability-related MA must apply for SSI as a potential resource.

A repay agreement is required when there is a potential benefit for state-funded FIP/SDA individuals; see BEM 272, State-Funded FIP, and SDA Repay Agreements.

Medicaid Only

Refusal to pursue potential benefits result in the individual's ineligibility.

An individual is required to apply for coverage under Medicare Part A, B and or D if it is likely that the individual would meet the eligibility criteria for any or all of those programs.

Exception: Pursuit of Benefits does not apply to beneficiaries covered under Pregnant Women.

CDC Only

Applicants for income eligible CDC should be made aware of other Michigan Department of Health & Human Services (MDHHS) programs and services they may be potentially eligible for and provided the MDHHS-1171, Assistance Application and MDHHS-1171-CDC, Supplement- Child Development and Care, if interested. However, the applicant is not required to apply for MDHHS programs.

TYPES OF POTENTIAL BENEFITS

The following can be a potential benefit:

- Retirement, Survivors, and Disability Insurance (RSDI).
- Supplemental Security Income (SSI).
- Worker's Compensation benefits.
- Veterans Administration benefits.
- Railroad Retirement benefits.
- Unemployment benefits (UB).
- Contractual care arrangement.
- Child support.
- Other potential benefits.
- Department benefits.
- Medicare part A, B, and/or D.

Retirement, Survivors, and Disability Insurance (RSDI)

FIP, SDA, RCA, CDC, and Medicaid

RSDI benefits are payable to a wage earner and/or his/her dependents. The benefits are administered by the Social Security Administration (SSA). The wage earner must be covered by Social Security and must be one of the following:

- Retired and at least age 62.
- Disabled or blind.
- Dead.

RSDI are potential benefits for all of the following persons:

- A person who is blind.

- A person who is retired and at least age 62.
- A person who claims illness or injury prevents him from working for at least 12 months.
- A person whose spouse is retired, disabled or dead.
- A child whose parent is retired, disabled or dead.

Supplemental Security Income (SSI)

FIP, SDA, RCA and CDC

SSI benefits are paid to persons who are aged (65 or older), blind or disabled. The following individuals must be referred to SSA to apply for SSI:

- Persons age 65 or older.
- Person applying, receiving or eligible for SDA and disability-related MA.
- Adults in a FIP group who are deferred more than 90 days from work related activities.
- Children who are blind or disabled. A child is considered disabled for SSI purposes if the child meets all of the following:
  - The child has a physical or mental condition(s) that can be medically proven.
  - The condition(s) results in **marked and severe** functional limitations.
  - The condition has lasted or is expected to last at least 12 months or end in death.
  - The child is not working at a job considered substantial work by SSA.

Medicare Part A and B

Medicare benefits are available to persons who are aged (65 or older), living with a disability, or with end state renal disease.

Medicare part A, B, D, are potential benefits for a person:

- Who is least age 65.
- Receiving disability under RSDI.

Worker's Compensation Benefits

FIP, SDA, RCA, CDC, and Medicaid

Worker's Compensation benefits are potential benefits paid to a person who has a job-related illness or injury. Claims are filed through the employer.

Veterans Administration Benefits

FIP, SDA, RCA, CDC and Medicaid

Veterans Administration (VA) benefits are administered by the VA and are paid to a disabled veteran, his/her survivors and dependents.

VA benefits are potential benefits for the following persons:

- A disabled veteran, his/her spouse and child(ren).
- The unmarried spouse of a deceased veteran.
- The child of a deceased veteran.

Railroad Retirement Benefits

FIP, SDA, RCA, CDC and Medicaid

Railroad Retirement benefits are administered by the U.S. Railroad Retirement Board and are payable to a wage earner employed by railroad or railroad-related industries and/or his/her dependents. The wage earner must be covered by Railroad Retirement and must be one of the following:

- Retired and at least age 60.
- Disabled or blind.
- Dead.

Railroad Retirement benefits are potential benefits for the following persons:

- A person who is blind.
- A person who is retired and at least age 62.
- A person who claims illness or injury prevents him from working for at least 12 months.
- A person whose spouse or divorced spouse receives Railroad Retirement benefits.
- A person whose spouse or divorced spouse is dead.
- A child whose parent receives Railroad Retirement benefits.
- A child whose parent is dead.

Unemployment Benefits

FIP, SDA, RCA, CDC and Medicaid

Unemployment benefits (UB) are cash payments to an unemployed person. The program is administered by the Michigan Unemployment Insurance Agency (UIA), a division of the Department of Talent and Economic Development (TED).

Note: Michigan unemployed workers may apply for unemployment benefits online through an internet filed claim service.

Potential UB eligibility usually exists if the person is employable and:

- Worked during the past 12 months **unless** it was self-employment or employment in a job that was not covered by UB.
- Has a UIA determination which indicates that he/she should reapply for UB at a later date.
- Has exhausted benefits during a benefit year but should now reapply for UB because he/she returned to work and then became unemployed again.
- Has exhausted benefits during a benefit year which has ended and should now reapply for UB.

Contractual Care Arrangement

Medicaid Only

A contractual care arrangement means there is a contract between an individual and another party which:

- Obligates the other party to provide or pay for all of the individual's medical care; **and**
- The obligation is not dependent on the individual's current income, assets or payments to the other party; **and**
- The other party is currently meeting the obligation.

An institutionalized individual with a contractual care arrangement is **not** eligible for Medicaid.

Child Support

FIP, CDC and Medicaid

Refer to BEM 255 for policy regarding pursuit of child support payments.

Other Potential Benefits

FIP, SDA, RCA, CDC and Medicaid

The following types of income can also be a source of potential benefits:

- Black Lung benefits.
- Railroad unemployment benefits.
- Pension payments.
- Disability or retirement benefits.
- Earned but unpaid wages.
- Strike pay.
- Vacation pay.
- Supplemental unemployment benefits.

Department Benefits

SDA

Potentially eligible SDA individuals must apply for financial and/or medical assistance provided for by the Department. The individual must cooperate in all actions necessary to determine eligibility for these other programs.

VERIFICATION REQUIREMENTS

FIP, SDA, RCA, and Medicaid

For individuals applying for FIP, SDA, RCA and disability-related MA, verification must be obtained from SSA that an application or appeal is on file **before** the case is referred to the DDS.

For FIP/SDA/RCA individuals receiving disability-related Medicaid, verification must be obtained from SSA that an SSI application or appeal is on file at program redetermination and medical determination review.

Document in case comments what verification was provided.

A Michigan SOAR Project Consent for Release of Information form may be used to verify a pending SSI application for an individual if ALL of the criteria listed below are met:

- The form has a SSA Liaison name listed.
- There is a SSA Field Office Code.
- Date of response is within 60 days. This form of verification is only acceptable for 60 days from the date of response. After 60 days the SOLQ should show a pending SSI application. If the SOLQ does not show a pending SSI application, verification must be provided by the individual.

Sources of Verification

Contractual Care Arrangement:

- Copy of contract.
- Correspondence or other contact with other party.

SSI:

- Single Online Query (SOLQ).
- DHS-1552, Verification of Application for SSI from SSA.
- Correspondence from SSA.
- Telephone or other contact with SSA.

Other:

- Correspondence from source of benefit.
- Telephone or other contact with source of benefit.
- DHS-3975, Reimbursement Authorization.
- DHS-2157, Repay Agreement.

LEGAL BASE

FIP

P.A. 280 of 1939, as amended.

SDA

DHS Annual Appropriations Act
Mich Admin Code, R 400.3151 - 400.3180

RCA

45 CFR 400.51

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

MA

42 CFR 435.608
MCL 400.106(2)(b)(ii)

DEPARTMENT POLICY

State-Funded FIP, SDA

The department's interim assistance reimbursement (IAR) process helps ensure recovery of interim state-funded Family Independence Programs (FIP) and State Disability Assistance (SDA) benefit payments when the client is later determined eligible for Supplemental Security Income (SSI) for a retroactive period; see BEM 270, Pursuit of Benefits, and BEM 272, Repay Agreements.

The disability standard for both disability-related MA and SSI is the same; see BEM 260, MA Disability/Blindness. The federal SSI benefit payment rates are substantially higher than the state-funded FIP/SDA payment rates. It is a benefit to both the state-funded FIP/SDA recipient and the state when the individual is determined eligible for federal SSI benefits.

Clients who receive state-funded FIP or SDA who meet potential eligibility for SSI **or** have a Disability Determination Service (DDS) decision that indicates they meet the criteria for MA based on blindness or disability are required to pursue SSI; see BEM 270, Pursuit of Benefits.

State-Funded FIP

Refer state-funded FIP clients to the Social Security Administration (SSA) to apply for or appeal SSI after a client has verified a disability lasting longer than 90 calendar days or if the individual also receives MA based on a DDS decision that he/she is blind or disabled.

SDA

Refer SDA clients to the SSA to apply for or appeal SSI when they also receive or have been found as potentially eligible for MA based on a DDS decision that he/she is blind or disabled.

Client Responsibilities

SDA clients receiving or those who have been found eligible for disability-related MA **must** comply with the requirements listed in this item. These clients **must** also cooperate with all SSA requirements and procedures when applying for SSI benefits. Failure to comply as required results in group ineligibility for SDA.

Local Office Responsibilities

Each local office **must** establish a system to:

- Identify potential SSI recipients.
- Refer SDA clients receiving or those who have been found eligible for disability-related MA to the SSA to apply for SSI.
- Monitor clients' progress through the SSI application and appeals process.
- Ensure that medical information (copy of the medical packet) is promptly forwarded to the Disability Determination Service (DDS) for consideration during the SSI initial application process.
- Submit a copy of a death certificate to SSA for clients who die while SSI is pending. This is obtained from the county clerk or the recipient's family. It is needed to request reimbursement from SSA for interim benefits.
- Clients must sign a DHS-3975, Reimbursement Authorization, as a condition of eligibility for state-funded FIP/SDA; see BEM 272, State-Funded FIP and SDA Repay Agreements.

  Note: Each local office must establish a procedure to make sure the DHS-3975 is signed by the client for state-funded FIP and SDA **before** the medical determination application information is sent to the DDS. The DHS-3975 is submitted to SSA to help ensure that the department will be able to successfully recover state funds issued while an SSI claim is pending. SSI lump sum payments are issued by SSA directly to the department's Payment Reconciliation Section (PRS) through the IAR process.

The local office must ensure that the client meets the time limits specified in this item for the following actions, if required:

- SSI application.
- SSI reconsideration request; see Request Reconsideration in this item.
- SSI hearing request.

- SSI appeals council review.

Use a DHS-4098, SDA/SSI Referral Checklist, to assist in completing these responsibilities and adhering to SSI time limits and deadlines.

Local Office Procedures for SSI Referral and Application

Refer to the DHS-4098, SDA/SSI Referral Checklist, when reviewing the following procedures. The DHS-4098 is an abbreviated, outline version of the local office procedures that is intended to assist in tracking a client's progress through the SSI application and appeals process. File the DHS-4098 in the front of each case record.

1. Receive information that an applicant or recipient meets the criteria for both SDA and MA based on disability or blindness based on a DDS, or administrative law judge (ALJ) decision that the client is blind or disabled.

2. Use a DHS-1551, Notice to Apply, to contact the client within 10 calendar days to arrange an interview.

3. Interview the client.

4. Verify that the client has filed an SSI application. Verification includes:

   - A copy of the DHS-1552.
   - Single Online Query (SOLQ).
   - Documented telephone contact or written verification from SSA.

5. If an SSI application has not been filed, go to No SSI Claim Filed with SSA.

6. If an **SSI application has already been filed,** go to SSI **Claim Pending With SSA.**

No SSI Claim Filed with SSA

1. Refer the client to SSA to file an SSI application.

Note: The client can establish a **protected filing date** for SSI benefits by taking the following actions:

- Calling SSA (toll-free at 1-800-772-1213).
- Indicating the intent to apply for SSI.
- Obtaining a scheduled appointment date and time with an SSA district office to file the formal SSI application.

Note: The local office can expedite the filing of the initial SSI application by providing the client with access to a telephone for the toll-free call to SSA.

2. Have the client sign the following:

   - DHS-1555, Authorization to Release Protected Health Information.
   - DHS-3975, Reimbursement Authorization.

   Note: A new DHS-3975 must be signed at every reapplication for SSI **and before** the medical determination application information is sent to DDS.

3. Approve client for SDA and disability-related MA.

4. Complete a DHS-1551, Notice to Apply, to notify the client in writing to keep the scheduled appointment with SSA and file the formal SSI application. Give the client the original DHS-1551. File a copy in the medical packet.

5. Send the following items to SSA:

   - DHS-3975.
   - A return envelope.
   - DHS-1552.

6. File the original DHS-1555 in the medical packet.

7. Verify whether the client has filed an application for SSI within 10 calendar days. Acceptable verification includes:

   - A copy of the DHS-1552.
   - Single Online Query (SOLQ).
   - Documented telephone contact or written acknowledgment from SSA.

8. Allow an extension if the client is unable to file an SSI application within the 10-calendar-day limit for any of the following reasons:

   - The client is ill.
   - The client's county of residence does not have an SSA district office.
   - SSA is unable to schedule an appointment within 10 calendar days. Allow the client to verify he/she has a scheduled appointment date and time to file the formal SSI application.

9. If the client is cooperating with the SSI application process, continue to step 10. **If the client is not cooperating, close state-funded FIP/SDA and MA-P.** End procedure.

10. Send a copy of the medical packet to the disability examiner at the DDS **after the client has applied for SSI**. Use DHS-1992, -1993, -1994, -1995, SSI Medical Evidences Routine Slip, to transmit a copy of medical evidence to DDS. Use the appropriate Medical Evidence Route Slip for the DDS office serving your local office. Use an interdepartmental mail envelope to preserve confidentiality.

11. Go to Monitoring the SSI Application below.

SSI Claim Pending with SSA

1. Have the client sign the following:

   - DHS-1555, Authorization to Release Protected Health Information.
   - DHS-3975, Reimbursement Authorization.

   Note: A new DHS-3975 must be signed **at every** reapplication for SSI **and before** sending the medical determination application information to DDS.

2. Approve client for SDA and MA based on disability.

3. Send all the following items to SSA:

   - DHS-3975.

- A return envelope.
- DHS-1552.

4. File the original DHS-1555 in the medical packet.

5. Send a **copy** of the medical packet to the disability examiner at DDS. Use a DHS-1992, -1993, -1994, or -1995, Medical Evidence Route Slip, to transmit a copy of medical evidence to DDS. Use the appropriate Medical Evidence Route Slip for the DDS office serving your local office. Use an interdepartmental mail envelope to preserve confidentiality.

Monitoring the SSI Application

1. Verify that SSA has correctly coded the pending SSI claim as **interim assistance**. Acceptable verification includes any of the following:

   - DHS-1552.
   - Single Online Query (SOLQ).
   - Documented telephone contact or written acknowledgment from SSA.

   Note: If the interim assistance code is incorrect, see BEM 272.

2. Review verification of the disposition of the SSI application:

   - If **approved**, advise the client to contact DHS immediately when the individual receives an SSI payment. End process.

   - If denied for **non-disability** reasons, review ongoing eligibility based on this information. End process.

   - If denied for **disability** reasons, go to Request an SSI Hearing in this item.

   Note: If a notification of disposition has not been received within 120 days of the date of the SSI application, determine the status of the SSI application. Acceptable verification includes any of the following:

   - DHS-1552.
   - Single Online Query (SOLQ).
   - Documented telephone contact or written acknowledgment from SSA.

Request Reconsideration

Applicants filing SSI applications in Michigan no longer have access to the reconsideration appeals step. Their first appeal step is to request a hearing. However, SSI applications filed in other states have access to this step in the appeals process.

Request an SSI Hearing

An SSI hearing **must** be requested within 60 days of the SSI application denial date. The specialist must:

1. Send the client a DHS-1551, a DHS-1552 marked “Appeal” and a return envelope.

2. Verify whether the client has requested an SSI hearing within 10 calendar days of the date the DHS-1551 is sent to the client. Acceptable verification of a request for an SSI hearing includes any of the following:

   - DHS-1552.
   - Single Online Query (SOLQ).
   - Documented telephone contact or written acknowledgment from SSA.

   Note: SSA does allow good cause for late filing. As a result, allow an extension if the client is unable to file the request for hearing at SSA within the 10-calendar-day limit for any of the following reasons:

   - The client is ill.
   - The client’s county of residence does not have an SSA district office.

3. If the client is cooperating with the SSI application process, continue with step 4. **If the client is not cooperating, close state-funded FIP/SDA and MA-P**. End procedure.

4. Review verification of the disposition of the SSI hearing:

   - If **approved**, advise the client to contact the department immediately when he/she receives an SSI payment. End process.

- If denied for **non-disability** reasons, review ongoing eligibility based on this information. End process.
- If denied for **disability** reasons, go to **Request an Appeals Council Review** below.

Note: If a notification of disposition is not received within 180 days of the date of the hearing request, determine the status of the SSI hearing request. Acceptable verification includes any of the following:

- DHS-1552.
- Single Online Query (SOLQ).
- Documented telephone contact or written acknowledgment from SSA.

Request an Appeals Council Review

An appeals council review request must be filed within 60 days of the SSI hearing decision date. The specialist must:

1. Send the client a DHS-1551, a DHS-1552 marked “Appeal” and a return envelope.
2. Verify whether the client has requested an appeals council review within 10-calendar-days of the date the DHS-1551 is sent to the client. Acceptable verification that an Appeals Council brief has been filed includes any of the following:

   - DHS-1552.
   - Single Online Query (SOLQ).
   - Documented telephone contact or written acknowledgment from SSA.

   Note: SSA does allow good cause for late filing. As a result, allow an extension if the client is unable to file the Appeals Council brief at SSA within the 10-calendar-day limit for any of the following reasons:

   - The client is ill.
   - The client’s county of residence does not have an SSA district office. The client or the client’s legal representative is still preparing the appeal.

3. If the client is cooperating with the SSI application process, continue with step 4. **If the client is not cooperating, close state-funded FIP/SDA and MA-P**. End procedure.

4. This verification may include any of the following:

   - DHS-1552.
   - Single Online Query (SOLQ).
   - SSA-831. Documented telephone contact or written acknowledgment from SSA.

5. If the appeals council decision is a denial, the decision is now binding on the MA case. The Final SSI Eligibility Determination procedures are listed below, as well as in BEM 260.

Final SSI Eligibility Determination

Once SSA's decision is **final**, the local office **must take the following actions:**

1. For clients receiving **SDA/MA**, SSA's determination that disability or blindness **does not exist** for SSI is **final and the SDA/MA case must be** processed for closure if:

   - The determination was made after January 1, 1990, **and**
   - No further appeals may be made at SSA; see Exhibit II in BEM 260, **or**
   - The client failed to file an appeal at any step within SSA's 60-day limit, **and**
   - The client is **not** claiming:
     - A totally different disabling condition than the condition SSA based its determination on, **or**
     - An additional impairment(s), change, or deterioration in his/her condition that SSA has reviewed and not made a determination on yet.

   Note: If the client alleges either condition listed above, obtain a new medical report and resubmit to the DDS for a new determination in accordance with BEM 260.

LEGAL BASE

FIP

Mich Admin Code, R 400.3120 et. seq.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

DEPARTMENT POLICY

State-Funded Family Independence Program (FIP) and State Disability Assistance (SDA) Only

State-funded FIP and SDA clients must sign an agreement to repay interim assistance when pursuing a potential benefit. BEM 270 and BEM 271 identify potential benefits the client must pursue.

Repay agreements are required for most **lump sum** payments (for example, inheritances, insurance settlements) and **accumulated benefits** paid retroactively (for example, Supplemental Security Income (SSI), Unemployment Compensation, Workers Compensation). See the BPG Glossary and the **LUMP SUMS AND ACCUMULATED BENEFITS** sections in BEM 400 and 500.

Repayment is **not** required from the following:

- Income tax refunds.
- Future wages **or** future monthly benefits (such as, ongoing benefits from SSI, unemployment insurance benefits, workers compensation).
- Presumptive SSI benefits.
- Social Security (RSDI) retroactive **or** future benefits.
- Railroad retirement retroactive **or** future benefits.

Explain **all** of the following to clients required to repay state-funded FIP or SDA:

- Signing the appropriate form is a condition of eligibility, and failure to do so results in denial or closure.
- The client must report receipt of income from the potential source.
- The repayment amount is determined by a prescribed formula see, the Collection Of Repayments section in this item.
- The exact repay amount will be calculated when the benefit is received.

Close the case or deny the application when the client refuses to sign a required repay agreement.

TYPES OF REPAY AGREEMENTS

There are three types of repay agreements, as described in this section:

- MDHHS-1171, Assistance Application.
- DHS-3975, Reimbursement Authorization.
- DHS-2157, Repay Agreement.

SSI Benefits

MDHHS-1171

The MDHHS-1171-INFO, Information Booklet, contains a reimbursement acknowledgment authorizing SSA to mail the retroactive SSI payment to DHS for repayment of interim state-funded FIP and SDA.

SSA tapes are electronically matched bi-weekly against Bridges to identify state-funded FIP and SDA recipients who are SSI applicants.

The automated system then sends SSA a tape identifying persons whom SSA does **not** have coded as state-funded recipients. SSA changes the coding to reflect the repayment authorization. (This process can take up to six weeks.) Complete a DHS-3975 for situations stated below.

DHS-3975

Use a DHS-3975 **only** when SSI is the potential benefit source. It serves as a prompt notice to SSA that an SSI applicant is active on a state-funded cash case. If SSI is approved before the automated crossmatch, it alerts SSA to send the retroactive SSI payment to DHS. The form remains in effect until SSI approval **or** a final SSI denial. Additional SSI applications require a new DHS-3975.

Complete a DHS-3975:

- To refer a client to SSA to apply for SSI.
- When the automated system does **not** code a client's case for repayment.

The Single Online Query (SOLQ) indicates that a client has **not** been automatically coded for interim assistance reimbursement (IAR) within six weeks of the SSI application, contact the individual and have him/her sign a DHS-3975. If the client refuses to sign, close the case.

Note: A DHS-3975 is usually **not** needed if the client applied for SSI **before** applying for state-funded FIP or SDA. In that situation, the signed MDHHS-1171 serves as the repay agreement. However, if the automated process fails to function, a DHS-3975 must be completed.

Other Benefits

SDA Only

DHS-2157

Use a DHS-2157 when the client is pursuing a potential benefit **other than SSI**.

Specify on the form the exact source of benefits to be repaid (for example, “proceeds from worker’s compensation lawsuit by client for job-related injury”). If the client is potentially eligible for benefits from multiple sources, use a separate DHS-2157 for each.

COLLECTION OF REPAYMENTS

When the lump sum or accumulated benefit is received, collection actions are as follows:

- Collections of **non-SSI** benefits are handled by the local fiscal unit.
- **SSI** checks are normally sent by SSA to the Reconciliation and Recoupment Section in central office for recovery actions. Reconciliation staff communicate information regarding the SSI to the locally designated IAR liaison, who forwards the information to the responsible worker for case actions. The liaison coordinates recovery actions with Reconciliation and Recoupment for retroactive SSI checks that are sent to the client or local office in error.

Note: SSA sends presumptive SSI payments directly to the recipient. Repayment is **not** required from these benefits. Verify presumptive SSI benefits by the recipient's award letter from SSA or other contact with SSA (Bridges does **not** distinguish presumptive SSI benefits from regular SSI benefits).

Calculation of Repay Amount

The client must repay the regular, vendored and supplemental state-funded FIP and/or SDA, including SLA provider payments (BAM 430), paid during the interim assistance period. (This includes General Assistance (GA) paid before 10/1/91 and State Family Assistance (SFA) paid before 7/1/97.)

SMP/GA/AMP medical payments to medical providers on the client's behalf are **not** counted when calculating the amount owed.

Note: The repay amount from retroactive SSI reflects **only** the interim assistance to the SSI individual; see Eligible Group in this item.

The repay amount is one of the following:

- For **lump sum** payments (example: insurance settlement), the SDA amount owed **or** the lump sum, whichever is **less.**
- For **accumulated benefits** (example: retroactive SSI), the state-funded FIP and/or SDA amount owed **or** the windfall amount covering the interim assistance period, whichever is **less**.

Interim Assistance Period

The interim assistance period is determined as follows:

- For **lump sum** payments, it begins with the SDA pay period in which the DHS-2157 was signed. It ends with the final interim assistance pay period.
- For **non-SSI accumulated benefits**, it begins with the first SDA pay period covered by the windfall benefit **or** in which the

DHS-2157 was signed (whichever is **more recent**). It ends with the final interim assistance pay period.

- For **SSI accumulated benefits**, it begins with the state-funded FIP and/or SDA pay period containing the retroactive SSI begin date.

Exception: It begins with the pay period in which a MDHHS-1171 or DHS-3975 was signed, if the SSI begin date precedes the date the MDHHS-1171 or DHS-3975 was signed.

It ends with the last interim assistance payment issued **before** the SSI accumulated benefit was received by the department, **unless** a payment has been prepared and it is too late to stop the payment from being mailed. If this happens then the interim assistance period includes this payment.

Eligible Group

When SSI is received by a client in a two-or-more person eligible group, determine the amount to be repaid by the following steps.

1. Calculate the interim state-funded FIP and/or SDA for all clients, disregarding any income, for **each** month in the interim assistance period.
2. Do the same calculation for the group less one person.
3. Attribute the difference in the amounts in steps 1 and 2 for **each** month to the SSI client.
4. Report the amount calculated for each month to the IAR liaison. The amount to be recovered each month will be based on the SSI amount received for each month.

Excess Benefits

Treat the excess benefit as an asset; see BEM 400.

Repay Agreements Not Honored

If the client receives the benefit directly but fails to repay the interim state-funded FIP and/or SDA as agreed, initiate recoupment; see BAM 700 and 720.

Exception: SSI benefit recovery is initiated by the Reconciliation and Recoupment Section in central office. If the client contacts the local office to arrange repayment, have the client sign form DHS-4358, Notice of Agency or Client Error Overissuance and Recoupment Action. Do **not** enter these debts on ARS unless the client signs a DHS-4358. Notify the IAR liaison if the client signs a DHS-4358.

Exceptions to Repay Obligations

Local office directors have the authority to renegotiate the terms of repay agreements to avoid extreme and unusual hardship to the client.

The circumstances prompting the request and the decision must be documented. Attach the documentation to the repay agreement and file in the case record. Renegotiations may occur if the client's circumstances change.

SOLQ Information

IAR codes can be located on the bottom of the last page of the SOLQ. The codes are as follows:

0 = There is no interim assistance involved.
1 = Payment has been made or is being made to the state.
2 = Payment was sent to the state.
3 = SSI was denied or there was no retroactive payment.
4 = Reimbursable assistance case pending or denied.

LEGAL BASE

State-Funded FIP and SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

OVERVIEW

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance (RCA), Group 2 Persons Under Age 21 (G2U), Group 2 Caretaker Relative (G2C), Refugee Medical Assistance (RMA), SSI-Related MA, Child Development and Care (CDC) and Food Assistance Program (FAP)

Consider assets in determining eligibility for FIP, SDA, RCA, G2U, G2C, RMA, SSI-related MA categories, CDC and non-categorically eligible FAP groups.

FIP, SDA, RCA, G2U, G2C, CDC and RMA consider only the following types of assets:

- Cash (which includes savings and checking accounts).
- Investments (which includes 401(k), Roth IRA etc.).
- Retirement plans.
- Trusts.

FIP, SDA, RCA, and CDC only

Homes and Real Property.

G2U, G2C, RMA and SSI-Related Medicaid

The department will utilize an asset verification program to electronically detect unreported assets belonging to applicants and beneficiaries.

Asset detection may include the following sources at financial institutions: checking, savings, and investment accounts, IRAs, treasury notes, certificates of deposit (CDs), annuities and any other asset that may be held or managed by a financial institution.

Asset detection will be requested by sending the required fields, name, Social Security number, and address, to the asset detection program. This request may occur at any day and time during the month.

Assets Defined

Assets

- Cash; see *Cash* in this item.

- Personal property. **Personal property** is any item subject to ownership that is not real property (examples: currency, savings accounts, and vehicles).

- Real property. **Real property** is land and objects affixed to the land such as buildings, trees, and fences. Condominiums are real property.

Overview of Asset Policy

Countable assets **cannot** exceed the applicable asset limit. Not all assets are counted. Some assets are counted for one program, but not for another program. Some programs do **not** count assets; see *Programs with No Asset Test* in this item.

Consider both of the following to determine if an asset is countable, and how much to count:

- Availability:
  - See *Available in this item.*
  - See *Jointly Owned Assets* in this item.
  - See *Non-Salable Assets* in this item.
- See *Exclusions* in this item.

An asset is countable if it meets the availability tests and is **not** excluded.

Note: Only certain types of assets are considered by FIP, RCA, SDA, G2U, G2C, RMA, CDC and FAP. See the list in this section. FIP asset rules apply to RCA.

Consider the assets of each person in the asset group; see the *Program's Asset Group* policy in this item.

An asset converted from one form to another (example: an item sold for cash) is still an asset.

Exception: See Bridges Eligibility Manual (BEM) 503, Income Unearned, Sale of Property in Installments.

FIP, SDA, RCA, G2U, G2C, RMA and CDC Only

The following types of assets are the only types considered for FIP, SDA, RCA, G2U, G2C, CDC and RMA:

- Cash (which includes savings and checking accounts).
- Investments (which includes 401(k), Roth IRA etc.).
- Retirement plans.
- Trusts.

FIP, SDA, RCA, and CDC only

Homes and Real Property.

SSI-Related MA Only

All types of assets are considered for SSI-related MA categories.

PROGRAMS WITH NO ASSET TEST

MAGI-Related MA

There is no asset test for MAGI- related Medicaid categories.

Do **not** deny or terminate those benefits because of a refusal to provide asset information or asset verification requested for purposes of determining eligibility for a category or program that has an asset test, such as FIP.

FAP Only

There is no asset test for categorically eligible FAP groups.

Note: Non-categorically eligible FAP groups **do** have an asset test.

FIP, RCA, SDA, CDC AND FAP ASSET ELIGIBILITY

FIP, RCA, SDA and FAP

Policy Overview

Determine asset eligibility prospectively using the asset group's assets from the benefit month. Asset eligibility exists when the group’s countable assets are less than, or equal to, the applicable asset limit at least one day during the month being tested.

Note: For FAP, Bridges budgets all countable assets for ineligible and/or disqualified individuals. All assets of non-group members such as ineligible students, furloughed prisoners, etc., will be excluded by Bridges.

CDC Only

For asset eligibility a program group's assets may not exceed the asset limit, as confirmed through self-certification.

Application

At **application**, do not authorize FIP, RCA, SDA, or CDC for future months if the person has excess assets on the processing date.

Pending Application Months

For pending FIP, RCA, SDA, CDC and FAP applications, use asset policy that is in effect for the month for which eligibility is being determined.

Ongoing

If an **ongoing** FIP, RCA, CDC or SDA recipient has excess assets, initiate closure. However, reinstate the program if it is verified that the excess assets are under the limit on or before the timely hearing request date.

FIP, RCA, SDA, CDC and FAP Only

Bridges produces an overissuance referral for benefits issued after the last month of eligibility only if a closure delay was caused by the group's failure to report the asset change timely. Bridges Administrative Manual (BAM) 700, Benefit Overissuances, and BAM 705, Agency Overissuances, explain overissuance and recoupment policies and procedures.

RCA Only

Do **not** consider the assets of a refugee's sponsor in determining the refugee's eligibility.

Exclude as an asset any cash assistance given to a refugee from a resettlement agency.

Evaluate and treat other assets as they are evaluated and treated for FIP.

FIP, RCA, SDA, CDC Asset Group

FIP, RCA, SDA Only

The asset group includes individuals with an EDG participation status of eligible or disqualified; see BEM 210, FIP Group Composition, 214, SDA Group Composition, and 215, RCA Group Composition.

CDC ONLY

The CDC asset group includes those individuals that would be included in the CDC program group; see BEM 205, CDC Group Composition.

FIP, RCA and SDA Asset Limit

FIP, RCA and SDA Only

$15,000 or less for cash, investments and retirement plans.

$200,000 for real property assets.

CDC Asset Limit

The total countable assets for the CDC program group cannot exceed $1 million.

FAP Asset Limits

Non-Categorically Eligible Groups:

$3,000 or less for non-SDV groups.

$4,500 or less for SDV groups.

See, BEM 213, Categorical Eligibility.

Lottery/Gambling Winnings:

All FAP Groups

A single lottery or gambling winning of $4,500 or more.

See BEM 403, FAP Lottery/Gambling Winnings.

FAP Asset Group

The asset group is:

- FAP eligible members; see BEM 212, Food Assistance Program Group Composition.
- All disqualified members; see BEM 550, FAP Income Budgeting.
- Alien sponsors; see BEM 226, Sponsored Aliens.

FAP Divestment

Divestment occurs when a non-categorical eligible FAP group transfers assets for less than the fair market value for any of the following reasons:

- To qualify for program benefits.
- To remain eligible for program benefits.

See BEM 406, FAP Divestment.

MA ASSET ELIGIBILITY

G2U, G2C, RMA, and SSI-Related MA Only

Asset eligibility is required for G2U, G2C, RMA, and SSI-related MA categories.

Note: Do **not** deny or terminate Group 2 Pregnant Women because of a refusal to provide asset information or asset verification requested for purposes of determining G2U, G2C, RMA or SSI-related MA eligibility.

Use the special asset rules in BEM 402, Special MA Asset Rules, for certain married L/H and waiver patients. See BPG Glossary, for the definition of L/H patient and BEM 106, MA Waiver For Elderly And Disabled, for the definition of waiver patient.

Asset eligibility exists when the asset group's countable assets are less than, or equal to, the applicable asset limit at least one day during the month being tested.

At **application**, do not authorize MA for future months if the person has excess assets on the processing date.

If an **ongoing** MA recipient or active deductible client has excess assets, initiate closure. However, delete the pending negative action if it is verified that the excess assets were disposed of. Payment of medical expenses, living costs and other debts are examples of ways to dispose of excess assets without divestment. LTC and waiver patients will be penalized for divestment; see BEM 405, MA Divestment.

G2U, G2C and RMA Asset Group

G2U, G2C and RMA

See BEM 211, MA Group Composition.

G2U, G2C and RMA Asset Limit

G2U, G2C and RMA

$3,000.

SSI-Related MA Asset Group

SSI-Related MA Only

See BEM 211, MA Group Composition.

SSI-Related MA Asset Limit

SSI-Related MA Only

For Freedom to Work (BEM 174) The asset limit for the initial eligibility determination is set to the current asset limit for a group of one in the Medicare Savings Program (listed below). Once eligibility for FTW has been established the countable asset limit increases to $75,000 for ongoing Medicaid. IRS recognized retirement accounts (including IRAs and 401(k)s) may be of unlimited value. These retirement accounts may continue to be excluded as assets from future MA eligibility determinations; see BEM 174, Freedom To Work (FTW).

Note: Retirement accounts excluded under this policy for FTW participants are also excluded for MSP eligibility determinations for FTW participants or former FTW participants.

For Medicare Savings Programs (BEM 165) the asset limit is:

- For an asset group of one:
    - $9430 effective January 1, 2024.
    - $9,090 effective January 1, 2023.
    - $8,400 effective January 1, 2022.
    - $7,970 effective January 1, 2021.
    - $7,860 effective January 1, 2020.
- For an asset group of two:
    - $14,130 effective January 1, 2024.
    - $13,630 effective January 1, 2023.
    - $12,600 effective January 1, 2022.
    - $11,960 effective January 1, 2021.
    - $11,800 effective January 1, 2020.

For Qualified Disabled Working Individuals (QDWI) (BEM 169) the asset limit is:

- $4000 for an asset group of one.
- $6000 for an asset group of two.

For all other SSI-related MA categories, the asset limit is:

- $2,000 for an asset group of one.
- $3,000 for an asset group of two.

DEEMING OF PARENTAL ASSETS

SSI-Related MA Only

Deeming means counting a portion of parents' assets as their child's assets. Do not deem when:

- Any parent living with the child is an SSI or FIP recipient; see BEM 211, MA Group Composition.
- When determining a child's eligibility under BEM 170, Home Care Children.

- When determining a child's eligibility under BEM 171, Children's Waiver.
- When determining a child's eligibility under BEM 172, Children with Serious Emotional Disturbance (SED) Waiver.

Deeming Calculation

SSI-Related MA Only

Use the following to calculate the deemed amount.

1. Determine the total value of the parents' countable assets, as if they were an asset group, even if they are **not** married.

   Note: The child is **not** eligible for SSI-related MA if the parents refuse to provide asset information or a required verification.

2. Subtract $2,000 for one parent ($3,000 for two parents) from the amount of the parents' countable assets (step 1). The result is the deemable asset amount.

3. Divide the deemable asset amount (step 2) by the number of the parents' unmarried children under age 18 in the parents' home who are:

   - SSI recipients.
   - Applicants for, or recipients of, MA based on blindness or disability, who also meet both:
     - The nonfinancial eligibility factors in BEM 155, 503 Individuals or BEM 166, Group 2 Aged, Blind And Disabled.
     - Are **not** Home Care Children (BEM 170), Children's Waiver (BEM 171), or SED Waiver (BEM 172).

The result is the amount of assets deemed to the child whose eligibility is being determined.

ALIEN SPONSOR ASSET DEEMING

FAP

A non-categorically eligible non-citizen's assets might include asset's deemed from the non-citizen's sponsor; see BEM 226.

AVAILABLE

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

An asset must be available to be countable. **Available** means that someone in the asset group has the legal right to use or dispose of the asset.

Exception: This does **not** apply to trusts. There are special rules about trusts. See *Trusts* in this item for FIP, RCA, SDA, CDC and FAP. See BEM 401, Trusts-MA.

Assume an asset is available unless evidence shows it is **not** available.

An asset remains available during periods in which a guardian or conservator is being sought. This includes situations such as:

- A person's guardian dies, and a new guardian has **not** been appointed yet.
- A court decides a person needs a guardian but has **not** appointed one yet.
- A person is unconscious, and their family asks the court to appoint a guardian.

Availability might also be affected by joint ownership and efforts to sell or the possibility of domestic violence. See *Jointly Owned Assets, Non-Salable Assets and Victims of Domestic Violence* in this item.

SSI-Related MA Only

A person's death and probating his estate does **not** make his assets unavailable for purposes of determining his eligibility. Determine asset eligibility for the days of the month the person was alive.

ESTATE RECOVERY

MA Only

The federal government requires Medicaid to recover money that it paid for services from the estates of Medicaid beneficiaries who have died. Medicaid will only recover the amount Medicaid paid for a beneficiary. This is estate recovery. The state will not seek recovery of certain Medicare cost-sharing benefits; see BAM 120, MSA/MDHHS Coordination.

Victims of Domestic Violence

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA, CDC and FAP

Assets owned by victims of domestic violence may be unavailable due to domestic violence. These assets do **not** have to be jointly owned but accessing them could put the client in danger. Exempt these assets for a maximum of three months. With FIM approval one three-month extension is permitted. Document in the case record the reasons for the temporary exclusion, and, if any extension is requested, document what steps have been taken to secure the asset. Clients should be advised at the time of the exemption that they are required to report any changes in the status of the asset within 10 days.

Exception: For FAP, there is no time limit for the length of the exemption.

JOINTLY OWNED ASSETS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Jointly owned assets are assets that have more than one owner.

Note: For Freedom To Work determinations, jointly owned assets are considered to belong to the initial person.

An asset is unavailable if all the following are true, and an owner **cannot** sell or spend his share of an asset:

- Without another owner's consent.
- The other owner is not in the asset group.

- The other owner refuses consent.

Exception 1: In SSI-related MA, when ownership is shared by an SSI-related child and his parent(s) **and** parental asset deeming applies, refusal to sell by either the child or the parent(s) does **not** make an asset unavailable; see *Deeming of Parental Assets* in this item, see definition of SSI-related child in BEM 211.

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only and CDC

Jointly owned real property is only excludable if it creates a hardship for the other owners.

Note: In SSI-related MA a divestment has occurred if joint owners are added during the five year look back period. See BEM 405 for determination of a divestment penalty.

Ownership documents for jointly owned real property commonly use one of four phrases:

- **Joint Tenancy**: no owner can sell unless all owners agree.
- **Joint Tenancy with Right of Survivorship**: no owner can sell unless all owners agree.
- **Tenancy by the Entirety**: same as joint tenancy except the owners are husband and wife. Neither owner can sell unless both owners agree.
- **Tenancy-in-Common**: each owner can sell their share without the other owner's agreement.

Note: For jointly owned real property count the individual's share unless sale of the property would cause undue hardship. Undue hardship for this item is defined as a co-owner uses the property as his or her principal place of residence **and** they would have to move if the property were sold **and** there is no other readily available housing.

Joint Cash and Retirement Plans

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

This section applies to the types of assets listed under *Cash and Retirement Plans* in this item.

Count the entire amount **unless** the person claims and verifies a different ownership. Then, each owner's share is the amount they own.

SSI-Related MA Only

Exception: Apply the following when an L/H or waiver patient (see BPG, Glossary, and BEM 106, MA Waiver For Elderly And Disabled) and his spouse jointly own the asset:

- Consider the client the sole owner in determining the community spouse resource allowance (CSRA). BEM 402, Special MA Asset Rules, describes the CSRA.
- Proceed as follows for all other purposes:
  - If the spouse is an MA-only client or receives FIP or SSI, each spouse owns an equal share unless otherwise claimed and verified.
  - If the spouse is **not** an MA-only client and does **not** receive FIP or SSI, consider the asset totally available unless otherwise claimed and verified.

Exception: Count equal shares of an asset owned by more than one SSI-related MA child unless the person claims and verifies a different ownership.

Exception: If the owners are an SSI-related MA child and their parent(s) and asset deeming applies, count the total amount as the child's unless the person claims and verifies a different ownership.

Other Joint Assets

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA, CDC and FAP

This applies to all assets that are **not** included under *Cash or Retirement Plans*.

Count an equal share for each owner.

Note: If specified otherwise by the ownership document, each owner's share is the amount specified.

Residents of Domestic Violence Shelters

FAP

Assets owned by residents of domestic violence shelters are unavailable when the assets cannot be accessed without agreement of a joint owner residing in the former household.

NON-SALABLE ASSETS

SSI-Related MA Non-Salable Assets

SSI-Related MA Only

Give the asset a $0 countable value when it has no current market value as shown by one of the following:

- Two knowledgeable appropriate sources (example: realtor, banker, stockbroker) in the owner's geographic area state that the asset is **not** salable due to a specific condition (for example, the property is contaminated with heavy metals). This applies to any assets listed under:
  - Investments.
  - Vehicles.
  - Livestock.
  - Burial Space Defined.
  - Employment and Training Assets.
  - Homes and Real Property (see below).

  In addition, for homes, life leases, land contracts, mortgages, and any other real property, an actual sale attempt at or below fair market value in the owner's geographic area results in no reasonable offer to purchase. Count an asset that no longer meets these conditions. The asset becomes countable when a reasonable offer is received. For most assets *non-salable* is a temporary condition.

  For applicants, an actual sale attempt to sell must have started at least 90 days prior to application and must continue until the property is sold. (That is, the property does not become *non-*

salable until the 91st day.) For recipients, the asset must have been up for sale at least 30 days prior to redetermination and must continue until the property is sold. An actual sale attempt to sell means the seller has a set price for fair market value, is actively advertising the sale in publications such as local newspaper and is currently listed with a licensed realtor. If after a reasonable length of time has passed without a sale, the sale price may need to be evaluated against the definition of fair market value. The definition of fair market value can be found in the glossary.

Note: The non-salable asset policy does **not** apply to the Initial Asset Assessment.

FAP Non-Salable Assets

FAP

Do **not** count **real property** that the FAP group is making a **good-faith effort** to sell. All the following must be met for the real property to be excluded:

- No reasonable purchase offer has been made.
- For active cases, the property is continuously up for sale by a real estate company, by owner, etc.
- An actual attempt has been made to sell it at a price not higher than the fair market value.

CASH

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

This section is about the following types of assets:

- Money/currency.
- Uncashed checks, drafts and warrants.
- Checking and draft accounts.
- Savings and share accounts.
- Money market accounts.

- LTC patient trust fund and all other money held by the facility for the patient. **Example:** Patient has prepaid in advance for the nursing home stay.
- Money held by others. **Example**: Sally does **not** have a bank account. She puts money in her mother's checking account, but it is **not** a joint account.
- Time deposits. A **time deposit** is a contract between a person and a financial institution whereby the person agrees to leave funds on deposit for a specified period in return for a specified interest rate. Common time deposits are certificates of deposit (CDs) and savings certificates.

Note: For FAP, use the lowest checking, savings or money market balance in the month when determining asset eligibility.

Note: Determining the cash value of investment instruments, such as stocks, bonds and mutual funds, is found in the *Investment* section of this item.

Crowdfunding Account

FIP, RCA, SDA, CDC and FAP

Funds that are available to the household in a crowdfunding account (such as, but not limited to, GoFundMe, Kickstarter) are considered a cash asset.

Cryptocurrency

All Programs

The value of cryptocurrency (Bitcoin, Ethereum, Litecoin and Monero, etc.,) available at the time of the interview, is a cash asset.

Determine the value by using the exchange rate the currency is stored in and then converting the currency into U.S. dollars.

Lump Sums and Accumulated Benefits

Lump sums and accumulated benefits are defined in the BPG, Glossary.

FIP, RCA, SDA, CDC and FAP

Lump sums and accumulated benefits are assets starting the month received.

A person might receive a single payment that includes both accumulated benefits and benefits intended as a payment for the current month. Treat the portion intended for the current month as income.

G2U, G2C, RMA, SSI-Related MA Only

Lump sums and accumulated benefits are income in the month received. See BEM 500, Income Overview, about countable income policy.

Exception: The following are assets:

- Income tax refunds; see *Tax Refund & Tax Credit Exclusions* in this item.
- Nonrecurring proceeds from the sale of assets.
- Payments that are excluded assets.
- Medical Loss Ratio Rebate.

Retroactive SSI Benefits

FIP, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Retroactive SSI benefits may be paid as a one-time payment or in installments over several months. The Social Security Administration determines how payment will be made.

Retroactive SSI benefits are treated as accumulated benefits (see above) even when paid in installments. See *Retroactive RSDI and SSI Exclusion* in this item for SSI-related MA determinations.

Note: For FAP households where all members receive FIP and/or SDA and/or SSI, retroactive SSI benefits are excluded in Bridges.

Value of Cash

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

The value of the types of assets described above is the amount of the:

- Money/currency.
- Uncashed check, draft or warrant.
- Money in the account or on deposit.
- Money held by others.
- Money held by nursing facilities for residents.
- Money in a vendor pre-paid debit card (for example, Direct Express, ReliaCard, etc.).

Exception: Reduce the value of a time deposit by the amount of any early withdrawal penalty, but **not** the amount of any taxes due.

CASH EXCLUSIONS

Homestead-Loss Funds Exclusion

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only and CDC

Use this exclusion only if the funds are **not** commingled with countable assets and not in time deposits.

Exclude funds an owner received for repairs or replacement of a damaged or destroyed homestead (example: insurance settlement) if both of the following are true:

- The owner intends to reoccupy the home.
- There is a written repair/replacement agreement.

The client must declare an estimated completion date. The exclusion lasts until that date. The local office may grant extensions.

Exclude funds for temporary housing while the homestead is being repaired or replaced.

Also see *Homestead-Loss Land Exclusion* in this item regarding the land the home was on.

FAP

Exclude any governmental payments which are designated for the restoration of a home damaged in a disaster if the household is subject to a legal sanction if the funds are not used as intended. Examples include, but are not limited to, payments made by the Department of Housing and Urban Development through the individual and family grant program or disaster loans, or grants made by the Small Business Administration.

Homestead Sale Exclusion

FIP, RCA, SDA, G2U, G2C, RMA, CDC and FAP

Use this exclusion only if the funds are **not** commingled with countable assets and are **not** in time deposits.

Exclude funds received from the **sale of a homestead**, or the land the home was on, for 12 months if there is a written agreement to purchase another homestead. The 12-month period starts the month the funds are received.

Note: See *Homestead Land Retained Exclusion* in this item if ownership of the land was retained.

SSI-Related MA Only

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

When an individual sells an excluded home, the proceeds (the net amount the seller receives at settlement) of the sale are excluded resources if the individual:

- Plans to use them to buy another excluded home and,
- Does so within three full calendar months of receiving the proceeds.

If the individual received the proceeds under an installment contract, the contract is an excluded resource for as long as the individual:

- Plans to use the entire down payment and the entire principal portion of a given installment payment to buy another excluded home and,

- Does so within three calendar months of receiving such down payment or installment payment.

Health Reimbursement Accounts

SSI-Related MA only

Health Reimbursement Account Plans (HRAs) are group health plans and need to be reported to Third Party Liability.

Health Savings Accounts and Medical Savings Accounts

MA programs, excluding MAGI-Related

Health savings accounts are countable resources. The value is the amount available for withdrawal minus any penalties but **not** taxes. Count amounts withdrawn as an asset in the month received.

Medicare Set-Aside Account

All Programs

Medicare Set-Aside Accounts are limited to payment of qualified medical expenses as determined by the Social Security Administration. They are created when a Medicare recipient has a workers' compensation settlement. They are excluded as income and as an asset.

Non-Homestead Loss Exclusion

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Use this exclusion only if the funds are **not** commingled with countable assets and are **not** in time deposits.

Exclude funds received for the planned repair or replacement of a non-homestead exempt item (example: furniture, clothing, vehicle) that was lost, stolen, or destroyed. Exclude the funds until the item is repaired or replaced.

Loan Exclusion

FIP, RCA and CDC

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

Exclude funds a person has borrowed provided it is a **bona fide** loan. This includes a loan by oral agreement if it is made a **bona fide** loan.

Bona fide loan means **all** the following are present:

- A loan contract or the lender's written statement clearly indicating the borrower's indebtedness.
- An acknowledgment from the borrower of the loan obligation.
- The borrower's expressed intent to repay the loan by pledging real or personal property or anticipated income.

This exclusion does **not** apply to:

- Interest earned on borrowed money.
- Purchases made with borrowed money.

Note: When a client has loaned money to another person, please refer to the policy in Promissory Notes/Land Contracts/Mortgages/Loans.

Reverse Mortgage Exclusion

FIP, RCA, SDA, CDC and FAP

Use this exclusion only if the funds are **not** commingled with countable assets and **not** in time deposits.

A reverse mortgage allows a homeowner to borrow some percentage of the value of his home via a mortgage. The homeowner receives periodic payments (or a line of credit) that does **not** have to be repaid while the homeowner lives in the home. Exclude these payments. They are loans.

SSI Related MA Only

Payments that a homeowner receives from a reverse mortgage are loan proceeds. The loan proceeds are an excluded resource in the month received but are a countable resource if retained in the month following the month of receipt. A transfer of reverse mortgage proceeds is subject to review for a divestment determination when the client is in a penalty situation; see BEM 405, MA Divestment.

Tax Refund and Tax Credit Exclusion

FIP, RCA, CDC and FAP

All state and local earned income tax credits and refunds are excluded, including home heating credits.

Note: Federal income tax refunds are excluded for 12 months from the month of receipt. The refund amount is subtracted from the household's total assets to determine if they meet the asset limit.

Note: This exclusion continues even if the client has already spent the refund.

Example: Clara applies for FAP in November and her total countable assets are $6,000. During the interview ask her if anyone in the household received a federal income tax refund in the past 12 months. Her tax refund of $2,000 was received in January and she used it to pay bills. The $2,000 is still subtracted from the $6,000 resulting in countable assets of $4,000.

SDA

Exclude tax refunds and credits.

Use this exclusion only if the funds are **not** commingled with countable assets and are **not** in time deposits.

G2U, G2C, RMA, SSI-Related MA Only

Exclude tax credits for nine months after the month of receipt. Tax credits include credits such as Earned Income Tax Credit and Child Tax Credit.

Exclude federal income tax refunds for 12 months from the month of receipt. The refund amount is subtracted from the household's total assets to determine if they meet the asset limit.

Note: This exclusion continues even if the client has already spent the refund.

Federal Stimulus Payments

SSI- Related MA only

The 3 federal stimulus payments received for the COVID 19 federal Health emergency are permanently excluded. The payment amount is subtracted from the household's total cash assets to determine if they meet the asset limit.

Excluded Income Under BEM 500 Series

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Use this exclusion only if the funds are **not** commingled with countable assets and are **not** in time deposits.

BEM 500, Income Overview, 501, Income From Employment, 502, Income From Self-Employment, 503, Income Unearned and 504, Income From Rental/Room And Board, identify certain sources of funds that are excluded as both income and assets. Time limits and other conditions applicable to the income exclusion also apply to the asset exclusion.

Note: For FAP, see *Excluded Assets* in this item.

Current Income Exclusion

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Do not count funds treated as income by a program as an asset for the same month for the same program.

When income must be prorated or averaged (example: self-employment), exclude the resulting assets for the months of proration.

Business Account Exclusion

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Use this exclusion only if the funds are **not** commingled with countable assets and **not** in time deposits.

Exclude a savings, share, checking, or draft account used **solely** for the expenses of a business. Continue the exclusion while the business is not operating, provided the person intends to return to the business.

SSI Dedicated Account

FAP

Exclude an SSI Dedicated Account. These accounts are mandated if a child under 18 is approved for SSI and receives a lump-sum payment.

Retroactive RSDI and SSI Exclusion

SSI-Related MA Only

Exclude retroactive RSDI and SSA-issued SSI benefits for nine calendar months beginning the month after payment is received. Do **not** exclude purchases made with such funds including CDs and other time deposits.

This exclusion applies only to any unspent portion of the retroactive payment from RSDI or SSI. Once the money from the retroactive payment has been spent, this exclusion does not apply to the items purchased with the money, even if the nine-month period has not expired.

The money may be commingled with other funds but, if this is done in such a fashion that the retroactive amount can no longer be separately identified, that amount will count toward the resource limit.

Use the following to separate countable and excluded funds that are commingled:

- Assume that countable funds are withdrawn first, leaving as much of the excluded funds as possible.
- Excluded funds withdrawn are **not** excluded if redeposited. The excluded amount can be increased only by deposits of subsequently received excluded payments.
- Count any interest paid to the account.

Example: A person received a $1,000 retroactive RSDI payment on December 3 via direct deposit. The account already contained $1,800.

DATE	DEPOSIT	WITHDRAW	BALANCE	EXCLUDE	COUNTABLE
12/3	$1,000	$0	$2,800	$1,000	$1,800
12/4	$0	$500	$2,300	$1,000	$1,300
12/31	$5	$0	$2,305	$1,000	$1,305
1/3	$400	$250	$2,455	$1,000	$1,455
1/4	$0	$1,500	$955	$955	$0
2/10	$50	$0	$1,005	$955	$50
2/12	$0	$400	$605	$605	$0
3/8	$100	$0	$705	$605	$100
3/15	$0	$50	$655	$605	$50

Funds for Burial Arrangements

SSI-Related MA Only

Money set aside for burial expenses might be excludable. See *Burial Fund Exclusion* in this item.

Retroactive Tax and Utility Cost Subsidy Payments

FAP

Use this exclusion only if the funds are **not** commingled with countable assets and are **not** in time deposits.

Exclude retroactive tax and utility cost subsidy payments in the month received and the following month.

Student Savings Exclusion

FIP, RCA, G2U, G2C, CDC and RMA

Use this exclusion only if the funds are not commingled with countable assets and are not in time deposits.

Exclude funds in a separate account under a student's name and accrued solely from a student's earnings; see Student Earnings Disregard in BEM 501, Income From Employment.

INVESTMENTS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

This section is about the following types of assets:

- U.S. Savings bonds.
- Securities such as:
  - Stocks.
  - Bonds.
  - Mutual funds.

Value of Investments

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

The value of a U.S. Savings bond is the amount the owner could get if the bond were cashed in.

G2U, G2C, RMA, SSI-Related MA Only

U.S. Savings bonds cannot be cashed in until 12 months after the date of issuance. However, if bonds are in this waiting period and the value of the bond(s) and other assets is over the client's asset limit, the client must seek a waiver of the waiting period.

The waiver is a written request from the bond holder or representative to the United States Department of Treasury outlining why a waiver of the waiting period is necessary. If the waiver is granted the value of the U.S. Savings bond is considered available. If the

waiver is denied the bond becomes available at the expiration of the waiting period.

G2U, G2C, RMA, SSI-Related MA Only, and FAP

The value of other investments is the amount the asset is selling for:

- Use the closing price for publicly traded stocks.
- Use the bid price or net asset value (NAV) for mutual funds.
- Use the bid price for bonds.

If a security was **not** paid for in full at the time of purchase (bought on margin), the securities firm has made a loan to the buyer. Deduct the balance owed from the price if there is written proof that the balance owed must be repaid when the security is sold.

INVESTMENT EXCLUSION

SSI-Related MA Only

Investments set aside for burial expenses might be excludable; see *Burial Fund Exclusion* in this item.

RETIREMENT PLANS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

This section is about the following types of assets:

- Individual retirement accounts (IRAs).
- Keogh plans (also called H.R. 10 plans).
- 401k plans.
- Deferred compensation.
- Pension plans.
- Annuities-- An annuity is a written contract establishing a right to receive specified, periodic payments for life or for a term of years.

FAP

The following retirement accounts are excluded:

- Traditional Defined-Benefit Plan.

- Cash Balance Plan Employee Stock Ownership Plan.
- Keogh Plan.
- Money Purchase Pension Plan.
- Profit-sharing Plan.
- Simple 401(k).
- 401(k).
- 403(a) and (b).
- IRA.
- Simple Retirement Account IRA.
- Simplified Employee Pension Plan (SEP).
- Roth IRA.
- myRA.
- Eligible 457(b) Plan.
- 501(c)18 Plan.
- Federal Thrift Savings Plan.
- Employer-Sponsored Annuities.

Exception: For annuities which are **not** employer-sponsored; see *Annuity* in this item.

Retirement Plan Value

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only and CDC

The value of these plans is the amount of money the person can currently withdraw from the plan. Deduct any early withdrawal penalty, but not the amount of any taxes due.

Funds in a plan are **not** available if the person must quit his job to withdraw any money.

Freedom to Work (FTW) Only

The value of funds in retirement accounts and individual retirement accounts may be excluded, see BEM 174.

Annuity

G2U, G2C, RMA, SSI-Related MA Only and FAP

Annuities are similar legal devices to trusts. Annuities are a written contract with a commercial insurance company, establishing a right to receive specified, periodic payments for life or for a term of years. They are usually designed to be a source of retirement

income; see BEM 503, Annuity Income policy. Policy in BEM 401 applies, including referring annuities to the Trust and Annuities Unit; see *FAP Trusts* below.

TRUSTS

FIP, RCA, SDA and CDC

A **trust** is a right of property created by one person for the benefit of them self or another.

Trust Definitions

FIP, RCA, SDA and CDC

Beneficiary - the person for whose benefit a trust is created.

Grantor or settlor - the person who established the trust. It includes anyone who furnishes real or personal property for the creation of the trust.

Principal (or corpus) - the assets in the trust. The assets may be real property (example: house, land) or personal property (example: stocks, bonds, life insurance policies, saving accounts).

Trustee - the person who has legal title to the assets and income of a trust and the duty to manage the trust for the benefit of the beneficiary.

FIP, SDA, CDC Trust Policy

FIP, RCA, SDA and CDC

The Probate Court decides availability of the trusts it administers. A grantor must petition the Probate Court to make the principal available.

For other trusts, the principal is an available asset of the person who is legally able to:

- Direct use of the principal for their needs.
- Direct that ownership of the principal reverts to himself or herself.

MA Trust Policy

G2U, G2C, RMA, and SSI-Related MA Only

See BEM 401, Trusts-MA.

FAP Trust Policy

FAP

The trust principal and any income retained by the trust are considered unavailable if **all** the following conditions apply:

- The trust arrangement is **not** likely to end during the benefit period.
- No asset group member has the power to revoke the trust or change the name of the beneficiary during the benefit period.
- The trustee administering the trust is one of the following:
    - A court or an institution, corporation, or organization **not** under the direction of ownership of any asset group member.
    - An individual appointed by the court who is restricted by the court to use the funds solely for the benefit of the beneficiary.
- Investments made on behalf of the trust do **not** directly involve or benefit any business or corporation under the control or direction of an asset group member.
- The funds in the irrevocable trust are one of the following:
    - Established from the asset group's own funds and the trustee uses the funds solely to make investments on behalf of the trust or to pay the educational or medical expenses of the beneficiary.
    - Established from funds of a person who is **not** a member of the asset group.

A homestead which continues to be the primary residence of the FAP group is excluded, even if the title is placed in a revocable/irrevocable trust.

Referrals to Trust and Annuities Unit

All trusts and annuities must be evaluated by the Trust and Annuities Unit. Send a completed DHS-1517, Request for Trust/Annuity Evaluation, to the following email box:

Email address boxes for requests or inquiries to Legal Affairs Administration can be found on the MDHHS-Net at: MDHHS-MA-FAP-Trusts_Annuities@michigan.gov.

Please see the EDM business process on Trust & Annuity Review for information on how to complete the referral process.

Advice is only available to local offices and only for purposes of determining eligibility when a trust exists. Advice is **not** available for purposes of estate planning, including advice on proposed trusts or proposed trust amendments.

HOME CARETAKER AND PERSONAL CARE CONTRACTS

SSI-Related MA Only

A contract that prospectively pays for expenses such as repairs, maintenance, property taxes, homeowner's insurance, heat and utilities for real property/homestead, or that provide for monitoring health care, securing hospitalization, medical treatment, visitation, entertainment, travel and/or transportation, financial management or shopping, etc., would be considered a divestment. Consider all payments for care and services which the client made during the look-back period as divestment; see BEM 405.

Note: The preceding examples should not be considered an all-inclusive or exhaustive list.

Assets transferred in exchange for a contract/agreement for a personal services/assistance or expenses of real property/homestead provided by another person **after** the date of application are considered an available and countable asset even if the contract is irrevocable.

INDIVIDUAL DEVELOPMENT ACCOUNTS

FIP, RCA, SDA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Individual Development Accounts (IDA) are established pursuant to Michigan Public Act 361 of 1998 and section 404(h) of the Social Security Act or Public Law 105-285. IDAs allow low-income families to promote their economic independence by saving for:

- Post-secondary educational expenses.
- First home purchase.
- Business capitalization.

IDAs are funded by periodic contributions from the family's earnings and matching contributions by or through a nonprofit organization. The IDA must be a trust or a joint account that requires the signatures of both the nonprofit organization and a family member to authorize withdrawals.

An IDA is excluded as an asset.

A 529 college savings plan is similar to an IDA. See *Education and Training Exclusion* in this item for FIP, RCA, SDA, G2U, G2C and RMA.

MIABLE/ ABLE (529A) ACCOUNTS

FIP, SDA, RCA, G2U, G2C, RMA, SSI Related MA Only, CDC and FAP

The Internal Revenue Code section 529A establishes ABLE (Achieving a Better Life Experience) accounts. These accounts are called MiABLE in Michigan. The account beneficiary must be an individual who lives with a disability; see BEM 260, MA/Disability/Blindness. Disregard funds on deposit in an MiABLE account, interest earned on the account, and any matching funds deposited in an MiABLE account. Disregard distributions from the account for qualified expenses.

The Michigan Department of Treasury administers MiABLE accounts in Michigan.

HOMES AND REAL PROPERTY

FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP

This section is about the following types of assets:

- Real property.
- Mobile homes.
- Life estates and life leases.

Real Property Definition

FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP

Real property is land and objects affixed to the land such as buildings, trees and fences. Condominiums are real property.

Real Property and Mobile Home Value

FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP

To determine the fair market value of real property and mobile homes use:

- Deed, mortgage, purchase agreement or contract.
- State Equalized Value (SEV) on current property tax records multiplied by two.
- Statement of real estate agent or financial institution.
- Attorney or court records.
- County records.

FIP, SDA, RCA

Use the fair market value.

SSI-Related MA Only, CDC and FAP

The value is the equity value. Equity value is the fair market value minus the amount legally owed in a written lien provision.

Deeds are considered legal if they are signed and notarized. It does not have to be registered with the registrar of deeds to be a legal document.

Note: In Michigan, a lien on a mobile home is on record with the Secretary of State. If the mobile home is on land the person owns, the lien may also be recorded with the land deed.

Life Estate/Life Lease Definition

FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP

A life estate or life lease gives the person who holds it certain rights to property during the person's lifetime. Usually, the right is the right to live on the property. The person holding the life estate or life lease can sell it but does **not** own the actual property and normally **cannot** sell the actual property.

Life Estate/Life Lease Value

FIP, SDA, RCA, SSI-Related MA Only, CDC and FAP

Use the life estate factors in Exhibit II to compute the value of a life estate or life lease. Choose the life estate factor that corresponds to the person's age. Multiply the fair market value of the actual property by the appropriate life estate factor. The result is the value of the life estate or life lease.

SSI-Related MA Only

Use the value of the life estate to determine if the purchase price was for fair market value when a person purchases a life estate in another individual's home.

When a person purchases a life estate in another individual's home, they must actually reside there for at least one year after the date of purchase to qualify for the homestead exclusion. If the person resides in the home for less than one year, treat the transaction as a transfer of assets. The amount of the transfer is the entire amount used to purchase the life estate. See BEM 405, to determine the penalty period.

FAP Only

Exception: Use a lower amount if verified. Verified means statements from two financial institutions or real estate firms with a lower value and the reason for it (example: terminal illness). Use the lowest amount if the statements have different values.

HOMES AND REAL PROPERTY EXCLUSIONS

Homestead Definition and Exclusion

FAP

A homestead is where a person lives (unless absent; see *absent from homestead,* in this item) that they own, is buying or holds through a life estate or life lease. It includes the home, all adjoining land and any other buildings on the land. Adjoining land means land which is **not** completely separated from the home by land owned by someone else. Adjoining land may be separated by rivers, easements and public rights-of-way (example: utility lines and roads).

Exclude only one homestead for an asset group. If a migrant claims two homesteads, exclude the homestead of the migrant's choice.

SSI-Related MA Only

A homestead is where a person lives that they own, is buying or holds through a life estate. It includes the home in which they live, the land on which the home is located, and any other related buildings on the adjoining land. Adjoining land means land which is not completely separated from the home by land owned by someone else. Adjoining land may be separated by rivers, easements, and public rights-of-way (example: utility lines and roads). A homestead does not include income producing property located on the homestead property.

Exclude only one homestead for an asset group. If the individual owns more than one home exclude the principal place of residence. See glossary for definition of homestead and principal place of residence.

BEM 402, Special MA Asset Rules, describes when both a client's and community spouse's assets are counted. If a client and community spouse own two homes, or they are separated, and each owns a homestead, exclude the homestead with:

- The lower equity value for purposes of the initial asset assessment, and
- The higher equity value for purposes of determining initial eligibility.

See policy in this item about exempting a homestead when the owner is absent from homestead.

Home Equity Limit for Long Term Care Costs

SSI-Related MA Only

Determine the equity value of the homestead; see *real property and mobile home value* in this item.

MA will not pay the client's cost for:

- Home health services.
- Home and community-based services (MIChoice Waiver/PACE).
- LTC services.
- Home Help.

When the equity in the client's homestead exceeds:

- $713,000 effective January 1, 2024.
- $688.000 effective January 1, 2023.
- $636,000 effective January 1, 2022.
- $603,000 effective January 1, 2021.
- $595,000 effective January 1, 2020.

Do not apply the home equity limit to the client if the spouse, child under 21, or the client's blind or disabled child is residing in the homestead.

Absent from Homestead

SSI-Related MA Only

Exclude the homestead (see definition in this item) that an owner lived in prior to the time the individual left the property if **any** of the following are true:

- The owner intends to return to the homestead.
- The owner is in an LTC facility, a hospital, an adult foster care (AFC) home or a home for the aged.
- A co-owner of the homestead uses the property as his home.

Relative Occupied. Exclude a homestead provided both of the following are true:

- The owner is in an institution; see BPG Glossary.
- The owner's spouse or relative (see below) lives there.

Relative for this purpose means a person dependent in any way (financial, medical, etc.,) on the owner and related to the owner as any of the following:

- Child, stepchild, or grandchild.
- Parent, stepparent, or grandparent.
- Aunt, uncle, niece, or nephew.
- Cousin.
- In-law.
- Brother, sister, stepbrother, stepsister, half- brother, or half-sister.

FAP

Exclude the homestead the owner formerly lived in if the owner intends to return and is absent for one of the following reasons:

- Vocational rehabilitation training.
- Inability to live at home due to a verified health condition.
- Migratory farm work.
- Care in a hospital.
- Temporary absence due to employment, training for future employment, illness, or a casualty (example: fire) or natural disaster.

Homestead Land Retained Exclusion

SSI-Related MA Only

If an owner sells a homestead (example: mobile home), but retains ownership of the land it was on, exclude the land for three months. The first month is the month the owner receives any payment from the sale. Also, exclude the land for the time between the sale and the receipt of such payment.

Homestead-Loss Land Exclusion

SSI-Related MA Only

Exclude the land of a damaged, destroyed, or condemned homestead if both of the following are true:

- The owner intends to reoccupy it.
- There is a written repair or replacement agreement.

The client must declare an estimated completion date. The exclusion lasts until that date. The local office may grant extensions.

Real Property and Employment Assets

SSI-Related MA Only and FAP

Employment-related assets such as farmland and the building where a business is located might be excluded; see *Employment Asset Exclusions* in this item.

Future Home Exclusion

FAP

Exclude a lot (including a partially built home) if the owner intends it to become the fiscal group's homestead and has no other homestead.

Real Property and Burial Arrangements

SSI-Related MA Only

Property intended as burial space might be excludable; see *Burial Space Exclusion* in this item.

FAP

Exclude burial plots and any burial and funeral arrangements purchased by members of the FAP group.

Income-Producing Real Property

SSI-Related MA Only

Exclude up to $6,000 of equity in income-producing real property if it produces annual countable income equal to at least 6 percent of the asset group's equity in the asset. Countable income is total proceeds minus actual operating expenses.

Exception: Use the Employment Asset Exclusions in this item for property used in a business or trade.

FAP Only

Exclude rental and vacation properties owned by the group if they are renting it to produce income.

Note: Time-share properties are excluded.

HOUSEHOLD AND PERSONAL GOODS DEFINED

FAP

Household Goods - those items customarily found in the home and used in connection with the maintenance, use and occupancy of the premises. This includes items necessary for an adequate standard of sustenance, accommodation, comfort, information and entertainment of occupants and guests. Examples are appliances, furniture, television sets, carpets, cooking utensils, eating utensils and dishes.

Personal Goods - items of personal property that are worn or carried by a person or that have intimate relationship to them. Examples are personal clothing and jewelry, personal care items, and educational or recreational items such as books, musical instruments, or hobby material.

SSI-Related MA Only

Household Goods - those items of personal property found in or near the home. Household goods are needed for maintenance, use, and occupancy of the premises as a home. Items are considered a person's household goods when they are currently used, or in the case of an institutionalized person, were previously used by the person in his or her own residence. Examples include furniture, carpets, and dishes.

Personal Effects - those items of personal property which are ordinarily worn or carried by the individual, or items which have an intimate relation to the individual. Examples include wedding and engagement rings, pets, books.

HOUSEHOLD AND PERSONAL GOODS EXCLUSION

SSI-Related MA Only and FAP

Exclude household and personal goods.

VEHICLES

SSI-Related MA Only

A **vehicle** is any registered or unregistered vehicle used for transportation. Vehicles used for transportation include, but are not limited to, passenger cars, trucks, motorcycles, boats, snow mobiles, animal-drawn vehicles, and even animals.

Note: See Homes and Real Property about mobile homes.

FAP

Vehicles are excluded as an asset.

Vehicle Value

SSI-Related MA Only

The value of a vehicle is its equity value. Equity value is the fair market value minus the amount legally owed in a written lien provision.

Liens must be on record with the Secretary of State or other appropriate agency.

VEHICLE EXCLUSIONS

SSI-Related MA Vehicle Exclusion

SSI-Related MA Only

Exclude one motorized vehicle owned by the asset group. If the asset group owns multiple motorized vehicles:

- Use the Employment Asset Exclusions first, then
  From any remaining motorized vehicles, exclude the one with the highest equity value.

PROMISSORY NOTES/LOANS/ LAND CONTRACTS/ MORTGAGES

Land Contracts

SSI-Related MA Only

A land contract is a form of seller financing. It is similar to a mortgage, but the buyer makes payments to the real estate owner (seller) until the purchase price is paid in full. A homeowner might also sell their home via a sale-leaseback agreement; see definition in this item. A land contract does not have to be recorded in Michigan.

The person who sold the property is the holder of the note. The note is the holder's asset.

Example: John sells land to Irma on a land contract. John is the land contract holder. The land contract is John's asset. The land is Irma's asset.

The value of a land contract is the amount it can be sold for in the holder's geographic area on short notice (usually at a commercial discount rate) minus any lien on the property the holder must repay.

A land contract may be treated as a transfer of assets unless all the following are true:

- The repayment schedule is actuarially sound; and
- The payments are made in equal monthly amounts during the term of the agreement with no deferral of payments and no balloon payments; and
- The contract must prohibit the cancellation of the balance upon the death of the lender.

See BEM 405, Uncompensated Value**,** to determine the value of any land contract which does not meet all of the bullets listed in this policy.

Note: The payments from a land contract are countable unearned income.

Mortgages

A mortgage is a loan that a bank or mortgage lender gives to a buyer to finance the purchase of a house. Mortgages are usually recorded to notify the public that the lender has a lien against the property.

The value of a mortgage is the amount it can be sold for in the holder's geographic area on short notice (usually at a commercial discount rate) minus any lien on the property.

A mortgage may be treated as a transfer of assets unless all the following are true:

- The payment schedule is actuarially sound; and
- The payments are made in equal monthly amounts during the term of the agreement with no deferral of payments and no balloon payments; and

- The mortgage contract must prohibit the cancellation of the balance upon the death of the lender.

See BEM 405, Uncompensated Value to determine the value of any mortgage which does not meet all of the bullets in this policy.

Promissory Notes/Loans

A promissory **note** is a written promise to pay a certain sum of money to another person at a specified time. Promissory notes are loans. The promissory note may call for installment payments over a period of time (installment note). The note is an asset to the lender. For eligibility, the value of the note is the outstanding balance due as of the date of application for long term care, home help, waiver services, or home health services.

The purchase of a promissory note or loan, **is a** transfer of assets. The purchaser has transferred cash in exchange for a written promise to be paid back by the borrower. This transfer must be reviewed to determine if the purchaser has received *fair market value*. A note that cannot be sold or transferred to another party does not meet the definition of *fair market value* and must be reviewed as a divestment. See the Glossary for definitions of *fair market value* and *arm length transaction*. In addition to the *fair market value* requirement the purchase of a promissory note is a transfer of assets for less than *fair market value* unless all the following are also true:

- The repayment schedule is actuarially sound; and
- The payments are made in equal monthly amounts during the term of the agreement with no deferral of payments and no balloon payments; and
- The note must prohibit the cancellation of the balance upon the death of the lender.

See BEM 405*, Uncompensated Value,* to determine the value of any promissory note or loan as a transfer for less than *fair market value*.

Note: Life expectancy tables used to determine actuarial soundness are in BEM 405.

Bona Fide Loans

A loan is bona fide if it meets all the following requirements:

- It is enforceable under state law.
- The loan agreement is in effect at the time of the transaction.
- The borrower acknowledges an obligation to repay.
- The loan document includes a plan for repayment.
- The repayment plan is feasible.

Note: Count principal payments from a bona fide loan or promissory note are the return of the principal as an asset in the month received. Payment of interest on a bona fide loan and all payments from a loan or promissory note which is not bona fide is countable unearned income.

The estate recovery program needs to know about a promissory note for the state to recover Medicaid expenses. Please send a copy of the promissory note to the estate recovery unit at: MDHHS-EstateRecovery@michigan.gov.

Sale-Leaseback Agreement Defined

SSI-Related MA Only

In a sale-leaseback agreement, a homeowner sells his home on an installment note and receives monthly payments from the buyer. The buyer allows the former homeowner to live in the home in exchange for rent. The difference between the buyer's payment and the rent is money the former homeowner can use for current expenses. Sometimes the arrangement involves purchase of an annuity that pays money to the former homeowner.

Sale-Leaseback Asset Value

SSI-Related MA Only

The note held by the former homeowner is an asset. The value is the amount the note can be sold for in the holder's geographic area on short notice (usually at a commercial discount rate) minus any liens on the property the former homeowner must repay.

The sale might also create income for the note holder; see BEM 503, *Sale-Leaseback Income*.

LIFE INSURANCE

SSI-Related MA Only

A **life insurance policy** is a contract between the policy owner and the company that provides the insurance. The company agrees to pay money to a designated beneficiary upon the death of the insured. Pure Endowment Life Insurance Contracts pay out on a specific date in the future, not just when the beneficiary dies, and does not meet the definition of life insurance for Medicaid.

Life Insurance Definitions

SSI-Related MA Only

Cash surrender value (CSV) - the amount of money the policy owner can get by canceling the policy before it matures or before the insured dies. It may be titled the cash surrender value or the cash value.

Face value (FV) - the amount of the basic death benefit contracted for at the time the policy is purchased. It might be titled the face value, face amount, amount of insurance, amount of policy or sum insured. It does **not** include dividends or additional amounts payable because of accidental death or other special circumstance.

Insured - the person whose life the policy insures.

Insurer - the company that contracts with the policy owner.

Policy owner - the person who has the right to change the policy. This is usually the person who pays the premiums. The policy owner and the insured can be different people.

Life Insurance Value

SSI-Related MA Only

A life insurance policy is an asset if it can generate a CSV. A policy is the policy owner's asset.

- A policy's value is its CSV. A policy can generate a CSV but have a CSV of zero. Such a policy is an asset with zero value.

- Generally, term insurance does **not** have a CSV. Whole or straight life policies generate a CSV. Policies called graded term or level term may have a CSV and must be verified and counted as an asset.
- The CSV usually increases over time. A loan against a policy reduces its CSV. Pre-death payment of the death benefit might reduce the CSV. See **Accelerated Life Insurance Payments** in BEM 500 about the payments received.
- CSV and FV are **not** the same thing.
- Tables included with a life insurance policy are not considered accurate. Verification of the CSV should be either a current notice (within the year) from the company or by contacting the company for the current value.

LIFE INSURANCE EXCLUSIONS

Life Insurance for Funeral

SSI-Related MA Only

In addition to the general exclusion below, some or all of the value of insurance might be excluded to pay for funeral expenses; see **Funeral Plans** in this item.

General SSI-Related MA Life Insurance Exclusion

SSI-Related MA Only

Look at each policy owner's life insurance separately.

Exclude the entire cash surrender value when the total **face values** of all policies a policy owner has for the **same insured** are $1,500 or less.

See the example and exceptions below.

Example:

Mr. and Mrs. Smith own the following policies:

Policy	Owner	FV	Insured	CSV	
1	Mr.	$1,000	Mrs.	$500	
2	Mr.	$800	Mrs.	$300	
3	Mr.	$1,500	Mr.	$1,000	Exclude
4	Mr.	$2,000	Son	$1,000	
5	Mrs.	$1,500	Mr.	$500	Exclude
6	Mrs.	$2,000	Mrs.	$1,000	

CSVs for policies 1 and 2 are **not** excludable under this policy for Mr. Smith. He owns both policies. They insure the same person. The combined FVs exceed $1,500.

CSV for policy 4 is **not** excludable under this policy for Mr. Smith. The FV exceeds $1,500.

CSV for policy 6 is **not** excludable under this policy for Mrs. Smith. The FV exceeds $1,500.

Exceptions: Do **not** count the face value of:

- Term insurance that does **not** generate a CSV.
- Burial insurance. Burial insurance is an insurance policy whose terms prevent the use of its proceeds for anything other than payment of the insured's burial expenses. A policy is not burial insurance if the policy has a CSV the owner can access. A policy used for a Life Insurance Funded Funeral below is not burial insurance. Michigan does **not** have burial insurance, but a person from another state could have such insurance.
- Endowment policies. An **endowment policy** is a policy which enables the insured to accumulate a sum of money payable to them at a date named in the policy (the maturity date). The policy states whether the money is paid overtime or all at once. The policy matures on the maturity date. An endowment policy is **not** life insurance. Because the applicant gives up the rights to control the money until the maturity date, a non-matured endowment policy must be considered a divestment; see BEM 405.

LONG TERM CARE INSURANCE PARTNERSHIP POLICIES

SSI-Related MA Only

Long term care insurance partnership policies are health insurance and are not countable as assets. However, there are special asset rules for individuals who use long term care insurance partnership policies to pay for long term care.

At the initial eligibility determination there is an asset disregard (starting with countable assets first) equal to the amount that the long-term care policy has paid to, or on the behalf of, the applicant. The asset disregard can increase at redetermination or case closure. The countable asset limit for Extended Care category remains the same. Assets of any type can receive the disregard. These disregarded assets are also disregarded (protected from) estate recovery.

LONG TERM CARE INSURANCE POLICIES

SSI-Related MA Only

Long Term Care (LTC) insurance is a potential third-party payer for some medical expenses. Usually, the LTC insurance can pay all or some of the LTC expenses before the MA program pays. LTC insurance policies need to be reported to TPL. TPL will process the information and update the MA payment of LTC medical claims accordingly. LTC insurance is not considered an asset or income for the individual. Individuals need to make arrangements with the nursing facility to forward any LTC insurance payments the individual receives to the nursing facility; the payments should not accumulate.

FUNERAL PLANS

SSI-Related MA Only

Funeral plan refers to the prearrangement for cemetery and/or funeral goods and services. Normally, the plan is established using one or more of the following:

- Burial fund.
- Purchase of burial space.
- Prepaid funeral contract.
- Life insurance funding.

Burial Fund Exclusion

SSI-Related MA Only

A limited amount of certain types of assets a person has clearly designated to pay for burial expenses is excluded as a burial fund. See below for information about:

- Types of assets.
- Burial expenses.
- Clearly designated.
- Not commingled.
- Amount excluded.
- Misuse of funds.

See Exhibit I of this item for examples of this exclusion.

Types of Assets

Assets under the following headings in this item can be a burial fund:

- Cash.
- Investments.
- Life insurance.
- Prepaid funeral contract.

Other types of assets (example: real property, vehicles, livestock) may **not** be a burial fund.

Burial Expenses

Expenses that qualify for the burial fund exclusion are generally those related to preparing a body for burial and any services prior to burial. Examples are:

- Services of funeral director and staff.
- Transportation of the body.
- Embalming.
- Cremation.

- Clothing.
- Cost of guest registry book.
- Cost of obituary.
- Flowers **not** displayed at gravesite.
- Cleric's honorarium if no services at gravesite.
- Burial space items that do **not** meet the held for test described in *SSI-Related MA Burial Space Exclusion* in this item.

Note: A Luncheon or similar service does not meet the definition of a burial expense as it is not related to the preparation of the body for burial. Do not certify a DHS-8A with such an expense and do not consider it as an allowable burial expense item.

Clearly Designated

The asset must be clearly designated. The designation can be on the asset (example: title on a bank account, prepaid funeral contract) or on a signed statement from the client. The designation must include the following information:

- Value and owner of the asset.
- Whose burial the fund is for.
- Date the funds were set aside for the person's burial.
- Form in which the asset is held (example: bank account, life insurance).

Not Commingled

Burial funds may **not** be commingled with any assets except excluded burial space assets; see *SSI-Related MA Burial Space Exclusion* in this item.

Amount Excluded

Exclude up to $1,500 for each qualified fiscal group member and/or spouse. In addition, exclude accumulated interest and dividends.

Reduce the $1,500 per person maximum by the following:

- The face value of excluded life insurance policies (including term insurance) when the person is the insured and:
    - If an adult, the policy is owned by the person or the person's spouse.

- If a child, the policy is owned by the child, the child's parent or the parent's spouse.

- The principal amount (**not** accumulated interest or dividends) held in an irrevocable prepaid funeral contract for the person's burial expenses (see above). Do **not** count the identifiable cost of burial space assets; see *Burial Space Defined* in this item.

- The cost of burial expenses (see above) identifiable in a life insurance funded funeral plan that was irrevocably transferred (see *Life Insurance Funded Funeral and Life Insurance Irrevocably Transferred* in this item.

- The face value of burial insurance on the person. See *Life Insurance* in this item for the definition of burial insurance.

Count only the original principal amount and any additions to the principal to determine if the maximum limit has been reached. Do **not** count accumulated interest and dividends.

Note: The principal amount of a life insurance policy is the cash surrender value (CSV) of the policy, **not** the face value. Increases in the CSV count against the limit. Increases in the CSV above the person's burial fund limit are countable as the policy owner's assets.

Misuse of Fund

Count the amount of an excluded burial fund used for another purpose **while the person was an MA recipient** as unearned income for one month. The month must be far enough in the future so that any negative action pend period would end before the month begins.

Exception: Do **not** do this if the value of countable assets plus the misused funds were within the asset limit for the month the misuse occurred.

Burial Space Defined

SSI-Related MA Only

A **burial space** is a(n):

- Burial plot, gravesite.

- Crypt, mausoleum.
- Casket, urn, niche.
- Some other type of repository customarily and traditionally used for the deceased's bodily remains.
- **Necessary** and **reasonable** improvements or additions to or upon such spaces including:
  - Vaults.
  - Headstones, markers, or plaques.
  - Burial containers.
  - Opening and closing of the gravesite.
  - Contracts for care and maintenance of the gravesite.

Note: Reasonable and **necessary** are those items required by the cemetery.

- Flowers if displayed at gravesite.
- Cleric's honorarium for service at gravesite.

Note: Of the items that serve the same purpose, exclude only one item per person.

Example: Exclude a cemetery lot and casket for the same person, but not a casket and an urn.

Value of Burial Space

SSI-Related MA Only

The value of a burial space item is its equity value. Equity value is fair market value minus the amount legally owed in a written lien provision.

SSI-Related MA Burial Space Exclusion

SSI-Related MA Only

An applicant can own and exclude burial space items for themselves. Burial space items in a prepaid funeral contract must be identified and valued separately from non-burial space times to

be excluded Burial space items on a revocable prepaid contract are excluded. Burial space items on an irrevocable contact are not a resource.

In addition to their own burial space items an applicant can own and exclude burial space items for each of the following individuals:

- Each qualified fiscal group member; see BEM 211.
- Whether by blood, adoption or marriage, the member's:
  - Parents.
  - Minor and adult children.
  - Siblings.
- The spouse of each person listed above.

The applicant must retain ownership and control of the burial space item to receive the exclusion; see *held for* policy in this item. The exclusion ends if the applicant's relationship to a relative only by marriage has ended by death or divorce.

The burial space must continue to meet the *held for* criteria to be excluded, see *held for* in this item. If a burial space is transferred to another individual (even if listed above) it no longer meets the *held for* criteria and must be reviewed for divestment; see BEM 405.

If the burial space items serve the same purpose, exclude only one item per person.

Note: An applicant may transfer a burial space item to a disabled child of any age or the applicant's spouse without incurring a divestment.

Held For. A burial space is held for an individual when the applicant currently has:

- Title to and/or possesses a burial space intended for the listed individual's use (for example has title to a burial plot, has paid for a burial urn).

- A contract with a funeral service company for specified burial spaces for the listed individual's burial (that is, an agreement that represents the listed individual's current right to the use of the items).

A burial space does not meet the definition of *held for* any applicant or listed individual under an installment sales contract or similar

device if the purchase price is not paid in full and any of the following are true:

- The individual does **not** currently own the space.
- The individual does **not** currently have the right to use the space.
- The seller is **not** currently obligated to provide the space.

Until all payments are made on the contract, the amounts paid might be considered burial funds; see *Burial Fund Exclusion* in this item.

Note: In Michigan only a provider licensed by the Michigan Department of Licensing and Regulatory Affairs can sell burial space items.

Prepaid Funeral Contract

SSI-Related MA Only

A prepaid funeral contract means a contract requiring payment in advance for funeral goods or services. Contracts may be revocable or irrevocable.

- See *Revocable Prepaid Funeral Contract Exclusions and Value* in this item if the contract is revocable.
- See *Irrevocable Prepaid Funeral Contracts* in this item if the contract is irrevocable.
- See BAM 805, Prepaid Funeral Contracts, about making Michigan contracts irrevocable.

Revocable Prepaid Funeral Contract Exclusions and Value

SSI-Related MA Only

Funds in a revocable prepaid funeral contract might be excludable using the *Burial Fund Exclusion* and/or the *SSI-Related MA Burial Space Exclusion* in this item.

The countable amount of the contract is the amount remaining on deposit after deducting those exclusions and any commissions or fees that would be charged upon withdrawal. There is no burial funds exclusion.

Irrevocable Prepaid Funeral Contracts

G2U, G2C, RMA, SSI-Related MA Only

Funds in an **irrevocable** prepaid funeral contract are unavailable and thus are **not** counted.

Funds in a Michigan contract (DHS-8A, Irrevocable Funeral Contract Certification) certified irrevocable are excluded.

Note: Prior to 1986 Michigan law allowed a pre-paid funeral contract to be funded with a Certificate of Deposit (CD). These contracts may be certified as irrevocable.

Life Insurance Funded Funeral

SSI-Related MA Only

A funeral plan can be funded using life insurance. A person purchases a life insurance policy and directs the proceeds to be used to pay for their funeral. In addition, the person might irrevocably/permanently transfer ownership of the policy to either:

- A trust.
- A funeral director who then transfers ownership to a trust.

Note: An annuity can be used in the same way to fund a funeral plan.

Proceeds of a life insurance policy means the face value of the policy plus any additions payable at maturity or death. Proceeds are reduced by the amount of outstanding loans against the policy and Accelerated Life Insurance Payments**;** see BEM 500.

A funeral plan funded with life insurance is **not** a prepaid funeral contract per BAM 805.

Life Insurance Funded Funeral Trusts

SSI-Related MA Only

Life insurance funded trusts, regardless of including specific goods or services, or naming a funeral provider, are countable if revocable and a divestment if irrevocable. Send a life insurance funded trust to the Trust and Annuity Evaluation Unit.

Other Funded Funeral Trusts

Other funded funeral trusts, regardless of including specific goods or services, or naming a funeral provider, are countable assets if revocable and divestment if irrevocable. These trusts are not prepaid funeral agreements and do not qualify for any funeral exemptions. A DHS-8A cannot be used to certify a revocable trust as irrevocable for purposes of exclusion.

Life Insurance NOT Irrevocably Transferred

SSI-Related MA Only

If a person has directed the proceeds of a life insurance policy be used to pay for their funeral, but has **not** irrevocably transferred ownership, the policy is treated as life insurance. See *Life Insurance and Burial Fund Exclusion* in this item.

Life Insurance Irrevocably Transferred

SSI-Related MA Only

Use the following when a person directs that the proceeds of a life insurance policy be used for their funeral **and** has **irrevocably** transferred ownership of the policy. Do this even if the person retains the right to change funeral providers, items, or services.

- Do **not** count the cash surrender value of the policy as an asset effective the month of transfer.
- Do not count the funeral contract as an asset.

- Do not apply policy in BEM 401.
- Do not consider the ownership transfer as divestment when all of the following are true:
  - The proceeds are still to be used to pay the insured's funeral expenses.
  - The value of the goods and contracted services at least equals the cash surrender value of the insurance.
  - The new owner **cannot** use the cash surrender value of the insurance policy for themselves.

Note: If the value of the goods and services contracted for is less than cash surrender value of the insurance, the difference is transferred for less than fair market value.

Limited Liability Companies

SSI-Related MA Only

Count any assets in a Limited Liability Company (LLC).

LIVESTOCK

SSI-Related MA Only and FAP

Exclude farm animals used for personal consumption. Exclude family pets.

Other livestock might be excluded as an employment asset; see *Employment Asset Exclusions* in this item.

EMPLOYMENT AND TRAINING ASSETS

SSI-Related MA Only and FAP

Employment assets are those assets commonly used in a business, a trade or other employment. Examples:

- Farmland.
- Tools, equipment and machinery.
- Inventory, livestock.
- Savings or checking account used solely for a business.

- The building a business is located in.
- Vehicles used in business such as a farm tractor or delivery truck. It does **not** include vehicles used solely for transportation to and from work.

Such assets might also be used in education or job training.

Employment or Training Asset Value

See the appropriate sections above regarding the value of vehicles, real property and savings or checking accounts. The value of other employment or training assets is their equity value. Equity value is fair market value minus the amount legally owed in a written lien provision.

Payment-In-Kind (PIK) Program

A PIK commodity or commodity certificate may be an asset; see BEM 502 and 503 (for MA), Payment-in-Kind (PIK) Program.

EMPLOYMENT ASSET EXCLUSIONS

General Employment Exclusion

SSI-Related MA Only and FAP

Exclude *employment assets* (see above) that:

- Are required by a person's employer.
- Produce income directly through their use.

Such assets remain excluded when a person is unemployed only if the person intends to return to that type of work.

Exception: For FAP, exclude assets essential to self-employment farming for one year after the person quits the farming activity, even if they have no intent to resume.

Lien Exclusion

FAP Only

Exclude a non-liquid asset against which a lien has been placed because of taking out a business loan and the household is prohibited by the security or lien agreement with the creditor from selling the asset(s). This asset is considered not accessible.

Education and Training Exclusion

FIP, RCA, SDA, G2U, G2C, RMA and CDC

529 college savings plans are designed to allow individuals to make after-tax deposits for their children's future higher education expenses. In Michigan, these plans are administered by the Department of Treasury and are known as Michigan Education Savings Plans. Funds deposited into these accounts may qualify for matching funds. After a child reaches age 18, the funds may be used for post-secondary education or a certified training program.

Disregard funds on deposit in a 529 college savings plan, interest earned on a 529 plan, and any matching funds deposited in a 529 plan.

SSI-Related MA Only

Exclude assets directly related to a person's current education or job training program. Directly related means the asset is necessary for the major program of study or related occupation. Current means ongoing participation except for school breaks.

Example: Exclude tools the person needs for their ongoing auto mechanics program.

Continue this exclusion for six calendar months following the month the program is completed if the person intends to seek employment in that occupation.

Note: This exclusion does **not** apply to real property and life estates.

Health Profession Opportunity Grant

All Types of Assistance

These payments are issued to provide education and training in the health care field to Temporary Assistance to Needy Families recipients and other low-income individuals.

Bridges excludes as income and assets.

EXCLUDED ASSETS

FAP

Exclude Native American lands held jointly with the Tribe, or land that can be sold only with the approval of the Department of the Interior's Bureau of Indian Affairs.

Public Law 79-396, Section 12(e) of the National School Lunch Act, as amended by Section 9(d) of Public Law 94-105, excludes assistance provided to children rather than that paid to providers. The programs include:

- School Lunch Program.
- Summer Food Service Program.
- Child and Adult Care Food Program.
- Commodity Distribution Program.

Public Law 89-642, the Child Nutrition Act of 1966, Section 11(b). The programs include but are not limited to:

- Special Milk Program.
- School Breakfast Program.
- Special Supplemental Food Program for Women Infants and Children (WIC).

Public Law 93-531, Section 22, 10/17/75 - Relocation assistance payments to members of the Navajo and Hopi tribes.

Public Law 97-403 - Payments to the Turtle Mountain Band of Chippewas and Arizona.

Public Law 97-408 - Payments to the Blackfeet, Grosventre and Assiniboine tribes, Montana, and the Papago, Arizona.

Public Law 97-458.

Public Law 98-500, Section 8, 10/17/84, Old Age Assistance Claims Settlement Act, provides that funds made to heirs of deceased Native Americans under this Act should not be considered as assets nor otherwise used to reduce or deny food stamp benefits except for per capita shares more than $2,000.

Public Law 99-146, Section 6(b), 11/11/1985 - Funds distributed per capita or held in trust for members of the Chippewas of Lake Superior. Judgments were awarded in Dockets Numbered 18-S, 18-U, 18-C and 18-T.

Public Law 99-377, Section 4(b), 8/8/86, - Funds distributed per capita to the Chippewas of the Mississippi or held in trust under this Act are excluded. The judgments were awarded in Docket Number 18-S.

Public Law 101-277, 4/30/90, funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73,151 and 73-A of the Indian Claims Commission.

Public Law 103-436, 11/02/94, Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act, Section 7(b), provides that payments made pursuant to this Act are totally excluded.

Public Law 111-291, Section 107(f)(2) of the Claims Resolution Act of 2010 - Payments received from the Cobell vs. Salazar Settlement.

VERIFICATION REQUIREMENTS

FIP, SDA, RCA, G2U, G2C, RMA, SSI-Related MA Only, CDC and FAP

Do **not** require verification when countable assets exceed the limit based on a person's own statement of value.

G2U, G2C, RMA and SSI-Related MA Only

Verify the value of countable assets at application, redetermination and when a change is reported.

Exception: For RMA, verify the value of countable assets at application only.

Verify joint ownership and that the countable amount is less than that presumed by policy at application and when a change is reported.

Verify the following factors affecting exclusion of an asset at application, redetermination, and when a change is reported:

- An asset is **not** available.
- Joint ownership prevents sale (other owner refuses to sell). Note: this does not apply to MA policy; see Jointly Owned Assets in this item.
- There is a written agreement to repair/replace a damaged or destroyed homestead (cash exclusion for G2U, G2C, RMA, SSI-Related MA Only; land exclusion for SSI-Related MA).
- There is a written agreement to purchase another homestead.
- The asset is a bona fide loan.

FIP, SDA, RCA and FAP

If questionable, verify countable assets at application, semi-annual, mid-certification, redetermination and when a change is reported. Examples include, but are not limited to, recent program closure or denial due to excess assets and a new application is received with an asset balance now under the asset limit, or the client is reporting they are close to the asset limit.

Example: Aaron applies for cash and FAP. The FAP group is non-categorically eligible. Aaron's total liquid assets are close to the asset limit. The specialist determines during a conversation with the client that the amount reported is questionable. Verification of the assets is requested.

Exception 1: Client statement is not an acceptable verification for trusts and annuities.

Exception 2: Client statement is not an acceptable verification for asset detection unless previously reported.

Exception 3: For FAP, client statement is not an acceptable verification for asset transfers/divestment.

If questionable, verify the following factors affecting exclusion of an asset at application, redetermination, and when a change is reported:

- An asset is not available.
- Joint ownership prevents sale (other owner refuses to sell). See *Jointly Owned Assets* in this item.
- There is a written agreement to repair/replace a damaged or destroyed homestead.
- There is a written agreement to purchase another homestead.
- The asset is a bona fide loan.

CDC Only

Do not verify countable assets.

SSI-Related MA Only

- An asset is non-salable.
- The equity value in income-producing real property.
- Any transfer of ownership of life insurance to fund a funeral.

VERIFICATION SOURCES

FIP, SDA, RCA, G2U, G2C, RMA, SSI-Related MA Only, and FAP

The following prove ownership and/or value of assets. Use the DHS-20, Verification of Assets, the DHS-27, Release of Information, or other specified form as appropriate, when helping a person verify assets.

Document information verified by telephone contact in the case or on a DHS-223, Documentation Record.

Other sources of verification are listed by asset type.

Note: For FAP the following are examples of acceptable verification sources and **not** an all-inclusive list.

Checking or Draft Account

- Telephone contact with financial institution.

- Written statement from financial institution.
- Monthly statement (Examination of checkbook is not sufficient.)

Crowdfunding Account

- Copy of Account site.
- Bank statement showing deposits from a crowdfunding account.

Cryptocurrency

- URL chosen by the client, exact exchange rate, amount of currency the household owns and a screenshot of the exchange site the client is using.
- Choose a URL such as Coinbase if a client does **not** wish to provide a URL. Document the URL used, exact exchange rate, amount of currency the household owns, and a screenshot of the exchange site used.

Federal Tax Refund

Proof of tax refund amount and date received.

Individual Development Account

- Copy of documents establishing the IDA.
- Statement from the trustee or custodian of the account.

Note: Documentation must specify the purpose for which the trust or account is established, that the trust or account will receive matching funds, and that withdrawals must be authorized by the trustee or custodian.

Irrevocable Funeral Contract

Copy of DHS-8A, Irrevocable Funeral Contract Certification, certifying contract irrevocable.

Loan

- Lien Exclusion.

- Letter from creditor.
- Telephone contact with creditor. Copy of financial institution loan contract.
- Lender's financial statement showing withdrawal of borrowed amount.

Life Insurance

- DHS-4786, Life Insurance Verification, completed by agent or company.
- Statement from insurance company or agent.

LLCs (limited liability company)

- Operating agreement for the company.

LTC Patient Trust Fund

Written statement from LTC facility.

Money Held by Other

Written statement from person holding the money.

Native American Land

- Letter from the tribe.
- Telephone contact with the tribe.

Prepaid Funeral Contract

- Statement of funeral home or contract seller.
- Copy of contract.

Real Property

- Deed, mortgage, purchase agreement or contract.
- State Equalized Value (SEV) on current property tax records multiplied by two.
- Attorney or court records.

- County records.
- Statement of real estate agent or financial institution.

Retirement Plan

- Written statement from plan administrator.
- Current plan statement.

Savings or Share Account

- Monthly statement.
- Written statement from financial institution.
- Telephone contact with financial institution.

Savings Certificate

- Written statement from financial institution.
- Certificate itself.

SSI Dedicated Account

- Letter from Social Security Administration.
- Telephone contact with Social Security Administration.

Stocks and Bonds

- Written statement from broker or company.
- Listing in current newspaper.

Trust

- Copy of trust document.
- Copy of documents transferring ownership of assets to the trust.
- Appropriate source for the asset types owned by the trust.

U.S. Savings Bond

- Statement from financial institution.
- Bond itself.

Vehicles

- Title, registration, or proof of insurance.
- Loan statement or payment book.
- Secretary of State (SOS) inquiry. This inquiry needs to be done only if no other verification source is available or if the client requests assistance.

Exception: This is the only acceptable verification source for unlicensed vehicles driven by tribal members on Native American

reservations. The SOS clearance must be completed by a local office.

To determine value of the vehicle, do the following:

- Use Kelley Blue Book fair condition option at (www.kbb.com) or NADA Book at (www.nadaguides.com) wholesale (rough trade-in) value. When comparing the value between the two sources, use the lowest value.
- Do **not** add the value of optional equipment, special equipment or low mileage when determining value.
- Enter the greater of actual mileage or 12,000 per year.
- Enter the client's ZIP code.
- Do **not** change the preset typical equipment.
- Enter "fair" as the condition.
- Use the lowest trade-in value.

Statement of vehicle dealer or junk dealer, as appropriate.

Allow the person to verify a claim that the vehicle is worth less (example: due to damage) than wholesale book value. If the vehicle is no longer listed, accept the person's statement of value.

Exception: Verify the value of antique, classic, or custom vehicles. For the definition of antique and classic vehicles; see BPG Glossary.

Vendor Pre-Paid Debit Cards

- Statement from the vendor or online printout which reflects the current account balance, (for example, Direct Express, ReliaCard, etc.).

  Note: The client may have to pay for the statement.

- ATM balance inquiry with sufficient information to support a match to the account. For example, the card number matches the printed digits on the ATM slip.

Note: For MA an ATM slip sets the day of the month to determine countable assets. If the slip balance causes the client to exceed the asset limit the client must be given the opportunity to supply sufficient information to determine a calendar day in the month when they may be asset eligible.

EXHIBIT I - BURIAL FUNDS EXAMPLES: SSI-RELATED MA CATEGORIES ONLY

EXAMPLE 1:		EXAMPLE 2:	
Client has: $2,500 Savings Account		Client has: $2,500 $2,000	Savings Account Irrevocable Funeral Contract - No Burial Space Items
BURIAL FUNDS MAXIMUM:		BURIAL FUNDS MAXIMUM:	
$1,500 - MAXIMUM		$1,500 -2,000 0	 Principal Sum of Irrevocable Funeral Contract MAXIMUM
Client may:	Designate up to $1,500 for self as excludable burial funds.	Client may not designate any assets as excludable burial funds. However, the client could use savings to purchase burial space items.	
Client must:	Establish a separate account for the amount designated.		
EXAMPLE 3:		**EXAMPLE 4**	
Client has: $2,500 $2,000	 Savings Account Irrevocable Funeral Contract as follows: - $1,000 Casket - $600 Headstone - $400 Assorted Professional Services	Client has: $2,500 $1,000	 Savings Account Face Value of Excludable Life Insurance
$1,500 - $400 $1,100	 Principal Amount of Irrevocable Funeral Contract for Non-Burial Space Items MAXIMUM	$1,500 -1,000 $500	 Face Value of Excludable Life Insurance MAXIMUM
Client may:	Designate up to $1100 excludable burial funds or buy more burial space.	Client may:	Designate up to $500 as excludable burial funds or buy burial space items.
Client must:	Establish a separate account for the amount designated.	Client must:	Establish a separate account for the amount designated.

EXAMPLE 5		EXAMPLE 6		
Client has:		Couple has:		
$2,500	Savings Account	$2,800	Savings Account (Joint)	
$400	Irrevocable Funeral Contract for Professional Services	$1,300	Common Stock Account (Husband)	
$500	Face Value of Excludable Life Insurance.	$1,600	Face Value Life Insurance - CSV=$300 (Wife)	
BURIAL FUNDS MAXIMUM:		BURIAL FUNDS MAXIMUM:		
$1,500				
- $400	Principal Amount of Irrevocable Funeral Contract	$1,500 - MAXIMUM PER PERSON		
$1,100				
- $500	Face Value of Excludable Life Insurance			
$600	MAXIMUM			
Client may:	Designate up to $600 as excludable burial funds or buy burial space items.	Client may:	Designate up to $1,500 per person as excludable burial funds. One way to do this is:	
		HUSBAND		WIFE
		$200	Savings Account	$1,200
		$1,300	Common Stock	0
		$0	Life Insurance	$300
		$1,500		$1,500
Client must: Establish a separate savings account for the amount designated.		Client must: Establish a separate savings account for any amounts designated from savings.		

EXHIBIT II - LIFE ESTATE AND LIFE LEASE FACTOR TABLE

Age	Factor	Age	Factor	Age	Factor
0	.97188	40	.91571	80	.43659
1	.98988	41	.91030	81	.41967
2	.99017	42	.90457	82	.40295
3	.99008	43	.89855	83	.38642
4	.98981	44	.89221	84	.36998
5	.98938	45	.88558	85	.35359
6	.98884	46	.87863	86	.33764

Age	Factor	Age	Factor	Age	Factor
7	.98822	47	.87137	87	.32262
8	.98748	48	.86374	88	.30859
9	.98663	49	.85578	89	.29526
10	.98565	50	.84743	90	.28221
11	.98453	51	.83674	91	.26955
12	.98329	52	.82969	92	.25771
13	.98198	53	.82028	93	.24692
14	.98066	54	.81054	94	.23728
15	.97937	55	.80046	95	.22887
16	.97815	56	.79006	96	.22181
17	.97700	57	.77931	97	.21550
18	.97590	58	.76822	98	.21000
19	.97480	59	.75675	99	.20486
20	.97365	60	.74491	100	.19975
21	.97245	61	.73267	101	.19532
22	.97120	62	.72002	102	.19054
23	.96986	63	.70696	103	.18437
24	.96841	64	.69352	104	.17856
25	.96678	65	.67970	105	.16962
26	.96495	66	.66551	106	.15488
27	.96290	67	.65098	107	.13409
28	.96062	68	.63610	108	.10068
29	.95813	69	.62086	109	.04545
30	.95543	70	.60522		
31	.95254	71	.58914		
32	.94942	72	.57261		
33	.94608	73	.55571		
34	.94250	74	.53862		
35	.93868	75	.52149		
36	.93460	76	.50441		
37	.93026	77	.48742		
38	.92567	78	.47049		
39	.92083	79	.45357		

LEGAL BASE

FIP

MCL 400.57a(3)

MCL 400.10d

Annual Appropriations Act

26 USC 6409

MA

Social Security Act title XX
Social Security Act, Sections 1902(a)(10); (r)(2)
Deficit Reduction Act of 2005
26 USC 6409
42 CFR 435.840 -.845
MCL 400.106,112g
The Patient Protection and Affordable Care Act (Pub. L. 111-148 and the Health Care and Education Reconciliation Act (Pub. L.111-152).

RMA

26 USC 6409

45 CFR 400.101-102

Annual Appropriations Act

RCA

26 USC 6409

45 CFR 400.66

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

FAP

Food and Nutrition Act of 2008, as amended, Sec. 5. 7 U.S.C. 2014

7 CFR 273.8

7 CFR273.8(c)(1)
7 CFR 273.8(h)
7 CFR 273.9

25 USCS 640d-22 (P.L. 93-531, Section 22, dated 12/22/74).

25 USCS 1407 Judgment Funds (as amended by P.L. 93-134 and P.L. 97-458).

25 USCS 1408 (as amended by P.L. 93-134 and P.L. 97-458, P.L. 103-66).

26 USC 6409

Public Law 79-396, Section 12(e) of the National School Lunch Act, as amended by Section 9(d) of Public Law 94-105.

Public Law 89-642, the Child Nutrition Act of 1966, Section 11(b)

Public Law 91-646, Section 216 Uniform Relocation Assistance and Real Property Acquisition Policy Act of 1970.

Public Law 92-203, Section 29, dated 1/2/76, the Alaska Native Claims Settlement Act and Section 15 of Public Law 100-241, 2/3/88 the Alaska Native Claims Settlement Act Amendments of 1987.

Public Law 93-113, the Domestic Volunteer Services Act of 1972, Title I and II Payments

Public Law 93-288. Section 312(d), the Disaster Relief Act of 1974, as amended by P. L. 100-707, Section 105(i) the Disaster Relief and Emergency Assistance Amendments of 1988.

Public Law 93-531, Section 22,10/17/75.

Public Law 94-114, Section 6,10/17/75.

Public Law 94-540.

Public Law 95-433, Section 2.

Public Law 96-420, Section 9(c),10/10/80.

Public Law 97-300.

Public Law 97-403.

Public Law 97-408.

Public Law 98-123.

Public Law 98-124 Section 5.

Public Law 98-500, Section 8, 10/17/84.

Public Law 98-500, Section 8, 10/17/84, Old Age Assistance Claims Settlement Act.

Public Law 98-524, the Carl D. Perkins Vocational Education Act, Section 507 as amended by P.L. 101-392, 09/25/90, Sections 501 and 701 of the Carl D. Perkins Vocational and Applied Technology Education Act of 1990.

Public Law 99-146, Section 6(b), 11/11/1985.

Public Law 99-346, Section 6(b)(2).

Public Law 99-377, Section 4(b), 8/8/86.

Public Law 99-425.

Public Law 99-498.

Public Law 100-175.

Public Law 100-383, Section 105(f)(2).

Public Law 100-435, Section 501.

Public Law 101-201.

Public Law 101-277, 4/30/90, funds appropriated in satisfaction of judgments awarded to the Seminole Indians in Dockets 73,151 and 73-A of the Indian Claims Commission.

Public Law 101-426.

Public Law 101-508.

Public Law 101-610.

Public Law 102-325.

Public Law 103-286.

Public Law 103-322.

Public Law 103-436, 11/02/94, Confederated Tribes of the Colville Reservation Grand Coulee Dam Settlement Act, Section 7(b).

Public Law 104-193.

Public Law 104-204.

Public Law 105-143, 12/15/97, Michigan Indian Land Claims Settlement Act, Section 111.

MCL 400.10d

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

All Programs

Public Law 111-291, Section 107(f)(2) of the Claims Resolution Act of 2010 - Payments received from the Cobell vs. Salazar Settlement.

Affordable Care Act, Public Law 111-148.

DEPARTMENT POLICY

MA Only

This item contains Medicaid policy for trusts. The item is divided into three parts:

- Medicaid trusts.
- Medicaid qualifying trusts (MQTs).
- Other trusts.

Which policy applies depends on the terms of the trust and when the trust was established.

Use policy in Bridges Eligibility Manual (BEM) 400 and Bridges Administrative Manual (BAM) 805 for prepaid funeral contracts and life insurance funded funerals.

MAGI-related MA

For MAGI related programs there is no asset test. However, disbursements from annuities are generally countable as income in the month that they are received. In some cases, such as structured annuities that result from lawsuit settlements, this annuity income may not be taxable. Therefore, part or all of the annuity payments may not be countable toward an individual's MAGI income. In order to determine what parts of an annuity payment may or may not be countable toward an individual's income please follow the process for referrals to the Trusts and Annuities Unit outlined in this item to have the annuity evaluated. In the case of MAGI-related annuity evaluations, a copy of the lawsuit settlement agreement **must** be submitted to the Trusts and Annuities Unit in order to make the determination.

GENERAL DEFINITIONS

MA Only

These definitions apply to all trust policy. There are special definitions for Medicaid trusts.

Beneficiary

The person for whose benefit a trust is created.

Grantor or Settlor

The person who established the trust. Any person who contributes to a trust is considered a grantor.

Principal or Corpus

The assets in the trust. The assets may be real property (house, land) or personal property (for example, stocks, bonds, life insurance policies, savings accounts).

Trust

A right of property created by one person for the benefit of himself or another. It includes any legal instrument or device that exhibits the general characteristics of a trust but is not called a trust or does not qualify as a trust under state law. Examples of such devices might be annuities, escrow accounts, pension funds and investment accounts managed by someone with fiduciary obligations.

Trustee

The person who has legal title to the assets and income of a trust and the duty to manage the trust for the benefit of the beneficiary.

REFERRALS TO TRUSTS AND ANNUITIES UNIT

A completed DHS-1517, Request for Trust/Annuity Evaluation, **must** accompany all trusts/annuities requests. Send all trusts and annuities to the Trusts and Annuities Unit for evaluation. The evaluation request must be sent to the following email box:

MDHHS-MA-FAP-Trusts_Annuities@michigan.gov

Email is the preferred method for submitting evaluation requests; however, if necessary, requests may also be sent via ID mail to:

Michigan Department of Health and Human Services
Legal Affairs Administration
Attn: Trust & Annuities
333 S Grand Avenue
P.O. Box 30195
Lansing, MI 48909

Email address boxes for requests or inquiries to the Legal Affairs Administration can be found on the MDHHS-Net at:

http://inside.michigan.gov/dhs/DeptSites/CentOff/olsp/Pages/default.aspx

This does not apply to the following:

- Prepaid funeral contracts.
- Life insurance funded funerals.
- Limited Liability Companies (LLC).
- S-Corporations.
- Employer sponsored annuities.

Once a trust has been evaluated, a re-evaluation is not required unless the local office believes a change has occurred affecting availability of the trust principal or income, including a change in department policy.

An evaluation of a trust advises local offices on:

- Whether a trust is revocable or irrevocable, and
- Whether any trust income or principal is available.

Advice is only available to local offices for purposes of determining eligibility or an initial assessment when a trust actually exists. Advice is not available for purposes of estate planning, including advice on proposed trusts or proposed trust amendments.

Send the referral as soon as possible so that everyone can complete their tasks timely. The referral must be in writing and include:

- Referring specialist's name, email address, phone number and local office.
- What advice is being requested.
- What programs are involved.
- Whether the grantor is living or dead.
- Whether the person is an applicant or recipient.
- Source of the assets used to establish the trust (for example money from the grantor's lawsuit settlement).
- The MA client's name and, if applicable, their spouse's name.
- The grantor's relationship to the MA client or spouse.

- The name of the person(s) who contributed to the trust and their relationship to the MA client and spouse.
- Legible copies of the complete trust document, all amendments to the trust, addenda, correspondence, and other pertinent information.

Note: Do not send asset and/or income verifications to the Trust and Annuities Unit.

EVALUATING TRUSTS

Determine if a trust established on or after August 11, 1993, is a Medicaid trust using:

- *Medicaid trust definitions* and
- *Medicaid trust criteria*.

Use the following policies if the trust is a Medicaid trust:

- *Countable assets from Medicaid trusts.*
- *Countable income from Medicaid trusts.*
- *Transfers for less than FMV*.

Determine if a trust established before August 11, 1993, is a Medicaid Qualifying Trust (MQT). Use the following policies if the trust is an MQT.

- *Countable MQT assets.*
- *Countable MQT income*.

Use *other trust* policy when a trust is **not**:

- An MQT.
- A Medicaid trust.

MEDICAID TRUST DEFINITIONS

Use the *general definitions* and these definitions when determining:

- Whether a trust is a Medicaid trust, and
- What is available from and transferred for a Medicaid trust.

Irrevocable Trust

A trust that is not a revocable trust; see *revocable trust* in this item.

Resources

All income and assets of a person and the person's spouse. It includes any income and assets the person or spouse is entitled to but does not receive because of action:

- By the person or spouse.
- By someone else (including a court or administrative body) with legal authority to act in place of or on behalf of the person or spouse.
- By someone else (including a court or administrative body) acting at the direction or upon the request of the person or spouse.

Revocable Trust

A trust which can be revoked or modified by:

- The grantor.
- A court.
- The trustee.
- Any other person or entity.

This includes a trust which allows for revocation or modification only when a change occurs, such as the grantor leaves the LTC facility, or the beneficiary becomes competent.

Modify means changing the beneficiaries or the availability of principal or income.

ANNUITY DEFINED

Annuity

A written contract, with a commercial insurance company, establishing a right to receive specified, periodic payments for life or for a term of years. They are usually designed to be a source of retirement income.

TRANSFERS TO AN ANNUITY EFFECTIVE 9/1/05

Converting countable resources to income through the purchase of an annuity or the amendment of an existing annuity by or on behalf

of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services on or after 09/01/05, is considered a transfer for less than fair market value unless the annuity meets the conditions listed below:

- Is commercially issued by a company licensed in the United States and issued by a licensed producer (a person required to be licensed under the laws of this state to sell, solicit, or negotiate insurance), and
- Is irrevocable, and
- Is purchased by an applicant or recipient for Medicaid or their spouse and solely for the benefit of the applicant or recipient or their spouse, and
- Is actuarially sound and returns the principal and interest within the annuitant's life expectancy, and
- Payments must be in substantially equal monthly payments (starting with the first payment) and continue for the term of the payout (no balloon or lump sum payments) and

If the annuity was purchased or amended by, or on behalf of, the applicant or recipient on or after February 8, 2006 the State of Michigan must be named as the remainder beneficiary in the first position, or as the second remainder beneficiary after the community spouse or minor or disabled child, for an amount at least equal to the amount of the Medicaid benefits paid on behalf of the institutionalized individual. The naming of the state in the first or second position must be verified at application or redetermination. If the State of Michigan is not named as a beneficiary as required in this paragraph, the total purchase price of the annuity will be considered to be the amount transferred for less than fair market value.

If an annuity is actuarially sound and provides for payment only to the community spouse during his/her lifetime then the annuity is considered to be for the sole benefit of the applicant's spouse, and it is not a transfer for less than fair market value and does not have to name the State of Michigan as a remainder beneficiary.

Annuities Funded with Certain Retirement Resources

An annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services on or after 2/8/2006 is **not** a transfer for less than fair market value if it is funded with certain retirement resources and established under any of the following sections of the Internal Revenue Code (IRC)

1. The annuity is considered either:
    - An individual retirement annuity under section 408(b) of the IRC; or
    - A deemed Individual Retirement Account under a qualified employer plan under section 408(q) of the IRC; or
2. The annuity is purchased with proceeds from one of the following:
    - A traditional individual retirement account (IRA) under section 408(a) of the IRC; or
    - Certain accounts or trusts which are established by employers or certain associations of employees under section 408(c) of the IRC; or
    - A simple retirement account under section 408(p) of the IRC; or
    - A simplified employee pension under section 408(k) of the IRC; or
    - A Roth IRA under section 408A of the IRC

Annuities established under any sections of the Internal Revenue Code referenced above do **not** have to be irrevocable or actuarially sound, and do not have to provide for equal monthly payments.

MEDICAID TRUST CRITERIA

A Medicaid trust is a trust that meets conditions 1 through 5 below:

1. The person whose resources were transferred to the trust is someone whose assets or income must be counted to determine MA eligibility, an MA post-eligibility patient-pay amount, a divestment penalty, or an initial asset assessment (IAA) amount. A person's resources include his spouse's resources (see definition).

2. The trust was established by:

   - The person.
   - The person's spouse.
   - Someone else (including a court or administrative body) with legal authority to act in place of or on behalf of the person or the person's spouse, or an attorney, or adult child.
   - Someone else (including a court or administrative body) acting at the direction or upon the request of the person or the person's spouse or an attorney ordered by the court.

3. The trust was established on or after August 11, 1993.

4. The trust was not established by a will.

5. The trust is **not** described in *Exception A, Special Needs Trust, or Exception B, Pooled Trust* in this item.

Exception A, Special Needs Trust

A trust is **not** a Medicaid trust if it meets all the following conditions:

- The trust must be unchangeable with regard to the provisions that make it an *Exception A, Special Needs Trust*. This is necessary to ensure that a trust initially meeting the other conditions still meets those conditions when the person dies; it must be irrevocable.
- The trust contains the resources of a person who is under age 65 and is disabled (not blind) per BEM 260. See *Continuing Exception A* when the person has attained age 65.
- The trust was established for the person described above. This means that the trust must ensure that none of the principal or

income can be used for someone else during the person's life-time, except for trustee fees per BEM 405.

- The trust was established by a court, by the person described above, or by the person's:
  - Parent.
  - Grandparent.
  - Legal guardian/conservator.
- The trust imposes on the trustee an automatic duty to repay Medicaid upon the person's death, up to an amount equal to the total medical assistance paid on behalf of the person.

  When a person has lived in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the individual received Medicaid, based on the state's proportionate share of the total amount of Medicaid benefits paid by all of the states on the person's behalf.

  Examples of circumstances under which a trust **fails** this repay condition are:

  - Requiring a trustee to reimburse Medicaid only if Medicaid first submits a claim.
  - Failing to provide that repaying Medicaid has priority over all debts and expenses except those given higher priority by law.

Transfers to Exception A Trust

Treat assets and income transferred into an *Exception A, Special Needs Trust* as part of the trust for the entire month of transfer.

Continuing Exception A

A trust that is an *Exception A, Special Needs Trust* when the person was under age 65 continues being an *Exception A, Special Needs Trust* after the person attains age 65. However, any additions or augmentations to the trust after the person attains age 65 are not protected by the exception. The additions/ augmentations are subject to trust and divestment policies without regard to *Exception A, Special Needs Trust.*

Countable Exception A Payments

Count as a person's unearned income any payment received from the trust.

Exception B, Pooled Trust

A trust is **not** a Medicaid trust if it meets all of the following conditions:

- The trust must be unchangeable with regard to the provisions that make it an *Exception B, Pooled Trust*. This is necessary to ensure that a trust initially meeting the other conditions still meets those conditions when the person dies.
- The trust contains the resources of a person who is disabled (not blind), per BEM 260; see *Transfers to an Exception B trust* in this item.
- The trust is established and managed by a nonprofit association.
- A separate account is maintained for each beneficiary of the trust, but for purposes of investment and management of funds, the trust pools these accounts.
- Accounts in the trust are established for the benefit of persons who are disabled (not blind) per BEM 260. This means the trust must ensure that none of the principal or income attributable to a person's account can be used for someone else during the person's lifetime, except for trustee fees per BEM 405.
- Accounts in the trust are established by the disabled person, the courts, or by the disabled person's:
  - Parents.
  - Grandparents.
  - Legal guardians/conservators.
- The trust provides that to the extent any amounts remaining in the beneficiary's account upon the death of the beneficiary are not retained by the trust, **the trust will pay to the state** the amount remaining up to an amount equal to the total amount of

medical assistance paid on behalf of the beneficiary under a state Medicaid plan.

When a person has lived in more than one state, the trust must provide that the funds remaining in the trust are distributed to each state in which the individual received Medicaid, based on the state's proportionate share of the total amount of Medicaid benefits paid by all of the states on the person's behalf.

Examples of circumstances under which a trust **fails** this repay condition are:

- Requiring a trustee to reimburse Medicaid only if Medicaid first submits a claim.
- Failing to provide that repaying Medicaid has priority over all debts and expenses except those given higher priority by law.

Transfers to Exception B Trust

Treat assets and income transferred into an *Exception B, Pooled Trust* as part of the trust for the entire month of transfer.

Transfers to an *Exception B, Pooled Trust* by a person age 65 or older are subject to divestment analysis. Do a complete divestment determination if the person is in a Penalty Situation per BEM 405.

Countable Exception B Payments

Count any payment received from the trust by the client as unearned income in the month received.

Multiple Contributors

When someone other than the person or the person's spouse has contributed to the principal of a trust, do not count as the person's assets or transferred assets an amount proportional to that other person's contributions to the principal.

Example: The Lang family contributed assets to the Lang Trust as follows:

John (MA applicant)	$50,000
Sally (John's daughter)	$10,000
Total Contributions	$60,000

Sally has contributed 1/6 of the total contributions. The value of the entire principal is currently $102,000. Therefore, $17,000.00 (one-sixth) of the current value cannot be counted as John's assets. Do not count the contributor's share as an asset.

REPAYMENT INQUIRIES

Refer trustees seeking to repay Medicaid to the following:

Michigan Department of Health and Human Services
Estate Recovery and Special Liability Section
PO Box 30435
Lansing, Michigan 48909

COUNTABLE ASSETS FROM MEDICAID TRUSTS

How much of the principal of a trust is a countable asset depends on:

- The terms of the trust, and
- Whether any of the principal consists of countable assets or countable income.

Countable Assets

The following are countable assets.

- Assets that are countable using SSI-related MA policy in BEM 400. Do not consider an asset unavailable because it is owned by the trust rather than the person.
- The homestead of an L/H or waiver patient or the patient's spouse even if the home was transferred before the patient was institutionalized or approved for the waiver.

Countable Income

Countable income from a trust is income that is countable using SSI-related MA policy in BEM 500. Income from a Medicaid trust that is not to or for the benefit of the person or their spouse is considered a divestment of income; see BEM 405.

Revocable Trust

Count as the person's countable asset the value of the countable assets and countable income in the principal of a revocable trust.

Exception: Exceptions:

- Reduce the countable amount when there are Multiple Contributors.
- Do not count the amount if it creates an Undue Hardship.

Irrevocable Trust

Count as the person's countable asset the value of the countable assets in the trust principal if there is any condition under which the principal could be paid to or on behalf of the person from an irrevocable trust.

Count as the person's countable asset the value of the trust's countable income if there is any condition under which the income could be paid to or on behalf of the person. Individuals can keep income made off of property and the money goes to the individual not the trust.

Exceptions:

- Reduce the countable asset amount by the amount of principal or income actually paid to or on behalf of the person during the month.
- Reduce the countable amount for multiple contributors.
- A trust may allow use of one portion of the principal, but not another portion. Count only the usable portion.
- Do not count the amount if it creates an undue hardship; see BEM 405.

Example: The principal of the Lang Trust consists of stocks, bonds, CD's, and a life insurance policy with a face value of $5,000 and cash surrender value of $2,000. The trustee is prohibited from using the life insurance policy in any way. The trustee can pay from the remaining portion of the trust principal enough to maintain John in the style to which he is accustomed. The trustee must pay the trust income to John. John wants MA for May. In May, the entire principal was worth $102,000. However, the usable portion of the

trust principal (the stocks, bonds, and CD's) was worth $100,000. The trustee used $300 to buy a TV for John and gave John $50 from the principal in May.

$100,000	usable principal
- 16,666	one-sixth reduction for multiple contributors from first example.
$83,334	
- 350	actually paid
$82,984	John's countable asset amount

Any portion of the principal or income that could never be paid to or on behalf of the person is transferred for less than fair market value. The look-back period is 60 months; see BEM 405. Reduce the transferred amount to account for multiple contributors and assets and income that are **not** countable assets or countable income.

Undue Hardship

Assume there is no undue hardship unless there is evidence to the contrary. Undue hardship exists when the person's physician (M.D. or D.O.) says:

- Necessary medical care is not being provided, **and**
- The person needs treatment for an emergency condition.

A medical emergency exists when a delay in treatment may result in the person's death or permanent impairment of the person's health.

A psychiatric emergency exists when immediate treatment is required to prevent serious injury to the person or others.

Payments actually made by a trustee to or on behalf of a beneficiary do not create an undue hardship.

See BEM 100, Policy Exception Request Procedure.

COUNTABLE INCOME FROM MEDICAID TRUSTS

Count as a person's unearned income any payment from a **Medicaid Trust** that is made to the person or his legal representative.

Example: In the preceding example for the Lang Trust, the $50 paid to John from the principal is countable unearned income. The trust income is also countable unearned income when paid to John.

TRANSFERS FOR LESS THAN FMV

Revocable Trust

Count payments from a revocable Medicaid trust to or on behalf of someone other than the person as follows:

- If the other person never contributed to the principal - any payment of countable assets or countable Income is a resource transfer for less than fair market value for purposes of BEM 405.
- If the other person contributed to the principal - any payment of countable assets or countable income exceeding the other person's proportional contribution to the principal is a resource transfer for less than fair market value for purposes of BEM 405.

The look-back period for such transfers is 60 months; see BEM 405.

Example: The Lang Trust pays Sally $300 per month from the trust's $600 per month income. Sally contributed only 1/6 of the trust principal. Therefore, $200 (1/6 of 600 = $100. $300 - 100 = $200) is a resource transferred for less than fair market value.

Irrevocable Trust

Count any portion of a trust's principal or income that is countable assets or countable income which cannot be paid to or on behalf of the person as transferred for less than fair market value for purposes of BEM 405.

Note: Be sure to adjust the transferred amount to account for multiple contributors.

The look-back period for such transfers is 60 months.

The date of transfer is the date payment is prohibited. The amount transferred is the amount which cannot be used as of that date plus any countable resources added by the person after that date.

Example: On 8/12/07 Ms. Thomas established an irrevocable Medicaid trust. Ms. Thomas transferred $50,000 cash to the trust on that date and $10,000 cash on 9/9/07. The trustee may pay all of the trust income to Ms. Thomas but cannot use any of the principal for Ms. Thomas. Ms. Thomas has transferred $60,000 for less than fair market value: $50,000 on 8/12/07 and $10,000 on 9/9/07.

Example: On 10/1/07 Mr. Lewis established an irrevocable Medicaid trust with $100,000 cash. The trustee has discretion to pay Mr. Lewis as much of the trust income and principal as Mr. Lewis may direct as long as Mr. Lewis is not in a nursing home. Once Mr. Lewis enters a nursing home, the trustee may only pay the trust income to Mr. Lewis. Mr. Lewis enters a nursing home on 12/12/07. The trust principal on 12/12/07 has a value of $101,250. On 12/14/07 Mrs. Lewis transfers $10,000 cash to the trust. The Lewis's have transferred $111,250 for less than fair market value; $101,250 on 12/12/07 and $10,000 on 12/14/07.

Count payments from an irrevocable Medicaid trust to or on behalf of someone other than the person as follows:

- If the other person never contributed to the principal - any payment of countable assets or countable income is a resource transfer for less than fair market value for purposes of BEM 405.
- If the other person contributed to the principal - any payment of countable assets or countable income exceeding the other person's proportional contribution to the principal is a resource transfer for less than fair market value for purposes of BEM 405.

The look-back period for such transfers is 60 months; see BEM 405.

MEDICAID QUALIFYING TRUST

Use the *general definitions* in this item.

A Medicaid qualifying trust (MQT) is a trust that has all of the following characteristics:

a. It was established before August 11, 1993.

b. It is established by a person whose assets must be considered or by that person's spouse.

c. The person whose assets must be considered is the beneficiary of all or part of the payments from the trust.

d. The amount distributed from the trust is determined by one or more trustees who are permitted to exercise at least some discretion with respect to the amount to be distributed to the person in (c) above.

A trust that is established by a person's guardian or legal representative, acting on the person's behalf, using the person's assets is treated as having been established by the person.

Exceptions:

- A trust is not considered an MQT if the sole beneficiary is a person who has a developmental disability who resides in an Intermediate Care Facility for Individuals with an Intellectual Disability (ICF/ID) **and** the trust or initial trust decree was established prior to April 7, 1986.

- A trust established by a will is not considered an MQT.

Countable MQT Assets

The countable asset amount for each person for whom assets must be considered is:

- The maximum payment that could be made from the trust (principal or income) to that person as a beneficiary of the trust if the trustee exercised his full discretion under the terms of the trust.

- **Minus** actual payments made by the trust to or on behalf of the person.

Clauses such as those that prohibit distributions that would affect MA eligibility are not considered limits on a trustee's discretion for purposes of this policy. To do otherwise would effectively negate the MQT policy.

Countable MQT Income

Count payments made to a beneficiary of an MQT as that person's unearned income.

OTHER TRUSTS

Use the *general definitions* in this item.

Use this policy for any trust that is not a Medicaid trust or an MQT.

Countable Assets

The trust principal is considered an available asset of the person who is legally able to:

- Direct use of the trust principal for his/her needs.
- Direct that ownership of the principal reverts to himself.

Count only the value of assets that are countable for the MA category being tested per BEM 400. Assume the person owns the asset in determining what is countable.

Transfers to Trust

Do a complete divestment determination when:

- A person has transferred assets to a trust,
- The principal is unavailable, and
- The person is in a penalty situation per BEM 405.

Countable Income

Count as a person's unearned income any payment received from the trust. This includes *Exception A, Special Needs Trust* and *Exception B, Pooled Trust trusts*.

VERIFICATION REQUIREMENTS

Verify income from a trust:

- Prior to authorizing benefits at application.
- At redetermination, and
- Whenever a change affecting income occurs.

Verify the value of a trust's principal if any portion is countable unless countable assets exceed the asset limit based on the client's statement of value.

See BEM 405 regarding verifications for divestment.

Verification Sources

Sources to verify income from a trust include:

- Trust records.
- Trustee correspondence.

Sources to verify the value of a trust's principal include:

- Statements from experts for the types of assets held by the trust.
- Trust records.
- Trustee correspondence.

LEGAL BASE

MA

Before August 11, 1993

Social Security Act, Section 1902(a)(10) and 1902(k)
42 CFR 435.840-.845
MCL 400.106

Starting August 11, 1993

Social Security Act, Section 1902(a)(18) and 1917(c)-(e)

42 U. S. C. § 1396p(d)(4)(A) and (C).

DEPARTMENT POLICY

MA Only

Unless the *special exception policy* in this item applies, an initial asset assessment is needed to determine how much of a couple's assets are protected for the community spouse. Do an initial asset assessment when one is requested by either spouse, even when an MA application is **not** made; see *definitions* and *initial asset assessment*.

FIP-Related MA Only

There is no asset test for Group 2 Pregnant Woman and MAGI categories.

It may be necessary to do an SSI-related MA determination in the future if such FIP-related MA eligibility ends. Therefore, initiate an initial asset assessment for an L/H or waiver client with a community spouse if one has not already been done. However, do **not** deny/terminate a Group 2 Pregnant Woman or MAGI MA category if the client chooses not to cooperate with the initial asset assessment. Also, do **not** delay authorizing MA while completing an initial asset assessment; see *definitions* and *initial asset assessment*.

SSI-Related MA Only

Use this item to determine asset eligibility for the first period of continuous care (see *definitions* in this item) that began on or after 9-30-89 when an L/H, PACE, or waiver client:

- Has a community spouse (see below), **and**
- A presumed asset eligible period has **not** yet been established, **or**
- If established, the presumed asset eligible period has **not** ended; see *presumed asset eligible perio*d in this item.

Use BEM 400 to determine asset eligibility for clients who do **not** meet the above conditions; see EXHIBIT II.

Example: Mary entered LTC on 5-3-03 and applied on 5-5-03. Frank, her spouse, stated he had been in the hospital for more than 30 days back in June and July 2001, but Mary has not been in a

hospital or LTC for 30 days or more. The initial asset assessment date would be 5-3-03.

Example: Anthony enters LTC on 4-6-03. His wife Joann applies for him on 4-18-03 and states that he had been in the hospital for 17 days and then LTC for the next 20 days beginning 12-12-99, but she had been in LTC for more than 30 days in July in 1999. The initial asset assessment date would be 12-12-99.

The continuous period of care applies to the L/H client who is applying, not the spouse who was hospitalized or in LTC first.

SPECIAL EXCEPTION POLICY

Do **not** do an *initial asset assessment*, even if the client or community spouse requests it, and do not do *initial eligibilit*y (in this item) when at the time a client becomes an L/H, PACE, or waiver client:

- The individual is already eligible for and receiving, SSI-related MA and one or both of the following is true:
  - The client's asset group for SSI-related MA included the spouse who is now the community spouse.
  - The community spouse is eligible for, and receiving, SSI-related MA from Michigan, including as an SSI recipient.

The client is considered asset eligible; therefore:

- Begin the client's *presumed asset eligible period*.
- Do **not** compute a community spouse resource allowance.
- Do **not** send a DHS-4588, Initial Asset Assessment Notice; or DHS-4585, Initial Asset Assessment and Asset Record.

DEFINITIONS

MA Only

Community spouse - Client's spouse when the spouse:

- Is not currently in, and is **not** expected to be, in a hospital and/or LTC facility for 30 or more consecutive days or the spouse is not approved for waiver, PACE, or Freedom to Work.
- For waiver clients, the spouse is **not** also approved for the waiver or PACE, or is not currently in, and is not expected to

be, in a hospital and /or LTC facility for 30 or more consecutive days.

For PACE clients, the spouse is **not** also approved for the waiver or PACE, or is not currently in, and is not expected to be, in a hospital and /or LTC facility for 30 or more consecutive days.

Continuous period of care - A period of at least 30 consecutive days where the institutionalized spouse/applicant has been, or is expected to be:

- In a hospital, and/or
- In an LTC facility, and/or
- Approved for the waiver as defined in BEM 106.
- Approved for PACE as defined in BEM 167.

The period is no longer continuous when none of the above is true for 30 or more consecutive days.

Example: Institutionalized spouse/applicant is in the hospital for 10 days, returned home for 5 days and then entered LTC. Because the applicant was not out of the hospital for 30 days or more, the continuous period of care begins with the hospital admission date.

Waiver - Provides home and community-based services to persons who, if they did **not** receive such services, would require nursing home care. The waiver is administered by the Michigan Department of Health and Human Services (MDHHS) through contracts with Pre-Paid Ambulatory Health Plans; see BEM 106.

Note: Persons applying for the waiver (BEM 106) may have received home and community-based supports and services for a period of time in the past or may be already receiving such services at the time of application. For those persons, the first day of continuous care may be the first day in which the person received at least 2 services listed in Exhibit III in this item for at least 30 continuous days.

COUNTABLE ASSETS

MA Only

Use SSI-related fiscal group policy in BEM 211 to determine fiscal groups. Use SSI-related MA policy in BEM 400 to determine countable assets.

CLIENT'S ASSET ELIGIBILITY

Initial Eligibility

SSI-Related MA Only

Apply the following formula to:

- Each past month, including retro MA months, and the processing month for applicants, and
- The first future month for MA recipients.

Exception: Do **not** do initial eligibility when the *special exception policy* in this item applies.

Begin the client's *presumed asset eligible period* in this item.

Initial Eligibility Formula

SSI-Related MA

The formula for asset eligibility is:

- The value of the couple's (applicant, spouse, joint) countable assets for the month being tested.
- **MINUS** the *protected spousal amount* (in this item).
- **EQUALS** the client's countable assets. Countable assets must **not** exceed the limit for one person in BEM 400 for the category(ies) being tested.

Exception: The client is asset eligible when the countable assets exceed the asset limit, if denying MA would cause undue hardship; see *undue hardship* in this item. Assume that denying MA will **not** cause undue hardship unless there is evidence to the contrary.

Presumed Asset Eligible Period

SSI-Related MA Only

Applicants eligible for the **processing month** and recipient's eligible for the first future month are automatically asset eligible for up to 12 calendar months regardless of:

- Changes in the community spouse's assets, or
- The number of MA applications or eligibility determinations that occur during the period.

The 12-month period begins with the month following the processing month and is called the presumed asset eligible period.

Exception: The 12-month period ends sooner if any of the following becomes true:

- The continuous period of care ends.
- The client's spouse no longer meets the definition of a community spouse when the spouse enters L/H, a waiver, or PACE.
- The client's spouse dies or the couple divorces.

Note: Do **not** extend the original 12-month period when the client becomes eligible for additional MA benefits (for example: QMB benefits were effective 8-1-91; Group 2 coverage began 10-1-91).

Presumed Asset Eligible Period Ends

SSI-Related MA Only

When the presumed asset eligible period ends, use BEM 400 to determine the client's asset eligibility. Count only the client's assets, **not** the spouse's assets, to determine continued eligibility. Verify all assets which are still owned by the individual, by the spouse, and jointly owned. Verify the transfers of all assets which were owned at the IAA, but which are no longer owned. Review all transfers for divestment.

Note: Because only the client's assets are counted after the presumed asset eligible period, the client may have to transfer some assets to his spouse to make sure that he owns no more than the asset limit for one person at the end of the presumed asset eligible period; see *asset transfer information* in this item.

ASSET TRANSFER INFORMATION

SSI-Related MA Only

The presumed asset eligible period allows time for the client to transfer assets to the community spouse. The client is **not** required to transfer assets to the spouse. However, if they fail to do so, the client may be ineligible for MA after the presumed asset eligible period.

When the rules in this item no longer apply, BEM 400 is used to determine continuing asset eligibility. The community spouse is **not** an asset group member. The protected spousal amount is **not** used. Therefore, the client's own countable assets must **not** exceed the appropriate asset limit (currently $2,000 for AD-Care or Extended Care categories).

Community Spouse Resource Allowance

SSI-Related MA Only

Federal law requires that the client and community spouse be told how much the community spouse resource allowance is and how it was calculated. Do this only when an applicant is MA eligible for the processing month or a recipient's eligibility continues.

Exception: Do **not** compute the allowance, notify the client or community spouse of the allowance, or send the asset transfer notice when the *special exception policy* in this item applies.

The allowance is:

- The *protected spousal amount*. (**MINUS** the value of the community spouse's current countable assets).

  Note: Do **not** count cash value assets owned jointly by the client and community spouse in this calculation.

- **EQUALS** the community spouse resource allowance.

However, the value of assets fluctuates constantly. Therefore, what the couple really needs to know is: when the rules in BEM 402 no longer apply, the client's countable assets must **not** exceed the appropriate asset limit (currently $2000 for the AD-Care and

Extended Care categories). All of the above information is in the asset transfer notice.

Notification

SSI-Related MA Only

Notify both the client and community spouse in writing of the above information:

- At the time an applicant is notified that he is eligible for the **processing** month, or a recipient continues eligible for MA, and
- When requested by the client, the community spouse, or the representative of either spouse.

Send **both** of the following to give notice:

- DHS-4586, Asset Transfer Notice.
- DHS-4585, Initial Asset Assessment and Asset Record.

Exception: Do **not** send the DHS-4585 when the *special exception policy* in this item applies.

INITIAL ASSET ASSESSMENT

MA Only

An initial asset assessment is needed to determine how much of a couple's assets are protected for the community spouse.

An initial asset assessment means determining the couple's (applicant's, spouse's, joint) total countable assets as of the first day of the **first** continuous period of care that began on or after September 30, 1989.

Example: A married man entered a nursing home on 12/6/89. He was released on 6/10/90 and returned home.

On 3/16/91 he re-entered the nursing home and has been there continuously ever since.

He applied for MA on 10/2/91. To determine his asset eligibility, do an initial asset assessment for 12/6/89 - the first day of the first continuous period of care that began on or after September 30, 1989.

Example: A married woman is hospitalized from 6-10-93 until 6-30-93 when she returns home and applies for waiver services.

> To determine her asset eligibility, do an initial asset assessment for 6-10-93, the first day of the first continuous period of care that began on or after September 30, 1989.

The federal law requires that an initial asset assessment be done when requested by either spouse **even when an application** for health care coverage **is not made**.

Exception: Do **not** do an initial asset assessment (even if the client or community spouse requests it) when the *special exception policy* in this item applies.

Form

MA Only

The DHS-4574-B, Assets Declaration, is used to request an initial asset assessment.

Notification

MA Only

Notify both spouses in writing of the results of the initial asset assessment whether it is done prior to, or at the time of, an MA application. Use the following:

- DHS-4588, Initial Asset Assessment Notice, and
- DHS-4585, Initial Asset Assessment and Asset Record.

The above notices inform the couple of the:

- Total amount of their countable assets, and
- The protected spousal amount, and
- Their hearing rights.

Send copies of all verifications or other documents used in making the initial asset assessment along with each copy of the notices.

Standard of Promptness

MA Only

Complete an initial asset assessment and mail notices within 45 days. The period begins on the date the local office receives the signed DHS-4574-B.

A person, who requests an initial asset assessment, without applying for MA, must be given the same assistance in completing the assessment and obtaining verification that would be provided to any client. See BAM 130 for types of verification, sources, and timeliness standards. An initial asset assessment **cannot** be completed if a client or the spouse refuses to provide verification or has **not** made a reasonable effort to obtain it within the time standards in BAM 130.

Do **not** deny/terminate a Group 2 Pregnant Woman or MAGI category if the client chooses **not** to cooperate with the initial asset assessment.

PROTECTED SPOUSAL AMOUNT

MA Only

The protected spousal amount is the amount of the couple's assets protected for use by the community spouse. It is the **greatest** of the amounts in 1-3 below.

1. Minimum Resource Standard:

    - $30,828 effective January 1, 2024.
    - $29,724 effective January 1, 2023.
    - $27,480 effective January 1, 2022.
    - $26,076 effective January 1, 2021.
    - $25,728 effective January 1, 2020.
    - $25,284 effective January 1, 2019.
    - $24,720 effective January 1, 2018.

    One-half the initial asset assessment amount (see *initial asset assessment* in this item), but **not** more than:

    - $154,140 effective January 1, 2024.
    - $148,620 effective January 1, 2023.
    - $137,400 effective January 1, 2022.

- $130,380 effective January 1, 2021.
- $128,640 effective January 1, 2020.
- $126,420 effective January 1, 2019.
- $123,600 effective January 1, 2018.

2. The amount (value)determined in a hearing per BAM 600.

3. The amount (value) of assets transferred to the community spouse by the client pursuant to a court order requiring the client to:

   - Pay support to the community spouse, and
   - Transfer assets to the community spouse for the support of the community spouse or a family member. Family member is defined under *family allowance* in BEM 546.

Immediately Refer Court Orders

SSI-Related MA Only

If a court has ordered a transfer of asset to a spouse for the spouse's support, use the value of the assets transferred by the order as the Protected Spousal Amount. Delay any **asset denial** and proceed as follows **immediately** upon receipt of such an order:

1. Prepare a memo with the following:

   - Subject - BEM 402.
   - Specialist name, telephone number and local office.
   - Client’s name and case number.
   - Community spouse's name.
   - If already computed:
     - Initial asset assessment amount.
     - Protected spousal amount per policy.
     - Amount of couple's countable assets.

2. Do **not** delay the memo to compute these amounts. The department has only 20 days to appeal the order. Attach a **legible** copy of the order to the memo and send them via ID mail to:

   Michigan Department of Health and Human Services
   Legal Affairs Administration
   333 South Grand Avenue, 5th Floor
   P. O. Box 30195
   Lansing, MI 48909

Central Office will send further instructions.

UNDUE HARDSHIP

SSI-Related MA Only

A client whose countable assets exceed the asset limit is nevertheless asset eligible when an undue hardship exists. Assume that denying MA will **not** cause undue hardship unless there is evidence to the contrary.

An undue hardship exists when the client's physician (M.D. or D.O.) states that:

- Necessary medical care is **not** being provided, and
- The client needs treatment for an emergency condition.

A medical emergency is any condition for which a delay in treatment may result in the person's death or permanent impairment of the person's health.

A psychiatric emergency is any condition that must be immediately treated to prevent serious injury to the person or others.

See BEM 100, Policy Exception Request Procedure.

Period of Eligibility

SSI-Related MA Only

The existence of a hardship **cannot** be used to establish eligibility for any month prior to the processing month because there must be a current need for medical care for a current emergency condition.

However, once eligibility is established for the processing month, the client is asset eligible for the presumed asset eligibility period.

INFORMATION UNAVAILABLE

SSI-Related MA Only

A spouse remains the applicant's spouse for Medicaid eligibility until there is a Judgement of Divorce. If the community spouse's whereabouts are unknown (a couple separated prior to the client entering an LTC/hospital setting and the client does **not** know where the spouse is living or how to contact the spouse), the

client's countable assets are compared to the appropriate asset limit in BEM 400 to determine eligibility.

Refusal of the community spouse to provide necessary information or verification about his assets results in ineligibility for the client.

VERIFICATION REQUIREMENTS

MA Only

The MA verification requirements in BEM 400 apply. In addition, the statement of the client's physician (M.D. or D.O.) is necessary to establish undue hardship.

Receipt of home and community-based services used to determine the first day of continuous care for the IAA (listed in Exhibit III in this item) must be verified. Sources to verify receipt of home and community-based services listed in the approved waiver include:

- Bill from medical provider with dates and types of provided services listed.
- Receipt from medical provider with dates and types of provided services listed.
- Contact with medical provider or the provider's billing service confirming the dates and types of services listed.

INSTRUCTIONS

MA Only

A completed, signed DHS-4574-B is used to request an initial asset assessment. All such requests, whether or **not** in conjunction with an MA application, must be registered and completed.

EXHIBIT I - DETERMINING SSI-RELATED MA ASSET ELIGIBILITY PER BEM 402

The determination of asset eligibility is a multi-step process.

1. Do INITIAL ASSET ASSESSMENT.
2. Determine PROTECTED SPOUSAL AMOUNT.
3. Determine applicant's (spouse, joint) countable assets for month being tested.

4. Subtract PROTECTED SPOUSAL AMOUNT from the couple's assets.

5. Compare result from step 4 to client’s asset limit to determine if asset eligibility exists for month being tested.

Repeat steps 3, 4 and 5 for each month tested. For applicants, test each past month, including retro MA months, and the processing month. For MA recipients, test only the first future month.

6. Calculate the Community Spouse Resource Allowance only when an applicant is eligible for the processing month or a recipient's eligibility continues. Then, the client’s Presumed Asset Eligible Period begins.

Example:	January 4	-	Mr. J admitted to hospital
	January 10	-	Mr. J transferred to LTC
	January 17	-	MA application made, and initial asset assessment requested
	February 27	-	Case processed

Initial asset assessment amount: $76,200 the couple's (his, her, their) countable assets on January 4 consist of joint checking and savings accounts).

Protected spousal amount: $38,100 (one-half the initial asset assessment amount).

Asset Eligibility

	January	February
Couple's countable assets (lowest balance during month tested):	$47,600	$40,050
MINUS the protected spousal amount (see above):	38,100	38,100
EQUALS Mr. J's countable assets:	9,500	1,950
Asset limit:	2,000	2,000
Result:	excess assets	eligible

Community Spouse Resource Allowance

Protected spousal amount (see above):	$38,100
MINUS Mrs. J's countable assets for the processing month (all joint cash assets are considered the L/H spouse's):	0
EQUALS community spouse resource allowance:	38,100

EXHIBIT II - WHEN TO USE BEM 400 TO DETERMINE SSI-RELATED ASSET ELIGIBILITY

Policy in BEM 400 is used for married L/H, PACE, and waiver clients when policy in this item does **not** apply. For example:

- The month being tested is **not** an L/H, PACE, or waiver month.
- The continuous period of care began before September 30, 1989.
- A continuous period of care ends because of the client's discharge of 30 or more days to a non-LTC/hospital/waiver/PACE setting.
- The client's spouse is in, or expected to be in, a hospital/LTC facility for at least 30 days.
- Both the client and spouse are approved for the waiver or PACE.

- The location of the client's spouse is unknown; see INFORMATION UNAVAILABLE, in this item.
- The client's spouse dies or the client and spouse divorce. Use BEM 400 starting with the month after divorce or the spouse's death.
- A presumed asset eligible period ends; see Presumed Asset Eligible Period.

EXHIBIT III HOME AND COMMUNITY BASED SUPPORTS AND SERVICES

- Adult Day Health.
- Chore Services.
- Community Health Worker.
- Community Living Supports.
- Community Transportation.
- Counseling.
- Environmental Accessibility Adaptations.
- Fiscal Intermediary.
- Goods and Services.
- Home Delivered Meals.
- Nursing Services
- Personal Emergency Response System (PERS).
- Private Duty Nursing/Respiratory Care.
- Respite.
- Specialized Medical Equipment and Supplies.
- Supports Coordination.
- Training in independent living skills.

LEGAL BASE

Social Security Act, Sections 1915(c) and 1924

DEPARTMENT POLICY

FAP ONLY

All FAP groups, no matter if they have an asset test, must report when they receive substantial lottery or gambling winnings by the 10th of the following month after the group receives the winnings. Substantial lottery or gambling winnings is currently $4,500 for a single payment. See Glossary regarding definition of substantial lottery or gambling winnings.

When MDHHS learns of a FAP group receiving a single lottery or gambling winning of $4,500 or more, close the FAP case, giving timely notice for the negative action.

Regaining Eligibility

All FAP groups closed for receiving substantial lottery or gambling winnings remain ineligible until they meet allowable income and asset tests. The next time the group reapplies, they will not be considered categorically eligible. The group's eligibility must be determined under regular FAP rules. It applies only to the first time the group is approved following the loss of eligibility for substantial lottery and gambling winnings. This means SDV groups must have countable assets of less than $4,500 and all other groups must have assets less than $3,000. Also, the group must have net income of less than the monthly net income limit, see RFT 250. This applies only to the first time the group is certified following the loss of eligibility for substantial lottery winnings.

Legal Base

7 CFR 273.8 and 273.9
7CFR 273.12(a)(5)(iii)(G) and 273.12(a)(2)
Agricultural Act of 2014, Section 4009

DEPARTMENT POLICY

Medicaid (MA) ONLY

Divestment results in a penalty period in MA, **not** ineligibility. Divestment policy does **not** apply to Qualified Disabled Working Individuals (QDWI); see Bridges Eligibility Manual (BEM) 169.

Divestment is a type of transfer of a resource and not an amount of resources transferred.

Divestment means the transfer of a resource (see *resource defined* in this item and in glossary) by a client or his spouse that are all the following:

- Is within a specified time; see *look back period* in this item.
- Is a transfer for *less than fair market value*; see definition in glossary.
- Is not listed under *transfers that are not divestment* in this item.

  Note: See *annuity not actuarially sound* and *joint owners and transfers* in this item and BEM 401 about special transactions considered transfers for less than *fair market v*alue.

During the penalty period, MA will **not** pay the client's cost for:

- Long Term Care (LTC) services.
- Home and community-based waiver services (such as MIChoice Waiver and PACE).
- Home help.
- Home health.

MA will pay for other MA-covered services.

Do **not** apply a divestment penalty period when it creates an undue hardship; see *undue hardship* in this item.

RESOURCE DEFINED

Resource means all the client's and spouse's assets and income. It includes all assets and all income, even countable

and/or excluded assets, the individual or spouse receive. It also includes all assets and income that the individual (or spouse) was entitled to but did **not** receive because of action by one of the following:

- The client or spouse.
- A person (including a court or administrative body) with legal authority to act in place of or on behalf of the client or the client's spouse.
- Any person (including a court or administrative body) acting at the direction or upon the request of the client or his/her spouse.

TRANSFER OF A RESOURCE

Transferring a resource means giving up all or partial ownership in (or rights to) a resource. **Not** all transfers are divestment. Examples of transfers include:

- Selling an asset for fair market value (not divestment).
- Giving an asset away (divestment).
- Refusing an inheritance (divestment).
- Payments from a **MEDICAID TRUST** that are **not** to, or for the benefit of, the person or his spouse; see BEM 401 (divestment).
- Putting assets or income in a trust; see BEM 401.
- Giving up the **right** to receive income such as having pension payments made to someone else (divestment).
- Giving away a lump sum or accumulated benefit (divestment).
- Buying an annuity that is **not** actuarially sound (divestment).
- Giving away a vehicle (divestment).
- Putting assets or income into a Limited Liability Company (LLC).

- Purchasing an asset which decreases the group's net worth and is not in the group's financial interest (divestment).

Also see Joint Owners and Transfers for examples.

Transfers to an LLC

Treat transfers to an LLC as a divestment unless the client retains the rights to the asset or income invested and may withdraw the asset invested on demand.

Treat transfers to an LLC that has no discernible product (goods and or services) produced as a divestment.

Transfers by Representatives

Treat transfers by any of the following as transfers by the client or spouse.

- Parent for minor.
- Legal guardian.
- Conservator.
- Court or administrative body.
- Anyone acting in place of, on behalf of, at the request of or at the direction of the client or the client's spouse.

Joint Owners and Transfers

When a client jointly owns a resource with another person(s), any action by the client or by another owner that reduces or eliminates the client's ownership or control is considered a transfer by the client.

Example: Mr. Jones is applying for MA. Before the look back period he added his sister's name to his bank account. Each is free to withdraw as much money as desired so adding the sister's name did **not** affect the client's ownership or control. On September 1 the sister withdrew $10,000 and deposited the money in her own bank account. Mr. Jones is considered to have transferred $10,000 on September 1, the day he no longer had ownership and control of his money.

Example: Mr. Jones is applying for MA. During the look back period Mr. Jones gave his sister half interest in real estate. His equity value at the time was $100,000. The ownership arrangement

prevents either sibling from selling without the other's permission. Mr. Jones transferred a resource on the day he reduced his ownership and control by giving his sister part ownership. The amount transferred depends on whether his sister is refusing to sell. The transferred amount is:

- $100,000 if she now refuses to sell.

  Note: The transferred amount is used to calculate the divestment penalty. It is not used towards the countable asset limit for Mr. Jones' eligibility.

- $50,000 if she now agrees to sell.

  Note: Unless otherwise excluded, one-half the equity for the month being tested is a countable asset for purposes of Mr. Jones' asset eligibility and the other half is used to calculate the divestment penalty.

The same policy applies to resources the client's spouse owns jointly with other persons.

Exception: No penalty is imposed if the parties involved verify that the resource transferred actually belonged solely to the person to whom it was transferred.

Annuity Not Actuarially Sound

Purchase of an annuity that is not actuarially sound is a transfer for less than fair market value. The transfer was made by the annuity's owner.

Owner means the person who pays the premium for the annuity.

Annuitant means the person to whom the annuity payments are made during the guarantee period of the annuity.

An annuity is not actuarially sound if the annuitant is not expected to live until the end of the guarantee period of the annuity. Use the Life Expectancy Tables, EXHIBIT I in this item to make this determination.

Note: Guarantee period may be called annuity certain or period certain.

Example: John purchased an annuity at age 65 with a guarantee period of 10 years and payments starting at purchase. John's life expectancy is 16.67 years. The annuity is actuarially sound.

Example: Sally purchased an annuity at age 70 with a guarantee period of 15 years and payments starting five years after purchase. The annuity is not actuarially sound because Sally's life expectancy at purchase was 15.72 years while the guarantee period ends in 20 years (five-year delay plus 15 years).

Example: Diane purchased an annuity at age 65 with a guarantee period of 25 years. The annuity is not actuarially sound because Diane's life expectancy is only 19.50 years.

The amount transferred for less than fair market value for an annuity that is not actuarially sound is the amount that would be paid after the end of the person's life expectancy. The amount transferred for less than fair market value is the value of the payments due in the last 5.5 years of the annuity (25 minus 19.50 = 5.50).

Example: Sally purchased an annuity at age 70 with a guarantee period of 15 years and payments starting five years after purchase. The annuity is not actuarially sound because Sally's life expectancy at purchase was 15.72 years while the guarantee period ends in 20 years. The amount transferred for less than fair market value is the value of the payments due in the last 4.28 years of the annuity (20 - 15.72 = 4.28).

LOOK-BACK PERIOD

The first step in determining the period of time that transfers can be evaluated for divestment is determining the baseline date; see *baseline date* in this item.

Once the baseline date is established, you determine the look-back period. The look back period is 60 months prior to the baseline date.

Entire Period

Transfers that occur on or after a client's baseline date must be considered for divestment. In addition, transfers that occurred within the 60-month look-back period must be considered for divestment.

Penalty Situation

A divestment determination is not required unless, sometime during the month being tested, the client was in a penalty situation. To be in a penalty situation, the client must be eligible for MA (other than QDWI) and be one of the following:

- In an LTC facility.
- Approved for MIChoice waiver see BEM 106.
- Approved for the PACE program; see BEM 167.
- Eligible for Home Help.
- Eligible for Home Health.

Baseline Date

A person's baseline date is the first date that the client was eligible for Medicaid and one of the following:

- In LTC.
- Approved for MIChoice waiver; see BEM 106.
- Approved for the PACE program; see BEM 167.
- Eligible for Home Health services.
- Eligible for Home Help services.

A client's baseline date does not change even if one of the following happens:

- The client leaves LTC.
- The client is no longer approved for the MIChoice waiver; see BEM 106.
- The client is no longer approved for the PACE program; see BEM 167.
- The client no longer needs Home Help.
- The client no longer needs Home Health.

LESS THAN FAIR MARKET VALUE

Less than fair market value means the compensation received in return for a resource was worth less than the fair market value of the resource. That is, the amount received for the resource was less than what would have been received if the resource was offered in the open market and in an *arm's length transaction* (see glossary).

Note: Also see *annuity not actuarially sound* in this item.

Compensation must have tangible form and intrinsic value.

Relatives can be paid for providing services; however, assume services were provided for free when no payment was made at the time services were provided. A client can rebut this presumption by providing tangible evidence that a payment obligation existed at the time the service was provided (for example a written agreement signed at the time services were first provided). The policy in Bridges Administrative Manual (BAM) 130 allowing use of best available information or best judgment as verification does not apply.

Value of Transferring Right to Income

When a person gives up his right to receive income, the fair market value is the total amount of income the person could have expected to receive.

Use EXHIBIT I - Life Expectancy Table in this item, to compute the fair market value of a lifetime income source such as a pension. Base the calculation on the person's sex and age on the date of transfer.

Personal Care & Home Care Contracts

Personal Care Contract means a contract/agreement that provides health care monitoring, medical treatment, securing hospitalization, visitation, entertainment, travel/transportation, financial management, shopping, home help or other assistance with activities of daily living.

Home Care Contract means a contract/agreement which pays for expenses such as home/cottage/care repairs, property maintenance, property taxes, homeowner's insurance, heat and utilities for the homestead or other real property of the client.

Home Care and Personal Care contracts/agreements may be between relatives or non-relatives. A relative is anyone related to the client by blood, marriage or adoption.

Note: When relatives provide assistance or services they are presumed to do so for love and affection and compensation for past assistance or services shall create a rebuttable presumption of a transfer for less than fair market value. Fair market value of the services may be determined by consultation with area businesses which provide such services. Contracts/agreements that include the provision of companionship are prohibited.

All Personal Care and Home Care contracts/agreements, regardless of whether between a client and a relative or a client and a non-relative, must be considered and evaluated for divestment.

Personal Care and Home Care contracts/agreements shall be considered a transfer for less than fair market value unless the agreement meets all of the following:

- The services must be performed **after** a written legal contract/agreement has been executed between the client and the provider. The contract/agreement must be dated, and the signatures must be notarized. The services are not paid for until the services have been provided (there can be no prospective payment for future expenses or services); **and**

- At the time the services are received, the client cannot be residing in a nursing facility, adult foster care home (licensed or unlicensed), institution for mental diseases, inpatient hospital, intermediate care facility for individuals with intellectual disabilities or be eligible for home and community-based waiver, home health or home help; and

- At the time services are received, the services must have been recommended in writing and signed by the client's physician as necessary to prevent the transfer of the client to a residential care or nursing facility. Such services cannot include the provision of companionship; and

- The contract/agreement must be signed by the client or legally authorized representative, such as an agent under a power of attorney, guardian, or conservator. If the agreement is signed by a representative, that representative cannot be the provider or beneficiary of the contract/agreement.

- MDHHS will verify the contract/agreement by reviewing the written instrument between the client and the provider which must show the type, frequency and duration of such services being provided to the client and the amount of consideration

(money or property) being received by the provider, or in accordance with a service plan approved by MDHHS.

Assets transferred in exchange for a contract/agreement for personal services/assistance or expenses of real property/homestead provided by another person after the date of application are considered available and countable assets.

Transferring Non-countable or Excluded Resources

Transfers of resources that are excluded or not countable assets under SSI-related MA policy may be divestment.

Transfer of the following may be divestment:

- Transfer of the Homestead by the individual in L/H, MIChoice client (see BEM 106) , PACE participant (see BEM 167), home help or home health participant or the spouse of any of the above, even if the transfer occurred before the client was institutionalized or approved for the waiver, PACE, home help or home health. See Transferring Homestead to Family section below in this item.
- Assets that are not countable because they were unavailable or not salable.

TRANSFERS THAT ARE NOT DIVESTMENT

Transferring Excluded Income

Transferring income that is not countable income for SSI-related MA according to BEM 500 is not divestment.

Transfers Involving Spouse

It is not divestment to transfer resources from the client to:

- The client's spouse.
- Another SOLELY FOR THE BENEFIT OF the client's spouse.

Transfers from the client's spouse to another SOLELY FOR THE BENEFIT OF the client's spouse are not divestment.

Transfers Involving Child

A transfer to the client's blind or disabled (see BEM 260) child, regardless of the child's age or marital status, are not divestment. This includes transfers to a trust established SOLELY FOR THE BENEFIT OF the child.

Transfer to Funeral Plan

See Life Insurance Funded Funeral in BEM 400 when a person has irrevocably transferred ownership in life insurance or a similar device designated for funeral expenses.

Transfer to Trust

Transfers to a trust established SOLELY FOR THE BENEFIT OF a disabled (see BEM 260) person under age 65 are not divestment.

Purchase of Funeral Contract

Placing money in an irrevocable prepaid funeral contract (see BAM 805) is not divestment.

Asset Conversion

Converting an asset from one form to another of equal value is not divestment even if the new asset is exempt. Most purchases are conversions.

Example: Using $5,000 from savings to buy a used car priced at $5,000 is conversion for equal value.

Example: Trading a boat worth about $8,000 for a car worth about $8,000 is conversion for equal value.

Payment of expenses such as one's own taxes or utility bills is also not divestment.

Transferring Homestead to Family

It is not divestment to transfer a homestead to the client's:

- Spouse; see Transfers Involving Spouse above.
- Blind or disabled child; see Transfers Involving Child above.
- Child under age 21.
- Child age 21 or over who:
    - Lived in the homestead for at least two years immediately before the client's admission to LTC or waiver approval (BEM 106), and
    - Provided care that would otherwise have required LTC or waiver services (BEM 106), as documented by a physician's (M.D. or D.O.) statement.
- Brother or sister who:
    - Is part owner of the homestead, and
    - Lived in the homestead for at least one year immediately before the client's admission to LTC or BEM 106/BEM 167 waiver approval.

Transfers for Another Purpose

A transfer of resources to a religious order by a member of that order in accordance with a vow of poverty are transfers for another purpose.

As explained in this item, transfers exclusively for a purpose other than to qualify or remain eligible for MA are not divestment.

Assume transfers for less than fair market value were for eligibility purposes until the client or spouse provides convincing evidence that they had no reason to believe LTC, PACE or MIChoice waiver services might be needed.

Example: Mr. Smith, age 40, was in good health when he gave his vacation cottage to his nephew. The next day Mr. Smith was in an automobile accident. His injuries require long-term care. The transfer was not divestment because Mr. Smith could not anticipate his need for LTC services.

Exception:

- Preservation of an estate for heirs or to avoid probate court is not acceptable as another purpose.
- That the asset or income is not counted for Medicaid does not make its transfer for another purpose.

Trustee Fees

Trusts which designate a business as trustee (for example a bank) usually must compensate the trustee. Reasonable compensation is not divestment. Reasonable compensation means compensation within the prevailing rate for the community. For example, banks usually base their fee on a percentage of the value of the principal. There may be a basic charge in addition to the percentage or the percentage may vary based on the value of the trust.

SOLELY FOR THE BENEFIT OF

All the following conditions must be met for a transfer or for a trust to be solely for the benefit of a person:

- The arrangement must be in writing and legally binding on the parties.
- The arrangement must ensure that none of the resources can be used for someone else during the person's lifetime, except for trustee fees.
- The arrangement must require that the resources be spent for the person on an actuarially sound basis. This means that spending must be at a rate that will use up all the resources during the person's lifetime. Life expectancies are in Exhibit I in this item.

PENALTY PERIOD

No Maximum Penalty

There is no maximum limit on the penalty period for divestment. There is no minimum amount of resource transfer before incurring a penalty, determine a penalty on any amount of resources that are transferred and meet the definition of a divestment even if the penalty is for one day. Divestment is a type of transfer not an amount of transfer.

Any penalty period established under previous policy continues until it ends.

Computing Penalty Period

Compute the penalty period on the total Uncompensated Value of all resources divested.

Determine the Uncompensated Value for each resource transferred and combine into a total Uncompensated Value.

Divide the total Uncompensated Value by the average monthly private LTC Cost in Michigan for the client's Baseline Date. This gives the number of full months for the penalty period. Multiply the fraction remaining by 30 to determine the number of days for the penalty period in the remaining partial month.

Apply the total penalty months and days. Apply a penalty even if the total amount of the penalty is for only a partial month.

Apply the penalty to the months (or days) an individual is eligible for Medicaid and actually in LTC, PACE, Home Health, Home Help, the MIChoice Waiver. Do not apply the divestment penalty to a period when the individual is not eligible for Medicaid for any reason (that is the case closes for any reason or is eligible for Medicaid but is not in LTC, Home Help, Home Health, MIChoice Waiver, PACE program. Restart the penalty when the individual is again eligible for Medicaid and in LTC, Home Help, Home Health, the MIChoice Waiver, PACE program. When a medical provider is paid by the individual, or by a third party on behalf of the individual, for medical services received, that month is not a penalty month. Do not count that month as part of the penalty period. This does not include payments made by commercial insurance or Medicare; see Resources Returned in this item.

Note: An individual is not eligible for MA in a month they have prepaid for LTC. Because federal law directs a resident in a nursing facility must have access to all monies held by the facility for the resident, count the money held by a nursing facility as cash.

A group 2 deductible eligible individual is not eligible for Medicaid until the deductible is met. Apply the penalty only to the days of the month after the deductible is met.

The 1st day the client is eligible to receive MA coverage for LTC, MIChoice, PACE, home help, or a home health service is the 1st day after the penalty period ends.

Baseline Date In Calendar Year	LTC Cost
2024	$10,871
2023	$9939
2022	$9880
2021	$9560
2020	$8618
2019	$8469
2018	$8261
2017	$8018

The penalty period starts on the date which the individual is eligible for Medicaid and would otherwise be receiving institutional level care (LTC, MIChoice waiver, PACE, home help, or home health services), and is not already part of a penalty period. When a medical provider is paid by the individual, or by a third party on behalf of the individual, for medical services received, the individual is not eligible for Medicaid in that month and the month is not a penalty month. That month cannot be counted as part of the penalty period. This does not include payments made by commercial insurance or Medicare.

Note: If a past unreported divestment is discovered or an agency error is made which should result in a penalty, a penalty must be determined under the policy in place at the time of discovery. If a penalty is determined for a transfer in the past, apply the penalty from the first day after timely notice is given; see Recipient Exception in this item.

Recipient Exception

Timely notice must be given to LTC recipients, and waiver recipients (BEM 106) before actually applying the penalty. Adequate notice must be given to new applicants.

Uncompensated Value

The uncompensated value of a divested resource is

- The resource's cash or equity value.
- Minus any compensation received.
- The uncompensated value of a promissory note, loan, or mortgage is the outstanding balance due on the date of application.

Spouses Sharing a Penalty

Penalize a client if her or his spouse divests. The penalty is imposed on whichever spouse is in a penalty situation. If both spouses are in a penalty situation, the penalty period (or any remaining part) must be divided between them.

Example: Mr. and Mrs. Brown divested themselves of assets prior to Mr. Brown entering an LTC facility and applying for Medicaid. Mr. Brown is in LTC and under a divestment penalty for 24 months. When Mrs. Brown enters the facility 6 months later, the remaining 18 months of Mr. Brown's penalty are divided between them, giving Mr. and Mrs. Brown each 9 months of the penalty still to complete. If either Mr. or Mrs. Brown dies before they complete their penalty the remainder of their penalty is transferred to their spouse.

Example: Mr. Brown enters a LTC facility and applies for Medicaid. He is found eligible for Medicaid. During the presumed asset eligibility period Mrs. Brown transfers Mr. Brown's assets to herself and then transfers the assets to her children (the first transaction is permitted the second transaction is divestment). Mr. Brown incurs the divestment penalty. Mrs. Brown then enters the LTC facility. Mr. and Mrs. Brown divide the remainder of the incurred divestment penalty.

Resources Returned

Cancel a divestment penalty if either of the following occurs before the penalty is in effect:

- All the transferred resources are returned and retained by the individual.
- Fair market value is paid for the resources.

Recalculate the penalty period if either of the following occurs while the penalty is in effect:

- All the transferred resources are returned.
- Full compensation is paid for the resources.

Use the same per diem rate originally used to calculate the penalty period.

Once a divestment penalty is in effect, return of, or payment for, resources cannot eliminate any portion of the penalty period already past. However, recalculate the penalty period. The divestment penalty ends on the later of the following:

- The end date of the new penalty period.
- The date the client notified you that the resources were returned or paid for.

UNDUE HARDSHIP

Waive the penalty if it creates undue hardship. Assume there is no undue hardship unless you have evidence to the contrary.

Undue hardship exists when the client's physician (M.D. or D.O.) says:

- Necessary medical care is not being provided, and
- The client needs treatment for an emergency condition.

A medical emergency exists when a delay in treatment may result in the person's death or permanent impairment of the person's health.

A psychiatric emergency exists when immediate treatment is required to prevent serious injury to the person or others.

See BEM 100, Policy Exception Request Procedure.

VERIFICATION REQUIREMENTS

Verification is not required when the client states he and his spouse have not transferred resources unless:

- The client's statement is unclear, inconsistent or conflicts with known facts, or

- Existing information in the case record indicates divestment may have occurred.

Verify the following to document divestment:

- Date of transfer.
- Fair market value or cash value.
- Uncompensated value.

Obtain a statement from the LTC or waiver client's physician (M.D. or D.O.) to verify:

- The client's non-disabled child (age 21 or older) provided the care that would otherwise have required LTC or waiver services and

- A doctor's statement or other medical records indicating the medical need for the services at the time the services were initiated.

- Undue Hardship.

Verify the non-disabled child who provided the care lived in the homestead for at least two years immediately before the client's admission to LTC or BEM 106 waiver approval.

Verify the sibling's ownership interest and length of residence in the homestead if a homestead was transferred to a sibling.

Verify disability and blindness according to BEM 260.

Verification Sources

Sources to verify transfers and the reasons for them include, but are not limited to, the following:

- Legal documents.
- Payment or tax records.
- Bills of sale.
- Court or attorney records.
- Correspondence regarding the transaction.
- Bankbooks or statements.

Sources to verify ownership interest in a homestead or other real property include, but are not limited to:

- Deeds.
- Mortgages.
- Purchase agreements.
- Contracts.
- Other court or county records.

Sources to verify length of residence in a homestead include, but are not limited to:

- Driver's license or State I.D.
- Income tax returns.
- Voter registration.
- Cancelled mail.
- Other type of I.D., which has both name and address.
- Written statement from one of the following who has knowledge of length of residence in the homestead:
  - Physician.
  - Clergy.
  - Other professional.

PET CODE

Program enrollment type (PET) code EXM-DIVM indicates a divestment penalty.

EXHIBIT I - LIFE EXPECTANCY TABLE

Exact Age	Male Life Expectancy	Female Life Expectancy
0	76.04	80.99
1	75.52	80.43
2	74.55	79.46
3	73.58	78.48
4	72.59	77.49
5	71.60	76.50
6	70.62	75.51
7	69.63	74.52
8	68.64	73.53
9	67.64	72.54
10	66.65	71.54

Exact Age	Male Life Expectancy	Female Life Expectancy
11	65.66	70.55
12	64.66	69.56
13	63.67	68.56
14	62.68	67.57
15	61.70	66.58
16	60.73	65.60
17	59.76	64.62
18	58.81	63.63
19	57.86	62.66
20	56.91	61.68
21	55.98	60.71
22	55.05	59.73
23	54.13	58.76
24	53.22	57.80
25	52.30	56.83
26	51.38	55.86
27	50.47	54.90
28	49.55	53.93
29	48.63	52.97
30	47.72	52.01
31	46.80	51.05
32	45.89	50.09
33	44.97	49.14
34	44.06	48.19
35	43.15	47.23
36	42.23	46.28
37	41.32	45.34
38	40.41	44.39
39	39.50	43.45

Exact Age	Male Life Expectancy	Female Life Expectancy
40	38.59	42.50
41	37.69	41.56
42	36.78	40.62
43	35.88	39.69
44	34.98	38.76
45	34.08	37.83
46	33.19	36.90
47	32.30	35.98
48	31.43	35.07
49	30.55	34.16
50	29.69	33.26
51	28.84	32.36
52	27.99	31.48
53	27.16	30.59
54	26.34	29.72
55	25.52	28.85
56	24.72	27.99
57	23.93	27.13
58	23.15	26.28
59	22.37	25.44
60	21.61	24.60
61	20.85	23.76
62	20.11	22.94
63	19.37	22.12
64	18.65	21.30
65	17.92	20.49
66	17.20	19.69
67	16.49	18.89
68	15.78	18.11

Exact Age	Male Life Expectancy	Female Life Expectancy
69	15.09	17.33
70	14.40	16.57
71	13.73	15.82
72	13.07	15.09
73	12.43	14.37
74	11.80	13.66
75	11.18	12.97
76	10.58	12.29
77	10.00	11.62
78	9.43	10.98
79	8.88	10.35
80	8.34	9.74
81	7.82	9.15
82	7.32	8.58
83	6.84	8.04
84	6.38	7.51
85	5.94	7.01
86	5.52	6.53
87	5.12	6.07
88	4.75	5.64
89	4.40	5.23
90	4.08	4.85
91	3.78	4.50
92	3.50	4.18
93	3.25	3.88
94	3.03	3.61
95	2.83	3.37
96	2.66	3.16
97	2.51	2.96

Exact Age	Male Life Expectancy	Female Life Expectancy
98	2.37	2.79
99	2.25	2.63
100	2.13	2.48
101	2.02	2.33
102	1.91	2.19
103	1.81	2.06
104	1.71	1.93
105	1.61	1.81
106	1.52	1.69
107	1.43	1.58
108	1.35	1.47
109	1.27	1.37
110	1.19	1.27
111	1.11	1.18
112	1.04	1.09
113	0.97	1.01
114	0.91	0.93
115	0.84	0.86
116	0.78	0.79
117	0.73	0.73
118	0.67	0.67
119	**0.62**	**0.62**

Example Female: In January 2004, Mrs. Jay established a Medicaid trust and ordered her $500 per month pension paid to the trust. She was 78 years old. The trustee cannot use the pension for Mrs. Jay. Mrs. Jay transferred $63,120 ($500 X 12 months X 10.52 years).

Example Male: In January 2004, Mr. Jay established a Medicaid trust and ordered his $500 per month pension paid to the trust. He was 78 years old. The trustee cannot use the pension for Mr. Jay. Mr. Jay transferred $52,800 ($500 X 12 months X 8.80 years).

LEGAL BASE

MA

Social Security Act, Sections 1902(a)(18), 1917

AGENCY POLICY

THIS POLICY APPLIES TO NON-CATEGORICALLY ELIGIBLE FAP GROUPS, BRIDGES ELIGIBILITY MANUAL (BEM) 213, CATEGORICAL ELIGIBILITY.

Divestment means the transfer of assets for less than fair market value for any of the following reasons:

- To qualify for program benefits.
- To remain eligible for program benefits.

Transfer of assets means giving, selling or trading assets to an individual/someone other than an asset group member. This includes a change from sole to joint ownership.

Divestment occurred:

- If an asset group member knowingly transferred assets during the three calendar months before the month of the application date.
- Knowingly transferred after the household is determined eligible for benefits. If divestment occurred, calculate a disqualification period.

The following are not divestment:

- The individual transfers assets for at or near fair market value.
- The individual sold or traded the asset for another asset at or near equal value.
- The asset sold, traded or given away is excluded in policy; see BEM 400, Assets.

Reminder:

- Unavailable assets are included in determining divestment.
- Traditional Categorically eligible households do not have to meet an asset limit.

Divestment Determinations

The value of a divested asset(s) is the cash or equity the asset group member(s) would have received had they sold it for at or near its fair market value.

Disqualified Group Members

When divestment occurs, the FAP case is closed for the disqualification period. The adults 18 and over remain disqualified during the entire disqualification period, even if they become a member of another FAP group.

Exception: If a child(ren) under 18 in the disqualified group leaves the FAP group, they can regain eligibility in the new FAP group.

Calculated Amount Divested

Determine the amount divested as follows:

Value of Divested Asset + Other Countable Assets = Total Countable FAP Assets

Total Countable FAP Assets - FAP Asset Limit = Calculated Amount Divested

Length of Disqualification Period

The calculated amount divested determines the disqualification period as follows:

Calculated **Amount** in Excess of FAP Asset Limit	**Disqualification Period**
$.01 - 249.99	1 Month
250 - 999.99	3 Months
1,000 - 2,999.99	6 Months
3,000 - 4,999.99	9 Months
5,000 or more	12 Months

Start the disqualification period with the month of application if it is verified the divestment occurred before the FAP EDG is certified.

Ensure timely notice of negative action if the FAP group is participating when the divestment is discovered. The DHS-1605

will explain the reason for and length of the disqualification period. The disqualification will be effective the first month after the negative action date.

Note: If case is being reinstated, but the client will still be denied due to divestment, the specialist will need to send the client a MDHHS-176, Benefit Notice, to inform them of the divestment and the disqualification period.

Effective 10-1-23, categorically eligible FAP groups that are currently serving a divestment disqualification, will not be eligible until the existing disqualification period ends.

Examples

Example 1: Sammy applies for FAP in September and has never received benefits. He is eligible for FAP, so the case is opened in October. It is later discovered that he may have divested, so verification is requested. He has existing assets of $6,000 and it is determined he divested $800 in May, $550 in July and $10,100 in August.

- $10,650 (Value of Divested Asset) + $6,000 (Other Countable FAP Assets) = $16,650 (Total Countable FAP Assets)
- $16,650 (Total Countable FAP Assets) - $15,000 (FAP Asset Limit) = $1,650 (Calculated Amount Divested)

He is disqualified for 6 months, beginning in December.

Note: May's divestment of $800 is not included because it is more than three months prior to the month of application.

Example 2: Sally and her children apply for FAP and are eligible for expedited processing. She has an existing divestment disqualification, so her application is denied.

Example 3: Mom, dad and two children have an ongoing FAP case. They receive $20,000 in an inheritance and have $300 in other countable assets. Case closes for excess assets. The client calls during the negative action period and indicate they have $500 left and gave the remainder to their family so they could still receive FAP.

- $20,000 (Value of Divested Asset) + $300 (Other Countable FAP Assets) = $20,300 (Total Countable FAP Assets)

- $20,300 (Total Countable FAP Assets) - $15,000 (FAP Asset Limit) = $5,300 (Calculated Amount Divested)

The disqualification period is 12 months, and the case will close. Using the previous example, dad and children move in with his girlfriend who receives FAP and is the head of household (HOH). They all purchase and prepare together. Dad continues to be disqualified for the remainder of the 12-month period, but the children are eligible group members on the girlfriend's case. Dad is working and all his income is budgeted on the FAP case; see BEM 550, FAP Income Budgeting. Any allowable expenses listed in BEM 554, FAP Allowable Expenses and Expense Budgeting, are allowed.

RECOUPMENT

Disqualification periods are served forward and not retroactive therefore, recoupment is not necessary. When it is discovered an incorrect disqualification period was established, a policy exception override request is needed; see BEM 100, Introduction. The Central Office staff will adjust the disqualification period.

Example: The value of the divested asset is entered as $600 resulting in a three- month disqualification period starting in June. In August a data entry error is discovered, and it should have been $6,000. The increased divested asset value results in a 12-month disqualification period. The central office exception staff will adjust the divestment period. The client will serve the remaining 11-month disqualification period starting with September and going through June. Send them a MDHHS-176, Benefit Notice, informing them of the change in the disqualification period.

VERIFICATION REQUIREMENTS

Verification of divestment is required when:

- The client's statement is unclear, inconsistent or conflicts with known facts.
- Existing information in the case record indicates divestment might have occurred.

When the client states a transfer has been made, verify the transfer and the reason for the transfer.

Document the following in the case:

- The divestment determination.
- The date and method of verification.
- Verification sources.

Verification sources and reasons for the asset transfer include, but are not limited to, the following:

- Legal documents.
- Payment or tax records.
- Bills of sale.
- Court or attorney records.
- Correspondence regarding the transaction.
- Bank/credit union statements.

LEGAL BASE

FAP

7 CFR 273.8(h)

DEPARTMENT POLICY

All Programs

This item discusses income for:

- Family Independence Program (FIP).
- Refugee Cash Assistance (RCA).
- State Disability Assistance (SDA).
- Child Development and Care (CDC).
- Applies to all CDC income eligible groups.
- Medicaid (MA) which, if policy differs, is divided into:
  - MAGI-related MA.
  - SSI-related MA.
  - Specific MA categories.
- Food Assistance Program (FAP).

See Emergency Relief Manual (ERM) for State Emergency Relief (SER) income rules.

The group composition and program budgeting manual items specify whose income to count. The program budgeting manual items also contain program-specific income deductions and disregards.

BRIDGES INCOME-RELATED FUNCTIONALITY

All Programs

Income-Related Logical Units of Work (LUW)

An income-related logical unit of work (LUW) is a series of data collection screens. Completion is required to collect information needed to determine countable income. The four income categories and income-related LUWs in Bridges correspond to the four income-related manual items:

- Income from Employment, Bridges Eligibility Manual (BEM) 501.
- Income from Self-Employment, BEM 502.

- Income, Unearned, BEM 503.
- Income from Rental/Room and Board, BEM 504.

Income-related manual items above do both of the following:

- Define each income type.
- Indicate which income types are excluded or counted for each program.

To create a new income record, go to the income questions screen and answer **yes** to the appropriate question for that income type. This will add the appropriate income-related LUW to the driver flow and cause Bridges to consider this income.

To view or change an existing income record, select the appropriate income-related LUW from the left navigation.

Income Data Considered and Applied to Benefit Issuance

Bridges determines countable income and effective dates of income changes based on data entry, income type and program.

Enter the gross income amounts and details in the appropriate LUW. Data entered in a LUW is not saved until all screens in the LUW are completed and saved. Use the tabs across the top of the Bridges screens to identify which screens are contained within the LUW.

Income data is not considered in the eligibility result until eligibility determination/benefit calculation (EDBC) is run. Income data does not affect benefit issuance until the eligibility results are certified for that program.

Bridges determines and/or redetermines eligibility for all benefit periods starting with the circumstance start/change date (CSCD) begin date of the LUW. If data is changed, but the CSCD begin date is not changed, Bridges will re-run eligibility back to the existing CSCD.

Bridges Tip

Change the CSCD begin date for a LUW whenever you change data, unless correcting historical records and want Bridges to redetermine eligibility for past months.

Exception: Do **not** change the CSCD begin date for an income record when ending unearned, self-employment or rental/room and board income.

When establishing a new pay/history projection period, be sure to change the CSCD begin date of the income record. Failure to do so may change historical income calculations causing inappropriate supplements and/or OP referrals.

When EDBC is re-run for a benefit period which has already been certified, the eligibility summary will display both the old and new eligibility result. If the new result is different, Bridges displays **no issuance change**, **supplement** or **OP referral** based on date client became aware, report date, verification received date and timely notice requirements.

DEFINITIONS

All Programs

Income

Income means a benefit or payment received by an individual which is measured in money. It includes money an individual owns even if **not** paid directly such as income paid to a representative.

Countable Income

Income remaining after applying the policy in the income related items is called **countable**. This is the amount used to determine eligibility and benefit levels. Count all income that is **not** specifically excluded.

Modified Adjusted Gross Income (MAGI)

MAGI for purposes of Medicaid eligibility is a methodology which state agencies and the federally facilitated marketplace (FFM) must use to determine financial eligibility. It is based on Internal Revenue Service (IRS) rules and relies on federal tax information to

determine adjusted gross income. It eliminates asset tests and special deductions or disregards.

Every individual is evaluated for eligibility based on MAGI rules. The MAGI rules are aligned with the income rules that will be applied for determination of eligibility for premium tax credits and cost-sharing reductions through exchanges.

Earned Income

Earned income means income received from another person or organization or from self-employment for duties that were performed for remuneration or profit. Some rental income is considered earned; see BEM 504, Income from Rental/Room and Board.

Unearned Income

Unearned income is all income that is not earned.

Gross Income

Gross income is the amount of income before any deductions such as taxes or garnishments. This may be more than the actual amount an individual receives.

Exception: The amount of self-employment income before any deductions is called **total proceeds**. The **gross** amount of self-employment income means the amount after deducting allowable expenses from total proceeds, but before any other deductions.

Garnishment or Other Withholding

Gross income includes amounts withheld from income which are any of the following:

- Voluntary.
- To repay a debt.
- To meet a legal obligation.

Some examples of amounts which may be withheld, but are still considered part of gross income are:

- Income taxes.
- Health or life insurance premiums.
- Medicare premiums.
- Union dues.

- Loan payments.
- Garnishments.
- Court-ordered or voluntary child support payments.

MAGI Related Medicaid

5 percent Disregard

- The 5 percent disregard is the amount equal to 5 percent of the Federal Poverty Level for the applicable family size.
- It is not a flat 5 percent disregard from the income.
- The 5 percent disregard shall be applied to the highest income threshold.
- The 5 percent disregard shall be applied only if required to make someone eligible for Medicaid.

Reasonable Compatibility

- Attested income will be found not reasonably compatible with income from trusted sources if the difference exceeds 10 percent
- If the group's attested income is below the income threshold for the program being tested and trusted data source also validates income below the income threshold, then no reasonably compatible test is performed. Applicant is eligible.
- If the group's attested income is above the income threshold for the program being tested but trusted data source finds income below the income threshold, then no reasonable compatibility test is performed, Applicant is not eligible based on attested income.
- If the group's attested income is above the income threshold for the program being tested and the trusted data source validates income above the income threshold, then no reasonable compatibility test is performed. Applicant is not eligible based on attested income.
- If the group's attested income is below the income threshold for the program being tested but the trusted data source indicates income above the income threshold, then reasonable compatibility test is performed:

- If income is reasonably compatible, then the applicant is eligible
- If the income is not reasonably compatible, then the program pends and the individual is required to provide proof of attested income.

Pre-tax Deductions

Pre-tax deductions should not be counted toward an indvidual's MAGI income.

Example: An individual has a gross income of $2,000 per month. They also contribute $400 pre-tax per month to a 401k. Their monthly MAGI income would be $1,600.

Returned Benefits

Benefits returned to the issuing agency are not part of gross income. They are excluded as income and assets.

Example: Mary returns her deceased mother's social security check to Social Security Administration (SSA). Do not enter such payments in Bridges.

Reduced Benefits Due to Overpayment

Amounts deducted by an issuing agency to recover a previous overpayment or ineligible payment are not part of gross income. These amounts are excluded as income.

Exceptions: The following overpayment amounts **must** be included in gross income:

- Any portion of an overpayment (that is normally countable) if the original payment was excluded income when received.
- Cash assistance recoupment amounts due to Intentional Program Violation (IPV) are automatically counted for FAP in Bridges.
- Supplemental Security Income (SSI) amounts recouped due to IPV are included in countable gross income for cash assistance programs and FAP.

  IPV means there is a finding of fraud or an agreement to repay in lieu of prosecution. Do not exclude recouped SSI when IPV

information is volunteered by the SSI recipient or other reliable source. Do not initiate any contacts to obtain this information.

ASSET EXCLUSION

All Programs

Income manual items identify certain income types that are excluded as assets as well as income. The conditions in BEM 400, Excluded Income Under BEM 500 must be met for the asset exclusion to apply.

Funds cannot be counted as both income and as assets in the same month. Do not include funds entered as income in asset amounts entered in Bridges.

LUMP SUMS AND ACCUMULATED BENEFITS

All Programs

Sometimes funds from a particular source are paid in a way that meets the definition of either lump-sum or accumulated benefit; see BPG Glossary for definitions. This section describes special treatment applicable to such payments. Enter lump sum data in the **Lump Sum/Accumulated Benefits** LUW in Bridges.

FIP, RCA, SDA, CDC, and FAP Only

Bridges treats lump-sums and accumulated benefits as assets starting the month received.

Exception: An individual might receive a single payment that includes both accumulated benefits and benefits intended as payment for the payment month. Bridges treats the portion intended for the payment month as income.

Medicaid

Lump-sums and accumulated benefits are income in the month received. Income may be countable or excluded. Follow the appropriate policy in items *BEM 501, Income from Employment; 502, Income from Self-Employment; 503, Income Unearned; and 504, Income from Rental Room and Board*, based on the income type.

Exception: The following are assets starting the month received:

- Income tax refunds.
- Nonrecurring proceeds from the sale of an asset.
- Payments that are excluded assets; see BEM 400, Cash Exclusions.
- The 3 Federal Stimulus Payments received for the COVID-19 Federal Health Emergency.

PAYMENT TO REPRESENTATIVE

All Programs

Income paid to an individual acting as a representative for another individual is **not** the representative's income. The income is the other individual's income. Common representatives include:

- Legal guardians; see Bridges Policy Glossary (BPG).
- Court-appointed conservators.
- Minor children's parents.
- Representative payees.

Example: Diane's RSDI check is sent to her representative payee. It is Diane's income.

A payment to an individual might include money intended for more than one individual. Create an income record for each individual, and enter that individual's share as income.

Example: A farm owner issued one paycheck to Mr. G. that included the earnings of the entire family. Create separate income records for each individual's share.

An organization's money that an individual has access to as a member of the organization is the organization's money.

Example: John is a scout troop leader. Scout troop dues that John collects belong to the scout troop and are **not** considered John's money. Do not enter this income in John's Bridges case.

Income an individual receives in their capacity as trustee of a trust is the trust's income.

INCOME RECEIVED JOINTLY

All Programs

Income is received jointly if the payment is made in the name of more than one individual other than a representative; see *payment to a representative* in this item.

Income received jointly is available. Absent evidence to the contrary, each individual is considered to have an equal share. Divide joint income equally among the recipients of the income.

GENERAL EXCLUSIONS

All Programs

This section describes exclusions that apply to more than one income type.

Asset Conversion

Consider an asset converted from one type to another (example: an item sold for cash) as an asset.

Exception: See BEM 503, Sale of Property in Installments.

Inconsequential Income

Inconsequential income means income that is unpredictable, irregular, and has no effect on continuing need. For example, occasional cash gifts.

Do not enter inconsequential income in Bridges if the amount received during a calendar quarter is $30 or less. Enter amounts in excess of $30 per quarter using the appropriate LUW and income type.

Note: Inconsequential income, including donations or gifts is not countable income for a MAGI Medicaid eligibility determination.

In-Kind Benefits

Bridges excludes as income any gain or benefit in a form other than money. For example: meals, clothing, home energy, garden

produce and shelter. It includes shelter provided by an employer instead of cash wages.

Loans

Bridges excludes funds an individual has borrowed provided it is a bona fide loan. This includes a loan by oral agreement if it is made a bona fide loan. Bona fide loan means all the following are present:

- A loan contract or the lender's written statement clearly indicating the borrower's indebtedness.
- An acknowledgment from the borrower of the loan obligation.
- The borrower's expressed intent to repay the loan by pledging real or personal property or anticipated income.

This exclusion does **not** apply to purchases made with borrowed money or interest earned on borrowed money.

Plan to Achieve Self-Support (PASS)

The Social Security Administration (SSA) allows an SSI recipient to divert income from sources other than SSI, to pay the expenses of an approved plan to achieve self-support (PASS). SSA does not consider the PASS portion of the income in determining the amount of the individual's SSI benefit. SSA monitors compliance with the plan.

Enter the portion of income diverted to a PASS on the appropriate income details screen under **monthly deductions**. Bridges counts amounts diverted to a PASS, when income from that source is normally counted.

FAP Only

Exception: Bridges excludes portions of income being diverted to a PASS as income and as an asset.

Reimbursements

All Programs

Bridges excludes compensation awarded for a particular use which carries a legal sanction if used for another purpose, as income and as an asset.

Bridges excludes that portion of income received from another individual, an agency or an organization that covers past, current or future expenses when all the following are met:

- The payment is **not** for normal household living expenses such as rent, mortgage, personal clothing or food eaten at home.
- The payment is for specifically identified expense(s).
- The payment is used for its intended purpose.
- The payment is made or documented separately from other payments.

Note: Consider the payment to equal the expense unless the individual who received the payment, or the individual who made the payment, volunteers to MDHHS that the payment exceeded the expense.

Examples of payments excludable as reimbursements are:

- Partnership. Accountability. Training. Hope. (PATH) support services payments.
- Payments for employment expenses such as travel expenses and the cost of military uniforms and other special clothing.
- Payments to volunteers for out-of-pocket expenses.
- Disaster-related grants.
- Insurance settlement for an identifiable loss.
- Keepseagle Track B, loan forgiveness related to the Internal Revenue Service.

  Note: See *lump sums and accumulated benefits* in this item if the settlement is a lump sum.

- Refund of Medicare premiums as a result of the Medicaid Buy-In program.
- Payments for medical expenses.

  Note: See *BEM 503, Insurance Payments for Medical Expenses,* information about which types of insurance payments are considered payments for medical expenses.

Expense money that is **not** excludable as a reimbursement is treated the same as other income from that source. For example, payments from an employer that are **not** excluded reimbursements are wages.

Note: Allowances in pension benefits for the Medicare Part B premium are **not** considered a reimbursement and are budgeted as unearned income.

Note: See *BEM 503, Child Support Reimbursements*, regarding such child support income.

Replacement Money

Do not enter a payment in Bridges when it was made to replace lost or stolen income if the original payment has already been considered.

THIRD PARTY ASSISTANCE

Payment of an individual's bills by a third party directly to the supplier using the third party's money is **not** income to the individual.

If the third party is paying the bill instead of paying money due the individual such as money owed for child support or owed on a loan, the payment is the individual's unearned income.

Exceptions: Exclude any portion of a payment that a court order or other legally binding agreement requires sending directly to an individual's creditor or service supplier.

Exclude voluntary spousal support used to pay the spouse's bill(s).

Example: Sally's ex-husband, Joe, pays Sally's rent. Joe uses his own money. Joe does **not** owe Sally any money. The payment is **not** income to Sally.

Example: Sally told her ex-husband it was acceptable to pay her rent instead of paying court-ordered spousal support to her. The payment is Sally's income.

DISABILITY BENEFITS

All Programs

Refer to the specific sections in BEM 503 for policies regarding:

- Railroad Retirement Board Benefits.
- Michigan Rehabilitation Services Payments.
- Retirement, Survivors, and Disability Insurance (RSDI).
- Supplemental Security Income (SSI).
- Workers' Compensation.
- U.S. Civil Service and Federal Employee Retirement System.

Payments an individual receives when absent from work due to illness or injury might be earned or unearned income.

- Consider regular wages received while on sick leave as earned income; see BEM 501, Wages.

- Consider the gross amount of other disability payments as unearned income; see BEM 503, Sick and Accident Insurance Payments.

VERIFICATION REQUIREMENTS

All Programs except Children Under 19

Verify all non-excluded income:

- At application, including a program add, prior to authorizing benefits.

  Note: See Bridges Administrative Manual (BAM) 117, Minimum Verification, for Expedited FAP income verification rules.

- At member add, only the income of the member being added.

  Note: See BAM 220, CDC Member Add, for CDC member add requirements.

- At redetermination.
- When program policy requires a change be budgeted.

  Exception: For FIP, RCA, SDA and FAP, verify income that decreases or stops. Do not verify starting and increasing income unless income change information is unclear, inconsistent or questionable. Select **starting or increasing income** as the verification source. Selecting **client statement** as the verification source results in Bridges incorrectly pending eligibility and generating a Verification Checklist.

  CDC only: During the 12-month continuous eligibility period, do not verify starting or increased income unless the income appears to be in excess of the income eligibility scale for the group size or it will positively affect the department payment or need hours.

Use available electronic methods (for example consolidated inquiry or SOLQ) to verify income. When electronic verification is not available or inconsistent with client statement, the client has primary responsibility for obtaining verification. Do not deny assistance based solely on an employer or other source refusing to verify income; see *BAM 130, Verification and Collateral Contacts*, and *BEM 702, CDC Verifications*.

Children Under 19 Only

Income and expenses, including self-employment are **not** verified for Children Under 19. Client statement is an acceptable verification source for income and income-related expenses.

ACCEPTABLE VERIFICATION SOURCES

All Programs

Verification may be from any of the following:

- Documents (example: pay stubs or award notice).
- Letter or document from person/agency making the payment.
- Document from or collateral contact with a knowledgeable source.

- Electronic verification from a reliable source.
- Consolidated Inquiry.

The verification must confirm the gross amount. If unknown, the frequency of the payment must also be verified.

Accept an award notice dated within the past 60 days if there is no reason to suspect the amount has changed.

Refer to appropriate income item for specific acceptable verification sources for each income type.

COMMON VERIFICATION SOURCES

All Programs

Each income type in Bridges has a list of verification sources on the pay details screen. The following verification sources are included in most lists and intended to be used as follows:

Client Statement

Select **Client statement** as the verification source for pay details entered when data is based solely upon information reported by the client verbally, electronically or in writing.

Exception: Select **Starting or increasing income** as the verification source when income starts or increases and you are not processing an application or redetermination.

After running EDBC, eligibility will pend for programs that require an income verification source other than client statement or starting/increasing income. Bridges will generate a DHS-3503, Verification Checklist, listing what needs to be verified and possible verification sources.

Verification fields associated with eligibility factors that do not normally require verification, default to client statement in Bridges.

Conversion

Many verification sources are populated with **Conversion** as the initial value when an individual is converted from Legacy systems to Bridges. Conversion is an acceptable verification source until the

case situation requires a new verification. This value cannot be selected by the user.

Not Verified/ Questionable

Select **Not Verified** or **Not Verified/Questionable** as the verification source **only** when income that does not normally require verification (for example starting or increasing income) is unclear, inconsistent or questionable. This causes Bridges to generate a VCL for that income type.

Other Acceptable

Select **Other Acceptable** when your verification source does not exactly match any of the specific sources listed in the verification drop down, but verifies all needed elements by another means.

Verification Not Required - Excluded Income

Select **Verification not required - excluded income** whenever it appears in the verification source drop down. This source is selectable only when the income is excluded for all programs, including SER.

LEGAL BASE

FIP

MCL 400.1 *et seq*.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

MA

Social Security Act Sections 1902(a)(10), 1931
42 CFR 435, Subparts H and I
MCL 400.106

The Patient Protection and Affordable Care Act (Pub. L. 111-148) and the health Care and Education Reconciliation Act (Pub. L- 111-152).

FAP

7 CFR 273.9
Section 5105(a)(3)
P. L. 108-447
Keepseagle v. Vilsack, 1:99cv03119 ("Keepseagle")

DEPARTMENT POLICY

All Programs

This item identifies both of the following:

Which income types are considered earned.

Which earned income types are excluded or counted for each type of assistance.

To create a new income record, go to the income questions screen and answer **yes** to the appropriate question for that income type. This will add the appropriate income-related logical unit of work (LUW) to the driver flow and cause Bridges to consider this income.

To view or change an existing income record, select the appropriate income related LUW from the left navigation.

Logical Unit of Work (LUW)

An income related LUW is a series of data collection screens. Completion is required to collect the information needed to determine countable income.

Data entered in an LUW is not saved until all screens in the LUW are completed and saved. Use the tabs across the top of the Bridges screens to identify which screens are contained within the LUW.

Income data is not considered in the eligibility result until eligibility determination/benefit calculation (EDBC) is run. Income data does not affect benefit issuance until eligibility results are certified for that program.

STRIKERS' COUNTABLE EARNINGS

Food Assistance Program (FAP) Only

If an individual is on strike, pre-strike and current wages both must be entered in the Bridges Employment LUW. Bridges will count the higher of:

The earnings of the individual prior to the strike.

The individual's current earnings.

Note: Strike benefits other than wages are unearned income; see Bridges Eligibility Manual (BEM) 503, Income Unearned.

STUDENT EARNINGS DISREGARD

All Programs

This disregard applies to all sources of earned income including wages and training income. It ends the month after the student stops meeting a requirement (Example: month after reaching age 18).

Note: There is a different disregard for Workforce Innovation and Opportunity Act (WIOA)-funded training income; see *Training Income*.

Bridges continues the student earnings exclusion during school breaks and vacations as long as the student plans to return as indicated by student's education details in Bridges.

See BEM 400, Assets, for the asset exclusion policy.

Family Independence Program (FIP), Refugee Cash Assistance (RCA), State Disability Assistance (SDA), Child Development and Care (CDC) and FAP Only

Bridges disregards the earnings of an individual who is all of the following:

- Under age 18.
- Attending elementary, middle, high school, homeschooled, or attending classes to obtain a GED.
- Living with someone who provides care or supervision.

Low-Income Family Medicaid (LIF) Only

Bridges disregards the earnings of a dependent child in the LIF eligibility determination group (EDG).

Group 2 Pregnant Women (G2P), Group 2 Under 21 (G2U) and Children Under 19

Bridges disregards the earnings of an individual under age 19 who is living with someone who provides care or supervision.

EARNED INCOME TYPES

All Programs

In addition to the earned income types identified in this item, income from self-employment is considered earned; see BEM 502, Income From Self-Employment.

Sometimes income from rental/room and board is considered earned income; see BEM 504, Income From Rental/Room and Board.

AMERICORPS

AmeriCorps/ VISTA

Volunteers in Service to America (VISTA) is now called AmeriCorps/ VISTA. This is a Domestic Services Volunteers Act, Title I program.

Family Independence Program (FIP), Refugee Cash Assistance (RCA), State Disability Assistance (SDA), Child Development and Care (CDC) and Medicaid (MA)

These payments are excluded as income and as assets.

FAP Only

These payments are countable income.

Exception: If the client was receiving FAP when they joined AmeriCorps/VISTA, these payments are excluded as income.

AmeriCorps Community Service

AmeriCorps, a national community service program, encompasses AmeriCorps State, AmeriCorps*National and AmeriCorps*NCCC.

Participants in these programs may receive any or all of the following:

- Living allowance.
- Child care allowance.
- Health insurance.
- Services to individuals with disabilities.
- National service education award.

FIP, RCA, SDA, CDC and FAP

Bridges excludes all allowances and benefits as income and as assets.

Medicaid

Bridges counts the living allowance as wages and excludes all other allowances and benefits as income and assets.

GREEN THUMB/ SENIOR COMMUNITY SERVICE EMPLOYMENT

All Programs

Bridges excludes income earned under the senior community service employment program (example: Green Thumb) established by Title V of Public Law 100-175 (Older Americans Act). These payments are excluded as income and as an asset.

HONORARIUMS

All Programs

An honorarium is a voluntary payment received for services rendered as distinguished from employment income (examples: guest speaker, participant in MDHHS advisory committee). Some or all of the payment might be reimbursement for expenses; see BEM 500, Income Overview.

MDHHS Honorarium

An MDHHS-paid honorarium is a reimbursement and excluded.

Other Honorarium

Bridges counts any amount not meeting the definition of a reimbursement as earned income; see *Wages*.

S CORPORATION (S CORP)/LIMITED LIABILITY COMPANY (LLC)

All Programs

Bridges counts the income a client receives from an S-Corp or LLC as wages, even if the client is the owner; see *Wages*.

Refer to BEM 503, regarding dividends and interest paid to an individual from an S-Corp. or LLC.

SENIOR COMPANION

This is a Domestic Services Volunteers Act, Title II program. Payments are excluded earned income under Title II of Public Law 93-113. Bridges excludes as income and asset.

TRAINING INCOME

All Programs

The training program decides if payments are from the Workforce Innovation and Opportunity Act (WIOA) and if payments are for on-the-job training (OJT). If a payment includes WIOA and Non-WIOA funds, apply appropriate policy below to the separate portions.

See BEM 400.

On-the-Job Training (OJT)

Bridges counts OJT (or paid work experience) income as earnings.

Exceptions:

- Bridges disregards OJT income received under the Summer Youth Employment and Training Program.
- Bridges disregards OJT if received by an individual who is **any** of the following:

- Under age 18.
- Age 18 and living with someone providing care or supervision.
- For LIF only, age 19 and a dependent child.

Workforce Innovation Opportunity Act (Not OJT)

Bridges excludes payments from WIOA training income that are **not** for OJT.

Other Training Income

Training income that is not specifically addressed in policy is countable earned income. This includes vocational training or training allowances that cannot be excluded due to being OJT, WIOA funded, MRS or reimbursements.

UNIVERSITY YEAR FOR ACTION

All Programs

This is a Domestic Services Volunteers Act, Title I program. Payments are excluded earned income under Title I of Public Law 93-113. These payments are excluded as income and as an asset.

WAGES

All Programs

Wages are the pay an employee receives from another individual organization or S-Corp/LLC. Wages include salaries, tips, commissions, bonuses, severance pay, and flexible benefit funds not used to purchase insurance.

Enter an employee's regular wages paid during a vacation or illness as earned income.

Enter a wage advance as earnings when the employer actually pays it. Do **not** count the money withheld to offset the advance.

Enter wages held by the employer at the request of the employee. Bridges will count as earnings. However, wages held as a general practice by the employer are **not** income until actually paid and should not be entered in Bridges until anticipated or received.

Exception: Income received in one month that is intended to cover several months (for example contractual income) is considered available in each of the months covered by the income; see BEM 505, Prospective Budgeting/Income Change Processing, or BEM 503, Bridges counts gross wages except as explained in this item for:

- *Earned Income Tax Credit (EITC).*
- *Flexible Benefits.*
- *Striker's Countable Earnings.*
- *Student Earnings Disregard.*
- *Census Workers*.

Census Workers

FIP, RCA, SDA, CDC, SSI- Related, Group 2 Medicaid and FAP Only

Bridges excludes wages paid for temporary census workers.

MAGI Medicaid

Temporary census income is taxable, earned income, therefore, it is countable in a MAGI determination.

Earned Income Tax Credit (EITC)

All Programs

Some individuals elect to receive a portion of an anticipated EITC in regular pay checks. Do not include these amounts in the earned income pay details entered in Bridges. Advance payments of the EITC are excluded as income and as assets.

Flexible Benefits

Some employers give employees a flexible benefit allowance from which they may choose to purchase health insurance.

Flexible benefit amounts used to purchase insurance are excluded as income. Do not enter such amounts in Bridges.

Include any flexible benefit payments included in an individual's paycheck and **not** used to purchase insurance, in the amounts entered in pay details. They are considered wages.

Independent Living Services (ILS)

Enter income as wages for an individual who provides ILS (also known as adult home help) as earned income. This income is not counted for the individual receiving the service.

Military Combat Pay

FAP Only

Military combat pay is paid to military personnel as a result of deployment to a combat zone. Bridges excludes military combat pay for FAP. Determine the excluded income amount by calculating the difference between the military pay received by the household before and after the military individual's deployment to the combat zone; see Exhibit I - Designated Combat Zones.

Enter *Combat Pay Period Amount* on the pay details screen in Bridges.

Members of Clergy & Other Religious Workers

MAGI Medicaid Only

Ordained, commissioned, or licensed ministers of the gospel may be able to exclude from income tax the rental allowance or fair rental value of a parsonage that is provided to them as pay for their services.

The church or organization that employs the individual must designate the payment as a housing allowance before the payment is made. The housing allowance may be indicated on the W-2 and/or paystubs.

A housing allowance that is not taxable is not counted in a MAGI Medicaid eligibility determination.

TANF-Funded Subsidized Employment Income

FIP, RCA, CDC and FAP

All TANF-funded subsidized employment income in the form of wages, regardless of the source of TANF funding, is countable earned income.

Military Subsistence Supplemental Allowance

All Programs

The Subsistence Supplemental Allowance is paid to certain military personnel. Payments appear on the leave and earnings statement. Count the allowance as earned income by including them in wage amounts entered in Bridges.

Work Study

All Programs

The wages that are earned as part of a post-secondary education financial assistance package are excluded.

VERIFICATION REQUIREMENTS

All Programs

Note: Equifax Verification Services (formerly known as the Work Number) is **not** an automated system match which must be checked at application, redetermination, semi-annual or mid-certification contact. The client has primary responsibility for obtaining verification. However, if for example, verification of income is not available because the employer uses Equifax Verification Services and won't provide the employment information, it is appropriate to use the Equifax Verification Services Number.

FAP Only

If the income information from Equifax differs from what the client reported, verification must be requested or a documented discussion with the client must be completed.

Do not deny or terminate assistance because an employer or other source refuses to verify income; see BAM 130, Verification And Collateral Contacts.

All Programs, except Children Under 19

Verify non-excluded earned income at all of the following:

- Application, including a program add, prior to authorizing benefits.
- At member add, only the income of the member being added.

  Note: See BAM 220, Case Actions**,** for CDC member add requirements.
- Redetermination.
- When program policy requires a change be budgeted.

  Exception: For FIP, RCA, SDA, CDC and FAP, verify income that decreases or stops. Do not verify starting and increasing income unless income change information is unclear, inconsistent, or questionable. Select **starting or increasing income** as the verification source. Selecting **client statement** as the verification source results in Bridges incorrectly pending eligibility and generating a Verification Checklist.

Children Under 19

Income and expenses are **not** verified for Children Under 19 MAGI-related Medicaid. Client statement is an acceptable verification source for income and expenses.

COMMON VERIFICATION SOURCES

See BEM 500, for common verification sources.

SPECIFIC VERIFICATION SOURCES

Independent Living Services Income

- Consolidated Inquiry with a statement from the individual receiving the service (also known as adult home help) if there are any co-pays.
- Statement from individual receiving the service.

Military Combat Pay

FAP Only

- Military individual's leave and earnings statement (LES).
- Orders issued to military individual.
- Client's statement of the amount of combat pay received from the military.
- Any other reasonable method of verifying deployment to a combat zone; see *Exhibit I - Designated Combat Zones.*

Tips

- Pay stub if client confirms the accuracy of the amount listed on the pay stub. (Tips shown on pay stubs are often a percentage of sales for tax purposes.)
- Client statement.

Wages, Salaries, and Commissions

All Programs

- Check stubs or earnings statement.
- MDHHS verification of employment forms, for example MDHHS-38, Verification of Employment.
- Employer signed statement providing all necessary information.

- Employer generated work schedule, when pay frequency, pay day and rate of pay are known. When this source is used, select **other acceptable** as the verification source.
- Equifax Verification Services (formerly known as the Work Number).
- Employment services contractors including the one-stop service center, the work participation provider and refugee employment services contractors.
- Starting or increasing income. Select this verification source when an individual reports starting or increasing income, other than at application or redetermination. No VCL will be produced.
- Federal income tax forms and schedules are allowable for Medicaid determinations.

EXHIBIT - DESIGNATED COMBAT ZONES

EXECUTIVE ORDER 12744

Country	Effective Date
Arabian Sea Portion that lies North of 10 degrees North Latitude and West of 68 degrees East Longitude	January 17, 1991
Bahrain	
Gulf of Aden	
Gulf of Oman	
Iraq	
Kuwait	
Persian Gulf	
Qatar	
Oman	
Red Sea	
Saudi Arabia	
United Arab Emirates	

EASTERN

Country	Effective Date
Turkey	January 1, 2003 - December 31, 2005
Israel	January 1 - July 31, 2003
Eastern Mediterranean	March 19 - July 31, 2003
Jordan	March 19, 2003
Egypt	March 19 - April 20, 2003

EXECUTIVE ORDER 13239

Country	Effective Date
Afghanistan	September 19, 2001

DIRECT SUPPORT OF EXECUTIVE ORDER 13239

Country	Effective Date
Pakistan	September 19, 2001
Tajikistan	September 19, 2001
Jordan	September 19, 2001
Incirlik Air Force Base Turkey	September 21, 2001- December 31, 2005
Kyrgyzstan	October 1, 2001
Uzbekistan	October 1, 2001
Philippines (only troops with orders that reference OEF)	January 9, 2002
Yemen	April 10, 2002
Djibouti	July 1, 2002
Somalia	January 1, 2004

EXECUTIVE ORDER 13119 PUBLIC LAW 106-21 ESTABLISHING KOSOVO AS QUALIFIED HAZARDOUS DUTY AREA

Country	Effective Date
The Federal Republic of Yugoslavia (Serbia/Montenegro)	March 24, 1999
Albania	
The Adriatic Sea	
The Ionian Sea north of the 39th parallel	

PUBLIC LAW 104-117 ESTABLISHING A QUALIFIED HAZARDOUS DUTY AREA

Country	Effective Date
Bosnia	November 1995
Herzegovina	
Croatia	
Macedonia	

LEGAL BASE

FIP

MCL 400.1 et. seq.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151– 400.3180

RCA

45 CFR 400.66

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

MA

Social Security Act Sections 1902(a)(10), 1931
42 CFR 435, Subparts H and I
MCL 400.106
The Affordable Care Act (Pub. L. 11-148) and the Health Care and Education Reconciliation Act (Pub. L. 11-152).

FAP

7 CFR 273.9
Child Care and Development Block Grant of 1990, P. L. 101-508, Section 5105(a)(3)
P. L. 108-447

POLICY

All Types of Assistance (TOA)

This item identifies all of the following:

- Guidelines for determining if an individual's income is considered to be from employment or self-employment.
- Allowable expenses of producing self-employment income.
- Self-employment income types.

SELF-EMPLOYMENT

All TOA

Individuals who run their own businesses are self-employed. This includes but is not limited to selling goods, farming, providing direct services, and operating a facility that provides services such as adult foster care home or room and board.

Note: S-Corporations and Limited Liability Companies (LLCs) are not self-employment.

Except for those noted above, a person who provides child care in his/her home is considered to be self-employed. If the care is provided in the child's home, the provider is considered to be an employee of the parent; see Bridges Eligibility Manual (BEM) 501, Income From Employment.

Rental income is sometimes counted as unearned income and sometimes as self-employment. Enter all types of rental income in the rental/room and board logical unit of work (LUW). Bridges will determine income type and countable portion based on program policy rules; see BEM 504, Income From Rental/Room And Board.

EMPLOYMENT OR SELF-EMPLOYMENT INCOME?

It is sometimes difficult to determine if an individual's income should be entered in the earned income or self-employment LUW. Make a determination based on available information and document your rationale. Use the following guidelines to help make that determination; consider the following to be indicators of self-employment:

- The individual sets own work hours.

- The individual provides own tools used on the job.
- The individual is responsible for the service being provided and for the methods used to provide the service.
- The individual collects payment for the services provided from the individual paying for them.

A client need not meet all of the above to be considered self-employed.

Do **not** consider the following in making the determination of whether a client's income is considered self-employment or employment:

- Withholding of income tax from payment made to individual.
- Whether or not the individual files income tax.
- Whether or not individual receives a federal Form 1099.

Example 1: Joe has a contract with the local hospital to provide snow removal services. He drives his own snow removal vehicle and pays for his own gas. The hospital pays him directly based on the number of times his services are used. Joe is self-employed.

Example 2: Jane is a hairdresser at a salon. The salon supplies all the products she uses on the job. Jane's clients pay the salon for the services Jane provides. Jane receives a paycheck from the salon each week for 50 percent of the income from her clients. For income budgeting purposes, Jane is an employee of the salon and her income should be entered in the earned income LUW; **not** the self-employment LUW.

Example 3: Rich provides home help care for his elderly neighbor; Sam. Sam receives assistance through MDHHS' Independent Living Services (Adult Home Help) program to pay for Rich's services. Rich is an employee of Sam and his income should be entered in the earned income LUW; **not** the self-employment LUW.

Example 4: Mary Jo is a massage therapist at a local chiropractor's office. She uses a room in the office and uses its table. She provides her own oils and linens used for the massages and sets her own hours. She collects payment directly from the clients and pays the chiropractor's office $10 for each massage provided. Mary Jo is self-employed.

COUNTABLE SELF-EMPLOYMENT INCOME

The amount of self-employment income before any deductions is called total proceeds. Countable income from self-employment equals the total proceeds **minus** allowable expenses of producing the income. If allowable expenses exceed the total proceeds, the amount of the loss cannot offset any other income **except** for farm loss amounts; see *Farming Expenses* in this item.

Example: An individual operates a retail store. Total proceeds for the month are $3,200. Allowable expenses total $3,800. The $600 deficit **cannot** be used to offset any other income.

Allowable expenses are the higher of 50 percent of the total proceeds, or actual expenses if the client chooses to claim and verify the expenses.

Note: MAGI related Medicaid uses adjusted gross income as declared on the federal tax return. SSI-Related MA self-employment deductions are limited to the higher of 25 percent of the total proceeds, or actual expenses if the client chooses to claim and verify the expenses.

SELF-EMPLOYMENT INCOME EXPENSES

Allowed

Allowable expenses include all of the following:

- Identifiable expenses of labor, stock, raw material, seed, fertilizer, etc.
- Interest and principal on loans for equipment, real estate or income-producing property.
- Insurance premiums on loans for equipment, real estate and other income-producing property.
- Taxes paid on income-producing property.
- Transportation costs while on the job (example: fuel).
- Purchase of capital equipment.

- A child care provider's cost of meals for children. Do **not** allow costs for the provider's own children.
- Any other identifiable expense of producing self-employment income except those listed below.

Note: Allowable expenses for rental/room and board are different than those listed above; see BEM 504. Policy in BEM 504 does not pertain to MAGI Medicaid determinations.

Not Allowed

Do **not** enter any of the following as self-employment expenses in Bridges:

- A net loss from a previous period.
- Federal, state and local income taxes.
- Personal entertainment or other individual business expenses.
- Money set aside for retirement.
- Depreciation on equipment, real estate or other capital investments.

Medicaid

Allowable expenses include those allowed by the IRS on forms such as the Schedule C or F. Expenses are listed in Part II of both schedules. An individual with new self-employment may submit an estimated Schedule C, not yet filed with the IRS to assist in verifying expenses.

Part V, other expenses on Schedule C requires documentation from the individual.

Some individuals may include Schedule 1-6 with the federal tax return.

FARMING EXPENSES

Family Independence Program (FIP), Refugee Cash Assistance (RCA), SDA, Child Development and Care (CDC), Food Assistance Program (FAP)

Allowable expenses of farming can exceed the proceeds if the actual or anticipated proceeds are $1,000 or more for the year. This farm loss can then be deducted from other budgetable income of the group to determine the benefit amount, as follows:

- Bridges will deduct the net farm loss from any other budgetable earned income of the group.
- If a net farming loss remains, Bridges deducts it from any budgetable unearned income of the group.

The previous year's tax return is the usual basis to calculate the farming income. The loss is prorated over the year to determine a monthly amount to apply to the other income sources.

CHILD CARE NUTRITION PAYMENTS

All TOA

When a child care provider receives payments under the Child Nutrition Act of 1965 or National School Lunch Act, enter this income in the self-employment LUW.

FIP, RCA, SDA, CDC, Medicaid (MA)

Bridges excludes payments received under the Child Nutrition Act of 1965 and the National School Lunch Act.

FAP Only

Bridges counts the following result as self-employment income of the child care provider:

Payment received under the Child Nutrition Act of 1965 (Child and Adult Food Care Program) or National School Lunch Act, **minus** the allowable cost of meals for the provider's own children during child care hours. Bridges will use the higher of actual costs (if reported and verified), or 50 percent of the total proceeds for allowable costs; see *Self-employment Expenses* in this item.

USDA PAYMENT-IN-KIND (PIK) PROGRAM

FIP, RCA, SDA, CDC and FAP

United States Department of Agriculture payment-in-kind (PIK) program pays farmers to divert land or reduce crop acreage. The Commodity Credit Corporation (CCC) issues PIK commodities (surplus agricultural products) and commodity certificates.

Count a commodity or a commodity certificate as self-employment income if either of the following:

- Cash is actually received for it.
- It is reasonably anticipated that it will be sold or returned to the CCC during the year for which the income is being calculated.

Exceptions:

- A commodity or commodity certificate is an asset if the intention is to hold it for over 12 months.
- Exclude a commodity intended for use as feed or seed as income and as an asset.

Enter PIK income in the self-employment LUW as **other self-employment**.

VERIFICATION REQUIREMENTS

All TOA except Children Under 19 (U19)

Verify countable income at **all** of the following:

- Application, including a program add, prior to authorizing benefits.

  Note: See Bridges Administrative Manual (BAM) 117, FAP Expedited Service, for expedited income verification rules.

- At member add, only the income of the member being added.

  Note: See BAM 220, Case Actions, for CDC member add requirements.

- Redetermination/Renewal.
- When program policy requires a change be budgeted.

  Exception: For FIP, RCA, SDA, and FAP, verify income that decreases or stops. Do not verify starting or increasing income unless income change information is unclear, inconsistent or questionable. Select **starting or increasing income** as the verification source. Selecting **client statement** as the verification source results in Bridges incorrectly pending eligibility and generating a verification checklist.

The individual has primary responsibility for obtaining verification. Do not deny assistance because an individual is unable to verify income. Assist the individual in obtaining verification when requested; see BAM 130, Verification And Collateral Contacts, and BEM 702, CDC Verifications.

Children Under 19 (U19) Only

Income and expenses are **not** verified for Children Under 19. Individual statement is an acceptable verification source for income and income-related expenses.

VERIFICATION SOURCES

All TOA, except Medicaid

Self-Employment Income

- Primary source - Income tax return provided:
  - The client hasn't started or ended self-employment, or received an increase/decrease in income, etc.
  - The tax return is still representative of future income.
  - The client filed a tax return.
- Secondary source - DHS-431, Self-Employment Statement, with all income receipts to support claimed income.
- Third source - DHS-431, Self-Employment Statement, without receipts.

Medicaid

Form 1040, U.S. individual federal income tax return.

Form 1040 NR, non-resident alien federal income tax return.

Schedule C, Profit or Loss From Business, including all attachments. P This form is used in conjunction with IRS form 1040. Schedule C is acceptable even if not yet filed with the IRS.

A non-tax filer may submit a completed Schedule C to verify expenses without a 1040. This may occur with a new business entity.

A tax-filer may submit a Schedule C along with the accompanying 1040.

Schedule F, Farm Rental Income and Expenses may be filed in conjunction with Form 1040.

The DHS-431, Self-Employment Statement, is not acceptable verification for Medicaid purposes.

Self-Employment Expenses

All Programs except Medicaid

DHS-431, Self-Employment Statement, with receipts.

Medicaid

Form 1040, U.S. individual federal income tax return.

Form 1040NR, Non-resident alien federal income tax return.

Schedule C, Profit or Loss From Business, if accompanied by a tax return.

Schedule F, Farm Rental Income and expenses if accompanied by a tax return.

USDA Payment-In-Kind (PIK)

All Programs

- PIK commodity/certificate income.
- Business receipts.
- Accounting or other business records.
- Written statement from the Commodity Credit Corporation (CCC) or purchaser.

USDA Payment-In-Kind (PIK) Commodities/ Certificates Asset

- PIK certificate.
- Statement from Commodity Credit Corporation.
- Statement from local livestock or implement dealers.
- Statement of county agricultural agent.

RESOURCES

FIP

MCL 400.1 et. seq.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151- 400.3180

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et. seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

MA

Social Security Act Sections 1902(a)(10), 1931
42 CFR 435, Subparts H and I
MCL 400.106

The Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

FAP

7 CFR 273.9.1, 273.2(f)(2)(i)
Child Care and Development Block Grant of 1990, P. L. 101-508, Section 5105(a)(3)
P. L. 108-447

DEPARTMENT POLICY

All Programs

This item identifies all the following:

- Unearned income types.
- Definition of each unearned income type.
- Whether an unearned income type is countable or excluded for each type of assistance.

To create a new income record, go to the income questions screen and answer *yes* to the unearned income question. This will add the unearned income logical unit of work (LUW) to the driver flow and cause Bridges to consider this income.

To view or change an existing income record, select the unearned income logical unit of work from the left navigation.

EXPENSES OF OBTAINING UNEARNED INCOME

Bridges excludes amounts paid or withheld from unearned income which are essential expenses of obtaining the income. Enter these amounts in the expense screen of the unearned income logical unit of work.

Examples:

- Legal and medical expenses withheld from a lawsuit settlement.
- Disability insurance premiums which must be paid to continue current disability payments.

Medicaid (MA) Only

There is a limit to the deduction of court-ordered guardianship and conservator expenses. See Bridges Eligibility Manual (BEM) 536, Determining Budgetable Income - Group 2 Under 21 and Caretaker Relative, 540, MA Deemed Income And Deduction --SSI-Related Children, 541, MA Income Deductions - SSI-Related Adults, or 546, Post-Eligibility Patient-Pay Amounts, depending on the type of budget being done. Enter guardianship/conservator expenses on the Support Expense Details screen in Bridges.

UNEARNED INCOME TYPES

All Programs

ACCELERATED LIFE INSURANCE PAYMENTS

An accelerated life insurance payment is payment of the death benefit of a life insurance policy prior to the insured individual's death. Some companies call the payment a living need payment or accelerated death payment. Details of the payment option vary from company to company. Under most plans, payment is available when the insured individual meets any of the following:

- Needs care in a long-term care (LTC) facility.
- Has a catastrophic illness.
- Is terminally ill.

The individual might have the option of receiving the payments over a period of months or all at once.

Receipt of such payments might reduce the cash surrender value of the insurance policy. In some cases, a lien might be attached to the insurance policy. Accelerated life insurance payments are **not**:

- Conversion of an asset from one form to another.
- A potential benefit for which an individual must apply.

Bridges counts the gross amount of an accelerated life insurance payment as unearned income.

Exception: It is a lump sum if payment is received all at once; see BEM 500. Income Overview.

ADOPTION SUBSIDIES

Family Independence Program (FIP), State Disability Assistance (SDA), Refugee Cash Assistance Program (RCA), Child Development and Care (CDC) and Food Assistance Program (FAP)

An adoption subsidy is a payment to the adopting parent(s) of an adopted child who would remain in foster care without the subsidy incentive. There are two types of adoption subsidies:

Support Subsidy

A support subsidy is a payment for ongoing care and support of the child. Bridges includes support subsidies as income.

Medical Subsidy

A medical subsidy is a payment for medical expenses due to a physical, mental or emotional condition of the child. Bridges excludes medical subsidies as income. They are reimbursements.

Do not include funds from these payments in liquid asset amounts entered in Bridges. They are excluded assets.

Note: Support Subsidy is excluded as income for Medicaid programs.

AGENT ORANGE PAYMENTS

All Programs

Agent Orange payments are received from Aetna Life and Casualty because of the Agent Orange lawsuit settlement and Public Law 101-201. Bridges excludes these payments as income. Do not include funds from these payments in liquid asset amounts entered in Bridges. They are excluded assets.

ALIEN SPONSOR INCOME

FIP, SDA, RCA, CDC, MA

Bridges counts actual contributions an alien receives from their sponsor as unearned income.

FAP Only

See BEM 550, FAP Income Budgeting, about how Bridges counts both of the following:

- The sponsor's actual contributions to the alien.
- An amount deemed to the alien from the sponsor by policy.

AMERICAN INDIAN PAYMENTS

All Programs

Gaming Revenue

Individuals may receive income from tribal gaming profits including casino profit sharing. Bridges counts as unearned income all payments made to American Indians from gaming revenues. Bridges does **not** exclude any part of these payments. If a payment is intended to cover multiple months, use the appropriate payment frequency in Bridges to average the income for applicable type of assistance.

Payments Excluded by Federal Laws

Many federal laws exclude all or a part of payments made to American Indians. These have been programmed into Bridges and are identified in *EXHIBIT I- NATIVE AMERICAN PAYMENT EXCLUSIONS* in this item.

ANNUITY INCOME

All Programs

Payments an individual receives from an annuity are unearned income. Bridges counts annuity payments as the individual's unearned income.

Note: For MAGI Medicaid some structured annuity income that is non-taxable may not be counted toward an individual's Medicaid income; see BEM 401, Trusts - MA,

BLACK LUNG

Black Lung benefits are administered by the federal government. The purpose of the program is to provide wage replacement and medical benefits to coal miners who are totally disabled due to black lung disease. Payments are also made to disabled coal miners' eligible survivors. Bridges counts black lung payments as the individual's unearned income.

CHILD/COMMUNITY SPOUSE ALLOCATION

MA and FAP Only

Sometimes policy deems someone's income (or a portion of income) available to another person. Deeming rules are programed into Bridges and deemed amounts are automatically calculated.

Money diverted by an L/H patient to their community spouse or dependents at home per BEM 546 is a contribution. Count the gross amount actually received as the community spouse's or dependent's unearned income.

CHILD FOSTER CARE PAYMENTS

FIP, SDA, RCA, CDC, MA

Bridges excludes government, court or private agency payments for child foster care and independent living stipends.

Note: For FIP, recipients of child foster care payments have an eligibility determination group (EDG) participation status of excluded; see BEM 210, FIP Group Composition.

FAP only

Bridges counts these payments as the unearned income of the foster child who has a FAP program request status of yes.

Reminder: A foster parent may choose whether or not to request FAP on behalf of a foster child. When FAP program request status for foster child is no, Bridges does not consider the child's needs or income in the FAP eligibility determination: see BEM 212, Foster Children.

Note: Contact the children's service worker for the amount paid.

Independent Living Stipend

Independent living stipends (ILS) are payments made to a foster child who is in an independent living arrangement. Michigan Department of Health & Human Services (MDHHS) services manual defines independent living as: "The youth's own unlicensed

residence or the unlicensed residence of an adult who has no supervisory responsibility for the youth."

FIP, SDA, RCA, CDC

Recipients of independent living stipends (ILS) have an eligibility determination group (EDG) participation status of excluded. Bridges does not consider the recipient's need, income or assets: see BEM 210, BEM 214, SDA Group Composition and, BEM 215, RCA Group Composition.

FAP

Bridges counts independent living stipend payments as unearned income.

CHILD SUPPORT

All Programs

Child Support is money paid by an absent parent(s) for the living expenses of a child(ren). Medical, dental, child care and educational expenses may also be included. Court-ordered child support may be either **certified** or **direct**. Certified support is retained by the state due to the child's FIP activity. Direct support is paid to the client.

Child support is income to the child for whom the support is paid.

FIP, SDA, RCA, CDC, FAP

Child support payments, including arrearage payments, received by a custodial party for an adult child or a child no longer living in the home, are considered the other unearned income of the payee if the money is not forwarded to the adult child or child. If the money is forwarded to the adult child or child, it is the other unearned income of the adult child or child.

Note: If the child support payments are paid for a minor child who has been removed from the home of the custodial parent, the income is still the income of the child, unless documented otherwise.

Exception: **MA Only** - Arrearage payments received and retained by a parent for an adult child, or a child not living in the home, are considered unearned income for the parent. Any amount of the

payment which is passed through to the adult child it is not income to the parent.

MAGI Medicaid

Child support payments are not countable for the payee nor are they deducible for the payer in a MAGI Medicaid determination.

Child Support Certified

All Programs

Certified support means court-ordered payments the Michigan State Disbursement Unit (MiSDU) sends to MDHHS due to a child's receipt of assistance. Office of Child Support refers to these collections as retained support. This may include court-ordered medical support payments.

CDC Only

Bridges excludes as income, both of the following:

- The amount of collections retained by MDHHS (certified support).
- Direct Support payments the group receives (in error) after the child support certification effective date and returns to MDHHS.

FAP Only

Bridges excludes collections retained by MDHHS (certified support) and court-ordered support payments the group receives after the child support certification effective date.

Child Support Non-FIP Arrears

FIP Only

For FIP eligibility determination groups whose initial eligibility is approved on or after October 1, 2009, collections attributed to a time when the family was not receiving FIP, are not retained by the state. Office of Child Support refers to these payments as pre-assistance arrears.

FIP and RCA Only

These payments are excluded income.

MA Only

Arrearage payments received and retained by a parent for an adult child, or a child not living in the home, are considered unearned income for the parent. Any amount of the payment which is passed through to the adult child it is not income to the parent.

CDC Only

This type of child support income has no effect on CDC eligibility when received by FIP recipients because they are eligible for CDC through the CDC Protective Services category.

When received by a non-FIP recipient, this is countable unearned income.

FAP Only

This type of child support income is countable.

Child Support Certified Potential Family Arrears

All Programs

For FIP eligibility determination groups whose initial eligibility of ongoing benefits was approved prior to October 1, 2009, collections attributed to a time when the family was not receiving FIP, are retained by the state. Office of Child Support refers to these payments as potential family arrears.

Child Support Client Participation Payment

All Programs

Child support client participation payment (CPP) means a payment issued to a current FIP recipient in lieu of current certified support.

FIP, SDA, RCA, CDC and MAGI Medicaid

This type of child support income is excluded.

RMA, SSI-Related Group 2 Medicaid and FAP

This type of child support income is countable.

Child Support Direct (Court-Ordered)

SDA, RCA, RMA, CDC, MA and FAP

Court-ordered direct support means child support payments an individual receives directly from the absent parent or the MiSDU. Count the total amount as unearned income, except any portion that is court-ordered or legally obligated directly to a creditor or service provider.

FIP Only

This is excluded as income.

Note: Court-ordered direct support payments, including arrearage payments, received by a custodial party for an adult child or a child no longer living in the home, are considered the countable other unearned income of the payee if the money is not forwarded to the adult child or child. If the money is forwarded to the adult child or child, it is the countable other unearned income of the adult child or child.

Child Support Refund

All Programs

Child support refund means a payment issued to a current or former FIP recipient when support was misdirected to MDHHS (retained in error) due to a delay in child support decertification. Office of Child Support refers to these payments as late decerts.

Bridges excludes as income.

Child Support Reimbursement

All Programs

Child support reimbursement means a payment issued to a current or former FIP recipient when the state receives certified support exceeding the amount that may be retained to offset FIP paid. Office of Child Support refers to these payments as excess Unreimbursed Grant (URG) amount.

Bridges excludes as income.

Child Support Voluntary (Not-Court Ordered)

All Programs

Voluntary support means child support payments that are **not** court-ordered. The payments are received by the individual directly from the absent parent. Count the total amount as the child's unearned income. See BEM 518, Voluntary Support, for the voluntary support income disregard for FIP.

CRYPTOCURRENCY

All Programs

Once cryptocurrency is converted/cashed out into U.S. dollars, it becomes unearned income.

Income received from crypto mining is considered unearned income, but only once it has been converted/cashed into U.S. dollars.

DEATH BENEFIT

All Programs

Death benefits are money an individual receives from Social Security or an insurance company due to the death of another individual. Enter as *death benefit* in both the unearned income logical unit of work and lump sum logical unit of work.

FIP, SDA, RCA, CDC, and FAP Only

A death benefit is a lump sum; see BEM 500.

Medicaid

A death benefit is unearned income. Bridges counts the gross benefit minus the amount used to pay the last medical expenses and burial costs of the deceased individual.

DONATIONS/ CONTRIBUTIONS

All Programs

Home Heating Fuel Supplier or Public/ Government Agency

Bridges excludes as income, a donation given to an individual by a home heating fuel supplier or a public/government agency for food, clothing, shelter or home energy.

Individual Outside the EDG

A donation to an individual by family or friends is the individual's unearned income. Bridges counts the gross amount received, if the individual making the donation and the recipient are not members of any common eligibility determination group.

Exception: See BEM 500.

Note: A donation or gift from this source is not countable income for MAGI Medicaid.

Private, for Profit/ Other Donations

Donations from a private, for-profit organization are countable unearned income. Donations from sources other than those specified in policy are countable unearned income.

Note: A donation or gift from this source is not countable income for MAGI Medicaid.

Private, Nonprofit Organization Assistance

This means money an individual receives from a private, nonprofit organization based on need, as determined by the contributing organization. Bridges excludes the first $300 received during a calendar quarter. Amounts more than $300 per calendar quarter are counted as unearned income.

Note: A donation or gift from this source is not countable income for MAGI Medicaid.

EDUCATIONAL ASSISTANCE (NOT WORK STUDY)

All Programs

Grants, Loans, Scholarships etc.

Educational assistance includes grants, loans, scholarships, assistantships, stipends and fellowships for education. Bridges excludes these income types as income and as assets.

See BEM 501, Income From Employment.

Operation Graduation

The Operation Graduation School Dropout Prevention Program is funded by the Michigan Department of Education and operated by local school districts. Recipients are secondary school students ages 12 through 18.

Bridges excludes as income.

FACTOR CONCENTRATE LITIGATION SETTLEMENT (WALKER VS. BAYER)

All Programs

Four manufacturers of blood plasma settled a lawsuit involving hemophilia patients who became infected with human immunodeficiency virus. The court case was referred to as Susan Walker vs. Bayer Corporation. Beneficiaries of the lawsuit may receive a settlement worth $100,000. Payment may be a one-time payment or periodic payments. Enter one-time payments as a lump sum. Enter periodic payments in the unearned income logical unit of work.

The recipient may have documents from the settlement law group regarding factor concentrate litigation settlement.

FIP, SDA, RCA, CDC, and FAP Only

Bridges will count lump sums as assets beginning the month received.

Bridges will count the periodic payments as unearned income.

Medicaid

Bridges excludes all settlement payments as both income and assets.

FILIPINO VETERANS EQUITY COMPENSATIOIN FUND

All Programs

These payments are issued to certain veterans and surviving spouses of veterans who served in the military of the Government of the Commonwealth of the Philippines during World War II.

Bridges excludes as income and assets.

FLEXIBLE BENEFITS

See BEM 501, Income From Employment.

FOSTER GRANDPARENTS

All Programs

This is a Domestic Volunteer Services Act, Title II program. Payments are excluded under Public Law 93-113 as income and as an asset.

GOVERNMENT AID

All Programs

Child Care Nutrition Payments

Child care nutrition payments may be made through the National School Lunch Act or the Child Nutrition Act of 1965. This income type is excluded for all programs when payment is received only for an individual's own child(ren). In this situation, do not enter any payments in Bridges.

This income type appears only in the self-employment logical unit of work for use when an individual receives payment on behalf of someone else's children for whom child care is provided.

Exception: **FAP Only**

When a child care provider receives payments for someone else's children, payments must be entered in the self-employment logical unit of work. Bridges will determine countable income from this source, for FAP only: see BEM 502, Income From Self-Employment.

Child Development and Care Program (CDC)

All Programs

When CDC is approved for a parent/substitute parent (PSP), do not enter CDC payments as income for the PSP. These payments are excluded income for the family receiving the care.

See BEM 502, for an individual who provides care in their home and not the home of the child or BEM 501, for an individual who provides the care in the home where the child lives.

Family Support Subsidy

All Programs

Department of Health and Human Services makes payments to families with impaired or autistic children under age 18. Bridges excludes Department of Health and Human Services family support subsidy payments to families when the child is living in the home. These payments are for needs **not** covered by the state standard of assistance.

Federal Emergency Management Assistance (FEMA)

All Programs

The FEMA program makes payments to individuals for a variety of emergent needs.

Bridges excludes as income and as an asset.

Exception: **FAP only**

If money received from the FEMA program is for temporary housing, and exceeds the actual cost, Bridges counts the difference as unearned income unless it is returned to the FEMA program.

FOOD ASSISTANCE PROGRAM

All Programs

Do not enter FAP issuances as income in Bridges. Food assistance is excluded as income and as an asset.

FIP, SDA, RCA or Cash Assistance

FIP, SDA, RCA, CDC, MA

Bridges excludes FIP, RCA and SDA as income.

FAP Only

FIP, RCA and SDA benefits are considered the unearned income of the FIP, RCA or SDA head of household (HOH, formerly grantee). Bridges counts as unearned income, the amount of cash assistance benefits minus any excludable portion.

The following portions of cash assistance benefits are excluded by Bridges:

- The amount of non-IPV administrative recoupment.
- The amount of initial cash benefits intended to cover a current or previous month, when FAP benefits have already been authorized for such months.

Some types of FIP and RCA penalties, require budgeting of cash assistance for FAP, even when not received. See:

- BEM 233A, Failure to Meet Employment and/or Self-Sufficiency Related Requirements: FIP.
- BEM 233C, Failure to Meet Employment Requirements: RCA.
- BEM 255, Child Support, budgeting last FIP grant when FIP closes and BEM 550, for how income is budgeted for disqualified or ineligible persons.

Bridges calculates countable cash assistance benefits for FAP based on program policy rules.

FIP, SDA, and RCA Supplements

FIP, SDA, RCA, CDC, MA

When Bridges determines a cash assistance underpayment for a benefit period for which benefits have already been issued, it displays supplement on the eligibility summary screen. When the new eligibility results are certified, the difference between the original issuance and the new benefit calculation is automatically authorized.

Bridges excludes these payments as income.

FIP, SDA, and RCA Reinstatement and Delayed Benefits

FAP Only

When initial cash assistance authorization is delayed until after FAP is authorized, Bridges does not count the cash assistance for that benefit period in the FAP benefit calculation.

Bridges counts FIP, RCA and SDA benefits issued because of reinstatement only if authorized before or at the same time FAP benefits are authorized for the benefit period for the first time. Bridges allows the exclusions described in FIP, RCA or SDA Cash Assistance.

Reinstatement benefits that cover or restore retroactive FIP, RCA or SDA benefits are lump sums. Lump sums are assets.

Home Help Services Under Medicaid

All Programs

Individual's needing care in their homes may qualify for MDHHS to make payment on their behalf to a service provider. Do not enter these payments for the individual receiving the care. These payments are excluded income for the individual receiving the care.

Enter home help services payments received by the individual providing the service as that individual's employment income; see BEM 501.

Housing Assistance

All Programs

The Federal Office of Housing and Urban Development (HUD) and the Farmers Home Administration (FMHA) provide many forms of housing assistance (example: subsidized housing) under the following laws:

- Subchapter II of the Uniform Relocation and Real Property Acquisition Act of 1970.

- U.S. Housing Act of 1937.
- Experimental Housing Allowance Program made under Annual Contribution Contracts entered into prior to January 1, 1975.
- National Housing Act.
- Section 101 of the Housing and Urban Development Act (HUD) of 1965.

Exclude any housing assistance with HUD or FMHA involvement as income and as an asset.

Nutrition Program for the Elderly, Title VII

All Programs

Enter payments received from the Nutrition Program for the Elderly, Title VII of the Older Americans Act of 1965, in the unearned income logical unit of work.

Bridges will exclude as income and assets.

Out of State Diversion

All Programs

Some states offer a Temporary Assistance for Needy Families (TANF) diversion program. It is intended as a one-time payment in lieu of periodic/monthly TANF assistance (Michigan uses the term FIP). This is considered a one-time payment and excluded income for all programs.

Refugee Matching Grant

All Programs

This is an employment program administered by refugee resettlement agencies. It provides job training and maintenance assistance (food, housing, transportation, etc.) to eligible refugees. The benefits are partly cash, but mainly in-kind goods and services. Enter any cash payments made directly to the refugee in the unearned income logical unit of work.

FIP, SDA, and RCA Only

Recipients of Refugee Matching Grant have an eligibility determination group participation status of excluded. Bridges does not consider the recipient's need, income or assets: see BEM 210, BEM 214, BEM 215, for Excluded RCA Eligibility Determination Group Members, and BEM 222, Concurrent Receipt of Benefits, for Refugee Matching Grant.

CDC and FAP Only

Bridges counts as unearned income.

Medicaid

Bridges excludes as income.

Refugee Resettlement Assistance

All Programs

Refugee resettlement assistance is distributed within 90 days of a refugee's date of entry. Payments may be made to third parties such as landlords, utility companies or other service providers: see Third Party Assistance in BEM 500.

Payments may also be made directly to refugees. The number and frequency of payments are determined by the refugee resettlement agency.

FIP, SDA, RCA, CDC, Medicaid

Exclude all payments as income.

FAP Only

If payments are made monthly, exclude the first $300 per calendar quarter as this is considered a donation. Budget remainder of payments made to refugees as unearned income. If payment meets the definition of a lump sum, see BEM 500.

Robert T. Stafford Disaster Relief

Payments from the Robert T. Stafford Disaster Relief and Emergency Assistance Act (formerly the Disaster Relief Act of 1974), are excluded as income and as an asset.

State Emergency Relief (SER)

Do not enter SER payments in Bridges. Such payments are excluded as income and assets.

Women, Infants and Children (WIC)

This is a supplemental food program for women, infants and children. WIC is excluded as income and as an asset.

Guardianship Assistance Program

FIP, SDA, RCA, CDC, FAP

Guardianship Assistance Program is counted as unearned income.

GUARANTEED INCOME PROGRAM (GIP)

All Programs

GIP is also, known as the Universal Basic Income Program (UBI). The GIP or UBI payments are funded solely from private and public funds or combination of both. They provide a modest cash income at regular intervals (such as, each month or year) to all individuals meeting minimal eligibility criteria.

Examples of the payments include the following:

- Detroit Jump Start.
- Flint RX kids.
- Grow Ann Arbor (GIG 2).

Do not enter the payments in Bridges, but the payment should be documented in the case.

Excluded as income and asset.

Medicaid Only

Guaranteed income pilot programs must be implemented in conjunction with MDHHS.

- Must be short term in nature, that is, less than 24 months.
- Must target low-income individuals and families.
- Must include a component that identifies the impact of short term guaranteed income payments on low-income families, for example, a research piece.

HEALTH PROFESSION OPPORTUNITY GRANT

All Programs

These payments are issued to provide education and training in the health care field to Temporary Assistance to Needy Families recipients and other low-income individuals.

Bridges excludes as income and assets.

HOME EQUITY CONVERSION PLANS

FIP, SDA, RCA, CDC and FAP

Reverse Mortgage

Reverse mortgages allow a homeowner to borrow, via a mortgage contract, some percentage of the value of his home. The homeowner receives periodic payments (or a line of credit) that does **not** have to be repaid while the homeowner lives in the home.

Money the homeowner receives from a reverse mortgage is a loan and is **not** countable as an asset or income.

Some reverse mortgages involve the purchase of an annuity and are called reverse annuity mortgages.

Payments the homeowner receives from a reverse annuity mortgage are unearned income. Count the gross amount.

SSI Related MA Only

Payments that a homeowner receives from a reverse mortgage are loan proceeds and are not countable income. See BEM 400, Assets, regarding the resource value.

Sale-Lease Back Income

All Programs

The homeowner sells a home on an installment note and receives monthly payments from the buyer. The buyer allows the former homeowner to live in the home in exchange for rent. The difference between the buyer's payment and the rent is money the former homeowner can use for current expenses. Sometimes the arrangement involves the purchase of an annuity that pays money to the former homeowner.

Payments the former homeowner receives from an annuity are unearned income. Bridges counts the gross amount.

Bridges counts payments the former homeowner receives from the buyer, minus allowable expenses, as unearned income. Allowable expenses are the former homeowner's cost of things such as mortgage or land contract payments, taxes and insurance on the property sold. The former homeowner's rent is **not** an allowable expense.

SSI-Related MA Only

Note: See BEM 400, for Sale-Lease Back Asset Value regarding the asset value.

Time Sale

All Programs

The homeowner signs a contract to sell his home at death but maintains ownership and can continue living in the home. The buyer makes monthly payments to the homeowner now and agrees to pay certain expenses such as property taxes, insurance, and some maintenance.

The contract may call for purchase of an annuity.

Payments the homeowner receives from an annuity are unearned income. Count the gross amount.

Count payments from the buyer to the homeowner, minus allowable expenses, as the homeowner's unearned income. Allowable expenses are the homeowner's costs of things such as mortgage or land contract payments. Expenses paid by the buyer are **not** allowable.

Payments the former homeowner receives from an annuity are unearned income. Count the gross amount.

INDIVIDUAL DEVELOPMENT ACCOUNTS

All Programs

Individual Development Accounts (IDA) are established pursuant to Michigan Public Act 361 of 1998 and section 404(h) of the Social Security Act or Public Law 105-285. IDAs allow low-income families to promote their economic independence by saving for any of the following:

- Postsecondary educational expenses.
- First home purchase.
- Business capitalization.

IDAs are funded by periodic contributions from the family's earnings and matching contributions by or through a nonprofit organization. The IDA must be a trust or a joint account that requires the signatures of both the nonprofit organization and a family member to authorize withdrawals.

Bridges excludes matching contributions and interest, or dividends earned by an IDA are excluded as income and assets.

INSURANCE PAYMENTS FOR MEDICAL EXPENSES

All Programs

Insurance payments that are specifically made as reimbursement for incurred medical expenses are excluded as income and as assets.

Common sources of such payments are:

- Health insurance; see Bridges Policy Glossary (BPG).
- Health Reimbursement Arrangements/accounts.
- Automobile insurance that covers medical expenses.
- Long term care facility insurance.

Note: Other insurance must pay claims for medical expenses before MA. See BEM 257, Third Party Resource Liability, for reporting insurance coverage using the DCH-0078, Request to Add, Terminate or Change Other Insurance.

INTEREST AND DIVIDENDS PAID DIRECTLY TO CLIENT

All Programs

Bridges counts interest and dividends paid directly to an individual as unearned income. Choose unearned income type of *Interest Paid Directly to Client* and budget over the period intended to cover. Interest and dividends that are reinvested or deposited back into the asset are excluded as income.

Example: Nicole receives a quarterly interest check from her certificate of deposit (CD). Choose income frequency of *contractual/single payment covering more than one month* and enter the number of months intended to cover *three*.

Example: Tiffany has an IRA and chooses to let her interest automatically reinvest in the IRA rather than receiving interest checks. Do not enter these payments in Bridges.

Note: An S-corporation and LLC may pay shareholders or partners dividends and/or interest. This is unearned income to the individual.

JAPANESE AND ALEUT PAYMENTS

All Programs

To acknowledge the fundamental injustice of being evacuated during World War II, payments are made under Public Law 100-383 to U.S. citizens of Japanese ancestry, resident Japanese aliens and Aleuts. Bridges excludes as income and assets.

JURY DUTY

All Programs

Enter payments an individual receives for being on jury duty in the unearned income logical unit of work. Bridges excludes money an individual receives for being on a jury.

LEASE OF NATURAL RESOURCES

All Programs

Enter payments received for leasing natural resources in the unearned income logical unit of work. Bridges counts the gross amount received for leasing natural resources as unearned income. This includes storage rights. Examples of natural resources are:

- Timber.
- Gravel.
- Oil and natural gas.

Exception: Lease income received by an American Indian might be excluded under Public Law 93-134; see *EXHIBIT I-Native American Payment Exclusions* in this item.

LOAN PROCEEDS

All Programs

Enter loan proceeds in the unearned income logical unit of work. Bridges excludes funds an individual has borrowed provided it is a bona fide loan. This includes a loan by oral agreement if it is **made into** a bona fide loan.

Bona fide loan means all the following are present:

- A loan contract or the lender's written statement clearly indicating the borrower's indebtedness.
- An acknowledgment from the borrower of the loan obligation.
- The borrower's expressed intent to repay the loan by pledging real or individual property or anticipated income.

This exclusion does **not** apply to either of the following:

- Purchases made with borrowed money.

- Interest earned on borrowed money. However, the interest might be Inconsequential Income as defined in BEM 500.

MICHIGAN REHABILITATION SERVICES PAYMENTS

All Programs

Payments from Licensing and Regulatory Affairs, and Michigan Rehabilitation Services are considered reimbursements. Enter this type of income in the unearned income logical unit of work.

Bridges excludes as income and as an asset.

MEDICAL LOSS RATIO REBATES

All Programs

Medical loss ratio rebates are paid by insurance carriers when less than 80 percent of premiums are spent on medical care. Eligible households receive the payments by August 1 each year.

Bridges excludes as income.

MILITARY ALLOTMENTS

All Programs

Allotments are payments for the support of dependents of military personnel, usually initiated by the service member.

It is possible to obtain an involuntary allotment when both following conditions are met:

- A court or administrative order for support exists.
- Payments are past due.

Support specialists can provide information on involuntary allotments. The local chapter of the Red Cross can assist in obtaining voluntary allotments.

Intact Families

A family is intact when an individual is temporarily absent from the home due solely to being in the military. Enter military allotments or

money made available to the family at home as military allotment/contribution from absent member. Absent member is in the FIP eligibility determination group and earnings are counted; absent member is not in the FAP eligibility determination group, so the allotment/contribution only is counted as unearned income.

Estranged Families

A family is estranged when the individual in the military is **not** temporarily absent due solely to being in the military. When a military allotment is intended for a child, enter the payments as voluntary child support. When payments are intended for an adult, enter as other unearned income.

NAZI VICTIMS' COMPENSATION

All Programs

Bridges excludes payments made as compensation for Nazi persecution. Enter the gross amount and pay details in the Bridges unearned income logical unit of work. Do not include these payments in liquid assets amounts entered in Bridges.

Austrian Social Insurance Payment

Payments made as compensation for Nazi persecution from paragraphs 500 through 506 of the Austrian General Social Insurance Act.

German Restitution Act

Payments made as compensation for Nazi persecution from the Federal Republic of Germany under the German Restitution Act.

Netherlands Act Victims of Persecution

Payments made as compensation for Nazi persecution from the Dutch government under the Netherlands Act on Benefits for Victims of Persecution 1940-1945 (Dutch acronym WUV).

OLDER AMERICAN VOLUNTEER PROGRAM

All Programs

This is a Domestic Services Volunteers Act, Title II program. Payments are excluded unearned income under Title II of Public Law 93-113.

Bridges excludes as income and as an asset.

USDA PAYMENT-IN-KIND (PIK) PROGRAM

MA Only

This program pays farmers to divert land or reduce crop acreage. Count the payments received as unearned income.

FIP, SDA, RCA, CDC and FAP

See BEM 502.

RADIATION EXPOSURE COMPENSATION

All Programs

Exclude payments received from Public Law 101-426, Radiation Exposure Compensation Act.

Exclude as income and as assets.

RAILROAD RETIREMENT BOARD BENEFITS

All Programs

Current and former employees of railroads and related industries and their families can receive the following types of benefits.

- Disability.
- Retirement.
- Sickness.

- Strike.
- Survivors.
- Unemployment.

The U.S. Railroad Retirement Board makes the payments.

Count the gross benefit amount as unearned income.

Note: Allowances in Railroad Retirement Board benefits for the Medicare Part B premiums are **not** considered a reimbursement and should be included in the amounts entered in the Bridges unearned income logical unit of work.

RETIRED SENIOR VOLUNTEER PROGRAM (RSVP)

All Programs

This is a Domestic Services Volunteers Act, Title II program. Payments are excluded unearned income under Title II of Public Law 93-113.

Bridges excludes as income and as an asset.

RETIREMENT INCOME-OTHER

All Programs

Other retirement income includes annuities, private pensions, military pensions, and state and local government pensions.

Refer to the specific sections in this item for policies regarding:

- Railroad Retirement Board benefits.
- Retirement, Survivors and Disability Insurance (RSDI).
- U.S. Civil Service and Federal Employee Retirement System.

Count the gross benefit as unearned income.

Note: Allowances in pension benefits for the Medicare Part B premiums are not considered a reimbursement and should be included in the amounts entered in the Bridges unearned income logical unit of work.

Sometimes benefits are reduced because of a previous overpayment. In such cases, the reduced amount is the gross amount; see Reduced Benefits Due to Overpayment in BEM 500.

RETIREMENT, SURVIVORS, AND DISABILITY INSURANCE (RSDI) (AKA SOCIAL SECURITY BENEFITS)

All Programs

RSDI is a federal benefit administered by the Social Security Administration that is available to retired and disabled individuals, their dependents, and survivors of deceased workers.

Bridges counts the gross benefit amount as unearned income.

Exceptions:

- Special rules apply when determining MA eligibility for certain former SSI recipients; see BEM 155, 503 Individuals, 157, Early Widow(er)s, and 158, Disabled Adult Children. These special rules do **not** apply to post-eligibility patient-pay amount calculations in BEM 546.
- Exclude Medicare premium refunds as income and as assets. Refunds are made because there is a delay of about 120 days between when Medical Services Administration initiates Medicare buy-in and an individual's benefit check changes; see Bridges Administrative Manual (BAM) 810, Medicare and Medicare Cost-Sharing.
- The Social Security Administration authorizes qualified organizations to deduct a fee for acting as a representative payee. Exclude the fee withheld by an authorized organization.
- See Returned Benefits, in BEM 500.
- See Retroactive RSDI and SSI Exclusion, in BEM 400.

Medicaid Only

Note: Countable RSDI for fiscal group members is the gross amount for the previous December when the month being tested is

January, February, or March. Federal law requires the cost-of-living (COLA) increase received in January be disregarded for these three months. For all other months countable RSDI is the gross amount for the month being tested.

MAGI Medicaid Only

Special budgeting rules apply when determining eligibility for MAGI Medicaid.

- All RSDI income is countable to tax-filers and adults not claimed as dependents.
- A child/tax-dependent's RSDI is countable only if that child or tax-dependent is required to file taxes.
    - In order to be required to file taxes the total of a child or tax-dependent's RSDI and other income must be over the tax filing threshold for the year.
    - Their RSDI income is only countable toward the tax threshold if half of their yearly RSDI amount (monthly amount times 12 and then divided by 2) plus all of their other taxable income is greater than $25,000.

Example: A child claimed by their parents has $4,000 a year in wages and $12,000 a year in RSDI income. Half of their RSDI is $6,000 per year. $6,000 + $4,000 = $10,000. $10,000 is less than $25,000 therefore their RSDI is not counted toward their tax filing threshold. Their wages alone are less than the filing threshold so none of their RSDI or wages are countable in their Medicaid eligibility determination.

Example: A child is claimed by their parents has $6,000 a year in wages and $40,000 in RSDI. Half of their RSDI is $20,000 per year. $6,000 + $20,000 is $26,000. $26,000 is more than $25,000 therefore their RSDI is counted toward the tax-filing threshold. The child is required to file taxes. Therefore, all of the RSDI and wages are countable in their Medicaid eligibility determination.

- If a child or tax-dependent meets an exception outlined in BEM 211 then all their RSDI income is countable to them even if they are not required to file taxes.

    Example: A child is receiving $12,000 per year in RSDI benefits and is claimed by their grandparent. Because they are claimed by someone other than a parent or

spouse use non-tax-filer rules to determine their household. All $12,000 of RSDI is countable in their Medicaid eligibility determination.

- Individuals who receive RSDI income will receive an SSA-1099 form. Included with that form is a worksheet that should help them determine which parts of their RSDI may be taxable.
- **Note**: The RSDI budgetable income worksheet is no longer valid in determining how much RSDI income may be countable to an applicant.

RICKY RAY HEMOPHILIA RELIEF ACT

All Programs

The Ricky Ray Hemophilia Relief Act (P.L. 105-369) established a temporary fund administered by the U.S. Secretary of the Treasury to pay money for certain human immunodeficiency virus infected individuals.

A payment an individual receives from that fund is excluded as income and as assets.

S-CORPORATION (S-CORP) AND LIMITED LIABILITY COMPANY (LLC)

All Programs

Dividend or interest income received from an S-Corp or LLC as a shareholder or partner, is unearned income. See *interest and dividends paid directly to client* in this item.

Wages paid to an individual from an S-Corp or LLC are earned income; see BEM 501.

SALE OF PROPERTY IN INSTALLMENTS

All Programs

This section applies only to the sale of real property with payments in installments (example: land contract). Other sales of real property are conversion of an asset from one type to another.

Bridges counts each installment payment, minus allowable expenses, as unearned income.

The seller may remain liable for certain expenses on the property even though the property has been sold. Such expenses are allowable. Examples include:

- Taxes.
- Insurance.
- Debts secured by property lien.

SCORE OR ACE

Service Corps of Retired Executives (SCORE) and Active Corps of Executives (ACE) are Domestic Services Volunteers Act, Title II programs. Payments are excluded unearned income under Title II of Public Law 93-113.

Bridges excludes as income and as an asset.

SICK AND ACCIDENT INSURANCE PAYMENTS

All Programs

Sick and accident insurance pay a flat rate benefit due to illness or injury without regard to actual charges or expenses incurred. This does not include long term care facility insurance payments. Examples include:

- $60 for each day hospitalized.
- Lost wage benefits following a car accident.
- Short or long-term disability payments.

Enter the gross amount of these payments as unearned income.

Bridges counts as unearned income. If there is an expense for obtaining these income types (for example insurance premium payment), enter the expense in Bridges.

MAGI Medicaid

Private disability insurance funded entirely by the individual, no employer contributions, is not taxable income. The income received under this type of self- funded plan is not countable income in a MAGI Medicaid eligibility determination.

SPOUSAL SUPPORT

All Programs

Spousal support is a payment from a spouse or former spouse because of a legally enforceable obligation for financial support. It includes maintenance and alimony payments.

See Third-Party Assistance, in BEM 500, if support is paid to a creditor or service provider.

MAGI Medicaid

Divorce or separation agreements executed or modified after December 31, 2018, exclude spousal support as countable income in a MAGI Medicaid eligibility determination.

The payments are not tax deductible for the payer spouse nor taxable income to the receiving spouse.

Spousal Support Certified

Certified spousal support means court-ordered payments the Michigan State Disbursement Unit (MiSDU) sends to MDHHS due to an individual's FIP activity. This occurs occasionally, when spousal support is part of a child support order.

Certified support is counted only in the FIP support income test.

Spousal Support Direct

Direct spousal support is a payment received by the spouse or ex-spouse because of a legally binding obligation.

Bridges counts the total amount as unearned income, except any portion that is court-ordered or legally obligated directly to a creditor or service provider.

Spousal Support Voluntary

Voluntary spousal support is a payment received by the spouse or ex-spouse that is not court ordered. Bridges counts the total amount as unearned income.

STRIKE BENEFITS

All Programs

Bridges counts the gross amount received as unearned income.

FAP Only

See BEM 227, Strikers, for budgeting policies.

SUPPLEMENTAL SECURITY INCOME (SSI)

All Programs

SSI is a benefit administered by the Social Security Administration. SSI is a means-tested program that can be received based on age, disability or blindness.

Michigan SSI benefits include a basic federal benefit and an additional amount paid from state funds. The amount paid by the state and the payment process varies by living arrangement; see BEM 660, State SSI Payment.

For SSI recipients in independent living or household of another, refer to Current SSA-Issued SSI, Retroactive SSA-Issued SSI and State SSI Payments below. For SSI recipients in other living arrangements, refer to just Current SSA-Issued SSI and Retroactive SSA-Issued SSI.

Current SSA-Issued SSI

FIP, RCA, Medicaid

Bridges excludes the amount of current SSA-issued SSI as income.

SDA, CDC, and FAP Only

Bridges counts the gross amount of current SSA-issued SSI as unearned income. SSI amounts withheld to recoup overpayments due to an intentional program violation (IPV) as defined below are also included in the gross amount.

IPV means there was a finding of fraud or an agreement to repay in lieu of prosecution. Bridges counts recouped SSI only if IPV information is volunteered by the SSI recipient or other reliable source. Do **not** initiate any contacts; see Reduced Benefits Due to Overpayment in BEM 500.

Exception: The Social Security Administration authorizes qualified organizations to deduct a fee for acting as a representative payee. Exclude the fee withheld by an authorized organization.

Retroactive SSA-Issued SSI

All Programs

Retroactive SSI benefits may be paid as a one-time payment or in installments over several months. SSA determines how the retroactive benefits will be paid.

FIP, SDA, RCA, RMA, CDC, and FAP Only

Retroactive SSI benefits are considered assets whether paid as a one-time payment or as installment payments.

An individual may receive a payment that includes a portion intended as current benefits as well as a portion intended as retroactive benefits. The portion intended as current benefits is income.

Medicaid

Retroactive SSI benefits are income in the month received; see Retroactive RSDI and SSI Exclusion, about the income and asset exclusion for SSI-related MA in BEM 400.

SDA Only

When retroactive SSI is issued while an SDA application or hearing is pending, determine eligibility for each potential SDA month by budgeting the amount of the SSI intended to cover that month.

State SSI Payments

All Programs

State SSI Payments (SSP) are issued quarterly. Payments are issued in the final month of each quarter; see BEM 660, State SSI Payment.

FIP, RCA, RMA, Medicaid

Bridges excludes as income.

SDA, CDC, and FAP Only

Whenever an SSA-issued independent living or household of another payment is budgeted, Bridges counts the corresponding monthly SSP benefit amount as unearned income; see RFT 248.

Example: If the federal SSI amount being budgeted is for independent living, Bridges counts the monthly SSP benefit amount for independent living.

Bridges does not count as income, SSP benefits paid when the individual is no longer an SSI recipient.

TAX REFUNDS AND TAX CREDITS

All Programs

Tax refunds and credits are assets, **not** income; see Tax Refund and Tax Credit Exclusion in BEM 400.

Earned Income Tax Credit, EITC, Advanced

Individuals can elect to receive a portion of an anticipated Earned Income Tax credit in regular pay checks. Do not enter advance payments of the Earned Income Credit as part of wages or as unearned income. They are not countable for any type of assistance; see Wages in BEM 501.

TRUST PAYMENTS

All Programs

Count payments from a trust to a beneficiary as the beneficiary's unearned income.

FIP, SDA, CDC, and FAP Only

In addition, count any amount of trust income that the beneficiary can instruct the trust to pay him. It is the beneficiary's unearned income.

UNEMPLOYMENT BENEFITS

All Programs Except Freedom To Work (FTW)

Unemployment benefits include all the following:

- Unemployment benefits (UB) available through the Michigan Unemployment Insurance Agency (UIA) and comparable agencies in other states.
- Supplemental unemployment benefits (SUB pay) from an employer or other source.
- Trade Readjustment Act (TRA) payments.

Count the gross amount as unearned income.

Exception: Sometimes benefits are reduced because the individual has earnings. In such cases, the reduced amount is the gross amount. See Returned Benefits in BEM 500, about excluding amounts listed under recoupment on the unemployment insurance agency payment stub.

FTW Only

Bridges excludes UB as income.

MAGI Only

Unemployment benefits should be treated as a reasonably predictable change in income and only be budgeted for the time period received.

URBAN CRIME PREVENTION

This is a Domestic Services Volunteers Act, Title I program. Payments are excluded unearned income under Title I of Public Law 93-113.

Bridges excludes as income and as an asset.

U. S. CIVIL SERVICE AND FEDERAL EMPLOYEE RETIREMENT SYSTEM

All Programs

The U.S. Office of Personnel Management makes payments because of the disability, retirement or death of a federal employee.

Bridges counts the gross amount as unearned income.

Exception: Exclude Medicare premium refunds as income and as assets. The refunds are because there is a delay of about 120 days between when Medical Services Administration initiates Medicare buy-in and an individual's benefit check actually changes; see BAM 810.

VETERANS BENEFITS

All Programs

The Department of Veterans Affairs (VA) has numerous programs that make payments to veterans and their families. The most common types are discussed below.

VA PENSION AND COMPENSATION

All Programs

Pension payments are based on a combination of need, age, and/or nursing home status. Pensions are normally paid monthly. However, the VA may make the payment quarterly, twice a year or annually if the amount is small (less than $19 per month).

Compensation payments are based on service-connected disability or death.

The pension and compensation payment can also include:

- The Aid and Attendance.
- Housebound allowance.
- VA Clothing Allowance.
- Adjustment for Unusual Medical Expenses.
- Augmented Benefits.

Note: These allowances are **not** identifiable on a check stub or award letter. Accept the client's statement that the payment does **not** include any of these additional allowances.

Bridges counts the gross amount of the pension or compensation as unearned income.

Exceptions:

- Bridges excludes any portion of a payment resulting from an Aid and Attendance or Housebound allowance from the eligibility determination.

- Bridges may exclude augmented benefits; see *augmented benefits* in this item.

Bridges excludes any portion of a payment resulting from unusual medical expenses; see VA Adjustment for Unusual Medical Expenses in this item. The VA calls a payment that is increased because of a dependent an augmented benefit. If the VA chooses to pay the dependent's portion directly to the dependent, it is called an apportionment payment; see apportionment payment in this item.

VA Educational Benefits

All Programs

VA provides educational benefits under several programs.

Bridges excludes as income and as an asset.

VA Aid and Attendance and Housebound Allowances

All Programs

Payments are made to veterans, spouses of disabled veterans, and surviving spouses who are:

- Housebound.
- In regular need of the aid and attendance of another individual.

The payment is included with the pension or compensation payment.

Bridges excludes as income and as an asset the portion of a VA pension or compensation that is the aid and attendance or housebound allowance.

Note: Aid and Attendance is not excluded from the patient pay calculation see; BEM 546.

VA Adjustment for Unusual Medical Expenses

All Programs

VA increases some pension and compensation payments due to unusual medical expenses.

Bridges excludes the increase due to unusual medical expenses as income and as an asset.

VA Clothing Allowance

All Programs

A lump-sum clothing allowance is payable in August of each year to veterans with a service-connected disability for which a prosthetic or orthopedic appliance or wheelchair is used.

Bridges excludes the clothing allowance as income and as an asset. It is a reimbursement.

VA Spina Bifida Benefits

All Programs

Benefits are available to Vietnam veterans' natural children with spina bifida.

Bridges excludes these benefits as income and as assets.

Apportionment Payment

All Programs

Apportionment is direct payment of VA benefits to a dependent of the veteran or veteran's surviving spouse. The VA decides whether and how much of such benefits to pay on a case-by-case basis.

These payments are the dependent's countable unearned income.

Augmented Benefit

All Programs

An augmented benefit is a VA benefit that has been increased because of a dependent. The increase is usually included in the payment made to the veteran or the veteran's surviving spouse.

The dependent's portion of an augmented benefit is the dependent's income. That portion is countable as the dependent's unearned income when the dependent lives with the individual receiving the VA benefit.

Bridges does **not** count the dependent's portion as income of either the dependent or the individual receiving the benefit if the dependent does **not** live with the individual receiving the VA benefit.

Note: Actual payments by the VA beneficiary to the dependent when they live apart are budgeted as unearned income to the dependent when determining the dependent's eligibility.

WORKERS' COMPENSATION

All Programs

Workers' compensation payments are available under various federal and state laws to individuals with a job-related illness or injury and to survivors of a deceased worker. Payments might be made by a government agency, an insurance company or an employer.

Count the gross payment as unearned income.

Exception: Exclude compensation awarded for a use which carries legal sanction if used for another purpose. Exclude as income and as an asset.

MAGI Medicaid Only

Workers' compensation amounts received for an occupational sickness or injury are not countable for MAGI Medicaid if they are paid under a workers' compensation act or statute. These amounts are also not countable for survivors.

If an individual retires due to an occupational sickness or injury, any retirement plan benefits that are received based on age, length of service, or prior contributions to the plan are countable.

Any countable workers' compensation payments should be treated as a reasonably predictable change in income and only be budgeted for the time period they are expected to be received.

YOUTHBUILD

All Programs

On-the-job training payments are disregarded as income if received by an individual who is:

- Under age 18.
- Age 18 and living with someone providing care or supervision.
- For LIF only, age 19 and a dependent child.

Other types of payments (stipends, grants, etc.) under Youthbuild are excluded.

VERIFICATION REQUIREMENTS

All Programs except Children Under 19 (U19)

Verify non-excluded income at all the following:

- Application, including a program add, prior to authorizing benefits.
- At member add, only the income of the member being added.

  Note: See BAM 220, Case Actions, for CDC Member Add, and CDC member add requirements.
- Redetermination.
- When program policy requires a change be budgeted.

  Exception: For FIP, SDA, RCA, CDC and FAP verify income that decreases or stops. Do not verify starting or increasing income unless income change information is unclear, inconsistent or questionable. Select *starting or increasing income* as the verification source. Selecting *client statement* as the verification source results in Bridges incorrectly pending eligibility and generating a Verification Checklist.

  Exception: For MA, Bridges accepts client statement regarding changes in income for ongoing eligibility determination groups unless you are completing a redetermination.

  Use available electronic methods (for example consolidated inquiry or SOLQ) to verify income. When electronic verification is not available or inconsistent with client statement, the client has primary responsibility for obtaining verification. Do not deny assistance based solely on an employer or other source refusing to verify income; see BAM 130, Verification and Collateral Contacts, and BEM 702, CDC Verifications.

Children Under 19 (U19)

Income and expenses are **not** verified for Children Under 19 (U19). Client statement is an acceptable verification source for income and expenses.

VERIFICATION SOURCES

All Programs

Child Support Certified, Direct (Court-Ordered), Refund and Reimbursement

- Consolidated Inquiry.
- Letter or document from person/agency making payment.
- Check stub.
- Data obtained from the Michigan child support enforcement system (MiCSES). (Select other acceptable).
- Contact with child support specialist. (Select other acceptable).
- Information from the friend of the court (DHS-243, Verification of Public Records).

Child Support Voluntary (Not Court Ordered)

- Letter or document from person making payment.
- Other acceptable method that provides necessary information.

Cryptocurrency

- Receipt, letter or statement showing the amount of U.S. dollars received.
- Other acceptable method which provides necessary information.

Refugee Matching Grant

- DHS-1564, Verification of Matching Grant.
- Letter or document from refugee resettlement agency.

Refugee Resettlement Income

- DHS-1565, Verification of Refugee Resettlement Income.

- Letter or document from refugee resettlement agency.

RSDI and SSI

- Recent check stub(s).
- Consolidated Inquiry.
- SOLQ.
- BENDEX/SDX.
- Award letter.
- Statement from or contact with a reliable source. (Select other acceptable as the verification source.)

Unemployment Benefits

- Recent check stub.
- Consolidated Inquiry.
- Unemployment Insurance Agency.
- Other acceptable method that provides necessary information.

VA Benefits

- DHS-75, Verification of VA Payments.
- Other acceptable method that provides necessary information.

MA only

- Award letter from the VA. The letter may be dated up to 18 months prior to the application or recertification.
- Contact with the VA which breaks down the amounts of the VA payments if the breakdown is not included on the letter. The breakdown amounts may be written on the award letter.

EXHIBIT- NATIVE AMERICAN PAYMENTS EXCLUSION

All Programs

Bridges excludes payments to Native Americans under the following laws as income and as assets:

- Public Law 92-203: Tax exempt portions of payments under the Alaska Native Claims Settlement Act.
- Public Law 92-254: Judgment funds to members of the Blackfeet Tribe of Blackfeet Reservation, Montana, and Gros Ventre Tribe of the Fort Belknap Reservation, Montana.

- Public Law 93-134: Funds distributed to members of the Indian tribes and the purchases made with such funds. Also, exclude up to $2,000 per year of income received by an individual Indian that is derived from leases or other uses of individually owned trust or restricted lands.
- Public Law 93-531: Relocation assistance payments to members of the Hopi and Navajo Tribes.
- Public Law 94-114: Receipts distributed to members of certain Indian tribes.
- Public Law 94-189: Payments received under the Sac and Fox Indian agreements.
- Public Law 94-540: Judgment funds to the Grand River Band of Ottawa Indians.
- Public Law 95-433: Payments by the Indian Claims Commission to the Confederated Tribes and Bands of the Yakima Indian Nation or the Apache Tribe of the Mescalero Reservation.
- Public Law 96-420, Section 5: Payments to the Passamaquoddy Tribe and the Penobscot Nation or any of their members received pursuant to the Maine Indian Claims Settlement Act of 1980.
- Public Law 98-64: Funds distributed to members of Indian tribes and purchases made with such funds.

  Exception: For FAP only, if recurring payments are made from funds held in trust by the Secretary of the Interior, count the amounts over $2,000 per person as unearned income. Amounts of onetime payments over $2,000 per person are countable assets. (Public Laws 97-458 and 98-64).
- Public Law 98-123: Funds distributed to members of the Red Lake Band of Chippewa Indians.
- Public Law 98-124: Funds distributed to the Assiniboine Tribe of the Fort Belknap Indian Community and the Assiniboine Tribe of the Fort Peck Indian Reservation.
- Public Law 99-346: Payments and distribution of judgment funds to the Saginaw Chippewa Indian Tribe of Michigan. May

be called payments from the Investment Fund or Elderly Assistance Investment Fund.

- Public Law 105-143: Distributions under this law are NOT considered income or assets. This law provides funds to Ottawa and Chippewa Indians of Michigan.
- Public Law 111-291, Sec.101(f)(2) of the Claims Resolution Act of 2010: Payments received from the Cobell vs. Salazar Settlement.

LEGAL BASE

FIP

Annual Appropriations Act
MCL 400.1 et seq.

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

RCA

45 CFR 400
P.L. 106-386 of 2000, Section 107

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

MA

Social Security Act Sections 1902(a)(10), 1931
42 CFR 435, Subparts H and I
MCL 400.106
The Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152).

FAP

7 CFR 273.9, 273.12(e)(3)

Child Care and Development Block Grant of 1990, as amended
42 USC 4601 et seq., 1437 et seq., 3001, 5121 et seq., 4950, 2210, 1612 (a)(2), 9858 et seq.
300 c-22
43 USC 1601 et seq.
50 USC app 1989b-4
25 USC 1401 et seq., 459 e
12 USC 1701
P. L. 108-447, 111-5, 1002(g)(2)
American Recovery and Reinvestment Act of 2009
Filipino Veterans Equity Compensation Fund

All Programs

P. L. 111-291, Sec.101(f)(2) of the Claims Resolution Act of 2010: Payments received from the *Cobell v Salazar* Settlement
Affordable Care Act, Public Law 111-148
P.A. 67 of 2019

POLICY

All Programs except MAGI Medicaid

Some types of rental/room and board income are counted as unearned income and some as earned income or self-employment.

Bridges will determine both of the following:

- Countable income (allowing expenses when appropriate).
- If the income is counted as unearned, earned or self-employment.

RENTAL INCOME

All Programs

Rental income is money an individual (landlord) receives for allowing another individual (renter) to use the landlord's property. It includes income from a lease.

Farm Land Rental

All Programs

Farm land rental means renting land to someone for the purpose of producing farm products.

Bridges counts the gross rent payment minus allowable expenses as unearned income. Bridges allows the higher of the following:

- 10 percent of the rental payment.
- The landlord's actual expenses if the landlord chooses to claim and verify the expenses.

See Bridges Eligibility Manual (BEM) 502, Income From Self-employment Expenses, for the types of actual expenses that can be allowed.

In-Home Rental

In-home rental is when a landlord rents out part of his own dwelling to another individual.

See Other Rental Income below when a landlord rents out a separate apartment in their dwelling or a separate building.

Bridges counts the gross rent payment minus expenses as earned income from self-employment. Bridges allows the higher of the following:

- 60 percent of the rental payment.
- Actual rental expenses if the landlord chooses to claim and verify the expenses.

Expenses must be both of the following:

- Clearly expenses of the rental unit (for example expenses the landlord would not have if not renting out part of their dwelling).
- Included in the list of allowable rental expenses below.

Room and Board

Room and board income is money an individual receives for providing another individual both food and a place to live.

Allowable expenses of producing room and board (or board only) income are the higher of:

- 50 percent of the income.
- Actual expenses if reported and verified.
- The maximum monthly FAP benefit for the number of boarders.

Note: MAGI related Medicaid uses adjusted gross income as declared on the federal tax return. SSI-Related MA self-employment deductions are limited to the higher of 25 percent of the total proceeds, or actual expenses if the client chooses to claim and verify the expenses.

Other Rental Income

Other rental income means any rental income that is not:

- Farm land rental.
- In-home rental.
- Room and board.

Example: Individual rents his non-homestead house to another individual. Bridges determines whether to treat the rent as earned or unearned income based on the time the landlord actively engages in managing the rental property:

- Under 20 hours per week- unearned income.
- 20 or more hours per week- earned income.

Active management includes, but is not limited to, the following:

- Advertising.
- Showings to prospective renters.
- Accounting activities.
- Inspections.
- Cleaning, repairing, and redecorating.

Accept the landlord's statement of the time spent actively managing the rental property unless the estimate is questionable. If necessary, verify the time estimate by contacting individuals who would be reasonably expected to know (example: the renter concerning inspections and repairs).

Bridges counts the gross rent payment minus allowable expenses as income. Bridges allows expenses that are the higher of:

- 65 percent of the rental payment.
- Actual rental expenses if the landlord chooses to report and verify the expenses.

See *Allowable Rental Expenses* in this item.

ALLOWABLE RENTAL EXPENSES

All Programs

Bridges uses the standard percentage for expenses if either of the following:

- The landlord chooses not to report actual expenses.
- The landlord does not verify reported expenses exceeding the standard percentage.

When a landlord chooses to report actual expenses for in-home rental, room and board, or other rental income, Bridges uses the following to determine what expenses are allowable and should be entered in Bridges.

Expenses must be the landlord's obligation and must solely be expenses of the rental property to be allowed. Allowable expenses may include:

- Real estate insurance.
- Repairs.
- Heat.
- Utilities.
- Property taxes.
- Lawn care.
- Snow removal.
- Furniture.
- Advertising for renters.
- Interest and escrow portions of mortgage or land contract payment.

Bridges will not deduct expenses exceeding the gross rental income (a loss) from other types of income.

VERIFICATION REQUIREMENTS

All Programs except Healthy Kids

Verify countable income at all of the following:

- Application, including a program add, prior to authorizing benefits.
- At member add, only the income of the member being added.
- Redetermination.
- When program policy requires a change be budgeted.

Exception: For FIP, RAP, SDA, CDC and FAP accept the client's statement for starting and increasing income. Select starting or increasing income as the verification source. Selecting client statement as the verification source will result in Bridges incorrectly pending eligibility and generating a Verification Checklist.

Verify stopping and decreasing income, or when the income change information is unclear, inconsistent or questionable.

Exception: For MA. accept the client's statement regarding changes in income for ongoing EDG's unless you are completing a redetermination.

The client has primary responsibility for obtaining verification. Do not deny assistance because a boarder or other source refuses to verify income. Assist the client in obtaining verification if requested;

see Bridges Administrative Manual (BAM) 130, Verification And Collateral Contacts, and BEM 702, CDC Verifications.

Healthy Kids Only

Income and expenses are not verified for Healthy Kids. Client statement is an acceptable verification source for income and expenses.

VERIFICATION SOURCES

All Programs

Property Expenses

- Mortgage or land contract.
- Bills or receipts.

Rental and Room-and-Board Income

- Written statement from the boarder/roomer.
- Accounting or other business records.
- Lease or contract.
- Rent receipt book.

Rental/Room and Board Expenses

- Receipts.

RESOURSES

FIP

MCL 400.1 et. seq.

SDA

Annual Appropriations Act
Mich Admin Code; R 400.3151 – 400.3180

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

MA

Social Security Act Sections 1902(a)(10), 1931
42 CFR 435, Subparts H and I
MCL 400.106

FAP

7 CFR 273.9
7 CFR 273.11

OVERVIEW

A group's benefits for a month are based, in part, on a prospective income determination. A best estimate of income expected to be received by the group during a specific month is determined and used in the budget computation.

Get input from the client whenever possible to establish this best estimate amount. The client's understanding of how income is estimated reinforces reporting requirements and makes the client an active partner in the financial determination process.

DEPARTMENT POLICY

FIP, SDA, RAP, CDC and FAP

A group's financial eligibility and monthly benefit amount are determined using:

- Actual income (income that was already received).
- Prospected income amounts (not received but expected).

Only **countable** income is included in the determination; see BEM 500.

Each source of income is converted to a **standard monthly amount** unless a full month's income will not be received; see standard monthly amount in this item.

Note: For FAP, in the month of application the income is not converted to a monthly standard amount.

Benefit month: The month an assistance benefit payment covers. For CDC, benefit month is the month in which the pay period ends.

Available income: Income actually received or reasonably anticipated. Reasonably anticipated means that the amount of income can be estimated and the date of receipt is known. Available income includes garnisheed amounts and income received jointly; see BEM 500.

DEFINITIONS

Stable income: Income received on a regular schedule that does not vary from check to check based on pay schedules or hours worked. Examples: a job in which the paycheck amounts do not vary and are paid on a regular schedule; or RSDI or SSI.

Fluctuating income: Income received on a regular schedule but that varies from check to check, such as a waitress' income whose hours vary each week.

Contractual/Single Payment Income: Income that is received in one month(s) that is intended to cover more than one month. For example, a teacher on a yearly contract who is paid over the nine-month school year; or the single payment distributed quarterly from casino profits.

Irregular income: Income that is not received on a regular schedule or that is received unpredictably, such as a person self-employed doing snow removal.

CDC Only

Temporary Excess Income: During 12-month continuous eligibility or at redetermination, an income increase that is greater than the income eligibility limit which is not expected to last more than six months; see RFT 270.

When excess income is reported, generate the MDHHS-5446, Child Development and Care (CDC) Temporary Excess Income Notice, to verify the excess income will not last more than six months. If the MDHHS-5446 and verification are returned and indicate excess income is not expected to last more than six months, CDC benefits should continue. If the MDHHS-5446 and verification are not returned, the CDC case should close.

Exception: If information is available that clearly indicates the income increase will last more than six months, do not generate the MDHHS-5446. Document in the case record what information was used to determine.

Note: When a case with previously established temporary excess income crosses over redetermination, or is discovered at redetermination, a policy exception and assistance from the Bridges Resource Center (BRC) are required to certify the eligibility; see BAM 210.

Determining Budgetable Income

FIP, SDA, RAP, CDC and FAP

Determine budgetable income using countable, available income for the benefit month being processed.

CDC Only

Note: When income eligibility is established in the first pay period of an application and a change in income is reported, the income change is not required to be verified for approval of subsequent pay periods.

Past Months

Use actual gross income amounts received for past month benefits, converting to a standard monthly amount, when appropriate; see Standard monthly amount in this item.

Exception: Prospective income **may** be used for past month determinations when all of the following are true:

- Income verification was requested and received.
- Payments were received by the client after verifications were submitted.
- There are no known changes in the income being prospected.

Current and Future Months

Prospect income using a best estimate of income expected to be received during the month (or already received). Seek input from the client to establish an estimate, whenever possible.

To prospect income, you will need to know:

- The type of income and the frequency it is received (such as, weekly).
- The day(s) of the week paid.
- The date(s) paid.

- The gross income amount received or expected to be received on each pay date.

Case Management Tip

Prospective budgeting requires knowledge of an individual's current, past and anticipated future circumstances. Asking the client questions, such as those that follow, will help establish the best estimate of future income.

- Do you have multiple jobs?
- When do you expect to receive a raise in pay?
- Do your work hours usually increase or decrease at a certain time of year?
- Have you recently received more or fewer hours than usual due to an unusual situation at work?

The reason you are doing the budget also affects the income budgeted. For example, if income is ending, past income will not be a good indicator of future income. Similarly, there may not be past income to use for a job that has just started.

BUDGETING INCOME

Use the following guidelines to budget income:

Child Support Income

Past Three Months

- Use the average of child support payments received in the **past three calendar months** unless changes are expected. Include the current month if all payments expected for the month have been received. Do **not** include amounts that are unusual and not expected to continue.

  Note: The three-month period used can begin up to three months before the interview date or the date the information was requested.

  If payments for the past three months vary, discuss the payment pattern from the past with the client. Clarify whether the pattern is expected to continue, or if there are known changes.

If the irregular pattern is expected to continue, then use the average of these three months. If there are known changes that will affect the amount of the payments for the future, then do **not** use the past three months to project. **Document the discussion with the client and how you decided on the amount to budget**.

Example 1: Janice applied for FAP on August 12. In discussion with Janice, you agree that the last 3 months payments are a reasonable estimate of future child support income, with one exception - one payment in June was unusually large. Janice confirms that this payment was a tax intercept payment and is **not** expected to recur. You use child support payments for May, June and July, excluding the large June payment.

Example 2: Mary receives child support for her son Joey sporadically. She received $70 in March, $0 in April, and $120 in May. Mary explains that Joey's father does not have steady work and pays as he is able. She is not aware of any changes in his circumstances that would impact his payments. You use the average of these 3 months payments ($190 divided by 3) when projecting for June.

One Month Projection

- If the past three months' child support is not a good indicator of future payments, calculate an expected **monthly** amount for the benefit month based on available information and discussion with the client.

  Example 1: Lisa calls on September 12 to report that she just received a $60 child support payment for her daughter, Rachel. The support order was established on September 3. You are projecting for October. The monthly order amount is $258. Budget $258 as the standard monthly amount for October.

  Example 2: Lisa calls you on October 27 to report that Rachel's father is not paying child support as ordered (as described in Example 1 above). She received only $60 in September, and so far in October, she has only received one $40 payment. You discuss with Lisa what to project for the future, and you agree that $40 is reasonable. You remind Lisa of her reporting requirements, and adjust the budget for November, projecting $40. **Document your discussion with Lisa and how you decided on the amount to budget.**

Non-Child Support Income

Using Past Income

Use past income to prospect income for the future unless changes are expected:

- Use income from the **past 30 days** if it appears to accurately reflect what is expected to be received in the benefit month.

  Note: The 30-day period used can begin up to 30 days before the interview date or the date the information was requested.

  Exception: For FAP only, when processing a semi-annual contact, the 30-day period can begin up to 30 days before the day the MDHHS-1046, Semi-Annual Contact Report, is received by the client or the date a budget is completed. Any 30-day period that best reflects the client's prospective income within these guidelines can be used.

  Discard a pay from the past 30 days if it is unusual and does not reflect the normal, expected pay amounts. Document which pay(s) is being discarded and why. For example, the client worked overtime for one week and it is not expected to recur.

Example: Mary works at Walmart and is paid every two weeks. Her income fluctuates but she is scheduled to work approximately 20 hours per week. In talking with Mary, you agree that the last 30 days income is an accurate reflection of future income. Using the two paychecks received in the last 30 days ($210.00 and $229.60), you determine the budgetable monthly income amount is $472.57 ($210.00 plus $229.60 divided by 2 times 2.15).

- Use income from the **past 60 or 90 days** for fluctuating or irregular income, if:

  - The past 30 days is not a good indicator of future income, and

  - The fluctuations of income during the past 60 or 90 days appear to accurately reflect the income that is expected to be received in the benefit month.

  Bridges will compute the average monthly income (and convert weekly and every other week amounts) based on the amounts and the number of months entered.

Note: The 60 or 90-day period used can begin up to 60 or 90 days before the interview date or the date the information was requested.

Change in Amount

When the income amount changes, adjust the amount(s) being budgeted for future pay periods.

For earned income:

- If the rate of pay changes, but hours are expected to remain the same, use the past hours worked times the new rate of pay to determine the amount to budget for future pay periods.
- If there is a change in expected hours, but no change in the rate of pay, use the expected hours times the rate of pay to determine the amount to budget per pay period.

If payments in the new amount have been received and they are accurate reflections of the future income, use them in the budget for future months.

For changes in self-employment income, determine the **monthly** gross income to budget based on discussion with the client of what he/she expects to receive on average per month.

Averaging Income

When income is received in one month but is intended to cover several months (such as, contractual income, farm income, etc.), establish a monthly average amount if the benefit month is one of the months covered by the income.

Establish the monthly average by dividing the income by the number of months it covers. This amount is considered available in each of the months covered by the income. Do not use overlapping months when averaging.

Bridges will compute the average monthly amount based on the amounts entered and the number of months you indicate the income covers.

Exception: **For FAP only**, see BEM 610, Migrant/Seasonal Farmworkers.

Starting Income

For starting income, use the best available information to prospect income for the benefit month. This may be based on expected work hours times the rate of pay. Or if payments from the new source have been received, use them in the budget for future months if they accurately reflect future income.

If the payment is not hourly, use information from the source (e.g., from the employer on the MDHHS-38), along with information from the client, and/or any checks the client may already have received to determine the prospective amount.

For starting self-employment income, determine the **monthly** gross income to budget based on discussion with the client of what he/she expects to receive on average per month.

Stopping Income

For stopping income, budget the final income expected to be received in the benefit month. Use the best available information to determine the amount of the last check expected. Use information from the source and from the client. Remove stopped income from the budget for future months.

FAP Only

Note: See BEM 233B for non-deferred FAP clients with job terminations within 30 days of application.

Standard Monthly Amount

A standard monthly amount must be determined for each income source used in the budget.

Stable and Fluctuating Income

Convert stable and fluctuating income that is received more often than monthly to a standard monthly amount. Use one of the following methods:

- Multiply weekly income by 4.3.
- Multiply amounts received every two weeks by 2.15.
- Add amounts received twice a month.

This conversion takes into account fluctuations due to the number of scheduled pays in a month.

Exception: Do **not** convert income for the month income starts or stops if a full month's income is not expected in that month. Use actual income received or income expected to be received in these months.

Example 1: On 10/18 the client reports being laid off from her job. She will receive one paycheck in November. Stop budgeting the standard monthly amount for November. Process a change to budget only one week of wages for November. Process a change for December to remove the income entirely unless the client reports another change.

Example 2: You are processing an application and are determining eligibility for August benefits. The client started a new job at the end of July and will be paid every two weeks. Her first check will be received on 8/7 but will be for only one week's wages. A full two-week paycheck is expected on 8/21. Complete the August budget using the expected pays and do **not** convert the income to a standard monthly amount. (Bridges will convert or not convert automatically if questions are answered correctly). Process a change for September to project a full month's pay and to convert to a standard monthly amount.

Contractual/Single Payment Income

For income received in one month intended to cover several months, establish a standard monthly amount by dividing the income by the number of months it covers. Consider this amount available during each month covered by the income.

Irregular Income

For irregular income, determine the standard monthly amount by adding the amounts entered together and dividing by the number of months used.

Bridges will convert or average income automatically, when appropriate, based on the information you enter about the income.

WHEN TO COMPLETE A BUDGET

FIP, SDA, RAP, and FAP

Client reporting requirements **do not** necessarily affect when a budget must be completed.

Complete a budget when either:

- The department is made aware of, or the client reports a change in income that will affect eligibility or benefit level.
- A reported change results in the need to convert income to or from a standard monthly amount.

Example 1: The client reports a change on 11/15 in unearned income of $5 that will continue beyond December. Complete a new budget to reflect the change in income. (Even though the client did not have to report the change, once reported, a budget must be completed.)

Example 2: The client reports on 11/23 that her job is on 3 week-shut down, due to an equipment changeover. She will receive only two checks in November and only three instead of four in December. She is paid weekly. You cannot affect November benefits. Complete a budget for December, entering zero income for the pay date in which she will not receive a check. Convert income (Bridges will do this for you) - add the check amounts together (including the $0), divide by 4, and then multiply by 4.3. Complete another budget for January, using a full month's income.

CDC Only

Complete a budget only when the client reports a change that will positively affect eligibility; see BAM 220; Case Actions.

Income Decrease

FIP, SDA and RAP

Income decreases that result in a benefit increase must affect the month after the month the change is reported or occurred, whichever is earlier, provided the change is reported timely. Do not process a change for a month earlier than the month the change

occurred. Supplements are not issued to correct underissuances caused by the group's failure to report timely.

Example 1: On 11/12 a client reports there will be a permanent reduction in work hours starting 11/15. Complete a budget to affect December benefits.

Example 2: On 11/01 a client reports being laid off on 10/29. Since the income decrease was reported timely, you must affect the month after the change occurred. Complete a budget for November, prospecting the reduced income, and supplementing for any underissuance. Also complete a budget for December to remove the stopped income.

Note: Had the client reported the change on 11/10 (a late report), December would be the effective month.

Example 3: On 10/17 the client reports she will miss one week of work in November due to her son's surgery, so will not receive a paycheck on 11/19. Complete a budget to increase November benefits, reflecting zero income for 11/19. Complete another budget for December, using a full month's income since the income change will only affect November.

FAP

Income decreases that result in a benefit increase must be effective no later than the first allotment issued 10 days after the date the change was reported, provided necessary verification was returned by the due date. Do **not** process a change for a month earlier than the month the change occurred. A supplement may be necessary in some cases.

Example 1: On 10/17, the client reports she will miss one week of work in November due to her son's surgery so will not receive a paycheck on 11/19. On 10/21, client returns required verifications. Complete a budget to increase November benefits, reflecting zero income for 11/19. Complete another budget for December, using a full month's income since the income change will only affect November.

Example 2: On 11/18, Jan reports there will be a permanent reduction in work hours starting 11/23. Verifications are returned 11/26. Complete a budget to affect December benefits.

If verification is required or deemed necessary, you must allow the household 10 days from the date the change is reported or the date

you request verification to provide verification. The change must still affect the correct issuance month i.e., the month after the month in which the 10th day after the change is reported.

Example 3: Using the previous example, you request verification on 11/25. Jan provides the verification on 12/2. You must make the change to affect December's benefits by issuing a supplement.

If necessary, verification is not returned by the due date, put the case into negative action. If verification is returned late, but before case closure, you must act within 10 days from the date the verification is returned. The increase must affect no later than the first allotment issued 10 days after the date the verification was returned.

Example 4: Using the same example, Jan fails to provide the verifications by the requested due date. On 11/28, the case is put into negative action to close. Jan provides the requested verification on 12/7, before the negative action pend period has expired. You must act on the change within 10 days from the date the verification is returned to affect January's benefits.

CDC Only

Income decreases that result in a benefit increase should be completed as soon as possible but no later than to affect the pay period after the pay period the change was reported.

Income Increase

FIP, SDA, RAP and FAP

For income increases that result in a benefit decrease, action must be taken and notice issued to the client within the Standard of Promptness (FAP - 10 calendar days, FIP/SDA - 15 workdays). The effective month is the first full month that begins after the negative action effective date.

Example: On 11/21 a FAP client reports starting employment on 11/14. Action must be taken to affect January benefits. (Allow for 10 calendar days processing and timely suspense period.)

CDC Only

An income increase that results in a CDC case closure must affect the first CDC pay period that begins after the end of the pend period, if timely notice is required. See BAM 220 to determine if

timely notice is required. Otherwise, affect the first pay period that begins after action is taken on the change.

TEMPORARY INELIGIBILITY

FIP, SDA, RAP, and FAP

Case closure is not required if all the following conditions exists:

- Ineligibility will exist for only one month for FIP, SDA or FAP because the conditions resulting in excess income are not expected to recur in the following month, and
- The group is currently active for FIP, SDA, or FAP, and
- For FIP and SDA, the group failed the deficit test.

Temporary ineligibility is limited to one month for FIP, SDA and FAP. Close the case if ineligibility will last beyond one month; see BAM 220, 506 and BEM 550.

OVERISSUANCE

FIP, SDA, RAP, CDC and FAP

There is no overissuance based on an incorrect prospective budget **unless**:

- The client withheld information or provided false information,
- The Department failed to act on known information in a timely manner, or
- The Department made a mathematical error.

If an overissuance did occur, see BAM 700 for instructions. **Use actual income instead of projected income when processing a budget for a past month, when that income source is the reason the OI occurred. Convert the income to a standard monthly amount, when appropriate.**

Note: For FAP overissuances only, income is **not** converted to a monthly amount when an overissuance occurred in the benefit month because:

- The client failed to properly report income, or

- The department failed to act timely on income learned of via a tape match.

Change reporting groups must report changes within ten days of when they become aware of the change. Income related changes for example, starting/stopping, change in hours/rate of pay etc., must be reported within 10 days of receiving the first payment reflecting the change; see BAM 105.

For establishing an overissuance, treat the date the client received a payment with the new amount as the date a client became aware of the change.

Exception: See BAM 200, Food Assistance Simplified Reporting, for FAP groups with earnings.

Example: On 9/5 a change reporting FAP recipient reports starting income. The employer verification states that the employee's first paycheck was 5/23. The latest date the client should have reported the change was 6/2. Allowing 10 calendar days to act and a full suspense period, the overissuance period begins with July.

For simplified reporting groups, an unreported change for another program is not a FAP overissuance unless the group's income exceeds their limit; see BAM 200.

VERIFICATION REQUIREMENTS

Verify income at application and at redetermination. Verify changes that result in a benefit increase or when change information is unclear, inconsistent, or questionable.

Verify income that stopped within the 30 days prior to the application date or while the application is pending before certifying the EDG. If eligibility fails due to lack of verification of stopped income, a client who reapplies, does not need to verify stopped income if it has been over 30 days.

Note: Expedited FAP cases may be opened with minimum verification before countable income is verified; see BAM 117.

CDC Only

Verify any change that may result in a benefit increase such as an increase in need hours, additional need or decrease in family contribution.

Exception: Verification of stopped income within 30 days prior to the application does not apply to Medicaid programs.

LEGAL BASE

FIP

P.A. 280 of 1939, as amended
Mich. Admin Code, R 400.3118

SDA

Annual Appropriations Act
Mich. Admin Code, R 400.3151 – 400.3180

RAP

45 CFR 400
P.L. 106-386 of 2000, Section 107

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

FAP

7 CFR 273.10

DEPARTMENT POLICY

FIP, RCA and SDA Only

The certified group must be in financial need to receive benefits. Need is determined to exist when budgetable income is less than the payment standard established by the department. Program, living arrangement, grantee status and certified group size are variables that affect the payment standard.

DEFINITIONS

The **eligibility determination group** (EDG) means those persons living together whose information is needed to determine eligibility for assistance; see BEM 210 for FIP, BEM 215 for RCA and BEM 214 for SDA.

The **certified group (CG)** means those persons in the cash EDG who meet all non-financial eligibility factors.

Exception: Otherwise eligible persons who are serving an immunization penalty are included in the FIP CG.

PAYMENT STANDARD

The payment standard is the maximum benefit amount that can be received by the CG. Income is subtracted from the payment standard to determine the grant amount; see BEM 518. The grant amount is for shelter, heat, utilities, clothing, food and items for personal care. It is not to be used to purchase lottery tickets, alcohol or tobacco. It is also not to be used for gambling, illegal activities, massage parlors, spas, tattoo shops, bail-bond agencies, adult entertainment, cruise ships or other nonessential items. Determine the correct payment standard based on the program, certified group size, and living arrangement (SDA) or grantee status (FIP/RCA).

See Adjustment to Payment Standard in this item for groups containing a member who is serving an immunization penalty.

FIP/RCA payment standards are found in RFT 210. For SDA groups, use RFT 225 or RFT 235.

LIVING ARRANGEMENT

SDA Only

Special Living Arrangement (SLA) groups live in a:

- Home for the aged.
- Adult foster care home.
- Hospital.
- Long-term care facility.
- Substance abuse treatment center.
- County infirmary (domiciliary or personal care only).

All other SDA groups are considered to be in **Independent Living**.

GRANTEE STATUS

FIP/RCA Only

Eligible Grantee

Bridges uses the eligible grantee payment standard when the grantee is a member of the CG (EDG participation status of eligible adult). Remember that a grantee disqualified due to a non-citizenship status, IPV, etc. has an EDG participation status of disqualified adult and therefore receives the eligible grantee payment standard.

FIP and SDA Only

A grantee disqualified due to a fleeing felon status has a participation status of disqualifed adult and for FIP receives the eligible grantee payment standard.

Ineligible Grantee

Bridges uses the ineligible grantee payment standard when the grantee is not a member of the CG. This grantee status includes grantees who are any of the following:

- SSI recipients.
- Non-parent caretakers who are not eligible for cash assistance or choose not to request cash assistance.
- Unrelated caretakers who receive FIP based solely on the presence of a child placed in the home by children’s services.

- Recipients of Children's Services Independent Living Stipend.

Certified Group Size

Bridges uses policy in BEM 210, BEM 215, BEM 214 and RFT 210 to determine CG size and the correct payment standard.

Adjustments to Payment Standard

FIP Only

Bridges reduces the CG's payment standard by $25 if one or more eligible children in the group is subject to an immunization penalty; see BEM 202.

CHANGES IN NEED

Changes in need occur when there are changes in:

- Certified group size.
- Living arrangement.
- Grantee status.

Note: For changes in income, see BEM 518.

Change Reported Timely

For changes reported timely (within 10 days), Bridges will reflect the change the first month that begins at least 10 days after the change is reported if administratively possible. Depending on the timing of the reported change and timely notice requirements, some benefits will be adjusted in the first month after the change is reported; others in the second month after the change is reported.

Exceptions:

- Member additions resulting in a grant increase will affect the month after the month the change occurred.
- For SDA recipients exiting an SLA facility, Bridges will increase the client benefit effective in the month following the month of exit, provided the client is eligible for SDA at the Independent Living rate; see BEM 616.

Change NOT Reported Timely

Bridges will reflect changes reported late as follows:

- For member additions resulting in a grant increase, reflect the change in the month after the month the change is reported.
- For changes **other than** member additions resulting in a grant increase, reflect the change no later than the first month that begins at least 10 days after the change is reported.
- For changes resulting in a grant decrease, Bridges determines when the change would have been effective had the client reported timely and DHS had acted timely. Initiate recoupment as appropriate; see BAM 700.

Note: Bridges will authorize payment to **SDA-SLA providers** for the time care was provided, regardless if a change was reported timely by the client, but no earlier than ten days prior to the date of application. Do **not** authorize payment for the date of discharge; see BAM 430.

Examples

Example 1: On March 5, the group reports that a member joined the group on February 26 (member add reported timely). The change results in a grant increase which you process on March 19 to affect April benefits. Authorize a supplement for March. (Must affect month after change occurred.)

Example 2: On July 24, the group reports that a member left the group on July 17. (Reported timely.) The change results in a grant decrease which you process on July 28 to affect September benefits. (Affect second month after change is reported due to timely notice requirements.)

Example 3: On December 7, you first learn that a member left the home on September 14. You determine that a benefit reduction should have been effective in November. Affect the grant decrease as soon as possible and initiate recoupment for overissuances beginning with November benefits.

Example 4: On October 8, the group reports that a member joined the group on August 23. (Reported late.) The change results in a grant increase which you process on October 13 to affect

November benefits. October benefits are **not** increased. (Affect month after change is reported.)

VERIFICATION REQUIREMENTS

Verification of need is **not** required.

LEGAL BASE

FIP

Social Security Act, Title IV-A
MCL 400.57 a (3)
Mich Admin Code, R 400.3109, .3118

RCA

45 CFR 400.66

SDA

Annual DHS Appropriations Act

DEPARTMENT PHILOSOPHY

The department's income budgeting policies are designed to support financial self-sufficiency by encouraging families to pursue all available means of income. We offer deductions from earned income so that families are financially advantaged by working. Staff should stress to clients the advantages of obtaining outside income.

DEPARTMENT POLICY

FIP, RCA and SDA Only

Financial need must exist to receive benefits. Financial need exists when the certified group passes the **Qualifying Deficit Test**, **Issuance Deficit Test** and the **Child Support Income Test.**

Exception: A Qualifying Deficit Test is not required for RCA and SDA groups.

Exception: A Child Support Income Test is not required for RCA and SDA groups.

At application, Bridges performs the qualifying deficit test by subtracting budgetable income from the certified group's payment standard for the application month; see BEM 515.

To perform the issuance deficit test, Bridges subtracts budgetable income from the certified group's payment standard for the benefit month.

To meet the child support income test, the FIP group's countable income plus the amount of certified support (or amount of support to be certified) must be less than the certified group's payment standard.

Note: The income of disqualified EDG members is countable.

The benefit month is the month an assistance payment covers. At application, the months subject to the qualifying deficit test are the first two application months in which the group could be eligible for an assistance payment. The income month is a calendar month in which countable income is received or anticipated. The income month is the same as the benefit month or application month.

Countable income is defined in BEM 500. Available income, the amount of income to budget and when to complete a budget, are defined in BEM 505. Bridges uses policy in this item to determine the budgetable income and financial eligibility.

RCA Only

See RMA Extended Medical Coverage in BEM 630 for recipients who lose eligibility due to excess income.

CHILD SUPPORT

FIP Only

Certified support means court-ordered support payments sent to the Michigan Department of Health and Human Services (MDHHS) by the Michigan State Disbursement Unit (MiSDU). Bridges excludes from the deficit test the amount of collections retained by the MDHHS.

Voluntary Support

Voluntary child support is countable in the eligibility determination. Exclude up to $50 received from the voluntary support in the benefit month.

Exception: Exclude any portion of a payment which a court order or other legally binding agreement requires to be sent directly to the group's creditor or service supplier; see BEM 500.

FINANCIAL NEED

FIP Only

Financial need exists if:

- There is at least a $10 deficit after income is budgeted in the issuance deficit test.
- The group passes the child support income test.

If the group fails either test, the group is ineligible for assistance. Certify FIP denial or closure in Bridges for the benefit month unless the group meets the conditions for temporary ineligibility.

Exception: At application, the certified group must have a deficit of at least $1 in the qualifying deficit test to be eligible for FIP. If the certified group fails this test, certify the FIP denial in Bridges.

RCA and SDA Only

Financial need exists if there is at least a $10 deficit after income is budgeted.

If there is no deficit, the group is ineligible for assistance. Certify denial or closure in Bridges for the benefit month unless the group meets the conditions for temporary ineligibility.

FIP, RCA and SDA Only

At application, if the group is ineligible due to excess income but a change is expected for the next benefit month, process the second month's benefit determination. If eligible, do not deny the application.

Determine eligibility for medical programs as part of the closure/denial process; see BEM 105 and 640.

Qualifying Deficit Test

FIP Only

At application, Bridges compares the budgetable income using the qualifying earned income disregard for the income month to the certified group's payment standard for the application month. The group is ineligible for the application month if no deficit exists.

Issuance Deficit Test

FIP, RCA and SDA Only

Bridges compares budgetable income for the income month using the earned income disregard to the certified group's payment standard for the benefit month. The group is ineligible for the benefit month if no deficit exists or the group has a deficit less than $10.

Child Support Income Test

FIP Only

A child support income test is required only when the group has certified support of more than $50. Bridges automatically completes a child support income test whenever a deficit test is required and

whenever a change in the amount of certified support is expected to continue.

To complete a child support income test, the group's total voluntary support amount is added to the gross monthly certified amount (for applicants, this includes the amount **to be** certified).

Up to $50 from this amount is excluded. The result is added to the group's net earned and other unearned income. Any support paid for persons not in the home is deducted from this total. The resulting amount is compared to the eligible group's payment standard. If the result is equal to or greater than the certified group's payment standard the group is **not** eligible for assistance.

Grant in Jeopardy

Bridges compares the approved ongoing FIP grant amount to the reimbursement and certified support when it is recorded in the MiSDU. The unearned income record is created and eligibility is determined prior to the negative action cut off date to affect the next month.

If the amount collected in child support exceeds the grant by $50 in two consecutive months, the FIP will close.

FIP cases that close due to child support exceeding the FIP grant are reported to the worker to record the direct support in Bridges that will now be decertified.

BENEFIT AMOUNT

FIP, RCA and SDA Only

A deficit of at least $10 is required to receive a cash benefit. If the deficit is less than $10, no financial need exists and the group is not eligible to receive benefit. Bridges will deny or close the program.

Temporary Ineligibility

Case closure is **not** required if all the following conditions exist:

- Ineligibility will exist for only one month because the conditions resulting in excess income are **not** expected to recur in the following month, **and**
- The group is currently active for FIP, RCA or SDA, **and**

- The group failed the qualifying deficit test or the issuance deficit test.

Suspend benefits by checking the *TempInelig* check box on the Bridges Certification screen. The group remains active and does **not** have to reapply for benefits.

Temporary ineligibility is limited to one month.

INCOME DEDUCTIONS

Income deductions are available at both the member and the group level. Apply deductions in the order they are presented in this item.

Qualifying Earned Income Disregard

FIP, RCA Only

At application, deduct $200 from each person's countable earnings. Then deduct an additional 20 percent of each person's remaining earnings. The total disregard cannot exceed countable earnings. Apply this disregard separately to each program group member's earned income.

Issuance Earned Income Disregard

FIP, RCA and SDA Only

Deduct $200 from each person's countable earnings. Then deduct an additional 50 percent of each person's remaining earnings. The total disregard **cannot** exceed countable earnings. Apply this disregard separately to each program group member's earned income.

Paid-out Support

Deduct the amount of court-ordered support payments including arrearages expected to be paid by the program group from the group's total countable income. Deduct payments made for children not in the home. Deduct legally obligated child support paid to an individual or agency outside the household, for a child who is now a household member, provided the payments are not returned to the household. Process reported changes and convert ongoing payments to a standard monthly amount using policy in BEM 505.

Spousal Deduction

SDA Independent Living Only

If both spouses are in the program group but only one is eligible (example, other spouse is not disabled or is not a caretaker), deduct $149 from the program group's total countable income.

VERIFICATION REQUIREMENTS

Verify child support payments paid by the group at opening, redetermination and when a change is reported that will continue into the second month after the report month; see BEM 505.

LEGAL BASE

FIP

P.A. 280 of 1939, as amended
MCL 400.57 et seq.
Annual MDHHS Appropriations Act

RCA

45 CFR 400.66

SDA

Annual MDHHS Appropriations Act

DEPARTMENT POLICY

FIP, RCA and SDA Only

Financial eligibility is documented for each FIP/RCA/SDA group in data collection and eligibility results in Bridges.

Documentation of financial eligibility is required at application, redetermination and when program policy requires a budget; see BEM 505, 515. Documentation must reflect the group's current financial eligibility status.

The remainder of this item covers the completion of the DHS-1172 for the FIP, RCA and SDA programs. The budget calculations are automatically completed as part of the eligibility determination and benefit calculation in Bridges and an automated budget worksheet are displayed in eligibility summary. In addition, hyperlinks can be used to view individual income and asset details.

Bridges applies all of the following rules when computing a FIP/RCA/SDA budget:

- Drop cents before entering any amount used to compute the issuance amount on the worksheet.
- If an entry on the worksheet is the result of a computation using other amounts that do not appear on the worksheet, cents are included in the computation and dropped from only the final result which is entered on the form.
- When the result of a computation is a negative number, a zero is entered on the worksheet.
- Cents amounts are included when computing recouped, vendored and benefit amounts.
- All amounts entered on the worksheet are monthly amounts unless otherwise specified in the instructions.
- Only countable, available income and assets, as defined in BEM 400, 500, 505 and 518, are entered on the worksheet.

The absence of an entry on any worksheet line in sections A-G is considered to represent an entry of zero. However, zero may be entered whenever appropriate.

DHS-1172 COMPLETION INSTRUCTIONS

Use these instructions if it is necessary to complete a budget worksheet manually.

ID Block:

Case Name - Enter the name of the grantee.

Case Number - Enter the group's assigned number.

Benefit Mo/Yr - Enter the month and year of the benefit month the worksheet being completed for.

County/Dist/Section/Unit/Specialist - Enter the load number.

Program - Check off the program type.

Process - Check off the budgeting process type.

Group Size - Enter the number of persons in the FIP/SDA eligible group. Include eligible children who are **not** immunized.

Section A; Cash Assets

Family Independence Program (FIP), Refugee Cash Assistance (RCA) and State Disability Assistance (SDA) Only - See BEM 400

1. Enter the total countable value of all the checking accounts.
2. Enter the total countable value of all the savings accounts.
3. Enter the total countable value of all the other liquid assets.
4. Enter the sum of lines 1, 2, and 3.
5. Enter the program's asset limit.

Section B; Payment Standard

FIP, RCA and SDA Only - See BEM 515

1. **SDA-SLA Only -** Enter the monthly rate for the SLA and level of care; see RFT 235.

2. **SDA-SLA Only -** Enter the SLA Incidentals allowance; see RFT 235.

3. **SDA-SLA Only -** Add the amounts on lines 1 and 2 and enter the sum.

4. **FIP/RCA/SDA-Independent only -** Enter the amount of the payment standard for this group's program, eligible group size and grantee status or living arrangement; see RFT 210 or 225.

5. **Immunization Penalty (FIP Only)** - Enter the amount on line 4 less the amount of the immunization penalty, if the group is subject to it.

6. **Payment Standard** - Subtract the amount in line 5 from the sum of line 3 plus line 4.

Section C; Qualifying Income Test

FIP and RCA Only - See BEM 518.

1. Enter the total gross earned income for the group that is from employment.

2. Enter all the self-employment income; see BEM 502.

3. Enter the sum of lines 1 and 2.

4. For each member with earnings enter the lesser of $200 or the amount on line 3.

5. Subtract line 4 from the total in line 3.

6. Enter 20 percent of the total in line 5.

7. Subtract line 6 from the remainder in line 5.

8. Enter all the countable unearned income.

9. Enter the sum of line 7 and line 8.

10. Enter the lesser of the countable child support income or $50.00.

11. Subtract line 10 from the remainder in line 9.

12. Enter the child support expense.

13. Subtract line 12 from the remainder in 11. If this is less than the payment standard in B6 continue onto section D.

Section D; Issuance Test

FIP, RCA and SDA Only

1. Enter the total gross earned income for the group.
2. Enter all of the self-employment income; see BEM 502.
3. Enter the sums of lines 1 and 2.
4. For each member with earnings enter the lesser of $200 or the amount on line 3.
5. Subtract line 4 from the total in line 3.
6. Enter 50 percent of the total in line 5.
7. Subtract line 6 from the remainder in line 5.
8. Enter all of the countable unearned income.
9. Enter the sum of line 7 and line 8.
10. Enter the lesser of the countable child support income or $50.00.
11. Subtract line 10 from the total in line 9.
12. Enter the child support expense.
13. Enter the Spousal Deduction.
14. Subtract lines 12 and 13 from the remainder in line 11.

Section E; Child Support Income Test

FIP Only

1. Enter the total monthly certified current support amount to the voluntary support amount.

2. Enter the child support exclusion the group is eligible to receive. Enter the lesser of the amount on line 1 or $50.

3. Enter the total from line D7.

4. Enter the monthly unearned income that the client receives.

   Note: The amount in line 4 should not include any child support payments.

5. Subtract line 2 from line 1 then add lines 3 and 4.

6. Enter the amount paid for the court ordered child support; see BEM 518.

7. Subtract line 6 from line 5.

Section F; Issuance Amount

FIP, RCA and SDA Only

1. Enter the amount from line B6.
2. Enter the amount from line D14.
3. Enter the recoupment amount.
4. Subtract line 2 and line 3 from the amount on line 1 and enter the result.

Note: Divide line 4 by 2 if the first month of issuance is only going to be the second half of the month.

Example: Client applies for FIP August 17th. The earliest the group can start to receive benefits is the second half of September.

Section G; Countable Income for Food Assistance

FIP, RCA and SDA Only - See BEM 550.

1. Enter the amount from line F4.

2. Enter an amount if recoupment is due to IPV.

3. If the group is subject to an immunization penalty enter $25, if not enter $0.

4. Enter the sum of line 1, line 2, and line 3.

LEGAL BASE

FIP

MDHHS Annual Appropriations Act
P.A. 280 of 1939, as amended

RCA

45 CFR 400.66

SDA

MDHHS Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

DEPARTMENT POLICY

For income eligible Child Development and Care (CDC) determinations, the income of all program group members must be considered. Some types of income are excluded.

See BEM 500-504 for a detailed description of income types, exclusions, treatment of income including lump sums, and required verifications.

Computation of Income

Use the gross (before deductions) countable, monthly income to determine income eligibility and the family contribution.

Note: When income eligibility is established in the first pay period of an application ***and*** a change in income is reported, the income change is not required to be verified for approval of subsequent pay periods.

See BEM 505 for details on when a budget is needed, income and benefit month definitions, and the conversion of income to a monthly figure.

When a Budget is Required

Complete a CDC budget at application and redetermination or when the client reports an increase in income that exceeds the highest category in the CDC Income Eligibility Scale for the family size; see RFT 270. This amount will be printed on the DHS-1605, Notice of Case Action, at application and redetermination.

Note: To be initially eligible for the CDC program, a family's gross monthly income must not exceed the Maximum Monthly Gross Income limit by family size associated with the column marked "entry" in the CDC Income Eligibility Scale. See RFT 270.

Bridges determines eligibility for CDC and addresses such questions as:

- Is a separate income determination required?
- What portion of the cost of care will the department pay?
- Is a particular need reason covered?
- What eligibility and need reasons should be entered?

- If a child is aged 13-18, is an age exception appropriate?

Client Notices

Bridges is the primary means of producing CDC client and provider notices for case actions; see BAM 220 for more details.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99
Social Security Act, as amended 2016

DEPARTMENT POLICY

SSI-Related, Group 2 Aged, Blind, Disabled MA

Use this item for any person whose income is considered in determining income eligibility or a post-eligibility patient-pay amount; see Exception in this item.

Determine income eligibility and post-eligibility patient-pay amounts (PPA) on a calendar month basis. Use one budget to determine income eligibility (or post-eligibility PPA) for multiple months if the circumstances for each of the months are identical.

Applicants and Deductible Cases

Determine income eligibility in calendar month order beginning with the oldest month. This is especially important when using medical expenses to determine Group 2 income eligibility.

In addition, do a future month budget to determine ongoing income eligibility, deductible status or post-eligibility PPA when a change in circumstances occurred in the processing month or a change is anticipated for the future month. For example:

- Client started a job and will get his first pay next month.
- A group member moved out of the client's home during the processing month.
- Client was admitted to, or discharged from, an LTC facility during the processing month.

MA Recipients and Deductible Cases

For a recipient, do a future month budget at redetermination and when a change occurs that may affect eligibility or a post-eligibility PPA.

For a deductible client, do a future month budget at redetermination and when a change occurs that may affect deductible status.

COUNTABLE INCOME

Use only countable income. Countable income is income remaining after applying MA policy in BEM 500, 501, 502, 503, 504. See *countable income* in BEM 546 for post-eligibility patient-pay amount computations.

AVAILABLE INCOME

Use only available income. Available means income which is received or can reasonably be anticipated. Available income includes amounts garnished from income, joint income, and income received on behalf of a person by his/her representative; see BEM 500.

AVERAGED INCOME

For SSI-related MA budgets, average only self-employment income. Convert self-employment income which is received less often than monthly to a monthly amount based on past and/or estimated future proceeds and allowable expenses.

Group 2 MA budgets, average income received in one month which is intended to cover several months. Divide the income by the number of months it covers to determine the monthly available income. The average amount is considered available in each of the months.

NON-AVERAGED INCOME

Budget non-averaged income for the month in which it was/will be received/available.

Exception: When doing a future month budget, do not budget income from an extra check (example: fifth check for a person who is paid weekly).

BUDGET MONTH INCOME

Past Month

Non-averaged income: Use amounts actually received/available in the past month.

Averaged income: Use the monthly average amount if this month is one of the months used to compute the average.

Processing Month

Non-averaged income: Use amounts already received/available in the processing month. In addition, estimate amounts likely to be received/available during the remainder of the month; see **PROSPECTING INCOME** in this item.

Averaged income: Use the monthly average amount if this month is one of the months used to compute the average.

Future Month

Non-averaged income: Use amounts that will be, or are likely to be, received/available in the future month; see *prospecting income* in this item.

Exceptions:

- Do not budget an extra check (example, fifth check for person paid weekly).

  If prospecting income based on bi-weekly or twice a month payments, multiply by 2. If prospecting income based on weekly pay, multiply by 4.

- Base estimate of daily income (example: insurance pays $40 for every day in hospital) on a 30-day month.

When the amount of income from a source changes from month to month, estimate the amount that will be received/available in the future month.

Averaged income: Use the monthly average amount if this month is one of the months used to compute the average.

PROSPECTING INCOME

Prospecting income means arriving at a best estimate of the person's income. Prospect income when estimating income to be received in a processing or future month. A best estimate may not be the exact amount of income received.

Some of the reasons income fluctuates is because:

- The number of hours worked in a month may fluctuate.
- The amount of tips may vary from payday to payday.

Use the following guidelines for prospecting income:

- For fluctuating earned income, use the expected hourly wage and hours to be worked, as well as the payday schedule, to estimate earnings.
- Paystubs showing year-to-date earnings and frequency of pay are usually as good as multiple paystubs to verify income.
- A certain number of paystubs is not required to verify income. If even one paystub reflects the hours and wages indicated on the application, that is sufficient information.
- If a person reports a pay rate change and/or an increase or decrease in the number of hours they usually work, use the new amount even if the change is not reflected on any paystubs.
- If you have an opportunity to talk with the client, that may help establish the best estimate of future income.

  Note: Do not require in-person interviews as a condition of eligibility.

AUTOMATED UPDATES

Central office automatic updates, such as Social Security cost-of-living increases, take effect the month the change occurs.

Social Security cost-of-living increases are calculated from BENDEX information. The increase is added to existing post-eligibility patient-pay amounts (PPAs). Since this increase is determined independently of the client's total income, the result (such as, post-eligibility PPA) may be affected by truncating (for example, dropping cents), but is considered correct.

LEGAL BASE

Social Security Act, Sections 1902(r)(2), 1931(b)
42 CFR 435.600-.832
MCL 400.106

DEPARTMENT POLICY

This item applies to Group 2 Under 21 and Caretaker Relative categories only.

A fiscal group is established for each person requesting MA and budgetable income is determined for each fiscal group member.

Since how a client's income must be considered may differ among family members, special rules are used to prorate a person's income among the person's dependents, and themselves.

Follow the multi-step process outlined below to determine a fiscal group member's income, then follow FISCAL GROUP'S NET INCOME in this item.

DETERMINING BUDGETABLE INCOME

Group 2 Under 21 and Caretaker Relative Follow **Step 1** through **Step 16** below for each fiscal group member with income. Apply the deductions in the order the steps are listed.

Step 1 - Countable Earned Income

Use the policies in BEM 500 and 530 to determine each fiscal group member's countable earned income.

Step 2 - Standard Work Expense

Deduct $90 from the countable earnings of each fiscal group member with earnings.

Step 3 - $30 Plus 1/3 Disregard

Deduct $30 plus 1/3 of a fiscal group member's remaining earned income if the member received FIP or LIF in at least 1 of the four calendar months preceding the month being tested.

Note: Received, for purposes of this disregard, includes months a member has been found eligible for LIF.

Example: Harry's countable monthly earnings are $420.98. The deductions are applied to $420. $420 - $90 = $330. $330 - $30 = $300. l/3 of $300 is $100. $300 - $100 = $200.

Step 4 - Dependent Care Deduction

Deduct an amount for dependent care expenses arising from employment from the remaining earnings of the parent in the fiscal group who pays for the care.

Compute the dependent care deduction separately for each fiscal group member who pays for dependent care. The deduction is $200 per month for each person receiving care, unless one of the rules below prohibits a deduction.

The following rules apply:

- The person receiving dependent care must:
  - Be living with the fiscal group member paying for the care, **and**
  - Be that fiscal group member's child, **and**
  - Be under age 13 or be under age 18 and need care due to a mental or physical limitation.
- If two parents in the fiscal group claim expenses for the same child, allow the deduction for the fiscal group member with the highest income.
- Do not allow the deduction if the employed person is paying a responsible relative of either the person paying for or the person needing care. Responsible relative means:
  - A person's spouse.
  - he parent of an unmarried child under age 18.
- Do not allow a deduction for a person receiving care if the **total** cost is paid by CDC or a third party.

Performing dependent care services should not interfere with the caregiver's schooling or employment.

Step 5 - Countable Child Support

Use policies in BEM 500 and 530 to determine countable child support income.

Step 6 - Child Support Disregard

Deduct $50 from the child support received by a fiscal group member.

Step 7 - Other Unearned Income

Use the policies in BEM 500 and 530 to determine the fiscal group member's other countable unearned income.

Step 8 - Total Net Income

Add together the fiscal group member's remaining:

- Earned income, and
- Child support income, and
- Other unearned income.

Step 9 - Court-Ordered Support

Deduct court-ordered support paid by a fiscal group member to a child who does not live with the fiscal group. The deduction cannot be greater than the amount ordered for the month; arrearage payments are not deducted.

Step 10 - Guardianship/ Conservator Expenses

Deduct $83 per month for court-appointed guardian and/or conservator expenses if verified paid by a fiscal group member.

Guardianship/conservator expenses include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

Fiscal Group Member's Total Net Income

The result after **Step 10** is the fiscal group member's total net income.

Step 11 - Determine Dependents

Determine the number of dependents living with the fiscal group member.

Dependent means a person's spouse and child (ren).

Child (ren) means an unmarried person under age 18.

Note: Do not count the member being processed as a dependent. The member is included in **Step 12** and **Step 15**.

Skip **Step 12** and **Step 13** if a member's number of dependents is zero.

Step 12 - Prorate Divisor

Add 2.9 to the amount determined in **Step 11**. (2.9 is a calculation using federal needs allowances.) The result is the prorate divisor.

Step 13 - Child's or Adult's Prorated Share

Divide the person's total net income (the result from **Step 10**) by the prorate divisor (**Step 12**). The result is the prorated share of the fiscal group member's income.

Step 14 - Non-Parent Caretaker Relative's Prorate Divisor

This step applies to a fiscal group member who meets the following criteria:

- This person's Group 2 MA eligibility is based on BEM 135, Group 2 Caretaker Relative, and

- This person is a core relative who is acting as parent for one or more dependent children in the home who are **not** the person's own children. Example: Person is acting as parent for a grandchild or a stepchild who is a dependent child.

Note: Dependent child is defined in BEM 135. Also, keep in mind the following policies from BEM 135:

- A child can have only one **non-parent** caretaker relative.
- A non-parent can act as parent even if the parent is in the home. If the parent and non-parent both claim to be acting as parent, assume the parent is caring for the child.

Skip **Step 14**, **Step 15** and **Step 16** if the person does not meet the criteria above.

If the fiscal group member being tested meets the criteria above, determine the number of dependent children who:

- Are unmarried and under age 18, and
- This member acts as a parent for but is **not** the parent of.

Step 15 - Non-Parent Caretaker Relative's Prorate Divisor

Add the following three amounts:

- Amount from **Step 11**, and
- Amount from **Step 14**, and
- 2.9.

Step 16 - Non-Parent Caretaker's Prorated Share

Divide the person's total net income (the result from **Step 10**) by the non-parent caretaker relative's prorate divisor (**Step 15**). The result is the prorated share of the fiscal group member's income for purposes of determining the member's eligibility.

Repeat **Step 1** through **Step 13** and if appropriate, **Step 14** through **Step 16** for each fiscal group member with income before proceeding to **FISCAL GROUP'S NET INCOME**.

FISCAL GROUP'S NET INCOME

Group 2 Under 21 and Caretaker Relative

Child's Fiscal Group's Net Income

A child's fiscal group's net income is the total of the following amounts:

- The child's net income (**Fiscal Group Member's Total Net Income**) if the child has no dependents **or** 2.9 prorated shares of the child's own income if the child has dependents (child's **Step 13** times 2.9), plus
- For each parent in the fiscal group, 3.9 prorated shares of the parent's own income (each parent's **Step 13** times 3.9), plus

  Note: This is the child's and parent's share of the parent's income.
- One prorated share of each of the parent's own income (each parent's **Step 13**) when:
  - Both of the child's parents are in the child's fiscal group, and
  - The parents are married to each other.

  Note: This is the couple's share of each other's income.

Adult's Fiscal Group's Net Income

An adult's fiscal group's net income is the total of the following amounts:

- The adult's net income (**Fiscal Group Member's Total Net Income**) if the adult has no dependents **or** 2.9 prorated shares of the adult's own income if the adult has dependents (adult's **Step 13** times 2.9), plus
- If the spouse is in the adult's fiscal group:
  - 3.9 prorated shares of the spouse's own income (spouse's **"Step 13"** times 3.9), plus

- One prorated share of the adult's (person requesting MA) income (adult's amount from **Step 13**).

Note: This is the couple's share of each other's income.

INCOME ELIGIBILITY

Group 2 Under 21 and Caretaker Relative

Group 2 Determination

Use the policies in BEM 544 and 545 to complete the determination of income eligibility for each person requesting MA.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10).
42 CFR 435.831(a)(1).
MCL 400.106.

DEPARTMENT POLICY

Medicaid (MA) Only

This item applies to SSI-related MA for children. A child is an unmarried person under age 18.

Exception: This item does **not** apply to Extended-Care (BEM 164).

An SSI-related child's income is:

- The child's own countable income from BEM 500 and BEM 530, plus
- Income deemed to him from his parent(s).

Deductions from an SSI-related child's income in this item explains what amounts must be deducted from an SSI-related child's income.

PARENTAL INCOME DEEMING

When Deeming Applies

Parents with sufficient income deem a portion to their SSI-related child. Deeming applies only when:

- Eligibility is **not** being determined under BEM 170, Home Care Children; BEM 171, Children's Waiver; or BEM 172, SED Waiver**; and**
- The child lives with (BEM 211) only one parent and that parent is not a FIP or SSI recipient; **or**
- The child lives with both parents and neither parent is a FIP or SSI recipient.

Use the following procedure when deeming applies.

Parental Income

1. Determine the parent's countable unearned income (see BEM 500 and 530). If two parents, add the amounts together. Go to 2.

2. Deduct court-ordered child support paid by a parent to a child who does not live with the group. Deduct the amount specified in the court order or the actual amount paid.

3. Determine the parent's countable earned income (see BEM 500 and 530). If two parents, add the amounts together.

   End procedure if the parents have no countable income. Go to *Deductions from an SSI-related child's income* in this item.

   Go to 4 if the parents have countable income.

Allocation to Non-SSI-Related Children

4. Determine if the parents have non-SSI-related child(ren) living in the home. A non-SSI-related child is a child or stepchild who:

   - Is unmarried and under age 18; and
   - Is **not** an SSI, FIP, SDA or title IV-E recipient; and
   - Is **not** a Department ward; and
   - Is **not** an applicant for, or recipient of, MA based on disability or blindness.

   If the parents do **not** have a non-SSI-related child in the home, the total allocation is zero. Go to 6.

   Follow steps (a) through (e) separately for each non-SSI-related child living with the parents to compute the child's allocation. Then go to 4.

   a. Determine the child's countable unearned income (see BEM 500 and 530). Go to b.

   b. Determine the child's countable earned income (see BEM 500 and 530). If the child is a full-time or half-time student (as determined by the institution), subtract $1700 from his countable earned income to get remaining earned income. Go to c.

   c. Add the child's countable unearned income and his remaining earned income (a + b above) to get remaining income. Go to d.

d. Deduct the following from the child's remaining income (c above):

- Court-ordered support paid by the child, and
- $83 for guardianship/conservator expenses paid by the child; see Guardianship/ Conservator Expenses in this item.

The income left after these deductions is called net income. Go to e.

e. Determine the allocation for the child. No income allocation is allowed to a child from his parents, if the child's net income (d above) is equal to or more than:

- $472 for months in calender year 2024.
- $458 for months in calender year 2023.

If the child's net income (d above) is less than $472, the difference ($472 minus d) is the allocation to this child from his parents.

Follow steps (a) through (e) for each non-SSI-related child and then go to 4.

Total Allocation Deduction

5. Add up all the allocations (3e above) to get the total allocation. Go to 5.

6. Subtract the total allocation (4 above) from the parents' countable unearned income (1 above) first. If countable unearned income is reduced to zero, subtract the remainder of the total allocation from the parents' countable earned income (2 above).

   If the parents have no countable unearned income, subtract the total allocation (4 above) from their countable earned income (2 above).

   Any countable unearned income left after the total allocation is subtracted is called remaining countable unearned income. Any countable earned income left is called remaining countable earned income. Go to 6.

Deductions for Parental Needs

7. Subtract the appropriate amount based on parents' remaining income after step 5.

   - Subtract $20 from the parents' remaining unearned income. Subtract $20 from the parents' remaining earnings if there is no remaining unearned income.
   - Disregard $65 plus 1/2 of the parents' earned income. Use RFT 295 to determine this amount.
   - Add the remaining unearned and earned incomes together. Subtract:

One Parent	
Calendar Year	**Amount Subtracted**
2024	$943
2023	$914
2022	$841
2021	$794

Two Parent	
Calendar Year	**Amount Subtracted**
2024	$1415
2023	$1371
2022	$1261
2021	$1191

Go to 7.

Deemed Income

8. The income after the deductions in step 6 above is the amount of deemable income. The amount of deemable income is divided by the number of the parents' children who:

   - Live with the parents (BEM 211), **and**
   - Are unmarried and under age 18, **and**
   - Are SSI recipients, **or**
   - Are:
     - Applicants for, or recipients of, MA based on blindness or disability; **and**
     - Meet the nonfinancial eligibility factors for MA in BEM 155 or 166; **and**

- Are **not** having MA eligibility determined, or are **not** receiving MA, under BEM 170, 171, 172, Home Care Children, Children's Waiver or SED Waiver.

Note: There is always at least one such child; that is, the child whose eligibility is being determined.

The result of the division calculation in this step is the amount of income deemed to the child whose eligibility is being determined.

Go to *Deductions from an SSI-related child's income* in this item.

DEDUCTIONS FROM AN SSI-RELATED CHILD'S INCOME

The following are subtracted from an SSI-related child's income in the order listed.

Blind and Impairment-Related Work Expenses

Blind work expenses are costs which are reasonably attributable to a blind child earning income.

Impairment-related work expenses are the cost of certain impairment-related services and items that a disabled child needs in order to work.

Subtract allowable work expenses paid by a blind or disabled child from his own countable earned income.

See BEM 260 for definitions of blindness and disability.

See EXHIBIT in BEM 541 for a list of allowable blind work expenses (BWE) and impairment-related work expenses (IRWE). Do **not** deduct:

- Normal living expenses such as meals outside work hours and cosmetics.
- Costs paid (or reimbursed) by an employer, other person or other source (such as insurance or Medicaid).

Student Child Disregard

Subtract $1700 from the child's remaining earned income when the child:

- Is a full-time or half-time student (as determined by the institution), and
- Lives with a person who provides for the child's physical care or supervision.

1/3 Child Support Disregard

Subtract one-third of the child support received by a child from his continuously absent parent from the child's countable unearned income when the child lives with a person who provides for the child's physical care or supervision.

$20 Disregard

Subtract $20 from the child's remaining unearned income (including parental deemed income). Subtract $20 from the child's remaining earned income if there is no remaining unearned income or parental deemed income.

$65 + 1/2 Disregard

Disregard $65 plus 1/2 of the child's remaining earned income.

Guardianship/ Conservator Expenses

Deduct $83 for court-appointed guardianship/conservator expenses if verified paid by the child from the child's remaining income (such as remaining unearned plus remaining earned income).

Guardianship/conservator expenses include:

- Basic guardianship fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)
42 CFR 435.831(a)(2)

DEPARTMENT POLICY

Medicaid (MA) Only

This item applies to SSI-related MA for adults. Adult means a person who is married or age 18 or over. Apply the deductions in the order listed to countable income as determined by using BEM 500 and 530.

Exception: This item does **not** apply to Extended-Care; see BEM 164.

COURT ORDERED CHILD SUPPORT

Deduct court-ordered child support paid by an initial person's spouse to a child who does not live with the fiscal group. The amount deducted is: the amount specified in the court order or the actual amount if less than the court order or the actual amount if more than the court order and the amount includes arrearages. Arrears must be paid on behalf of a dependent child to allow the deduction.

BLIND AND IMPAIRMENT-RELATED WORK EXPENSES

Blind work expenses are costs which are reasonably attributable to a blind person earning income.

Impairment-related work expenses are the cost of certain impairment-related services and items that a disabled person needs in order to work.

Subtract allowable work expenses paid by a blind or disabled person from his own countable earned income.

See BEM 260 for definitions of blindness and disability.

See *allowable work expenses* in this item for a list of allowable blind work expenses (BWE) and impairment-related work expenses (IRWE). Do **not** deduct:

- Normal living expenses such as meals outside work hours and cosmetics.

- Costs paid (or reimbursed) by an employer, other person or other source (such as insurance and Medicaid).

ALLOCATION TO NON-SSI-RELATED CHILDREN

Allocate parents' and stepparents' income to meet the needs of their non-SSI-related child(ren) living with them; see BEM 211. A non-SSI-related child is a child who:

- Is unmarried and under age 18; and
- Is **not** an SSI, FIP, SDA or title IV-E recipient; and
- Is **not** a department ward; and
- Is **not** an applicant for, or recipient of, MA based on disability or blindness.

Allocation Calculation

Calculate the allocation for each non-SSI-related child (defined above) separately as follows:

1. Determine the non-SSI-related child's countable unearned income; see BEM 500 and 530. Go to 2.

2. Determine the non-SSI-related child's countable earned income; see BEM 500 and 530. If the child is a full-time or half-time student (as determined by the institution), subtract $135 from his countable earned income. Go to 3.

3. Add the non-SSI-related child's countable unearned income and his remaining earned income (1 + 2 above). Go to 4.

4. Deduct the following from the non-SSI-related child's remaining income (3 above):

   - Court-ordered support paid by the child, and
   - $83 for guardianship/conservator expenses if verified paid by the child; see *guardianship/conservator expenses* in this item.

   The income left after these deductions is called net income. Go to 5.

5. If the non-SSI-related child's net income (4 above) is less than $472, the difference ($472 minus net income) is the allocation

to this non-SSI-related child. Otherwise, the allocation to this child is zero.

Note: Use $458 for months in calendar year 2023.

Repeat steps 1-5 separately for each non-SSI-related child before proceeding to step 6.

6. Add up the individual allocations to get the total allocation. Go to 7.

7. Deduct the total allocation from the parents'/stepparents' countable unearned income first. If unearned income is reduced to zero, deduct the remainder of the total allocation from the parents'/stepparents' remaining earnings.

If the parent/stepparent has no countable unearned income, deduct the total allocation from the parents'/stepparents' remaining earnings.

$20 DISREGARD

Subtract $20 from the fiscal group's remaining unearned income. Subtract $20 from the fiscal group's remaining earnings if there is no remaining unearned income.

$65 + 1/2 DISREGARD

Disregard $65 plus 1/2 of the fiscal group's remaining earnings.

GUARDIANSHIP/ CONSERVATOR EXPENSES

Deduct $83 for court-appointed guardian and/or conservator expenses paid by a fiscal group member from the remaining combined income of the fiscal group. Verification of the expense is required.

Guardianship/conservator expenses include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

ALLOWABLE WORK EXPENSES

TYPE OF EXPENSE	DEDUCTIBLE AS BWE	DEDUCTIBLE AS IRWE	AMOUNT DEDUCTIBLE
A guide dog	x	x	The cost of purchasing the dog and all associated expenses (such as its food, breast straps, licenses, veterinary services, etc.)
Fees **Examples:** • Licenses • Professional association dues • Union dues	x	X	The amount paid.
Transportation to and from work	x	x	Actual cost of bus, carpool or cab fare. Private automobile; see BAM 825 for rate.
Vehicle modifications	x	x	
Training to use an impairment-related item or an item which is reasonably attributable to work **Examples** • Cane travel • Braille • Use of special equipment • Grammar • Use of vision and sensory aids for the blind • Use of one-handed typewriter • Computer program course for a computer operator • Stenotype instruction for a typist **Note:** Training does not include general education courses.	x	x	The cost of the training plus travel expense to and from the training facility. Compute travel expenses to and from the training facility in the same manner as transportation to and from work (shown previously in this chart). **+** To be deductible as an IRWE, the training must be for an impairment-related item or service (such as a one-handed typewriter, telecommunication device for a deaf person, etc.).
Federal, State and local income taxes	**X**		The amount withheld. Assume the amount withheld reflects the individual's tax liability.
Social Security taxes	**X**		The actual amount paid on wages and self-employment income.

TYPE OF EXPENSE	DEDUCTIBLE AS BWE	DEDUCTIBLE AS IRWE	AMOUNT DEDUCTIBLE
Mandatory pension contributions	X		The actual amount of the contribution. **Note**: Mandatory pension contributions are considered reasonably attributable to earning income and, therefore, deductible. Voluntary pension contributions are considered savings plans and, as such, are life maintenance expenses and not deductible.
Meals consumed during work hours	X		The actual value of the meals.
Attendant care services which are rendered in the: • Work setting, or • Process of assisting an individual in making the trip to and from work.	X	X	
Structural modifications to the individual's home to create a work space or to allow the individual to get to and from work.	X	X	The cost of the modification.
Medical devices **Examples**: • Wheelchair • Respirator • Pacemaker • Inhalers • Braces	X	X	The cost of the items plus maintenance and repair of such items whether the individual works at home or at the employer's place of business.
Prostheses	X	X	The cost of the item plus maintenance and repair of such item.
Other work-related equipment/services **Examples:** • One-handed typewriters • Typing aids (e.g. page turning devices)	X	X	The cost of the item plus maintenance and repair of such item whether the individual works at home or at the employer's place of business.

TYPE OF EXPENSE	DEDUCTIBLE AS BWE	DEDUCTIBLE AS IRWE	AMOUNT DEDUCTIBLE
• Vision and sensory aids for the blind • Telecommunications devices for the deaf • Special tools designed to accommodate an individual's impairment • Translation of materials into braille			
Nonmedical equipment/services **Examples:** • Safety shoes • Tools used on the job • Uniforms • Child care costs • Air conditioners • Air cleaners • Humidifiers • Posture chairs • Portable room heaters	**X**	**+**	The cost of the item plus maintenance and repair of such item whether the individual works at home or at the employer's place of business. + To be deductible as an IRWE, the item or service must be impairment-related.
Drugs and medical services which are essential to enable the individual to work (e.g., medication to control epileptic seizures)	**X**	**X**	The amount paid.
Physical therapy	**X**	**X**	The amount paid.
Expendable medical supplies • Bandages • Face masks • Catheters • Incontinence pads	**X**	**X**	The amount paid.

LEGAL BASE

MA

Social Security Act, Section 1902(a)(10)
42 CFR 435.831(a)(2)

MCL 400.106

DEPARTMENT POLICY

Medicaid Only

Apply the policies in this item to all Group 2 Medicaid categories.

Use the appropriate protected income level (defined below) for each fiscal group. Include other need items **only** when the fiscal group meets the requirements for them. Determine the fiscal group's total needs. Refer to BEM 545 to complete the income eligibility determination.

PROTECTED INCOME LEVEL

The protected income level (PIL) is a set allowance for non-medical need items such as shelter, food and incidental expenses.

RFT 240 lists the Group 2 MA PILs based on shelter area and fiscal group size.

RFT 200 lists the counties in each shelter area.

For **past months**, use the shelter area for the county the fiscal group lived in on the last day of the month tested. For **all other months**, use the shelter area for the county the fiscal group lives in on the processing date.

HEALTH INSURANCE PREMIUMS

Count as a need item the cost of any health insurance premiums (including vision and dental insurance) and Medicare premiums paid by the **medical group** (defined in **"EXHIBIT I"**) regardless of who the coverage is for.

Example: Medical group of five pays health insurance premiums for six (themselves and another person **not** in the medical group). Allow health insurance premiums for six.

- Do **not** include premiums paid by the employer or any other non-medical group source.
- Include Medicare premiums paid by the medical group that may later be reimbursed by the Buy-In program (See BAM 810).

- Convert premiums paid other than monthly to a monthly cost.

REMEDIAL SERVICES

Remedial services produce the maximum:

- Reduction of physical and mental limitations, and
- Restoration of an individual to his best possible functional level.

Note: Remedial services do not include personal care services. (BEM 545, "**EXHIBIT ID**", explains personal care services.)

At a minimum, remedial services include basic self-care and rehabilitation training which teach and reinforce the following skills:

- Dressing.
- Grooming.
- Eating.
- Bathing.
- Toileting.
- Following simple instructions.

Always count the cost of remedial services when you determine eligibility for a person in an adult foster care (AFC) home. However, only count the cost for a person in a home for the aged (HA) when you verify the person receives remedial services.

For **past months**, the person must have been in the AFC home or HA on the last day of the month tested. For **all other months**, the person must be in the AFC home or HA on the processing date.

RFT 241 lists remedial services allowances by shelter area, type of home and, for AFCs, by type of care received.

VERIFICATION REQUIREMENTS

Verify the cost of health insurance and Medicare premiums before allowing them as a need item at application, redetermination or change. Individuals must report and verify premium increases or decreases before changing the allowance.

For beneficiaries in an HA, verify the receipt of remedial services before allowing the cost as a need item and at annual renewal.

Compute eligibility without an allowance for these items if the beneficiary refuses to verify them.

Verification Sources

Health Insurance Premiums

- Insurance policy.
- Receipt or bill for premium.
- Contact with insurer.

Medicare Premiums

- BENDEX.
- Notice from Social Security Administration.

Remedial Services

- Contact with the home operator.

EXHIBIT 1 - MEDICAL GROUPS

A medical group consists of persons whose medical needs and costs may be considered when determining eligibility. See the **"DEFINITIONS"** and **"LIVING WITH"** sections in BEM 211 when identifying the composition of a medical group.

In an L/H or waiver month, the L/H or waiver client is a medical group of **one**. L/H month, waiver month and L/H client are defined in the Bridges Policy Glossary (BPG). See BEM 106 for definition of waiver client.

MAGI-Related Categories

The medical group for MAGI-related categories is the fiscal group.

SSI-Related Children

An SSI-related child's medical group includes the child and the following persons who live with the child:

- The child's parents, **and**
- Medical group members' children.

SSI-Related Adults

An SSI-related adult's medical group includes:

- Fiscal group members, **and**
- Fiscal group members' children and stepchildren.

LEGAL BASE

MA

42 CFR 435.811, .814, .831(c)(i), .1007
MCL 400.106, .107

DEPARTMENT POLICY

Medicaid (MA) Only

This item completes the Group 2 MA income eligibility process.

Income eligibility exists for the calendar month tested when:

- There is no excess income.
- Allowable medical expenses (defined in **EXHIBIT I**) equal or exceed the excess income.

When **one** of the following equals or exceeds the group's excess income for the month tested, income eligibility exists **for the entire month**:

- Old bills (defined in EXHIBIT IB).
- Personal care services in client's home, (defined in Exhibit ID), Adult Foster Care (AFC), or Home for the Aged (HA) (defined in EXHIBIT ID).
- Hospitalization (defined in EXHIBIT IC).
- Long-term care (defined in EXHIBIT IC).

When **one** of the above does **not** equal or exceed the group's excess income for the month tested, income eligibility begins either:

- **The exact day of the month** the allowable expenses **exceed** the excess income.
- **The day after the day of the month** the allowable expenses **equal** the excess income.

In addition to income eligibility, the fiscal group must meet all other financial eligibility factors for the category processed. However, eligibility for MA coverage exists only for qualified fiscal group members. A qualified fiscal group member is an individual who meets all the nonfinancial eligibility factors for the category processed.

Group 2 for Pregnant Women

The deductible for a pregnant woman is usually met at the first office visit because the woman incurs the full cost of obstetric (OB) services (including labor and delivery) at their first OB visit. The

total cost of the OB services must be equal to or greater than the amount of the deductible in order to open. She is Medicaid eligible for the remainder of the pregnancy and twelve months post-partum.

RULES FOR MA GROUP 2 INCOME ELIGIBILITY

Use the following rules to determine MA Group 2 income eligibility.

The individual must be given the most advantageous use of their old bills (also known as incurred expenses). The individual may request coverage for the current month, up to six future months (see eligibility based on old bills in this item), and for any prior months.

1. Use the budgeting rules in BEM 530. Determine income eligibility in calendar month order, starting with the oldest calendar month.
2. Use BEM 546 to determine the post-eligibility patient-pay amount (PPA) for each L/H month that a beneficiary is Group 2 eligible.
3. Determine Medicare Savings Program eligibility separately for Group 2 beneficiaries entitled to Medicare Part A (see BEM 165).
4. Request information about **all** medical expenses incurred during and prior to each month with excess income.
5. Notify the group of the outcome of each determination. **NOTIFICATION** explains which forms to use and when.

MONTHS WITHOUT EXCESS INCOME

Income eligibility exists for the entire month tested when the group does **not** have excess income.

For **L/H months,** also go to BEM 546 to determine the post-eligibility PPA.

MONTHS WITH EXCESS INCOME

Income eligibility exists for all or part of the month tested when the **medical group's** (defined in BEM 544, **EXHIBIT I**) allowable medical expenses (BEM 545, EXHIBIT I) equal or exceed the fiscal group's excess income. The **NON-L/H** and **L/H** sections that follow list the exact order in which to subtract specific types of these allowable expenses.

NON-L/H PAST AND PROCESSING MONTHS

Use these instructions to determine Group 2 income eligibility for each non-L/H past and processing month with excess income.

Old Bills

1. Compare the **medical group's** allowable old bills (defined in EXHIBIT IB) to the excess income.

   - If there are no old bills, go to 2.
   - If there are old bills and they total **less** than the excess income, subtract the old bills to get the remaining excess income. Go to 3.
   - If the old bills **equal** or **exceed** the excess income, subtract the excess income from the allowable old bills to get the **unused old bills**.

     Income eligibility exists for the entire month tested, **and**:

     - If this is a **past** month, stop.
     - If this is the **processing** month, go to NON-L/H FUTURE MONTH.

Personal Care Services

2. If a group member is/was receiving personal care services in his/her home, AFC, or HA does income eligibility exist based on “EXHIBIT ID"?

   - If **no**, go to 3.
   - If **yes**, income eligibility exists for the entire month.

- If this is a **past** month, stop.
- If this is the **processing** month, income eligibility may be ongoing **unless** you project a change(s); see Exhibit II.
- If you project a change, go to NON-L/H FUTURE MONTH.

LTC Expenses

3. Determine each qualified fiscal group member's LTC (or hospice care in LTC) expenses for the month.

   - If expenses incurred by **one qualified fiscal group member equal or exceed** the excess income, income eligibility exists for the entire month. If expenses incurred by **one qualified fiscal group member** are **less** than the excess income, go to 4.

Inpatient Hospital

4. Determine each qualified fiscal group member's allowable hospital expenses for the month.

   - If expenses incurred by **one qualified fiscal group member** for one admission **equal or exceed** the excess income, income eligibility exists for the entire month.
   - If expenses incurred by **one qualified fiscal group member** for one admission are **less** than the excess income, go to 5.

All Medical Expenses

5. Determine the medical group's allowable medical expenses for the month.

   - If **less** than the remaining excess income, income eligibility does not exist for this month.
     - If this is a **past** month, stop.
     - If this is the **processing** month, the group has or continues to have a deductible. Go to “deductible.”
   - If **equal to or more** than the remaining excess income, income eligibility exists starting on:

- The **day after the day the expenses equaled** the excess income.
- The **exact day the expenses exceeded** the excess income. However, MA may only be billed for the amount that exceeds the group's liability; go to *identifying a group's liability* in this item.

IDENTIFYING A GROUP'S LIABILITY

Use these instructions to determine a fiscal group's liability for all or part of a medical expense incurred on the first day of MA coverage. A fiscal group is not responsible for liabilities of less than $1.00.

1. Identify a group's liability on the date allowable medical expenses exceeded its excess income as follows:

   - The group's excess income for the month tested.
   - **MINUS** allowable medical expenses for the month tested through the day before the date MA coverage begins.
   - **EQUALS** the group's liability.

   If the group's liability is less than $1.00, stop. If it is $1.00 or more, go to 2.

2. Total the group's non-qualified expenses (defined below) incurred on the date expenses exceeded the excess income.

   A **non-qualified expense** is an allowable expense used to meet a deductible but not billable to MA. Such expenses include those incurred:

   - For services not covered by MA.
   - By fiscal or medical group members who are not eligible for MA coverage for this date.

   Go to 3.

3. Subtract the group's total non-qualified expenses from the **group's liability**. Is the remainder less than $1.00?

   If **yes**, stop.
   If **no**, the remainder is the **group's liability balance**. Go to 4.

4. Arrange the rest of the expenses incurred on the date expenses exceeded excess income as follows:

   a. Largest to smallest paid expenses.
   b. Largest to smallest unpaid expenses.

   Go to 5.

5. Subtract the first (next) expense in the order arranged in step 4 above from the group's liability balance. Is there a remainder?

   - If **no**, enter the **group's liability balance** on the DHS-114 as the client payment for this expense. Stop.
   - If **yes**, enter the entire amount of this expense on the DHS-114 as the client payment. The remainder becomes the group's liability balance. Go to 6.

6. Is the group's liability balance less than $1.00?

   - If **yes**, stop.
   - If **no**, repeat step 5.

NON-L/H FUTURE MONTH

Use these instructions to determine ongoing income eligibility for non-L/H months with excess income.

Old Bills

1. Compare the **medical group's** allowable old bills (**EXHIBIT IB**) to the excess income.

   - If there are no old bills, go to 2.
   - If there are old bills and they total **less** than the excess income, the group has or continues to have a deductible. Go to deductible. If the old bills **equal or exceed** the excess income, go to *eligibility based on old bills* in this item to determine whether one or more future month(s) of income eligibility exists.

Personal Care Services

2. If a group member is receiving personal care services (Exhibit ID) in their home, AFC, or HA, does income eligibility exist based on “EXHIBIT II”?

- If **no**, the group has or continues to have a deductible. Go to deductible.
- If **yes**, income eligibility exists for the entire month and continues.

L/H PAST AND PROCESSING MONTHS

See BRG for the definitions of **L/H patient** and **L/H month**.

For L/H months, the L/H patient is the **only** medical group member. Use only his medical expenses to establish income eligibility. Do not recalculate a PPA for the month of death.

Use these instructions to determine Group 2 income eligibility for each L/H past and processing month with excess income.

LTC and Hospital Expenses

1. Determine the beneficiary's allowable LTC and hospital expenses for the month.
   - If **less** than his excess income, go to 2.
   - If **equal to or more than** his excess income, income eligibility exists for the entire month; go to *post eligibility* in this item.

Old Bills

2. Compare the beneficiary's allowable old bills (see EXHIBIT IB) to the excess income.
   - If they are **less** than his excess income, subtract the old bills to get the remaining excess income. Go to 3.
   - If the beneficiary's allowable old bills **equal or exceed** the excess income, income eligibility exists for the entire month; go to *post eligibility* in this item.

All Medical Expenses

3. Determine the beneficiary's allowable medical expenses for the month.

- If **less** than the remaining excess income, income eligibility does not exist for the month.

  - If this is a **past** month, stop.
  - If this is the **processing** month, this client has or continues to have a deductible; go to Deductible in this item. If **equal to or more** than the remaining excess income, income eligibility exists for the entire month. Go to *post eligibility* in this item.

L/H FUTURE MONTH

Use these instructions to determine ongoing income eligibility for L/H patients with excess income.

LTC Expenses

1. Determine the L/H patient's allowable LTC expenses for the month.

   - If **less** than his excess income, go to 2.
   - If **equal to or more** than his excess income, income eligibility exists for the entire month; go to *post eligibility* in this item.

Old Bills

2. Compare the L/H patient's allowable old bills to his excess income.

   - If the old bills are **less** than his excess income, he has or continues to have a deductible; go to **Deductible in this item.** If the beneficiary's old bills **equal** his excess income, income eligibility exists for the entire month.

     If his old bills **exceed** his excess income, income eligibility may exist for more than one month; go to *eligibility based on old bills* in this item.

     Also, go to *post eligibility* in this item to determine the post-eligibility PPA.

POST-ELIGIBILITY

You determined the L/H patient is income eligible for the entire month.

You now must calculate the amount of the beneficiary's liability to the hospital or LTC provider by completing a separate

determination. The result of this second determination is called the **post-eligibility patient-pay amount (PPA).**

Go to BEM 546 to determine the post-eligibility PPA, then:

1. Authorize MA coverage:
   - for the month tested if this is a past month or the processing month, **or**
   - on an ongoing basis if this is a future month.
2. If this is a **past month**, stop.

   If this is the **processing month**, determine continued income eligibility as follows:
   - If the client is still in a hospital or LTC facility on the processing date, go to *L/H future month*.
   - If not, go to *non-L/H future month*.

   If this is a **future month**, and the client was income eligible based on old bills, go to *eligibility based on old bills*.

ELIGIBILITY BASED ON OLD BILLS

A group with excess income can delay deductible for one or more future months based on allowable old bills; see EXHIBIT IB in this item.

Determining the Number of Months to Delay Deductible

1. Do the total old bills equal or exceed the group's excess income?
   - If **yes**, go to 2.
   - If **no**, go to 5.
2. Divide the total old bills by the group's excess income. Drop any fractions. The result equals the number of months the group may delay deductible.
   - If the result is more than one month, go to 3.

- If not, authorize MA for the future month. Go to 5.

3. Authorize MA for the additional months, but not more than a total of six future months. Go to 4.

4. Set a follow-up for whichever is **earliest**:

   - The fifth future month, **or**
   - The month before the last month of MA coverage. Go to 5.

5. Transfer the case to active deductible effective the month following the last month the group's old bills exceeded its excess income.

   Go to Deductible in this item.

Old Bills Follow-up

At follow-up:

- Re-verify the group's liability for old bills, if any.
- Authorize up to six additional months of MA if the group is eligible.
- Notify the group of:
  - Additional MA coverage, or
  - Transfer to active deductible (see step 5 above).

DEDUCTIBLE

Deductible is a process which allows a client with excess income to become eligible for Group 2 MA if sufficient allowable medical expenses are incurred.

Active Deductible

Open an MA case **without ongoing Group 2 MA coverage** on Bridges as long as:

- The fiscal group has excess income, **and**
- At least one fiscal group member meets all other Group 2 MA eligibility factors.

Such cases are called active deductible cases. Periods of MA coverage are added each time the group meets its deductible.

Deductible Period

Each calendar month is a separate deductible period.

Starting the First Deductible Period

The first deductible period:

- Cannot be earlier than the processing month for applicants.
- Is the month following the month for which MA coverage is authorized for recipients.

Deductible Amount

The fiscal group's monthly excess income is called a deductible amount.

Meeting a Deductible

Meeting a deductible means reporting and verifying allowable medical expenses (defined in “EXHIBIT I) that equal or exceed the deductible amount for the calendar month tested.

Use the NON-L/H PAST AND PROCESSING MONTHS section for non-L/H months and the L/H PAST AND PROCESSING MONTHS section for L/H months to determine both:

- The order in which to deduct expenses.
- When to identify a group's liability.

IDENTIFYING A GROUP'S LIABILITY explains how to determine the group's share of its expense(s) on the first day of MA coverage.

Example: The client incurs a medical expense in January 2016. The expense was **reported** and verification turned in to DHHS in August 2016.

- As the expense was reported later than the last day of the third month (April 30, 2016) after the expense, it cannot be used for January 2016.

- The expense can be used as an old bill.

    - When eligibility determination is done in August 2016 the old bill (Jan 2016 expense) can be used for May 2016, June 2016, July 2016, August 2016 or future months. To

allow the client to choose the most advantageous month(s) in which they want to use the old bill, enter the "Apply to Deductible Determination From/To Dates" Most Advantageous does not mean they can turn in an expense at any time and eligibility can be determined for the month the expense was incurred. If the client had **reported** the January 2016 expense between January 1 and April 30th 2016 but had not verified, then the expense can be used for the January 2016 expense when the verifications are received. It is important for the specialist to **document** when the client reports an expense even if the client does not yet have the bill to verify the expense. The expense does not need to be verified before using as an expense.

Example: The client applies for Health Care Coverage in January 2016. Determination of eligibility is not completed until August 2016 and results in the determination of a deductible case for January 2016 ongoing. The client has until the last day of the third month (that is November 2016) following the notification that they client has a deductible case (notice sent August 2016) to report the expense.

Remember: to use an old bill the group/individual's current liability for the expense must be verified by the specialist.

Adding MA Coverage

Add periods of MA coverage each time the group meets its deductible; see INSTRUCTIONS for details.

Renewal

Renew eligibility for active deductible cases at least every 12 months regardless of whether a group has met its deductible.

Processing Changes

The group must report changes in circumstances within 10 days. Redetermine the group's eligibility when a change that may affect eligibility is reported.

Apply changes for the corresponding period as follows if MA coverage has been authorized:

Reductions in MA Coverage

A **reduction** in MA coverage means:

- Higher hospital or LTC patient-pay amount.
- Transfer from MA coverage to active deductible.
- Later MA eligibility begin date.

Do not reduce MA coverage already authorized on Bridges for the processing month or any past month.

Increases in MA Coverage

An **increase** in MA coverage means**:**

- Lower hospital or LTC patient-pay amount.
- Transfer to ongoing MA coverage from active deductible.

Increase MA coverage for any month(s) with coverage already authorized on Bridges.

- Start increased coverage the calendar month the change occurred, if reported within 10 days.

- Start increased coverage the calendar month the change was reported, if not reported within 10 days.

Expenses Reported After Coverage Authorized

A group may report additional expenses that were incurred prior to the MA eligibility begin date you calculated for that month.

Do not alter the MA eligibility begin date if you have already authorized coverage on Bridges. However, any expenses the group reports that were incurred from the first of such a month through the day before the MA eligibility begin date might be countable as old bills.

See EXHIBIT IB and EXAMPLE 7 in EXHIBIT IV.

Closures

Close an active deductible case when **any** of the following occur:

- No one in the group meets **all** nonfinancial eligibility factors.
- Countable assets exceed the asset limit.
- The group fails to provide needed information or verification.

Exception: Do not close the case just because the group fails to verify sufficient allowable medical expenses to meet its deductible.

- The group does not return the redetermination form.
- You cannot locate any of the group members.

Use **adequate notice** to close the case.

NOTIFICATION

This section contains a list of the form(s) you need to notify groups about MA Group 2 eligibility determinations and tells you when to send them.

Send the group a DHS-1606, Health Care Coverage Notice when you:

- Approve or deny MA.
- Add periods of MA coverage to an active deductible case.
- Transfer an active deductible case to ongoing MA coverage.

DHS-114, Deductible Notice

Use a DHS-114 or its Bridges equivalent to notify the group of:

- The start of or transfer to active deductible.
- A change in its deductible amount.
- The begin and end date(s) of MA coverage, when added.
- Its share of the expenses incurred on the date it meets its deductible.
- The names of all providers notified to collect payment from the group for all or part of an expense used to meet deductible.

When a group is liable for all or part of any expense(s) incurred on the first day of MA coverage, send a copy of the DHS-114 (or Bridges equivalent) to **each** provider(s) who must collect all or part of an expense from the group.

DHS-114A, Deductible Report

Send a DHS-114A to the group with every Deductible Notice. At their option, groups may use the DHS-114A to report:

- Incurred medical expenses.
- Changes in circumstances.

MSA-Pub. 617, Medicaid Deductible Information

Give the group a MSA-Pub. 617 or send one with the deductible notice when an active deductible starts and at each redetermination.

VERIFICATION REQUIREMENTS

Verify the following **before** using an allowable medical expense to determine eligibility:

- Date expense incurred.
- Amount of expense.
- Current liability for an old bill.
- Receipt of personal care services provided in a home, an adult foster care home, or home for the aged; see EXHIBIT ID or Exhibit II if verifying ongoing eligibility.

Verify both of the following when you authorize MA based on a personal care co-payment:

- Amount DHHS has authorized for personal care services.
- Amount required but not covered by DHHS payment.

See EXHIBIT II in this item.

Note: Verify continuing residence in a long-term care facility / AFC home at application and redetermination as verification of allowable medical expenses when determining on-going eligibility.

Verification Sources

Sources to verify an incurred expense include:

- Bill from medical provider.
- Receipt from medical provider.
- Contact with medical provider or the provider's billing service.

Sources to verify current liability for an old bill include:

- Current billing or statement from provider.
- Contact with medical provider or provider's billing service.

EXHIBIT I - MEDICAL EXPENSES

A **medical expense** must be incurred for a medical service listed below. Except for some transportation, the actual charge(s) minus liable third-party resource payments counts as an allowable expense. However, not all sources of payment are considered liable third-party resources; see THIRD PARTY RESOURCES, EXHIBIT IA.

Note: A charge cannot be incurred until the service is provided.

You will need additional information to calculate the costs of some medical services. Such information is detailed in separate exhibits. You will be referred to the necessary exhibit where these services are listed.

Count allowable expenses incurred during the month you are determining eligibility for, whether paid or unpaid. You may also count certain **unpaid** expenses from prior months that have not been used to establish MA eligibility; see OLD BILLS, EXHIBIT IB.

Medical Services

Medical services include the following:

- Cost of a diabetes patient education program.
- Service animal (such as a guide dog) or service animal maintenance. In Michigan the animal must be fully trained and cannot be for emotional support, companionship, therapy for others, or crime deterrence.
- Personal cares services in home, AFC, or HA; see EXHIBIT ID.
- Transportation* for any medical reason.
- Medical service(s) provided by any of the following:

- Anesthetist.
- Certified nurse-midwife.
- Chiropractor.
- Christian Science practitioner, nurse or sanatorium.
- Clubhouse psychosocial rehabilitation programs.
- Dentist.
- Family planning clinic.
- Hearing aid dealer.
- Hearing and speech center.
- Home health agency.
- Hospice; see EXHIBIT III.
- Hospital; see EXHIBIT IC.
- Laboratory.
- Long-term care facility; see EXHIBIT IC.
- Maternal support services provider.
- Medical clinic.
- Medical supplier. **
- Mental health clinic.
- Nurse.
- Occupational therapist.
- Ophthalmologist.
- Optometrist.
- Oral surgeon. Orthodontist.
- Pharmacist. ***
- Physical therapist.
- Physician (MD or DO).
- Podiatrist.
- Psychiatric hospital; see EXHIBIT IC.
- Psychiatrist.
- Psychologist.
- Radiologist.
- Speech therapist.
- Substance abuse treatment services provider.
- Visiting nurse.

* Includes ambulance at actual cost and other transportation for medical services at the rates in BAM 825. Includes clients driving themselves for episodic and pharmacy trips at the rate they are paid in BAM 825 for chronic ongoing trips.

** Includes purchase, repair and rental of supplies, such as:

- Prosthetic devices.
- Orthopedic shoes.
- Wheelchairs.

- Walkers.
- Crutches.
- Equipment to administer oxygen.
- Personal response system (for example Lifeline Emergency Services).

*** Includes:

- Legend drugs (that is, can only obtained by prescription).
- Aspirin, ibuprofen and acetaminophen drug products which are prescribed by a doctor and dispensed by a pharmacy.
- Non-legend drugs and supplies, such as:
  - Insulin.
  - Needles.
  - Syringes.
  - Drugs for the treatment of renal (kidney) diseases.
  - Family planning drugs and supplies.
  - Ostomy supplies.
  - Oxygen.
  - Surgical supplies.
  - Nicotine patches and gum.
  - Incontinence supplies.

It does not include medicine chest and first aid supplies, such as:

- Band-Aids.
- Alcohol.
- Cotton swabs.
- Nonprescription cold remedies.
- Ointments.
- Thermometers.

EXHIBIT IA - THIRD PARTY RESOURCES

Third party resource payments are payments from any liable third party for medical care. They include payments Medicare, other health insurers or any liable third party made or will make.

Payments made by any third party cannot be included as part of the beneficiary's medical expense for **any** of the medical service(s) listed in EXHIBIT I. Therefore, you must try to find out if any liable third-party resource payment has been, or will be made to

determine a beneficiary's costs. Count **only** the beneficiary's cost as a medical expense. However, do not delay the eligibility determination just because third party payment information is not readily available.

Exceptions: Payments made by the following are not third-party resource payments:

- Indian health service.
- Payments made by a state- or locally-funded government program are not third-party resource payments. State- and locally-funded government programs include those administered by:
  - County health departments.
  - Community Mental Health.
  - State and county DHHS.

  Any program that receives federal funds is not a state- or locally-funded program.

Such payments can be used to meet the beneficiary's deductible as follows:

- Count the entire expense for the month during which the service was provided.

- Count **only** the portion of the expense the client must actually pay when using an expense as an old bill; see EXHIBIT IB.

Example: Community Mental Health (CMH) provides $300 in services to a client in February 2016. CMH determines the beneficiary's ability to pay is $30. Therefore, CMH will not attempt to collect more than $30 from the client for February's services.

The client applies for MA on May 31, 2016, and requests MA for February, March and April.

This medical expense could be counted in one of two ways:

A. **The month being tested is February.**

Count the entire expense ($300) for February.

B. **The month being tested is March or April or May.**

The client was not eligible for February and verifies:

- His February CMH bill is unpaid, and

- He is still liable for the $30 for February.

  Count the $30 the client is still liable for as an old bill; see **EXHIBIT IB** in this item.

Note: All services and supports provided by a CMH program, including case management services, are considered medically necessary and all charges for these services should be applied fully to the beneficiary's monthly deductible obligation.

EXHIBIT IB - OLD BILLS

Medical expenses listed under **Medical Services** in EXHIBIT I can be used as **old bills** if they meet **all** of the following criteria:

- The expense was incurred in a month prior to the month being tested.
- During the month being tested:
  - The expense is/was still unpaid, **and**
  - Liability for the expense still exists (existed).
- A third-party resource is **not** expected to pay the expense.
- The expense was **not** previously used to establish MA income eligibility.
- The expense was one of the following:
  - Incurred on a date the person had no MA coverage.
  - **Not** an MA covered service.
  - Provided by a non-MA enrolled provider.
- A member of the medical group incurred the expense. This includes expenses incurred by a deceased person if both:
  - The person was a medical group member's spouse or unmarried child under 18.
  - The medical group member is liable for the expense.

Note: An expense which has been turned over for collection is still a medical expense until the provider has written off the expense.

You must give groups that have excess income the opportunity to verify old bills before you start an active deductible case.

Use old bills in chronological order by date of service.

EXHIBIT IC - HOSPITAL AND LONG-TERM CARE EXPENSES

A person cannot incur hospital care or long-term care expenses until he is actually admitted to the facility.

A person may receive **hospice** care in a hospital or long-term care facility. Do not consider the expense of such care a hospital or long-term care expense; see EXHIBIT III, HOSPICE CARE, in this item.

Hospital Care

Calculate the expense of inpatient hospital care or inpatient care in a private psychiatric facility as follows:

Actual charge for inpatient care
- Liable third-party resource payments*

= Countable expense of hospital care

Long-term Care

Calculate the expense of long-term care as follows:

LTC facility's charge at the private rate
- Liable third-party resource payments*

= Countable expense of long-term care

Medicare Part A may cover up to 100 days of care per episode of illness. If so, the first 20 days the Medicare beneficiary's LTC expenses are zero, because there is no coinsurance. Beneficiaries must pay coinsurance for days 21 through 100.

*Liable third-party resource payments are explained in EXHIBIT 1A.

EXHIBIT ID - PERSONAL CARE SERVICES

Allowable medical expenses (EXHIBIT I) include amounts the medical group **incurs** for personal care services in their home or AFC, or Home for the Aged. Clients may receive personal care services

while living in their own home, an adult foster care (AFC) home or a home for the aged (HA).

Personal care expenses in their home, AFC or HA are incurred monthly regardless of when services are paid for.

In addition, the client may be liable for the employer's portion of FICA taxes. This FICA liability is an allowable medical expense. If the client claims this expense, use the current percentage for the employer's portion of the FICA tax on the incurred cost rather than the actual FICA payment. The services specialist has information about the current percentage for the employer's portion of the FICA tax.

Allowable Services

Personal care services in their home, AFC or HA must be services related to activities of daily living. Activities of daily living include:

- Eating/Feeding.
- Toileting.
- Bathing.
- Dressing.
- Transferring.
- Grooming.
- Ambulation.
- Taking medication.

Household services provided in the beneficiary's home must be services essential to the ill person's health and comfort. Such services include:

- Personal laundry.
- Meal preparation/planning.
- Shopping/errands.
- Light housecleaning.

Excluded Services

The following services are **not** allowable as personal care:

- Heavy housecleaning.
- Household repairs.
- Yard work.

The following services are **not** allowable as personal care for clients residing in an AFC or HA:

- Room.
- Board.
- Supervision.
- Household services.
- Remedial services; see BEM 544.

Personal Care Services in Beneficiary's Home, AFC, or HA

The personal care services provider **cannot** be a responsible relative of the person requiring care if the client lives in his own home. Responsible relative means:

- A person’s spouse.
- The parent of an unmarried child under age 18.

A physician (MD or DO) must verify the need for personal care services in their home, AFC, or HA and the estimated duration of need. At the end of the estimated duration of need, a physician must verify continued need.

If available, use the verifications obtained by Adult Services for the Home Help eligibility determination or the Adult Community Placement (ACP).

Verifications

The personal care services provider must verify all of the following:

- Date the service was provided.
- The charge for that day for the services provided.
- That the services rendered are services related to activities of daily living.
- That household services rendered in the beneficiary's home are services essential to the ill person's health and comfort. See Exhibit ID.

EXHIBIT II - MA ELIGIBILITY AND PERSONAL CARE

Beneficiary's with excess income who are receiving personal care Home Help Services in their home, AFC, or HA may be eligible for

ongoing MA coverage. MA coverage can be authorized or continued at the beneficiary's option provided all conditions in this Exhibit are met.

The beneficiary's option to pay a portion of his personal care cost works much the same as paying a patient-pay amount to a hospital or long-term care facility. When a client chooses this option, his services specialist subtracts his excess income from the MDHHS payment for personal care services. The client is then responsible for paying his excess income amount directly to his personal care provider. This ensures MA does not pay the beneficiary's liability.

Discuss this policy option with the client. Advise the client that he will be responsible for paying his excess income to his Home Help Services personal care provider, AFC provider, or HA provider. This cost may include the employer's portion of FICA taxes. The services specialist has information about what portion of the beneficiary's excess income is for the provider and what portion, if any, is for FICA taxes.

Sometimes personal care costs exceed the maximum amount services will pay. In such cases the client is responsible for the amount services will not pay. If the client chooses the policy option described in this Exhibit, he will be responsible for the amount services will not pay in addition to his excess income. Under these circumstances, this option may not be advantageous to the client.

Conditions of Eligibility

1. The client must meet all nonfinancial eligibility factors and all financial eligibility factors **except** income.

2. The client must have an active Adult Services case with Home Help or ACP services **and** be receiving personal care services in his home, AFC, or HA. Consider the services case active as soon as the services specialist begins to work with the client.

   The services specialist is responsible for obtaining verification of the need for personal care services and making the ACP or Home Help eligibility determination.

3. The amount DHHS has or will approve for personal care services must exceed the beneficiary's excess income. Contact the services specialist for the following information:

- The amount DHHS has or will approve for personal care services.
- The amount of personal care services required but not approved by MDHHS (ACP determines the need for personal care, AFC determines the cost for the personal care).

4. The beneficiary must agree to pay his excess income to his provider.

If **all** of the above conditions exist, income eligibility begins the month DHHS reduces or will reduce its payment for personal care services by the amount of the beneficiary's excess income. The beneficiary's excess income becomes his **personal care co-payment.**

Within two working days of determining the client is eligible under this option, notify the services specialist in writing of the MA effective date and the amount of the beneficiary's personal care co-payment.

Income eligibility does not exist if **any** of the above conditions are not met. Return to the procedure that sent you to this Exhibit.

Changes in Circumstances

MA eligibility cannot continue based on this policy option if the beneficiary's circumstances change for reasons including, but not limited to, the following:

- The beneficiary no longer needs personal care services in their home, AFC, or HA.
- The cost of personal care no longer exceeds his excess income.
- The beneficiary enters LTC.

Notify the services specialist in writing **within two working days** when a change(s) in the beneficiary's circumstances changes the amount of his personal care co-payment. Send a memo to the services specialist for SSI-related cases.

If the personal care co-payment **decreases**, use adequate notice. The begin date for the lower personal care co-payment is the first day of the month in which you make the determination.

If the personal care co-payment **increases**, use timely notice (see BAM 220). The begin date for the higher personal care co-payment is the first day of the month following the month in which the negative action period ends.

Do not close a case eligible under this option because the beneficiary does not pay the provider. MA funds will not be used to pay the beneficiary's liability because the beneficiary retains responsibility for that portion of his incurred expenses. The issue of payment of these expenses remains between the individual, services and the personal care services provider.

EXHIBIT III - HOSPICE CARE

A terminally ill person may receive hospice care. Hospice organizations provide or arrange for all care related to the person's terminal illness. Hospice organizations do not provide or arrange other medical services (such as dental care).

A person is eligible for hospice care under MA when all of the following are true: He knows of the illness and his life expectancy. He chooses to receive hospice services. A doctor (MD or DO) certifies he has six months or less to live.

The hospice notifies the Michigan Department of Health and Human Services (MDHHS) when an MA beneficiary enrolls. MDHHS authorizes the appropriate PET code on Bridges.

Hospice Services

Hospice services fall under five categories:

1. **Routine home care** - Non-continuous at-home care.

2. **Continuous home care** - Predominantly nursing care provided at home as short-term crisis care. May also include home health aide or homemaker services.

3. **Inpatient respite care** - Short-term inpatient care for the terminally ill individual to give the at-home caregiver relief. Inpatient respite care is usually five continuous days or less in

a hospital, nursing facility, intermediate care facility or freestanding hospice facility.

4. **General inpatient care** - Usually for pain control or acute or chronic symptom management. May be provided in a hospital, nursing facility or freestanding hospice facility.

5. **Routine at-home care in a nursing facility** - Individuals who do not have a home or family member or friend who can care for them may stay in a nursing facility and receive routine home care from the hospice.

EXHIBIT IV - MA GROUP 2 CASE EXAMPLES

EXAMPLE 1

Deductible Delayed with Old Bills

10/15/16 - Mr. B. applies for MA. He also requests MA coverage for July, August and September 2016.

Mr. B. verifies an old bill for $315.00.

11/22/16 - Process Mr. B's application and determine the excess income is $30.00.

Mr. B. is eligible for MA coverage for 10 months based on old bills. You set a follow-up for 3/17.

After the MDHHS-176 Deadline Date you send Mr. B. a MDHHS-176, DHS-114, DHS-114A and MSA-Pub. 617 to notify him his case will have a $30.00 monthly deductible effective 5/1/17.

4/1/17 - Any day on or before the MDHHS-176 Deadline Date, transfer Mr. B's case to active deductible:

EXAMPLE 2

Deductible Met with Old Bill Balance and Current Bills

5/3/16 - Mr. B. contacts you, indicating he has met his $30.00 deductible for May 2016. He drops off copies of a prescription charge for $14.71 for 5/2/16 and a doctor's office visit on 5/3/16 for $25.00. You also verify he still owes the $315.00 old bill he reported at application. $300.00 of the old bill was used to establish 10 months of initial income eligibility, leaving a $15.00 balance.

5/10/16:

- Allow the $15.00 unused old bill, $14.71 prescription and $25.00 office call.
- Calculate a new budget.
- Determine Mr. B. met his deductible on 5/3/16.

Authorize MA coverage:

Send Mr. B. a DHS-1606, DHS114 and DHS-114A. The DHS-114 notifies Mr. B. that:

- He has MA coverage for 5/3/16 - 5/31/16, and
- His monthly deductible is $30.00.

Mr. B.'s liability for 5/3/16 is less than $1.00. Therefore, Mr. B. doesn't have to pay it.

EXAMPLE 3

Deductible Met With Incurred Expenses

7/8/16 - Ms. J. submits a DHS-114A and attaches the following verification:

- Office call 7/2/16 - $35.00.
- X-rays 7/316 - $60.00.
- Prescriptions 7/5/16 - $34.93.

Ms. J.'s monthly deductible amount is $115.00.

7/12/16 - Calculate a budget on Bridges. The beneficiary is liable for $20.00 for 7/5/16.

Send the beneficiary a DHS-114 and a DHS-114A. The DHS-114 indicates Ms. J. is eligible for MA coverage for 7/5/16 through 7/31/16 but is responsible for $20.00 to the pharmacist for services rendered 7/5/16.

Send the pharmacist a copy of the notice to verify the beneficiary's $20.00 liability for services rendered 7/5/16.

Authorize MA:

EXAMPLE 4

Ongoing MA to Active Deductible

Mrs. N. has received MA coverage for five years.

10/8/16 - Mrs. N. reports additional continuing income that results in excess income of $43.00 per month.

10/11/16 - Request incurred medical expense information. Mrs. N. states that she has no old bills.

10/12/16 - Start timely negative action procedures to transfer the case from ongoing Group 2 MA to active deductible, effective 11/1/16.

Send the beneficiary a DHS-114, DHS-114A and MSA-Pub. 617. The DHS-114 informs Mrs. N. that her case is being transferred to active deductible effective 11/1/16, with a deductible amount of $43.00 per month.

EXAMPLE 5

Excess Assets

2/4/16 - Mr. M. has an active deductible case. His monthly deductible amount is $456.00. He reports $95,000 from the sale of his apartment building (previously excluded as income-producing property).

2/7/16 -Send Mr. M. adequate notice (DHS-417, Excess Assets Notice) and close the case based on excess assets.

EXAMPLE 6

Deductible Not Met in Three Months

Jodi H. has an active deductible case. Her annual renewal is due 1/17.

12/6/16 - Jodi's case appears on the 12/16 RD-093. You review the case and determine that Jodi has not met her deductible in 9/16, 10/16 and 11/16.

Bridges automatically generates a negative action notice.

EXAMPLE 7

Expenses Reported After MA Coverage Added

Mr. C. has a $55.00 deductible amount.

10/7/16 - Mr. C. reports the following allowable medical expenses:

- 10/1/16 Dentist for filling - $37.50.
- 10/6/16 Outpatient blood test - $52.00.

10/14/16 - Authorize full MA coverage effective 10/6/16 with Mr. C's liability = $17.50.

10/28/16 - Mr. C. verifies the following additional allowable medical expenses:

- 10/2/16 Specialist exam - $75.00.
- 10/2/16 Prescription - $18.75.

Determine that the specialist exam is unpaid. However, Mr. C. paid for the prescription.

Coverage cannot be backdated to an earlier date in 10/16. Therefore, you complete a budget on Bridges for 11/16, counting the $75.00 expense as an old bill. The paid prescription cost cannot be counted.

Mr. C. meets his deductible for 11/16, based on the $75.00 old bill. $20.00 remains as an unused old bill.

Authorize MA coverage for 11/1/16 through 11/30/16 and send Mr. C. a DHS-1606, DHS-114 and DHS-114A.

EXAMPLE 8

Changes in the Deductible Amount

Tina has a $45.00 deductible.

On 9/3/16, Tina submits the following:

- A DHS-114A, indicating a change in income for 7/16 and 8/16 due to overtime.
- Check stubs for 7/16 and 8/16. A statement of expected hours for 9/16.

On 9/6/16, calculate budgets for 7/16, 8/16 and 9/16. You determine Tina's deductible amounts are:

- $61.00 for 7/16.
- $57.00 for 8/16.
- $42.00 for 916.

Send Tina a DHS-114 to notify her of her new deductible amounts for 7/16, 8/16 and 9/16.

Deductible and SLMB

Mr. A. applies for MA on 3/12/16. You process the application on 3/26/16 and determine Mr. A.:

- Is eligible for limited-coverage QMB (SLM), but
- Has $342.00 excess income for Group 2 MA.

Mr. A. submits proof of the following medical expenses:

- Doctor's Office 3/2/16 - $200.00.
- Prescription 3/2/16 - $142.00.

Mr. A.'s expenses on 3/2/16 equal his excess income, so Group 2 MA eligibility exists starting 3/3/16.

Send Mr. A. a DHS-1606, DHS-114, DHS-114A, DHS-4660 and MSA-Pub. 617 to notify him of **all** of the following. He:

- Is eligible for SLMB starting 3/1/16.
- Is eligible for Group 2 MA 3/3/16 - 3/31/16.
- Has an active deductible case with a deductible amount of $342.00, starting 4/1/16.

Send a copy of the QMB memo to DHHS-MSA.

3/26/16**,** authorize MA coverage:

EXAMPLE 11

Deductible and ALMB

Mr. C. applies for MA on 3/4/16. Process the application on 3/25/16 and determine that Mr. C.:

- Has $572.00 excess income for Group 2 MA, and
- Has incurred expenses equaling his deductible on 3/3/16, and
- Would have qualified for ALMB except for his March MA eligibility.

On 3/25/16, authorize MA coverage:

Send Mr. C. a DHS-1606, DHS-114, DHS-4660, DHS-114A and MSA Pub. 617 to notify him that he:

- Is eligible for MA 3/4/16 - 3/31/16, and
- Has an active deductible case with a $572.00 deductible amount starting 4/1/16, and
- Is qualified for ALMB starting 4/1/16.

  Note: You did a future month (April 2016) budget on Bridges to show Mr. C. ALMB-qualified and to get the ALMB notice.

Bridges updates the scope coverage.

LEGAL BASE

MA

42 CFR 435.831(b)-(d)
MCL 400.106, .107

DEPARTMENT POLICY

Medicaid (MA) Only

Use this item to determine post-eligibility patient-pay amounts. A post-eligibility patient-pay amount is the L/H patient's share of the cost of LTC or hospital services.

First determine MA eligibility. Then determine the post-eligibility patient-pay amount when MA eligibility exists for **L/H patients** eligible under:

- A U19 Healthy Kids category.
- A Group 2 (G2U, G2C) category.
- An SSI-related Group 1 or 2 category ***except:***
  - QDWI.
  - Only Medicare Savings Program (with **no** other MA coverage).

MA income eligibility and post-eligibility patient-pay amount determinations are **not** the same. Countable income and deductions from income often differ. Medical expenses, such as the cost of LTC, are never used to determine a post-eligibility patient-pay amount. Do **not** recalculate a patient-pay amount for the month of death.

PATIENT-PAY AMOUNT

The post-eligibility patient-pay amount is total income minus total need.

Total income is the client's countable unearned income plus his remaining earned income; see *Countable Income* in this item.

Total need is the sum of the following when allowed by later sections of this item:

- Patient allowance.
- Home maintenance disregard.
- Community spouse income allowance.
- Family allowance.
- Children's allowance.
- Health insurance premiums.
- Guardianship/conservator expenses.

COUNTABLE INCOME

For all persons in this item, determine countable income as follows:

- RSDI, Railroad Retirement and U.S. Civil Service and Federal Employee Retirement System.
- Non-SSI income for SSI recipients.

Use countable income per BEM 500, 501, 502, 503, 504 and 530. Deduct Medicare premiums actually withheld by:

- Including the L/H patient's premium along with other health insurance premiums, and
- Subtracting the premium for others (example, the community spouse) from the unearned income.

Exception: Do **not** use the following special exclusion policies regarding RSDI. These policies only apply to eligibility, **not** post-eligibility patient-pay amounts. VA Aid and Attendance income is not excluded from the Patient Pay Calculation.

- BEM 155, 503 COUNTABLE RSDI.
- BEM 157, COUNTABLE RSDI.
- BEM 158, COUNTABLE RSDI.
- BEM 503, Countable VA PENSION.

Note: The benefits of clients on buy-in increase about three months after buy-in is initiated. Recompute the patient-pay amount when the client's benefits actually change. BAM 810 has information about buy-in.

- **Earned and Other Unearned Income.**

  Use BEM 500, 501, 502, 503, 504 and 530. For clients, use MAGI- or SSI-related policy as appropriate. Use SSI-related policies for all other persons.

  For the **client only**, disregard $65 + 1/2 of his or her countable earned income. Earned income minus the disregard is **remaining earned income**.

PATIENT ALLOWANCE

The patient allowance for clients who are in, or are expected to be in, LTC and/or a hospital the entire L/H month is $60.

Exception: The patient allowance for a veteran is $90 per month.

Note: The VA determines who receives the Improved Pension and therefore the $90 allowance. The VA may give the Improved Pension to a widow or other member of the veteran's family, see exhibit in this item.

Use the appropriate protected income level for one from RFT 240 for clients who enter LTC and/or a hospital but are not expected to remain the entire L/H month.

Reminder: The patient-pay amount is not reduced or eliminated in the month the person leaves the facility.

HOME MAINTENANCE DISREGARD

Medicaid beneficiaries who will be residents of a long-term care facility for less than six L/H months may request a disregard to divert income for maintenance of their home for a maximum of six months.

Beneficiaries who have been or are expected to remain in long term care for longer than six months do not meet the criteria for this disregard.

The PPA will be reduced when all of the following are true:

- A physician has certified the beneficiary is medically likely to return home in less than six months from the date of admission.
- The request is being made for an individual who is a current Medicaid beneficiary and responsible for a patient pay amount.
- The beneficiary is a current resident of a long-term care facility.
- The beneficiary has a legal obligation to pay housing expenses and has provided verification of the expenses. The housing

expenses must be in the beneficiary's name. A foreclosure, eviction or bankruptcy proceedings must not have begun.

- The home is not occupied by a community spouse or children eligible for a family allowance income deduction.
- The written or verbal request is being made by the beneficiary or an individual authorized to act on behalf of the Medicaid beneficiary.

The effective date of the disregard is the first day of Medicaid eligibility as a nursing facility resident. The disregard is for a maximum of six months but may be granted multiple times if the total months do not exceed six months.

COMMUNITY SPOUSE INCOME ALLOWANCE

L/H patients can divert income to meet the needs of the community spouse. The **community spouse income allowance** is the maximum amount they can divert. However, L/H patients can choose to contribute less. Divert the **lower** of:

- The community spouse income allowance.
- The L/H patient's intended contribution; see *Intent to Contribute* in this item.

Compute the community spouse income allowance using steps one through five below. An L/H client can transfer income to the spouse remaining in the home even if that spouse no longer meets the definition of a community spouse because they are in a MA waiver program such as PACE, MIChoice, or others listed in the BEM manual.

That is because without the transfer of income the spouse would not be able to remain in the home and avoid also becoming an L/H client.

1. Shelter Expenses

Allow shelter expenses for the couple's principal residence as long as the obligation to pay them exists in either the L/H patient's or community spouse's name.

Include expenses for that residence even when the community spouse is away (for example, in an adult foster care home). An

adult foster care home or home for the aged is **not** considered a principal residence.

Shelter expenses are the total of the following monthly costs:

- Land contract or mortgage payment, including principal and interest.
- Home equity line of credit or second mortgage.
- Rent.
- Property taxes.
- Assessments.
- Homeowner's insurance.
- Renter's insurance.
- Maintenance charge for condominium or cooperative.

Also add the appropriate heat and utility allowance if there is an obligation to pay for heat and/or utilities. The heat and utility allowance for a month is $664.00.

Convert all expenses to a monthly amount for budgeting purposes.

2. Excess shelter allowance.

Subtract the appropriate shelter standard from the shelter expenses determined in step one. The shelter standard for a month is $766.50

The result is the **excess shelter allowance**.

3. Total allowance.

Add the excess shelter allowance to the appropriate basic allowance. The basic allowance for a month is $2555.00. The result, up to the appropriate maximum, is the **total allowance**. The maximum allowance for a month is $3853.50.

Exception: In hearings, administrative law judges can **increase** the total allowance to divert more income to an L/H patient's community spouse; see BAM 600.

4. Countable income.

Determine the community spouse's countable income; see COUNTABLE INCOME in this policy.

5. Community spouse income allowance.

Subtract the community spouse's countable income from the total allowance. The result is the **community spouse income allowance**.

Exception: Use court-ordered support as the community spouse income allowance if:

- The L/H patient was ordered by the court to pay support to the community spouse, **and**
- The court-ordered amount is **greater** than the result of step five.

Intent to Contribute

DHS-4592, Intent to Contribute Income:

- Determines the amount of income an L/H patient intends to contribute to his community spouse.
- Instructs the L/H patient to report how much income he intends to make available.
- Should be returned within 10 days.

If the DHS-4592 is **not** returned within 10 days:

- Do **not** delay case actions, and
- Budget the entire community spouse income allowance.

The entire allowance will be budgeted **until** the DHS-4592 is returned indicating the L/H patient intends to contribute **less**.

When the DHS-4592 indicating an intent to contribute **less** income is received:

- **Decrease** the income diverted to the community spouse to the indicated amount.

- Do **not increase** the income diverted to the community spouse without a new DHS-4592.
- **Decrease** the income diverted if:
  - The community spouse's circumstances change, **and**
  - The change reduces the community spouse income allowance **below** the amount indicated on the DHS-4592.
- Use timely negative action procedures to increase the patient-pay amount.

Do **not** use amounts from previous DHS-4592s when diverting income again after stopping a diversion for one of these reasons:

- An L/H patient is discharged to a non-L/H setting for 30 or more days.
- An L/H patient's ongoing Medicaid case (including active deductible) terminates.
- An L/H patient's spouse is hospitalized or in LTC for 30 or more consecutive days.

Start the diversion process from the beginning.

FAMILY ALLOWANCE

An L/H patient's income is diverted to meet the needs of certain family members. The amount diverted is called the **family allowance**.

Family members must**:**

- Live with the community spouse, **and**
- Be **either** spouse's:
  - Married and unmarried children under age 21.
  - Married and unmarried children age 21 and over if they are claimed as dependents on either spouse's federal tax return.
  - Siblings and parents if they are claimed as dependents on either spouse's federal tax return.

The **basic allowance** for each dependent is the monthly amount **minus** the dependent's countable income, divided by 3. The monthly amount is $2555.00.

The **family allowance** is the sum of the dependents' basic allowances.

CHILDREN'S ALLOWANCE

L/H patients without a community spouse can divert income to their unmarried children at home who:

- Are under age 18, **and**
- Do **not** receive FIP or SSI.

The amount diverted is called the **children's allowance**. It is the children's protected income level from RFT 240 **minus** their net income. **Net income** is:

- 80 percent of countable earned income, **plus**
- Countable unearned income.

Do **not** divert income if information concerning the children's income is **not** provided.

HEALTH INSURANCE PREMIUMS

Include as a need item the cost of any health insurance premiums (including vision and dental insurance) the L/H patient pays for another member of their fiscal group, regardless of who the coverage is for. This includes Medicare premiums that a client pays. See Bridges Glossary for the definition of health insurance.

Example: L/H patient pays health insurance premiums for two (self and spouse). Allow health insurance premiums for two.

Do **not** include premiums paid by someone other than the L/H patient as a need item. If the community spouse pays their own premium it is included in the CSIA budget. Verify who pays the premium if questionable.

Convert the cost of all premiums to a monthly amount for budgeting purposes.

Note: Allow the $5 deduction paid by GM retirees which includes LTC insurance coverage as an insurance expense deduction.

GUARDIANSHIP/ CONSERVATOR EXPENSES

Allow $83 per month when an L/H patient pays for his court-appointed guardian or conservator.

Guardianship/conservator expenses must be verified and include:

- Basic fee.
- Mileage.
- Other costs of performing guardianship/conservator duties.

DHS-3227, TENTATIVE PATIENT-PAY AMOUNT NOTICE

Send a DHS-3227, Tentative Patient-Pay Amount Notice, within five working days of application when:

- The applicant is in LTC, **and**
- A final determination will **not** be made within five working days from date of application.

Send the DHS-3227 to the client and the LTC facility.

NOTIFICATION

Notify both L/H patients and their community spouses **in writing** of:

- Their hearing rights, **and**
- The amount of and method for computing the:
  - Community spouse income allowance, **and**
  - Family allowance.

Provide notice when:

- First calculating community spouse income or family allowance.
- The amount of either allowance changes.
- L/H patients, their community spouses, or representatives of either spouse request it.

Use the following forms to provide notice:

- DHS-4587, Community Spouse and Family Income Allowance Notice.
- DHS-4584, Community Spouse and Family Income Allowance Record.

Send a DHS-4592, Intent to Contribute Income, when the community spouse income allowance is greater than zero.

POST ELIGIBILITY PATIENT PAY OFFSETS

Long-term Care (LTC) facilities may deduct the following post eligibility expenses from a resident's patient pay amount:

- The cost of certain medically necessary services not covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers.
- The MA co-payments for covered services.

The remainder of the patient-pay amount is then applied to the cost of care provided by the LTC facility.

MDHHS determines if an offset is allowable.

The post eligibility patient-pay amount is **not** off-set by local office staff.

Note: If an LTC applicant requests an offset of the patient pay to cover old medical bills, see PEME in the glossary and this item. Assist the applicant by forwarding the unpaid bills to:

Medical Services Administration
Michigan Department of Health and Human Services
PO Box 30479
Lansing, MI 48909-9634
Attn: PEME

PRE-ELIGIBILITY PATIENT PAY OFFSETS(PEME)

Long-term care (LTC) facilities may deduct the following from a person's patient-pay amount:

- The cost of certain medically necessary services **not** covered by MA such as chiropractic, podiatry, dental (other than emergency dental and oral surgery) and hearing aid dealers, and
- The MA co-payments for covered services.

The remainder of the patient-pay amount is then applied to the cost of care provided by the LTC facility. The Department of Health and Human Services determines whether an offset is allowable.

Patient-pay amounts are **not** offset by local office staff. Contact the PEME unit at MDHHS-MSA-PEME@michigan.gov with requests to offset a patient pay to cover old medical bills, see PEME in glossary and in this policy.

MSA will determine whether an offset is allowable.

Pre-Eligibility Medical Expenses (PEMEs) are unpaid medical expenses incurred in the three months prior to the application for Medicaid.

The offset of the PPA is only allowed if the money is used to pay the provider(s) for the incurred medical expense and will be terminated if the recipient fails to pay the provider.

Offsets will be applied to the months following an approval. In general, the allowable expenses are the same as allowed for a group 2 deductible case.

In addition, the medical expense(s):

- Must be unpaid, and an obligation still exists to pay.
- The expenses were incurred in the three months prior to the initial approved application for Long Term Care Medicaid.
- Cannot be from a month where Medicaid eligibility existed.
- Cannot be covered by a third-party source (public or private).
- Cannot be from a month in which a divestment penalty has been imposed.
- Cannot have been used previously as a pre-eligibility medical expense to offset a patient-pay amount.

- Can include cost of room and board for Medicaid LTC facilities, remedial care, and other medical expenses recognized by Michigan law but not covered under the Michigan state plan.

- Request for PEME must be made within one year after eligibility for LTC Medicaid has been established and prior to the first Long Term Care Medicaid redetermination following the approved LTC application.

Note: MSA will terminate offsets if there is a failure to pay the medical provider with the funds.

VERIFICATION REQUIREMENTS

Verify income per BEM 500, 501, 502, 503, 504.

Clients must verify the following before the cost can be used to determine excess shelter:

- Shelter obligation and amount.
- Heat and utility obligation but **not** amount.

These must be verified at application, redetermination or change.

Verify the cost of health insurance premiums before allowing the expense at application, redetermination or change.

Verification Sources

Shelter Obligation and Amount:

- Mortgage or rental contracts.

- Statement from mortgage company, bank or landlord.

- Tax or assessment bill or a collateral contact with the appropriate government department.

- Insurance policy, receipt or bill for premium or collateral contact with the insurance company.

Heat and Utility Obligation:

- Current bill or receipt or a written statement from the heat/utility provider.

- Collateral contact with the heat/utility provider.

Home Maintenance Disregard:

- Physician statement signed by a M.D. or D.O.

Health Insurance Premiums:

- Insurance policy (not an application for insurance).
- Receipt or bill for premium.
- Contact with insurer.

Guardian/Conservator Expenses:

- Court Documents.

EXHIBIT - VA NOTICE

This is a portion of an April 1991 letter announcing reduced VA benefits. Key wording is highlighted.

You have been **a patient in a Medicaid-approved nursing home and covered by a Medicaid** plan for services since (Date) . **Because you have no dependents and are receiving Improved Pension, the law requires that we limit your pension to $90.00 monthly** while you are receiving this type of care.

For that reason, we propose to reduce your benefits from (Date) . No overpayment will be created.

This $90.00 monthly payment is for your incidental needs, such as toilet articles, snacks, etc. and **no part of this payment should be used by Medicaid to cover your medical expenses.** You should notify your state Medicaid office that your Improved Pension is being reduced.

LEGAL BASE

MA

Social Security Act, Section 1924
42 CFR 435.725,.726 and.832

DEPARTMENT POLICY

MA Only

The medical services authorization data elements are:

- Provider ID number.
- Program Enrollement Type (PET) code.
- Patient-pay amount.
- Begin date.
- End date.

MANAGED CARE BENEFICIARY ENTERS L/H

It is the local MDHHS's responsibility to enter the medical services authorization. However, see BAM 120 when a beneficiary in managed care becomes an long term care or hospital (L/H) patient.

The Michigan Department of Health and Human Services (MDHHS) and Medical Services Administration (MSA) share responsibility for the medical services authorization for these beneficiaries.

PET (PROGRAM ENROLLMENT TYPES - FORMERLY LOC CODES)

Long term care (LTC) facilities and waiver services providers will not be paid unless the appropriate program enrollment type (PET) code is in CHAMPS. For MDHHS staff, adding, removing or changing - PET codes are not negative actions.

Note: Changing a PET code to EXM-DIVM for an L/H or waiver MA patient is a negative action; see BEM 405.

LTC

Long Term Care facilities enter the admission date and other required information directly into the CHAMPS system.

See BAM 120 when a beneficiary with managed care PET codes enters LTC.

Medical Services Administration within MDHHS is responsible for notifying the beneficiary and LTC facility if nursing care is not needed. MSA enters the appropriate PET code and the facility will not be paid by Medicaid.

A beneficiary in an LTC facility may also be enrolled in a hospice. MSA enters PET codes for these cases.

Note: Do not change the post-eligibility patient pay amount when a beneficiary is transferred to a hospital or another LTC facility.

Note: Use instructions in BEM 405 to end the divestment penalty, PET code EXM-DIVM.

Hospitals enter the admission date and other required information directly into the CHAMPS system.

MIChoice waiver agents enter the admission date and other required information directly into the CHAMPS system.

Note: Use PET code EXM-DIVM for a divestment penalty period; see BEM 405.

HOSPICE AND LTC

When a beneficiary receiving hospice care enters LTC determine the patient pay amount (PPA).

When a beneficiary in LTC begins receiving hospice care determine that the PPA has not changed. If it has changed re-enter the correct PPA. PATIENT-PAY AMOUNTS

There are different patient-pay amounts (PPAs):

- **LTC** and **hospital** - Used to establish Group 2 income eligibility; see BEM 545.
- **Post-eligibility** - Certain L/H patients' share of their cost of care; see BEM 546.

Approval of MA for a month is a positive action even when there is a PPA.

Always enter the PPA when adding MA coverage regardless of:

- How long an application has pended.

- Which month of coverage is being added to an active deductible case.
- Whether the DHS-3227, Tentative Patient-Pay Amount Notice, was sent to the LTC facility.

Adding MA Coverage with a PPA

When adding MA coverage for a month having a hospital, LTC, or post-eligibility PPA:

- The begin date of the PPA is the first day of the month **or** the hospital admission date/LTC admission date, **whichever is later**.
- The end date is the hospital discharge date/LTC discharge date **or** the last day of the month, **whichever is earlier**.

Exception: When MA eligibility will be ongoing for an L/H patient, the end date of the ongoing post-eligibility PPA is 9s.

Changing Post-Eligibility PPAs

When changing a post-eligibility PPA for an MA beneficiary:

- Begin a **higher** PPA the first day of the month following the month in which the negative action pend period ends.
- Begin a **lower** PPA the first day of the month:
  - The change occurred, if it was reported within 10 days.
  - The change was reported, if not reported within 10 days.

Note: Changes that result in a lower PPA include reduced income and higher needs as allowed by BEM 546. For example, a beneficiary will have a higher patient allowance when in an LTC facility only part of a month.

RETROACTIVE ADJUSTMENTS

Do **not** increase or add a PPA for a past period for which the beneficiary already has MA coverage.

Correct PPAs that should have been lower for past periods. In addition to the beneficiary, notify the hospital/LTC facility so that the providers may adjust their MA billings.

LEGAL BASE

MA

42 CFR 435.725, .726 and .832
42 CFR 456

DEPARTMENT POLICY

This item applies **only** to the Food Assistance Program (FAP)**.**

A non-categorically eligible Senior/Disabled/Veteran (SDV) FAP group must have income below the net income limits.

A non-categorically eligible, non-SDV FAP group must have income below the gross and net income limits.

Use **only** available, countable income to determine eligibility. The Bridges Eligibility Manual (BEM) 500 series defines countable income. BEM 505, Prospective Budgeting/Income Change Processing, defines available income and income change processing. This item describes income budgeting policy.

Always calculate income on a calendar month basis to determine eligibility and benefit amounts. Use income from a month specified in this item for the benefit month being considered.

Budget the entire amount of earned and unearned countable income. Gross countable earned income is reduced by a 20 percent earned income deduction. Every case is allowed the standard deduction; see Reference Tables Manual (RFT) 255.

Document income budgeting on either a manually-calculated or an automated FAP worksheet.

SDV GROUP

An SDV FAP group is one which has an SDV member.

Senior

A person at least 60 years old.

Disabled

A person who receives one of the following:

- A federal, state or local public disability retirement pension **and** the disability is considered permanent under the Social Security Act.
- Medicaid program which requires a disability determination by Disability Determination Service (DDS) or Social Security Administration.

Note: Breast and Cervical Cancer Prevention and Treatment Program Medicaid cases are **not** considered disabled.

- Railroad Retirement **and** is eligible for Medicare or meets the Social Security disability criteria.

A person who receives or has been certified and awaiting their initial payment for one of the following:

- Social Security disability or blindness benefits.
- Supplemental Security Income (SSI), based on disability or blindness, **even if** based on presumptive eligibility.

Disabled Veteran

One of the following:

- A veteran of the armed services with a service or non-service connected disability rated or paid as total by the Veterans Administration (VA).
- A veteran's surviving spouse or child who receives or is approved for VA disability benefits, or is entitled to VA death benefits and has a disability considered permanent under the Social Security Act.

DISQUALIFIED OR INELIGIBLE PERSONS

Budgeting income for disqualified persons living with the FAP group differs based on the reason for the disqualification. Family Independence Program (FIP) and State Disability Assistance (SDA) benefits are considered the unearned income of the FIP/SDA head of household (HOH).

Non-Group Members

The income of a non-group member is excluded; see BEM 212 Food Assistance Program Group Composition.

IPV, Employment Related Activity, FAP Trafficking or Parole or Probation Violation

Bridges budgets **all earned and unearned income** of a person disqualified for:

- Intentional Program Violation (IPV).
- Non-cooperation with employment related activities.
- FAP trafficking.
- Parole or probation violation.
- Fleeing Felon.
- Divestment.

Example: John lives with his wife and two children. John is employed and is disqualified for IPV. Bridges budgets all of John's earned income to determine the FAP benefits for his wife and two children.

SSN Enumeration, Citizenship/Non-Citizen Statusand Time Limited

Bridges budgets a **pro rata** share of earned and unearned income of:

- A person disqualified for refusal to provide a social security number. See BEM 223.
- A person disqualified for refusal to declare citizenship/non-citizen status. See BEM 225.
- A person disqualified for not meeting citizenship/non-citizen status requirements. See BEM 225.
- A person who does not meet time limited requirements. See BEM 620.

Each source of income is prorated individually as follows:

1. The number of eligible FAP group members is added to the number of disqualified persons that live with the group.

2. Next the disqualified/ineligible person's income is divided by the number of persons in step 1.

3. Then the result in step 2 is multiplied by the number of eligible group members.

Do **not** apply these rules to the income of eligible group members, or non-group members; see BEM 212.

Example: Group consists of Mary and her 2 children. Mary's children are U.S. citizens. Mary is an ineligible non-citizen for FAP. Mary's income is divided by 3 (number in Mary's group). Of Mary's income, Bridges budgets the children's portion (2/3) and excludes Mary's portion (1/3).

MEMBER ADDS/ DELETES

A **member add** that increases benefits is effective the month **after** it is reported **or**, if the new member left another group, the month after the member delete. In determining the potential FAP benefit increase, Bridges assumes the FIP/SDA supplement and new grant amount have been authorized.

When a member leaves a group to apply on his own or to join another group, do a **member delete** in the month you learn of the application/member add. If the member delete decreases benefits, **adequate notice** is given for the negative action.

STRIKERS

Bridges compares the striker's income prior to going on strike to the striker's current income. It subtracts the earned income deduction prior to making the above comparison and budgets the higher amount.

Use the above policy to reevaluate changes in source or amount of income.

Average income received on an annual contractual basis over 12 months, **regardless** of the frequency that the wages are paid, such as a school teacher's wages.

SPONSORS OF ALIENS

Apply the BEM 500 Series Income Policy, to determine the sponsor's and the sponsor's spouse's (if living with the sponsor) gross monthly income.

Bridges determines the deemable monthly income as follows:

- All gross monthly earned income minus 20 percent, **plus**
- All gross monthly unearned income, **minus**
- The total monthly countable income limit in RFT 250, FAP Income Limits table, for a FAP group size equal to:
  - The sponsor, plus
  - The sponsor's spouse, plus
  - Any other person the sponsor or sponsor's spouse claims or could claim as a dependent for federal income tax purposes.

Exception: If the non-citizen and spouse are disqualified, the sponsor's income is not deemed.

Exception: The total amount actually contributed by the sponsor if it exceeds the deemed amount determined above is budgeted as unearned income.

Note: See BEM 226 for exemptions to sponsor deeming.

TEMPORARY INELIGIBILITY

If it's determined that ineligibility will last for **only** one month, Bridges temporarily suspends issuance of benefits.

VERIFICATION REQUIREMENTS

Disabled/Disabled Veteran

A person with a disabilty or a disabled/veteran status **must** be verified.

VERIFICATION SOURCES

Disabled/Disabled Veteran

Verify disability using at least one of the listed sources.

- Statement from the Social Security Administration indicating the receipt of SSI or RSDI based on disability.
- State On-line Query (SOLQ).
- Statement from the Department of Veterans Affairs indicating the disability is rated or paid as total by VA.

  Note: A DHS-27, Release of Information, can be used. Send the completed form to:

  Department of Veterans Affairs Regional Office
  Federal Building
  477 Michigan Avenue
  Detroit, Michigan 48226

  Specifically request verification that states the “disability is rated or paid as total by VA.”
- Statement from the VA indicating receipt of:
  - VA disability benefits for a veteran's surviving spouse or child.
  - VA death benefits paid to a surviving spouse or child.

Unless disability is obvious, obtain from the physician a statement (or a completed DHS-49 or DHS-54A) for:

- A veteran's disabled surviving spouse or child who is entitled to VA death benefits but **not** VA disability benefits.
- A recipient of a federal, state or local public disability retirement pension;
- A recipient of Railroad Retirement who is **not** eligible for Medicare.

The following is a partial list of disabilities considered permanent by SSA:

- Permanent loss of the use of both hands, both feet, or one hand and one foot.
- Amputation of a leg at the hip.
- Amputation of a leg or foot because of diabetes mellitus or a peripheral vascular disease.
- Total deafness, not correctable by surgery or a hearing aid.
- Statutory (legal) blindness, except if due to cataracts or a detached retina.
- IQ of 59 or less, established after age 16.
- Paraplegia or quadriplegic.
- Multiple sclerosis that is severe, recurring, and includes muscle weakness, paralysis, or interference of vision or speech.
- Muscular dystrophy with a significant effect on the use of the arms or legs.
- Chronic renal disease (documented by persistent, adverse objective findings) resulting in severely reduced kidney function.

LEGAL BASE

7 CFR 271.2
7 CFR 273.1(b)(2)
7 CFR 273.1 (e)
7 CFR 273.9
7 CFR 273.10
7 CFR 273.11
7 CFR 273.8(h)

DEPARTMENT POLICY

Food Assistance Program (FAP) Only

Bridges uses certain expenses to determine net income for FAP eligibility and benefit levels.

- For groups with **no** senior/disabled/disabled veteran (SDV) member, Bridges uses the following:
  - Dependent care expense.
  - Excess shelter up to the maximum in Reference Tables Manual (RFT) 255.
  - Court ordered child support and arrearages paid to non-household members.
- For groups **with** one or more SDV member, Bridges uses the following: see Bridges Eligibility Manual (BEM) 550, FAP Income Budgeting:
  - Dependent care expense.
  - Excess shelter.
  - Court ordered child support and arrearages paid to non-household members.
  - Medical expenses for the SDV member(s) that exceed $35.

Complete either a manually calculated or Bridges budget to document expenses every time an expense change is reported.

ALLOWABLE EXPENSES

An expense is allowed if all the following:

- The service is provided by someone outside of the FAP group.
- Someone in the FAP group has the responsibility to pay for the service in money.
- Verification is provided, if required.

Responsibility to Pay

Responsibility to pay means the expense is in the name of a person in the FAP group.

Exception: If the expense is in someone else's name, allow the expense if the FAP group claims the expense **and** the service address on the bill is where they live.

Do **not** allow any expense if the entire expense is directly paid by an agency or someone outside of the group.

An expense that is fully reimbursed is not allowed; see BEM 500, Reimbursements.

If an expense is partially reimbursed or paid by an agency or someone outside of the FAP group, allow **only** the amount the group is responsible to pay, **unless** specific policy directs otherwise.

Example 1: HUD pays $150 toward a FAP group's $325 rental expense. Allow only the $175 ($325 rent - $150 HUD pays = $175) that the group is expected to pay.

Example 2: Natalie's rental amount is $400 per month. Her mother pays $200 every month directly to the landlord. Natalie is allowed a $200 rental expense.

Shared Expenses

Allow only the FAP group's portion of child support, medical or dependent care expenses if another person outside of the FAP group is jointly responsible. If the FAP group's share can be identified, allow that portion. Otherwise, the expense is evenly prorated among the groups responsible for it and the FAP group's prorated share is allowed.

Note: The heat and utility standard and the individual utility standards are **never** prorated, even if the expense is shared. Refer to the following sections found in this item:

- Mandatory heat and utility standard.
- Mandatory individual standards.

Member Removal

The expenses of a FAP member who is no longer living with the group are removed when the member removal is processed.

Verification

The Michigan Department of Health and Human Services (MDHHS) must verify the responsibility to pay, and the amount of certain expenses; see the individual expense policy for verification requirements. Document verification used in the case record.

Do **not** budget expenses that require verification until the verification is provided. Determine eligibility and the benefit level without an expense requiring verification if it cannot be verified.

Note: Do **not** include a medical expense that might be covered by a reimbursement if the amount of the reimbursement cannot be verified.

Treat subsequently provided verification from an eligible FAP group as a change. A supplement for lost benefits is issued **only** if the expense could **not** be verified within 30 days of the application and the local office was at fault.

BUDGETING EXPENSES

Budget Month

Expenses are used from the same calendar month as the month for which benefits are being determined.

Example: June expenses are used to determine June's benefits.

Expenses remain unchanged until the FAP group reports a change; see Bridges Administrative Manual (BAM 220), Change Processing.

Determining the Monthly Amount

Bridges converts all expenses to a nonfluctuating monthly amount.

Exception: One-time only expenses the group does not wish to average or those which must be manually converted and entered as a monthly amount in Bridges.

The same conversion method is used to determine countable available income in BEM 505, Prospective Budgeting/Income Change Processing. Bridges will convert a(n):

- Weekly expense, multiply the average weekly expense by 4.3.

- Twice a month expense, multiply the average weekly expense by 2.
- Every other week expense, multiply the average expense by 2.15.
- Yearly expense, average the bill over 12 months beginning with the first billing of the year.
- Quarterly expense, average the bill over three months.
- Expense billed less often than monthly. Bridges will average the one-time-only expense over the balance of the benefit period or over the period of time the client has the responsibility to pay. The expense is allowed beginning with the first benefit month the change can affect.

Example: Groups that have 24-month benefit periods must be given options for one-time-only medical expenses; see *Medical Expenses* in this item.

Home Equity Loan Expense

To determine the countable monthly expenses for a home equity loan, use either:

- The entire amount (principal and interest) for a fixed, non-fluctuating home equity loan.
- The average of two or more recent month's payments (principal and interest) for a variable home equity loan payment, **unless** the FAP group states the payment amount is different for the benefit month being determined.

Document in the case record or in Bridges what months were used and why they were representative.

Non-Converted Expenses

Expenses that will not continue beyond the month following the benefit month being processed are not converted.

Budget **non-converted** expenses for the month they are billed or otherwise become due, regardless of when the FAP group intends to pay the expense.

Non-converted expenses are budgeted for **one** benefit month only.

Expenses for Disqualified or Ineligible Persons

The treatment of expenses paid by or billed to ineligible or disqualified persons differs depending on the reason the person is not in the group.

Determine the appropriate month's expenses for a disqualified or ineligible person as if he were a member of the FAP group.

Student *Status*

Expenses for which the ineligible student is responsible are not budgeted.

Employment Related Activities, IPV, Trafficking, Parole or Probation Violation, Fleeing Felon or Divestment

Budget total expenses, including medical expenses of a senior, disabled, disabled veteran (SDV) disqualified person. Allow unlimited excess shelter even if the only SDV member is the disqualified person.

Social Security Enumeration, Citizenship/Non-Citizen Status, or Time Limited

The mandatory heat and utility standard, mandatory individual standards ,actual utility expenses are never prorated and internet standard. However, only a prorated portion for dependent care expenses, child support, and shelter expenses is allowed.

To determine the prorated amount to allow:

1. Divide the expense evenly by the number of group members, including the disqualified person(s) living with the FAP group.

2. Multiply the result by the number of eligible group members.

Example: One person in the group is disqualified with a child support expense of $200.00 per month. The total group size is 4. Bridges divides $200.00 by 4 which equals $50.00. It then multiplies $50.00 by 3 eligible group members which equals $150.00 and allows a child support expense of $150.00.

Bridges does **not** allow:

- Medical expenses for SDV disqualified persons.

- Unlimited excess shelter if the only SDV member is disqualified.

CHILD SUPPORT EXPENSES

The following child support expenses are allowed:

- The amount of court-ordered child support and arrearages paid by the household members to non-household members in the benefit month.
- Court-ordered third-party payments (landlord or utility company) on behalf of a non-household member.
- Legally obligated child support paid to an individual or agency outside the household, for a child who is now a household member, provided the payments are not returned to the household.

Do not allow more than the legal obligation if the client is up to date on their child support payments. However, if they are behind and making arrearage payments, allow the total amount paid even if it exceeds the court-ordered amount. Current and arrearage child support expenses must be paid to be allowed.

Verification

Verify child support expenses and arrearages paid to non-household members at application, redetermination and when a change is reported. All the following must be verified:

1. The household's legal obligation to pay.
2. The monthly amount of the obligation for current child support.
3. The amount of child support the household actually pays.

Current payments must be entered separately from arrearage payments on Bridges. A separate arrearage order is not needed to allow arrearage payments. If MDHHS verifies child support payments are court ordered, the original court order also serves as verification of the arrearage.

Verification Sources

Acceptable verification sources include, but are **not** limited to:

- For the household's legal obligation to pay and current obligation amount:
  - Court or administrative order.
  - Legally enforceable separation agreement.
- For the household's actual child support and arrearages paid:
  - Wage withholding statements (paycheck stub).
  - Verification of withholding from unemployment compensation or other unearned income.
  - Statements from the custodial parent regarding direct payments.
  - Statements from the custodial parent regarding third party payments the noncustodial parent pays or expects to pay on behalf of the custodial parent.
  - Data obtained from the state's Child Support Enforcement System (MICSES).

Note: Documents that are accepted as verification of the household's legal obligation to pay child support and arrearages are **not** acceptable as verification of the household's actual monthly payment.

DEPENDENT CARE EXPENSES

Allow an **unreimbursed** dependent care expense for a child under the age of 18 or an adult of any age who is incapacitated and a member of the FAP group, when such care is necessary to enable a member of the FAP group to work. This is the amount the FAP group actually pays out-of-pocket. The expense does **not** have to be paid to be allowed. Allow only the amount the provider expects the client to pay out-of-pocket. Work includes seeking, accepting or continuing employment, or training or education preparatory to employment.

Note #1: Unreimbursed dependent care expenses may also include:

- Preschool.

- Activity fees associated with the care provided to the dependent such as taking an art class for an after-school program, an adult day care program, or additional equipment fees charged for attending a sports camp.
- Cost of transportation to and from dependent care facilities incurred by the household.
    - Use cents-per-mile to determine the transportation expense.
    - Go to the Michigan Department of Management and Budget at www.michigan.gov/dtmb, select Services then select Travel. On the travel page, select Travel Rates in Cost cities for the current year then use Premium Rate under Mileage Rates.

Note #2: The dependent care expense must be manually converted into a monthly amount.

Case Management Tip: Be especially careful in following the above dependent care expense budgeting policy if the client's dependent care is reimbursed by the Child Development and Care program (CDC) or another agency or person.

Verification

Verify dependent care expenses at application, reported change and redetermination.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Bills or written statement or collateral contact with the provider for the dependent care expenses including activity fees.
- Written statement from the client on the number of miles from home to the facility and use the same miles from the facility to home.

MEDICAL EXPENSES

Application and Redetermination

Consider **only** the medical expenses of SDV persons in the eligible group or SDV persons disqualified for certain reasons; see Expenses for Disqualified or Ineligible Persons in this item. Estimate an SDV person's medical expenses for the benefit period. Base the estimate on all the following:

- Verified allowable medical expenses.
- Available information about the SDV member's medical condition and health insurance.
- Changes that can reasonably be anticipated to occur during the benefit period.

Standard Medical Deduction (SMD)

An SDV group that has a verified one-time or ongoing medical expense(s) of more than $35 for an SDV person(s) will receive the SMD. The SMD is $165. If the group has actual medical expenses which are more than the SMD, they have the option to verify their actual expenses instead of receiving the SMD.

Example 1: Mickey has monthly ongoing medical expense totaling $36 dollars and verifies the medical expense. After subtracting $35, he has a remaining balance of $1. He will receive the SMD in his budget.

Example 2: Corbin has monthly medical expenses of $235 and verifies the medical expenses. His expenses exceed the SMD, so he would receive a higher medical expense of $200. ($235-$35)

Example 3: Using the above example, Corbin only returns verifications in the amount of $50. Since the verified expenses are less than the SMD, he will receive the SMD in his budget.

During the Benefit Period

A FAP group is not required to but may voluntarily report changes during the benefit period. Process changes during the benefit period **only** if they are one of the following:

- Voluntarily reported and verified during the benefit period such as expenses reported and verified for MA deductible.

- Reported by another source and there is sufficient information and verification to determine the allowable amount without contacting the FAP group.

One-Time-Only Expenses

Groups that do not have a 24-month benefit period may choose to budget a one-time-only medical expense for one month or average it over the balance of the benefit period. Bridges will allow the expense in the first benefit month the change can affect.

Exception: Groups that have 24-month benefit periods must be given the following options for one-time-only medical expenses billed or due within the first 12 months of the benefit period:

1. Budget it for one month.

2. Average it over the remainder of the first 12 months of the benefit period.

3. Average it over the remainder of the 24-month benefit period.

Example: Sally has a $1,200 emergency room bill in 11/08. It is not covered by Medicaid, or any medical insurance and she received the first bill for this service in 1/09. Her FAP benefit period is 10/1/08 through 9/30/10. She can elect to use:

- The entire $1,200 deduction to affect 2/09 benefits. This would probably increase her FAP to the maximum amount for that one month.

- $150 per month ($1,200 bill divided by 8 months remaining in the first 12 months of her benefit period) to affect 2/09 through 9/09. This would probably increase her FAP benefits by $50 per month for eight months.

- $60 per month ($1,200 bill divided by 20 months remaining in the benefit period) to affect 2/09 through 9/10. This would probably increase her FAP benefits by $20 for 20 months. (If she were within $20 of the maximum, this option would benefit her the most.)

Allowable Medical Expenses

Allowable medical expenses are limited to the following:

- Medical and dental care including psychotherapy and rehabilitation services provided by a licensed practitioner authorized by State law or other qualified health professional.
- Hospitalization or nursing care. Include these expenses for a person who was a group member immediately prior to entering a hospital or nursing home.
- Prescription drugs and the postage for mail-ordered prescriptions.
- Costs of medical supplies, sickroom equipment (including rental) or other prescribed medical equipment (excluding the cost for special diets).
- Over-the-counter medication (including insulin) and other health-related supplies (bandages, sterile gauze, incontinence pads, etc.) when recommended by a licensed health professional.

  Note: Eyeglasses when prescribed by an ophthalmologist (physician-eye specialist) or optometrist.
- Premiums for health and hospitalization policies (excluding the cost of income maintenance type health policies and accident policies, also known as assurances). If the policy covers more than one person, allow a prorated amount for the SDV person(s).
- Medicare premiums.
- Dentures, hearing aids and prosthetics.
- The cost of securing and maintaining a seeing eye or hearing dog, or other service animal used to assist an SDV client with a specific verified medical need(s). Allowable costs include animal food, veterinary bills, and other expenses necessary to maintain the service animal.

  The service animal **must** be specially trained to serve the specific verified medical need(s) of an SDV individual. However, verification of the specialized training is not required.

Note: An existing pet or companion animal does not automatically become a service animal, unless specifically trained.

- Actual costs of transportation and lodging necessary to secure medical treatment or services. If actual costs **cannot** be determined for transportation, allow the cents-per-mile amount at the standard mileage rate for a privately owned vehicle in lieu of an available state vehicle. To find the cents-per-mile amount go to the Michigan Department of Management and Budget at https://www.michigan.gov/dtmb/services/travel, select Services & Facilities from the left navigation menu, then select Travel. On the travel page, choose Travel Rates and High-Cost Cities using the rate for the current year.

- The cost of employing an attendant, homemaker, home health aide, housekeeper, home help provider, or child care provider due to age, infirmity or illness. This cost must include an amount equal to the maximum FAP benefits for one person if the FAP group provides most of the attendant's meals. If this attendant care cost could qualify as both a medical expense and a dependent care expense, it **must** be treated as a medical expense.

- A Medicaid deductible is allowed if the following are true.

  - The medical expenses used to meet the Medicaid deductible are allowable FAP expenses.

  - The medical expenses are not overdue. See below.

Note: Medical marijuana is **not** an allowable medical expense.

Estimating and Determining an Allowable Medical Expense

Estimate an SDV person's medical expenses for the benefit period. The expense does **not** have to be paid to be allowed. Allow medical expenses when verification of the portion paid, or to be paid by insurance, Medicare, Medicaid, etc. is provided. Allow **only** the non-reimbursable portion of a medical expense. The medical bill cannot be overdue.

The medical bill is **not** overdue if one of the following conditions exists:

- Currently incurred (for example, in the same month, ongoing, etc.).
- Currently billed (client is receiving the bill for the first time for a medical expense provided earlier and the bill is not overdue).
- Client made a payment arrangement before the medical bill became overdue.

VERIFICATION

Verify allowable medical expenses, including the **amount of reimbursement,** at initial application and redetermination. Groups that continue to have a medical expense(s) that allow them to receive the SMD, will not need to reverify the expense at redetermination, unless questionable. Verify reported changes in the source or amount of medical expenses if the change would result in an increase in benefits.

Do not verify other factors, unless questionable. Other factors include things like the allowability of the service or the eligibility of the person incurring the cost.

Verify the specific need for a service animal.

VERIFICATION SOURCES

Acceptable verification sources include, but are not limited to:

- Current bills or written statement from the provider, which show all amounts paid by, or to be paid by, insurance, Medicare, or Medicaid.
- Insurance, Medicare, or Medicaid statements which show charges incurred and the amount paid, or to be paid, by the insurer.
- DHS-54A, Medical Needs, completed by a licensed health care professional.
- SOLQ for Medicare premiums.
- Written statements from licensed health care professionals.

- Collateral contact with the provider. (Most commonly used to determine cost of dog food, over-the-counter medication and health-related supplies, and ongoing medical transportation).

SHELTER EXPENSES

Allow a shelter expense when the FAP group has a shelter expense or contributes to the shelter expense. When shelter expenses are shared, groups are only allowed the amount they contribute. Shelter expenses are allowed when billed. The expenses do **not** have to be paid to be allowed.

Late fees and/or penalties incurred for shelter expenses are **not** an allowable expense.

Example: Sally receives FAP and the total monthly rental amount is $700. Her roommate, who is not in her FAP group pays $500 to the landlord. Sally has a rental expense of $200.

Note: When a shelter expense is paid in advance, continue to allow the ongoing monthly shelter expense. Example: A client's monthly shelter expense is $300. They pay $900 to the landlord to cover the months of April-June. Continue to allow the monthly shelter obligation of $300 in the FAP budgets for April-June.

Homeless Shelter Deduction

Groups in which all members are homeless may receive a homeless shelter deduction; see RFT 255, Food Assistance Standards, if they have a shelter expense.

The FAP group has the choice between using their actual shelter expense(s) or the homeless shelter deduction.

Example 1: Alivia and her children are at a domestic violence shelter, and they do not have any shelter expenses. Since she does not have any shelter expenses, they do not qualify for the HSD.

Example 2: Connor and his wife sleep on a park bench. They received a home heating credit in an amount greater than $20 in the current month or past 12 months. Their specialist inquires if they want to have the h/u standard or the HSD in their budget. Once the specialist explains the two different amounts, the clients choose the h/u standard.

Housing Expenses

Housing expenses include rent, mortgage, a second mortgage, home equity loan, required condo or maintenance fees, lot rental or other payments including interest leading to ownership of the shelter occupied by the FAP group.

The expense must be a continuing one. Payments that exceed the normal monthly obligation are **not** deductible as a shelter expense unless the payment is necessary to prevent eviction or foreclosure, **and** it has **not** been allowed in a previous FAP budget. Additional expenses for optional charges, such as carports, pets, etc. are **not** allowed.

Note: Some finance companies or banks may combine billings for allowable shelter expenses with other loans. Be careful to only allow the portion that is an allowable shelter expense. Home equity loans are allowable, see *Determining the Monthly Amount, Home Equity Loan Expense* in this item.

Temporary Housing

If FIP or SDA shelter vendor payments are made on behalf of a FAP group residing in **temporary housing** per BEM 500, Income Overview, subtract the vendor payment from the total shelter amount to determine the allowable shelter expense.

Rental Income Situations

Do **not** deduct the cost of doing business from the shelter expense of a FAP group with rental income.

Property Taxes, Assessments, and Insurance

Property taxes, state and local assessments and insurance on the structure are allowable expenses. Do **not** allow insurance costs for the contents of the structure, for example, furniture, clothing, and personal belongings.

Allow the entire insurance charge for structure and contents when the amount for the structure cannot be determined separately.

Renter's insurance is **not** allowed.

Home Repair Expenses

Allow charges for repair of a home which was substantially damaged or destroyed due to a natural disaster such as fire or flood.

Note: Do **not** allow any portion of an expense that has been or will be reimbursed by any source.

Verification

If considered questionable, verify shelter expenses at application and when a change is reported. If the client fails to verify a reported change in shelter, which is considered questionable, remove the old expense until the new expense is verified.

If questionable, verify the expense **and** the amount for housing expenses, property taxes, assessments, insurance, and home repairs.

Note: Adult Foster Care Homes (AFC), Center for Substance Abuse Services (CSAS) and CMH/MDHHS Supported Community Living Facilities still require verification.

Verification Sources

Acceptable verification sources include, but are **not** limited to:

- Mortgage, rental or condo maintenance fees contracts or a statement from the landlord, bank, or mortgage company.
- Copy of tax, insurance, assessment bills or a collateral contact with the appropriate government or insurance office.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address if verifying shelter, the provider of the service and the name of the person paying the expense.
- MDHHS-3688, Shelter Verification form. A copy of this form will be sent to the FAP group, and a task and reminder sent to the specialist when a change of address is done in Bridges. The due date will be on the form. The specialist must monitor for return of the form and take appropriate action if it is or is **not** returned.

- Current lease.

MANDATORY HEAT AND UTILITY STANDARDS

The heat/utility (h/u) standard covers all heat and utility costs including cooling, **except** actual utility expenses, for example, installation fees etc.; see *Actual Utilities* in this item. Do **not** prorate the h/u standard even if the heating/cooling expense is shared.

FAP groups that qualify for the h/u standard **do not** receive any other individual utility standards. Do **not** require verification, unless questionable of the other utility standards if the household is already eligible for the h/u standard.

Note: FAP groups whose heat is included in their rent may still qualify for the h/u standard. Some additional ways include but are not limited to, receipt of the Home Heating Credit (HHC) or a Low-Income Home Energy Assistance Payment (LIHEAP). The amount of either payment must be greater than $20 in the month of application or in the immediately preceding 12 months prior to the application month.

Heating Separate from Housing Costs

A FAP group which has a heating expense or contributes to the heating expense separate from rent, mortgage or condominium/maintenance payments must use the h/u standard.

Note: Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Heat Verification

If questionable, verify heating separate from housing costs at application or when a change is reported.

Exception: For groups that have verified that they own or are purchasing the home that they occupy, verify the heat obligation only if questionable.

Heat Verification Sources

If questionable, acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for heating/cooling expenses.
- Collateral contact with the landlord or the heating/cooling provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
- MDHHS-3688, Shelter Verification.
- Current lease.

Cooling Separate from Housing Costs

FAP groups who pay for cooling (including room air conditioners) are eligible for the h/u standard if, they have the responsibility to pay for non-heat electric.

Note: Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Verification

If questionable, verify non-heat electric at application or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for electric expenses.

- Collateral contact with the electric provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
- MDHHS-3688, Shelter Verification.
- Current lease.

Heat Included in Rent or Fees

FAP groups whose heat is **included** in their rent or fees are not eligible for the h/u standard, **unless** they are billed for **excess heat** payments from their landlord.

Note: Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Verification

If questionable, verify the excess heat expense at application or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the landlord for excess heat expenses.
- Collateral contact with the landlord.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

Home Heating Credit (HHC)

New Applications

FAP groups who have received an HHC in an amount greater than $20 in the application month or in the immediately preceding 12 months prior to the application month are eligible for the h/u standard.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Bridges inquiry. (HHC Approved Client Inquiry).
- Letter from provider.
- Collateral contact with provider.
- Copy of HHC warrant.

Existing FAP Groups

FAP groups who are at redetermination and have received an HHC in an amount greater than $20 in the certification month or in the immediately preceding 12 months prior to the certification month are eligible for the h/u standard.

Note: Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Verification

If questionable, verify receipt of HHC at application, redetermination or when a change is reported.

Low Income Home Energy Assistance Payment (LIHEAP)

New Applications

FAP groups who have received a LIHEAP payment, or a LIHEAP payment was made on their behalf in an amount greater than $20

in the application month or in the immediately preceding 12 months prior to the application month are eligible for the h/u standard.

Existing FAP Groups

FAP groups who are at redetermination and have received a LIHEAP payment or a LIHEAP payment was made on their behalf in an amount greater than $20 in the certification month or in the immediately preceding 12 months prior to the certification month are eligible for the h/u standard.

Note: LIHEAP payments may include State Emergency Relief (SER) energy related payments or Michigan Energy Assistance Program (MEAP) payments. Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.

Verification

If questionable, verify receipt of a LIHEAP payment at application, redetermination or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Bridges Inquiry (benefit issuance for energy related SER).
- Letter from provider.
- Collateral contact with provider.
- Proof of LIHEAP payment.

Electricity Included in Rent or Fees

FAP groups whose electricity is **included** in their rent or fees are not eligible for the h/u standard **unless** their landlord bills them separately for excess cooling.

Verification

If questionable, verify separate excess cooling expense at application or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- A written statement from the landlord for separate cooling expense.
- Collateral contact with the landlord.

Shared Meters or Expenses

If the FAP group has **any** responsibility for the heating/cooling expense, use the h/u standard.

Verification

If questionable, verify the heating/cooling expense at application or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the landlord.
- Collateral contact with the landlord.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

MANDATORY INDIVIDUAL STANDARDS

FAP groups not eligible for the h/u standard who have other utility expenses or contribute to the cost of other utility expenses are eligible for the individual utility standards. Use the individual standard for each utility the FAP group has responsibility to pay. Do **not** prorate the utility standard even if the expense is shared.

Non-Heat Electric Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for non-heat electricity separate from rent/mortgage or condo/maintenance fees must use the non-heat electric standard. The standard covers **only** non-heat electric.

Verification

If questionable, verify non-heat electric expense at application or when a change is reported.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for electric expenses.
- Collateral contact with the electric provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
- MDHHS-3688, Shelter Verification.
- Current lease.

Water and/or Sewer Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for water and/or sewer separate from rent/mortgage or condo fees, must use the water and/or sewer standard. The standard covers **only** water and/or sewer expenses.

Verification

Do **not** verify the water or sewer expense, unless questionable; see BAM 130, Verification and Collateral Contact, regarding verification of questionable data.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for water or sewer expenses.
- Collateral contact with the water or sewer provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

Telephone Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for a traditional land-line service, cellular phone service including per-minute or per-call service and voice over Internet protocol (VoIP) must use the telephone standard. The standard covers **only** the telephone expense.

Verification

Do not verify the telephone expense, unless questionable; see BAM 130 regarding verification of questionable data.

Verification Sources

Acceptable verification sources include, but are **not** limited to:

- Current bills or a written statement from the telephone provider.
- Collateral contact with the telephone provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

Cooking Fuel Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for cooking fuel separate from rent/mortgage or condo fees must use the cooking fuel standard. The standard covers **only** cooking fuel expenses.

Verification

Do not verify the cooking fuel expense, unless questionable; see BAM 130 regarding verification of questionable data.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for cooking fuel expenses.
- Collateral contact with the cooking fuel provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

Trash Removal Standard

A FAP group which has no heating/cooling expense but has a responsibility to pay for trash or garbage removal separate from rent/mortgage or condo fees must use the trash removal standard. The standard covers **only** trash removal.

Verification

Do not verify the trash or garbage removal expense, unless questionable; see BAM 130.

Verification Sources

If the trash or garbage removal expense is questionable, acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for trash removal.
- Collateral contact with the trash removal provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

INTERNET EXPENSE

A FAP group who is responsible to pay for an internet service (at least the basic service) is eligible for the internet standard. This expense is separate from any of the utility standards.

Do not prorate this expense even if the expense is shared by others.

Verification

If questionable, verify receipt of internet expense at application, redetermination or when a change is reported. See BAM 130.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current statement/bill.
- Collateral contact with the provider.

ACTUAL UTILITY EXPENSES

Actual utility expenses will be used for the following expenses only:

- Utility installation charges (not deposits).
- Water well installation and maintenance.
- Septic installation and maintenance.

Note: Do **not** allow an actual utility expense for reconnection fees after service has been turned off for the same people at the same address.

Verification

Verify the actual expense.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider.
- Collateral contact with the provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

SHELTER COSTS FOR UNOCCUPIED HOME

Allow shelter costs for a home temporarily unoccupied by the FAP group due to:

- Employment or training away from home.
- Illness.
- Abandonment caused by a natural disaster or casualty loss.

Include shelter costs for a temporarily unoccupied home, provided all the following are true:

- The FAP group intends to return to the home.
- The current occupants of the home, if any, are **not** claiming shelter costs on that home for FAP purposes.
- The home is **not** being leased or rented to others during the FAP group's absence.

Allowable Expenses

Allow the following expenses:

- Basic shelter expenses as described above.
- Heat and Utility Standard, or individual utility standards.
- Utility installation fees charged by the utility provider, excluding deposits.
- Well/septic installation and maintenance.

Exception: Heat and utility expenses may only be claimed for one home.

Verification

If questionable, the shelter and heat and utility expenses must be verified.

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider for electric expenses.
- Collateral contact with the electric provider.
- Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.
- MDHHS-3688, Shelter Verification.
- Current lease.

Verification

Verify the actual utilities at application, redetermination and when a change is reported***.***

Verification Sources

Acceptable verification sources include, but are not limited to:

- Current bills or a written statement from the provider.
- Collateral contact with the provider.
- Cancelled checks, receipts, or money order copies, if current. the receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense.

Actual utility expenses will be used for the following expenses only:

- Utility installation charges (not deposits).
- Water well installation and maintenance.
- Septic installation and maintenance.

NOTE: Do not allow an actual utility expense for reconnection fees after service has been turned off for the same people at the same address.

FAP ALLOWABLE EXPENSES - DESK AID

Ineligible student has expense?	If no, go to the next section. If yes, do not allow the expense.

Disqualified due to: • Lack of SSN, non-citizen status. • Time limited, child support. Has expense?	If no, go to the next section. If yes, allow full shelter, heat, and utility expenses. **Note:** Prorate other expenses, such as shelter, and dependent care expenses, between the household members. Allow the prorated portion designated for the eligible group members.
Disqualified due to: • IPV. • Employment related. • Divestment. Has expense?	If no, go to the next section. If yes, allow full expense.
Receives subsidized housing?	If no, go to the next section. If yes, allow only the portion of the rent for which the client is responsible.
Verifications.	**If questionable, required** at application and reported change. **Acceptable verifications:** • MDHHS-3688. • Current lease. • Rent receipt. • Collateral contact with the landlord. • Statement from HUD. **Note**: These types of verifications must identify the client and the client's address and obligations.
Housing/rent responsibility?	If no, do not allow an expense. Go to the next section. If yes, allow the expense. Do not allow late fees, penalties, or one-time deposits.
Verifications.	**If questionable, required** at application and reported change. **Acceptable verifications:** • MDHHS-3688. • Current lease. • Rent receipt. • Collateral contact with landlord. **Note**: These types of verifications must identify the client's address and obligations.

Homeless Shelter Deduction?	If a group is homeless and chooses the homeless shelter standard; see RFT 255, Food Assistance Standards.
Purchasing home or ownership responsibility?	If no, do not allow an expense. Go to the next section. If yes, allow the full expense. **Note**: 1. Allow taxes, insurance, required maintenance and condo fees the client is responsible for that are not included in the mortgage payment. 2. Do not allow late fees or penalties.
Verifications.	**If questionable, required** at application and reported change. **Acceptable verifications:** • MDHHS-3688. • Land contract. • Tax bills. • Insurance bills. • Mortgage papers. • Assessment bills. • Collateral contact. **Note**: These types of verifications must identify the client's address and obligations.
Responsible for heating expenses separate from mortgage/rent/fees?	If no, do not allow the heat and utility (h/u) standard. Go to the next section. If yes, allow the h/u standard, which includes all the individual utility standards.
Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.	

Heat Verifications.	**If questionable,** at application and reported change, enter the appropriate verification source, if available. **Acceptable verifications:** • MDHHS-3688. • Current lease. • Current bill that identifies the expense. • Collateral contact with the landlord or provider. **Note:** 1. Verify the heat obligation only if questionable for groups that have verified that they own or are purchasing the home they occupy. 2. If the heating bill is in someone else's name, allow the expense if the client claims the expense and the service address on the bill is where the FAP group lives.
Responsible for cooling expenses separate from rent/fees?	If no, do not allow the h/u standard. Go to the next section. If yes, allow the h/u standard, which includes all the individual utility standards if the client has a non-heat, - electric expense.
Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.	
Cooling Verifications	**If questionable,** enter the appropriate verification source, if available. **Acceptable verifications**: • MDHHS-3688. • Current lease. • Current bill that identifies the expense for the FAP group. • Collateral contact with the landlord or provider. **Note**: If the non-heat electric bill is in someone else's name, allow the expense if the client claims the expense and the service address on the bill is where the FAP group lives.
Heat included in rent/fees, but responsible for: • Excess heat costs.	If no, do not allow the heat and utility standard. Go to the next section. If yes, allow the h/u standard.
Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.	

Excess heat verifications.	**If questionable,** enter the appropriate verification source, if available. **Acceptable verifications**: • Current bills or written statement from the landlord. • Collateral contact with the landlord. • Cancelled checks, receipts, or money order copies, if current.
Receipt of HHC in an amount greater than $20 in the current month or preceding 12 months.	If no, do not allow h/u standard. Go to the next section. If yes, allow the h/u standard.
Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.	
HHC verifications	If questionable, enter the appropriate verification source, if available. **Acceptable verifications:** • Bridges inquiry. (HHC Approved Client Inquiry). • Letter from provider. • Collateral contact with provider. • Copy of HHC warrant.
Receipt of LIHEAP payment or a LIHEAP payment was made on the group's behalf in an amount greater than $20 in the current month or immediately preceding 12 months. (energy related SER or MEAP)	If no, do not allow h/u standard. Go to next section. If yes, allow the h/u standard.
Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.	
LIHEAP payment verification.	If questionable, enter the appropriate verification source, if available. **Acceptable verifications:** • Bridges inquiry. (Benefit issuance for energy related SER.)

	• Letter from provider. • Collateral contact with provider. • Proof of MEAP payment.
Electricity included in rent/fees, but responsible for: Excess cooling costs.	If no, do not allow the heat and utility standard. Go to the next section. If yes, allow the h/u standard.
Effective August 1, 2017, FAP groups that receive a $20.01 LIHEAP payment by having a shelter expense greater than zero, are not homeless (based on the head of Household Living Arrangement) and do not meet any other eligibility factors to receive the h/u standard, will receive the h/u standard because of the $20.01 LIHEAP payment.	
Excess cooling verifications.	**If questionable,** enter the appropriate verification source, if available. **Acceptable verifications**: • Written statement from the landlord. • Collateral contact with the landlord.
Responsible for non-heat electric expenses and not eligible for the h/u standard?	If no, do not allow the heat and utility standard. Go to the next section. If yes, allow the non-heat electric standard.
Non-heat electric verifications.	**If questionable,** enter the appropriate verification source, if available. **Acceptable verifications**: • MDHHS-3688. • Current lease. • Current bill that identifies the expense for the FAP group. • Collateral contact with the landlord or provider. **Note:** If the non-heat electric bill is in someone else's name, allow the expense if the client claims the expense, and the services address on the bill is where the FAP group lives.
Responsible for water and/or sewer expenses and not eligible for the h/u standard?	If no, do not allow the heat and utility standard. Go to the next section. If yes, allow the water and/or sewer standard.

Water and/sewer verifications	Not required, unless questionable. Acceptable verifications: • Current bill that identifies the expense for the FAP group. • Collateral contact with the landlord or provider. **Note:** If the water and/or sewer bill is in someone else's name, allow the expense if the client claims the expense and the service address on the bill is where the FAP group lives.
Responsible for telephone, monthly cellular phone plans and not eligible for the h/u standard (Y/N)?	If no, do not allow the heat and utility standard. Go to the next section. If yes, allow the telephone standard.
Telephone verifications.	**Not** required, unless questionable. **Acceptable verifications**: • Current bill that identifies the expense for the FAP group **and** must include at least the monthly basic fee. • Collateral contact with the provider.
Responsible for cooking fuel expenses and not eligible for the h/u standard?	If no, do not allow the heat and utility standard. Go to the next section. If yes, allow the cooking fuel standard.
Cooking fuel verifications.	**Not** required, unless questionable. **Acceptable verifications**: • Current bill that identifies the expense for the FAP group. • Collateral contact with the provider.
Responsible for trash removal expenses and not eligible for the h/u standard (Y/N)?	If no, do not allow the heat and utility standard. Go to the next section. If yes, allow the trash removal standard.

Trash removal verifications.	**Not** required, unless questionable. **Acceptable verifications**: • Current bill that identifies the expense for the FAP group. • Collateral contact with the provider.
Internet Expense	Is the client eligible for at least the basic internet service? If yes, allow the internet standard.
Internet Service Verifications	**Not** required, unless questionable. • Current statement/bill. • Collateral contact with provider.
Actual utility expenses?	If yes, allow only the following expenses: Utility installation charges (**not deposits**). Water well installation and maintenance. Septic installation and maintenance.
Actual utility verifications.	**Verify** the actual expense. **Acceptable verifications include, but are not limited to:** • Current bills or a written statement from the provider. • Collateral contact with the provider. • Cancelled checks, receipts, or money order copies, if current. The receipt must contain minimum information to identify the expense, the amount of the expense, the expense address, the provider of the service and the name of the person paying the expense. **Note:** Do not allow an actual utility expense for reconnection fees after the service has been turned off for the same people at the same address.

LEGAL BASE

7 CFR 273.8(h)
7 CFR 273.9(d), 9(d)(6)(iii),.10(d)(6),.11(c),.21
7 CFR 273.9 (c)(10)(11)
42 USC 8621 - 8630
Michigan Low Income Heating Assistance and Shut Off Protection Act, MCL 400.1201 et. seq.
Food and Nutrition Act of 2008, as amended, Sec. 5. 7 U.S.C. 2014

DEPARTMENT POLICY

FAP Only

A food assistance worksheet must be completed at initial application, semi-annual, mid-certifications and at each redetermination for all approvals, denials and closures made based on income. In addition, the worksheet is used to document changes in assets (non-categorically eligible FAP groups), income and expenses, and to document supplemental benefits. The worksheet is not needed to document withdrawn requests or applications, but this must be documented somewhere within the case.

Specialists must use the automated food assistance budget in Bridges to complete the required worksheet whenever possible.

Categorical eligible groups automatically meet the asset test for food assistance unless the group is reapplying after closing for having a single lottery or gambling winning of $4,500 or more; see Bridges Eligibility Manual (BEM) 213, FAP Categorical Eligibility or BEM 403, Food Assistance Lottery/Gambling Winnings.

COMPLETING THE DHS-2242, FOOD ASSISTANCE WORKSHEET

Complete the DHS-2242, Food Assistance Worksheet, in the following manner:

1. Complete the Case Name and Case Number/EDG and specialist name and date when completing the form.

2. Complete the first line of the Action box.

    - Check New, if the worksheet is being prepared for an initial application and application date.

    - Check Redetermination, if the worksheet is being prepared for a redetermination.

    - Check Change, if the worksheet is being prepared as the result of a change.

- Check Semi-Annual, if the worksheet is being prepared because of processing the MDHHS-1046, Semi-Annual Contact Report.
- Check Mid-Certification, if the worksheet is being prepared because of processing the MDHHS-2240-A, Mid-Certification Contact Notice.

3. Enter the number of members in the Food Assistance Group.

4. Complete the Categorical Food Assistance section.

   Check the appropriate box:

   - Categorially Eligible.

Non-categorically eligible.

5. Complete the SDV section.

   - Senior/Disabled/Disabled Veteran or
   - Non-Senior/Disabled/Disabled Veteran.

Countable Assets

Complete the Countable Assets section of the worksheet if the group is non-categorically eligible. If the FAP group exceeds the asset limit, (BEM 400, Assets) deny FAP benefits.

6. Complete the *Income Calculation* section.

Note: Individual calculations used to arrive at each income and expense figure for lines 1 through 47 must be clearly documented. Cents are included in the computation for each person's earned income then dropped before totaling the group's gross earned income. The same computation is completed for each person's unearned income. No cents are involved when totaling the final group amounts to enter on lines 3 and 6. Complete the income calculation to determine the benefit amount.

Exception: If the individual(s) has earned and/or unearned income and is disqualified (Social Security Enumeration, Citizenship/Non-citizenship Status, or Time Limited) the income is prorated; see BEM 550. The remainder of the income computation is unchanged.

Line 1- Enter Monthly Self-Employment Income minus allowable farm income loss. Use the Self-

Employment Income Workspace (on page 2). Round the monthly amount down by dropping all cents from the final figure. If farm income loss exceeds self-employment income, enter zero and record any remaining farm loss income in the Remarks section for use in line 1.

Line 2- Calculate the countable total of all other monthly earned income by using the Other Countable Earned Income Workspace (on page 2). List each countable source of earned income and the verified gross income used as the basis of the calculation. Then, determine the countable monthly amount for each source. Round the monthly amount down by dropping all cents from the final figure and enter it in the Monthly Amount column.

Line 3- Self-explanatory.

Line 4- Enter the amount of FIP/RCA/SDA income.

Line 5- Calculate the countable total of all other unearned income (RSDI, SSI, UCB, retirement benefits, etc.,) by using the Other Countable Unearned Income Workspace (on page 3). List each countable source of unearned income and the verified gross income used as the basis of the calculation. Then, determine the countable monthly amount for each source. Round the monthly amount down by dropping all cents from the final figure and enter it in the Monthly Amount column.

Line 6- Self-explanatory.

Line 8- Enter 80 percent of the amount on line 3. Drop cents.

Exception: Not allowing 20 percent earned income deduction is used by Overpayment Establishment Analyst only when determining the overpayment amounts for failure to report earned income timely; see Bridges Administrative Manual (BAM) 720, Intentional Program Violation:

- For IPV overpayments issued in or after October 1987.
- For client error overpayments issued in or after September 1996.

Line 9- Enter the amount from line 6.

Line 10- Determine the amount of gross income by adding the amount from line 8 to the amount from line 9 and deducting any remaining allowable farm income loss; see line 1.

Line 11- Enter standard deduction; see RFT 255, Food Assistance Standards.

Line 12- Self-explanatory.

7. Complete Medical Expenses Calculation.

Note 1: For non-Senior/Disabled/Disabled Veteran groups, enter 0 on line 15 and 16. Go to line 17. For Senior/Disabled/Disabled Veteran groups, complete lines 13-18, if applicable.

Note 2: If an SDV individual is disqualified (Social Security Enumeration, Citizenship/Non-citizenship Status, or Time Limited) their medical expense(s) is not allowed; see BEM 554.

Line 13- Total allowable monthly medical expenses. Round down if cents are 01-49, round up if cents are 50-99. Enter total.

Line 14- $35 medical deduction.

Line 15- Self-explanatory.

Line 16 Standard Medical Deduction.

Line 17- Enter 15 or 16 whichever is greater.

Line 18- Subtract 17 from 12.

8. Complete Dependent Care Calculation.

Note: If the individual responsible to pay the expense is disqualified (Social Security Enumeration, Citizenship/Non-citizenship Status, or Time Limited) the expense is prorated; see BEM 554.

Line 19- Enter Actual Monthly Out-of-Pocket Dependent Care Costs. Round down by dropping cents.

9. Complete Child Support Expenses Calculation.

Note: If the individual responsible to pay the expense is disqualified (Social Security Enumeration, Citizenship/Non-citizenship Status, or Time Limited) the expense is prorated; see BEM 554.

Line 20- Enter monthly child support expenses. Drop cents after totaling.

Line 21- Self-explanatory.

Line 22- Self-explanatory.

10. Complete Shelter Expense Calculation section.

In lines 24-34 enter only the heat and utility expenses, and internet expense the group is responsible to pay or contributes to, which are separate from rent. Unless otherwise noted.

Line 23- Enter allowable monthly shelter costs (rent, mortgage, taxes, insurance, etc.,). Use exact amount including cents.

Note: If the individual responsible to pay the expense is disqualified (Social Security Enumeration, not meeting Citizenship/Non-citizenship Status, or Time Limited) the shelter expense is prorated.

Line 24- If the group has a heat expense separate from shelter, enter the h/u standard; see RFT 255, Food Assistance Standards. Go to line 33.

Line 25- Enter non-heat electric standard if applicable; see RFT 255.

Line 26- Greater than $20 of LIHEAP, SER energy-related or MEAP, enter the h/u standard; see RFT 255. Go to line 33.

Line 27- Home Heating Credit greater than $20, enter the h/u standard; see RFT 255. Go to line 33.

Line 28- Excess Cooling- is the household responsible for excess cooling billed by their landlord and their non-heat electric is included in their rent, enter the h/u standard; see RFT 255.

Note: If the client is eligible for the h/u standard, then go to line 33.

Line 29- Enter water/sewer standard if applicable; see RFT 255.

Line 30- Enter telephone standard if applicable; see RFT 255.

Line 31- Enter cooking fuel standard if applicable; see RFT 255.

Line 32- Enter trash/garbage removal standard if applicable; see RFT 255.

Line 33- Enter actual utilities expense. Enter monthly amount for initial heat or utility installation, or well/septic installation and/or maintenance if applicable.

Line 34- Enter the internet standard if applicable; see RFT 255.

Note: this standard is separate from the heat/utility standard.

Line 35- Add lines 23 - 34. Round down if cents are 01 - 49, round up if cents are 50 - 99.

Line 36- Divide the amount on line 22 by 2 and enter the result. Drop cents.

Line 37- Subtract line 35 from line 36 Excess Shelter.

Line 38- For Non-SDV groups enter the shelter maximum; see RFT 255.

Line 39 Enter the lesser of line 37 or line 38 for non-SDV. Enter line 37 for SDV.

Line 40- If group is homeless, enter the Homeless Shelter Deduction; see RFT 255.

Line 41 Subtract line 39 or 40 (whichever is higher) from line 22.

Note: If Line 41 Exceeds Maximum Net Income in RFT 250 Column B and Categorical FAP Criteria is not Met - Deny Benefits. Verify all countable income before application can be denied for exceeding the income limit.

11. Complete Benefit Calculation; see RFT 260, Food Assistance Issuance Table. Line 43 is not used for Group Sizes of 1 and 2, use RFT 260 and enter the benefit amount on line 44.

Line 42- Enter the amount of benefits the FAP group would receive if it had 0 income; see RFT 260.

Line 43- Multiply line 42 by .30 (30%) and enter the result. Round up.

Line 44- Subtract 43 from 42 = Monthly Benefit. If amount is zero, deny benefits or close the program except for recoupment situations or in the case of temporary ineligibility.

Note: If the benefit is reduced to zero due to recoupment, the Food Assistance case must remain active with zero benefits if all other eligibility criteria are met.

Line 45- If benefits require proration and Bridges is **not** accessible, use the following formula: Multiply the monthly benefits by the number of days remaining in the month including the application date. Divide this amount by the total number of days in the month. Drop cents. If the benefit amount is less than $10.00, the FAP group will **not** receive an initial benefit. (This applies to initial benefits only.)

Line 46- If the case has an administrative recoupment, enter amount. Drop cents when calculating AR benefit reduction amount.

Line 47- Subtract line 46 from 44.

12. Complete the Approved/Denied section.

    - Decision - check whether Food Assistance benefits were approved or denied. (Denied is checked if a change results in closure.)

13. Action box on page 1.

    - Benefit Period - Indicate the month(s)/year(s) of the benefit period.

    - Effective Date - For approval of an application filed during any period a FAP group was not certified for benefits, the effective date is one of the following:

        - The date of application if the group is eligible for the application month (even if the benefit amount prorates to zero).

- The first day of the application month for a migrant/seasonal farmworker group that received FAP benefits in the month before the application month (this will prevent proration of benefits on Bridges).
- The first day of the application month for MiCAP cases (these cases are not prorated).
- The first day of the month following the application month if the group is **not** eligible for the month of application but is eligible in the next month.
- The actual date the group complies with all application eligibility requirements if the application was delayed beyond the 30-day standard of promptness and the group was at fault for the delay.

This effective date indicates whether the FAP group should be authorized full or prorated benefits for the first month of eligibility.

For approval of an application filed during a current benefit period**,** the effective date is the first day of the month of the new benefit period.

For a change **-** The effective date is the first day of the month that a change is reflected in the FAP group's issuance.

LEGAL BASE

7 CFR 273.10
Food and Nutrition Act of 2008, as amended, Sec. 5. 7 U.S.C. 2014

DEPARTMENT POLICY

Medical Assistance (MA) and Food Assistance Program (FAP) Only

This item defines migrant and seasonal farmworker. Groups composed of migrants/seasonal farmworkers must meet the same eligibility requirements as all other applicants and recipients for all programs, with certain exceptions for MA and FAP described in this item.

DEFINITIONS

Migrant

A migrant is a person who does both of the following:

- Works or seeks work in agriculture or a related seasonal industry.
- Moves away from his usual home to a temporary residence as a condition of employment or because the distance from his usual home is greater than 50 miles.

Migrant status continues as long as the migrant meets one of the following:

- Is employed in agriculture or a related seasonal industry.
- Has a commitment of employment or is actively seeking employment.

Migrant status continues for 30 days from the date the migrant last worked in an agricultural activity or entered Michigan, whichever is more recent.

Exception: Migrant status continues beyond 30 days when any of the following occurs:

- Legal circumstances require a migrant to remain in the area such as labor relations dispute, immigration or incarceration.
- Illness or hospitalization prevents a migrant from leaving the area.

- Unusual agricultural circumstances affect farm work or crops in Michigan or the migrant's home base such as weather conditions or natural disasters.

Seasonal Farmworker

A seasonal farmworker is a person who meets both of the following:

- Works in agriculture or a related seasonal industry.
- Is not required to be absent overnight from his permanent place of residence.

Note: Seasonal farmworker status continues as long as the FAP group contains at least one individual engaged in seasonal farm work during the current benefit period regardless of the amount of income it may receive from that source.

Agriculture/ Related

Employment is any of the following:

- On a farm, ranch orchard or vineyard performing field work related to planting, cultivating or harvesting operations; and tree or plant maintenance such as pruning or thinning.
- In canning, sorting, packing, ginning, seed conditioning, processing operations or related research.
- Nursery and greenhouse activities, excluding landscaping.
- Reforestation.
- Preparation and harvest of Christmas trees and other evergreen products.
- Dairy, livestock (including swine and sheep), poultry and beekeeping.

Migrant/Seasonal Farmworker FAP Group

FAP Only

A group that contains at least one individual who is a migrant/seasonal farmworker is considered a migrant/seasonal farmworker group.

Two unusual living arrangements common to migrants modify FAP group policy:

- A group of individuals such as single persons in a migrant camp that hires someone to purchase and prepare meals for the group is considered one FAP group. Each person cannot be a FAP group of one.
- If members of a migrant household are lodged in separate dwellings in a camp, the members qualify as a single FAP group if they purchase and prepare their meals together.

INTERVIEWS

MA Only

In-person interviews are not required. The application and redetermination process may be conducted through correspondence and phone contact.

FAP Only

An interview is required at application and redetermination. The interview may be an in-office appointment, telephone appointment or home call. Because migrant groups often reside in isolated areas and may have transportation problems and/or no access to a telephone, a face-to-face interview at the group's work site may be required; see Bridges Administrative Manual (BAM)115, Application Processing.

AUTHORIZED REPRESENTATIVES

FAP Only

Migrant or seasonal farmworker groups have the right to appoint an authorized representative. The representative must be an adult who is knowledgeable about the group's circumstances and who is

trusted by the group; see BAM 110, Application Filing And Registration.

CONCURRENT RECEIPT OF BENEFITS

FAP Only

A group cannot receive benefits in more than one county/state in any given month. Contact the other state to verify if the migrant was receiving FAP benefits in the month of the move. The migrant is not entitled to benefits in Michigan for the month of the move if the other state verifies receipt or the migrant acknowledges participation. The migrant may receive benefits in Michigan the month after the move, provided the other state verifies that benefits will not be available to the migrant that month. Benefits are not available if they are not authorized for the month or the migrant cannot obtain the authorized benefit.

Note: Some Electronic Benefit Transfer (EBT) systems make authorized benefits available to out-of-state recipients via a 1-800 number.

Contact the other state for verification by telephone, if at all possible. Confirm the information received and the fact that the client is now in Michigan by sending a DHS-3782, Out-of-State Inquiry, to the other state; see Bridges Eligibility Manual (BEM) 222, Concurrent Receipt Of Benefits.

RESIDENCE

MA Only

Children meet the residence requirement when the parent or specified relative they live with is a migrant.

FAP Only

Verify a migrant group's address; however, the group cannot be required to have a fixed residence in the local area. If they live at a camp site, motel, temporary shelter, etc., they meet the residence requirement. Do not deny benefits solely for lack of residence verification if they do not have a permanent address. Note the lack of verification and the reason in the case file .

A migrant group must live in the county at the time it files the application for FAP. Migrant groups cannot be required to live in the county or state for any length of time or have any intent of staying for any length of time to receive FAP benefits. For example, a migrant group arriving in Michigan to look for work could be eligible on the day of its arrival; see BEM 220, Residence.

CITIZENSHIP AND NON-CITIZEN STATUS

FAP Only

If a group member is identified on the application as a U.S. citizen, do **not** require verification unless the statement about citizenship is inconsistent, in conflict with known facts or is questionable. The following are not sufficient reasons to question citizenship:

- General appearance of the applicant.
- Accent.
- English is not first language.
- Employment as a migrant farmworker.
- Unique sounding name.

Medicaid

U.S. citizenship must be verified to receive Medicaid; see BEM 225, Citizenship/Non-Citizen Status, for a list of acceptable documents.

Citizenship/non-citizen status is not an eligibility factor for emergency services only (ESO) MA. However, a person must meet all other eligibility factors including residency.

MA and FAP

If a group member is identified as a non-citizen, require proof that the identified non-citizen has an eligible classification; see BEM 225.

ASSETS

MA and FAP (Non-categorically eligible groups)

Exclude a migrant's homestead outside of Michigan if the migrant intends to return to it. If the migrant has both in-state and out-of-state homesteads, exclude only one; see BEM 400, Assets.

EXPEDITED SERVICE

FAP Only

Issue FAP expedited service to migrant and seasonal farmworker groups that meet expedited criteria. If these groups are determined to be destitute, the $150 monthly gross income requirement can be waived; see BAM 117, FAP Expedited Service.

Destitute Defined

Migrant or seasonal farmworker groups are destitute when their only income during the application month is one or both of the following:

- Stopped income received before the date of application.
- Starting income, if no more than $25 is expected by the 10th calendar day after the application date.

Note: Disregard travel advances when determining destitute status; see *Travel Advances* below.

Stopped and Starting Income and Destitute Status

The groups stopped or starting income must meet the following conditions for the purpose of determining destitute status.

Income received monthly or more frequently is:

- **Stopped income** if it will not be received again from the same source during the balance of the month of application or the following month.
- **Starting income** if no more than $25 was received from a new source within 30 days before the application was filed.

Income normally received less often than monthly is:

- **Stopped income** if it will not be received in the month in which the next payment would normally be received.
- **Starting income** if no more than $25 was received from the new source within the last normal interval between payments; see BAM 117.

Source of Income

A migrant farmworker's source of income is the grower, not the crew leader. Therefore, a migrant who changes growers has stopped income and starting income even though the migrant travels with the same crew leader.

Special Income Determination for Destitute Migrant or Seasonal Farmworker Groups

In the month of application, only count income received between the first day of the month and the date of application.

At redetermination, exclude all income from a new source in the first month of the new benefit period if no more than $25 is received from the new source within the first 10 days of the new benefit period. Any money received after 10 days does not affect this determination.

BUDGETING INCOME AND EXPENSES

MA and FAP Only

Always budget income and expenses prospectively. This means estimate the income and expenses expected each month. Include expected changes.

Prospecting Guidelines

Use the best available information to arrive at the prospected amounts. Seek input from the client whenever possible to establish an estimate and document the client's case.

Prospect income **only** if it can be reasonably anticipated. Income can be reasonably anticipated if the following is known:

- The expected amount of income.
- The approximate date of receipt.

Example: Mr. G. applies for MA and FAP on 4/10/18. He has a firm job offer and will start work 4/20/18.

He does not know whether he'll work full hours the first week. He also does not know if he'll get his first pay check on 4/24/18 or 5/1/18.

Do not prospect income for 4/18.

Use the following guidelines to prospect migrant and seasonal farmworker income:

- Current pay stubs may be used as an indication of income.
- Do not use past income figures for the expected amount **unless** the client agrees that the past amount is the amount he expects to receive in the prospective month.
- Income information from the prospective employer **or** a DHS-3569 can be used to project income.
- Do not project income from potentially available employment. It cannot be assumed that simply because work is available, everyone will be employed.

Supplemental Benefits

FAP Only

Advise clients of supplemental benefit policy. Decreases in income of $50 or more must be effective for the month the change was reported (but not sooner than the month the change occurs) **if** the eligible group provides requested verification within 10 days. This is the only situation in which a supplement can be issued for the month a change is reported.

Travel Advances

FAP Only

Some employers provide travel advances to employees to cover the costs of moving to their new employment.

A travel advance is an advance on wages when a written contract specifies it will be subtracted from later earnings. Otherwise, it is a reimbursement and excluded.

Exclude travel advances when determining destitute status based on starting income. Do not count travel advances when determining if starting income of $25 or less was received by the 10th calendar day after the date of application.

Budget a travel advance as income when it meets both of the following:

- It is an advance on wages.
- It is received between the first day of the month and the date of application.

INCOME VERIFICATION

FAP Only

Verify all countable earned income before authorizing benefits at application, redetermination and whenever a change occurs which results in a benefit increase.

The following methods of income verification are recommended because of the unique nature of income received by migrants and seasonal farmworkers:

- DHS-3569, Agricultural Worker Income Verification Statement.
- Check stubs and pay envelopes.
- Contact with the grower or crew leader. Verification may be by telephone, or by examination of the grower's records.
- If check stubs are not available and the grower will not cooperate, or if information from the client does not appear to be reliable, the worker may contact other persons or sources having knowledge of similar earning situations such as:
  - Crew leaders.
  - Michigan Employment Security Commission.
  - Cooperative Extension Service.
  - Child Care records.
  - Grower associations.
- **(Optional)** If the applicant states that he will be working for various growers and crew leaders:
  - Provide a calendar form such as form DHS-1423, Appointment Calendar.

- Allow space for recording each day's income and hours worked.
- Ask the grower or crew leader to sign and date the form.

Note: If the client states the grower did not provide him with pay stubs, it may be to his benefit to file a wage complaint form, WH-1981, with the Michigan Department of Labor, Wage and Hour Division. The applicant's refusal to file this form may not be used as a basis for denial for refusal to cooperate.

EMPLOYMENT-RELATED ACTIVITIES

FAP Only

Defer migrants and seasonal farmworkers from employment-related activities if they are one of the following:

- Employed an average of 30 hours or more per week over the benefit period.
- Receiving weekly earnings at least equal to the federal minimum wage times 30 hours.
- Under a contract or agreement to begin employment within 30 days.

BENEFIT PERIODS

FAP Only

Bridges assigns a 12-month benefit period. Groups with unstable or unpredictable circumstances will be assigned a three-month benefit period; see BAM 115.

INITIAL BENEFITS

Initial FAP benefits for migrants/seasonal farmworkers are prorated **only** when the group is not active the month prior to the date of application.

Groups that were active in the food assistance program the month **before** the date of application in any state, not just Michigan are eligible for a full month's benefit. This is true whether the entire group or any member of the group was active in the month **before** the FAP application date.

CHANGES

Change Report Form

FAP Only

Migrant/seasonal farmworker groups are required to report non-income changes within 10 days of the date the change becomes known to the group. Income-related changes such as starting/stopping, change in hours/rate of pay, etc., must be reported within 10 days of receiving the first payment reflecting the change. Give the DHS-2240, Change Report Form, or DHS-2240-SP (Spanish version) to these groups at the following times:

- At the time of the application interview.
- Upon benefit approval.
- Whenever a DHS-2240 is returned.
- At redetermination.
- Upon client's request.

See BAM 105, Rights And Responsibilities.

EXPEDITED HEARINGS

Request an expedited hearing if the migrant group plans to leave the state within 60 days.

To request an expedited hearing, do all of the following:

- Complete the DHS-3050, Hearing Summary, within two work days after the local office receives the hearing request.
- Write **Expedited Hearing** at the top of the DHS-18, Hearing Request.
- Forward the request according to BAM 600, Hearings, and local office procedures.

This is intended to assure that the group receives any benefits ordered before they leave the state; see BAM 600.

CASE TRANSFERS

FAP Only

Do not transfer migrant FAP-only (physical) case records. A separate case record (using the existing case number) must be established in the new county.

The transfer-out county retains the migrant FAP-only (physical) case record but must transfer FAP eligibility to the new county on Bridges; see BAM 305, Assignment, Reassignment, And Transfer.

Exception: The entire physical case record must be transferred to the new county if MA is active.

LEGAL BASE

MA

45 CFR 435.845
Deficit Reduction Act 2005, Social Security Act 1903(x), PL 109-171

FAP

7 CFR 273.2(i), .10, .12
7 CFR 274.12
Section 330(g) of the Public Health Service Act

DEPARTMENT POLICY

SDA and FAP Only

Residents of certain group living facilities can qualify for State Disability Assistance (SDA) and/or Food Assistance Program (FAP). This item defines these facilities and the programs residents may be eligible for. Bridges Eligibility Manual (BEM) 616, State Disability Assistance (SDA) Special Living Arrangement (SLA), and BEM 617, FAP In Nonprofit Group Living Facilities, provide special eligibility and budgeting rules. Bridges Administrative Manual (BAM) 430, SDA Special Living Arrangement Authorization And Payment, has instructions for authorizing payments to facilities.

FAP Only

Unless otherwise stated in this item, a facility is **not** permitted to accept food assistance benefits for meals served to its residents. Clients may use their food assistance benefits for purchases at regular outlets.

Adult Foster Care Home (AFC)

SDA and FAP Only

AFCs must be licensed by the License and Regulatory Affairs (LARA) Bureau of Community and Health Systems (BCHS) to offer either, or both, of the following levels of care:

- **Domiciliary care.** This includes meals, lodging, and supervision of basic living activities, such as eating, bathing and dressing.
- **Personal care.** This includes meals, lodging, supervision **and** personal assistance in basic daily living activities.

SDA Only

MDHHS adult community placement (ACP) workers determine the level of care for AFC residents. Facility payment **cannot** be authorized until the level of care determination is made.

MDHHS allows Community Mental Health (CMH) staff to place clients in an AFC homes under some circumstances. MDHHS accepts the CMH level of care determination (without ACP staff

approval). Facility payment **cannot** be authorized until the type of care determination is made.

FAP Only

In order to be eligible for FAP as an AFC home resident, the home must be nonprofit and licensed for 16 or fewer residents. **Nonprofit** means IRS tax exempt.

CMH/MDHHS Supported Community Living Facility

FAP Only

Persons participating in the CMH/MDHHS Supported Community Living Program live independently, usually two or three to an apartment. Local CMH or MDHHS agencies assist these clients or contract with independent agencies to enable residents to live more independently in their own home.

Such persons receiving CMH/MDHHS services are **not** in institutional status. Verify the amount of the client's shelter obligation from the provider. Do **not** calculate the client's portion of the shelter obligation by using the lease agreement and prorating the amount among all of the residents.

Note: CMH/MDHHS contributes toward shelter costs for some of these clients. Allow **only** the client's portion of a shelter expense in these situations.

County Infirmary (CTI)

SDA Only

CTIs are **not** licensed as AFCs but **are** regulated by BCHS. Thus, AFC licensing requirements are met.

The ACP worker determines whether a CTI resident needs domiciliary or personal care; see Adult Foster Care Home in this item. Facility payment **cannot** be authorized until the level of care determination is made.

Substance Abuse Treatment Center (SATC)

SDA and FAP Only

SATCs are licensed by the Substance Abuse Licensing Section (SALS) within LARA to provide treatment for drug and/or alcohol addiction.

SDA Only

SATCs (including residential alcoholism treatment centers) must be licensed by SALS. Eligible residents receive the **incidentals allowance only**. SALS makes all provider payments.

SATCs owned by the State of Michigan, are not required to meet licensing requirements within LARA.

When a client is requesting SDA and resides in a SATC and licensing requirements are questionable, the local office must contact Cash Policy at Policy-FIP-SDA@michigan.gov to request a policy exception.

FAP Only

In order to be eligible for FAP as a resident of an SATC the facility must be:

- Nonprofit, IRS tax exempt **and** licensed.
- If not licensed, certified by the Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration, Office of Recovery Oriented Systems of Care, will certify if the SATC is operating to further the purposes of Part B of Title XIX, by providing treatment and rehabilitation for drug addicts and/or alcoholics.

If an SATC applies for FAP on behalf of its residents and they are not licensed or certified, refer them to the Michigan Department of Health and Human Services Behavioral Health and Developmental Disabilities Administration, Office of Recovery Oriented Systems of Care at either:

- Email: mdch-bhdda@michigan.gov. The subject line should include Title XIX.
- Mail: Capitol Commons Center, Sixth Floor, 400 South Pine St., Lansing, MI 48913.

Home for the Aged (HFA)

SDA Only

HFAs must be licensed by LARA. Clients living in an HFA receive meals, lodging and special services for the aged. No level of care determination is necessary as there is only one rate for HFA payments.

Long-Term Care (LTC) Facility

SDA Only

LTC facilities must be licensed by LARA. Typically, such a facility provides meals, lodging and some level of medical care, for which Medicaid funding is received. Eligible residents receive the **incidentals allowance only.** See Bridges Program Glossary, Long-Term Care, for types of facilities that qualify.

Shelter for Victims of Domestic Violence

FAP Only

A shelter for victims of domestic violence and their children can be a public or private nonprofit residential facility. It might have other purposes (YWCA) and sets aside a portion of the facility on a long-term basis for use by victims and their children.

Federally Subsidized Housing for the Elderly

FAP Only

This is housing for the elderly, built under either Section 202 of the Housing Act of 1959 or Section 236 of the National Housing Act. There are **no** special budgeting or eligibility rules for residents of these facilities.

Temporary Housing for the Homeless

FAP Only

Temporary housing for the homeless is designed to provide meals, lodging and special services. The facility may be either public or private and either nonprofit or for profit. Clients may use food assistance benefits to purchase meals **only** from nonprofit facilities. Clients in for-profit facilities may use food assistance benefits at regular retail outlets.

VERIFICATION REQUIREMENTS

SDA and FAP Only

The local office must determine if the group living facility is acceptable before certifying eligibility for residents.

SATC, HFA and LTC

Obtain a copy of the facility's license. If the facility **cannot** provide a copy of its license, the license status for an SATC or LTC is available from LARA and for HFA it is available from OCAL.

Note: For FAP, an SATC which is not licensed may provide a letter or other certification from LARA indicating it is operating to further the purposes of Part B of Title XIX.

AFC, CTI

Obtain a copy of the facility's license. If the facility **cannot** provide a copy of its license, the license status is available from LARA; see FO-132, AFC Homes Listing by County.

Note: For FAP, AFC homes must be licensed for 16 or fewer residents.

SATC, AFC

FAP Only

The facility has nonprofit (IRS tax exempt) status. IRS provides documentation of tax status to each approved facility.

Note: For worker reference, the local office must maintain a list of group living facilities where residents may receive FAP if otherwise eligible.

LEGAL BASE

SDA

Annual Appropriations Act
Mich Admin Code, R 400.3151 – 400.3180

FAP

7 CFR 271.2
7 CFR 273.11(e),(f),(g),(h)

DEPARTMENT POLICY

SDA

A **Special Living Arrangement** (SLA) is a group living facility that provides food, shelter and some level of supervision and/or care, see BEM 615, Group Living Facilities.

The following living arrangements are considered SLAs. A client in an SLA may be eligible for SDA and Medicaid. If eligible for SDA, they may be entitled to an incidentals allowance and/or provider payments. If not eligible for SDA, they still may be eligible for Medicaid.

- Adult Foster Care (AFC) home.
- County Infirmary (CTI) (domiciliary or personal care clients only).

  Note: If not certified for domiciliary or personal care, the client is considered to be in independent living.

- Home for the Aged (HFA).
- Hospital (incidentals only) (HSP).
- Long-Term Care (LTC) facility (incidentals only).
- Substance Abuse Treatment Center (SAT) (incidentals only).

Reminder: A commercial room and board home is not an SLA.

SDA-SLA residents must meet all SDA eligibility factors unless indicated otherwise in this item. Policy and procedures for SDA SLA provider payments are in BAM 430.

Application before Admission

SDA

When possible, obtain the SDA application **before** the SLA admission. You must process it if:

- The client resides in your county; **and**
- The SLA is in your county; **or**
- The SLA is in another county but the stay is expected to be 30 days or less (see Temporary Absence in this section).

If the client's expressed purpose in applying is to receive SLA benefits, determine eligibility using the facility as the living arrangement. Do not enter the provider authorization in Bridges before being notified of the client's date of admission and the level of care needed; see BAM 430, SDA Special Living Arrangement Authorization and Payment.

Application after Admission

SDA

Applications filed after SLA admission must be processed by the local office where the SLA is located, **regardless** of the client's county of residence or projected stay.

The local office where the client resides assists by:

- Removing the client's needs from any multimember case (see Processing an SLA Admission in this item), **or**
- Transferring the single-member SDA case record to the local office now responsible for handling the client's benefit determination.

An SLA resident may apply for SDA at any time during their stay. However, SLA provider payment **cannot** begin more than **10 calendar days** prior to the date of application. The date of application is the date DHS receives a signed application. The client and facility are jointly responsible for timely application.

Application Interview

SDA

An application interview **must** be conducted before or after a SLA admission.:

Responsible Relatives

SDA

Married clients in SLAs must try to obtain spousal support in some situations. Refer clients estranged from their spouses to the prosecutor according to instructions in BEM 256, Spousal/Parental Support.

Residence

SDA

To establish residence, a person entering a Michigan SLA facility must express intent to remain in the state after leaving the facility. Accept the statement of intent **unless** evidence contradicts it. Examples of such evidence:

- An out-of-state job is held for the client.
- An out-of-state home is maintained.
- A spouse/child whom the client lived with before the SLA admittance remains out of state.

Temporary Absence

SDA

A temporary absence is 30 days or fewer away from the client's home. No extensions are permitted.

Note: For temporary absence purposes, admission to an SLA is not an absence for medical reasons.

When a client's SLA stay in another county is expected to be temporary, process the application or make any necessary changes to the client's benefits, and retain the case record. The local office where the facility is located assists by:

- Forwarding SDA-SLA provider payment authorization information.
- Following up with the facility if problems arise in obtaining needed information.

When an SLA stay in a facility served by another local office is not expected to be temporary, transfer the application, or transfer the case to that local office immediately after notice of the admittance; see **Processing an SLA Admission** in this item and BAM 305, Assignment, Reassignment and Transfer.

BUDGETING

SDA

To be eligible, the client must have a $1 deficit based on SDA standards. Bridges will compare the client's budgetable income against

the payment standard (provider payment and incidentals) for clients residing in an AFC, CTI or HFA.

For SATs, LTC facilities, and hospitals compare the client's budgetable income against the payment standard (incidentals allowance **only**) for those living arrangements.

Income will be budgeted against the appropriate SDA payment standard for that living arrangement.

Note: The amount of client **budgetable income** is the **client pay amount**.

Intake Cases

SDA

When an applicant reports income, enter the correct circumstance change date (CSCD). Bridges will combine the amounts already received and expected to be received to determine financial eligibility and the client pay amount.

Change Processing

SDA

In Bridges, changes, such as, SLA admission/discharge and changes in income, must be reported timely (within 10 calendar days). Failure to report a change timely will affect client benefits. Pay providers for the time care was provided, but no earlier than the date of admission, and not for the date of discharge.

A grant increase**,** or a decrease in the client pay amount, is considered a positive action. A grant decrease**,** or an increase in the client pay amount, is considered a negative action.

See BEM 515, FIP/RCA/SDA Needs budgeting, regarding change processing and how the timely or non-timely report of a change affects the effective date of the change.

Processing an SLA Admission

SDA

When an SDA client enters an SLA update the CSCD. Bridges recalculates the benefit amount using all countable income for the

benefit month and the payment standard for the new living arrangement.)

Complete a budget for subsequent month(s) whenever a change in income is expected.

If the SLA resident is part of a multimember case, use adequate notice to remove the individual from that case. The individual must file an SDA application, which cannot be approved until the client is removed from the other case. Once the SDA is approved, the client benefit is the incidentals allowance. The allowance is paid as a client warrant and added to the clients Bridge Card.

Upon SDA approval, the SLA provider payment for care may begin **up to 10 days prior to the date of application**. The provider payment amount, including pay for the period between admission and application, is the SLA **per diem** rate (minus any client pay amount). A provider payment authorization **must** be entered in Bridges in order for the provider to be paid; see BAM 430, SDA Special Living Arrangement Authorization and Payment.

Processing an SLA Discharge

SDA

When you learn that an SDA client has left a facility:

- Update the Household Information Screen and remove/update the Special Accommodations field.
- Update the CSCD and client address on the Household Address Screen.
- Update the Living Arrangement screen, change the CSCD and Living Arrangement Type.
    - Bridges recalculates the client benefits using all countable income for the benefit month and the payment standard for the new living arrangement.
    - Bridges ends the provider payment authorization to that provider.
    - Bridges begins an MPS provider payment authorization to the new provider, if appropriate.

- Bridges initiates closure **unless**:
  - The client entered another SLA facility and continues to be eligible; **or**
  - The client has a further need for SDA. Then, Bridges recalculates benefits according to the new living arrangement's payment standard; see BEM 261 regarding continued disability.

Final Provider Payment

SDA

The final payment to an SLA provider is based on the **per diem** rate. The last day of payment is the **earlier** of either:

- The day prior to the day the client becomes ineligible (day preceding the negative action effective date).
- The day prior to the date of discharge. (DHS does not pay for the day of discharge).

Income Reporting

SDA

When the client reports an income change, do the following:

- Follow BEM 505 for income change processing.
- If required, recalculate the budget and determine how much the new client pay (budgetable income) should be (if any). The client pay amount will affect the provider payment amount and possibly the incidentals allowance benefit.
- Project the next month's income:
  - If projected to **increase** the **client pay** amount, timely notice is required to notify the client of the negative action; see BAM 220, Case Actions..
  - If the **client pay** (budgetable income) is projected to **exceed the provider payment**, this will end the provider payment authorization. The remainder of the client's budgetable income (exceeding the provider payment amount) will budget against the client benefit (incidental

allowance). The case will close, if there is not at least a $1 budget deficit.

Reminder: Manually end Provider assignments for the case.

When the projected income includes SSI, refer to BEM 272, SDA Repay Agreements and BAM 430, Repayment Agreements.

LEGAL BASE

SDA

Annual Appropriations Act
Michigan Administrative Code R 400.3151 - 400.3180

DEPARTMENT POLICY

FAP Only

Persons residing in an eligible facility as defined in Bridges Eligibility Manual (BEM) 615, Group Living Facilities, may have to meet special eligibility requirements to receive food assistance benefits. Also, the facility may have certain responsibilities regarding its residents who are food assistance applicants or recipients.

AFC HOMES

Eligible Persons

You must verify that an AFC home is an eligible facility. A resident in an eligible AFC home must be **disabled** or **veteran** per BEM 550, FAP Income Budgeting, for senior/disabled/veteran policy.

Note: A **senior** is eligible **only** when the person meets the definition of either **disabled** or **veteran**.

Residents may apply individually as one-person FAP groups; or residents who purchase and prepare food together may apply together as one FAP group.

A resident must be a one-person FAP group if he/she applies or must apply through an Authorized Representative. See BAM 110, Application Filing And Registration.

Budgeting

The AFC home operator provides shelter and certain medical services (personal attendant care, supervision of medicines, follow through on physician's, visiting nurses' or therapists' recommendations for home treatment, medical transportation, etc.).

Room and medical costs which can be separately identified are allowable shelter and medical expenses. Normally, the group home will identify the part of the payment that is being charged for separate costs. If the amount the resident pays for room and meals is combined into one amount, the amount which exceeds the food assistance maximum allotment amount for a one-person household can be allowed as a shelter expense.

You must determine what portion of the client's payment is for shelter and what portion is for medical care. The AFC home operator must provide a statement showing:

- The amount the resident pays toward his care; and
- The medical services provided; and
- The amount of the client's payment that represents shelter costs.

This statement does **not** need to be itemized. The provider may simply state that a percentage or fixed dollar amount is the shelter expense and the remainder is medical expense. In these cases, the total payment to the provider is shelter plus medical expenses. If providers ask for guidance in determining these amounts, you may suggest that the same amount or percentage should be used for shelter for all clients in the same accommodations, i.e. single, double or multiple resident rooms. You do **not** need to review shelter expense records for the home. You do **not** determine the amounts. The provider receives the payment and must specify the shelter and medical amounts.

Disregard payments made to the AFC home on behalf of the residents for special programming or treatment as reimbursements.

See also BEM 550, 554, FAP Allowable Expenses And Expense Budgeting, and 556, Computing The Food Assistance Budget.

Use of FAP Benefits

If the facility is the Authorized Representative, it may either:

- Receive and spend the Food Assistance benefits for food prepared by and/or served to the eligible resident; or

- Allow the eligible resident to use all or any portion of the Food Assistance benefits on his own behalf.

The facility may be the Authorized Representative for the use of FAP benefits even if a different Authorized Representative made the application for the resident.

If the facility is **not** the Authorized Representative, the Food Assistance benefits may be:

- Given to the facility to be used to purchase food for meals served either communally or individually to eligible residents.

- Used by eligible residents to purchase and prepare food for their own meals.
- Used by the resident to purchase meals prepared and served by the AFC home.

ELECTRONIC BENEFIT TRANSFER IN GROUP HOMES

Group homes may contact the appropriate Food and Nutrition Service (FNS) field office to become an FNS certified retailer.

Authorized FNS Retailer

Group homes approved to participate in the Electronic Benefit Transfer (EBT) program as an FNS certified retailer will be supplied with the necessary equipment to process EBT transactions inside of the group home. This will allow food assistance benefit clients to exchange their benefits for food by swiping their Bridge Card through the home's Point Of Sale (POS) device.

The Bridge Card can be used in group homes between the 1st and the 15th of the month reducing the client's food benefit account by half. The group home's account is increased by the same amount that is decreased from the client's account. A second transaction is done between the 16th and the last day of the month for the remaining month's balance, again debiting the client's account and crediting the group home's account.

Food Stamp Authorized Representative

Clients are allowed a Food Stamp Authorized Representative (FSAR) to shop for them. Group homes that are **not** approved as authorized retailers may be an authorized representative for the clients in their homes. In these situations, an employee of the home is identified as the residents FSAR, accessing the clients' benefits at an FNS retailer location with a POS terminal.

Clients receive a Bridge Card for their FSAR with both their name and the FSAR's on the card. The group home's employee identified as the FSAR receives the Bridge Card from the client and the Personal Identification Number (PIN).

As an FSAR, the group home's identified employee can only access the client's food benefit account. Group homes should only use the Bridge Card that specifies their employee as the FSAR.

SHELTERS FOR VICTIMS OF DOMESTIC VIOLENCE

Eligible Persons

Consider a person (or a person and his or her children) residing in a shelter for victims of domestic violence as one FAP group for the purpose of applying for and participating in the Food Assistance Program.

Many shelter residents have recently left a Food Assistance group containing the person who abused them. Such residents may apply and participate (if otherwise eligible) as a separate FAP group during the same month they were included in the former case. Treat the application as an initial application and prorate the initial FAP benefit. This additional issuance of benefits can be authorized only once a month.

Remove the client (or client and her children) from the former FAP case promptly. Follow policy in BAM 220, Cast Actions, to insure that the former FAP group's eligibility and benefits reflect the change in group composition.

Note: Bridges will prevent opening of the separate FAP group's case until members are made inactive in the original case. When it is necessary to open the new case before the negative action period ends, process the negative action immediately. If the negative action period would normally extend into the month following the move, provide the former FAP group with the benefits it would have received if the negative action was **not** processed early. Use a supplemental issuance.

Budgeting

Consider only the assets of non-categorically eligible groups, income, and the expenses for shelter that the resident is responsible for. Room rent paid to the shelter is a shelter expense. Do **not** count the assets, income and expenses of the former FAP group members. Any assets jointly owned by a resident and a member of the former FAP group are inaccessible if the resident's

access to them is dependent upon the agreement of the joint owner who still resides with the former FAP group. See also BEM 550, 554 and 556.

Use of FAP Benefits

Residents may use their Food Assistance benefits to purchase food from a retail food store like any other FAP group. They may also use their Food Assistance benefits to purchase meals prepared and served by the shelter to its eligible residents, provided the shelter is authorized to do so by FNS. The shelter can identify an employee to act as an FSAR for its residents. For more information (See "Authorized Representatives" in this item.)

SUBSTANCE ABUSE TREATMENT CENTERS (SATC)

Eligible Persons

The resident receiving treatment and the resident's child(ren), if any, who live with the resident in the treatment center are the FAP group. You must verify that an SATC is an eligible facility. Residents must use the center as the Authorized Representative. See BAM 110 and Authorized Representatives in this item.

Budgeting

The entire payment made by the resident to the treatment center is a shelter expense.

Do **not** exclude payments made directly to the center on behalf of the resident if they are vendored for the convenience of the department and the treatment center.

Example: Mr. J is eligible for $234 in SDA funds. $202 is vendored to the SATC where he resides. Budget $234 as income and $202 as a shelter expense.

Center for Substance Abuse Services (CSAS) payments and payments from voluntary agencies are **not** otherwise available to the client. They are excluded.

See also BEM 550, 554 and 556.

Use of FAP Benefits

The SATC receives and spends the food assistance benefits for food prepared by and/or served to the eligible resident and the resident's child(ren).

SATCS LICENSED AS AFCS

Residents who are **not** participating in the substance abuse treatment program are **not** eligible unless they meet the requirements described earlier in this item for residents of AFC homes.

Budgeting

Budget as for residents of AFC homes. Only Senior/Disabled/Veteran persons are eligible for medical expense deductions.

Example: Mr. H (48 years old) resides in a treatment center which is licensed as an AFC home. He is participating in the treatment program. He is eligible for $344.00 SDA. $312.00 is paid directly to the home. The home operator states that $150.00 of the payment covers the home's shelter charge. Mr. H is **not** eligible for a medical deduction. Budget $344.00 as income and $150.00 as shelter expense.

See also BEM 550, 554 and 556.

Use of FAP Benefits

The treatment center receives and spends the food assistance benefits for food prepared by and/or served to the eligible residents as described in the “Food Stamp Authorized Representative” section of this item.

TEMPORARY SHELTERS FOR THE HOMELESS

Eligible Persons

Homeless persons residing in a temporary shelter facility may receive Food Assistance benefits if otherwise eligible. The temporary shelter may be a nonprofit or for profit facility.

Residents are treated as separate FAP groups regardless of whether they purchase and prepare food together or separately.

Persons who must be in the same FAP group according to BEM 212, RELATIONSHIPS, must be in the same FAP group when residing together in the homeless shelter.

Example: Spouses residing in the same homeless shelter will be in one FAP group together.

Budgeting

Budget like any other Food Assistance group. Do **not** allow shelter expenses covered by excluded income.

See also BEM 550, 554 and 556.

Use of FAP Benefits

Residents may use their Food Assistance benefits to purchase food from a retail food store like any other FAP group. They may also use their FAP benefits to purchase prepared meals from nonprofit homeless meal providers authorized by FNS, such as a soup kitchen, etc.

RESPONSIBILITIES OF SATCS/AFCS

Changes

The SATC/AFC home (acting as Authorized Representative) must notify the local office of changes in the FAP group's income or other circumstances. See BAM 105.

Resident Moves

When the resident moves from the SATC/AFC home, the home must do all of the following:

- Notify the local office that the resident has left.
- Return the FSAR Bridge Card to the resident.
- Give a pro-rata share of one-half the monthly FAP benefit to an ex-resident who left prior to the sixteenth of the month.

Note: This should be done only if the entire month’s benefits have been taken by the home.

- If possible, give a change report form to the ex-resident and advise him to complete and return it to the local office within 10 days.

Note: The local office must give each SATC/AFC home a sufficient supply of DSS-2240s, Change Report Form, to facilitate this process.

The SATC/AFC home can no longer act as the ex-resident's FSAR.

Temporarily stop benefits if the ex-resident does **not** report a new address by the 10th day after the SATC/AFC home has reported that the resident moved.

Overissuances and Recoupment

The SATC/AFC home acting as an authorized representative:

- Must be knowledgeable about the FAP group's circumstances; and
- Should have carefully reviewed those circumstances with the FAP group prior to applying on its behalf.

Therefore, the SATC/AFC home is liable for:

- All losses or misuse of food assistance held on behalf of residents; and
- All overissuances which occur while FAP groups are residents.

Also, the SATC/AFC home is responsible for any misrepresentation or IPV which it knowingly commits while representing residents in the certification process.

Misuse of Food Stamp Authorized Representative Cards

You must promptly notify the Family Support Services (FSS), central office, in writing if you have reason to believe that an SATC/AFC home is misusing the FSAR cards in its possession.

The Food and Nutrition Service (FNS) will investigate the complaint forwarded by central office.

After initially notifying FSS, take no further action against the facility other than recoupment action for any overissuances discovered during an investigation or hearing procedure. Central office will notify you of the FNS decision regarding the matter and of any subsequent action needed.

LEGAL BASE

FAP

7 CFR 273.11(e)(f)(g)(h)
Food and Nutrition Act of 2008, as amended

DEPARTMENT POLICY

FAP

The Michigan Combined Application Project (MiCAP) is a Food Assistance demonstration project approved by the Food and Nutrition Service (FNS). MiCAP is a series of waivers that allows Michigan Department of Health and Human Services (MDHHS) to issue Food Assistance Program (FAP) benefits to Supplemental Security Income (SSI) individuals who qualify for this program.

The program is administered by the centrally located MiCAP unit. Final eligibility determination and redeterminations are the responsibility of the MiCAP unit.

All eligibility factors in this item must be met.

MiCAP Targeted Population

The targeted MiCAP population is SSI individuals with the following characteristics:

- Age 18 or older.
- Receives SSI income and no other type of income.
- Meets the Social Security Administrations (SSA) definition of independent living (Living arrangement code A).
- Resides in Michigan.
- Purchases and prepares food separately.

Note: Individuals are considered to be receiving SSI even if their SSI is in suspense status.

Application of MiCAP

A simplified application form, DHS-513, Michigan Combined Application Project (MiCAP), is used when determining eligibility for MiCAP. The MiCAP unit automatically sends a DHS-513 to all SSI individuals who may qualify when their SSI case is opened in Bridges informing them of the program and giving them the opportunity to apply for MiCAP.

ELIGIBILITY DETERMINATION

The MiCAP unit determines eligibility for MiCAP whenever it receives a DHS-513.

The MiCAP unit registers the application and determines FAP eligibility at application and redetermination. Once an individual has been determined eligible, a Bridge card will be issued if an individual has never received one.

Clients may receive only one free replacement Bridge card during their lifetime. Clients' available benefits will be reduced to cover the cost of all subsequent replacement cards, with no exceptions granted.

The MiCAP unit is responsible for:

- Running the MiCAP Application Report (Social Security Administration interface) daily and mailing the DHS-513 to individuals on the report.
- Completing a file clearance to determine if an individual has an active FAP case.
- Registering the application in Bridges.
- Completing the case actions and certifying eligibility in Bridges.
- Referring individuals to customer service at 888-678-8914 to assign a Bridge card personal identification number and for Bridge card replacements.
- Maintaining the MiCAP case record.
- Completing redeterminations.

BENEFITS

Benefit Period

Once an individual is determined eligible for MiCAP, eligibility will be for a 36-month benefit period. A redetermination of eligibility will be completed every 36 months. Food Assistance benefits continue for the duration of the benefit period unless an individual is no longer eligible for MiCAP or fails to return the DHS-542, MiCAP Redetermination Form.

Note: Eligibility factors are the same at application and redetermination.

Eligibility for MiCAP begins the first day of the month the application is received in the MiCAP unit via U.S. mail, fax, or local office referral. The begin date of the benefit period for MiCAP is always the first day of the application month. There is no proration of benefits.

Benefit Amount

The amount of Food Assistance Program (FAP) benefits MiCAP individuals receive is determined by their total shelter expenses, (shelter plus heat and utility expenses). If an individual's total shelter expenses are:

- Below $450, the FAP benefit is $81 per month.
- Between $450 and $749 the FAP benefit is $142 per month.
- Equal to or exceed $750, the FAP benefit amount is $261 per month.

NONFINANCIAL ELIGIBILITY FACTORS

Residence

An individual must be a resident of the State of Michigan. Individuals are considered residents if they live in Michigan and intend to remain in Michigan.

Age

An individual must be age 18 or older.

Concurrent Receipt of Benefits

An individual cannot receive both MiCAP and FAP in the same month.

FINANCIAL ELIGIBILITY FACTORS

Group Composition

The MiCAP group is always a group of one.

Assets

There is no asset test.

Exception: This does not apply to a single lottery or gambling winning of $4,500 or more.

Income

There is no income test.

ONGOING ELIGIBILITY

Once eligible, eligibility continues unless an individual:

- Loses SSI eligibility or has any other type of income.
- Moves out of state.
- Is ineligible due to a change in the SSA living arrangement code.
- Dies.
- Becomes a mandatory member of another active FAP case.

  Exception: An adult child, age 18-22, who meets the criteria under MiCAP Targeted Population, may receive MiCAP benefits even if living with parents.

Example: SSI individual has a baby and applies for food assistance benefits at a MDHHS local office. The SSI individual is a mandatory member of the baby's active FAP case so the MiCAP case must be closed.

ELIGIBILITY FOR OTHER PROGRAMS

When a MiCAP individual applies for FAP at a MDHHS local office, contact the MiCAP specialist to request case closure. The MiCAP phone number is 877-522-8050.

REFERRALS TO MICAP

The MDHHS local offices may refer an individual to MiCAP. The DHS-513 must be completed and signed by an individual, then sent to the MiCAP unit as follows:

- Send or give the client a MiCAP application.
  - Provide the client with the fax number 517-324-9919 and the mailing address.

    Michigan Department of Health & Human Services
    Michigan Combined Application Project SPO/MICAP
    PO Box 30037
    Suite 1403
    Lansing MI 48909
    Phone number: 877-522-8050
    Fax number: 517-324-9919

  - If the DHS-513 is returned to the local office, it should be faxed to the MiCAP unit.
- Or give the client the MiCAP unit's phone number (877-522-8050) so an application may be mailed to them.

CASE TRANSFERS

Do **not** transfer any case records to the MiCAP unit. Retain them at the local office.

MiCAP cases are not transferred to local offices; they remain at the MiCAP office.

LEGAL BASE

Food and Nutrition Act of 2008, as amended
7 USC 2026

OVERVIEW

The Michigan Summer Electronic Benefit Transfer (SEBT) program is a federally funded program that provides grocery-buying benefits to low-income families with school-age children when schools are closed for summer as a supplement to summer meal sites. This may include students in Head Start and/or Great Start Readiness Program. The SEBT program is also known federally as Sun Bucks.

Michigan Department of Health and Human Services (MDHHS) is the lead agency and is partnering with the Michigan Department of Education (MDE) for the SEBT program administration and eligibility determination.

ELIGIBILITY CRITERIA

A child is eligible for SEBT if they are:

- Household participants, between the ages of 6 to 18, who receive Food Assistance Program (FAP), Temporary Assistance for Needy Families (TANF), Food Distribution Program on Indian reservations (FDPIR), or eligible Medical Assistance (MA) households at or below 185% of the federal poverty level; or
- Students of any age receiving free or reduced priced lunch through the National School Lunch Program (NSLP)/School Breakfast Program (SBP); or
- An approved summer EBT application, MDHHS-6138, 2024 Summer Electronic Benefit Transfer (EBT) Application.

STREAMLINED CERTIFICATION

MDHHS will identify eligible children for SEBT using program eligibility for FAP, TANF, FDPIR, and eligible MA households at or below 185% of the federal poverty level. Children ages 6 to 18 who are active during any month from July of the previous year through the end of the current year's summer period. This includes children who are categorically eligible for SEBT (foster, unsheltered, migrant, or a runaway).

Example: For the year 2024, a child would need to be active on one of the programs for one month during the period of July 1st, 2023, to August 31st, 2024.

MDE will provide information for eligible children that are attending a NSLP/SBP school who qualified from direct certification, or have an approved application from the school, or is categorically eligible.

Information from MDHHS and MDE will be combined and deduplicated. Eligible children will automatically be issued the SEBT benefit.

APPLICATON

Children who are enrolled in NSLP/SBP schools can establish eligibility for SEBT by submitting an application (MDHHS-6138 2024 Summer EBT Application). Households can establish eligibility for SEBT up to the last day of the summer operational period, August 31st of each year.

- Must be currently residing in Michigan and enrolled in a NSLP/SBP participating school.
- Households must be income eligible based on free or reduced priced lunch guidelines.
- Children who are not enrolled in an NSLP/SBP participating school and not eligible through streamlined certification, are not eligible.
- If the submitted application is not complete or does not meet eligibility criteria, the denial notice must be provided to households within 15 business days of receipt of the application.

BENEFIT

A one-time lump sum benefit of $120 per eligible child will be issued. This payment covers the months of June, July, and August. The issuance will be staggered over a 5-to-10-day period. For any students that were missed in the first issuance or became eligible through an approved application after the first issuance, a second issuance will be completed two months after the initial issuance to issue the lump sum.

EBT CARDS

EBT Card Issuances

Students will be issued benefits in one of the following ways:

1. Benefits for children on existing FAP, TANF, or FDPIR groups will be placed on the head of household's Bridge card associated with the case.

2. Benefits for children in an existing MA group will be placed on a new card in the head of household's name and include all eligible children in the group.

3. Benefits for children enrolled in the NSLP/SBP and found eligible through the SEBT application process will receive individual cards.

Address Used

The EBT card will be sent to the current mailing address on file with MDHHS or the school.

For children that are unsheltered, the card will be sent to the last school on file.

To update an address, contact the SEBT call center by phone or email.

Call Center Phone: 1-833-905-0028, Monday through Friday from 9:00 am – 3:00 pm.

Email: MDHHS-SEBT@michigan.gov.

DUPLICATE BENEFITS

Children may not receive benefits from more than one state or more than one $120 benefit from Michigan. Should any instances of dual participation come to the State's attention, they will be investigated swiftly and thoroughly based on cost effective measures and in accordance with Summer EBT claims against households.

NOTICES

A notice of approval will be sent to all eligible children either individually or by household depending on how the benefits were issued.

The notice of eligibility will include a general explanation of the SEBT program, who is eligible for the program, benefit amount, how to check balances, how to request a replacement card, where the benefit can be used, who to contact for questions, and a way to apply for missing payments.

EXPUNGEMENT

The SEBT benefit, in their entirety, must be used within 122 days after the issuance date. Regardless of if they were partially used or recently used, after 122 days the benefit will be expunged. If the SEBT benefit was issued to an existing Bridge card, the system will automatically use the SEBT benefit first before using other benefits. If a card is returned as undeliverable mail and a replacement card is sent, the benefits are not technically re-issued and therefore the expungement clock is not reset. A letter will be issued to the client no later than 30 days prior to the benefits being expunged.

HEARINGS

Clients have the right to contest a MDHHS decision affecting SEBT eligibility including an application the household has made for SEBT benefits, a streamlined certification for SEBT benefits, or a verification process or procedure, if they believe the decision is incorrect. Households may appeal within the 90 days after the end of the summer operational period, August 31st of each year.

Hearings policy for SEBT can be found in Bridges Administrative Manual (BAM), see BAM 600, Hearings.

PROGRAM VIOLATIONS

MDHHS will investigate complaints received or irregularities noted during the implementation of the SEBT program. Issues that require in-depth review will be forward to the MDHHS Office of Inspector General for further analysis. If complaints or irregularities are substantiated, recoupment of SEBT benefits may be initiated, following current SNAP regulations, see BAM 720, Intentional Program Violation.

RESOURCES

For more information on the Summer EBT Program see: https://www.michigan.gov/mdhhs/assistance-programs/food/summer-ebt

Call Center Phone: 1-833-905-0028, Monday through Friday from 9:00 am – 3:00 pm.

Email: MDHHS-SEBT@michigan.gov

During non-business hours, parents can leave a voicemail or send an email. Voicemails and emails will be addressed within two business days.

In addition, the EBT customer service, 888-678-8914, is available 24 hours a day, 7 days a week to assist clients with card issues.

LEGAL BASE

7 CFR 292.2
7 CFR 292.6
7 CFR 292.13(g)
7 CFR 292.15(c)(2)
7 CFR 292.15(e)(1)
7 CFR 292.15(h)
7 CFR 292.27
7 CFR 292.8(e)(12) and 292.26

AGENCY POLICY

FAP Only

A Time-Limited Food Assistance (TLFA) individual also known as Able Bodied Adults without Dependents (ABAWD'S) must meet specific work requirements to receive Food Assistance Program (FAP) benefits. Failure to do so limits the individual's FAP eligibility to three months within a 36-month period. TLFA individuals who meet all other FAP eligibility criteria are eligible for three countable months of FAP benefits during a 36-month period.

The 36-month period is a standardized period. Eligible individuals can receive three countable months of benefits within each of the following periods:

Initial Period: January 1, 2017, through December 31, 2019.
Current Period: January 1, 2020, through December 31, 2022.
Next Period: January 1, 2023, through December 31, 2025.

TLFA Waiver Counties

Effective December 1, 2020, all counties are part of the ABAWD waiver and will no longer be subject to Time Limited Food Assistance policy.

ELIGIBILITY FACTORS

TLFA Individuals

All FAP individuals aged 18 through 52 are subject to TLFA policy unless deferred.

Note: The policy applies to the first calendar month after the 18th birthday through the calendar month prior to the 52nd birthday.

Screening

All individuals subject to TLFA should be screened for any deferrals they may qualify for at application, redetermination, member add or when an individual becomes subject to the TLFA work rules.

TLFA Deferrals

To be deferred from TLFA policy an individual must be one of the following:

A member of a FAP group that includes a FAP group member under age 18, even if the individual under age 18 is disqualified or otherwise not eligible; see Bridges Eligibility Manual (BEM) 212, Food Assistance Program Group Composition.

Verification:

Information known to the agency.

1. In any stage of pregnancy.

   The deferral will begin the month of conception and include the month of the child's birth or until the individual is no longer pregnant.

   Verification:

   Client statement, unless questionable.

2. Determined to be medically certified as physically or mentally unfit for employment (even if temporary).

   The physical or mental condition must make the individual unfit to work 20 hours per week on an ongoing basis. An individual is considered unfit for work if they meet any of the following criteria:

   - Applied for/receiving temporary or permanent public or private disability benefits. Individuals who have applied for or are receiving temporary or permanent public or private disability benefits are deferred from the time limit.

     This includes but is not limited to:

     - Veterans' disability benefits (any rating of disability).
     - Workers' compensation.
     - SSI application, approval or appeal.
     - Participating in Michigan Rehabilitation Services program.
     - State issued temporary or permanent disability benefits.

   Verification:

If information regarding application or receipt of the disability benefits is known to the agency, no further verification is needed. If this information is not known to the agency, request proof of the receipt or pending application for disability benefits.

3. Obviously mentally or physically unfit for employment, as determined by the Michigan Department of Health and Human Services specialist (MDHHS).

   Individuals who are obviously mentally or physically unfit for work are exempt from the time limit.

   To determine if an individual is obviously unfit for work, the MDHHS specialist must conduct an interview with the client. A discussion of the individual's inability to work or participate in work activities for more than 20 hours per week on an ongoing basis is required to make the determination. The discussion should focus on the physical and/or mental challenges that affect or impact the individual's inability to work.

   - ***A victim of domestic violence.***

     An experience of domestic violence may indicate the individual is obviously unfit for work. The MDHHS specialist may identify an individual as obviously unfit for work if they are a victim of domestic violence.

   - ***Struggling with drug or alcohol addiction***.

     A struggle with drug or alcohol addiction may indicate an individual is obviously unfit for work.

     Individuals who are not participating in a treatment/rehabilitation program but are dependent on drugs or alcohol to maintain day to day function may be considered struggling with addiction.

   Verification:

   Domestic Violence

   Use the individual's statement as documentation of the domestic violence circumstance unless a reason exists to question it. If further documentation is necessary, use any of the following:

- Documentation of service from a domestic violence shelter.
- Medical records.
- Court records (for example, personal protection order or petition.
- Police records (for example domestic disturbance response).
- School records (for example, statement from a school counselor).
- Statement by a licensed therapist or counselor.
- Other case information (including children's services).

Struggling with Drug or Alcohol Addiction

Individuals who are struggling with drug or alcohol addiction, the individual must provide verification of their participation in a substance abuse treatment program. Individuals who are not participating in a treatment program, MDHHS specialists may accept a written or verbal statement from a medical or mental health professional confirming the individuals alcohol/drug dependency negatively impacts the individual's fitness to work.

Example: John applies for FAP benefits in April and states he has recently moved to Michigan and is currently homeless. John states he is currently staying with friends, sleeping at a different place each night until he can secure housing. John is not subject to TLFA policy in April since it is a prorated month. The MDHHS specialist gives John good cause for May in order for John to secure housing. John will be subject to TLFA policy beginning in June.

Example: Stan applies for FAP benefits and is potentially subject to TLFA policy. Stan states at the interview he has been homeless for the last three years. The MDHHS specialist requests and receives verification from HARA verifying Stan has been homeless for the past 3 years. The MDHHS specialist observes during the interview that Stan has poor hygiene and struggles with social skills. Based on the MDHHS specialist's observations of poor hygiene and that Stan struggles with social skills, the verification received from HARA and information provided by Stan, the MDHHS specialist defers

Stan from TLFA work requirements due to being chronically homeless and having a disabling condition due to poor hygiene and his struggle with social skills. The MDHHS specialist enters the deferral in Bridges and documents the deferral information in case comments.

Note: TLFA policy does not apply when an individual is deferred per BEM 230B, Employment-Related Activities: FAP; see *Deferred From General Work Registration Requirements* in this item.

Noncompliance and refusing employment penalties may apply to TLFA applicants or recipients; see BEM 233B, Failure to Meet Employment Requirements: FAP.

4. Homeless

   Individuals who are homeless are deferred from the TLFA work requirements.

   A homeless individual means an individual who lacks a fixed and regular nighttime residence or an individual whose primary nighttime residence is:

   - A supervised shelter designed to provide temporary accommodations.
   - A halfway house or similar institution that provides temporary residence for individuals who intend to be institutionalized.
   - A temporary accommodation for not more than 90 days in the residence of another individual.
   - A place not designed for, or ordinarily used, as a regular sleeping accommodation for human beings (a hallway, bus station, lobby, or similar place.

     Verification: Client statement unless questionable.

5. Veteran

   Individuals who have served in the United States Armed Forces (such as Army, Marine Corp, Navy, Air Force, Space Force, Coast Guard, And National Guard), including an individual who served in a reserve component of the Armed

Forces, and who was discharged or released there from regardless of the conditions of such discharge.

Verification: Client statement, unless questionable.

6. Foster Care

An individual who is 24 years of age or younger who was in foster care under the responsibility of the state on the date when the individual turned 18 years of age or later. This includes any individual who was in a foster care program run by the state, district, territory, or Indian tribal organization as of their 18th birthday or later and who is under 25 years of age.

Verification: Client statement, unless questionable.

7. Deferred from general work registration requirements**;** see BEM 230B.

Individuals who are deferred from general work registration rules outlined in BEM 230B are also deferred from TLFA work requirements. Individuals who are subject to the time limits must meet the general work registration requirements.

Deferrals from the general work registration requirement (also deferred from TLFA work requirements) include:

- Under age 16 or over age 59 (work registration age limits are different than the age limits under TLFA rules).
- Age 16 or 17 years old who are not the grantee.
- A grantee age 16 or 17 years old who:

  Is attending school, or is enrolled in an employment training program, on at least a half-time basis.

  See BEM 240, Age and BEM 245, School Attendance and Student Status, for verification requirements.
- A parent or other household member responsible for the care of a dependent child under age 6 (the child does not have to be in the FAP group nor reside with the caregiver).
- Responsible for the care of an incapacitated person (the incapacitated person does not have to be in the FAP group nor with the caregiver).

- Physically or mentally unfit for employment.
- Has applied for or is receiving Unemployment benefits (including application or appeals).
- An active participant in an in-patient or outpatient Substance abuse treatment program. This does not include AA or NA.
- An individual who has applied for both FAP and SSI through the Social Security Administration. The application for FAP and SSI must be made at the same time.
- Employed or Self Employed at least 30 hours per week or receiving weekly earnings equal to or in excess of 30 hours times the Federal minimum wage.
- A person subject to and complying with FIP (TANF) work requirements.
- A student enrolled at least half-time in any recognized school, training program, or institution of higher education.

Note: Students enrolled 1/2 time or more in an institution of higher education (Post-Secondary Education) must meet also meet student status defined in BEM 245.

General work registration verification:

Age

- Birth Certificate.
- Hospital certificate of birth.
- Other official records that contain birth information, such as school records, medical records, baptismal records, marriage certificate, insurance policy, etc.
- Forms of identification which contain age or date of birth, such as driver's license, state-issued I.D. card, etc.
- Written statements from two or more individuals who know the individual's age.

Caretaker to a dependent child or disabled individual

Acceptable verification of a caretaker to a child under 6 or caretaker of a disabled individual includes, but is not limited to:

- Medical records about disability.
- DHS 54A.
- Verification from MSW.
- Physician statement.
- Court order.

Physical or Mental Impairment

Verify a medical deferral only in cases where the unfitness is not obvious to the specialist. Document in Bridges and set the review date accordingly. If questionable, a statement from a nurse, nurse practitioner, designated representative at a doctor's office, social worker, or other medical personnel may be accepted verification. If the impairment is not obvious, a MDHHS-54A, Medical Needs, or an MD/DO statement may be used. Verify receipt of RSDI based on disability or blindness and SSI.

If an individual cannot obtain verification free of charge, use a MDHHS-93A, Medical Services Authorization/Invoice, to authorize payment for medical evidence.

Unemployment Compensation (UC) Applicant or Recipient

Use a DHS-32, UCB Claims Information Request, to verify.

Substance Abuse Treatment Center Participant

Use a verbal or written statement from the center.

FAP/SSI

SOLQ. Award letter from SSA; see Bridges Administrative Manual (BAM) 116 SSI/FAP Joint Application Processing.

Earned Income

See BEM 500, Income Overview, for a complete list of acceptable verifications.

In-Kind income

See, In-Kind benefits in BEM 500, for a complete list of verifications.

Education

- DHS-3380, Verification of Student Information.
- Telephone contact with the school.
- Other acceptable documentation that is on official business letterhead.

See BEM 230B for detailed verification requirements.

Note: General work registration requirements and TLFA work requirements are two separate policies that while related to each other, stand alone.

8. Participating in an Office of Refugee Resettlement training program

   Individuals participating in the local refugee contractor program for at least half time will be deferred from the ABAWD time limit as long as they continue to participate with the Refugee contractor.

   Verification:

   Statement from the local refugee contractor

SATISFYING THE TLFA WORK REQUIRMENTS

TLFA individuals who are not deferred must satisfy the TLFA work requirement to maintain FAP benefits for more than 3 months within the 36-month period. There are several ways these individuals can satisfy the work requirement.

The TLFA work requirements must be explained to the individual at application, redetermination, or anytime the individual becomes subject to the TLFA work requirements. The purpose of this explanation is to identify the work rules the individual must follow, how the individual can meet the TLFA work requirement and advise the individual that these rules must be followed in order to receive food assistance beyond 3 months.

Note: All individuals subject to the Time Limited Food Assistance work requirements will receive the MDHHS-6015, Consolidated Work Notice, at application, redetermination, member add or when the individual becomes subject to the work rules outlining the TLFA work requirements.

For a FAP benefit month not to be countable, a TLFA individual must perform one of the following:

1. Work at least 80 hours monthly (20 hours/week on average).

   Work includes:

   - Work in exchange for money, including self-employment.
   - Work in exchange for goods or services (in-kind).
   - Unpaid (volunteer) work.

2. MI Works! Agency Employment and Training program.

3. Participate 80 hours monthly (20 hours/week on average) in an employment and training program administered by the local Michigan Works! Agency (MWA) if available in the county.

   Individuals in a MI Works! employment and training component cannot be required to participate more than 30 hours per week. The MWA may permit a participant to substitute hours of education to meet the 80-hour requirement.

   Local variations, restrictions and/or policies may apply. Check with the local MI Works! Agency to determine what employment and education/training services are available in the area.

4. Combine work hours and MWA work hours, except workfare or self-initiated community service, that total an average of 80 hours per month.

5. Participate in MWA-assigned workfare. The number of hours worked must equal the FAP benefit divided by state minimum wage, as determined by Bridges. Engage in self-initiated community service activities for a non- profit organization. The number of hours worked must equal the FAP benefit amount divided by state minimum wage, as determined by Bridges.

   Note: Do not include non-working TLFA recipients in simplified reporting as outlined in BAM 200, Food Assistance Simplified Reporting. See *Change Reporting* in this item for a complete explanation.

Employment

Employed TLFA individuals must work at least 80 hours monthly (20 hours/week on average) in order to satisfy the TLFA work requirement.

This activity cannot be combined with self-initiated community service/workfare to meet the work requirement.

Note: TLFA individuals do not have to make minimum wage in order to satisfy the work requirement.

Referral to MI Works! Agency Employment and Training program. (In counties where available)

Bridges will generate an automated FAP TLFA referral to the one-stop service centers' One Stop Management Information System (OSMIS), as well as generating a MDHHS-4785-F, FAP Employment and Training Appointment Notice, which is sent to the participant, at the following times:

- Application.
- Redetermination.
- Case change or end of a deferral.
- Member add.

Bridges will automatically refer each mandatory TLFA individual to the local MWA when the MDHHS specialist runs eligibility. If the TLFA individual does not attend the MWA, OSMIS will interface this information to Bridges, but there will be no negative action to the benefits.

Individuals working 20-29 hours or those who are participating in SICS will not receive the automated MDHHS-4785-F.

The MDHHS-4785-F will be generated overnight and can be viewed the next day in *Bridges correspondence history*. When generating the TLFA referral and the MDHHS-4785-F, Bridges will allow 6 days for the referral to be processed through central print before requiring the client to attend the MWA. Bridges will include the date, time, and location to appear for their FAP employment and training assignment on the automated MDHHS-4785-F.

If the TLFA individual indicates to the MDHHS specialist they intend to complete self-initiated community service instead of participating at the MWA, the MDHHS specialist will indicate this by answering yes to the question *Has the individual indicated an interest in completing self-initiated community service to meet the TLFA participation* on the *FAP Time Limited Community Service Activity* Screen. This will end the referral to the MWA and Bridges will generate the MDHHS-1997, Community Service Activity Report.

Bridges will notify OSMIS when a referred applicant is denied FAP benefits, a member is removed, or the case is closed.

MWA Assessment

MWA assesses employability and need for employment support services. TLFA recipients are then assigned to an appropriate employment-related activity.

MWA Participation

OSMIS will interface participation compliance daily which will be populated into the *FAP Time-Limited MWA Activity* screen. Participation hours will be summarized per activity and month. Bridges will determine if the TLFA individual has met their required hours or will be assigned a countable month.

The specialist will need to go into OSMIS to view other information relevant to the MWA participation.

The MWA may continue to monitor individuals for 90 days after employment begins, even if the FAP case closes, for retention services. OSMIS will interface all terminations to Bridges through the overnight file.

Self-Initiated Community Service

Self-initiated community service (SICS) is unpaid work for a nonprofit organization in exchange for FAP benefits. Local MDHHS offices may maintain and make available a list of nonprofit organizations willing to accept volunteers. The MDHHS-1997, Community Services Activity Report, will be sent monthly when it is indicated in Bridges that the individual intends to use this activity to meet their TLFA requirement.

If an applicant has used countable months but has initial countable months remaining, Bridges will approve the application for that number but will require verification of the self-initiated community service monthly, via the MDHHS-1997, to avoid a countable month.

The number of hours worked must equal the monthly FAP benefit divided by state minimum wage, as determined by Bridges.

Note: Bridges will display the required SICS hours on the FAP EDG, as well as populating them on the MDHHS-1997, FAP Community Service Activity Report.

Instruct the individual on Self-initiated community service policy and potential sites. It is the individual's responsibility to approach the organization and to obtain the signed MDHHS-1997, Community Service Activity Report, from an agency representative certifying the number of hours to be worked each month.

Note: ABAWD's participating in SICS to meet their TLFA work requirement are not eligible for Direct Support Services funds to support this activity; see BEM 232 Direct Support Services.

Self-Initiated Community Service Verification:

Case copy of a MDHHS-1997, Community Service Activity Report, certified by the nonprofit or government organization.

Self-Initiated Community Service/Workfare – Multiple Group Members

If a FAP group has more than one TLFA member and one member selects SICS or workfare (in counties where available) to meet their required hours, all mandatory group members will meet the work requirement, as the hours of participation for SICS and workfare are based on the FAP benefit divided by the state minimum wage.

Members of the same FAP group may split the required workfare or self-initiated community service hours in any combination between the FAP group members or a single group member subject to the time limit may choose to complete all the required hours on behalf of the household.

Regardless of the combination, by the end of the month, the household must complete the required hours, or the entire group

may receive a countable month (unless the work requirement was met another way).

Example: In a single-member case with $192 in monthly FAP benefits, the individual must perform 20 hours per month of community service ($192/ state minimum wage = 20.31 hours), round down.

Example: In a two-member case with $268 in monthly FAP benefits, a total of 28 hours, or 14 hours per month of community service per individual ($268 /state minimum wage = 28.35 hours, or 14 hours each), must be performed.

Example: Harold and Maude are a married couple who are both subject to TLFA work requirements. They opt to complete SICS as their activity. Their combined hourly requirement for SICS is 43 hours a month. Harold volunteers at the local food bank for 43 hours each month and both TLFA members meet the requirement and do not receive any countable months.

Example: In the month of October, Harold only completes 38 hours of SICS of the 43 hours required. Maude does not complete any hours of SICS. It is determined he does not have good cause, and both TLFA members receive a countable month.

Referral to the Refugee Contractor

Refer mandatory refugee TLFA individuals who have arrived in the U.S. within the last 5 years to the refugee contractor upon application, when a recipient's reason for deferral ends or a member add is requested. When a referral to the refugee contractor is required, the MDHHS specialist must manually generate the MDHHS-4785-RF, FAP Refugee Employment and Training Notice, and the MDHHS-142, Time Limited Food Assistance Notice.

The MDHHS specialist will generate the MDHHS-4785-RF and MDHHS-142 for each mandatory TLFA individual who has arrived in the U.S. within the last 5 years. If the individual has been in the country for 5 years or more, the MDHHS specialist will run eligibility to automatically generate a MDHHS-4785-F, Employment and Training Referral Notice, and the individual will be referred to the local MWA.

If the local MDHHS does not have a refugee contractor, the MDHHS specialist will use the automated process to refer the mandatory TLFA individual to the local MWA.

The last date for a participant to contact the refugee contractor is 30 days from the date the MDHHS 4785-RF is sent. If a mandatory TLFA individual calls to indicate the he or she needs more time to attend orientation at the refugee contractor, the MDHHS specialist will contact the refugee contractor to extend the deadline.

The MDHHS 4785-RF must be returned to the local office with a date stamp from the refugee contractor to verify completion of the orientation.

See BEM 230C, Employment And/Or Self-Sufficiency Related Activities: RCA, *Exhibit - Refugee Contract Providers*, for a list of the counties and providers.

Case Documentation

Bridges will track each countable month on the *Time-Limited Food Assistance Activities* screen which displays a month-by-month account of work, work-related activities, self-initiated community service, deferrals, countable months, case number changes and closures. Update the documentation at every redetermination, when notified by the MWA, and when a TLFA individual's status changes.

FAE&T PROVIDER DETERMINATION

The FAP Employment and Training Program (FAE&T) is available to all adults who receive FAP and are not receiving FIP. The program is available through the MWA and is an opportunity to learn a valuable skill that will assist the individual with becoming employable. The FAE&T program is also a way for TLFA participants to meet the TLFA work requirement.

A FAE&T provider determination is issued when the MWA has determined they are unable to serve an individual in their program. The MWA will notify the DHHS Specialist within 10 days of the FAE&T provider determination being made via the FAE&T interface in Bridges. The DHHS Specialist will receive a task and reminder notifying them to contact the client. The DHHS Specialist must contact the client within 10 days to notify them that a provider determination has been issued. The DHHS Specialist must

document in case comments that the client has been contacted about the provider determination and what was discussed during the call.

If a provider determination has been made for a TLFA individual, the individual will accrue a countable month towards the three month time limit the next full benefit month following the month DHHS informs the individual of the provider determination, unless the individual fulfills the TLFA work requirement, is deferred, receives good cause or lives in a waived area.

PENALTIES

Noncompliance or refusing employment penalties in BEM 233B do not apply to TLFA countable months. Use *countable month* and *36-month time-period policies* in this item instead.

Countable Month

A countable month is a calendar month in which a full FAP benefit is posted to an EBT account, and the recipient does not meet a TLFA deferral or work requirement, without good cause.

The MDHHS specialist must explain to each TLFA individual the work requirement is in effect for the first full month of benefits and the individual is responsible for meeting the work requirement in that first month.

Example: A TLFA individual applies for FAP on February 6th and is approved, with March being the first full month of benefits. The individual is referred to the MWA in March but does not attend. The individual does not complete 80 hours of MWA participation or meet the work requirement in another way. March is a countable month. As February is a prorated month, the individual is not subject to the TLFA work requirements.

Example: The MWA documents the individual was assigned to a work activity on August 1st but did not meet the participation requirement for the month. If the individual did not have good cause, August is countable.

A month is also countable if the individual begins meeting the work requirement but does not continue through the end of the month, without good cause, and the individual does not become deferred.

Example: A nonprofit agency documents that an individual offered janitorial help, which is self-initiated community service. On August 25-26 the individual completed 10 hours (out of 14 hours needed to work-off the $130 FAP benefit). The individual did not return to complete the hours and did not have good cause. August is countable.

Out of State Countable Months

A month in which an individual received FAP benefits in another state as a TLFA individual, beginning January 1, 2017, without meeting the work requirement or deferral criteria, is countable. Accept the other state's word and document in Bridges on the *FAP Time-Limited Details* Screen. Email Policy-Employment@michigan.gov if you need a countable month added due to an out of state inquiry.

Example: Maude moved from Colorado in June and reported she had been receiving FAP benefits ongoing. The MDHHS specialist confirmed that two of the months received were countable time limited months. The MDHHS specialist added the months to the *FAP Time-Limited Details* Screen. Maude has one countable month remaining.

Bridges tracks each TLFA individual's countable months, on the *FAP Time-Limited Details* Screen, as well as displaying the countable months on the *FAP EDG* screen. Other FAP group members may remain eligible even if one TLFA group member uses three countable months and is no longer eligible; see *Disqualified Or Ineligible Persons* in BEM 550, FAP Income Budgeting, and *Closure And Member Disqualification*, in this item.

Removing a Countable Month

Remove a month recorded as countable if later information verifies the month should not have been countable by updating the information on the *FAP Time-Limited Good Cause* Screen.

Example: The individual failed to work, cooperate with the MWA or perform community service in July and August. Medical documentation received in September verifies she has been pregnant since July. In order to remove the countable month, the specialist will update the *Time-Limited Good Cause* page to give good cause to July and August. The specialist will also update the

employment code in Bridges data collection to pregnant. Document the good cause reason in Bridges.

Example: The individual completed only part of the required community service hours for July and August. In September verification is provided documenting illness and inability to work during the last two weeks of July. Update the *Time-Limited Good Cause* Screen to give good cause to July. August remains a countable month.

Met Requirements

In some instances, individuals may have met TLFA work requirements but still received a countable month. Reasons for met requirements:

- Late hour entry.
- Hearing decision.
- Work requirement was met – other.

If the individual or MWA verifies the individual met requirements, indicate in the TLFA summary under the *good cause tab*, the met the requirement reason and document in the comments box how the individual met requirements.

Example: John completed SICS with a local non- profit agency in the month of October. John returned his DHS 1997; to verify his SICS on November 3rd. John received a countable month for October due to not verifying his SICS hours until November. The MDHHS specialist indicated in the TLFA summary that John met requirements due to late hours entry. Bridges removed the countable month and sent John a MMDHHS-5538, Countable Month Correction Notice.

Good Cause

Good cause is having a valid reason for failing to work at least 80 hours monthly (20 hours/week on average), failure to participate in an employment and training program at the MWA or failure to participate in workfare or self-initiated community service.

An individual who worked or participated less than the required hours is considered to have met the work requirement if all the following conditions are met:

- The absence was due to circumstances beyond the individual's control.

- It was temporary.

Document the good cause determination on the *FAP Time-Limited Good Cause* screen. Case comments detailing the reason for good cause are mandatory. The following are examples of good cause reasons:

- Personal illness.
- Death or illness of a household member requiring the presence of the TLFA recipient in the home.
- The unavailability of transportation.
- Lack of work (employer must verify).
- Household emergency.
- Temporarily unfit for work.

Verification of Good Cause

Verification of good cause is only required if the specialist considers the claim questionable. If questioning the good cause, the specialist will need to answer yes to the question *Is the good cause claim questionable* on the *FAP Time-Limited Good Cause* screen.

A MDHHS -3503 will be triggered when EDBC is run, to request the verification. Once received, the specialist will need to return to this screen and select the appropriate verification source from the drop-down menu to approve the good cause reason. If the verification is not returned, the month will remain countable.

If the month the good cause was not verified is the third countable month, Bridges will take the appropriate action to close the FAP case (if a single person case) or disqualify the TLFA individual.

36-Month Time-Period

Individuals who are neither deferred nor meeting the TLFA work requirement may receive FAP benefits for only three countable months in a 36-month period.

If an applicant has used some countable months, but has initial countable months remaining, Bridges will approve the application for the number of months remaining.

Follow redetermination procedures before the end of the current benefit period; see BAM 210, Redetermination/Ex Parte Review. Unless the individual is deferred or meets the TLFA work requirement, deny further eligibility until the 36-month period expires or the individual meets *regained eligibility criteria* in this item, whichever is earlier. Do not continue eligibility based on individual assurance that requirements will be met.

REGAINED ELIGIBILITY

An individual who has received three countable months of FAP benefits can regain FAP eligibility (within the 36-month period) by meeting one of the following within any 30-day period after the last benefit month but prior to application:

- 80 hours of employment.
- Self-initiated community service for the number of hours determined by Bridges (the number of hours must equal the FAP benefit amount divided by minimum wage) that would have equaled the individual's FAP benefit for that period.
- TLFA deferred; see *Time-Limited Deferrals* in this item.

Note: Individuals who regain eligibility via deferral, then lose the deferral, must meet one of the other criteria above before benefits can be authorized, including the three-month extension.

Do not prospect regained eligibility; unless deferred, the applicant must have met the 30-day work requirement prior to application. If the individual wants to perform self-initiated community service determine the monthly benefit and required hours. The individual must complete the community service hours prior to authorization of any benefits. If the individual plans to work or participate in an employment and training component, 80 hours must be completed prior to authorization of any benefits.

At application, treat the work requirement like a verification requirement. If the individual meets the work requirement within any 30-day period prior to the application date, the begin date is the

date of application. If the individual fails to meet regain criteria within any 30-day period prior to the application date, the application will be denied.

Individuals who regain eligibility remain eligible each month they continue to meet one of the above work requirements or are deferred.

Regained Eligibility - Expedited FAP

TLFA individuals who indicate on the application or during the FAP interview they have regained eligibility but have not provided proof of their regained eligibility activity, can be eligible for expedited food benefits if all other eligibility factors are met.

The MDHHS specialist will request the regained eligibility verification and approve expedited FAP. Once the verification is returned the MDHHS specialist can proceed with normal case processing. If the verification is not returned, the MDHHS specialist will close the FAP for failure to return verifications.

TLFA individuals who have not indicated they have regained eligibility on the application or during the FAP interview are not eligible for expedited food benefits.

Verification Regained Eligibility:

Verification the work requirement was met prior to application is required in order to regain eligibility.

If verification of meeting the work requirement is not returned the application may be denied after the verification due date; see BAM 115, Application Processing.

Three-Month Extension

Individuals who have regained eligibility by meeting the TLFA work requirement, then fail to maintain the work requirement, receive three additional months of benefits if otherwise eligible. The first month of these extended months, is the first month the work requirement is not met.

The extended months of benefits cannot be interrupted, regardless of whether the individual participates in a work activity or becomes

deferred. Bridges will end the benefits during the extension months only if the individual fails to meet other FAP eligibility criteria. The extension is available only once in a 36-month period.

Example: The individual regained TLFA eligibility for the first time by meeting the work requirement in July, then failed to meet it in August and is not deferred. They are eligible for extension benefits for August, September and October. To receive November benefits, they must first meet the work requirement or be deferred.

Example: The individual regains eligibility for July due to a medical condition that does not extend beyond July. They are not eligible for extension benefits in August, September or October because they did not regain eligibility through the work requirement. To receive further benefits during the 36-month period, they must meet one of the criteria in *Regained Eligibility* in this item.

Note: A policy exception is required for any adjustment to extension months.

After the Three-Month Extension

There is no limit to the number of times an individual can regain eligibility. Following the extension, for the remainder of the 36 months, Bridges will determine the individual's eligibility on a month-to-month basis. Each month, the individual must meet the TLFA work requirement or be deferred to receive benefits.

If the individual fails to meet the work requirement after the three-month extension, FAP benefits must be recouped for any benefits received for any months the work requirements were not met or the individual was not deferred.

CASE CLOSURE OR MEMBER DISQUALIFICATION

Bridges will determine when the countable months (either the initial three or from an extension) have been exhausted for each individual; see *Countable Months* in this item.

- On the 17th of the third countable month Bridges will generate the MDHHS-142-A, TLFA Third Countable Month/Out of State Countable Month, notice to inform the individual that unless they meet the work requirement for the third countable month

the case will close, or the individual will be disqualified from the group.

- If the countable months are exhausted, Bridges will generate the MDHHS-1605, client notification, with timely notice to close the case or disqualify the TLFA member.
- If a TLFA member in a TLFA group becomes ineligible, a pro-rata share of their income counts toward the remaining eligible group members. If the benefit period will expire at or before the third countable month, just complete the redetermination.

Case closure or member disqualification verification:

If sending a MDHHS-1605, Client Notice, the effective date is the last workday of the third countable month unless timely notice is too late to affect that month. (Do not recoup any additional issuance provided the change was reported timely and the timeliness standard was met for processing the change.).

BENEFIT PERIODS

Bridges will determine a benefit period based on the individual's situation at application and redetermination and will assign the benefit period end date to avoid ineligible issuances.

If the individual has already used countable months. Bridges will assign the appropriate benefit period for each month to ensure benefits are not issued incorrectly. Bridges will review data entered in Bridges for employment, MWA participation or community services when determining eligibility for the next benefit period.

For individuals deferred due to an incapacity expected to last longer than three months, Bridges will set the benefit period to end the month the incapacity will end; see *Deferral For Disability* in BEM 230B and *TLFA Deferrals* in this item.

It is the TLFA individual’s responsibility to report when hours of work drop below 80 hours monthly. If a change is not reported timely, establish an over-issuance for any ineligible months; see BAM 700, Benefit Overissuance.

Change Reporting

TLFA applicants and recipients are required to report as specified in BAM 105, Rights And Responsibilities. Do not include TLFA

applicants or recipients who are not working 20 hours or more per week in simplified reporting; *see* BAM 200.

If a FAP recipient who is following simplified reporting requirements becomes subject to TLFA requirements during the 6-month benefit period, do the following:

If a change is reported during the benefit period:

- Process the change according to policy outlined in BAM 220, Case Actions.
- End the simplified reporting requirement. Do not change the benefit period.
- Bridges will issue the individual MDHHS-2240, Change Report.
- Inform the individual of the eligibility requirements for TLFA as out- lined in policy; see *Informing Individuals* in this item.
- Bridges will assign the appropriate benefit period based on client participation documented in the system.

Note: TLFA individuals working over 20 hours a week can remain a simplified reporter until their hours drop below 20 hours a week.

If a change is discovered at redetermination:

- Inform the individual of the eligibility requirements for TLFA; see *Informing Individuals* in this item.
- Process the redetermination as a new TLFA application.
- Do not process any over-issuances or penalize the individual.

When informing Individuals, Bridges will issue the MDHHS-142, Time Limited Food Assistance Notice, to everyone who becomes subject to the TLFA requirements. Use the MDHHS-142 to explain Time-Limited FAP policy to every TLFA individual at application, redetermination, and when a change results in TLFA status (for example, individual reports employment ended).

Note: Bridges will generate the MDHHS-142-B, Time Limited Food Assistance Requirements Ending, to inform individuals when they are no longer subject to TLFA work requirements. This notice will be issued in the following instances:

- The individual becomes deferred.
- The individual is no longer subject to TLFA requirements.

Example: Aretha lives in Kent County and is subject to the TLFA work requirements. On July 28 Aretha turned 50 years old. Bridges will issue the MDHHS-142-B indicating Aretha is no longer subject to the time limit due to turning age 50.

REPORTS

TL-200 TLFA Report

The TL-200, TLFA Report, will allow users to view important details on TLFA participants and their current participation status.

This daily report can be broken out by county and district. This report identifies individuals aged 18 through 49 who are subject to TLFA policy. These individuals are identified by participation status, as well as the deferral/participation reason, deferral end dates, and the number of countable months that have been used.

Local offices may use this report in any manner considered beneficial.

VERIFICATION REQUIREMENTS

Verify eligibility factors, work requirement criteria and educational participation.

Verify a reason for deferral from the TLFA work requirement only if it is not obvious and the information provided is questionable (for example, information is unclear, inconsistent or incomplete); see *deferrals* in BEM 230B.

Document in the case record the reason for granting the deferral and the length of time before the continuing need for the deferral will be reviewed.

Do not deny an application solely because an employer has not verified the income and hours. After taking reasonable measures to obtain actual income and hours, consult the individual and use the best avail-able information. Document in Bridges the attempts to verify and why they were unsuccessful.

LEGAL BASE

FAP

Public Law 104-193, as amended. Public Act 294 of 2000. 7CFR 273.2.12, 24.

DEPARTMENT PHILOSOPHY

The refugee assistance programs are federal programs which help refugees to become self-sufficient after their arrival in the U.S. Refugee Assistance Program (RAP) has two components; Refugee Cash Assistance (RCA) and Refugee Medical Assistance (RMA).

DEPARTMENT POLICY

RCA is a cash program for refugees who are not eligible for the Family Independence Program (FIP). RMA is a medical program for refugees who are not eligible for other Medicaid (MA) programs.

In addition to refugees, eligibility for RCA and RMA is available to certain other non U.S. citizens with specified immigration statuses, identified in the section refugees in this item. **Treat these individuals as refugees**, for purposes of this item.

RCA/RMA ELIGIBILITY PERIOD

RCA and/or RMA is available **only** during the twelve months immediately following the refugee's date of entry into the U.S. or date asylum is granted. Month one is the month containing date of entry or date of adjustment to refugee status.

PROGRAM ADMINISTRATION

Michigan Department of Health and Human Services (MDHHS) local office specialists determine eligibility for all programs. For participants in RCA, the specialist must complete the manual referral to the refugee contractor.

The Refugee Services Program under the Office of Global Michigan in the Department of Labor and Economic Opportunity (LEO) administers all refugee assistance programs. MDHHS is responsible for eligibility determinations for the RCA and RMA programs. The Office of Global Michigan partners with MDHHS on refugee health programming.

Refugee Resettlement Agencies

Refugee Resettlement Agencies also known as Voluntary Agencies (VOLAGs) may provide the following services:

- Reception and placement services to newly arrived refugees including orientation, counseling, resettlement grants, translation/interpretation, and related services.
- Employability services such as English language instruction, transportation, child care, citizenship and employment authorization document assistance, translation/interpretation, and related services.
- Matching Grants (MG) to help refugees attain economic self-sufficiency without accessing public cash assistance.

CONCURRENT RECEIPT OF BENEFITS

At application, all refugees must provide the name of the resettlement or other agencies that assisted them.

RCA

Individuals **may** voluntarily leave the MG program by applying for cash assistance. An individual **may not** receive MG and FIP/SDA/RCA concurrently.

Notify the resettlement agency when a refugee applies for cash assistance. If a MG case is active, the resettlement agency must close the MG prior to cash approval.

RMA

An individual **may** receive MG and MA/RMA concurrently.

REFUGEES

Only a person who is a refugee (or is treated as a refugee) and who is **not** a U.S. citizen can be eligible for RCA/RMA.

United States Citizenship and Immigration Services (USCIS) determines immigration status. If the status of a refugee cannot be verified through immigration documents, contact the local resettlement agency that provided for the refugee's initial resettlement.

Individuals with the following statuses may be eligible for RCA/MA:

- **Refugee or Asylee**. An individual from any country admitted into the U.S. with the status of refugee or asylee.

  Documentation is an I-94, Arrival/Departure Record, indicating the Individual is one of the following:

  - Admitted as a refugee under section 207 of the Immigration and Nationality Act (INA).
  - Granted asylum under section 208 of the INA**.**

- **Afghan and Iraqi**. Individuals granted a special immigrant visa (SIV).

- **Derivative Asylee.** A spouse and/or child of a principal asylee entering the U.S. at a later date through an Asylee Relative Petition (I-730).

- **Cuban/Haitian Entrant.** An individual admitted into the U.S. from Cuba or Haiti who meets entrant criteria.

  Documentation is an I-94, Arrival/Departure Record, indicating the Individual was admitted into the U.S. from Cuba or Haiti and one of the following:

  - Document is annotated as a Cuban/Haitian Entrant (Status Pending), parole, 212(d)(5) or Form I-589 Filed.
  - Individual has letter or notice from USCIS indicating ongoing (**not** final) deportation, exclusion or removal proceedings.

- **Amerasian**. An individual admitted into the U.S. under P.L. 100-202.

  Documentation is one of the following documents annotated with class code AM.

  - I-94.
  - I-551.
  - U.S. or Vietnamese Passport.

- Vietnamese Exit Visa (Laissez Passer).

- **Parolee.** An individual from Cuba or Haiti paroled into the U.S. under INA section 212(d)(5) for at least one year.

  Documentation is an I-94 annotated with INA section 212(d)(5) which has a parole end date (duration) at least one year later than the date of entry.

- **Permanent Resident.** An individual admitted for permanent residence, provided the individual previously held one of the refugee or asylee statuses identified above.

  Documentation is an I-551 annotated with class code RE, AS, SI, SQ, CH, or CU.

- **Victim of Trafficking.** An individual determined by the federal Office of Refugee Resettlement (ORR) to be a victim of trafficking.

  Documentation is **both** of the following:

  - The **original** certification letter from ORR, or for victims under age 18, an **original** eligibility letter from ORR (see Exhibits I and II).

  - Telephone contact with the ORR trafficking verification line at 1-866-401-5510 verifying the validity of the letter(s).

  Note: No other immigration documents are necessary for victims of trafficking.

DATE OF ENTRY

RCA

USCIS determines an individual's date of entry into the U.S. and enters it on the I-94 or other immigration document. This USCIS determination is **not** subject to the MDHHS fair hearing process.

For **asylees,** acceptable non-citizen status begins on the date asylum is granted on the I-94, or on the Asylum Approval letter, regardless of arrival date. If the date of arrival and the date asylum is granted are different, notify the Office of Global Michigan via the policy email box: LEO-RefugeeServices@michigan.gov

For **victims of trafficking**, the date of entry is the date on the ORR certification/eligibility letter.

For **derivative asylees**, acceptable non-citizen status does not begin on the date that asylum is granted. The acceptable non-citizen status date begins on the I-94 entry date or the date the I-730 is approved.

For **Afghan and Iraqi special immigrants**, acceptable non-citizen status begins with the month containing the date of entry in the U.S.

ELIGIBILITY

Bridges uses the following guideline when determining eligibility for refugees:

- Bridges determines eligibility for FIP and MA before determining eligibility for RCA and /or RMA.
- Bridges determines FIP and MA eligibility when an RCA/RMA recipient reports a change that indicates potential for FIP or MA eligibility for (example when an RCA recipient becomes pregnant).

RCA

RCA eligibility factors are listed in BEM 209, Cash Assistance General Requirements and in BEM 245, School Attendance and Student Status.

RMA

RCA recipients who are **not** eligible for MA are **automatically** eligible for RMA.

Note: Excess income for MA resulting in a deductible is not considered MA eligible.

See extended medical coverage in this item about when RMA may be extended.

Note: An ex parte review (see Glossary) is required before a Medicaid closure when there is an actual or anticipated change; unless the change would result in closure due to ineligibility for all Medicaid categories. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes all consideration of all MA categories; see BAM 115, Application Processing, and BAM 220, Case Actions.

Note: A full-time student in post-secondary education is not eligible for RCA or RMA. The school determines full-time enrollment and attendance; see BEM 245, School Attendance and Student Status.

Group Composition

RCA

See BEM 215 for RCA group composition policy.

RMA

See BEM 216, RMA Group Composition, for refugees who are not eligible for MA.

FINANCIAL ELIGIBILITY FACTORS

Assets

RCA

Use FIP policy in BEM 400 to evaluate assets.

Note: The following are special RCA asset rules:

- Do **not** consider the assets of a refugee's sponsor in determining the refugee's eligibility.
- Cash assistance given to a refugee from a resettlement agency is **not** an asset.

RMA

Use RMA policy in BEM 400 to evaluate assets.

See extended medical coverage in this item

Income

RCA

Follow income policy in BEM 500.

Income eligibility exists when net income of individuals with an RCA EDG status of eligible or disqualified is less than the needs of the certified group (CG). See RFT 211 for RCA payment standards.

RMA Only

Income eligibility exists when net income does not exceed the income limit of Group 2 Medicaid categories.

- Do **not** count any income received by the refugee from a refugee resettlement agency or the refugee's sponsor.
- Apply policy in BEM 546 if an eligible person is an L/H individual.
- If net income exceeds the income limit, RMA eligibility is still possible using policy in BEM 545.
- See extended medical coverage in this item for recipients who lose eligibility due to excess income.

Income and Assets at Application

RMA

At application, determine eligibility based on the group's income and assets on the date of application. Bridges uses policy in BEM 536 to determine the group's net income. Do **not** prospect income from a source if no income has been received by the date of application.

Example: The Smith family applies on November 6, 2009. Mr. Smith has started a job but has not received his first paycheck. Do **not** prospect any earned income for Mr. Smith in determining initial eligibility.

Income and Assets After Application

RMA

After initial eligibility has been established for RMA or MA, exclude recipient's earned income and assets for RMA determination.

Example: Mr. Smith (example above) reports receiving his first paycheck on November 7, 2009. These earnings are **not** counted to determine initial or ongoing eligibility.

EXTENDED MEDICAL COVERAGE

Bridges will continue or initiate RMA coverage for refugees when all of the following are true:

- RCA eligibility is lost due to excess earned income or assets.
- Members are within twelve months of their date of entry into the U.S. or date asylum was granted.
- Members are **not** eligible for MA or MI Child.

Do not require a new application; see benefit periods in this item.

RMA Termination

Bridges will **only** terminate RMA for a group member who is either of the following:

- No longer meets the MA eligibility factors found in BEM 220, Residence.
- Becomes eligible for MA.

STANDARD OF PROMPTNESS

RCA

Approve or deny an application for RCA and mail the individual a notice within **30 days** from the date of application; see BAM 115 for all other application processing policies.

BENEFIT PERIODS

RCA

Bridges sets the benefit period based on date(s) of entry.

Specialists must follow-up to remove each group member whose eligibility ends before the benefit period end date. Bridges automatically stops RCA benefits effective the month when the last group member has been in the U.S. for twelve months.

RMA

Bridges sets the redetermination date based on date(s) of entry.

Note: An ex parte review (see Glossary) is required before a MA closure when there is an actual or anticipated change, unless the change would result in closure due to ineligibility for all Medicaid categories. When possible, an ex parte review should begin at least 90 days before the anticipated change is expected to result in case closure. The review includes consideration of all MA categories; see BAM 115 and 220.

RMA

RMA recipients receive a MiHealth card. Covered services for RMA are the same as in Medicaid. Medicaid reimbursement procedures, such as billing instructions and prior authorization procedures, are used for RMA.

TRANSLATION AND INTERPRETATION SERVICES

RCA and RMA

Use the DHS-848, Certification of Translation/Interpretation for Non-English Speaking Applicants or Recipients, whenever an individual who is non-English speaking or has limited English proficiency (LEP) is provided translation/interpretation services. The 848 is documentation an individual has been provided written or verbal notice in a language they can understand.

See BAM 105, rights and responsibilities, for additional information regarding translation and interpretation.

VERIFICATION REQUIREMENTS

RCA and RMA

Verify the refugee statuses of each individual at application or member add. See the refugees section in this item for documents that verify refugee status. If the applicant provides verification of a non-citizen status other than what is listed in this item or in BEM 225, Citizenship/Non-Citizen Status, contact the Office of Global Michigan for approval of the verification documents via the policy mailbox: LEO-RefugeeServices@michigan.gov

Verify each refugee's date of entry into the U.S. Use the I-94, other pertinent USCIS document, or contact with USCIS to verify date of entry.

RMA

Use Group 2 MA verification requirements for all other eligibility factors.

EXHIBIT I - SAMPLE ADULT VICTIM OF TRAFFICKING ORR CERTIFICATION LETTER

HHS Tracking Number
55555555555

Ms. Susie Doe
c/o Smith County Community Service Office
Department of Social Services
123 Main St.
Everytown, CA 33333-3333

CERTIFICATION LETTER

Dear Ms. Doe:

This letter confirms that you have been certified by the U.S. Department of Health and Human Services (HHS) under section 107(b) of the Trafficking Victims Protection Act of 2000. With this certification, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria. Certification does not confer immigration status.

Your certification date is **JANUARY 1, 1999**. The benefits outlined in the previous paragraph may offer assistance for only limited time periods that start from the date of this certification. Therefore, if you wish to seek assistance, *it is important that you do so as soon as possible after receipt of this letter*.

You should present this letter when you apply for benefits or services. **Benefit-issuing agencies must call the trafficking verification line at (202) 401-5510 in the Office of Refugee Resettlement to verify the validity of this document and to inform HHS of the benefits for which you have applied.**

Sincerely,

Nguyen Van Hanh, PhD
Director
Office of Refugee Resettlement

EXHIBIT II - SAMPLE CHILD VICTIM OF TRAFFICKING ORR ELIGIBILITY LETTER

HHS Tracking Number
55555555555

Ms. Susie Doe
c/o Community Service Office
Department of Social Services
555 Main St.
Everytown, WA 55555-5555

Dear Ms. Doe:

This letter confirms that under section 107(b) of the Trafficking Victims Protection Act of 2000, you are eligible for benefits and services under any Federal or State program or activity funded or administered by any Federal agency to the same extent as an individual who is admitted to the United States as a refugee under section 207 of the Immigration and Nationality Act, provided you meet other eligibility criteria. This letter does not confer immigration status.

Your eligibility date is **JANUARY 1, 1999**. The benefits outlined in the previous paragraph may offer assistance for only limited time periods that start from the date of this eligibility letter. Therefore, if you wish to seek assistance, *it is important that you do so as soon as possible after receipt of this letter.*

You should present this letter when you apply for benefits or services. **Benefit-issuing agencies must call the trafficking verification line at (202) 401-5510 in the Office of Refugee Resettlement to verify the validity of this document and to inform HHS of the benefits for which you have applied.**

Sincerely,

Nguyen Van Hanh, PhD
Director
Office of Refugee Resettlement

LEGAL BASE

45 CFR 400
P.L. 106-386 of 2000, Section 107

DEPARTMENT POLICY

The Insurance Assistance Program (IAP) is designed to help persons infected with HIV/AIDS maintain health insurance. These programs seek to continue health insurance coverage by paying health insurance premiums on current policies for private pay health insurance plans and Medicare Medigap plans. This would prevent a client's insurance lapse due to lack of financial resources.

The IAP offers assistance with private health insurance premiums and Medicare Medigap plans.

The payment of health insurance for private pay health insurance plans and Medicare Medigap plans is available through the IAP only. Recipients of other department medical programs, for example Medicaid, must apply separately for these programs.

INSURANCE ASSISTANCE PROGRAM (IAP)

The Michigan Department of Health and Human Services (MDHHS) pays health insurance premiums for persons with HIV/AIDS who have a private health insurance policy and Medicare Medigap plans.

Eligibility Requirements

To be eligible for the Insurance Assistance Program (IAP) an client must meet all of the following requirements:

- Be a current Michigan resident.
- The person must have a current health insurance policy; see Department Policy in this item.
- A DHS-1661, Insurance Assistance Program application, must be completed.
- Client must be HIV positive and be currently too ill to work, or there is a substantial likelihood they will be too ill to work within the next three months, as verified by a physician.
- Monthly income must be less than 200 percent of the federal poverty level. If an applicant's income exceeds the federal

poverty level, the cost of monthly medical expenses may be deducted from income to meet the income limit. The cost of the health insurance premium is not deductible.

- Cash assets must be less than $10,000.
- Client may be eligible for Medicaid.

APPLICATION AND PUBLICATION

The DHS-1661, Insurance Assistance Program application, and Pub-734, Insurance Assistance Program For People With HIV/AIDS, are available by contacting the Insurance Assistance Office by phone, mail, or on our website at the contact information below:

Mailing Address:

Insurance Assistance Program
Michigan Department of Health and Human Services
109 Michigan Ave, 9th floor
Lansing, MI 48913

Michigan Department of Health and Human Services/Keeping Michigan Healthy/Chronic Diseases/Insurance Assistance Program

Phone Number: 1-877-342-2437
Fax Number: 517-335-7723

LEGAL BASE

Ryan White Care Act of 1990, P.L. 101-381
P.L. 104-146 of 1996
P.L. 106-345 of 2000

DEPARTMENT POLICY

Maternity Outpatient Medical Services (MOMS) is a health coverage program operated by the Department of Health and Human Services (DHHS).

MOMS provides prenatal and postpartum outpatient pregnancy-related services to women who are pregnant or recently pregnant and are eligible for Medicaid Emergency Services Only (ESO).

COVERAGE PERIOD

Pregnant or recently pregnant Medicaid ESO beneficiaries receive prenatal care along with medically necessary ambulatory postpartum care for 60 days after the pregnancy ends regardless of the reason.

TARGETED POPULATION

Women who are pregnant or within two calendar months following the month pregnancy ended and are:

- Eligible for Medicaid emergency services only.
- Applicants for Medicaid whose income, after deductions, appears to be at or below 195 percent of the federal poverty level.

APPLICATION FOR MOMS

The DCH-1426, Application for healthcare coverage and help paying costs, is required for MOMS eligibility.

Local health departments, federally qualified health centers, and other trained providers assist pregnant women with applications for Medicaid:

- Assisting the woman over the telephone and making appointments with eligible/interested women.
- Advising the applicant of any verification requirements and assisting in securing any required documentation.

MSA Rsponsibilities

Medical Services Administration (MSA) is responsible for verifying eligibility and establishing the coverage period.

NONFINANCIAL FACTORS

Residence

The individual must be a Michigan resident.

Social Security Number

A Social Security number (SSN) is not required for this program.

Pregnancy

Verification of pregnancy is **not** required.

FINANCIAL ELIGIBILITY FACTORS

Assets

There is no asset test.

Fiscal Group Income

The group is the same as MAGI related groups. Fiscal group income must be at or below 195 % of the poverty level. Verification of income is not necessary unless the individual's statement is inadequate or questionable.

COVERED SERVICES

Coverage for pregnant Medicaid ESO beneficiaries is limited to the following outpatient pregnancy and postpartum-related services:

- Prenatal care and pregnancy-related care.
- Pharmaceuticals and prescription vitamins.

- Radiology and ultrasound.
- Professional fee for labor and delivery (including live birth, miscarriage, ectopic pregnancy and stillborn).

  Note: Outpatient deliveries are not covered.
- Outpatient hospital care.
- Postpartum care through two calendar months after the pregnancy ends.
- Other pregnancy-related services approved by MSA.

Labor and delivery and associated inpatient hospital costs are covered by Medicaid.

Note: Services to the infant are **not** covered under MOMS.

Private insurance coverage must be billed first. MOMS will be the secondary payer of services if private insurance coverage exists.

LEGAL BASE

DCH Appropriations Act.

Public Health Code, PA 368 of 1978, as amended.

The Patient Protection and Affordable Care Act (PublicLaw. 111-148 and the Health Care and Education Reconciliation Act (Public Law. 111-152).

SSI BENEFITS

Supplemental Security Income (SSI) is a cash benefit to needy persons who are aged (at least 65), blind or disabled. It is a federal program administered by the Social Security Administration (SSA). States are allowed the option to supplement the federal benefit with state funds. In Michigan SSI benefits include a basic federal benefit and an additional amount paid with state funds. The amount of the state benefit varies by living arrangement.

Issued Benefits

The SSA issues the federal benefit to all SSI recipients. The SSA also issues the state funded benefit for SSI recipients in the following living arrangements:

- Adult foster care.
  - Domiciliary care.
  - Personal care.
- Home for the aged.
- Institution.
  - Nursing home.

Initially, a lump sum check maybe issued for any retroactive benefits. Thereafter, the SSA issues SSI benefits monthly, on the first of the month.

State SSI Payment

The Michigan Department of Health and Human Services (MDHHS) issues the State SSI Payment (SSP) to SSI recipients in the following living arrangements:

- Independent living.
- Household of another. (Living in the household of another person and receiving partial or total support and maintenance in kind from that person.)

Note: For payment levels see RFT 248 Reference Tables.

Payments are made for only those months the recipient received a regular first of the month federal benefit. These are shown on SOLQ as a **recurring payment dated the first of the month**.

SSPs are not issued for retroactive or supplemental federal benefits.

SSPs are not issued for 1619 Recipients.

1619 Recipients - Certain blind or disabled SSI recipients who work and have too much income for an SSI cash grant may be eligible for continued MA coverage.SSP benefits are issued quarterly. These benefits are paid the last month of each quarter. The yearly quarters are:

- January through March.
- April through June.
- July through September.
- October through December.

Payments are processed by recipient ID digit ending; see RFS 106 (Reference Schedules Manual).

SSP warrants are issued to the individual or payee account designated by the SSA.

Death of Recipient

See BAM 505 for processing returned benefits. Notify the local Social Security Administration office of the recipients death if you believe they do not have that information.

Representative Payee

The Social Security Administration designates the representative payee. However, if the SSA does not notify the MDHHS of a change in payee or the recipient becomes his/her own payee, a change or deletion can be done on Bridges.

Recoupment

Follow Benefit Overissuance policy in BAM 700.

Note: The State SSI Payment program **cannot** be entered onto the Automated Recoupment System. If recoupment is indicated follow local office accounting procedures for manual recoupments.

Mandatory SSI Recipients

Mandatory SSI recipients are those clients who were receiving benefits under the state administered aged, blind and disabled programs that were taken over by the federally administered SSI

program in 1974. In order to ensure a continuity in the SSI income level of these recipients, the SSA uses a separate, complex formula to determine the amount of the state supplement. Therefore, the Michigan Department of Health and Human Services (MDHHS) has left the administration of mandatory supplements for all living arrangements as a federal responsibility.

However, some of the recipients receiving mandatory supplements in independent living or household of another living arrangements receive less than the State SSI Payment.

Benefit Reduction

The DHS-430, Notice of State SSI Payment Change, is sent to each SSI recipient whose current quarterly State SSI Payment is less than the previous quarterly State SSI Payment.

If the recipient wants to request a hearing, he/she is referred to the local office Hearings Coordinator; see BPG Glossary.

The DHS-430, Notice of State SSI Payment Change, does all of the following:

- Gives recipients timely notice of any proposed benefit reduction.
- Notifies recipients of their hearing rights and the date by which a timely hearing request will preserve benefits at the current level pending the hearing decision.
- Notifies recipients of the date they will receive their next (reduced) quarterly check.

Recipients receiving an DHS-430 will receive their check with the recipient ID digit end 9's; see RFS 106, State SSI Payment Payroll Deadline Schedule.

Payment History

The SSP quarterly warrants are listed on Bridges benefit issuance screen.

SSP monthly amounts are shown on Bridges eligibility search screen.

Local Office Responsibilities

- Respond to all recipient inquiries; see BAM 800.
- Process rewrites for undelivered, lost, stolen, not received or destroyed SSP warrants. Use warrant rewrite procedures in BAM 500 and 505.
- Process hearing requests; see BAM 600.
- Represent the department at the hearing.

LEGAL BASE

20 CFR 416
Social Security Act, 1616 [42 USC 1382e]

POLICY

The client is responsible for obtaining any requested verifications needed to determine eligibility. Use the DHS-3503, Verification Checklist (VCL), to inform the client of what verifications are needed at application and redetermination. Include on the VCL the list of acceptable verification sources for each specific eligibility factor. Send the client any forms that are on the list of acceptable verifications sources. All verifications must be included in the case record.

Note: During 12-month continuous eligibility, a request for positive change must be verified. If verification has not already been received, use the DHS-5419, Child Development and Care (CDC) Request for Additional Assistance, to request verifications for an additional provider, need reason, or need hours. Use the DHS-3503 to request verifications for all other changes that would result in increased benefits.

See BAM 210 and this policy item, Redeterminations, for policy regarding verification at redetermination.

See BAM 118, CDC Expedited Service, for policy regarding verification when a group is entitled to expedited service.

Verification Timeframes

The client is allowed a full 10 calendar days from the date verification is requested (the date of request is not counted) to provide the requested information. If requested, at least one extension must be given if the client cannot provide the verification despite a reasonable effort. For active cases, Bridges will allow timely notice if verifications are not returned.

Note: Beginning 10-1-2023, when a signed redetermination form is received prior to the end of the redetermination month, and verifications are missing or are incomplete, send a VCL. Verifications are due by the end of the redetermination month, or within 10 days after they are requested, which ever allows more time.

Verifications At Application

All of the following are required prior to opening Child Development and Care (CDC) on Bridges, unless the group is eligible for CDC Expedited Service; see BAM 118:

- Verify the **identity** of the applicant and authorized representative, if any; see BEM 221, Identity.
- Verify the client's address; see BEM 220 for acceptable verifications.
- Obtain the **Social Security number (SSN)** of the CDC grantee. Do **not** deny eligibility solely because you are unable to obtain the SSN.
- Verify the non-citizen **status** for each child needing care that **is not a U.S. citizen;** see BEM 225.
- Verify the need for CDC; see BEM 703, including documentation of the need reason for **each** parent/substitute parent.
- Verify need for CDC services for children over age 12 with a copy of the court order or a statement from a D.O. or M.D.
- Verify all countable income, if CDC Income Eligible group; see BEM 500-504.

Note: When income eligibility is established in the first pay period of an application ***and*** a change in income is reported, the income change is not required to be verified for approval of subsequent pay periods.

- Verify presence of children, only if questionable.
- Verify need hours.

Verifications at Redetermination

All of the following are required prior to certification of CDC at redetermination:

- Verify the client's address **if** it has changed since the last eligibility determination **and** has not yet been verified; see BEM 220 for acceptable verifications.
- Verify the **non-citizen status** for each child needing care that **is not a U.S. citizen**; see BEM 255, Citizenship/Non-Citizen Status.
- Verify the need for CDC; see BEM 703, including documentation of the need reason for **each** parent/substitute parent.
- Verify need for CDC services for children over age 12 with a copy of the court order or a statement from a D.O. or M.D.
- Verify all countable income, if CDC income eligible group; see BEM 500-504.
- Verify presence of children, only if questionable.
- Verify need hours.

Verification Prior to Assigning Provider to Case

Use the DHS-4025, Child Development and Care Provider Verification, to verify the child(ren) in care, the date care began, where care is provided and the provider's relationship to the child(ren). This form must be signed per the instructions on the form and is required in the following situations:

- Before adding a provider assignment to a child.
- When there is a break in a provider's assignments.

Note: A new DHS-4025 is **not** required at redetermination if the client has not reported a change in providers.

If the DHS-4025 is signed but missing the care begin date, provider ID, or other information needed to make the assignment, contact the parent or the provider to obtain this information. Document the information directly on the form or in Bridges Case Comments.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

PROGRAM OVERVIEW

The goal of the Child Development and Care (CDC) program is to support low-income families by providing access to high-quality, affordable and accessible early learning and development opportunities and to assist the family in achieving economic independence and self-sufficiency.

The Child Development and Care program is intended to promote continuity of care and to extend the time an eligible child has access to child care assistance by providing a subsidy for child care services for qualifying families.

INTRODUCTION

Once eligibility has been determined, the child(ren) will remain eligible for the entire 12-month certification period unless the CDC EDG closes for one of the reasons listed in BAM 220. A change or termination in the parent/substitute parent's (P/SP) valid need reason will not affect the child's eligibility.

At application or redetermination, eligibility for CDC services exists when the department has established **all** of the following:

- There is a signed application and a request for CDC services.
- Each child for whom CDC is requested is a member of a valid *eligibility group*.
- Each P/SP meets the *need* criteria as outlined in this item.
- All eligibility requirements are met.

ELIGIBLE CHILDREN

The child(ren) needing child care services must be one of the following:

- Under age 13 at application or redetermination.
- Age 13, but under age 18 when one of the following apply:
  - Requires constant care due to a physical/mental/psychological condition.
  - Supervision has been ordered by the court.

- Age 18 and requires constant care due to a physical/mental/psychological condition or a court order, and is all of the following:

  - A full-time high school student.
  - Reasonably expected to complete high school before reaching age 19.

Verify need for CDC services for children over age 12 with a copy of the court order or a statement by a D.O. or M.D.

Note: Eligible children who turn age 13 during a CDC pay period are eligible through the end of the 12-month continuous eligibility period.

ELIGIBILITY CHART

The following chart provides the valid CDC services by eligibility group and need reason.

Child Development and Care Eligibility Chart Effective January 1, 2016				
Eligibility Groups	**Valid Need Reasons** Each CDC parent/substitute parent must be unavailable due to a valid need reason.			
	Family Preservation	**High School Completion**	**Approved Activity**	**Employment**
Children's Protective Services	✓ If required by an active Protective Services Case plan			
Foster Care	✓ If required by an active Foster Care Case plan	✓	✓	✓
FIP Related	✓	✓	✓	✓
Migrant	✓	✓	✓	✓
Homeless	✓	✓	✓	✓
Income Eligible*	✓	✓	✓	✓

Income Determination Required; see RFT 270.

PARENT/ SUBSTITUTE PARENT

At application or redetermination, each P/SP must demonstrate a valid need reason. This section specifies who must demonstrate those valid need reasons.

Parent/substitute parents are often the same for all the children in the family. However, there are some homes where the children may not all share the same P/SP. Therefore, P/SPs must be identified separately for each child for whom CDC is requested. P/SP means the following person(s) who live in the home and are unavailable to care for the child due to a valid need reason:

- The child's legal or biological parent(s).
- The child's stepparent.
- The child's foster parent(s).
- The child's legal guardian(s).
- The applicant/client, if:
  - The child has no parent, stepparent or legal guardian who lives in the home.
  - The child's only P/SP that lives in the home is excluded from providing the care; see Need in this item.

Note: See BAM 220, CDC MEMBER ADD for CDC member add requirements.

NEED

There are four valid CDC need reasons listed below. Each P/SP of the child needing care must have a valid need reason when child care is requested. Each need reason must be verified.

1. Family preservation.
2. High school completion.
3. An approved activity.
4. Employment.

Note: A P/SP may be considered as unavailable and excluded from providing the care if a court order mandates that he/she not be alone with the child or if he/she is the person being investigated for the neglect or abuse of any child in a confirmed open children's protective services case.

However, in no instance is information to be shared with the client regarding the family member's status on the central registry. If the only P/SP in the home is considered unavailable due to this reason, the availability of the applicant/client must be considered in determining need.

Note: In two-parent households, both parents' need reasons must be verified at application and redetermination with the appropriate verification.

Multiple Need Reasons May Exist

More than one need reason may exist in some cases. Consider each need reason (family preservation, high school completion, approved activity, employment) separately to determine need hours.

Example: A P/SP may need child care while at work and also when attending school.

In a two-parent household, there may be instances when both are unavailable at the same time, due to different need reasons. When there is more than one need reason, enter all applicable need reasons. Bridges will select the appropriate hierarchy when the case is certified.

REQUEST FOR ADDITIONAL NEEDS

When a client requests additional assistance during the 12-month continuous eligibility period, and verifications are needed, generate the MDHHS-5419, Child Development and Care (CDC) Request For Additional Assistance, from Bridges *left navigation*. The MDHHS-5419 allows the client to request additional CDC assistance (need reason, hours and/or provider).

If the MDHHS-5419 and required verifications are returned by the due date:

- Log the MDHHS-5419 into Bridges as being received.
- Process the change according to BAM 220.

Note: If only the verifications are returned, the MDHHS-5419 should be logged as being received, to prevent the MDHHS-5420, Child Development and Care (CDC) Continued Benefits Notice,

from being automatically generated. The MDHHS-5420 is mailed to inform the client the additional need request will not be processed due to missing or incomplete verifications.

If the MDHHS-5419 and or verifications are not received by the due date:

- The MDHHS-5420 will be generated and sent 10 calendar days after the due date on the MDHHS-5419.
- There will be no change to the client's benefits.

Note: If the verifications are received after the due date, but before the MDHHS-5420 is generated, process the change according to BAM 220.

NEED REASONS

1. Family Preservation

Child care may be approved for a child whose P/SP is:

- Unavailable to provide care because they are participating in a court-ordered activity.
- Unavailable to provide care because they are required to participate in the treatment activity of another member of the CDC program group, the CDC applicant or the CDC applicant's spouse who lives in the home.
- Unable to provide care due to a condition for which they are being treated by a physician.
- Unavailable to provide care due to an employment or educational need that is part of the child protective services/foster care services case plan.

Child care for this need reason cannot be authorized for **ongoing** 24-hour care.

Note: The family preservation need is based on the P/SP's need, not the child's need.

Allowable conditions may include, but are not limited to the following:

- Disability or mental disturbance.
- Chronic health conditions.
- Drug/alcohol abuse.
- Social isolation.
- Domestic violence.
- History of child abuse/neglect in family or poor, inadequate parenting.

Allowable treatment activities may include, but are not limited to the following:

- Hospitalization.
- Physical therapy.
- Occupational therapy.
- Speech therapy.
- Counseling sessions.
- Alcoholics Anonymous (AA) meetings.
- Narcotics Anonymous (NA) meetings.
- Parenting classes.
- Support classes.
- Food and nutrition classes.
- Court-ordered community service.
- Money management classes.

Unless part of the foster care services plan, allowable treatment activities do not include elementary, secondary, post-secondary or vocational education classes under this need reason. Specialists who receive notice that an educational activity is necessary as part of the foster care services plan should use family preservation as the need reason and refer the client to the one-stop service center for approval. If the one-stop service center approves the educational activity, the specialist should change the need reason to approved activity. If the one-stop service center does not approve the activity, continue to use family preservation as the need reason for as long as indicated by the foster care worker.

Note: Child care payments may **not** be approved for respite care, as defined in BPG Glossary.

The DHS-4575, Child Development and Care (CDC) Proof of Family Preservation Need, must be used to document the family preservation child care need. The form must be signed by one of the following:

- A physician (M.D. or D.O.).
- The MDHHS children's protective services, foster care services, or preventive services worker if child care is needed to allow a parent/substitute parent to participate in a treatment activity as a component of an active children's protective services, foster care services or preventive services case plan.
- A clinical psychologist.
- A clinical social worker.
- The clinical supervisor or director of a substance abuse treatment program.
- A substance abuse counselor.
- The specialist, if it is a MDHHS-assigned family support services (FSS) activity.

  Note: Child care needed for MDHHS-assigned FSS activities may be paid using Direct Support Services (DSS) funds or the CDC program if eligibility exists. Take care to avoid duplicate payments.

The DHS-4575 must be completed at application and redetermination.

The DHS-4575 verifies:

- The reason CDC services are needed (diagnosis of condition or explanation of activity which prevents the P/SP from providing the care).
- The activities in which the P/SP is expected to participate while the child is receiving CDC services.
- How often the P/SP is being treated/seen.
- The length of time CDC services will likely be required.
- The days per week and number of hours per day that child care will be needed.
- The child(ren) needing child care.

2. High School Completion

Child care may be approved for a child whose P/SP is enrolled full or part-time, as defined by the educational institution, in order to participate in classes leading to a high school diploma or its equivalent.

Examples of this need reason would be high school completion, general educational development (GED), adult basic education (ABE) or English as a second language (ESL) classes.

Verify the educational activity and number of hours of the activity with one of the following:

- A completed copy of the DHS-4578, Child Development and Care (CDC) Proof of Education.
- Documentation from the institution that includes all of the following (contact the institution if information is questionable or not clear):
    - Student's name.
    - Name of the institution.
    - Class schedule.
    - Program begin and end dates.

If any portion of the education program is online, and time, location, and pace of instruction is the student's choice, clarify with the institution the estimated online class time per week. Use this information to authorize hours, and document it in the case record.

If requested, authorize study time up to one hour for each hour of class time. Tutoring is considered study time.

Obtain this verification and file it in the case record at application, redetermination, or when additional assistance is requested for this need reason.

3. Approved Activity

Child care may be approved under this need reason when a P/SP needs child care to participate in one of the following:

- Employment preparation and/or training activity.

- Employment preparation and training programs are presumed to be occupationally relevant. If questionable, email the CDC office at Policy-CDC@Michigan.gov.

- Post-secondary education.
  - Online educational programs can be approved.
  - Child care benefits for this need reason cannot be approved for graduate, medical, or law school.
  - Educational programs are presumed to be occupationally relevant. If questionable, email the CDC office at Policy-CDC@Michigan.gov.

Child care needed to enable a P/SP to attend compliance test activities may also be approved under this need reason if eligibility requirements are met. Direct support services (DSS) may be used for these activities; see BEM 232. Whatever option is used, care must be taken to avoid duplicate payments.

The activity or education program must be approved by one of the following:

- Michigan Department of Health and Human Services (MDHHS).
- One-stop service center (for example Michigan Works Association).
- Refugee services contractor.
- Tribal employment preparation program.
- Michigan Rehabilitation Services (MRS).
- Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP), CDC office.

Verify the activity or educational program and number of hours with one of the following:

- A completed copy of the DHS-4578, Child Development and Care (CDC) Proof of Education.

- Documentation from the institution or program that includes all of the following (contact the institution or program if information is questionable or not clear):

    - Student's name.
    - Name of the institution or program.
    - Class schedule.
    - Program begin and end dates.

Note: If any portion of the education program is online, and time, location, and pace of instruction is the student's choice, allow one hour per credit hour per week. If more hours are requested than supported by documentation, clarify with the institution or program the estimated online class time per week. Use this information to authorize hours, and document it in the case record.

If requested, authorize study time up to one hour for each hour of class time and required lab time. Tutoring is considered study time.

Obtain this verification and file it in the case record at application, redetermination, or when additional assistance is requested for this need reason.

4. Employment

Child care may be approved for P/SPs who are employed or self-employed and receive money, wages, self-employment profits or sales commissions.

Note: A P/SP is not eligible for CDC if his/her only need reason is employment as a license exempt-related or license exempt-unrelated child care provider, regardless of enrollment in the CDC program.

P/SPs participating in the following activities are considered to meet the need criteria based on employment including:

- Jury duty.
- Residency/internship for which wages are received.

  Note: If wages are not received, the need should be categorized as approved activity.
- Required to be on call.
- Required strike duty.

- Sleep periods (up to eight hours) for the employed P/SP when:
  - This person is the only P/SP available to provide care during the time period for which CDC is being requested.
  - This person works during the child's normal sleep time.
  - This person must sleep when the child is awake.
- The paid employment portion of a co-op or work study program.

Tools to Verify Need Based on Employment/Self-Employment

Self-employment: Use the following tool to verify the **need** for CDC based on self- employment:

- **DHS-431**, Self-Employment Income and Expense Statement.

  Note: S-Corporations and Limited Liability Companies (LLCs) are **not** self-employment; see BEM 502.

Employment: Use one of the following as tools to verify the **need** for CDC based on employment:

- A copy of a work schedule indicating the number of hours worked.
- Pay stubs indicating number of work hours.
- **MDHHS-38,** Verification of Employment, completed by the employer.
- Equifax Verification Services (formerly known as the TALX/Work Number) and MIS (Management Information System).
- **DHS-3569,** Agricultural Worker Income Verification, completed by the employer.
- **Signed statement** by the employer that contains:
  - Employment begin date.
  - Number of hours the client works.
  - For income eligible clients, dates and amounts of client's paychecks for the requested period.

- **Collateral contact** with the employer **if** the employer refuses or is unable to complete the MDHHS-38, DHS-3569, or a signed statement, or if the client is unable to obtain his/her work schedule from the employer or the pay stubs do not indicate number of work hours. Complete the MDHHS-38 or DHS-3569 based on the information obtained from this contact.

When to Verify Need

Verification of need must be obtained at application and redetermination, or when there is a request for an increase in need hours during 12-month continuous eligibility.

ELIGIBILITY GROUPS

There are six eligibility groups. Five are income waived and one is income eligible. All eligibility groups must not have assets that exceed $1 million.

To be eligible for CDC payments, the P/SP must:

- Apply for CDC.
- Meet the requirements of an eligibility group.
- Have a valid need reason (at application and redetermination).
- Use an eligible provider.

Each P/SP of the child needing care must have a valid need reason when child care is requsted.

All children needing care must be U.S. citizens or have an acceptable non-citizen status; see BEM 225.

Determine eligibility by assessing CDC Protective Services eligibility first, then income eligibility. More than one eligibility group may exist in some cases.

Note: The eligibility category is based upon the child's circumstances. Cases with more than one child may have more than one eligibility category.

CDC PROTECTIVE SERVICES

The following five eligibility groups are income waived and do not require an income determination:

- Children's protective services.
- Foster care.
- FIP-related.
- Migrant farmworkers.
- Homeless.

Children's Protective Services

CDC eligibility for the child whose family has an **open** children's protective services case may be based solely on the need (family preservation) verified in the case record with the DHS-4575, Child Development and Care Proof of Family Preservation Need.

Foster Care

CDC may be approved in the foster care eligibility category when the child needing care has an active MDHHS foster care case.

Note: P/SP need reason requirements must also be met; see *need* in this policy item.

If foster care eligibility is expected but not produced in Bridges, contact Children's Services to confirm the child has an active foster care case and has been placed in the CDC applicant's home. If questions remain, contact the CDC Policy mailbox: policy-cdc@michigan.gov.

Eligibility for CDC for active MDHHS foster care cases ends on the date the child(ren) is removed from the foster parent's home.

If a foster child is adopted by the child's current foster parents during the 12-month continuous eligibility period, CDC should remain open until redetermination with no negative action taken on the case. Assistance from the Bridges Resource Center (BRC) is required.

FIP Related

A child who needs care may qualify under this eligibility group if:

- The child needing care receives FIP or SSI.
- The P/SP of the child needing care receives FIP or SSI.
- The family has a pending application for FIP and CDC is needed to participate in a required one-stop service center/MDHHS activity.

Note: P/SP need reason requirements must be met; see *need* in this policy item.

Migrant Farmworkers

CDC may be approved in the migrant eligibility category when the P/SP states he/she is a migrant farmworker on the MDHHS-1171, Assistance Application or the MI Bridges application. Eligibility based on migrant status does not need to be verified.

Note: P/SP need reason requirements must be met; see *need* in this policy item.

Homeless

CDC may be approved in the homeless eligibility category when a child is considered to be homeless based on the McKinney-Vento Homeless Assistance Act of 1987, as amended 2015.

Note: P/SP need reason requirements must also be met; see *need* in this policy item.

Examples of a child being homeless are:

- Sharing housing due to economic hardship or loss of housing.
- Living in motels, hotels, trailer parks, or camp grounds due to lack of alternative accommodations.
- Living in emergency or transitional shelters.
- Children whose primary nighttime residence is not ordinarily used as a regular sleeping accommodation (for example park benches, etc.)
- Living in cars, parks, public spaces, abandoned buildings, substandard housing, bus or train stations.

Below are some questions that may be used to determine if a child is homeless:

- How long have you been living with others? Is this a temporary situation?
- Are you sharing housing due to loss of housing? Economic hardship? Other?

- Is your name on the lease? Could you be asked to leave at any time?
- Where would you live if you were not sharing housing?

Eligibility based on the homeless category does not need to be verified. Verification of need is required.

INCOME ELIGIBLE

If the child does not qualify for one of the CDC Protective Service groups, determine eligibility for the income eligible group.

To be eligible for the CDC program at application, a program group's countable gross monthly income must not exceed the maximum monthly gross income limit by family size associated with the program entry limit (the column marked ***entry***). Income eligible families may have a co-payment amount called a family contribution. For program group definition; see BEM 205.

After initial eligibility has been determined, a family's income must not exceed the maximum monthly gross income eligibility limit by family size associated with the program exit limit. For income limit and family contribution amounts; see RFT 270.

Note: During 12-month continuous eligibility, CDC income eligibility ends if the family's gross income exceeds the program exit limit, unless the increase is determined to be temporary excess income. For temporary excess income details; see BEM 505.

CDC for Income Eligible Clients

CDC may be provided for income eligible clients who:

- Do not qualify as a member of a CDC Protective Services group.
- Have a valid need reason.
- Pass the income eligibility test.
- Have child(ren) needing care who meet the U.S. citizenship/non-citizen status requirements as described in BEM 225.

Income Eligibility Ends

CDC eligibility ends for this category when the program group's income exceeds the income eligibility scale; see RFT 270.

Exception: CDC income eligibility will continue if the increase is determined to be temporary excess income; see BEM 505.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.
McKinney-Vento Homeless Assistance Act of 1987, amended 2015, 42 USC 11431 *et seq.*

OVERVIEW

NOTE: Policy updates related to provider verifications are effective February 1, 2024.

Parent/substitute parents (P/SP) have the right to choose the type of child care provider they wish to use. Also, P/SPs have the right to full access to their children at any time while they are in care.

ELIGIBLE PROVIDERS

Care must be provided in Michigan by an eligible provider. Eligible providers are:

- Licensed Providers:
  - Child care centers.
  - Group homes.
  - Family homes.
- License Exempt Providers:
  - License exempt-tribal.
  - License exempt-military.
  - License exempt-related.
  - License exempt-unrelated.

Note: If the client identifies an individual who is not currently enrolled as a license exempt provider, instruct the client that provider applications can be found at www.michigan.gov/childcare in the *Providers* section. The application should be completed by the provider applicant and submitted to the Child Development and Care (CDC) office.

PROVIDER DEFINITIONS

Licensed

Child care centers, group homes and family homes must be licensed by the Michigan Department of Lifelong Education, Advancement and Potential (MiLEAP) Child Care Licensing Bureau (CCLB) in order to bill and receive payment for Child Development and Care (CDC) subsidy eligible children. CCLB ensures that all required background checks are completed, and that initial and ongoing health and safety training is completed pursuant to The

Child Care Organizations Act, as amended (1973 P.A. 116) and the rules promulgated under this act.

As part of MiLEAP's broader work to assure that each licensed child care setting is and remains conducive to the welfare of children, MILEAP maintains documentation for providers with known system matches that were previously approved and are allowed to stay open. This pertains to providers who were licensed prior to reauthorization of the Child Care and Development Block Grant (CCDBG), who would have become ineligible due to non-mandatory, exclusionary crimes. MILEAP allows these providers to continue to provide care and is responsible for oversight to ensure the setting remains conducive to the welfare of children. These providers remain eligible to receive CDC subsidy.

Clients who request assistance with finding a licensed provider should be referred to Great Start to Quality, the online early learning resource site, at www.greatstarttoquality.org. All active licensed providers are searchable. If additional assistance is needed, clients can be referred to 877-614-7328 to reach the Great Start to Quality Resource Center serving their county. Resource centers can provide personal consultation to families in need of child care.

In instances where the local office identifies a licensed child care center or a group or family home that does not have a provider ID number, and one is needed in order to authorize payments to that provider, the local office must request assistance from the Provider Management Unit using the JIRA Portal: https://brg-jira-prd.state.mi.us/servicedesk/customer/portal/141.

License Exempt

Certain child care centers, homes and individuals that provide child care do not require licensure under The Child Care Organizations Act, as amended (1973 P.A. 116). These include the following provider types:

License Exempt-Tribal

Facilities located on tribal land and child care homes located on tribal land or in their tribal service area.

License Exempt-Military

Facilities located on federal land, including military installations.

License Exempt-Related

A license exempt-related provider must be all of the following:

- An adult who is 18 years or older.
- Provides care for no more than six children at one time.
- Provides care in the provider's home or where the child(ren) lives.
- Related to the child(ren) by blood, marriage or adoption as one of the following:
  - (Great) Grandparent.
  - (Great) Aunt or Uncle.
  - Sibling (allowable only if the provider lives at a different residence).

  Note: A divorce ends a relationship gained through marriage.

License Exempt-Unrelated

A license exempt-unrelated provider must be all of the following:

- An adult who is 18 years or older.
- Provides care for no more than six children at one time.
- Provides care where the child(ren) lives.

Note: An entire Agricultural Labor Camp (migrant camp), licensed by the Michigan Department of Agriculture and Rural Development, pursuant to P.A. 368 of 1978 part 124, shall be considered as the child's own home.

PROVIDER ENROLLMENT

Licensed

Licensed child care centers, group homes, and family homes can bill and receive payment for CDC subsidy eligible children, as long as the provider is not under disciplinary action, as defined in this policy item. No further enrollment activity is necessary for the CDC program.

License Exempt Enrollment Process

All License Exempt

To receive CDC subsidy payment for care of eligible children, a provider must complete and submit the appropriate application to be enrolled by the CDC office. Additional requirements may apply.

Each required application can be found at www.michigan.gov/childcare in the Providers section.

Applications must be submitted to the CDC office using one of the following:

Mail: Child Development and Care
Provider Enrollment
P.O. Box 30267
Lansing, MI 48909

Fax: 517-284-7529

Email: MiLEAP-ApplyProvider@michigan.gov

Note: If choosing to email documentation, the applicant accepts the risk that unencrypted messages and any attachments could be intercepted.

If the Michigan Department of Health and Human Services (MDHHS) receives an application or a request for a facility or individual to be enrolled as a license exempt child care provider, date stamp any documents and forward to CDCProviderEnrollment@michigan.gov. All documents must be date stamped and forwarded within 48 hours of the receipt. The CDC office will check the applications for completeness and follow-up with the provider if additional information is required.

License Exempt-Tribal

Complete the CDC License Exempt-Tribal Child Care Center Provider Application or the CDC License Exempt-Tribal Group and Family Home Provider Application. If there are questions about applying, call the CDC office at 866-990-3227.

Each license exempt-tribal provider is monitored by a tribal oversight agency, which ensures that all required background checks, health and safety training (both initial and ongoing), and health and safety monitoring visits are completed.

License Exempt-Military

Complete the Child Development and Care (CDC) License Exempt Military Provider Application. To request an application, call the CDC office at 866-990-3227.

Each license exempt-military provider is monitored by a military oversight agency, which ensures that all required background checks, health and safety training (both initial and ongoing), and health and safety monitoring visits are completed.

License Exempt-Related

Complete the Child Development and Care (CDC) License Exempt Provider Application, available at www.michigan.gov/childcare.

Prior to enrollment, provider applicants must complete a telephone interview with CDC staff. During the interview the applicant's age, identity, and place of residence will be confirmed. Verification(s) may be requested if information does not match State of Michigan systems. The provider applicant may also be subject to an address inquiry. An address inquiry is not required for a provider who is living in a shelter or a migrant camp.

Note: A license exempt-related provider living in a shelter must provide all care in the home of the child until permanent housing is found.

License exempt-related providers and their household members are subject to the following background check clearances prior to enrollment:

- Central Registry.
- ICHAT.
- OTIS.
- PSOR.

Clearances are completed on the provider/applicant. If no match is found clearances are completed on any confirmed adult household members entered in Bridges on the Provider Associated Household People screen.

Note: This includes parents requesting child care and living in the same household as the provider. Providers denied from a background clearance result on a parent will be required to provide a written statement that the provider will only provide care for the children of the parent who does not meet program requirements and that the provider will not be eligible to receive CDC payment for any other children, regardless of where care is provided. This statement must be provided to the CDC office.

Enrollment is complete when the completed application has been received, the telephone interview has been conducted, all background check clearances have been returned, and the provider applicant meets all criteria to be a license exempt-related provider. Failure to complete any portion of the enrollment process will result in the denial of the provider application.

Note: To be eligible to receive the CDC subsidy, a provider applicant must also complete an initial health and safety training called License Exempt Provider Pre-service Training (LEPPT); see BEM 706 *payment issuance requirements*.

License Exempt-Unrelated

Complete the Child Development and Care (CDC) License Exempt Provider Application, available at www.michigan.gov/childcare.

Prior to enrollment, provider applicants must complete a telephone interview with CDC office staff. During the interview the applicant's age, identity, and place of residence will be confirmed. Verification(s) may be requested if information does not match State of Michigan systems.

License exempt-unrelated providers are subject to the following background check clearances prior to enrollment:

- Central Registry.
- ICHAT.
- OTIS.
- PSOR.

The following clearances require fingerprint submission. The cost of background checks is the responsibility of the provider applicant.

- MSP Criminal History Records.
- FBI Identity History Summary.
- NCIC NSOR.

- Inter-state clearances.

Enrollment is complete when the completed application has been received, the telephone interview has been conducted, all background check clearances have been returned, and the provider applicant meets all criteria to be a license exempt-unrelated provider. Failure to complete any portion of the enrollment process will result in the denial of the provider application.

Note: To be eligible to receive the CDC subsidy, a provider applicant must also complete an initial health and safety training called License Exempt Provider Pre-service Training (LEPPT) see BEM 706 *payment issuance requirements.*

The provider applicant may be denied if the fingerprint submission is not completed within 30 days of the Fingerprint Request Form mailing date.

Background check clearances based on fingerprints remain valid 180 days from the date the provider stops providing care.

A **new** fingerprint submission is required in the following situations:

- Re-enrollment after provider closure if more than 180 days from the date the provider was closed.
- An out of state move (voids previous clearances).
- A provider's 5-year renewal of eligibility.

  Note: Failure to complete 5-year renewal of eligibility will result in a provider's closure.

Service Begin Date

License Exempt-Related and License Exempt-Unrelated

The service begin date for an eligible license exempt provider is one of the following:

- The receipt date of the application.
- An adjusted date based on the end date of the exclusionary period for a previous conviction if the applicant or adult household member has an exclusionary period that ends between the receipt of application and the background check.

Exception: The service begin date is the day after the closure if the provider:

- Was closed in error.
- The provider appeals a denial/closure within 30 days, and the denial/closure is overturned.
- The provider requests a reconsideration of his/her disqualification, and the disqualification is reversed.

Exception: The service begin date will be the first day of the pay period after a provider and/or household member's expungement, whichever is later, if the provider is approved after a Central Registry related denial/closure.

Provider Notices

License Exempt-Related and License Exempt-Unrelated

When an eligible provider is enrolled, Bridges will send a DHS-4481-D, CDC License Exempt Provider Confirmation, to the provider.

All Child Care Providers

When a provider is authorized to provide care for a CDC eligible child, Bridges will send a DHS-198, Child Development and Care (CDC) Provider Notice, to the provider. The client will receive a DHS-198-C, Child Development and Care (CDC) Client Notice.

Bridges will send a DHS-4807, Notice of Child Development and Care Provider Ineligibility, to a provider if he/she is denied or closed. Bridges will send the DHS-4807-C to the client and end the authorizations if the provider is associated with a CDC case.

Closure for Training

License Exempt-Related and License Exempt-Unrelated

A provider who has not completed the License Exempt Provider Pre-service Training (LEPPT) within 5 months after enrollment may be closed due to failure to complete the required training.

Note: To be eligible to receive CDC payment, a provider must complete LEPPT; see BEM 706 *payment issuance requirements*.

A provider who fails to complete the ongoing training requirement by December 16th of the current calendar year may be closed; see *ongoing provider training* in this item.

Closure for Inactivity

License Exempt-Related and License Exempt-Unrelated

A provider who has not submitted billing in the past 5 months may be closed due to inactivity.

Note: A license exempt-unrelated provider who is closed for inactivity will require a new fingerprint submission at re-enrollment.

Re-enrollment After Closure

All License Exempt

Providers who want to re-enroll after closure must submit a new provider application to the CDC office.

Note: Completion of the current year's ongoing training, or LEPPT if not already completed, will be required prior to re-enrollment.

Health and Safety Coaching Visits

License Exempt-Unrelated

A license exempt-unrelated provider must provide care where the child(ren) lives. An annual health and safety coaching visit at this location is required. The visit will include a check for compliance with the required health and safety standards. This visit may be announced or unannounced. License exempt-unrelated providers must respond to the health and safety coach when they are contacted to set up this visit or when the coach arrives for an unannounced visit. Failure to respond to repeated, documented, contact attempts shall be considered refusal to complete the health and safety visit.

An additional unannounced visit(s) may be required for corrective action plans or other concerns arising out of an annual visit, when health and safety compliance is not demonstrated.

The provider assignment to the child(ren) will end if the coaching visit is not completed, or when health and safety compliance cannot be demonstrated after a corrective action plan. A provider will not be re-assigned to care for the child(ren) until the visit has been completed.

Provider Training

All Child Care Providers

All providers are required to complete an initial health and safety training and child development training that covers the topics below. Each training topic includes detailed standards that providers must meet to be eligible for CDC payment:

1. Child Development Training.
2. Prevention and control of infectious diseases (including immunization).
3. Prevention of Sudden Infant Death Syndrome and use of safe sleeping practices.
4. Administration of medication, consistent with standards for parental consent.
5. Prevention of and response to emergencies due to food and allergic reactions.
6. Building and physical premises safety, including the identification of and protection from hazards that can cause bodily injury, such as electrical hazards, bodies of water, and vehicular traffic.
7. Prevention of shaken baby syndrome, abusive head trauma, and child maltreatment.
8. Emergency preparedness and response planning for emergencies resulting from a natural disaster or a human-caused event (such as violence at a child care facility), within the meaning of those terms under section 602(a)(1) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5195a(a)(1)). Emergency preparedness and response planning (at the child care provider level) must also include procedures for evacuation; relocation; shelter-in-place and lockdown; staff and volunteer training and practice drills;

communications and reunification with families; continuity of operations; and accommodations for infants and toddlers, children with disabilities, and children with chronic medical conditions.

9. Handling and storage of hazardous materials and the appropriate disposal of bio-contaminants.
10. Precautions in transporting children (if applicable).
11. Pediatric first aid and cardiopulmonary resuscitation (CPR) certification.
12. Recognition and reporting of child abuse and neglect.

Ongoing Provider Training

All Child Care Providers

All providers are required to complete annual ongoing health and safety and child development training that includes review of the *provider training* topics in this item.

Failure to comply with ongoing training requirements will result in the provider being ineligible to receive the CDC subsidy.

Licensed

Required ongoing health and safety training for child care centers, group homes and family homes is monitored by MILEAP.

License Exempt-Tribal

Required ongoing health and safety training for license exempt-tribal providers is monitored by each tribal oversight agency.

License Exempt-Military

Required ongoing health and safety training for license exempt-military providers is monitored by each military oversight agency.

License Exempt-Related and License Exempt-Unrelated

Ongoing health and safety training is developed annually by the CDC office to meet health and safety requirements. The training is

called the Michigan Health & Safety Refresher. Each year the training includes the following:

- Review of a subset of the provider training topics; see *provider training* topics listed in this policy item.
- New guidance published by the CDC office based on health and safety updates.

Each year the CDC office's approved ongoing health and safety training is available to providers in the Michigan Registry system (www.miregistry.org) in both online and face to face formats. Each format includes knowledge checks and opportunities for providers to reflect on and process the content.

Providers must complete the ongoing training by December 16th of the current calendar year, **unless** exempt from the requirement until the following year based on one of the following:

- The provider completed LEPPT during the current calendar year.

  Note: LEPPT was formerly called Great Start to Quality Orientation (GSQO).

- The provider has not yet completed LEPPT.
- The CDC office determines that the ongoing training requirement was met during the re-enollment process.

Provider Changes

All Child Care Providers

The following changes shall be reported within 10 calendar days to avoid unnecessary closures and disruptions to child care enrollment and services.

- Name.
- Address.
- Staff (when applicable).
- Adult household members (when applicable).
- Social Security Number or Tax ID.

Note: When the local office receives a request for an address change from a license exempt provider, send an email with all pertinent information to CDCProviderEnrollment@michigan.gov.

Information Shared with Providers

Bridges sends a DHS-198 to the provider when CDC services are authorized, or when the authorization changes or ends.

Information may also be shared with the provider when an application is filed, withdrawn denied, or when the CDC case is closed.

The MiBridges online application and the MDHHS-1171, Assistance Application include a release of information allowing the department to provide this information. All other provider concerns should be directed to the client.

If the client has questions about the denial of the provider enrollment, the client should be told to discuss the issue with the provider applicant.

BACKGROUND CLEARANCES

A child care provider must undergo specific background clearances based on provider type. When an individual applies to be enrolled, and exclusionary background information or disciplinary action is discovered, this information will be utilized for all future enrollment attempts for the individual, including when subsequent enrollment attempts would not otherwise require such background information.

The following are definitions of previously identified required background checks, applicable by provider type.

Note: Background check clearances based on fingerprints remain valid180 days from the date employment with a child care provider ends, or the date a provider stops providing child care. An of out of state move voids background check clearances based on fingerprints. A background check clearance based on fingerprints is required every 5 years and the failure to comply will result in the provider being ineligible to receive the CDC subsidy.

Disciplinary Action

An individual may not be eligible to receive CDC subsidy payment as a child care provider if one of the following actions has been taken against a license or registration, and the license or registration has not been restored.

MiLEAP CCLB or MDHHS:

- Revoked.
- Suspended.
- Refusal to renew.
- Denial of issuance.
- Other closure under disciplinary action.

Note: A provisional license does not constitute disciplinary action for these purposes.

Note: If the action was based on a Central Registry match that has since been expunged, a license exempt-related or unrelated provider/applicant may be considered for enrollment through an Administrative Review; see *administrative review process* in this policy item.

Child Abuse and Neglect Central Registry

The MDHHS Child Abuse and Neglect Central Registry is reviewed daily for all providers and applicable household members over the age of 18 who are identified as perpetrators of child abuse or neglect, as confirmed by Children's Protective Services (CPS).

Note: Central Registry information is confidential and cannot be released. No other clearances will be completed if there is a Central Registry match.

ICHAT

ICHAT is a public resource maintained by MSP for name-based Michigan criminal history background checks.

OTIS

OTIS provides information about criminal offenders previously or currently under the jurisdiction or supervision of the Michigan

Department of Corrections (MDOC). Information is provided on any offender who is, or was, in a Michigan prison, on parole or probation under the supervision of the MDOC, has transferred in or out of Michigan under the Michigan Interstate Compact, or who has escaped or absconded from their sentence.

PSOR

PSOR is developed and maintained by MSP to better assist the public in preventing and protecting against the commission of future criminal sexual acts by convicted sex offenders.

MSP Criminal History Records

Criminal history background checks are performed through a search using fingerprints. A criminal history record includes information on misdemeanor convictions and felony arrests and convictions.

For providers, this background check is administered by MiLEAP through the Child Care Background Check (CCBC) system. Results are provided by the Michigan State Police, and decisions may only be appealed to MiLEAP.

FBI Identity History Summary

The FBI provides an Identity History Summary, often referred to as a criminal history record or a rap sheet, listing certain information taken from fingerprint submissions kept by the FBI and related to arrests.

All arrest information included in an Identity History Summary is obtained from fingerprint submissions, disposition reports, and other information submitted by authorized criminal justice agencies.

For providers, this background check is administered by MiLEAP through the CCBC system. Results are provided through the Michigan State Police, and decisions may only be appealed to MiLEAP.

NCIC NSOR

The NCIC database includes a NSOR file of nationwide records on individuals who are required to register in a jurisdiction's sex offender registry.

For providers, this background check is administered by MiLEAP through the CCBC system. Results are provided through the Michigan State Police, and decisions may only be appealed to MiLEAP.

Inter-State Clearances

For any individual required to submit to Michigan and national background clearances, who has resided in any other state in the past five years, the criminal background clearance shall include a check of all the following systems in each state of residence:

- The criminal registry or repository.
- The sex offender registry or repository.
- The child abuse and neglect registry and database.

For providers, this background check is administered by MiLEAP through the CCBC system. Decisions may only be appealed to the Child Care Licensing Bureau (CCLB) at MiLEAP.

Automated Background Clearances

For determining continued eligibility, automated clearances are completed for providers and adult household members. These monthly automated processes match providers and applicable household members.

For confirmed Michigan system matches, the CDC office will verify the information is correct and close the provider with the appropriate closure reason. Bridges will send the DHS-4807 and the DHS-759, Request for Administrative Review of the Denial or Termination of Provider Enrollment, to the provider, if the provider is active. A DHS-994, Michigan State Police Criminal Notice, will also be sent if the match is on ICHAT. Bridges will send the DHS-4807-C to the client and end the authorizations if the provider is associated with a CDC case.

Mandatory Denial

There are crimes in the following categories for which arrests and convictions may result in the mandatory denial or closure of a provider's enrollment:

- Arson.
- Assault or battery.
- Child and vulnerable adult abuse/neglect.
- Crime against a child, including child pornography.
- Criminal sexual conduct.
- Homicide.
- Kidnapping.
- Spousal abuse.

Administrative Review Process

All Providers

Child care providers or applicants who have been denied or closed as a result of a criminal conviction, arrest or pending charge record based on results not housed in the CCBC system (the CDC office findings from ICHAT, OTIS, and/or PSOR) may request an administrative review by following the instructions on the DHS-759 when applicable. This form instructs providers to send all documentation to the CDC office.

Note: For findings housed in the CCBC system, appeal to the CCLB at MiLEAP only.

If the local office receives a request for an administrative review the information should be faxed to 517-284-7529. The CDC office will:

- Make a determination to approve or deny the provider/applicant.
- Notify the provider/applicant of the approval or denial.
- Remove the closure reason and re-enroll the provider, if applicable.

Note: The following convictions will not be overturned in an administrative review:

- A felony conviction for a crime on the mandatory denial list; see mandatory denial in this item.

- A violent misdemeanor conviction; committed as an adult against a child.
- A misdemeanor conviction involving child pornography.

Central Registry Clearance

License Exempt-Related and License Exempt-Unrelated

An applicant, provider, or household member denied or closed due to a Central Registry match may request to have the individual's name expunged from Central Registry by submitting a DHS-1929, Central Registry Clearance Request, to the local MDHHS Children's Services office. When an individual has been expunged, the CDC office can verify the information using State of Michigan systems or with written proof of the expungement forwarded to the CDC office by the provider. The date of any enrollment may not precede the first day of the pay period after the expungement was effective.

Administrative Hearings

All Providers

Neither child care providers nor CDC recipients are entitled to administrative hearings based on a provider's denial or closure.

Suspected Child Abuse or Neglect

All Providers

Child Care providers are required by law to report suspected child abuse or neglect. A referral to CPS can be made to the MDHHS Centralized Intake Unit by calling at 855-444-3911 or through the online reporting system at www.michigan.gov/mandatedreporter. CPS will make a determination of whether a child(ren) is at risk.

If substantiated abuse results in closure of a child care setting, Bridges will send the DHS-4807 and DHS-4807-C to notify the provider and the client of the closure.

Reporting Serious Injury or Death

Licensed

Child care providers must report a serious injury or death of a child in care according to requirements specified by MiLEAP pursuant to The Child Care Organizations Act, as amended (1973 P.A. 116) and the rules promulgated under this act. Details of each incident should be reported to the provider's child care licensing consultant within 24 hours.

License Exempt

Child care providers must report a serious injury or death of a child in care within five days. Details of each incident should be reported to the CDC office by completing the License Exempt Provider Serious Injury Report form (MDE-4590). This information is compiled annually for public posting of aggregate data by provider type. The aggregate data report is available at www.michigan.gov/mikidsmatter.

Provider Questions

If a child care provider contacts the local office regarding questions about enrollment or billing, refer him/her to 866-990-3227.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.
P.A. 368 of 1978 part 124.
P.A. 116 of 1973, as amended 2018.

OVERVIEW

A child care provider's enrollment must be denied or closed if the Department is made aware that the provider has certain pending criminal charges or has been convicted of any of the crimes listed in the crime codes exhibit, or crimes of a similar statue, unless an administrative review of the crime(s) determines he/she is eligible; see BEM 704, Administrative Review Process.

When applicable, these requirements also apply to adult household members, age 18 and over, who live with the provider or license exempt facility staff members.

The Department shall review the arrest records and pending charges and may require additional follow-up or review. The Department reserves the right to deny an enrollment based on the provider or child care setting not being conducive to the welfare of the children.

CRIME CODES

Acess crime codes from the Michigan Department of Health and Human Services (MDHHS) website under policy manuals at:

Work/External Website Resources/Criminal Information and Tracking/Crime Codes Exhibit.

MANDATORY DENIAL

There are crimes in the following categories for which arrests and convictions may result in the mandatory denial or closure of a provider's enrollment:

- Arson.
- Assault or battery.
- Child and vulnerable adult abuse/neglect.
- Crime against a child, including child pornography.
- Criminal sexual conduct.
- Homicide.
- Kidnapping.
- Spousal abuse.

For the complete list, see the crime codes list linked above.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.
Child Care Organizations Act, 1973 PA 116, as amended 2017.
Sex Offenders Registration Act, 1994 PA 295 as amended.

INTRODUCTION

Child Development and Care (CDC) payments are made when all of the following are true:

- All eligibility requirements are met.
- A CDC case is open in Bridges.
- An eligible provider is assigned to the child and provides care.
- The provider successfully bills for child care.
- Payment limits have not been reached.

FACTORS THAT IMPACT PROVIDER PAYMENT

Child care providers are paid for costs associated with child care by submitting billing through the internet billing (I-Billing) system. Providers must bill the department every two weeks for allowable child care reimbursement. Each bill covers a two-week pay period.

The amount of payment generated is based on the child, the provider and the provider's billing.

Child factors that impact payment:

- Child's age.
- Child's authorization:
  - Number of approved hours.
  - Family Contribution amount and Family Contribution Limit.

Provider and billing factors that impact payment:

- Child care provider type.
- The provider's Star Rating/Quality Level or Training Level.
- Number of hours billed.
  - Child Care.
  - Allowable Absences.
- Child Care Fees billed.
- Payment Limits/Caps.
- Multiple billing submissions.
- Multiple providers billing.
- Previous billing for the same pay period.

CHILD FACTORS

Child's Age

Most provider service types receive a department hourly payment rate that is differentiated for infants/toddlers (age birth to 2 ½ years), preschool (over 2 ½ to age 5) and school age children (over age 5). For details of how a child's age effects department hourly payment rates by provider type and star rating/quality level or training level; see RFT 270.

Approved Hours

Approved hours (sometimes referred to as authorized hours) are established in the child's eligibility determination, based on the Parent/Substitute Parent's (P/SP) valid need reason. A child may be authorized for any of the following increments:

- 20 hours.
- 40 hours.
- 60 hours.
- 80 hours.
- 90 hours.

Approved hours constitute the hours available for payment that all assigned providers share for the child in a two week pay period.

For more information about how approved hours are determined; see BEM 710.

Family Contribution

The Family Contribution (FC) is based on family income when the child is determined income eligible. A family may have one or more children that are income eligible and one or more children that are income waived on the same case.

The FC amount is subtracted from the provider payment issued by the Department and the family may be responsible to pay this amount to the provider.

FC amounts are per child, per every two-week pay period, not to exceed the Family Contribution Limit per family, per every two-

week pay period. For FC amounts and limits based on income eligibility, review the Family Contribution Based on Income Eligibility chart in RFT 270.

The FC amount is waived for a child in the CDC Protective Services (income waived) eligibility category and for income eligible children assigned to a Child Care Center or a Family Child Care (FCC) (includes Group and Family Homes), that has a star rating/quality level of 3 Star/Enhancing Quality or higher.

An income eligible child who is reassigned from a 3 Star/Enhancing Quality or higher provider to a 2 Star/Reflecting on Quality or lower provider, will no longer have the FC amount waived. This is a negative action that is allowed during the 12-month continuous eligibility period.

For information about star ratings and quality levels see *provider star rating/quality level* in this item.

CHILD CARE PROVIDER FACTORS

Provider Type

Child care provider service types are a determining factor in the department hourly payment rate. Child care provider service types include the following:

- Child Care Center.
  - Licensed.
  - License Exempt-Tribal.
  - License Exempt-Military.
- Family Child Care (FCC).
  - Group Home.
    - Licensed.
    - License Exempt-Tribal.
    - License Exempt-Military.
  - Family Home.
    - Licensed.
    - License Exempt-Tribal.
    - License Exempt-Military.
- License Exempt-Related.

- License Exempt-Unrelated.

For detailed information about the different child care provider service types; see BEM 704.

For department hourly payment rates by provider type; see RFT 270.

Provider Star Rating/Quality Level

A C/FCC provider with a 2 Star/Reflecting on Quality or higher in Great Start to Quality (GSQ) shall receive a department hourly payment rate higher than that of the base rate (Blank/1 Star)/Maintaining Health & Safety.

For department hourly payment rates by provider star rating/quality level; see RFT 270.

Star Rating	Quality Level
Blank Star/1 Star	Maintaining Health & Safety
2 Star	Reflecting on Quality
3 Star	Enhancing Quality
4 Star	Enhancing Quality-Validated
5 Star	Demonstrating Quality

Provider Training Levels

The department shall issue a higher hourly payment rate for a license exempt-related or license exempt-unrelated provider who completes 10 hours of approved training per year beyond the required License Exempt Provider Pre-service Training (LEPPT), achieving a training Level 2. Failure to complete 10 hours each year shall result in a return to Level 1 status and the corresponding department hourly payment rate.

For department hourly payment rates by provider training level; see RFT 270.

BILLING AND PAYMENT

A provider must bill the department every two weeks for allowable child care reimbursement. Each bill covers a two-week pay period.

A provider must bill the department within 90 days after the end of the pay period being billed or 90 days after the authorization was entered by the local office in order to receive payment. If the provider bills and the payment is rejected as a result of late billing, the provider must contact the Child Development and Care (CDC) office at 866-990-3227 to request that the payment be released. For late billing to be approved, providers shall be required to demonstrate good cause for not billing within the 90-day period. The CDC office shall determine if good cause has been demonstrated and if the payment is to be released.

Providers cannot charge the department for care when they have already received or expect to receive reimbursement from another funding source, a non-custodial parent, employer, etc. Examples of other funding sources include, but are not limited to:

- Head Start (HS).
- Early Head Start (EHS).
- Migrant HS/EHS.
- Great Start Readiness Program (GSRP).
- AmeriCorps.
- Department of Education.

Exception: When there is an agreement between the CDC program office and a partner organization that allows for layered funding, or another special funding agreement, multiple funding sources may be utilized.

Child care payments are issued weekly. This accommodates those billings or authorizations that miss the first billing deadline for the pay period but meet the second deadline for the pay period.

Payments may be delayed for many reasons such as:

- Holidays.
- Postal service delays.
- Problems with billing/payment systems.
- The CDC office deems it necessary to delay issuance of a payment.

Payments are issued in the name of the provider and mailed or electronic fund transferred (EFT) to the provider, except payments for license exempt-related and license exempt-unrelated providers, which are issued to the client.

Billing Based on Enrollment

Licensed Providers (C/FCC)

Licensed providers should bill the Department based on a child's enrollment. Enrollment is defined as the days and times a child is expected to be in care based on an agreement between the provider and the child's parent/substitute parent (P/SP).

The following rules apply to Enrollment Billing:

- Beginning 3/1/2024, to bill the CDC subsidy for a child, licensed providers must maintain a CDC Enrollment Agreement form, or their own document that includes the following:
  - Name of child.
  - Effective date of schedule.
  - Total agreed enrollment hours.
  - Child's schedule.
  - Explanation if schedule varies.
  - Signature of P/SP.
- A provider must not have more children enrolled for the same days and times than their maximum child capacity allows.
- If a child is absent up to 10 enrolled days in a row, and the child is expected to return, a provider should bill the enrolled times as regular care hours instead of absence hours.
- If a child is absent **more** than 10 enrolled days in a row, and the child is expected to return, on day 11 the provider must begin to bill absence hours by selecting the absent box in the I-Billing system, until the child returns to care.
- The following is true for absences and Enrollment Billing:
  - Payment for absences is limited to 10 days when no regular care hours are billed.

- Payment for absences is limited to 360 hours annually each fiscal year (10/1-9/30).

Note: If the absence limits cause unusual hardship; see BEM 100 *policy exceptions*.

- Absences may occur when the child care provider is open for business, as well as when the facility is temporarily closed (for example closed due to bad weather or a holiday).

- A provider must not bill for the hours a child is in school or enrolled in another program.
- A provider must not bill before a child's first day in care or after a child's last day in care.
- A provider must not charge a CDC client more than they charge the public for the same care.

Billing Based on Attendance

License Exempt-Related and License Exempt-Unrelated

License exempt-related and unrelated providers should bill the department based on a child's attendance. Attendance is defined as the actual days and times the child was in the provider's care.

The following rules apply to Attendance Billing:

- A provider must not have more than six children in care at one time and care must be provided in the required location; see BEM 704 *license exempt*.
- A provider should bill for the actual days and times the child was in care, as documented on time and attendance records.
- A provider must not bill for the hours a child is in school or enrolled in another program.
- Absence hours may be billed for periods in which the child is not in care when he/she would have normally been in attendance. Normally in care is based on a historical trend or routine of when the child has been in care. Absence hours are billed by selecting the absent box in the I-Billing system.

Note: Payment for absences is limited to 360 hours annually each fiscal year (10/1-9/30) and to 10 days when no care hours have been billed. If the absence limits cause unusual hardship; see BEM 100 *policy exceptions*.

Record-Keeping

All Providers

Providers must maintain time and attendance records for all care provided. Attendance records must document each child's *actual* care begin and end time and be certified daily by the P/SP. Attendance records must be retained by the provider for four years. License exempt-related and license exempt-unrelated providers are required to use the Child Care Time and Attendance Record for their record-keeping. For information about provider record reviews; see BEM 707.

Licensed Providers (C/FCC)

Beginning 3/1/2024, licensed providers must maintain a written enrollment agreement for each child in care; see *billing based on enrollment* in this policy item.

Hourly Payment

Hourly payment is the reimbursement amount for time billed (rounded to the nearest hour) that has been multiplied by the applicable hourly rate, limited to no more than the child's authorized hours. See RFT 270 for hourly rates.

Note: All payments are potentially limited by the child and provider factors listed in this policy item.

Bi-Weekly Block Reimbursement Payment

Block reimbursement rate is the reimbursement amount for child care hours billed that has been rounded up and multiplied by the applicable hourly rate. Block reimbursement allows eligible providers to be paid by the CDC program in a manner more consistent with how the general public pays for child care, by

reimbursing for part-time or full-time care, rather than hourly care. See RFT 270 for hourly rates.

Note: All payments are potentially limited by the child and provider factors listed in this policy item.

Child Care Centers, Group and Family Homes (C/FCC)

Beginning October 9, 2022, the following bi-weekly block reimbursement schedule is in effect:

Part-time: Billing 1 to 30 hours, payment is the hourly rate multiplied by 30 hours.

Part-time: Billing 31 to 60 hours, payment is the hourly rate multiplied by 60 hours.

Full-time plus: Billing 61 or more hours, payment is the hourly rate multiplied by 90 hours.

Example: When a child is authorized for **60 hours** per pay period and a C/FCC provider bills 61 hours, payment is limited to 60 hours based on the child's authorization limit.

Provider	Hours Billed	Hours Paid	Reason for Payment Amount	Hours Remaining
Group Home A	61	60	Hours billed (61) are between 61 and 90. Payment is limited by the child's authorization and results in a 60-hour block payment.	No hours remaining.

Example: When a child is authorized for **40 hours** per pay period and a C/FCC provider bills 31 hours, a 60-hour block payment will issue. Nine hours remain available for billing by another provider. If the same C/FCC provider submits billing for any additional hours, no payment will be issued, but the increased hours billed will reduce the remaining available hours by the additional billing amount.

Provider	Hours Billed	Hours Paid	Reason for Payment Amount	Hours Remaining
Family Home B	31	60	Hours billed (31) are between 31 and 60, and result in a 60-hour block payment. Note: A 40-hour authorization will allow a C/FCC provider to be paid up to the 60-hour block payment amount.	40 – 31 = 9 hours.

License Exempt-Related and License Exempt-Unrelated

A license exempt-related or unrelated provider is not eligible to receive block payment rates; see *hourly payment* in this policy item.

Billing Submission by Multiple Providers

When two providers submit billing for care of the same child, the first provider's billing will deduct from the total authorized hours for which the child is approved. The second provider's billing will be limited to the remaining available hours. This allows for block payment under the guidelines described in this policy item.

Example: When a child is authorized for **90 hours** per two-week pay period and a C/FCC provider bills 33 hours, a 60-hour block payment will issue. The remaining hours available for billing are 57.

If a second C/FCC provider bills 62 hours, based on the 57 remaining available hours, a 60-hour block payment will issue.

Provider	Hours Billed	Hours Paid	Reason for Payment Amount	Hours Remaining
Center A	33	60	Hours billed (33) are between 31 and 60, resulting in a 60-hour block payment.	90 – 33 = 57 hours.
Center B	62	60	Hours billed (62) limited by remaining hours, resulting in a 60-hour block payment.	No hours remaining.

Multiple Submissions by One Provider

When a child care provider submits billing for a child and later amends the billing to increase the reported amount of child care that was provided, payment will not issue when the total number of hours billed were previously paid under the block payment guidelines described in this policy item.

Example: When a child is authorized for **80 hours** per two-week pay period, and a C/FCC provider bills 33 hours, a 60-hour block payment will issue. The remaining available hours for billing are 47.

If the C/FCC provider corrects the billing by adding 12 hours, for a billed total of 45, no payment will be issued, because 60 hours were previously paid. The increased hours billed will reduce the remaining available hours to 35.

Provider	Hours Billed	Hours Paid	Reason for Payment Amount	Hours Remaining
Center C	33	60	Hours billed (33) are between 31 and 60 resulting in a 60-hour block payment.	80 – 33 = 47 hours.
Center C	12	0	Total hours billed (45) by same provider are less than 60 hours, and the 60-hour block payment has already issued to this provider, so no payment is issued.	47 – 12 = 35 hours.

Payment Limits/Caps

The maximum number of hours that can be authorized per child is 90 hours in a two-week pay period.

The total number of hours a provider will be paid in a two-week pay period is limited to:

- License exempt-related or license exempt-unrelated – 2,016 hours.
- Family homes – 2,016 hours.
- Group homes – 4,032 hours.
- Child care centers – No limit.

Child Care Fee Payments

The payment of child care fees (such as registration fees, annual fees or field trip fees) supports parents by paying reasonable and mandatory fees that align with Michigan's market rate.

A payment is issued when all of the following are true:

- The CDC Eligibility Determination Benefit Calculation (EDBC) is approved and certified.
- The child care provider has been assigned to the child in Bridges.
- The child care provider has submitted billing for a child care fee after EDBC approval/certification and provider assignment.
- The annual child care fee limit has not been reached.

The per child, per fiscal year payment issuance limit is based on provider type and can be found in RFT 270.

The fees charged to CDC clients and/or the CDC program must not exceed what is charged to the general public (including a provider's own employees).

Child care fees may **not** be billed to cover late payment fees, bounced check fees, late pick-up fees, or other fees levied due to a family's action.

Note: License exempt-related and license exempt-unrelated providers are not eligible for payment of child care fees.

Internet Billing

Providers must use the internet (I-Billing) to bill for hours of child care, absences or child care fees. I-Billing can be accessed at www.michigan.gov/childcare.

PIN Resets

PINs are mailed to the provider when authorizations are initially certified in Bridges. Providers who have misplaced or forgotten their PIN have three options to request a PIN reset:

- Select the Forgot PIN link on the I-Billing system to reset a PIN, if security questions have previously been completed.
- Call the CDC office at 866-990-3227.
- Fax a request to 517-284-7529. Faxed requests must include the provider's name, address, telephone number, provider ID number, and signature.

Note: The provider's mailing address must be correct prior to requesting a PIN reset.

Correspondence

The DHS-4481, Provider Confirmation, shall be mailed to each provider upon initial approval, which shall include the provider's Bridges ID number.

The DHS-1381, Child Development and Care (CDC) Statement of Payments, shall be mailed to all providers who have billed. This statement shows the amount paid in the previous payroll.

The DHS-198, Child Development and Care (CDC) Provider Notice, shall be mailed upon assignment in Bridges of a child care provider to a child, indicating the ability of the provider to bill for the child. A DHS-198-C, Child Development and Care (CDC) Client Notice, provides this same information to the client.

Every January providers are mailed income information for tax reporting purposes. License exempt-related and license exempt-unrelated providers are mailed an annual statement of payments, and licensed providers are mailed Form 1099-MISC.

PAYMENT ISSUANCE REQUIREMENTS

Licensed C/FCC

Providers must be registered in the State of Michigan's SIGMA Vendor Self Service (VSS) system in order to receive CDC payments.

License Exempt-Tribal and Military

Providers must be registered in the SIGMA VSS system in order to receive CDC payments. Providers must be enrolled by the CDC office.

License Exempt-Related and License Exempt-Unrelated

License exempt-related and license exempt-unrelated providers are **not** required to register in the SIGMA VSS system.

Providers must be enrolled by the CDC office and complete the License Exempt Provider Pre-service Training (LEPPT) training (Level 1) prior to being able to bill for care provided. There is a $10 fee for this one-time LEPPT training.

Note: LEPPT was formerly called Great Start to Orientation (GSQO).

Providers are eligible to receive department payment when all of the following are true:

- The enrollment and training process is complete.
- The provider has billed for care that was provided both:
  - After enrollment.
  - Up to 30 calendar days prior to training completion.

Providers may still be assigned to a CDC case without the LEPPT being completed. Once the training is completed, if appropriate, the provider shall receive a DHS-198, Child Development and Care (CDC) Provider Notice, indicating his/her ability to bill.

All Providers

Providers have an ongoing health and safety training requirement. Failure to comply with this requirement may result in the provider being ineligible to receive CDC payments. For information about ongoing training requirements by provider type, see BEM 704.

Closure for Inactivity

License Exempt-Related and License Exempt-Unrelated

A provider who has not submitted billing in the past 5 months may be closed for inactivity. To begin caring for children after this closure, the provider must submit a new provider application to the CDC office.

Health and Safety Coaching Visits

License Exempt-Unrelated

A license exempt-unrelated provider must provide care where the child(ren) lives. An annual health and safety coaching visit at this location is required. Additional visits may be required for corrective actions plans or other concerns arising out of an annual visit. The provider assignment to the child(ren) shall end if the annual visit is not completed. See BEM 704 for details.

INDIVIDUALS NOT PERMITTED TO RECEIVE PAYMENT

The following persons or providers are not permitted to be assigned to or paid for the care of a CDC eligible child:

- A member of the CDC program group.
- The applicant/client.
- The applicant/client’s spouse who lives in the home.
- The parent of the children in care or a legal guardian who is not a member of the CDC program group.
- A sibling of the child(ren) in care who lives at the same residence as the child(ren).

- A home help provider who is also providing adult home help at the same time as child care is being provided.
- A CDC program group member, applicant or applicant's spouse who owns in whole or part the child care center, group or family home where the child care is provided.
- A licensed family or group home provider who employs a parent/substitute parent (P/SP) of the child(ren) in care.

Note: If a P/SP is employed at the licensed child care center that the child attends there must be documentation that the child is not in care of the P/SP while the P/SP is working. Confirm this information with the owner or director of the child care center. If confirmed verbally, document the conversation on the case record. If confirmation is obtained via written verification, upload the document to the client's electronic case file (ECF).

Additionally, an individual may not be eligible to receive CDC subsidy payment as a child care provider if one of the following actions has been taken against a license or registration by the Michigan Department of Lifelong Education, Advancement and Potential (MiLEAP) Child Care Licensing Bureau (CCLB) or the Michigan Department of Health and Human Services (MDHHS), and the license or registration has not been restored.

- Revoked.
- Suspended.
- Renewal refused.
- Denied issuance.
- Closed under disciplinary action.

Note: A provisional license does not constitute disciplinary action for these purposes.

PROVIDER RESOURCES

Various resources for providers are available in the Providers section at www.michigan.gov/childcare, including:

- Child Development and Care Handbook.
- Provider Instructional Videos.
- Child Care Time and Attendance Record.
- CDC Payment Schedule.

PROVIDER/PARENT QUESTIONS

Providers or parents with questions regarding CDC billing or payments should be directed to call the CDC office at 866-990-3227.

LEGAL BASE

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

OVERVIEW

In order to be eligible to bill and receive payments, child care providers are required to comply with the Child Development and Care (CDC) program requirements. Providers who are found to be in violation of the rules may serve a disqualification period.

RULE VIOLATIONS

Rule violations include, but are not limited to:

- Failure to maintain time and attendance records.
- Inappropriate billing.
- Failure to respond to requests for time and attendance records and/or other requested documentation by the Michigan Department of Lifelong Education, Advancement and Potential (MiLEAP).

TIME AND ATTENDANCE REVIEW PROCESS

The Child Development and Care (CDC) office at the MiLEAP will request time and attendance records from randomly selected child care providers.

The CDC office will determine if the provider's records:

- Comply with program requirements.
- Indicate an error or errors.
- Indicate an intentional program violation may have occurred.

Provider Errors

Provider errors are defined as unintentional errors made by the provider.

When it is determined that a provider error has occurred, a notice of violation will be sent to the provider informing him or her of the error, even if the error is found on a second or subsequent review. If the same error continues, the provider may be assessed for an Intentional Program Violation. The following are examples of provider errors:

- Caring and billing for more children than allowed at one time.

- Providing care in the wrong location.
- Licensed exempt-related or license exempt-unrelated provider failing to use required Child Care Time and Attendance Record.
- Time and attendance records missing:
  - Parent/provider certifications.
  - Day/date.
  - Children's names.
  - In/out times.

Intentional Program Violations

Intentional program violations (IPV) are defined as an intentional act which leads to a provider receiving a greater payment amount than they are entitled to and/or failing to respond to requests by the department for information.

If a review determines an IPV may exist, additional attendance records will be requested from the provider. Once the review is completed, a summary will be presented to a review team for recommendation. The recommendation will be forwarded to CDC Program Policy for final review and determination.

The following are examples of IPVs:

- Billing for children while they are in school.
- Two instances of failing to respond to requests for records.
- Two instances of providing care in the wrong location.
- Billing for children no longer in care.
- Knowingly billing for children not in care or more hours than children were in care.
- Maintaining records that do not accurately reflect the time children were in care.

Egregious IPVs will be forwarded by the CDC office to the Office of Inspector General for review.

DISQUALIFICATIONS

Providers determined to have committed an IPV may serve the following penalties:

- First occurrence - six month disqualification. The closure reason will be **CDC not eligible due to 6 month penalty period**.
- Second occurrence - twelve month disqualification. The closure reason will be **CDC not eligible due to 12 month penalty period.**
- Third occurrence - lifetime disqualification. The closure reason will be **CDC not eligible due to lifetime penalty.**

Bridges will send the DHS-4807, Notice of Child Development and Care Provider Ineligibility, and the DHS-4807-C, Client Notice of Child Development and Care Provider Ineligibility, when a disqualification is applied.

Local offices can view disqualification information in Bridges on the Search Enrolled Provider screen in Inquiry or on the Provider Service Details screen in Provider Management.

Disqualifications will apply to all CDC service types.

RECONSIDERATIONS

Providers are notified on the Provider Disqualification Notice that a reconsideration of the disqualification may be requested. The notice informs providers the reconsideration information must be requested within 15 calendar days of the date on the notice and sent to the CDC office. No reconsiderations will be accepted after the 15-day time period, unless there are extenuating circumstances.

Note: Fraud convictions are not subject to the reconsideration process.

RECONSIDERATION PROCESS

When the CDC office receives a request for reconsideration of the disqualification, any additional information provided by the due date will be reviewed. A reconsideration decision notice will be sent informing the provider whether the disqualification has been reversed or upheld.

The decision is final and no further requests for reconsideration will be granted.

ENROLLMENT OF A PROVIDER AFTER THE PENALTY PERIOD HAS ENDED

When the penalty period has ended, the closure reason will change to **CDC penalty period has ended. See BEM 704 for re-enrollment requirements.**

If the provider is licensed he/she will need to contact the CDC office at 517-241-9492. The CDC office will email MDHHS-Provider-Management@michigan.gov to reinstate the provider. The service begin date will be the first day that starts the pay period after the penalty period has ended, if the licensed provider is eligible.

License exempt providers will need to follow the enrollment process; see BEM 704.

LEGAL BASE

CDC

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

OVERVIEW

In order to be eligible for child care benefits, clients or adult group members must comply with the Child Development and Care (CDC) program rules.

Clients or adult group members, who are found to be in violation of the identified program rules, may serve a six-month, twelve-month or lifetime disqualification.

RULE VIOLATIONS

Rule violations include failure to:

- Provide accurate eligibility information.
- Verify eligibility information.
- Cooperate with a Department investigation.
- Report changes timely and accurately.

Rule violations shall be considered intentional and result in a disqualification if established by:

- A court.
- An administrative law judge (ALJ).
- The client or adult group member's signed disqualification form.

DISQUALIFICATION PROCESS

When it is determined that a client or adult group member intentionally violated a program rule, a referral should be submitted to the Office of Inspector General (OIG). If the OIG investigation determines an intentional program violation was committed, a disqualification referral and the Investigation Closure Packet will be sent to CDC policy for review.

CDC Policy will impose the appropriate disqualification. Disqualification periods will be:

- Six months for the first occurrence.
- Twelve months for the second occurrence.
- Lifetime for the third occurrence.
- Lifetime for welfare fraud conviction.

If the CDC case is active at the time the disqualification is imposed, Bridges will send the DHS-1605, Notice of Case Action, giving timely notice to close the case.

The client or adult group member will be ineligible for the entire disqualification period unless good cause is determined.

The disqualification will be applied to all adult members on the case, unless the IPV is only for a specific adult member.

If the CDC case is closed at the time the disqualification is imposed, the disqualification period would not be applied until the client or adult group member reapplies for CDC benefits.

The client CDC Non-coop/Sanction information screen can be viewed in Bridges Data Collection.

NOTIFICATION PROCESS

The local office recoupment specialist (RS) will be required to send the DHS-4357, Intentional Program Violation Client Notice, with all standard recoupment information. OIG will provide notice of the disqualification.

GOOD CAUSE

CDC Policy may grant good cause when:

- The disqualification was entered incorrectly.
- An ALJ determines that one parent/substitute parent in a two-parent household is not responsible and the parent/substitute parent with the disqualification leaves the home.

If a CDC case closes as a result of a disqualification and a good cause determination is made, a task and reminder will be sent to the specialist. The specialist will need to reinstate the case.

If the case is pending closure when the good cause determination is made, the specialist will need to run eligibility determination and benefit calculation (EDBC) and certify the case for the disqualification period.

If a CDC case closes as a result of a disqualification and the client or adult group member re-applies and is determined to have good cause, eligibility may need to be run for the previous months.

INTRODUCTION

Beginning November 11, 2016, and ending with requests received prior to October 1, 2019, a special population in Genesee County may be eligible for Flint Emergency Declaration Child Development and Care (CDC) assistance for 40 hours every two weeks. Income eligibility and need requirements are waived for this group.

Follow standard policy from all applicable Bridges Policy Manuals for CDC, including Bridges Administrative Manuals (BAM) and Bridges Eligibility Manuals (BEM), with the following exceptions related to Flint Emergency Declaration CDC.

Date Restrictions at Application and Review

The following date restrictions apply to Flint Emergency Declaration CDC eligibility:

- A child found eligible for Flint Emergency Declaration CDC based on an application or review document received prior to October 1, 2019, remains eligible for Flint Emergency Declaration CDC the remainder of the 12-month continuous eligibility period.
- A child for whom CDC is requested on an application or review document received on or after October 1, 2019, is not eligible for Flint Emergency Declaration CDC. Eligibility for CDC should be determined based on standard policy.

Special Population

This special population includes each child who satisfies all of the following criteria:

- CDC is requested for the child by an application or review document that is received prior to October 1, 2019.
- The child is under age four at the time of application or redetermination.
- The child (or the child's mother while pregnant) consumed water from the Flint water system while living, working or attending child care or other regular activity at an address that was serviced by the Flint water system at any time during the crisis [April 25, 2014, through August 14, 2016]

- **The child** currently resides in the Flint water system Affected Area (defined in this item).

Exception: See the Alternative Criteria in this item for clients who reside outside of the Affected Area.

Policy Exceptions

Request Flint Emergency Declaration CDC policy exceptions in case specific situations not covered by published policy. In addition to CDC policy exceptions defined in BEM 100, Flint Emergency Declaration CDC policy exception decisions shall be granted when the parent/substitute parent (P/SP) valid CDC need exceeds 40 hours every two weeks and/or meets the Alternative Criteria defined in this item.

The Department of Education, Office of Great Start, Child Development and Care, issues Flint Emergency Declaration CDC policy exception decisions on form DHS-1785, Policy Decision. Policy decisions issued on the DHS-1785, is official policy, but only for the case specified on the form.

Need Exceeds 40 Hours

If the P/SP indicates a need for more than 40 hours of care every two weeks, inform the P/SP that upon receipt of supporting documentation a policy exception will be requested. If the P/SP can immediately produce supporting documentation (for example, check stub(s), work or school schedule, etc.), request the policy exception before certifying the eligibility results. If the P/SP is unable to provide supporting documentation immediately, certify the 40 hours of eligibility, and request a Flint Emergency Declaration CDC policy exception upon receipt of supporting documentation.

Alternative Criteria

Alternative Criteria for the special population exists for a child who does not currently reside in the Affected Area, but will experience hardship if the child does not have access to the Flint Emergency Declaration CDC benefit.

Request a policy exception to review potential approval for Flint Emergency Declaration CDC benefits when all of the following are true:

- CDC is requested for the child by an application or review document that is received prior to October 1, 2019.The child is under age four at the time of application or redetermination.

- The child (or the child's mother while pregnant) consumed water from the Flint water system while living, working or attending child care or other regular activity at an address that was serviced by the Flint water system at any time during the crisis [April 25, 2014, through August 14, 2016].

- The child is still attending a regular activity (school, child care, etc.) in the Affected Area identified in this item.

A policy exception is required for all children satisfying the Alternative Criteria, regardless of the number of hours requested.

Note: When an approved policy decision is received, assistance from the BRC is required to authorized Flint Emergency Declaration CDC hours for a child currently residing outside the Affected Area.

Exception Requests

Any staff member may initiate a request for a Flint Emergency Declaration CDC policy exception, but it must be in writing and go through regular administrative channels. Send requests to Policy-CDC@michigan.gov. Upload confidential information to the electronic case file (ECF) and include remarks in the exception request identifying which documents support the greater need hours. Do not send confidential information by email.

Flint Emergency Declaration CDC policy exception requests must include:

- Case name (group member needing exception).
- Case number.
- Name and phone number of local office contact person.
- A detailed reason for the exception request.
- Copies of all supporting documentation (if the information is confidential or is already in the ECF, note in the email).

If further information is necessary, a response will be sent by email with the specific request. If complete information is received, the decision will be sent by email. Document the decision in Bridges case comments and upload the DHS-1785 to the ECF.

If more than 40 hours of need every two weeks is approved through a policy exception, enter all need hours in a single time block under the Flint Emergency Declaration CDC need reason, regardless of the need(s) for which the exception was approved.

Example: The P/SP requests Flint Emergency Declaration CDC, indicates a total need greater than 40 hours for a valid BEM 703 CDC need reason, and provides supporting documentation of an activity lasting 35 hours every two weeks. Upon receiving a completed policy exception approval, enter 45 hours under the Flint Emergency Declaration need reason, which would result in 60 authorized hours.

Note: If a client only requests Flint Emergency Declaration CDC and has no other need, authorize 40 hours. The 40 hours of Flint Emergency Declaration CDC includes all needs considered for a parent (for example, travel time) and no calculation is done.

RIGHTS AND RESPONSIBILITIES

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

APPLICATION FILING, REGISTRATION AND PROCESSING

A client must submit the MDE-4583-Simplified Application, or the MI Bridges application before October 1, 2019, in order to request Flint Emergency Declaration CDC assistance for a child under four years of age in the Flint Emergency Declaration Affected Area.

Exception: A P/SP with an open CDC case may submit the Child Development and Care (CDC) Flint Emergency Declaration Certification form before October 1, 2019, rather than submitting a new application. This form is an official request to have currently authorized children, who are potentially eligible for Flint Emergency Declaration CDC, changed to this category. If currently authorized hours are more than 40 hours every two weeks, follow the Policy Exceptions instruction in this policy item.

If the P/SP submits information about children who are not under four years old and indicates a desire for CDC for those children on the MDE-4583-Simplified application before October 1, 2019, utilize the application as a filing form and provide or send a MDHHS-1171,

Application for Assistance or MDE-4583, Child Development and Care (CDC) Application. Follow normal application filing and registration procedures.

If the P/SP has an open CDC EDG, that P/SP may submit one of the acceptable applications for the applicable child(ren) before October 1, 2019. In these instances, the child(ren)'s only need reason should be listed as Flint Emergency Declaration. If this action causes the authorized hours to be reduced, review Hours Reduced in 12-month Continuous Eligibility in this item.

Interview

An interview is required for all new CDC requests. Make an initial attempt to interview the applicant. If contact fails, schedule an interview and send the applicant notification by mail. If the interview is missed, notify the applicant by mail of the need to respond and complete an interview by the 30th calendar day of the standard of promptness.

Note: Clients who have ongoing CDC cases are not required to participate in an interview when they apply for Flint Declaration CDC.

Application Location

An application must be received and processed in Genesee County only.

Standard of Promptness

For Flint Emergency Declaration CDC, it is recommended that the Eligibility Specialist (ES) certify program approval of the application within 10 days. Allow the client every opportunity to return verifications and meet the interview requirement. Do not deny eligibility until the 30th day of the standard of promptness.

CASE ACTIONS

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

When adding a member to the group, the waiver of income and need still applies to those children under four years old who are receiving Flint Emergency Declaration CDC.

Valid CDC EDG Closure Reasons for Flint Emergency Declaration CDC include:

- Client requests closure.
- Incarceration.
- Loss of Michigan residency.
- Only child leaves the home.
- Assets exceed one million dollars.

When a child who is eligible for Flint Emergency Declaration CDC turns four years old during the 12-month continuous eligibility period or the family changes the current address to one outside the Affected Area, Flint Emergency Declaration CDC will end at redetermination, unless all eligibility criteria are met under the Alternative Criteria. Send all necessary required information to the P/SP to request CDC eligibility under BEM 703 criteria.

CDC GROUP COMPOSITION

Because the income and need of the group are waived for Flint Emergency Declaration CDC, the only required group member(s) include the child(ren) receiving Flint Emergency Declaration CDC. When additional child(ren) are applied for outside of the Flint Emergency Declaration CDC the CDC Group Composition includes all members listed in BEM 205 and does not exclude those children receiving the Flint Emergency Declaration CDC.

Accept all provided information from any acceptable application for Flint Emergency Declaration CDC. If historical information is available from previous applications or in Bridges, confirm the historical information if possible. Do not request more than the required information.

AGE

The Flint Emergency Declaration CDC need reason is available for children from birth to under age four.

CHILD SUPPORT

Do not deny Flint Emergency Declaration CDC eligibility for a child solely because the P/SP is in non-cooperation with the Office of Child Support.

INCOME

Income is not a reporting requirement for Flint Emergency Declaration CDC need reasons. If income is or has been reported for any reason, waive the income eligibility. Do not deny Flint Emergency Declaration CDC eligibility for a child solely because the group's income exceeds the CDC Income Eligibility Scale in RFT 270.

CDC VERIFICATIONS

Do not request verifications of need.

Do not request verification of income.

CDC PROGRAM REQUIREMENTS

Eligibility for 40 hours of Flint Emergency Declaration CDC is not dependent on any P/SP being unavailable due to a valid need reason.

When a P/SP applies prior to October 1, 2019, for the Flint Emergency Declaration CDC and certifies that a child under four years old has been affected by the Flint water system, meets the definition referenced in Special Population and is determined eligible, authorize 40 hours with a need reason of Flint Emergency Declaration.

Once eligibility has been determined, the child(ren) will remain eligible for the entire 12-month certification period with few exceptions; see Closure Reasons in this item.

Affected Area

The following zip codes comprise the Flint Emergency Declaration Affected Area:

- 48502.
- 48503.
- 48504.
- 48505.
- 48506.
- 48507.
- 48509.
- 48519.
- 48529.

- 48532.

Multiple Eligibility/Need Reasons

The need reason for all children in which the P/SP has made a request for Flint Emergency Declaration CDC prior to October 1, 2019, has certified that the child was affected according to the requirements listed above, and the family currently resides in the Affected Area should be marked as Flint Emergency Declaration. For those individuals who provide supporting documentation for more hours of need, do not enter additional need reasons. Instead, submit a Flint Emergency Declaration CDC Policy Request to Policy-CDC@michigan.gov with the appropriate information pertaining to additional need hours.

Family Contribution

Because there is no income determination for this eligibility group, waive the Family Contribution (FC) listed in RFT 270 (listed as $0). This waiver is due to high lead levels, confirmed by each applicant's self-attestation.

CDC NEED CALCULATION

Hours Reduced in 12-month Continuous Eligibility

When a child has active CDC, authorized hours cannot be lowered during 12-month continuous eligibility. Request a Flint Emergency Declaration CDC Policy Exception for any child whose hours would be reduced by changing to the Flint Emergency Declaration CDC need reason during 12-month continuous eligibility. Do not request new supporting documentation.

Need in Two-Parent Household

When requesting a policy exception for additional need hours, consider need calculation for a two-parent household according to BEM 710. If the parents indicate there is an overlap in need hours and the parent with the fewest hours has a need greater than 40

hours, submit a Flint Emergency Declaration CDC policy exception as instructed in this policy item.

Documenting the Need Determination

When a Flint Emergency Declaration CDC policy exception is approved, upload the DHS-1785, Policy Decision, and document the approval in Bridges including the following information:

- Calculations used to arrive at the need determination.
- The source of the information used in the need determination.
- The date of the policy exception approval.

CONTACT

Direct questions or clarification requests to the policy mailbox at Policy-CDC@michigan.gov.

REDETERMINATION

At redetermination follow standard policy found in BAM 210, (unless otherwise stated in this policy item), including the requirement that a client submit a MDHHS-1010, Redetermination, or other review document.

A child for whom CDC is requested on a review document received on or after October 1, 2019, is not eligible for Flint Emergency Declaration CDC. Eligibility for CDC should be determined based on standard policy.

At redetermination if the Flint Emergency Declaration CDC eligible child fulfills the following three conditions, the child will remain eligible for 40 hours of Flint Emergency Declaration CDC until next redetermination date:

1. The review document was received prior to October 1, 2019.
2. The child is under age four.
3. The child resides in the Affected Area during redetermination.

Policy Exception Requests at Redetermination

At redetermination, if more than 40 hours of CDC are requested:

- A new policy decision **is not** required if the current P/SP(s) have an approved policy decision for the same or a greater number of hours. Document the hour calculation.

- A new policy decision **is** required if the current P/SP(s) do not have an approved policy decision, or if the hours requested are greater than previously approved.

A new policy decision **is** required for a child who qualifies under the Alternative Criteria, regardless of the number of hours requested or previously approved.

Follow the policy exception guidance in this policy item to request a new policy decision.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

DETERMINING NEED

Determine the valid need hours for each parent/substitute parent (P/SP) at application, redetermination, and when a change in work or activity hours is reported that results in a positive change. Bridges will determine the authorization based on the actual need hours entered.

Calculate the actual need hours considering:

- Time spent in the activity. See BEM 703 to determine if an activity may be approved and the required verifications.
  - For the employment need reason, use the **highest** verified hours that are included in the 30-day income period.
  - If employment is paid weekly use the highest weekly hours multiplied by two.

  Note: If the highest verified hours are not accurate, confirm with the P/SP which verification is the most accurate and use it. Document this information on the case record.
- Meal periods during the work or school day.
- Study, tutoring and required lab time.
- Travel time from the child care provider to and from the activity.
  - Add 10 hours of travel time per pay period for each need reason.
  - P/SPs requiring more than 10 hours of travel time per pay period, per need reason, must provide documentation supporting the need. The local office can approve the additional hours, if reasonable.

Round the biweekly total up to the next whole hour if it includes a fraction and enter the calculated figure into Bridges. Bridges will adjust and authorize to the correct:

- 20 hours.
- 40 hours.
- 60 hours.
- 80 hours.
- 90 hours.

Note: Hours of need are based on the P/SP's schedule, not the child's schedule.

Example: Sally works 8.5 hours per day (8 work hours + 30 minute lunch) Wednesday through Friday each week, resulting in 25.5 hours weekly. Calculate bi-weekly hours: 25.5 weekly hours x 2 weeks = 51 hours + 10 hours travel time = 61 hours. Enter into Bridges the actual biweekly need hours of 61. Bridges will convert to the appropriate tier, which would be 80.

Need in Two-Parent Household

If there are two parents/substitute parents for the child and both have valid need reasons, Bridges will authorize hours based on the parent with highest need hours.

Note: For dates prior to 11/3/2024, Bridges will authorize hours based on the parent with the fewest need hours.

Example: Sandy and Jeff are part of a two-parent household. Sandy's valid need hours are 72 hours every two weeks + 10 hours travel time = 82 hours. Jeff's valid need hours are 37.5 hours every two weeks + 10 hours travel time = 47.5 hours, rounded to 48 hours (the next whole number). Enter into Bridges each parent's actual bi-weekly need hours of 82 and 48. Bridges will authorize hours based on Sandy's higher need hours of 82. Bridges will convert to the appropriate tier, which would be 90.

Shared/Joint Custody

If a child's parents do not live together but have shared/joint custody of the child, authorize care only for the time periods when the parent who is applying has physical custody of the child.

The parent's statement of shared/joint custody is acceptable.

Documenting the Need Determination

Document each need determination in the case record. This documentation must include:

- Calculations used to arrive at the need determination.

- The source of the information used in the need determination.

Note: The case comments section in Bridges can be used to document the need.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

INTRODUCTION

A special population may be eligible for Child Development and Care (CDC) Disaster Assistance for 40 hours every two weeks. Income eligibility and need requirements are waived for this group.

The CDC Disaster Assistance eligibility category should **only** be selected after a county has received official notification from the Michigan Department of Lifelong Education, Advancement, and Potential (MiLEAP) that this eligibility category is approved to be used.

Follow standard policy from all applicable Bridges Policy Manuals for CDC, including Bridges Administrative Manuals (BAM) and Bridges Eligibility Manuals (BEM), with the following exceptions related to CDC Disaster Assistance.

Special Population

This special population includes each child who satisfies all of the following criteria:

- The child is age eligible at the time of application or redetermination.
- The child lived in the Affected Area and was impacted by the disaster for which a State or Federal Emergency was declared, during the time-period of the emergency declaration.
- The child currently resides in the Affected Area.

CDC Disaster Assistance Policy Exceptions

Request CDC Disaster Assistance policy exceptions in case specific situations not covered by published policy. In addition to CDC policy exceptions defined in BEM 100, CDC Disaster Assistance policy exception decisions shall be granted when the parent/substitute parent (P/SP) valid CDC need exceeds 40 hours every two weeks.

The CDC office at MiLEAP issues CDC Disaster Assistance policy exception decisions on form DHS-1785, Policy Decision. A policy decision issued on the DHS-1785 is official policy, but only for the case specified on the form.

Need Exceeds 40 Hours

If the P/SP indicates a need for more than 40 hours of care every two weeks, inform the P/SP that upon receipt of supporting documentation a policy exception will be requested. If the P/SP can immediately produce supporting documentation (for example, check stub(s), work or school schedule, etc.), request the policy exception before certifying the eligibility results. If the P/SP is unable to provide supporting documentation immediately, certify the 40 hours of eligibility, and request a CDC Disaster Assistance policy exception upon receipt of supporting documentation.

Exception Requests

Any staff member may initiate a request for a CDC Disaster Assistance policy exception, but it must be in writing and go through regular administrative channels. Send requests to Policy-CDC@michigan.gov. Upload confidential information to the electronic case file (ECF) and include remarks in the exception request identifying which documents support the greater need hours. Do not send confidential information or Personally Identifiable Information (PII) by email.

CDC Disaster Assistance policy exception requests must include:

- Case name (group member needing exception).
- Case number.
- Name and phone number of local office contact person.
- A detailed reason for the exception request.
- Copies of all supporting documentation (if the information is confidential or is already in the ECF, note in the email).

If further information is necessary, a response will be sent by email with the specific request. If complete information is received, the decision will be sent by email. Document the decision in Bridges Case Comments and upload the DHS-1785 to the ECF.

If more than 40 hours of need every two weeks is approved through a policy decision, enter all need hours in a single time block under the CDC Disaster Assistance need reason, regardless of the need(s) for which the exception was approved.

Example: The P/SP requests CDC Disaster Assistance, indicates a total need greater than 40 hours for a valid BEM 703 CDC need

reason, and provides supporting documentation of an activity lasting 35 hours every two weeks. Upon receiving a completed policy exception approval, enter 45 hours under the CDC Disaster Assistance need reason, which would result in 60 authorized hours.

Note: If a client only requests CDC Disaster Assistance and has no other need, authorize 40 hours. The 40 hours of CDC Disaster Assistance includes all needs considered for a parent (for example, travel time) and no calculation is done.

RIGHTS AND RESPONSIBILITIES

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

Application Filing, Registration and Processing

In order to request CDC Disaster Assistance a client must submit a valid application and a Child Development and Care (CDC) Disaster Assistance Certification form.

A P/SP with an open CDC case may submit the CDC Disaster Assistance Certification form, rather than submitting a new application. This form is an official request to have currently authorized children, who are potentially eligible for CDC Disaster Assistance, changed to this category. If currently authorized hours are more than 40 hours every two weeks, follow the Policy Exceptions instruction in this policy item.

If the P/SP submits information about children who are not eligible for CDC Disaster Assistance, and indicates a desire for CDC for those children, utilize the application as a filing form and provide or send a MDHHS-1171, Assistance Application, and the MDHHS 1171-CDC program specific supplement form. Follow normal application filing and registration procedures.

If the P/SP has an open CDC EDG, that P/SP may submit one of the acceptable applications for the applicable child(ren). In these instances, the child(ren)'s only need reason should be listed as CDC Disaster Assistance. If this action causes the authorized hours to be reduced, review Hours Reduced in 12-month Continuous Eligibility in this item.

Interview

An interview is required for all new CDC requests. Make an initial attempt to interview the applicant. If contact fails, schedule an interview and send the applicant notification by mail. If the interview is missed, notify the applicant by mail of the need to respond and complete an interview by the 30th calendar day of the standard of promptness.

Note: Clients who have ongoing CDC cases are not required to participate in an interview when they apply for CDC Disaster Assistance.

Application Location

An application must be received and processed in a county that is included in the State or Federally Declared Emergency.

Standard of Promptness

For CDC Disaster Assistance, it is recommended that the Eligibility Specialist (ES) certify program approval of the application within 10 days. Allow the client every opportunity to return verifications and meet the interview requirement. Do not deny eligibility until the 30th day of the standard of promptness.

CASE ACTIONS

Clients are not required to report a change in income when income exceeds the CDC Income Eligibility Scale in RFT 270.

When adding a member to the group, the waiver of income and need still applies to those children who are receiving CDC Disaster Assistance.

Valid CDC EDG Closure Reasons for CDC Disaster Assistance include:

- Client requests closure.
- Incarceration.
- Loss of Michigan residency.
- Only child leaves the home.
- Assets exceed one million dollars.

When a family changes the current address to one outside the Affected Area, CDC Disaster Assistance will end at redetermination.

CDC GROUP COMPOSITION

Because the income and need of the group are waived for CDC Disaster Assistance, the only required group member(s) include the child(ren) receiving CDC Disaster Assistance. When additional child(ren) are applied for outside of CDC Disaster Assistance, the CDC Group Composition includes all members listed in BEM 205 and does not exclude those children receiving the CDC Disaster Assistance.

Accept all provided information from any acceptable application for CDC Disaster Assistance. If historical information is available from previous applications or in Bridges, confirm the historical information if possible. Do not request more than the required information.

AGE

Follow standard policy for age limits for the CDC Disaster Assistance need reason.

CHILD SUPPORT

Do not deny CDC Disaster Assistance eligibility for a child solely because the P/SP is in non-cooperation with the Office of Child Support.

INCOME

Income is not a reporting requirement for the CDC Disaster Assistance need reason. If income is or has been reported for any reason, waive the income eligibility. Do not deny CDC Disaster Assistance eligibility for a child solely because the group's income exceeds the *CDC Income Eligibility Scale* in RFT 270.

CDC VERIFICATION

- Do not request verification of a valid need reason.
- Do not request verification of income.

CDC PROGRAM REQUIREMENTS

Eligibility for 40 hours of CDC Disaster Assistance is not dependent on any P/SP being unavailable due to a valid need reason.

When a P/SP applies for CDC Disaster Assistance and certifies that a child was impacted by the approved State or Federal disaster, meets the definition referenced in Special Population, and is determined eligible, authorize 40 hours with a need reason of CDC Disaster Assistance.

Once eligibility has been determined, the child(ren) will remain eligible for the entire 12-month certification period with few exceptions; see Closure Reasons in this item.

Affected Area

The CDC Disaster Assistance Affected Area will be defined and communicated if this eligibility category is activated.

Multiple Eligibility/Need Reasons

The need reason for all children in which the P/SP has made a request for CDC Disaster Assistance, has certified that the child was affected according to the requirements listed above, and the child currently resides in the Affected Area, should be marked as CDC Disaster Assistance. For those individuals who provide supporting documentation for more hours of need, do not enter additional need reasons. Instead, submit a CDC Disaster Assistance Policy Exception Request to Policy-CDC@michigan.gov with the appropriate information pertaining to additional need hours.

Family Contribution

Because there is no income determination for this eligibility group, waive the Family Contribution (FC) listed in RFT 270 (listed as $0). This waiver is due to impact by a State or Federal disaster, confirmed by each applicant's self-attestation.

CDC NEED CALCULATION

Hours Reduced in 12-month Continuous Eligibility

When a child has active CDC, authorized hours cannot be lowered during 12-month Continuous Eligibility. Request a CDC Disaster Assistance Policy Exception for any child whose hours would be reduced by changing to the CDC Disaster Assistance need reason during 12-month Continuous Eligibility. Do not request new supporting documentation.

Need in Two-Parent Household

When requesting a policy exception for additional need hours, consider the need calculation for a two-parent household according to BEM 710. If the parent with the fewest hours has a need greater than 40 hours, submit a CDC Disaster Assistance Policy Exception as instructed in this policy item.

Documenting the Need Determination

When a CDC Disaster Assistance policy exception is approved, upload the DHS-1785, Policy Decision, and document the approval in Bridges including the following information:

- Calculations used to arrive at the need determination.
- The source of the information used in the need determination.
- The date of the policy exception approval.

CDC Disaster Assistance Policy Questions Clarification

Direct questions or clarification requests to the policy mailbox at Policy-CDC@michigan.gov.

REDETERMINATION

At redetermination follow standard policy found in BAM 210, (unless otherwise stated in this policy item), including the requirement that a client submit a MDHHS-1010, Redetermination, or other review document.

At redetermination if the CDC Disaster Assistance eligible child fulfills the following two conditions, the child will remain eligible for 40 hours of CDC Disaster Assistance until next redetermination date:

1. The child is age eligible.
2. The child resides in the Affected Area.

Policy Exception Requests at Redetermination

At redetermination, if more than 40 hours of CDC are requested:

- A new policy decision **is not** required if the current P/SP(s) have an approved policy decision for the same or a greater number of hours. Document the hour calculation and proof provided.
- A new policy decision **is** required if the current P/SP(s) does not have an approved policy decision, or if the hours requested are greater than previously approved.

Follow the policy exception guidance in this policy item to request a new policy decision.

LEGAL BASE

The Child Care and Development Block Grant (CCDBG) Act (42 USC § 9858 et seq.), as amended by the CCDBG Act of 2014 (Pub. L. 113-186).
45 CFR Parts 98 and 99.
Social Security Act, as amended 2016.

DEPARTMENT POLICY

When clients request replacement of their food assistance benefits, follow policy in BAM 502, Food Benefit Replacement.

INTRODUCTION

Disaster assistance benefits are designed to provide disaster cash and disaster food assistance to households affected by federally declared disasters/mandatory evacuations including but not limited to tornadoes, floods, storms, chemical spills etc. Eligibility for cash, the Disaster Relief Program (DRP), and Disaster Food Assistance Program (DFAP) is not limited to households that are typically eligible for Financial Independence Program (FIP) and Food Assistance Program (FAP).

DFAP has also been developed for other households requesting food assistance who sustain less apparent disaster damage and provided verification of the damage. This may include water damage to furniture or essential personal items, water in the basement due to flooded sewers, and other damage.

For individual assistance, follow Disaster Assistance policy once a disaster is federally declared. Clients who come to Michigan as a result of a federally declared disaster in another state may apply for DRP. DFAP applies to Michigan residents who are victims of a federally declared disaster.

The Food and Nutrition Service (FNS) will approve the operation of a DFAP in Michigan once a federally declared disaster/mandatory evacuation occurs. The DFAP application period will occur within 48 hours of approval of the DFAP.

See Concurrent Receipt of Benefits and Semi-Annual Contacts/Mid-Certifications/Redeterminations in this item for treatment of ongoing cases.

DRP

DRP is a lump sum, non-recurring benefit paid to families who have been evacuated from their homes due to a natural or technological disaster. The federal government must issue a major disaster declaration for the area that includes their normal residence.

Program Benefits

The intent of issuing DRP is to do the following:

- Provide short term, non-recurring payments to families recovering from a disaster to prevent the need to apply for ongoing FIP.
- Provide financial support to families affected by a disaster that will not count toward their federal 60-month time limit or Michigan's 48-month time limit to receive cash assistance.
- Provide financial support to families affected by a disaster in a way that will not impact Michigan's work participation rate.
- Involve less work than processing ongoing FIP.
- Focus the work participation program employment resources on long-term FIP recipients.
- Issue disaster relief payments in lieu of State Emergency Relief (SER), saving state funds.

DISASTER FOOD ASSISTANCE PROGRAM

This one-time food assistance payment is for households that lived or had been employed in the disaster area at the time of the disaster. These households must plan on purchasing food during the disaster period.

Note: Active FAP recipients residing in the declared disaster area may receive an automatic replacement of their FAP benefits through a Bridges mass update upon FNS waiver approval.

Eligibility Criteria

Households **must** have experienced at least **one** of the following to qualify for benefits:

- Food lost due to disaster.
- Damage to or destruction of their home or place of employment.

- Lost or inaccessible income including reduction or termination of income, or a delay in receipt of income for a substantial part of the benefit period.
- Inaccessible liquid assets for a substantial portion of the benefit period.
- Unreimbursed, out-of-pocket disaster-related expenses not expected to be reimbursed during the benefit period.

APPLICATION

DRP, DFAP

A DHS-3220, Application for Disaster Cash and Food Assistance, must be completed to request disaster benefits for Michigan residents. A request for disaster benefits may be in person or by an authorized representative applying in person for the client.

The date of application is the date the local office receives the completed application.

DRP

Clients from another state, who are applying for an out-of-state disaster, must complete the MDHHS-1171, Assistance Application, the MDHHS-1171-CASH, and the DRP addendum, Out-of-State Disaster Cash Assistance Application, to be considered for disaster assistance.

Application Period

DRP, DFAP

After the Food and Nutrition Service (FNS) approves the state's request to operate DFAP, clients may apply for disaster assistance. The application period is generally **seven** calendar days. However, the state has the option of decreasing the application period based on the circumstances. The disaster will be defined in Bridges to complete the registration process. If simultaneous disasters occur, Bridges will identify each disaster separately. Choose the correct disaster for which the client is applying. If a DHS-3220 is received after the seventh day, treat it as a request for assistance and provide the client a MDHHS-1171 and program specific supplement form(s), and/or DHS-1514, State Emergency Relief Application.

Note: In rare instances, the federal government may extend or shorten the application period. If Michigan determines a longer application period is needed due to high demand for disaster assistance, an extension period will be requested from the federal government.

DRP

Clients from another state may apply for disaster assistance in Michigan up to **30** calendar days after the federal government declares an out-of-state disaster.

Where to Apply

DRP, DFAP

Clients may apply for disaster assistance at a designated local office or predetermined temporary location.

Authorized Representatives

The client may choose to designate an authorized representative (AR) for disaster assistance that may file the application for the head of household. This authorized representative, or a different authorized representative chosen by the client, may receive the Bridge card and/or utilize the benefits on behalf of the client. All authorized representatives must be designated in writing. The head of household will need to call the toll-free number on the back of the new Bridge card for a personal identification number (PIN).

STANDARD OF PROMPTNESS (SOP)

DRP

The standard of promptness (SOP) is seven calendar days starting with the application date.

DFAP

The standard of promptness is three calendar days starting with the application date. Questionable applications may be given an SOP of seven calendar days and a front-end eligibility (FEE) referral must be made.

INTERVIEW REQUIREMENTS

DRP, DFAP

Conduct an in-person interview at application before determining eligibility. If clients choose to have an authorized representative file an application on their behalf, the authorized representative must participate in an in-person interview.

DFAP

Active FAP clients do not need to participate in an interview or complete an application. However, they must complete the DHS-601, Food Replacement Affidavit, unless benefits are automatically replaced through a mass update upon FNS waiver approval.

DRP

An interview is **not** required before denying the program if it is clear from the application or other sources that the group is ineligible.

Deny DRP on the 30th day if the client has not participated in an interview.

DFAP

For DFAP only, conduct an interview before denying the application for assistance even if it is clear from the application or other sources that the group is ineligible.

Deny DFAP on the 7th day if the client has not participated in an interview.

DRP, DFAP

If the group is ineligible **or** refuses to cooperate in the application process, certify the denial of the appropriate program and Bridges will generate a DHS-82, Disaster Benefits Eligibility Notice.

BENEFIT PERIOD

The benefit period for disaster benefits is 30 days from the date of the federally declared disaster or the date of any mandatory evacuation preceding the declared disaster. During this 30-day period, the following are used to determine eligibility:

- The household's income received or expected to be received.

- The household's accessible liquid assets.
- The household's unreimbursed disaster expenses.

Multiple Disasters

A client can receive only one disaster payment per declared disaster. If there are multiple disasters in a 30-day period, each disaster must be federally declared and identified on Bridges separately.

DFAP

Households cannot receive more than one DFAP allotment in any benefit period. If there are multiple federally declared disasters in the same disaster area in the same 30-day period, the household may participate only in one automatic replacement in the benefit period. If the second disaster destroys the original replacement, the client can request a second replacement by completing a DHS-601, Food Replacement Affidavit.

APPLICATION PROCESSING

DRP, DFAP

A new case number is given to each disaster application in Bridges, even if the head of household already has an existing case. The disaster application takes priority over any pending applications that the client may already have.

Example: Client has a pending FIP/FAP application in May. A disaster is federally declared in June and the client is eligible for DRP/DFAP. DRP/DFAP benefits are issued for June. FIP/FAP eligibility is determined for May, July and forward.

Send the DHS-3503, Verification Checklist, (VCL) out of MS Word to the client. Encourage clients to bring all verifications with them, however; do **not** delay processing the disaster application for the return of verifications that are not mandatory.

Note: For DFAP only, identity is the only required verification.

NON-FINANCIAL ELIGIBILITY FACTORS

Identity

The identity of the head of household **must** be verified. If an authorized representative is applying on behalf of the head of household, the identity of the authorized representative must also be verified.

Verification Sources

Verification of identity includes but is not limited to:

DRP and DFAP

- Driver's license.
- State-issued ID.
- Military ID.
- School-issued identity card.
- Social Security Administration cross match in Bridges.

Residence

DRP, DFAP

For disasters that occur in Michigan, the client's geographical location must be in a federally declared disaster area. The client must have lived or been employed in the disaster area at the time of the disaster.

Clients that are indicated as homeless in Bridges at the time the disaster occurred and state they resided in the geographical disaster location are potentially eligible for disaster assistance. Applicants who are staying in a shelter, regardless of their length of stay, are potentially eligible.

Note: The temporary address of a homeless client does not have to be in the declared geographical disaster location.

Overrides

If the client does not have a ZIP code or the ZIP code from Postal Soft is incorrect, a manager/supervisor must approve the override by initialing the DHS-3220. A daily report will indicate the cases that required a manual override.

DRP

Applicants must have been evacuated from their home or forced to relocate in order to receive a payment. The family cannot be residing in the home where the disaster occurred at the time of application.

For clients coming to Michigan from out-of-state federally declared disasters, the out-of-state address must be in the declared area (usually by county or parish). The client must have moved to Michigan due to the disaster and apply for disaster assistance within 30 days of the disaster being declared.

Note: Federally declared disasters are listed at www.fema.gov/news/disasters.fema.

A client does not have to intend to remain in Michigan to receive DRP.

Verification

DRP, DFAP

Verify residence if possible.

Verification Sources

Verification of residence includes but is not limited to:
- Driver's License.
- Other ID with address.
- Utility bills.
- Tax bills.

Accept client statement if verification is unavailable.

Food Loss

DFAP

Food loss due to a disaster.

Verification

Verify only if questionable.

Verification Sources

- Check if residence is within the disaster area.
- Check with power company.

Group Composition

DRP

The group must contain at least one dependent child and a caretaker and/or a pregnant woman**.**

A dependent child is an unemancipated child, including a child who receives SSI, who lives with a caretaker and is one of the following:

- Under age 16.
- Age 16 to 18, attending high school/equivalent at the time of the disaster.

A caretaker is a legal parent, stepparent or specified relative who acts as a parent to a dependent child.

A specified relative must be at least age 18 and legally related to the child by blood, marriage, or adoption. Specified relative includes:

- Grandparent (including great or great-great).
- Aunt or uncle (including great or great-great).
- Sibling (including half-sibling).
- Niece or nephew.
- First cousin or first cousin once removed.
- Spouse of any of the above, even if the marriage ended due to death or divorce.
- The parent of a child's putative father.
- A child's legal guardian.
- An adult at least age 21 whose petition for legal guardianship of the child is pending.

All other aspects of group composition (mandatory/optional members) are the same as FIP; see BEM 210.

Note: Do not include members of the household with whom applicants are temporarily staying during the disaster.

DFAP

All members of the household that are living and eating together at the time of the disaster are mandatory group members.

Note: Do not include members of the household with whom applicants are temporarily staying during the disaster.

Group Composition Corrections

DRP, DFAP

After program certification, any corrections needed for group composition, including member adds, must be done by central office.

Verification

Verify members of the household if questionable.

Verification Sources

Ask the applicant to orally list the names, ages, and birthdates of all household members.

DRP

Pregnancy Verification

Verify pregnancy only if questionable **and** when DRP eligibility is based solely on the pregnancy.

Pregnancy Verification Sources

Use a statement, including expected date of delivery, from one of the following:

- Doctor of medicine (MD).
- Doctor of osteopathy (DO).
- Physician's assistant (PA).
- Ob-gyn nurse practitioner (NP).
- Ob-gyn clinical nurse specialist (NS).
- Certified nurse-midwife.
- Form DHS-49, Medical Examination Report, DHS-54A, Medical Needs or other written statement may be used.

Disqualified Group Members

DRP, DFAP

Disqualified clients are potentially eligible for disaster benefits unless they are disqualified in an active EDG.

Pete is currently disqualified on an active FIP and FAP EDG for failing to provide his Social Security number. He is not eligible for disaster benefits. However, if the EDG is closed, Pete would be potentially eligible for disaster benefits.

An applicant's status as any of the following is not relevant to his or her eligibility for DFAP:

- Student.
- Striker.
- Citizen/or non-citizen.
- Work program participant.
- Someone disqualified under the regular FAP program.

Social Security Number

DRP

A Social Security number (SSN) must be provided, or the client must cooperate in obtaining an SSN for each group member.

Verification

Client statement is acceptable.

DFAP

An SSN is not a requirement. Do not deny/disqualify a client if they refuse or are unable to provide an SSN.

Citizenship/Non-Citizen Status

DRP

Individuals must meet citizenship/non-citizen status requirements; see BEM 225.

Verification

Client statement is acceptable.

DFAP

Citizenship and non-citizen status are not a requirement.

School Attendance and Student Status

DRP

Clients who are 16 to 18 years old and **not** the head of household must be attending high school/equivalent full-time at the time of the disaster to be eligible for a DRP benefit. If the disaster is during a vacation, the 16- to 18-year-old must be returning to school after break.

Verification

Client statement is acceptable.

DFAP

School attendance and student status determination is not a requirement.

Intentional Program Violation (IPV)

DRP

A client who is disqualified for an IPV is not eligible to receive DRP.

DFAP

A client who is disqualified for an IPV may still receive benefits under DFAP.

Concurrent Receipt of Benefits

DRP, DFAP

The eligibility determination month (EDM) for disaster benefits will be the month in which the disaster occurred or the month of the mandatory evacuation date, whichever is earlier.

Example: Mandatory evacuation date is 6/29. Disaster occurred 7/1. Benefits issued 7/3. EDM is June. Benefit period will be 6/29 to

7/29. Client is potentially eligible for regular FIP/FAP benefits in July.

DRP

A client is not eligible for FIP benefits the same month as a DRP benefit.

Send a DHS-3782, Out-of-State Inquiry, for clients who come to Michigan from out-of-state. Do **not** delay processing while waiting for a response. Advise clients if they receive duplicate benefits that they must return any assistance they receive from another state for the same period. Failure to return benefits from another state for the same period could result in a 10-year federal disqualification for cash, food, SSI, **and** MA.

DFAP

A client is not eligible for FAP benefits the same month as a disaster benefit.

Ongoing FAP Recipients

Active FAP recipients residing in the declared disaster area may receive an automatic replacement of their FAP benefits through a Bridges mass update upon FNS waiver approval.

Assets

DRP, DFAP

There is no asset limit for disaster benefits. However, accessible liquid assets are used to determine eligibility; see Budgeting Income, Assets and Expenses in this item.

Pursuit of Benefits

The client is not required to pursue any potential benefit; see BEM 270.

Employment Related Activities

Disaster assistance does not have any employment and training requirements as in the BEM 230 series.

BUDGETING INCOME, ASSETS AND EXPENSES

DRP, DFAP

Budget income, accessible liquid assets, and disaster-related expenses the household expects to receive/have during the 30-day disaster benefit period. Only budget unreimbursed, out-of-pocket, disaster related expenses, not expected to be reimbursed during the 30-day disaster benefit period.

Income

Prospect the **net** earnings the household received or expects to receive in the 30-day benefit period. All income of all household members regardless of age and type of income is countable. **Net** pay is defined as:

- Wages a household receives after taxes and all other payroll withholding such as child support payments, 401K deductions, garnishments, etc. are deducted.
- Self-employment income minus the expenses.
- Unearned income such as RSDI/SSI, unemployment compensation, FIP, worker's compensation, etc. (after all deductions).

Exception: DRP income is **not** budgeted as unearned income in the DFAP budget.

Note: The DRP payment is excluded as income for FAP, CDC and MA. For SER, it is excluded income but any amount of the DRP in the client's possession at the time of SER is a cash asset.

Verification

Verify if possible. Accept client's statement if verification is unavailable.

Assets

Budget all accessible liquid assets. Liquid assets include only:

- Cash on hand.
- Accessible checking/draft and savings/share account balances.

Note: Remember, with ATM cards and electronic transmission, few liquid assets are truly inaccessible.

Verification

Verify if possible. Accept client's statement if verification is unavailable.

Disaster-Related Expenses

Allow the deduction of disaster-related expenses paid or anticipated to be paid **out-of-pocket** by the household during the disaster benefit period. If the household receives or anticipates receiving a reimbursement for these expenses during the disaster period, only the net expense is deductible (do **not** allow the reimbursable expense).

Note: If the household pays disaster-related expenses using a credit card and will pay their credit card bill after the disaster benefit period, that expense is **not** considered out-of-pocket and is not deductible.

No other expenses are considered in determining eligibility for disaster benefits.

Example: If a client pays voluntary child support, it is not considered a disaster expense and is not allowable.

Examples of deductible disaster-related expenses:

- Home repairs.
- Temporary shelter expenses.
- Evacuation expenses.
- Disaster-related personal injury expenses.
- Disaster-related funeral expenses.
- Disaster-related pet boarding fees.
- Expenses related to replacing necessary personal and household items such as clothing, appliances, tools, and educational materials.
- Clean-up items.

- Disaster-damaged vehicle expenses.
- Disaster-related moving and storage expenses.
- Food lost due to the disaster (flooding, power outage, etc.)

Note: Do not mistakenly equate a household's total disaster losses with disaster expenses. For example, a family might report the destruction of their $80,000 home. However, only that household's out-of-pocket expenses that were not reimbursed or are **not** expected to be reimbursed during that benefit period would be considered for determination of eligibility, not the entire value of their destroyed home.

Verification

Verify disaster-related expenses only if questionable.

Benefit Calculation

DRP, DFAP

The household's net (take-home) income received or expected to be received during the benefit period **plus** its accessible liquid assets **minus** unreimbursed disaster-related expenses equals the countable disaster income. Bridges compares this amount to the disaster income limits based on group size. If the household's disaster income is less than or equal to the disaster income limit, the household is eligible for DRP and /or DFAP; see Income Eligibility and Allotment Tables in this item.

Note: The DHS-3221, Disaster Food Assistance Application Worksheet, may be completed if Bridges is unavailable.

BENEFIT ISSUANCE

Disaster assistance is issued through the normal electronic benefit transfer (EBT) process; see BAM 401E, Electronic Benefit Transfer Issuance System.

Semi-Annual Contacts/ Mid-Certifications/ Redeterminations

FIP, FAP, CDC

EDG's that are active and due for review in the month the disaster occurred will have their review date extended by two months in Bridges. The FAP certification period end date will also be extended in Bridges. This allows workload relief, so redeterminations, semi-annual contacts and mid-certifications are not handled during the disaster.

HEARINGS

DRP, DFAP

Who May Request

Any household that applied for disaster assistance benefits and was denied benefits may request a fair hearing.

Who May Not Request

Households that never applied for disaster assistance for any reason do not have a right to a fair hearing. This includes households that were unaware of the DRP/DFAP programs or were not able to apply during the application period.

Denials

Clients do **not** have the right to reopen their denied case in order to have their eligibility recalculated because their personal circumstances have changed during or after the application period.

Supervisory Review

A household which has requested a fair hearing is entitled to an immediate, on-site expedited supervisory review which in no way shall interfere with the applicant's right to a fair hearing.

Withdrawal of Request

If a head of household wants to withdraw its request for a fair hearing, the request may be done verbally or in writing. Send a written confirmation of the withdrawal when the client verbally withdraws their fair hearing request.

Hearing Decisions

If an administrative law judge finds in favor of the client, and the client is due a benefit issuance, central office will issue the benefit through a manual process.

RECOUPMENT

Recoupment for DRP and DFAP will be a manual process. The DRP and DFAP agency error, client error and suspected intentional program violation (IPV) must be a priority for recoupment specialists. Recoupment must be started within six months after the disaster. The recoupment procedures will follow current processes in place for each type of error excluding the exceptions listed below.

An IPV committed in DRP/DFAP will increase the number of IPV's a client has. The IPV will be served on regular cash and/or FAP.

Exceptions

Overpayment Processing

When the specialist discovers a potential overpayment (OP) regarding the disaster, make a referral to the Overpayment Establishment Analyst (OEA) within **30 days** of suspecting an OP has occurred using the DHS-4701, Overissuance Referral.

The OEA must make disaster OPs their first priority. Within **30 days** of receiving the referral, the OEA must establish the claim or refer the suspected intentional program violation (IPV) to Office of Inspector General (OIG).

Suspected IPVs must be a priority with OIG and within **30 days** an agent must have determined if the overpayment is an agency or client error or OIG continues with the investigation for IPV. Within **120 days** of receiving the referral, OIG must determine if the case is an IPV and return to the OEA for entering the claim on Bridges.

Overpayment Period

The benefit period for DFAP will be one month. DRP will be three months of benefits for each disaster.

Benefit Collections

Overpaid disaster benefits will automatically be recouped from all respective ongoing benefits. Automated recoupment will never be deducted from disaster benefits.

Collections of disaster benefits will follow the current processes.

LEGAL BASE

DRP

42 USC 602(a)

DFAP

7 CFR 280.1INCOME ELIGIBILITY AND ALLOTMENT TABLES

DRP Payment Standard

Group Size	DRP Payment
1	$918
2	$1,209
3	$1,476
4	$1,791
5	$2,082
6	$2,484
7	$2,715
8 or more	Add $240 for each additional person

DRP Monthly Income Limit

Group Size	Monthly Income Limit
1	$1,805
2	$2,428
3	$3,052
4	$3,675
5	$4,298
6	$4,922
7	$5,545
8 or more	Add $623 for each additional person

DFAP Maximum Allotment Effective 10-1-24

Group Size	Maximum Benefit
1	$ 292
2	$ 536
3	$ 768
4	$ 975
5	$ 1,158
6	$ 1,390
7	$ 1,536
8	$ 1,756
Each Additional Member	+ $ 220

DFAP Monthly Income Limit Effective 10-1-24

Group Size	Income Limit
1	$2,171
2	$2,620
3	$3,068
4	$3,529
5	$4,015
6	$4,500
7	$4,948
8	$5,397
Each Additional Member	+ $449