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3618.15.00 SPEND-DOWN SUMMARY NOTICE (MED 1, MED 2)

3618.20.00 MEMBER SERVICES (MED 1, MED 2)

3620.00.00 FOOD STAMP ACCOUNTABILITY (F)

3620.10.05 Retention Of Issuance Materials (F)

3620.15.10 Other Returned Food Stamp Benefits (F)

3699.00.00 FOOTNOTES FOR CHAPTER 3600

3600.00.00 BENEFIT ISSUANCE

This chapter presents policy regarding benefit issuance. The chapter covers:

Representatives and Protective Payees (Section 3605);
Food Stamp Issuance/Benefits, Cash Benefits/Issuance (Section 3610);
FS and MA Identification Cards (Section 3615);
Food Stamp Issuance/Accountability (Section 3620); and
Footnotes for Chapter 3600 (Section 3699).

3605.00.00 REPRESENTATIVES AND PROTECTIVE PAYEES

An AG may designate an authorized representative to receive FS benefits, use FS benefits, or present medical expense verification for Medicaid spend-down eligibility purposes. Additionally, in certain defined circumstances a protective payee may be assigned by the Local Office to receive a TANF check.

3605.05.00 AUTHORIZED REPRESENTATIVE (F)

The Food Stamp AG may designate an authorized representative to receive Food Stamps and/or use the Food Stamps on behalf of the AG. The authorized representative is named on AEFAR and the name appears on the EBT card if the person is authorized to access the Food Stamps.

There is no limit on the number of individuals that may be designated as authorized representatives by the AG; however, only one representative can be listed on AEFAR and the EBT card. The authorized representative must not be an AG member.

Authorized representatives designated for application processing purposes for food stamps may also carry out other household responsibilities during the certification period such as reporting changes for the household.

3605.05.05 Withdrawal of Authorization (F)

The authorized representative authorization is valid only for the current entitlement period. The payee or another responsible AG member may withdraw the authorization at any time. Withdrawal of authorization will be made upon request in person, by telephone, or in writing. Requests made in

person or by telephone must be entered in ICES. Written requests will be placed in the case record.

3605.05.10 Restrictions On Representatives (F)

The following restrictions apply to authorized representatives:

- State employees and Food Stamp retailers authorized to accept food stamp benefits cannot act as authorized representatives unless no other individual is available to act on behalf of the individual;
- Individuals disqualified for fraud cannot act as authorized representatives during the period of disqualification, unless the disqualified individual is the only adult member of the AG able to act on the AG's behalf; and
- Providers of meals for the homeless may not act as authorized representatives for homeless individuals.

3605.05.15 Documentation And Control Of Representatives (F)

There is no limit placed on the number of individuals a representative may represent. When employers such as those employing migrant/seasonal farm workers are named as representatives, or when a single representative has access to a large number of EBT cards or Food Stamp benefits, caution should be exercised to ensure the following:

- that the payee or another responsible AG member freely requested the representative;
- that the individual's situation is correctly represented;
- that the representative is receiving the correct amount of benefits; and
- that the representative is using the Food Stamp benefits properly.

3605.05.15.05 Evidence of Misrepresentation (F)

When evidence is obtained that an authorized representative has misrepresented an individual's circumstances and has knowingly provided false information or has improperly used Food Stamp benefits, the representative may be disqualified from participating as an authorized representative. This disqualification may be for a period of up to one year.

A written notice must be sent to the affected AG and the authorized representative 30 days prior to the date of disqualification. This notification will include:

- the proposed action;

the reason for the action;
the AG's right to request a fair hearing;
the telephone number of the Local Office; and
the name of the caseworker to contact for more information.

Disqualification of representatives does not apply in the case of drug/alcohol treatment centers and those group facilities which act as authorized representatives for their residents. In these instances, the facility is liable for any overissuance which may occur.

3605.15.00 SPECIAL REPRESENTATIVE CIRCUMSTANCES (F)

Special provisions exist for authorized representatives for residents of drug/alcohol rehabilitation centers, residents of facilities for the blind and disabled, and residents of shelters for battered women and children. These situations are discussed in the following sections.

3605.15.05 Drug/Alcohol Treatment Center Representative (F)

The resident in the facility is prohibited from applying on his own behalf. The residents of drug/alcohol treatment centers shall apply and be certified through the use of an authorized representative who shall be an employee. The employee of the facility will apply for as well as receive and spend benefits on behalf of the residents.

3605.15.05.05 When The AG Leaves The Facility (F)

Once the AG leaves, the center is no longer allowed to act as that AG's authorized representative. The center shall, if possible, provide the AG with a change report form (DFC-2420) to report to the Local Office the individual's new address and other circumstances after leaving the center, and shall advise the AG to return the form to the Local Office within 10 days.

When the AG leaves the center, the center shall provide the resident AG with his EBT card. The departing AG shall also receive its full allotment if no Food Stamp benefits have been spent on behalf of that individual AG. These procedures are applicable any time during the month. However, if the Food Stamp benefits have already been issued and any portion spent on behalf of the individual, and the AG leaves the treatment and rehabilitation program prior to the 16th day of the month, the treatment center shall provide the AG with one-half of its monthly Food Stamp benefit allotment. If the AG leaves after the 16th day of the month and the allotment has already been issued and used, the AG's allotment is gone for the month.

3605.15.05.10 Liabilities And Penalties Of Facilities (F)

Facilities will be held responsible for any misrepresentation or fraud it commits in the certification of facility residents. As an authorized representative, the facility must be knowledgeable about the individual's circumstances and should carefully review those circumstances with residents prior to applying on their behalf.

In addition, facilities will be held liable for all losses or misuse of Food Stamps held on behalf of residents and for any over issuances which occur while the individual is a resident of the facility. A benefit recovery referral will be filed against the facility for any overissuance of Food Stamps.

If there is reason to believe a facility has misappropriated or used Food Stamp benefits for purchases that did not contribute to an entitled individual's meals, the Local Office will promptly notify the Central Office, who will notify the United States Department of Agriculture (USDA). USDA may disqualify a facility as an authorized retail food store and may suspend the facility's authorized representative status for the same period.

If the facility loses its authorization from USDA (whereby the facility can no longer act as the authorized representative) or, if the facility loses its certification from USDA, the facility is no longer an eligible institution. As a result, residents of the center are no longer eligible to participate.

3605.15.05.15 Group Living Arrangement (F)

Residents in these facilities may apply on their own behalf or through an authorized representative. The group facility must ensure that each resident's Food Stamps are used for meals intended for that resident, regardless of whether the facility purchases and prepares food consumed by eligible residents or if the residents purchase and prepare food for their own consumption.

If the resident applies with the facility as the authorized representative, the facility may obtain and use the Food Stamp benefit allotment for food prepared by and/or served to the residents, or the facility may allow the resident to use all or any portion of the allotment on his own behalf.

If the resident is certified on his own behalf, the Food Stamp benefit allotment may be:

returned to the facility to be used to purchase food for meals served either communally or individually;
used by eligible residents to purchase and prepare food for their own consumption; or

used to purchase meals prepared and served by the facility.

3605.15.05.20 Food Stamp Benefits Used In Shelters For Battered Women And Children (F)

Food Stamp benefits may be used by shelter residents in any one of the following ways:

Shelter residents may use the Food Stamp benefits to purchase meals prepared specifically for them at the shelter;
A shelter resident may designate the shelter as an authorized representative so that the shelter can purchase food for meals served to the resident; or
Shelter residents may use the Food Stamp benefits to purchase food for their own consumption.

3605.20.00 AUTHORIZED REPRESENTATIVE FOR SPEND-DOWN ELIGIBILITY

If the recipient has authorized in writing a representative to apply for MA on his behalf, that representative may also provide verification of incurred medical expenses without a separate authorization. Additionally, the recipient may authorize a different individual to provide medical expense documentation. The signed authorization may be time limited or indefinite.

3605.25.00 PROTECTIVE PAYMENTS (C)

The protective payment system is a procedure by which a non-AG member is appointed by the Local Office to receive and manage the TANF payments. Protective payments are to be utilized when:

The TANF payee has demonstrated such an inability to manage funds that the TANF payments have not been used in the best interest of the child; (f1)

The parent is a minor required to live with a supervisory adult who receives the minor's TANF benefit in the form of protective payments. (f3a)

The protective payment procedure enables the Local Office, without the intervention of the court, to select and appoint another individual to receive the TANF payment. The protective payee is expected to manage or supervise the expenditure of the TANF payment so as to protect the best interest of the child until discharged from such responsibility by the Local Office.

3605.25.05 Money Mismanagement (C)

Protective payments may be made when the payee mismanages funds deliberately or because of inexperience or lack of training in money management. They are intended for caretaker relatives who have the capacity to learn to manage their funds. They are not intended for caretaker relatives whose mental or physical limitations would prevent them from learning how to manage their own affairs.

3605.25.05.05 Criteria For Determining Mismanagement To Exist (C)

Consideration is to be given to the appointment of a protective payee when it is clearly established that the caretaker relative persistently mismanages the TANF payments to the detriment of the child. Evidence of such mismanagement must be clear and specific. Examples of such evidence include, but are not limited to:

- Continued refusal or inability to properly feed or clothe the dependent child;
- Continued expenditures made for nonessentials or for other items so as to threaten the child's chances for healthy growth and development;
- Continued, persistent, and deliberate failure to meet obligations for rent, food, or other essentials;
- Repeated evictions or incurring of debts with attachments or levies made against current income;
- Continued inability to plan and spread necessary expenditures over the usual period between assistance checks; and
- Conviction of an TANF payee of a drug felony. Mismanagement is presumed to continue until such time as the convicted felon has successfully complete a state certified drug treatment program or has completed the court ordered sentence for the offense.

Documentation is to be entered in the case record of the evidence that demonstrates the need for protective payments. (f4)

<u>Before</u> steps are taken to appoint a protective payee, the Local Office must first undertake special efforts to develop greater ability on the part of the caretaker relative to manage funds. Specialized services are to be given on family budgeting and purchasing, meeting financial obligations, debt management, and so forth. The individual must be notified that continued misuse of the TANF payments will result in protective payments. If there is then continued evidence of persistent mismanagement of the TANF payments, protective payments are to be arranged.

3605.25.10 Reserved

3605.25.15 Standards For Selection Of The Protective Payee (C)

The selection and appointment of the individual designated to receive the TANF payment in behalf of the AG is to be made by the Local Office in accordance with the following standards:

- Interest in and concern with the well-being of the AG members. This interest may have been demonstrated by regular and frequent visits to the AG or past efforts to help the AG at time of crisis.
- Ability in ordinary household budgeting, experience in purchasing food, clothing, and household supplies within a restricted income, and knowledge of effective household money management practices;
- Willingness to serve as a protective payee without remuneration;
- Geographical proximity or means of transportation to the AG to be accessible for frequent consultation on budgeting and other money payment problems;
- Ability to establish and maintain positive relationships with members of the AG. The protective payee must assume a teaching role to facilitate the acquisition of new money management skills in money mismanagement cases; and
- Capacity to handle highly confidential AG information.

The protective payee may be:

- A relative, friend, or neighbor;
- A member of the clergy;
- A member of a church or community service group;
- A staff member of the Local Office or another social service agency; or
- A home economist with a public or voluntary organization.

The protective payee may not be:

- The Director of a Local Office;
- The caseworker/supervisor determining financial eligibility for the AG;
- Special investigative or resource staff;
- Staff handling fiscal processes related to the AG; or
- A landlord, grocer, or other vendor of goods or services dealing directly with the AG. [f6]

To the extent feasible, the TANF AG is to participate in and consent to the selection of the person designated as the protective payee. [f7]

The Local Office should make a potential protective payee aware of his responsibilities by:

- Reviewing the responsibilities listed on Form 337, Agreement with Protective Payee for TANF Grant; and

Supplementing the agreement by an oral discussion of said responsibilities, the objectives of protective payments, and the nature and frequency of the reporting expected by the Local Office.

3605.25.20 Responsibilities Of The Protective Payee (C)

Responsibilities of the protective payee include:

- Paying maintenance needs (such as rent, utilities, food, clothing, and so forth) from the cash benefit;
- Explaining to the TANF AG how the cash benefit will be spent;
- Keeping records of payments received and disbursements made and providing the Local Office with a general report of the disbursements every six months; and
- Treating confidentially all personal information concerning the AG.
- For money mismanagement situations, helping the caretaker relative to appropriately handle and manage the AG's funds. It is recommended that the protective payee allow the caretaker relative to participate in decisions or at least have the opportunity to discuss expenditures before they are made. As the caretaker relative demonstrates the ability to use the funds appropriately, the protective payee is to gradually increase self-management until the caretaker relative is able to manage the entire TANF payment.

3605.25.25 Protective Payment Review Period (C)

The Local Office is responsible for reviewing and evaluating each protective payment case at least every six months to determine if the protective payee is carrying out his responsibilities in the best interest of the child. In addition, for cases involving money mismanagement, the situation is to be reviewed to determine if progress is being made by the AG in overcoming money mismanagement problems. A decision is to be made to:

- Restore the AG to regular money payment status;
- Continue the AG under protective payment status; or
- Arrange for the appointment of a legal guardian when it appears that the AG is unable to respond to the beneficial effects of the protective payment plan or progress is so slow as to require continuation of the plan beyond the 24 month limitation on protective payments. [f8]

3605.25.30 Protective Payment Time Limitation (C)

A protective payment arrangement in money mismanagement cases is limited to 24 months. [f9] The protective payee and caseworker are to make every effort to eliminate the

money mismanagement problem sooner than the 24 month limitation.

There is no specific time limitation on the protective payment arrangement in minor parent cases.

For TANF AG's headed by minor parents, protective payments are discontinued if one of the following circumstances occurs:

- The minor parent reaches the age of 18
- The minor parent has become exempt from the requirement (See Section 3215.05.25.05)

3605.25.35 Protective Payee Authorization Procedures (C)

The following procedures are to be used in authorizing a protective payee:

- The new payee must acknowledge his acceptance of protective payee responsibilities in writing. Both he and the Director of the Local Office are to sign Form 337, Agreement With Protective Payee For TANF Grant, one copy of which is sent to the AG. The protective payee receives the original while a third copy is retained in the casefile.
- The appointment of a protective payee is made known to ICES by coding "Y" in the PP/REP? field on the Assistance Group Payees screen (AEFPY). A screen designed to capture information about authorized representatives and protective payees (AEFAR) will then appear. Completion of this screen informs the system that the TANF check is to be sent to the new payee's address rather than that of the AG. A system-generated notice then advises the protective payee and the AG that the protective payee will be receiving the TANF warrant directly for use in providing for the needs of the AG. The protective payee will also receive copies of all TANF eligibility notices sent to the AG.

3605.25.40 Change Of Protective Payee

In the event that it is necessary to change the protective payee, the authorization procedures contained in the previous section are to be followed in authorizing a new protective payee.

3610.00.00 FOOD STAMP ISSUANCE/BENEFITS

Sections 3610.05.00 through 3610.30.20 discuss Food Stamp issuance and benefits, including warrants.

3610.05.00 ISSUANCE TYPES (F)

Issuance of Food Stamps is performed by Electronic Benefit Transfer (EBT) where the client uses a debit card at the store to make food purchases.

3610.05.25 Staggered Issuance (F)

AGs who access Food Stamp benefits on the normal issuance cycle have their issuance days staggered over the first 10 days of each month. The EBT issuance cycle is as follows:

1st LETTER	DAY	1st LETTER	DAY
A, B	1st	M, N	6th
C, D	2nd	O, P, Q, R	7th
E, F, G	3rd	S	8th
H, I	4th	T, U, V	9th
J, K, L	5th	W, X, Y, Z	10th

Exceptions to Staggered Issuance requirements are:

AGs that are receiving their initial month's benefits; and
AGs that meet expedited criteria.

3610.05.30 Validity Periods (F)

Food Stamp allotments have a validity period of one year from the month the benefits are authorized. If not used within the one year time period, the benefits are expunged.

3610.05.35 Combined Issuance (F)

An AG must receive the prorated allotment for the month of application and the first full month at the same time when the following situation exists:

The AG is not eligible for expedited service, and
The application is made after the 15th day of the month, and
all required information/verification is provided, and all necessary activities to determine eligibility are completed by the 30th day from application, and
the AG is determined eligible for the month of application and the following month.

The AG must also receive a combined issuance if the AG applies after the 15th of the month and is eligible for expedited service.

Screen AEWAA will require that both months be authorized at the same time.

The following are exceptions to this rule:

The combined issuance rule does not apply to migrant and seasonal farm worker AGs unless there were more than 30 days during which the AG did not participate. This would mean that the initial month's benefits would not be prorated. Therefore, if there is no proration for the migrant/seasonal farm worker AGs, the first month they do not receive combined allotments.
If the first month's allotment of less than $10 is prorated to zero, the issuances are not to be combined; however, the AG must receive benefits by the eighth day of the first full month, if eligible.

3610.05.40 Maximum Time Between Issuances (F)

AGs that participate longer than two consecutive, complete months should have no more than 40 days elapse between any two issuance dates. Since each AG is placed on an issuance schedule that will allow it to receive benefits on the same date each month, this will not be a problem.

3610.10.00 AUXILIARY BENEFITS (C, FS)

The system automatically generates benefits for current and future months once they have been authorized on AEWAA. However, it is necessary to issue auxiliary benefits whenever the recurring Food Stamp, Cash Assistance or Child Care benefit must be augmented or replaced. When an underpayment occurs for a month prior to the recurring month, procedures should be followed to restore benefits. (Refer to Section 3610.15.00)

Examples of situations requiring auxiliary issuance include:

Verified FS and TANF changes after cut-off which will increase benefits for the following month;

The replacement of lost, stolen, or destroyed benefits (TANF only);

A warrant has been cashed, as shown on the State Auditor's Recon File;

The refund of FS and TANF claim overpayments;
Timely fair hearing requests necessitating an increase in FS or TANF benefits after cut-off;

Fair hearing results requiring the issuance of retroactively higher FS or TANF benefits;

Changes in agency policy which require FS or TANF retroactive benefit increases or next month increases after cut-off.

To generate auxiliary benefits it is necessary to access the Cash Auxiliary Request screen (BICS) for cash auxiliaries, or the Food Stamp auxiliary request screen (BIFS) for Food Stamp auxiliaries. NOTE: All auxiliary requests must be approved by the supervisor on BIOR. The auxiliary issuance is authorized when the supervisor enters an "A" for approved on BIOR.

3610.10.05 Lost, Stolen, Destroyed Warrants

An auxiliary benefit is never authorized for a lost, stolen or destroyed warrant. An affidavit is signed and sent to the State Auditor's Office for a rewrite warrant.

Only if a warrant has been cashed, as shown on the State Auditor's Recon File, and the client certified that the signature is not their own, would an auxiliary benefit be authorized.

3610.10.10 Lost Or Stolen EBT Benefits/Card (F)

Replacement issuances should not be completed when benefits are lost, stolen or misplaced after receipt. Clients who report such occurrences should be advised to contact EBT Customer Service to request a new EBT card and contact the local law enforcement agency if the benefits were stolen.

3610.15.00 RESTORING BENEFITS (F)

The Local Office must restore benefits when a determination is made that benefits were under issued because all or part of the AG's benefits were denied, delayed, or terminated due to administrative error. Benefits must be restored even if the AG is currently ineligible.

For Food Stamps only:

Benefits will be restored to the AG for not more than 12 months prior to whichever of the following occurred first:

> The date the Local Office was notified by the AG or by another individual or agency in writing or orally of the possibility of lost benefits; or
> The date the Local Office discovered in the normal course of business that a loss of AG benefits occurred.

EXCEPTION: Benefits must be restored when the collections on a claim exceed the amount owed, without regard of the 12 month time frame.

3610.15.05 Payments Of Benefits Wrongly Withheld (F)

An AG's benefits which were found to have been wrongfully withheld will be restored. Screen BVUI collects information regarding an under issuance.

Benefits will be restored for a period of not more than 12 months from whichever of the following dates occurred first:

- the date the Local Office receives a request for restoration; or
- the date fair hearing action was initiated.

Benefits will not be restored for any period more than one year from the date the Local Office is notified of, or discovers, the loss.

3610.15.10 Errors Discovered By The Local Office (F, C)

If the Local Office determines that an AG is entitled to restoration of under issued benefits, the Local Office must take action to restore benefits. It is the Eligibility Worker’s responsibility to complete the restoration. The under issuance is not referred to Benefit Recovery.

A restoration for the current month should be done as an auxiliary. A restoration for any previous months should be done as an under issuance. Screen BVUI is used to start a restoration and screen BVUO completes the process and sends the auxiliary to the supervisor for approval. If these under issuance screens are used, any overpayments will be offset by the restoration and the client will receive an ICES generated notice of the restoration and the accompanying appeal rights. Screen BVUO displays all outstanding over issuance claims against which an under issuance claim may be offset. See Section 4635.15.00 for more information.

3610.15.15 Disputed Restorations (F)

If an AG believes it is entitled to restoration of under issued benefits but the Local Office, after reviewing the case information, does not agree, the AG has 90 days from the date of the determination by the Local Office to request a fair hearing. The Local Office must restore under issued benefits to the AG only if the fair hearing decision is favorable to the AG.

Benefits lost more than 12 months prior to the date the Local Office was initially informed of the AG’s possible entitlement will not be restored.

If the AG disagrees with the amount to be restored as calculated by the Local Office or any other action taken by the Local Office to restore under issued benefits, the AG may request a fair hearing within 90 days of the date the AG is notified of its entitlement.

If the fair hearing decision is favorable to the AG, the Local Office must restore any under issued benefits in

addition to those previously restored, in accordance with that decision.

3610.15.20 Computing The Amount To Be Restored (F)

To prevent future losses, correct the error and then determine the months affected (excluding those months for which benefits may have been lost prior to the 12 month limit) and calculate the amount to be restored.

3610.15.20.05 Determining The Months Affected (F)

If the AG was eligible but received an incorrect allotment, the under issuance of benefits must be calculated only for those months the AG participated.

If the under issuance was caused by an incorrect delay, denial, or termination of benefits, the months affected by the under issuance must be calculated as follows:

- For an under issuance due to erroneous denial, the month the under issuance initially occurred will be the month of application;
- For an eligible AG filing a timely reapplication, the month following the expiration of its entitlement period will be the month of application;
- For an under issuance due to erroneous delay, the months for which benefits may have been lost due to the Local Office’s delay must be calculated; and
- For an under issuance due to erroneous termination, the month the under issuance initially occurred will be the first month benefits were not received as a result of the erroneous action.

3610.15.20.10 Calculation Of Under Issued Benefits (F)

The caseworker must then calculate the amount of the restoration for each month subsequent to the date the under issuance initially occurred until either the first month the error was corrected, or the first month the AG is found ineligible.

Documentation must establish the AG’s eligibility for each month affected by the loss. If information is not available that verifies the AG’s eligibility, the Local Office must advise the AG of the information that must be provided to determine eligibility for those months. For each month the AG cannot provide the necessary information to demonstrate its eligibility, the AG must be considered ineligible.

Calculating the amount of the restoration can be completed in Scratch Pad by entering the correct information and running Scratch Pad ED/BC. Then BVCC should be accessed to

view a month-by-month summary identifying the restoration amount.

3610.15.20.15 Determining Amount To Be Restored (F)

The amount of the restoration due an AG is to be based on the issuance tables that were in effect at the time of the incorrect issuance. If the AG received a smaller allotment than it was eligible to receive, the difference between the actual and correct allotment equals the amount to be restored.

3610.15.20.20 Completion Of ICES Screens For A Restoration (F)

When the worker needs to complete an auxiliary to restore under issued benefits for a previous month, the worker must complete BVUI. An under issuance claim initially entered on BVBR may also be updated on BVUI.

The worker may access BVCC or BVMC and use one of these screens to calculate the under issuance claim. The amount calculated on BVCC or BVMC will display on BVUI. If the amount of the under issuance claim is changed, it should be recalculated on BVMC or BVCC.

After BVUI is completed, BVUO should be accessed. BVUO displays the current status of the under issuance claim and displays any outstanding claims against which the under issuance may be used to offset. After BVUO is completed, the worker must invoke PF16 from BVUO to issue the auxiliary. When PF16 is invoked the status is changed to "aux pending" and the supervisor receives an alert to approve the claim. The supervisor then cancels or approves the auxiliary on BIOR.

When the supervisor takes action to approve or cancel the auxiliary, system updates the status of BVUI to CA (cancel) or CL (closed).

3610.15.25 Lost Benefits - IPV (F)

If the decision of disqualification for Intentional Program Violation (IPV) is subsequently reversed, the individual is entitled to restoration of benefits lost during the period of disqualification not to exceed 12 months prior to the date of Local Office notification.

The amount to be restored must be determined by comparing the allotment the AG received with the allotment the AG would have received had the disqualified member been allowed to participate.

3610.15.30 Method Of Restoration (F)

Regardless of current eligibility, benefits must be restored by issuing an allotment equal to the amount of benefits that were under issued minus any offsets when an outstanding benefit recovery claim exists.

For eligible AGs, the total amount to be restored must be issued in addition to the current amount. For ineligible AGs, the amount to be restored must be issued in a lump sum.

The Local Office must honor reasonable requests by AGs to restore benefits in monthly installments if, for example, the AG fears that the amount restored is more than it can use in a reasonable amount of time.

Whenever a restoration of benefits is due an AG and the AG's composition has changed, lost benefits must be restored to the AG containing the majority of individuals who were AG members at the time the loss occurred. If the Local Office cannot locate or determine the AG which contains the majority, benefits must be restored to the AG containing the payee at the time the under issuance occurred.

3610.15.35 Replacement Of Food Destroyed In A Disaster (F)

An AG may request replacements for any food purchased with Food Stamp benefits destroyed in a disaster. The AG may be eligible for a replacement issuance provided in the amount of the loss, up to a maximum of one month's allotment, unless the issuance included restored benefits, which shall be replaced up to their full value.

To qualify for a replacement the AG must report the destruction to the Local Office within 10 days of the incident and sign an FS-48 attesting to the destruction of the AG's food. The FS-48 must be received by the local Food Stamp Office within 10 days of the date of the report if signed in the office. If mailed to the AG, the FS-48 is to be sent within one work day of the report. If the FS-48 is not received within 10 days of the date of the report or returned within 12 days of mailing, no replacement shall be made.

Upon receiving a request for a replacement the Local Office must:

> Verify the disaster through either a collateral contact, documentation from a community agency including, but not limited to, the Fire Department or the Red Cross, or a home visit;
>
> There is no limit to the number of replacement issuances for food purchased with Food Stamp benefits which was destroyed in an AG disaster.

Authorize an auxiliary on BIFS in the amount of the replacement. The replacement issuance shall be provided to the AG within 10 days after the report of the loss or within two working days of receiving the FS-48, whichever date is later.

Where FNS has issued a disaster declaration and the AG is eligible for emergency Food Stamp benefits, the AG shall not receive both the disaster allotment and a replacement allotment under this provision.

When the request for a replacement for food lost in a disaster is denied, a manual notice FS-41 must be sent to the Assistance Group.

3610.20.00 CASH BENEFIT ISSUANCE (C)

When cash benefits have been authorized on ICES, the system produces warrant tapes (containing all relevant benefit information) which are sent to the State Auditor's office. It is from these tapes that the benefits are generated and routed to the Electronic Benefit Transfer (EBT) system.

Benefits which have been approved on AEWAA are generated automatically from month to month until a change is put into the system. This type of issuance is known as the recurring cash payment and is made available to the payee on or as near as possible to the first business day of the month.

The issuance of non-recurring (auxiliary) benefits, unlike the automatically generated monthly payment, requires on-line intervention. When the monthly benefit must be augmented or replaced, an auxiliary request is made on BICS. (See Section 3610.10.00 for a discussion of auxiliary benefits.)

3610.20.05 (Reserved)

3610.20.05.05 (Reserved)

3610.20.10 Unrestricted Money Payment (C)

The TANF benefit is delivered without restriction to the payee. This means that the TANF benefit is for the sole use and benefit of the AG in whose behalf the award is made.

When the TANF benefit is issued, the AG is responsible for handling the funds. The Local Office may assist in planning expenditures, but such service is to be provided in such manner that the expenditures are not controlled. A payee may find it necessary to delegate the actual expenditure of

the AG's money to relatives and friends, but such an arrangement is not considered a restrictive action. If the Local Office determines that the payee is unable to handle the funds in the best interest of the child(ren), steps are to be taken to appoint a protective payee. (f12) (See Section 3605.25.00)

3610.20.15 Endorsement Of Checks (C)

TANF checks cannot be cashed unless they are endorsed personally by the payee. If a protective payee has been appointed, the protective payee is to endorse the check in his own name. If a legal guardian has been appointed, the legal guardian is to endorse the check.

If the payee is unable to sign his name in writing, he is to sign by mark and this mark is to be witnessed by two persons who are to sign their names. Additional documentation may be required by the financial institution handling the transaction.

A check may not be endorsed after the death of a payee. If the payee dies before a check is delivered or before it is endorsed, the check must be returned to the Local Office in order to allow a new check to be issued for the remaining AG members. The TANF check does not become part of the assets of any payee's or recipient's estate. The authority of a protective payee or legal guardian to endorse checks terminates immediately upon the death of the caretaker relative.

Payments are automatically authorized by ICES following the case action deadline.

3610.20.25 Returned Benefits

Benefits which the post office is unable to deliver are not forwarded or delivered to another address, but are sent to the Local Office. The following ICES inquiries should be made upon receipt of a returned warrant or MA ID:

The Case Information Screen (AEICI) should be checked to determine whether a more current address is on the system;
The Assistance Group Eligibility History Screen (IQAE) will provide current eligibility information;
The Assistance Group Payees Screen (AEFPY) should be checked for an alternate address or (if the returned benefit is a TANF check) a protective payee; and
For warrants, the Cash Issuance History screen (IQCH) should be checked to determine whether a stop payment has been requested. (The warrant status field will be coded SR for a request; SP if the stop payment has been executed and a replacement issued.)

If a new address is found on ICES or has been reported by the AG, the TANF warrant benefit is to be redirected as discussed in Section 3610.20.05.05.

Warrants only: If the Local Office is unable to find a new address for the AG, the returned warrant may be cancelled on the Cancel Held/Returned Benefits screen (SFRB). Should it become necessary to provide the benefit after cancellation, an auxiliary warrant is to be requested on the Cash Auxiliary Request screen (BICS). The benefit must be made available if the AG's whereabouts become known during the period covered by the warrant. (f13)

3610.20.30 Replacement Of Lost Or Stolen Warrants (C)

Whenever a recipient notifies the Local Office of the loss or theft of his TANF check, the Local Office is to:

Enter a stop payment on ICES within 72 hours of the notification of loss or theft from the AG. Stop payment requests are made on SFSP;

Inform the payee that he must immediately complete and sign State Form 45735(12-92) Affidavit for Lost or Not Received Warrant, before a replacement warrant will be issued and that failure to immediately execute said affidavit will delay the replacement of the check;

Mail the affidavit to:

Office of the State Auditor
State House, Room 240
Attention: Dawn Hendry
Indianapolis, Indiana 46204

NOTE: To rewrite the check, the State Auditor's Office must receive the original affidavit. A photocopy or fax is unacceptable.
Any inquiries as to specific stop payment requests or check rewrites should be directed to Financial Management at (317) 232-4252 or (317) 232-4725.

Inform the AG of the right to appeal to the Hearings and Appeals Section if a replacement check is not issued within 17 working days after the date the recipient signed the affidavit. (f14)

During the 72 hour period allowed Local Offices for issuance of the stop payment order it should be determined that a check was actually mailed to the AG and that adequate time for delivery of the check has passed. Under no circumstances should the Local Office refuse to allow a payee to execute the affidavit when he requests to do so.

If fraud is suspected, the Local Office should conduct an investigation. However, the issuance of a replacement check is not to be delayed because of the fraud investigation.

3610.20.35 Warrant Registers (C)

The recurring warrant register is a detailed listing of all monthly recurring cash benefits. These listings are generated each time a recurring pull down or daily run is processed and are distributed to the districts in the form of computer printouts. Warrant registers reflect action authorized through ICES. Information on each warrant register is listed in district, county, unit, category, case, and sequence number. Other information listed includes:

- payee name;
- street address;
- city;
- state;
- zip code;
- warrant number;
- warrant date; and
- warrant amount.

A duplicate warrant register is generated by township and the local agency is responsible for mailing the warrant register to each township trustee.

3610.20.40 Outstanding Warrants (C)

If a TANF check is outstanding according to records in the County Treasurer's Office for any period in excess of 60 days, the Local Office is to reinvestigate the circumstances of the AG to determine whether he continues to be eligible for assistance.

3615.00.00 FS AND MA IDENTIFICATION CARDS

Sections 3615.05.00 through 3615.10.00 discuss identification cards.

3615.05.00 FOOD STAMP EBT (HOOSIER WORKS) CARDS (F)

To participate in the Food Stamp Program, an AG must obtain an EBT Hoosier Works card. The card is used at participating retailers where food items may be purchased:

- when an eligible AG purchases a Specialty Meal (Communal Dining or Meal Delivery Service, See Section 1460.10.05 - 1460.10.10).

EBT cards may be released to any of the individuals named on the card. Access to EBT cards is restricted to authorized individuals. The EBT card will contain:

- the name of the payee (unless it is a vault card) and the 16 digit card number, if there is an authorized representative, this person has his own card;
- the signature of the AG member, the authorized representative will sign his own card.

The AG must immediately report loss or theft of the EBT card to customer service or liability for its misuse is solely the responsibility of the AG. The client must request a new card be sent.

Once an AG is authorized on AEWAA, an EBT card is mailed overnight unless a vault card is issued over-the-counter. When a new card is issued, the old card is no longer valid for transactions.

See the EBT Policy Guide for issuance, replacement and destruction of EBT cards.

3615.10.00 MEDICAID IDENTIFICATION CARDS (MED)

The Medicaid Identification Card is the authorization by which the individual secures Medicaid benefits. The card is a permanent plastic ID card expected to be retained by the recipient during his/her lifetime. It contains the Recipient ID (RID) number, name, date of birth, and sex. The ID card does not denote a specific eligibility period. The recipient must present the ID card to each Medicaid provider from whom he requests medical services, and the provider is responsible for verifying eligibility through the automated verification process. Local Offices are not responsible for verifying recipient eligibility periods for providers. Providers are responsible for either seeing the ID card or obtaining the RID from the recipient and verifying eligibility in order to file their claims for services. If there is a delay or problem in the generation of the ID card, Local Offices should provide the RID to the recipient or to providers who inquire.

(January 1995 was the last month for the ICES-generated monthly paper Medicaid cards.)

3615.10.05 Issuance Of Medicaid Cards (MED)

From the date a new recipient is first approved and authorized, it will take approximately two weeks for the recipient to receive the card. Generally, within four days of authorization, IQMA will reflect the generation of the card. It then takes an additional three days to produce the card and at least another three days for mailing. If, after four days from the date of authorization, IQMA does not show the card generation, the Policy Answer Line should be contacted.

Individuals who are eligible for Medicaid under the spend-down provision will receive an ID card the same as non-spend-down recipients. However, their eligibility is determined on a month by month basis in accordance with Section 3615.15.05.

3615.10.05.05 Issuance Of Medicaid Cards To Homeless Individuals (MED)

For a recipient who has no fixed address, specific arrangements must be made with him regarding the issuance of his Medicaid card.

The card will be mailed to the address specified by the recipient, such as:

- the Local Office;
- a friend or relative;
- social service agency;
- church; or
- shelter for the homeless.

3615.10.10 Replacement Of ID Cards (MED)

A Medicaid ID Card which has been lost, stolen, or damaged can be replaced by accessing screen BIMD. However, a replacement cannot be requested if IQMA does not show that an original card has been generated. Before requesting a replacement, it is necessary to wait a full seven days from the date on IQMA indicating card generation. This allows the appropriate length of time to produce and mail the card. If, within the full seven days, the client still has not received the card, the caseworker must check the recipient's address on AEICI or AEIII as appropriate, and make sure it is entered correctly before requesting a replacement.

3617.00.00 SPEND-DOWN EFFECTIVE DATE PRIOR TO 1-1-06 (MED 1, 2)

The policies stated in this section apply to MA A, MA B, and MA D. Within MED 2, the policies only apply to the MA Q category of assistance.

Prior to January 1, 2006, a spend-down effective date was determined each month when the recipient submitted documentation of incurred medical expenses to the Local Office. The spend-down effective date was the date on which the amount of the incurred medical expenses equaled or exceeded the spend-down amount. Refer to Section 3618.00 for the new automated spend-down procedures implemented on January 1, 2006.

The documentation was presented to the local office in person or by mail/fax by the recipient or by an individual whom the recipient authorized in writing to act on his behalf.

Screen BIMT was used to track incurred medical expenses in order to determine whether the spend-down amount was met for the benefit month. Use of this screen is now limited to

instances when it is necessary to correct a spend-down effective date established by the system prior to 1-1-06.

3617.05.00 MULTIPLE RECIPIENT SITUATIONS PRIOR TO 1-1-06 (MED 1, 2)

The information in this section is applicable only when a spend-down effective date that was established prior to January 1, 2006 must be corrected to an earlier date. Current spend-down procedures follow in Section 3618.

The policies in this section apply to the MA A, MA B, and MA D categories of assistance. Within MED 2, the policy only applies to MA Q.

In situations where more than one member of the AG qualifies under the spend-down provision, the following principles apply:

A recipient couple's combined medical expenses must equal or exceed the surplus income. Both are eligible when the spend-down amount is incurred.

When there is a recipient child and a recipient parent, both with surplus income, each is responsible for incurring his own medical expenses and each will have a separate spend-down.

When there is a recipient child and both parents are recipients, the recipient child with surplus income must incur his own medical expenses. The parents must also meet a spend-down by incurring their own combined medical expenses. If only one of the parents is a recipient, equal shares of the nonrecipient adult's medical expenses are applied toward his spouse's spend-down and his child's spend-down.

When two or more children are recipients with surplus income, equal shares of their nonrecipient parents' medical expenses are applied toward each child's spend-down. If both parents are recipients, their medical expenses are applicable to their own spend-down and each child's medical expenses count toward his own spend-down. If only one parent is a recipient, equal shares of the nonrecipient adult's medical expenses are applied toward his spouse's spend-down and each of his children's spend-down.

3617.15.00 CALCULATION OF EFFECTIVE DATE DEDUCTIBLE (MED 1, 2)

The information in this section is applicable only when a spend-down effective date that was established prior to January 1, 2006 must be corrected to an earlier date.

The policies in this section apply to the MA A, MA B, and MA D categories of assistance. Within MED 2, the policy only applies to MA Q.

The deductible represents the amount which the Medicaid program will not pay for services rendered on the spend-down effective date. It is only applicable to that particular date (when the total of the incurred medical expenses equals the spend-down amount.)

The formula for calculating the deductible for a single recipient or a recipient with a nonrecipient spouse is as follows:

Total Incurred Amount (up to and including the effective date)
- Spend-Down Amount
= Amount Medicaid Can Pay

Amount Incurred on Effective Date by Recipient (other than health insurance premiums and old bills)
- Amount Medicaid Can Pay
= Deductible

EXAMPLE 1:

The spend-down amount is $236 for April.

The recipient presents the following expenses:

Date	Amount	
4/01	$40	
4/02	75	
4/06	11	
4/06	50	
4/12	19	unpaid
4/12	71	unpaid
Total =	$266	

The spend-down effective date is 4/12 with a $60 deductible determined as follows:

$266 (total incurred amount)
-236 (spend-down)
= $ 30 (amount Medicaid can pay)

$ 90 {amount incurred on effective date by recipient ($19 + $71)}
- 30 (amount Medicaid can pay)
$ 60 (deductible)

EXAMPLE 2:

The spend-down is $50 for April.

The recipient presents the following expenses for himself and his wife:

Date	Amount	Description
4/02	$20	wife
4/05	15	wife
4/05	20	recipient (unpaid)

Total = $55

The effective date is 4/5 with a $15 deductible determined as follows:

  $55 (total incurred amount)
  -50 (spend-down)
= $ 5 (amount Medicaid can pay)

  $20 (amount incurred by recipient on effective date)
  - 5 (amount Medicaid can pay)
= $15 (deductible)

EXAMPLE 3:

The spend-down is $100 for April.

The recipient presents the following expenses for himself and his nonrecipient wife:

Date	Amount	Description
4/04	$20	wife
4/10	10	wife
4/10	20	recipient (unpaid)
4/10	60	recipient’s health insurance

Total = $110

The effective date is 4/10 with a $10 deductible determined as follows:

  $110 (total incurred amount)
  -100 (spend-down)
= $ 10 (amount Medicaid can pay)

  $ 20 (total incurred by recipient on effective date excluding health insurance premium)
  - 10 (amount Medicaid can pay)
= $ 10 (deductible)

The formula for calculating the deductibles for a recipient couple is as follows:

Total Incurred Amount (up to and including the effective date)

- Spend-down Amount
= Amount Medicaid Can Pay
Amount Incurred on Effective Date by Couple (other than health insurance premiums and old bills)
- Amount Medicaid Can Pay
= Couple Deductible

The couple deductible must then be divided between the spouses, as appropriate, according to the following guidelines in order to assign the Individual deductible:

If only one spouse incurred expenses on the effective date, the couple deductible becomes that spouse's Individual Deductible.
Assign the couple deductible first, in whole or in part, to the spouse with paid expenses (excluding health insurance premiums). Assign the remaining amount to the spouse with unpaid expenses.

If all expenses on the effective date are paid, assign the couple deductible to one spouse if the expense equals or exceeds the deductible. Otherwise, divide the couple deductible and assign it equitably.

EXAMPLE 1:

Recipient couple's spend-down for May is $100. Incurred expenses are as follows:

5/1	$50	husband
5/2	$60	husband
Total =	$110	

The effective date is 5/2; the Couple Deductible is $50, determined as follows:

$110 total incurred amount
-100 spend-down
= $ 10 amount Medicaid can pay

$ 60 amount incurred by couple on effective date
- 10 amount Medicaid can pay
= $ 50 Couple Deductible

The Individual Deductibles are:

$ 50 husband
$ 0 wife

EXAMPLE 2:

Recipient couple’s spend-down for September is $100.
Incurred expenses are as follows:

9/1 $50 husband
9/3 $30 husband; unpaid
$60 wife; paid
Total = $140

The effective date is 9/3; the Couple Deductible is $50 determined as follows:

$140 total incurred amount
-100 spend-down
= $ 40 amount Medicaid can pay

$ 90 total incurred by couple on effective date
- 40 amount Medicaid can pay
= $ 50 Couple Deductible

The Individual Deductibles are:

$ 50 wife
$ 0 husband

EXAMPLE 3:

Recipient couple’s spend-down for June is $75.
Incurred expenses are as follows:

6/2 $10 husband
6/3 $15 wife; paid
$20 wife; unpaid
$30 husband; unpaid
$20 husband; paid
Total = $95

The effective date is 6/3; the Couple Deductible is $60, determined as follows:

$95 total incurred amount
-75 spend-down
= $20 amount Medicaid can pay

$85 total incurred by couple on effective date
-20 amount Medicaid can pay
= $65 Couple Deductible

The Individual Deductibles are:

$50 husband
$15 wife

3617.35.00 AUTHORIZATION OF PROVIDER CLAIMS (MED 1, 2)

The information is this section is applicable only if a spend-down effective date that was established in the system prior to 1-1-06 must be corrected to an earlier date, and a provider rendered services on the new effective date.

The policies stated in this section apply only to MA A, MA B, and MA D. Within MED 2, the policies only apply to the MA Q category of assistance.

Providers who render services to a recipient on the spend-down effective date must have a payment authorization, Form 8A, in order to receive Medicaid reimbursement. This authorization is sent to the providers by the Local Office. Local Offices are not to send a Form 8A, Notice to Provider of Recipient Deductible, to a provider who was paid in full by the recipient. A provider who has been paid will not submit a claim to Medicaid. Please remember that Form 8A must contain only the Medicaid number, that is, RID, not the ICES case number. The RID for an individual can be found on screen AEIPC.

After determining the effective date and deductible, the Local Office is to complete a Form 8A for each provider who was not paid in full by the recipient on the spend-down effective date. The deductible is to be assigned to one provider, unless the deductible is greater than any of the providers' charges. In that case the deductible is to be divided between two or more providers. A copy of each 8A is to be retained in the hard copy case file.

All claims for services rendered on the spend-down effective date will be rejected by the Fiscal Contractor unless a payment authorization is attached. The deductible will be subtracted from the amount of the provider's Medicaid claim. All claims for services rendered after the spend-down effective date are submitted to the Fiscal Contractor in the usual manner. An authorization of payment is not required in such situations.

A problem arises when a hospital is required to submit separate billings for Medicare Parts A and B and the full deductible will be subtracted from each claim total when the claim is received by Medicaid, causing an incorrect payment. This situation can be prevented if the worker will issue two Forms 8A with differing deductible amounts for inpatient and outpatient hospital bills incurred on the same day by recipients with Medicare A & B coverage when the hospital requests it. In this particular instance, the worker could simply consider that the outpatient services are being provided by one provider, and inpatient services by another; consequently, two Forms 8A would be issued, one showing a deductible, the other showing none.

When a pharmacist files a Medicaid claim for more than one prescription dispensed on the spend-down effective date, the Local Office must list each prescription number on the bottom of the Form 8A with a deductible shown for each prescription. If the pharmacist is billing Medicaid for only one prescription it is not necessary to list the prescription number.

Claims for multiple prescriptions dispensed on the effective date will be rejected by the Fiscal Contractor of the prescription numbers are not listed with a deductible for each.

3618.00.00 THE PROCESS OF SATISFYING SPEND-DOWN (MED 1, MED 2)

This section applies to MA A, MA B, MA D and MA Q.

The spend-down process works basically like an insurance deductible. Recipients have access to Medicaid covered services at the first of every month in which they are enrolled. Medicaid will reimburse claims once the spend-down amount is satisfied.

Providers will submit recipient claims to IndianaAIM just as they do for all fee-for-service members. The spend-down amount will be applied to claims for Medicaid covered services and will be deducted from the amount, if any, that Medicaid reimburses on the claim. For example, a recipient with a $50 spend-down goes to his pharmacy to get his prescription refilled. The cost of the prescription is $75 and the Medicaid co-payment is $3. The member is responsible for $50, which includes the Medicaid co-payment, and Medicaid covers the remainder in accordance with Medicaid reimbursement rules. Later in the month, his doctor gives him a new prescription which he takes to the pharmacy. Because his spend-down is already satisfied, Medicaid reimburses the pharmacy. The recipient owes the $3.00 co-pay and it will be automatically carried forward to the next month to satisfy spend-down. Certain allowable medical expenses cannot be filed as claims directly to IndianaAIM. These expenses are referred to as non-claims and must be submitted to the Local Office of Family Resources. Refer to Section 3618.05.00 which explains how non-claims are to be considered. These expenses are transmitted electronically to AIM to satisfy spend-down.

Providers must first bill any third party insurance of the recipient before billing Medicaid. A medical expense that is subject to payment by a third party will not be considered for satisfying spend-down until the third party adjudicates the claim. The amount that can credit spend-down is the amount owed by the recipient after the third party payment. For recipients who also have QMB (MA L)

coverage, their Medicare coinsurance and deductibles will not credit spend-down, since QMB Medicaid pays those costs.

3618.05.00 NON-CLAIMS SUBMITTED TO LOCAL OFFICES (MED 1, MED 2)

This section applies to MA A, MA B, MA D, and MA Q.

Certain medical expenses apply to spend-down and must be submitted to the Local Office because they cannot be filed directly by providers to the AIM system. These expenses are called non-claims and are as follows:

1. Medical services paid for by a state or local program such as CHOICE or Township Trustee assistance. For these expenses, documentation from the provider of the service must be submitted and it must contain a statement from the provider that he or she will bill the state or local program, not Medicaid. A state or local program is one which is funded 100% by state or local funds.

   Any service which is paid for by the CHOICE program must be an allowable medical expense in order for the expense to be entered as a non-claim and allowed to satisfy spend-down. For example, home health care provided by a licensed home health agency is an allowable expense. However, in addition to medical home health care, the CHOICE program pays for non-medical in-home services that can't be used to satisfy spend-down. Therefore, specific documentation is required in order to allow a non-claim for an expense that the provider will bill to CHOICE. The documentation from the provider must list the specific service provided and the procedure code. The allowable home health services and their procedure codes are listed below:

Licensed Home Health Aide	99600
Registered Nurse (RN)	99600TD
Licensed Practical Nurse (LPN)	99600TE
Physical Therapy	G0151
Occupational Therapy	G0152
Speech Therapy	G0153

   This information is required in order for the services to be correctly considered for spend-down. If the documentation presented lists other service types or procedure codes for home health services, the expense must be entered as a disallowed non-claim.

Documentation submitted from providers must indicate that the services will be billed to CHOICE, not Medicaid. If this statement does not appear on the bill/statement, the expense is not allowed. The preferred documentation is a copy of the provider's invoice to the Area Agency on Aging.

2. Medical services received from a provider who does not participate in the Medicaid program. Local Offices must contact the provider and verify that s/he is not a Medicaid provider if that information is not documented on the bill/receipt received by the Local Office.

3. Medical services received by non-recipient spouses and parents whose income was used to determine the spend-down.

4. Bills for medical services received before the recipient became eligible for Medicaid.

5. Co-payments required by other insurance coverage and Medicare.

A non-claim will be applied to spend-down in the month following the month the Local Office receives the receipt/bill, unless the recipient wants it to be applied to the month of the medical service or to the month the expense is submitted to the Local Office. Local Offices must maintain fail-safe controls that ensure that no non- claim expense is ever counted for spend-down more than once. Hard copies of the documentation must be retained subject to regular record retention rules.

All expenses that the local office receives must be entered in ICES except a bill for a service that should be filed as a claim to Medicaid. These are not non-claims and the local office must notify the provider (if faxed to the local office) or the recipient of the proper procedure to follow.

Allowable Medical Expenses (f18):

Listed below are the types of medical expenses that can credit spend-down. Medical services of the recipient must be billed to the AIM system except in the circumstances described above for non-claims. At the end of this section are verification requirements for non-claims.

1. Medical care provided by physicians, psychiatrists, and other licensed medical practitioners;

2. Laboratory testing, x-rays, and other diagnostic procedures;

3. Dental services including dentures provided by a licensed dentist;

4. Hospitalization and outpatient treatment;

5. Nursing facility services and rehabilitative services;

6. Respiratory, occupational, speech, physical, and audiology therapy services;

7. Prescription drugs and over the counter medication (including insulin) when prescribed by a licensed medical practitioner who is authorized under State law to prescribe legend drugs. For Medicare beneficiaries, this includes drugs that are excluded from coverage under Medicare Rx. Excluded drugs **include** barbiturates, benzodiazepines, and over-the-counter drugs that are Medicaid covered. A Prescription Drug Plan may choose to cover a Medicare excluded drug, in which case the cost of the drug is not an allowable medical expense in the Medicaid budget. An excluded drug under Medicare Rx is different from a non-formulary drug. Refer to 3618.05 for a list of non-allowed medical expenses.

8. The cost of postage incurred by the individual for mail-order prescriptions;

9. Medical supplies if ordered in writing by a licensed physician or dentist for treatment of a medical condition;

10. Durable medical equipment if ordered in writing by a licensed physician;

11. Home health care provided by a licensed home health agency;

12. Nursing services provided by a registered nurse or licensed practical nurse;

13. Audiology services and hearing aids if ordered in writing by a physician;

14. Prosthetic devices other than those dispensed for purely cosmetic purposes, if ordered in writing by a physician, optometrist, or dentist;

15. Vision care services, including eyeglasses, examinations, and diagnostic procedures;

16. Cost of transportation to obtain medical services that are allowable medical expenses. If transportation is provided by a business transportation carrier, the verified carrier's charge will be allowed. If the individual or friend, or family member drives the individual to medical services, mileage costs is allowed at the rate per mile established for state employee business travel. The state employee business travel rate of $0.40 will be allowed for medically-related transportation expenses incurred on or after 10-1-09. (If incurred 7-1-08 through 9-30-09, the allowed amount was $0.44 per mile; if incurred prior to 7-1-08, the allowed amount was $.40 per mile.)

17. The premium of the recipient's spouse who is on MED Works (MADW);

18. Co-payments required by other health insurance that covers the individual, including Medicare Rx co-payments. The Medicaid co-payments are allowable medical expenses when the recipient is satisfying spend-down and will be credited to spend-down by the AIM system when the claim is filed by the provider.

19. Any waiver service approved for the individual who is approved under one of the Medicaid Home and Community-Based Services (HCBS)

20. Targeted case management services provided to pregnant women, individuals with HIV, and individuals receiving services from a community mental health center under the Medicaid rehabilitation option.

VERIFICATION OF NON-CLAIM MEDICAL EXPENSES:

Verification of non-claim medical expenses will include the type and amount of the expense, the date the expense is incurred, whether or not it is reimbursable by a third party, and the reimbursed amount. Medical expenses and third party reimbursed amounts can be verified by the following:

Bill from a provider;
Receipt from a provider;
Written statement from a provider; and/or
Telephone contact with the provider, as a last resort.

Verification must show whether a third party has or will be billed, and if a third party has paid, the amount of the payment must be shown so that the DFR staff can determine the individual's out-of-pocket expense.

Medicare or other insurance reimbursement can also be verified by the Medicare Summary Notices that Medicare sends

to beneficiaries and other explanation of benefit notices from insurance payers.

For transportation expenses incurred from a non-business carrier, a record of the provider's name, address and date of service for the expense must be provided. MapQuest or similar website can be used by the DFR staff to determine the distance traveled.

3618.10.00 DISALLOWED NON-CLAIMS (MED 1, MED 2)

This section applies to MA A, MA B, MA D, and MA Q.

If an expense is subject to payment by a third party that has not yet adjudicated the claim, the expense is to be entered into the system as disallowed. Local office staff must follow the ICES data entry procedures very carefully. This will ensure that proper information is given to the recipient on the monthly Spend-down Summary Notice. If the third party has adjudicated the claim when it is submitted to the local office, the portion that the individual owes, that is, the out-of-pocket cost is the allowable amount.

Non-allowed expenses include the following and will not credit spend-down:

1. Special diets and nutritional supplements.
2. Emergency response systems.
3. Non-medical home care such as companions, attendants, homemakers, etc.
4. Home and vehicle repairs/modifications to accommodate a handicapped individual.
5. For Medicare beneficiaries, drugs that are not on the Prescription Drug Plan's formulary.

Non-allowed claims will be listed on the Spend-down Summary Notice as not being applied to spend-down.

3618.15.00 SPEND-DOWN SUMMARY NOTICE (MED 1, MED 2)

On the second business day of every month the IndianaAIM system generates the monthly Spend-down Summary Notices. A notice will be issued to every spend-down recipient for whom claims or non-claims were applied to spend-down during the month. A copy of the notice will be sent to authorized representatives. In the case of a recipient couple, each member of the couple will receive a notice. More than one month of claims activity may be listed on the notice. The notice reports claims and non-claims processed during the month without regard to the date(s) of the service.

The Spend-down Summary Notice is a very important document for spend-down recipients. The notice informs them of how and to what services their spend-down was applied. The notice informs them of the amount of their spend-down that they owe to each medical provider. Except for pharmacies, medical providers may not collect payment from their spend-down patients, until the patient is notified via the Spend-down Summary Notice of the amount of the bill that was applied to the patient's spend-down. Because of the point of service billing device used by pharmacies to submit Medicaid claims, they know the amount of the spend-down that was credited to their claim when the prescription is dispensed.

Local Office staff should stress to recipients and their authorized representatives the importance of retaining these notices. The notices are important for the client's personal record keeping. If recipients have questions about a certain amount that is shown as being owed to a certain provider, they should contact the provider first. Providers are notified via a weekly Remittance Advice (RA) statement of how much of a spend-down was applied to their claim. The provider's notification and the recipient's should match. If questions cannot be resolved with the provider, the recipient should contact Member Services. Local Offices do not receive copies of the Spend-down Summary Notices and do not have information available to them that would allow them to answer questions or resolve any problems relative to the information on the Notice. Refer to Section 3618.20.00 regarding Member Services.

Recipients have the right to appeal any information on the Spend-down Summary Notice with which they do not agree.

3618.20.00 MEMBER SERVICES (MED 1, MED 2)

Local Office staff members are responsible for informing applicants and recipients and their representatives about spend-down and how the process works. However, specific questions about the Spend-down Summary Notice and individual Medicaid claims must be addressed to Member Services. For these issues Local Offices are to tell recipients and their representatives to call Member Services at (317)713-9627 or toll-free at (800)457-4584.

3620.00.00 FOOD STAMP ACCOUNTABILITY (F)

This section provides guidelines for accountability of food stamp records.

3620.10.05 Retention Of Issuance Materials (F)

All issuance related materials such as: Affidavit for Replacement of Food Coupons (FS 48) forms and all EBT vault

card issuance records must be retained for three years and six months after the report or activity month. Also see the EBT Policy Guide for additional instructions for issuance materials maintenance.

3620.15.10 Other Returned Food Stamp Benefits (F)

Occasionally AGs will request that Food Stamp benefits be applied to a repayment on a claim. The benefits are paid back in the EBT BOSS system. The claim payment should then be entered as a payment in ICES on screen BVPC, using payment code “EB”.

Other reasons for repayments in BOSS are as follows:

The AG voluntarily withdraws;

The AG moves out of state;

Death of all AG members;

Late change after adverse that will result in a claim and the client requests that the benefits be returned in order to avoid a claim.

See Section 4635.05.05 for how to process this on SFRF or on BVPC.

(f18) 405 IAC 2-3-10

3699.00.00 FOOTNOTES FOR CHAPTER 3600

Following are footnotes for Chapter 3600:

(f1) Social Security Act, Section 406(b);
45 CFR 234.60
(f2) Social Security Act, Section 402(a)(26);
45 CFR 232.11;
45 CFR 232.12
(f3) Social Security Act, Section 402(a)(19);
45 CFR 224.51
(f3a) 470 IAC 10.1-2-5;
45 CFR 233.107
(f4) 45 CFR 234.60
(f5) Reserved
(f6) 45 CFR 234.60
(f7) 45 CFR 234.60
(f8) 45 CFR 234.60
(f9) 45 CFR 234.60
(f10) Reserved
(f11) Reserved
(f12) 45 CFR 234.60
(f13) 45 CFR 205.10
(f14) 470 IAC 2-4-12
(f15) NOT USED

(f16) 470 IAC 14-3-6
(F17) 470 IAC 14-3-6