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Foster Care Medicaid Basics

- ✗ Each foster child has a separate Medicaid case. The foster child is listed as “PI” on this case.
- ✗ Medicaid eligibility is determined for an entire month.
- ✗ A foster child must be a U.S citizen or qualified alien.
 - ◆ Birth, citizenship and identity verification are required.
- ✗ A foster child must be a resident of Utah.
 - ◆ A foster child receiving Title IV-E assistance from any State is eligible for Medicaid in the state in which the child is residing.
 - ◆ A foster child from another State, who does not qualify for the Title IV-E assistance is considered a resident of the State that has custody and is making the placement. These foster children are not eligible for Utah Foster Care Medicaid.
 - ◆ A Utah foster child, who is not IV-E Eligible and is placed out of state, may remain open for Utah Foster Care Medicaid if they meet all the requirements.
- ✗ A Social Security Number is required for Medicaid eligibility.
- ✗ Duty of Support must be completed by the agency that has custody of the child and forwarded to ORS.
- ✗ Third Party Liability (TPL) must be completed for each foster child and entered into eRep.
 - ◆ Do not deny Medicaid assistance while waiting for TPL information.
- ✗ A foster child must meet the age requirements for the specific Medicaid Program used to determine eligibility.
 - ◆ Age requirements vary for each Medicaid Program.
- ✗ Medicaid Eligibility of the foster child is determined on the income and assets of the child only, **unless the child is in custody through a voluntary placement agreement.**
 - ◆ When a foster child is placed in State Custody through a voluntary agreement, the FC Medicaid eligibility must be determined using the parent’s income and assets (if applicable), unless that child is IV-E Eligible and IV-E Reimbursable.
- ✗ A Foster Care Maintenance Payment must be made on behalf of the child in order for the child to be Foster Care Medicaid eligible.
 - ◆ A child placed in the home of their parent is not eligible for Foster Care Medicaid.
 - ◆ A runaway child is not eligible for Foster Care Medicaid.
- ✗ A foster child may be determined eligible for Medicaid using any one of several different Medicaid Programs.
- ✗ Medicaid Policy Manuals are available on the Internet at:
<http://utahcares.utah.gov/infosourcemedicaid/>

Medicaid Programs of Choice

Foster Care

- ☀ DD/MR Waiver
- ☀ Nursing Home (State Hospital placement)
- ☀ Foster Care Medicaid
 - ✓ IV-E
 - ✓ Blind/Disabled
 - ✓ Children's
 - ✓ Prenatal
 - ✓ NB/NB+
 - ✓ Pregnant
 - ✓ Emergency

Foster Children who are not eligible for Foster Care Medicaid can be eligible for Medicaid programs through DWS.

- ☀ Disabled Medicaid
- ☀ Family Medicaid Programs
- ☀ CHIP
- ☀ PCN

Adoption

- ☀ DD/MR Waiver
- ☀ Nursing Home (State Hospital)
- ☀ Subsidized Adoption

SA Medicaid is the program of choice over the Medicaid programs listed below. If a child that is eligible for SA Medicaid is open for one of these programs, notify the worker to close that Medicaid program and open the SA Medicaid.

- ☀ Disabled Medicaid
- ☀ Family Medicaid Programs

Subsidized Adoption

A subsidized adoption refers to the adoption of a child with special needs where an adoption assistance agreement is established between the adoptive parents and a state or local government agency. The adopted child may qualify for either Title IV-E or State adoption assistance.

A child who has an adoption assistance agreement in effect with a state or local government agency is eligible to receive Medicaid. It does not matter if the child is receiving a monthly cash subsidy. **There is no income or asset test for this type of Medicaid.**

DD/MR Waiver

Clients who are eligible for the DD/MR Waiver would be medically appropriate for institutional care. This waiver offers incentives for the client to remain at home or to live in a community setting like a group home. These clients are eligible for medical services that are not generally available to Medicaid recipients, such as day treatment programs, supported work, respite care, and group home placement.

The DD/MR worker will maintain information on clients who have been approved for the Waiver.

Nursing Home (State Hospital)

To qualify for Institutional or HCB Medicaid, a foster child must fit into one of the categories of coverage. AB&D Medicaid Section covers the categories for people who are Aged, Blind or Disabled. Family Medicaid Section covers the categories for children and for adults who have a dependent child in their home.

A person residing in a medical institution or who wants coverage under an HCB waiver program must meet the non-financial criteria for one of the Medicaid categories of coverage. Unless otherwise specified, the person can meet any one of the categories of coverage including Aged, Blind, Child, Disabled, Family or Prenatal coverage groups.

Disabled/Blind

A foster child receiving Supplemental Security Income (SSI) may be eligible for Medicaid. For a person under age 65, receipt of SSI means the person meets the disability or blindness criteria and the Citizenship/Qualified Alien Status requirements for Medicaid.

An individual must meet Social Security's definition of statutory blindness or the criteria for having a disabling condition to qualify for Blind or Disabled Medicaid.

- **Income - 100% of Poverty Level** (*Income of an SSI recipient is not countable*)
- **Assets- HH 1 \$2,000**

Income spend down is allowed.

IV-E

The First type of assistance provided to children in the custody of the state is referred to as Title IV-E assistance. Title IV-E eligibility is based on AFDC eligibility criteria in place in July 1996. Children receiving Title IV-E assistance are eligible for Medicaid under the FC/F program type.

- ✓ **See Title IV-E Foster Care Manual for income and asset information for initial and ongoing eligibility.**

Children

The second type of assistance provided to children in the custody of the state is referred to as Title XIX (Medicaid) assistance; Title XIX means Medicaid. Children receiving Title XIX (Medicaid) assistance may qualify for Medicaid under the FC/C program.

- **Income - BMS level - HH 1-\$382**
- **No asset test**

Income spend down is allowed.

Newborn/Newborn +

The Newborn Medicaid program covers foster children under age 19 who do not qualify for coverage under Children's and whose income does not exceed the income limit for their age group. This program covers children in two age groups. There are different income and asset rules for each group. The first group, Newborn (NB), covers children age 0 through the month in which they turn age 6. The second group, Newborn Plus (NB+), covers children age 6 through the month in which they turn 19.

NB (under age 6)

Income - 133% of Poverty level

Assets - no assets test

No spend down allowed.

NB+ (age 6-19)

Income - 100% of Poverty Level

Assets – no asset test

Prenatal

The Prenatal Program (PN) covers pregnant foster children that do not qualify for coverage under Children's and whose household net countable income does not exceed 133% of the federal poverty level for the household size. Once the pregnant woman is determined to be eligible for PN, she remains eligible through the end of her pregnancy and for an automatic postpartum period regardless of changes to the household's income and/or assets.

- ✓ **Income - 133% of Poverty Level**
- ✓ **Assets - \$5,000 asset spend down allowed**

No income spend down allowed.

Pregnant

Consider PG Medicaid coverage for a pregnant foster child only if she does not qualify for coverage under any other Medicaid program.

- ✓ **Income - BMS Level
HH 1 \$382**
- ✓ **Assets - \$2,000 HH 1**

Income spend down allowed.

Emergency

Emergency Medicaid is not a separate type of Medicaid. Emergency Medicaid provides coverage for only emergency services to individuals who meet all the requirements for a Medicaid program but are not U.S. citizens and do not meet the eligible qualified alien status requirements for full Medicaid coverage.

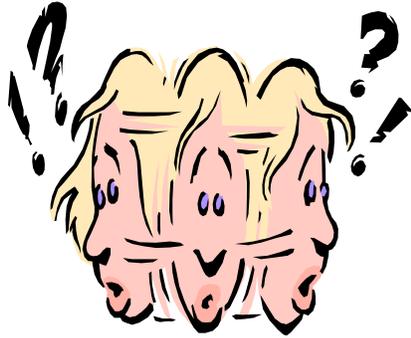
There are no special considerations for ineligible aliens for deeming income or determining household size. Follow the rules for the program type for which you are determining eligibility.

Foster Care Independent Living Program

Individuals aging out of the Foster Care System can receive Medicaid from age 18 until age 21 under this program. These youth must meet the following criteria:

- 18 years old but not 21 (eligibility runs through the month in which they turn 21)
- In Foster Care on their 18th birthday, under State custody through DCFS or DHS if the primary case manager is DCFS, or in the custody of an Indian tribe.
- Not eligible for another Medicaid program that does not require a spenddown or premium payment.
- Referred by DHS or a tribe as an individual in the Foster Care Independent Living program.
- Not in the custody of DJJS.
- No income or asset requirements.
- This program may be used for youth who remain in custody after age 18 if they don't meet the requirements for another Medicaid program.





What are the Medicaid Program Age Requirements?

Family/Children's Medicaid Program - FC/F & FC/C

To meet the dependent child requirements for Family and Children's Medicaid programs, a foster child must be under 18, or between the ages of 18 and 19 if all of the following are met:

1. The foster child is a full-time student, **AND**
2. Takes part in a program of secondary school or equivalent level of vocational or technical training (not post high school or college), **AND**
3. Expects to complete that educational program **before** reaching age 19.

Blind/Disabled Medicaid Program - BM/DM

The criteria for the Blind/Disabled Medicaid Program are the same for adults and children. No age requirement must be met.

Newborn Medicaid Program – NB

The Newborn Medicaid program covers children from birth to age 6 years. Children may receive coverage through the end of the month in which they turn 6 years old.

1. The eligibility worker must set an alert for when the foster care child turns age 6 to determine NB+ income eligibility.

Newborn Plus Medicaid Program - NB+

The Newborn Plus Medicaid program covers children age 6 years and older. Eligibility begins the month after the child turns age 6 and continues through the month in which the child turns age 19. There is no student or graduation requirement with this Medicaid program.

Prenatal & Pregnant Woman's Program - PN/PG

There is no age requirement for these Medicaid programs.

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CHIP

The CHIP program is available to children until age 19. A child found eligible for CHIP will be enrolled for 12 months unless the child turns 19, moves out of state, becomes eligible for Medicaid, or is covered under another health insurance program.

PCN

Adults age 19 to 64
Application during open enrollment period.

Foster Care Independent Living Program

Beginning July 1, 2006, individuals aging out of the foster care system can receive Medicaid from 18 until age 21 under the Foster Care Independent Living Medicaid Program. These youth must meet the following criteria:

- A. 18 years old but not 21 (eligibility runs through the month in which they turn 21)
- B. In foster care on their 18th birthday under State custody through DCFS or DHS with DCFS as the primary case manager, or in the custody of an Indian tribe.
- C. Not eligible for another Medicaid program that does not require a spenddown or premium payment.
- D. Is identified by DCFS, DHS or a tribe through electronic or written verification as someone who was in foster care on his or her 18th birthday.
- E. DCFS eligibility workers will provide electronic verification. At age 18, the eligibility worker will add a person alert to eRep to notify DWS of the Independent Living Medicaid eligibility status.

MAGI or Non-MAGI

"Modified Adjusted Gross Income," or MAGI

The term "Modified Adjusted Gross Income," or MAGI, refers to a methodology of determining if an individual is eligible for medical assistance. It is used for the following eligibility groups:

1. Parents and other caretaker relatives
2. Pregnant women
3. Children under age 19
4. Non-title IV-E foster children
5. Individuals infected with tuberculosis
6. Primary Care Network (PCN)
7. Utah's Premium Partnership (UPP)

B. Non-MAGI Groups

The MAGI methodology does not apply when determining eligibility for the following eligibility groups:

1. Individuals age 65 and older when age is the basis of eligibility.
2. Individuals who are blind or disabled when determining eligibility for the blind or disabled eligibility groups.
3. The Medicare Cost-Sharing programs.
4. Individuals in any category who are eligible for a medically needy eligibility group.
5. Individuals applying for nursing home eligibility.
6. Individuals who are applying for waiver services, with some exceptions for the New Choices waiver.
7. Individuals for whom an income determination is not required including the breast and cervical cancer program, the Former Foster Care Children, Foster Care Independent Living Program, state subsidized foster care, Title IV-E children, and Refugee Medical Assistance.
8. The MAGI methodology is not used by entities making presumptive eligibility decisions.

Medicaid Bus Pass Policy

- ✿ Children who are eligible for Foster Care or Subsidized Medicaid are eligible to receive a monthly bus pass if they live within the UTA or Cedar Area Transportation (CATS) service areas.
- ✿ Medicaid bus passes are to be used for transportation to and from medical treatment.
- ✿ The child must be able to use the bus. Coverage for an attendant if needed is allowed for children under age 18. An authorized representative must be designated in eRep and then an asterisk will appear next to the name on the bus pass. The asterisk tells the driver that these people are allowed an attendant to accompany them.
- ✿ Bus passes have 12 one-way trips on them.
- ✿ Medicaid recipients may receive as many bus passes, as they need to obtain Medicaid-covered services from a Medicaid provider. When the client has a medical condition requiring frequent treatment and takes the bus, document this in the case record; do not verify each appointment. Update the continued medical need at each review. If a recipient makes frequent requests for more bus passes, workers may request verification of the medical need for frequent trips.
- ✿ The bus passes also work on UTA Light Rail, but not on Front-Runner Commuter trains.
- ✿ Request a bus pass from the program home in eRep. Extra bus passes may be ordered by using the request a new Medicaid card function.
- ✿ Do not order bus passes for recipients who do not want them.
- ✿ Parents with small children who are eligible for Medicaid may request personal mileage reimbursement instead of bus passes. (*Adoption only*)
- ✿ See DOH policy 651-2 for bus passes on the website at:
<http://utahcares.utah.gov/infosourcemedicaid/>



When is it Income? When is it an Asset?

Income

- ✚ Income is cash or in-kind benefits a person receives.
- ✚ Count cash or in-kind benefits as income in the month a client receives it or when it is made available for the client's use.
- ✚ Income includes earned income and unearned income.

Asset

- ✚ An asset is something someone owns that is worth money.
- ✚ Assets include real property and personal property.
- ✚ Countable assets include all assets that are available to the client and are not exempt.
- ✚ Any amount of the cash or in-kind benefit remaining at the end of the month is counted as an asset in the month after it is received, unless it is a type of income that has special resource exclusions.
- ✚ An asset includes any portion of income that remains in someone's possession after the month it is received.

✚ **An item can never be both income and an asset in the same month, *except* as specified in Medicaid policy section 512 relating to trusts. Most foster children will not have the type of resource described in this section. Representative Payee Accounts do not fall into these categories. If you believe a foster child on your caseload has the type of trust described in this section, please contact one of the State Specialists.**

<http://utahcares.utah.gov/infosourcemedicaid/>



First Moment of the Month Rule

Disabled/Blind Medicaid Categories

503-2 "First Moment of the Month" Rule
<http://utahcares.utah.gov/infosourcemedicaid/>

S	M	T	W	T	F	S
				1		1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30						

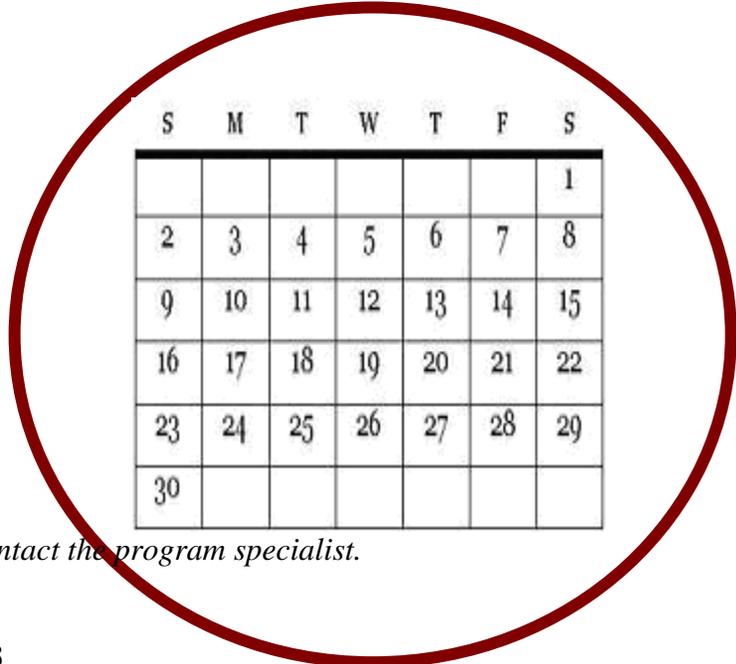
- ✗ Use assets held on the first moment of a calendar month to compute eligibility for that month. The case is ineligible for the entire month if countable assets exceeded the limit on the first moment of the month.
- ✗ Do not count anything as an asset if it is being counted as income in that month.
- ✗ Make sure that income for the month is not being counted in the asset balance.

Any Moment of the Month Rule

Family Medicaid Programs (*except Prenatal*)

503-2 When Must Assets Be Below the Asset Limit?

- ✗ If assets are below the asset limits at any time during the month, the client has met the asset limit rule for the entire month.
- ✗ Make sure that income for the month is not being counted in the asset balance.



***If using the PN program see DOH policy or contact the program specialist.*

Lump Sum Payments For Medicaid Eligibility

Medicaid policy 407

Count the net lump sum payment as income for the month it is received. Any amount remaining after the end of that month is considered an asset.

Family Programs

SSA lump sum payments are exempt as an asset for **9 months** after the month of receipt.

Disabled Medicaid

SSA & SSI lump sums are exempt as an asset for **9 months** after the month of receipt.

Lump sum payments are windfalls or retroactive payments of earned or unearned income. Lump sums include inheritances, settlements from personal injury suits, insurance settlements, awards, winnings, and gifts. They also include lump sums consisting of Social Security and Railroad Retirement benefits, VA lump sums, unemployment compensation lump sums, and other one-time payments. Earned Income Tax Credit (EITC) payments are NOT lump sum payments.



****Remember****

Cost of legal fees expended to make the lump sum available, payments for past medical bills, and funeral or burial expenses (if the lump sum was intended to cover funeral or burial expenses) are subtracted from the lump sum before determining income eligibility.

Any kind of lump sum payment of excluded earned or unearned income is excluded. If that kind of income is excluded, the lump sum payment is also excluded.

Do not count any lump sum payments received by an SSI recipient as either income or assets when determining if a child is eligible for Foster Care Medicaid.

Prenatal Medicaid Procedures



Scenario 1- Pregnant Foster Child open for FC Medicaid

Baby removed from the mother at the time of birth and placed in State custody.

- A IV-E/Medicaid determination will be made based on the child's information.
- A Foster Care Medicaid case will be opened (or denied) in eRep for the child based on the child's eligibility. A new eRep case will be created for the baby using the mother, who is also a foster child, as the removal home member on that case.
- The child will remain open for Foster Care Medicaid program as long as he/she remains eligible.

Scenario 2-Pregnant Foster Child open for FC Medicaid

The mother, who is a foster child, retains custody of the baby and the baby resides in the same foster placement as the mother.

- When the baby is born:
 - The mother of the baby should be referred to DWS to make application for Medicaid for the baby. The caseworker should assist the mother (foster child) with this process as needed.
 - A Social Security Number is required for Medicaid eligibility. Notify the caseworker to help the mother apply for a SSN as soon as possible. Coverage is allowed for 60 days until the SSN is obtained.

Scenario 3- Pregnant Foster Child Open for FC Medicaid

The baby is placed privately for adoption at the time of birth.

- When the baby is born:
 - The mother of the baby should be referred to DWS to make application for Medicaid for the baby. The caseworker should assist the mother (foster child) with this process as needed.

NOTE:

- ✓ **When using the PN program you look at the income and assets for the month of application (month pregnancy is verified) and then you don't consider any changes in income or assets until 60 days after the baby is born.**

**DJJS PRACTICE GUIDELINES FOR ONGOING MEDICAID
FOR YOUTH EXITING FOSTER CARE AT AGE 18**

Purpose: To provide continued Medicaid coverage until age 19 for an eligible youth who has had foster care Medicaid and is leaving state custody at age 18.

ELIGIBILITY WORKERS STEPS:

1. Identify 18-year old foster youth on caseload.
 - a. Set an eRep task or use an existing eRep task for three months prior to youth's 18th birthday.
 - i. Contact caseworker; in person, via e-mail or phone, for information regarding the permanency plan for the youth.
 - ii. Ask to be included in child and family team meetings or case staffing, including discussions to prepare the youth to transition from custody. The eligibility worker's role and participation in CFTM's and case staffing will be determined by the individual worker and office needs.
2. Inform caseworker of the process for determining ongoing Medicaid eligibility for the youth leaving foster care and the caseworker's role in the process.
 - a. Provide caseworker with *review Form 61 mr* approximately 60 days prior to planned custody termination. Caseworker should be made aware that this form must be completed and returned to the eligibility worker 30 days prior to planned custody termination date.
 - i. Request that verification of student status, income, assets and third party liability information be provided with review form. Income must be verified by interface match or hard copy. Caseworker and youth statement is acceptable verification of student status, assets and TPL information, unless the eligibility worker has reason to question that information.
Documentary evidence of birth and identity must be provided.
 - ii. Be available to answer questions from youth and caseworker.
 - iii. Eligibility staff should be available for individual team trainings and staffing in their area as needed.
3. DWS will do all determinations for ongoing Medicaid eligibility of youth exiting foster care at or after age 18.

4. When 61mr review form is received, review information.
 - a. Verify receipt of necessary information.
 - i. Ensure that review form is complete and requested verifications have been provided. Youth must sign the review form to acknowledge the rights and responsibilities. Request additional information from caseworker if necessary.
 - ii. Verify with caseworker the expected custody termination date.
 - b. Review information and ensure that all necessary documentation has been received. If you do not receive the review form, complete the referral to DWS. DWS can open the ongoing Medicaid program for 30 days while they attempt to obtain the information from the youth.
 - i. Send an e-mail to FosterCare_DWS@utah.gov The e-mail should contain the following information.
 - a) Client's name
 - b) PID
 - c) Date state custody is expected to end or has ended or the date the you turns 19.
 - d) Current address.
 - e) Program information.
 - f) Other necessary information (pregnancy, SSI, living arrangement etc.)
 - ii. Document in e-Rep program notes.
 - iii. Document in the e-Rep notes from the person home that this youth is not eligible for the Foster Care Independent Living Medicaid program because he was in DJJS custody on the 18th birthday.
 - iv. Send the appropriate e-Rep notices.
 - c. Transfer case and case information.
 - i. Receive e-mail from the **PHIL** team. E-mail will contain new case number for client.
 - ii. Send copies of initial 61FC Medicaid application, review form 61 mr, income, citizenship, identity and SSN verification, **with appropriate cover sheet** to, DWS Central Imaging Unit (CIU), imagingops.DWS@utah.gov. **Documentary evidence of citizenship and identity must be included.**
 - d. File eligibility record in the family case file.

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CASEWORKERS STEPS:

1. Identify 18-year old foster children on caseload.
 - a. Set an alert or use an existing alert for three months prior to youth's 18th birthday
 - i. Respond to eligibility worker's request for information.
 - ii. Complete *Medicaid Eligibility Review for Youth Leaving Foster Care*. Eligibility worker will provide form 60 day prior to expected custody termination.
 - iii. Caseworker is encouraged to include the youth in the review process.
 - iv. Assist youth in gathering requested verifications.
 - v. Submit completed review form to eligibility worker, along with requested verifications 30 days prior to planned custody termination date
 - vi. Provide Eligibility worker with all information necessary to complete the review process, including an accurate physical and mailing address for the youth after custody termination.
 - vii. Notify eligibility worker immediately of custody termination.
2. Familiarize youth with location of the nearest DWS office.
 - a. Local offices would be nearest location to expected living arrangement after custody termination.
3. Include in transition planning information to help the youth become familiar with Medicaid policies and procedures regarding Health Plans, billing by providers and mental health services.

STATE ADMINISTRATION STAFF STEPS:

1. Establish and review pathways between DHS and DWS.
 - a. Meet with regional DWS staff.
 - b. Establish pathways consisting of a DWS team to case manage foster care transfer cases.
 - c. Type and distribute approved pathways to DHS eligibility workers and appropriate state personnel.
2. Statewide training of DHS eligibility and administrative staff.

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- a. Develop a standard practice and procedure to be used by eligibility staff statewide.
 - b. Distribute pathway and procedural process to regional eligibility staff and help trouble-shoot problems in pathways being effective when needed at the state level.
3. Provide on-going support and clarification for eligibility workers and regional staff.
 4. Work with SAFE personnel, JJS and administration staff to develop an effective mechanism for having caseworker's follow-up on needed eligibility reviews for youth leaving care, such as an action item to be cleared by eligibility workers.

DEPARTMENT OF WORKFORCE SERVICES (DWS) STEPS:

1. Meet with DHS administration to establish pathways.
 - a. Pathways should consist of one or two contacts in each regional area familiar with case transfers from DHS eligibility workers.
2. DWS will accept referrals from DHS eligibility workers.
 - a. A new case will be registered in e-Rep when an e-mail with case information is received from a DHS eligibility worker. DWS will return an e-mail to the DHS eligibility worker with a case number for the new e-Rep case record and for imaging purposes
 - b. DWS should contact the current DHS eligibility worker if they receive a request for services and a Foster Care Medicaid program is showing "open" in e-Rep.

**DCFS PRACTICE GUIDELINES FOR ONGOING MEDICAID
FOR YOUTH EXITING FOSTER CARE AT OR AFTER AGE 18**

Purpose: To provide continued Medicaid coverage for an eligible youth who has had foster care Medicaid and is leaving state custody at or after age 18.

ELIGIBILITY WORKERS STEPS:

1. Identify 18 year old foster youth on caseload.
 - a. Set a SAFE action item or e-Rep task or use an existing action item or task for three months prior to youth's 18th birthday.
 - I. Contact caseworker in person, via e-mail or phone for information regarding the permanency plan for the youth.
 - II. Ask to be included in child and family team meetings or case staffing, including discussions to prepare the youth to transition from custody. The eligibility worker's role and participation in CFTM's and case staffing will be determined by the individual worker and office needs.
2. Inform caseworker of the process for determining ongoing Medicaid eligibility for the youth leaving foster care and the caseworker's role in the process.
 - a. Provide caseworker with **Review Form 61 mr** approximately 60 days prior to planned custody termination. Caseworker should be made aware that this form must be completed and returned to the eligibility worker 30 days prior to planned custody termination date. Caseworker should also be made aware that the youth must sign the 61 mr.
 - I. Request that verification of student status, income, assets and third party liability information be provided with review form. Interface match or hard copy must verify income. Caseworker and youth statements are acceptable verification of student status, assets and TPL information, unless the eligibility worker has reason to question that information. **Documentary evidence of citizenship and identity must be provided.**
 - II. Be available to answer questions from youth and caseworker.
 - III. Eligibility staff should be available for individual team trainings and staffing in their area as needed.
3. DWS will do all determinations for ongoing Medicaid eligibility of youth exiting foster care at or after age 18.
 - a. Beginning July 1, 2006, individuals aging out of the foster care system can receive Medicaid from 18 until age 21 under the Foster Care Independent Living Medicaid Program. These youth must meet the following criteria:

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- III. Set a caution alert on the person: Narrate in person notes that the client does or does not meet the requirements for Foster Care Independent Living Medicaid.
 - IV. Send the appropriate e-Rep notices
- c. Transfer case and case information.
- I. Receive e-mail from the **PHIL** team. E-mail will contain new case number for client.
 - II. Send copies of initial 61FC Medicaid application, review form 61 mr, income, citizenship, identity and SSN verification, **with appropriate cover sheet** to DWS Central Imaging Unit (CIU), imagingops@utha.gov **Documentary evidence of citizenship and identity must be included.**
 - III. Documentation submitted to the CIU should be identified with the new case number provided by the PHIL team. Documentation must be imaged under the new case number.
- d. File eligibility record in the family case file.

CASEWORKERS STEPS:

1. identify 18 year old foster children on caseload.
 - a. Set an alert or use an existing alert for three months prior to youth's 18th birthday.
 - I. Respond to eligibility worker's request for information.
 - II. Complete **Medicaid eligibility Review for Youth Leaving Foster Care.** Eligibility worker will provide form 60 days prior to expected custody termination.
 - III. Caseworker is encouraged to include the youth in the review process.
 - IV. Assist youth in gathering requested verifications.
 - V. Submit completed review form to eligibility worker, along with requested verifications, 30 days prior to planned custody termination date. Youth must sign the review form.
 - VI. Provider eligibility worker with all information necessary to complete the review process, including an accurate physical and mailing address for the youth after custody termination.
 - VII. Notify eligibility worker immediately of custody termination.
2. Familiarize youth with location of the nearest DWS office and with DWS online application process.

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- a. Local offices would be nearest location to expected living arrangement after custody termination.
3. Include in transition planning information to help the youth become familiar with Medicaid policies and procedures regarding health plan providers, billing by providers and mental health services.

STATE ADMINISTRATION STAFF STEPS:

1. Establish and review pathways between DHS and DWS.
 - a. Meet with state and regional DWS staff.
 - b. Establish pathways consisting of a DWS team to case manage foster care transfer cases.
 - c. Type and distribute approved pathways to DHS eligibility workers and appropriate state personnel.
2. Statewide training of DHS eligibility and administrative staff.
 - a. Develop a standard practice and procedure to be used by eligibility staff statewide.
 - b. Distribute pathway and procedural process to regional eligibility staff and help trouble-shoot problems in pathways effectiveness when needed at the state level.
3. Provide on-going support and clarification for eligibility workers and regional staff.
4. Work with SAFE personnel, JJS and administration staff to develop an effective mechanism for having caseworkers follow-up on needed eligibility reviews for youth leaving care, such as an action item to be cleared by eligibility workers.

DEPARTMENT OF WORKFORCE SERVICES (DWS) STEPS;

1. Establish pathways with DHS administration.
 - a. Pathways should consist of one DWS team to case manage youth exiting foster care at age 18.
2. DWS will accept referrals from DHS eligibility workers.

Medicaid Section

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- a. A new case will be registered in e-Rep when an e-mail with case information is received from a DHS eligibility worker. DWS will return an e-mail to the DHS eligibility worker with a case number for the new e-Rep case record and for imaging purposes.
- b. DWS should contact the current DHS eligibility worker if they receive a request for services and a Foster Care Medicaid program is showing “open” in e-Rep.

Medicaid Section

12/2014

EREP – RECEIVING FOSTER CARE AND SUBSIDIZED ADOPTION TRANSFER CASES

Revised: 3/21/2011

Effective: 3/21/2011

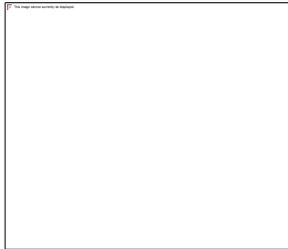
Introduction: Use this procedure when a foster care child or subsidized adoption child is leaving state custody at 18 years of age, becomes eligible for SSI, is pregnant, has children, or receives supportive services through DWS. For specific situations, see the Foster Care – Independent Living and special Situations procedure.

Note: These cases are high priority as there should not be a lack of coverage.

- 1. Received a case transfer referral from the FosterCare_DWS@utah.gov email for Foster care or Subsidized Adoption case from DHS worker.**
 - The email should include the information necessary to make determination of eligibility.
 - Name
 - PID
 - Date the state custody is ending or date the child turns 18
 - Current address, if known
 - Program information
 - Date review was sent to the client
- 2. Register NEW case in eRep.**
 - Refer to Case Registration procedure.
- 3. E-mail the DHS worker with the new eRep case number.**
 - The DCFS eligibility worker will send copies of applications, Form 61 mr, income, and any birth verifications they may have to Imaging Operations.
- 4. Narrate all actions on Case Notes.**

Note: ERep will automatically close the DHS case, based on the custody end date for Foster Care or the agreement end date for subsidized adoption and follows 10 day notice rules.

Keys to Medicaid Closures after Age 18



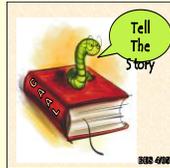
Case Closures

ERep programs will close with the custody end date entry or the end of the subsidized adoption agreement. Notices will be sent for these closures. If the program does not close and you process an administrative closure, a closure notice must be sent manually. The closures follow the 10 day rule.

Document, Document, Document!!!!

ERep notes must contain the details of the FC closure and NB+ determination.

Tell the Story!



Send the Closure Notices from ERep.

Notice of Medicaid case closure is a Medicaid requirement. The case is in error if the notice is not sent at case closure.

Independent Living Medicaid Program

Youth exiting Foster Care at or after age 18 can be eligible for Independent Living Medicaid until age 21 with no income or asset test. Follow the established practice guidelines for continued Medicaid eligibility and case transfer to DWS.

Former Foster Care Individuals

This program is for individuals who age out of foster care and are under the age of 26 if they are not eligible for SSI recipient Medicaid, poverty level child Medicaid, parent/caretaker Medicaid or pregnant woman Medicaid.

They must be age 18-26 and must have been enrolled in Medicaid when foster care ended.

**Former Foster Care – Independent Living and special Situations
DWS Procedure
Effective: 10/01/2014**

Introduction: These cases will require coordination between the Foster Care Eligibility Workers at the Department of Human Services and DWS eligibility. These cases are handled by a specialized worker and cases should be referred to *fostercare_dws@utah.gov*. A new case may need to be created and the case number should be sent back to the DHS worker as needed so that they can forward any needed verifications to be imaged.

<p>Former Foster Care – Independent Living 18-21 and 18-26</p>	<p>Use this section of the procedure when you receive a referral from DHS stating that the individual is aging out of Foster Care (turning 18 years old) or when an individual has indicated on their application they had been in Foster Care or those that have been in the custody of Catholic Community Services Foster Care System and on Medicaid at DWS. This procedure outlines specific requirements the child must meet to qualify for this program.</p>
<p>Minor Foster Care Mothers</p>	<p>Use this section of the procedure when a minor parent mother is currently open for Foster Care with DHS, and she gives birth to her own child.</p>
<p>Guardianship/Kinship Placement</p>	<p>Use this section of the procedure when you have a non-relative guardian who is interested in receiving Medicaid for a child.</p>
<p>Exiting Subsidized Adoption</p>	<p>Use this section of the procedure when there is an individual turning 18 years old and aging out of the Subsidized Adoption program.</p>

Former Foster Care - Independent Living

INTRODUCTION: Individuals aging out of the Foster Care system may qualify for a special coverage group under the Former Foster Care Independent Living program which has two groups; 18-21 and 18-26. There is not an income or asset test for either program. This procedure outlines the process on how to determine if a customer is eligible for Foster Care Independent Living and how to process the case.

1. **Receive email referral from the *FosterCare_DWS@utah.gov* email from DHS worker or from an eligibility specialist.**
2. **Determine if a new application is needed**

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- If the customer's Foster Care program is still open or has been closed less than 30 days, this would be a continuation of Medicaid, and a new application is not needed, however the youth must sign the rights and responsibilities form as well as TPL requirements. A review form is acceptable in gathering the information. eREP will automatically close the DHS case and follow 10-day notice rules.
- Customers who were placed in foster care under the Catholic Community Services (CCS) under the Unaccompanied Refugee Minor (URM) Program and age out of that program meet the criteria for Foster Care Independent Living as long as they are not eligible for any other Medicaid Program.
- If the customer's Foster Care DCFS or DCFS/DHS case has been closed for more than 30 days, new application is needed.
- The Department of Human Services (DHS) eligibility worker manages the Foster Care Independent Living program for youth who remain in custody past their 18th birthday. Once they leave custody the case would be handled by DWS on a new case number.

3. Determine which Foster Care Independent Living program the customer will be eligible for.

- First look at eligibility for the 18-26 group, if the final month they were in Foster Care they were at least 18 years old AND received a Medicaid card that month.
- If they did not receive a Medicaid card in their final month but they were in custody on their 18th birthday they will only qualify for the 18-21 group.
- All other eligibility criteria must also be met as listed in policy 354-3 and 354-4.
 - o For those customers who were in foster care under the Catholic Community Services (CCS) under the Unaccompanied Refugee Minor (URM) Program, a new Foster Care Case will need to be set up before the Foster Care Independent Living can be set up. Contact a Medicaid Program Specialist and ask them to set this up in order to be able to cascade/create the correct program.

4. Register new DWS eREP case, when necessary

- Update all case evidence

5. Check Medical Assistance Eligibility from the Case Home Page

- eREP will automatically look for all eligible medical programs. The hierarchy is different for 18-26 than it is for the 18-21 group.

6. Request all appropriate verifications

- Customer must sign the review form or application to complete the Assignment of Rights requirement. A review form can be obtained from the DHS Foster Care eligibility specialist, which the individual would have signed.
- TPL requirements must be completed.

Medicaid Section

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- Customers with a child must complete duty of support requirements.
- Citizenship and ID requirements must also be met.

Note: Do not deny this program for income and/or asset verifications as there are no income or asset tests for this program. However this information may be needed to help determine eligibility for Medicaid if Medicaid eligible.

7. Process the case

- Temporary Medicaid card (form 695) should be issued to the client for the overlapping month that the client is on Foster Care Medicaid and Foster Care – Independent Living Medicaid.

8. Set a Person alert with the alert type of “Independent Living” for Foster Care Independent Living with a Note from the Person Home Page for this alert to explain that the customer is eligible for this program until the month the customer turns age 21 or 26. Also, add a task to the case to flag the PI is eligible for this program until the determined age, 21 or 26.

9. Send appropriate notice(s)

10. Narrate on case

Minor Foster Care/Subsidized Adoption Mothers

INTRODUCTION: There may be a minor parent on Foster Care or Subsidized Adoption Medicaid who may be pregnant. Once they give birth to their own child, that child needs to be covered for Medicaid under a different case number with DWS because the baby will not be in DHS or DCFS custody..

1. Receive email referral from the *FosterCare_DWS@utah.gov* email from DHS worker.

- No applications are needed for these cases.
- Minor parent will report birth of baby to DHS worker first.
- Email should have mother’s name, mother’s date of birth, mother’s social security number, baby’s name, baby’s date of birth, and information if the social security number has been ordered for the baby.

2. Register new DWS Case

- Foster care mother will be the PI
- Benefits will be for newborn only. Under Other Benefits add evidence to indicate the mother has Medicaid on another case.

3. Email imaging operations with the documents that need to be imaged to the new case number

4. Check Medical Assistance Eligibility once the case is ready to process

Medicaid Section

12/2014

- The child should be eligible for the Child 0-1 program if the mother was open for Foster Care or Subsidized Adoption Medicaid during the month of birth.
- The child should be eligible for the Child 0-5 program if the mother was not open for Medicaid during the month of birth.

5. Narrate in case Notes

6. Educate customer on new case number for the child

Note: We process these cases as normal, following policy. The difference is that the PI is not included on the benefit until they are no longer in state custody and their Foster Care or Subsidized Adoption Medicaid program closes. Because the coverage is only for the child we can not put the baby on the Family program as there is not an eligible adult.

Guardianship / Kinship Placement (Non Relative Guardianship Placement)

INTRODUCTION: This procedure is used when a child (at least 12 yrs old) leaves DCFS custody to a non-relative guardianship placement. The non-relative guardian is usually the former foster parent. This follows Medicaid policy for non-relatives requesting Medicaid for a child.

1. Receive emailed referral from the *FosterCare_DWS@utah.gov* email from DHS worker.

Note: eREP will automatically close the DHS case and follows 10 day notice rules.

2. Add a Person Alert with “Caution” and note

- Copy and paste email from DHS into the note.

3. Receive request for Medicaid

4. Determine if a new application is needed

- If customer's Foster Care program is still open, this would be a continuation of Medicaid, and a new application is not needed.
- If customer's Foster Care program has been closed for more than 30 days, new application is needed

5. Verify the child is with a non-relative and no longer in state custody

- DHS eligibility worker will inform the DWS eligibility worker that the guardianship is in the child's permanency plan and the approximate termination date of the DCFS custody. DHS eligibility worker will inform the DWS eligibility worker of the guardianship subsidy amount. This is counted as unearned income for the child.

6. Register new DWS Case

Medicaid Section

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- On these cases, the case is registered with the child as the PI, the non-relative guardian is not added to the case or included as a household member.

7. Email the DWS eREP case number to DHS worker

8. Check to make sure verifications are imaged

- The DCFS eligibility worker will attach the following in their email to *fostercare_dws@utah.gov*:
 - o Name
 - o Case #
- Completed Medicaid review form.
- Copy of Guardianship Subsidy Agreement (if applicable).
 - o Remember that a guardianship subsidy payment is considered countable income for the child for family Medicaid programs. For blind and disabled Medicaid programs, the guardianship subsidy is not considered countable income.
- Copy of court order terminating DHS/DCFS custody.
- All other relevant documents such as: a copy of the Foster Care Medicaid application, copy of birth verifications, social security number, and any income and asset verifications.
 - o If the needed verifications are not imaged, contact the DHS eligibility worker listed on the Integrated Case Home Page or Notes screen for the Foster Care program case number.

9. Narrate on all actions in Notes.

10. Educate customer on new case number for the child.

Exiting Subsidized Adoption

INTRODUCTION: When an individual ages out of Subsidized Adoption (turns 18 years old), they can still be eligible for Medicaid until they turn 19. This follows all normal policies for the Child Medicaid program.

- 1. Receive emailed referral from the *FosterCare_DWS@utah.gov* email from DHS**
- 2. worker stating that the customer is interested in continuing their Medicaid Coverage.**

Note: eREP will automatically close the DHS case and follows 10 day notice rules.

2. Request a new application, if not already submitted

A new application is needed to capture all changes to the individuals household situation. The application needs to include all household members, and will follow the normal policies for the family programs for individuals over the age of 18.

- 3. Receive new application**
- 4. Follow the normal [Application Lifecycle](#)**

Guardianship as a Permanency Goal

- ☀ Child and Family Services supports permanency for children and recognizes that sometime neither family reunification nor termination of parental rights and adoption best serve the permanency needs of the child. Child and Family Services offers guardianship as a permanency goal option only if other permanency goals, including a return to the parents or adoption, are determine not to be in the child's best interest.

Qualifications

- ☀ Child in Child and Family Services custody for 12 months or longer.
- ☀ Child in current placement for 6 months or longer.
- ☀ Licensed placement in good standing,
- ☀ Parties committed to placement as permanent.
- ☀ The child and caregiver no longer need services from Child and Family Services.
- ☀ Permanent guardianship is in the child's best interest.
- ☀ The child cannot safely return home.
- ☀ Screening Committee has determined adoption is not in the child's best interest.
 - ✓ The child is age 12 years or older.
 - ✓ Adoption has been explored; child does not want to be adopted.

Medical coverage

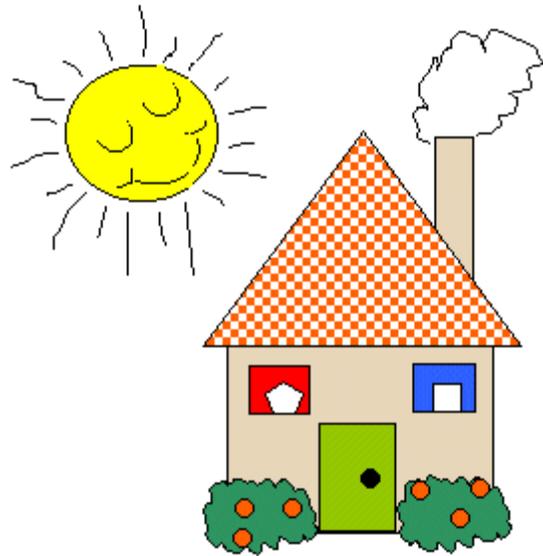
- ☀ Utah Medicaid Card available through application with DWS.
 - ✓ DWS application process may be completed online or at the local office. DWS prefers online applications. The application is available at www.utahhelps.utah.gov
 - ✓ The guardians will be asked to provide citizenship, identity, income and asset information.
 - ✓ Mental health coverage is available through Medicaid under the capitated mental health coverage.
 - ✓ If the guardian moves out of the State of Utah, loss of Utah Medicaid coverage would result. Interstate Medicaid eligibility is not guaranteed under guardianships agreements.

Guardianship Funding Options/Subsidies

- ☀ Relative: Specified Relative Grant
- ☀ Non-Relative: Guardianship Subsidy



Independent Living Youth



- ✚ Independent living payments paid to the foster child are countable unearned income for Medicaid eligibility, unless the child is receiving SSI.
 - Income of an SSI recipient is not countable for Medicaid purposes.
 - Payment codes include ILP, TLN and TLP.
- ✚ When the monthly income, including IL payments, exceeds the income limit of the Medicaid program; the child is not Medicaid eligible for that month.
 - Children's Medicaid program - Basic Maintenance Standard \$382.
 - NB+ Medicaid program - 100% of Poverty Level.
 - PN Medicaid program - 133% of Poverty Level.
 - Disabled Medicaid program - 133% of Poverty Level.
- ✚ BAB payments are countable income to the child of the foster child.
- ✚ Independent living youth who are over 18 and were in the custody of DHS/DCFS on their 18th birthday can be eligible for Foster Care Independent Living Medicaid while still in custody.

ERep Notices

- **Medicaid policy requires that proper notice of action taken on a Medicaid case be sent to the applicant or recipient. Notices must be sent when an application is approved and when benefits are denied or changed.**
 - **DOH Policy 811 Notification**
 - A. **Notice Requirements**

The agency must provide all applicants and recipients with a written notice of:

 - **The decision on an application or review;**
 - **Any action to terminate, discontinue, or suspend a client's medical assistance;**
 - **Any action that changes the form or amount for benefits;**
 - **Any request for information or verifications needed to determine eligibility.**
- **10*10*10 Rule**
 - **The agency must send the written notice of what action is being taken that affects the client's eligibility for medical assistance to the recipient at least 10 days before the effective date of any negative action.**
 - **The 10*10*10 Rule says that a Medicaid household must report a change within 10 calendar days from the date of the change, the agency has 10 calendar days to take action on the reported change, and the agency must provide a 10 day advance notice of a negative action.**
 - **If 10 day notice cannot be provided, make the change effective the following month.**
 - **A worker shall take action on a change as soon as possible, but no later than 10 days after the change is reported or discovered.**

Medicaid Eligibility for Children Placed in DCFS Custody through a Voluntary Placement Agreement



- ◆ DCFS may apply for Medicaid benefits for a child placed into State custody through a Voluntary Placement agreement.

Factors to Consider

- ◆ A Voluntary Placement Agreement is in place, DCFS has care and placement responsibility and the placement is receiving a Foster Care Maintenance payment.
- ◆ **The household size, income of the parents must be considered when determining Medicaid eligibility if the child is not IV-E eligible.**

Medicaid Applications

- ✚ An application for Medicaid consists of the following:
 - ❖ A completed and signed application form.
 - ✓ Paper application: Applicants may pick up a paper application at one of the agency's local offices, print one from the agency's website or ask that one be mailed to them. A paper application must be completed, signed, dated and filed at a DWS local office or outreach location by delivering it in person, mailing it or faxing it.
 - ✓ Telephone applications: Applicants may ask to apply by telephone. The agency has the discretion to decide when to complete applications over the phone. When applying by phone, the agency will send a copy of the application form to the applicant. The applicant must sign and return the signature page to the appropriate office no later than the last day of the application processing period.
 - ✓ Online applications: Applicants may complete an on-line application and send it via the internet. When applying on-line applicants must complete the on-line signature. The agency accepts an on-line signature as a legal signature of the individual applying for Medicaid. The applicant can print a copy of the application, the rights and responsibilities, and other important information provided for their own records.
 - ❖ All applications must have an original signature. A signed application sent by fax is treated as an original signature. The on-line signature is accepted as an original signature.
 - ❖ If an application is received without a signature, a signature will need to be obtained.
 - ❖ An application for Medicaid may be submitted in person, by mail, by fax or by phone, or on-line through Utah Helps.

- ✚ Every Medicaid application must be date stamped on the date that it is received.
 - ❖ The date of application must be established to determine when medical assistance coverage can begin. Retroactive coverage is based on the date of application and the date the individual met the eligibility criteria.
 - ❖ Every Medicaid application that is received must be registered in eRep. Appropriate action to approve or deny that application must be taken.

Medicaid Section

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- ✚ The eligibility worker must make an eligibility decision with 30 days of the date of the application. There is one exception: if the applicant is claiming to be disabled, a decision must be made within 90 days of the date of the application.
 - ❖ If a decision cannot be made before the deadline, document the cause of the delay in the case record.

- ✚ An applicant must apply for assistance and sign the application form in his own behalf unless he is unable to do so because he is a minor or because of incapacity that prevents him from completing the application process. If the applicant is a minor, the applicant's parent, legal guardian, or representative must sign the forms.

- ✚ When DCFS/DJJS has custody of a child and the child is placed in foster care, the division with custody will complete the application process.
 - ❖ The Medicaid Information Form must be signed by the child's caseworker.

- ✚ Record the eligibility decision on the program notes screen.
 - ❖ If the application is approved, indicate the date and the medical assistance programs approved for the household members. Narrate your decision clearly.
 - ❖ If the application is denied, note the date and the reason for the denial.

- ✚ When the application is approved or denied, notify the applicant in writing of the approval or denial.
 - ❖ If the client must pay for coverage, explain this in the notice and how and where payment can be made. The notice must give the citation that covers the reason for a payment.
 - ❖ If the application is denied, state the reason for the action and give the policy citation for the denial reason.
 - ❖ Tell the client where to call if the client has questions or concerns.

- ✚ Set tasks on the case to control for changes that are expected to occur before the next review, or for actions that should be taken for the next review.



Detention Placements



➔ **Was the foster child court ordered to spend time in detention?**

<u>No</u>	<u>Yes</u>
<p>Medicaid Policy 215-3</p> <p>Who is a Resident of an Institution?</p> <p>A child living in an institution is a resident of that institution. One exception applies to all kinds of institutions: a child in the custody of the State is not a resident of an institution if he is:</p> <ol style="list-style-type: none"> 1. Under age 18, AND 2. In the custody of a State agency, AND 3. Living temporarily in an institution while arrangements are being made for an appropriate placement. <p>Foster children may be put in a detention center while authorities decide where they should be placed. These children are not residents of the detention center.</p> <p>A foster child who is placed in detention, but has not been ordered by the court to stay in detention, remains eligible for Medicaid during the detention placement.</p>	<p>Medicaid Policy 215-2</p> <p>Who is a Resident of a Household?</p> <p>A person living in a household is a resident of that household.</p> <p>Medicaid Policy 216-6</p> <p>Residents of Non-Medical Institutions.</p> <p>Non-medical institutions include jails, prisons, and community residence facilities. Other institutions may also be non-medical. Medicaid policy differs for residents of public or private non-medical institutions.</p> <p>A public institution is and institution that is the responsibility of a governmental unit or that is under the administrative control of a governmental unit.</p> <p>Juvenile detention centers are public non-medical institutions. Residents of most public, non-medical institutions are not eligible for Medicaid. Foster children who have been court ordered to stay in detention are not eligible for Medicaid while they are staying in the detention center.</p> <p>Once a person becomes a resident of a public non-medical institution, he must continue to be considered a resident of a public institution until released from the facility.</p> <p>If a person “escapes” from the institution or if a person leaves and is supposed to return when the purpose for the absence ends (medical treatment) institution he has not been released.</p> <p>A foster child who is court ordered to spend time in detention is not eligible for Medicaid while staying at the detention facility. Medicaid eligibility can begin again when the foster child leaves detention and is placed in an eligible foster care placement providing they meet all the other FC Medicaid eligibility</p>

Dedicated Accounts



Lump Sum SSI Payments

When a minor child receives an SSI lump sum payment for retroactive months' benefits, in excess of 6 months of benefits, the Social Security Administration requires the child's representative payee to establish a "**dedicated account**" to receive and maintain such payments.

The payee may also deposit subsequent SSI lump sum payments that equal or exceed one month's benefits into the dedicated account.

Medicaid Policy 531-2

Excluded Resource

The dedicated account will be an excluded resource for Medicaid purposes as long as the account is maintained according to SSA's requirements for such accounts. In addition, income earned on these funds is excluded from income.

If the individual with a dedicated account is no longer receiving an SSI payment, the dedicated account becomes a countable asset the month after the person becomes ineligible for SSI.

Specific Expenses

The funds in dedicated accounts can only be used for specific expenses related to the impairment of the child. The funds cannot be used to reimburse the cost of support and maintenance of the SSI recipient. The allowed uses are as follows:

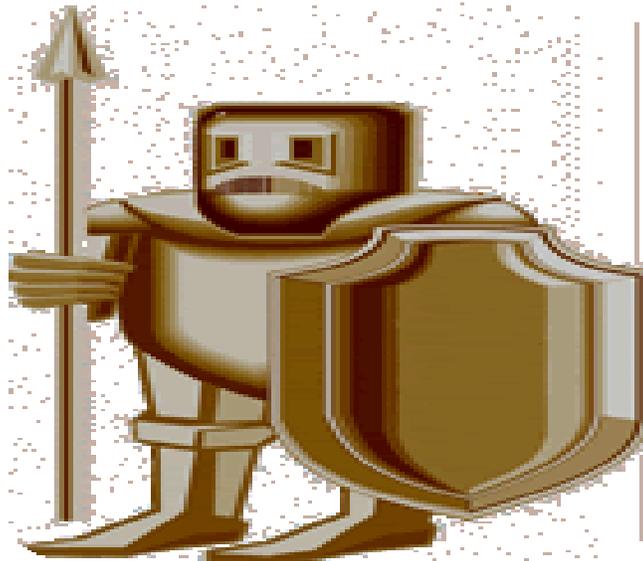
- ❖ Education or job skill training.
- ❖ Personal needs assistance.
- ❖ Special equipment or housing modifications.
- ❖ Medical treatment, therapy or rehabilitation.
- ❖ Other items or services, which SSA determines are appropriate.

The representative payee will be required to report to SSA on the use of these funds.

Assets Managed by a Guardian, Conservator, Representative Payee or Other Responsible Person

Medicaid Policy 511-2

- ✦ The assets of a foster child that are managed or controlled by a legal guardian, a conservator, a representative payee or some other responsible person acting for the client are available resources of the child, and the asset is countable for Medicaid purposes. This is true even if the child does not live with the person managing the assets. The child does not have to have the physical or mental ability to access the assets; the assets are still treated as assets belonging to the child.
- ✦ The assets do not belong to the person managing them, because that person is obligated to hold and use the assets for the benefit of the child. The person managing the child's assets is not to use the assets for his own benefit.



Trusts

Medicaid Policy 512-2.1

- Medicaid policy and rules regarding trust funds are **very complex**. The availability of assets from a trust is viewed differently depending on when the trust was established. There are two periods of time that you must look at: Trusts established before August 11, 1993, and trusts established on or after August 11, 1993.
- Assets from trust accounts are viewed differently depending on the Medicaid program you are basing eligibility on. The policy for family or children's categories differs from the policy for blind and disabled categories. For all children's Medicaid programs there is no asset limit.
- **Revocable Trust:** A trust, which can be terminated by the grantor. A trust is also considered revocable if a court can modify or terminate it, because the client can petition the court to terminate the trust. In addition, a trust that is called "irrevocable" but which terminates if the grantor takes some action is considered revocable.
- **Irrevocable Trust:** A trust is considered irrevocable when the grantor cannot, in any way, terminate the trust.
- Medicaid eligibility for a foster child with a trust must be reviewed with the State Specialist prior to approving Medicaid eligibility.
- If a determination of availability cannot be made, a copy of the trust agreement must be sent to the DOH program specialist for a decision. Include a cover page with the client's name, date of application, Medicaid program applying for, whose funds were used to establish the trust, and other pertinent information.



What is Income?



Income is cash or in-kind benefits a person receives. Income includes earned income and unearned income. In-kind income is not cash. It is something other than cash that a person receives.

- ✿ Count cash or in-kind benefits as income in the month the foster child receives it or when it is made available for their use.
- ✿ Any amount of the cash or in-kind benefit remaining at the end of the month is counted as an asset in the month after it is received.
- ✿ Workers must identify a child's total monthly income. The total income is used to determine the child's countable income for Medicaid eligibility, and to calculate a spenddown if applicable.



Countable Earned Income	Countable Unearned Income
Wages and Salaries	Interest and dividends
Living allowance stipend	SSA survivors or retirement benefits
Training incentive payments	IL payments made to the foster child
Work allowances	Cash gifts
Severance pay	BAB payments made for the child or a foster child



Earned Income Exclusions	Unearned Income Exclusions
Earned income of a dependent child	All unearned income of an SSI recipient
All earned income of an SSI recipient	FEP
Earned Income Tax Credits	Child Support – MAGI programs

Medicaid Spenddowns Things You Need to Know



- ✿ Medicaid policy requires that ongoing Medicaid recipients must pay their spenddown by the 10th of the month following the benefit month. Otherwise the case must be closed and the client must reapply.
- ✿ The medical expenses for a child must exceed or are expected to exceed the amount of the spenddown for the month.
- ✿ The eligibility worker is responsible to authorize the payment of the spenddown each month. A spenddown form, authorizing the payment, must be received from the eligibility worker **each month**.
- ✿ Spenddowns must be paid before cost of care.
- ✿ A child receiving SSI is not be required to pay a spenddown. The income of an SSI recipient is not countable for Medicaid purposes.
- ✿ Spenddowns should be paid immediately following the receipt of the spenddown form whenever possible. There is no Medicaid benefit for the month until the spenddown has been cleared. Healthcare costs for a child with a spenddown must be paid in another way while waiting for a spenddown to clear.
- ✿ Income limit for a child ages 6-19 is 100% of poverty level.
- ✿ Income limit for a child ages 0-5 or pregnant teen is 133% of poverty level.
- ✿ When the child's income exceeds the limits a spenddown must be made to the Medicaid BMS of \$382.

Medicaid Spenddown Helpful Hints

Determination Factors

- ✓ Countable Income over the BMS of \$382.00 is used for calculating the need and amount of the spenddown. SSI income is not countable. Spenddowns are allowed for Children, Pregnant Women, Blind, and Disabled Medicaid categories. Spenddowns are not allowed for IV-E, Newborn, Newborn Plus or Pre Natal Medicaid categories.
 - If a child receives a monthly SSA benefit of \$950.00, they must spenddown to the \$382.00 level. The spenddown amount would be \$568.00. A spenddown cannot be made to NB or NB+ income level.
- ✓ ERep entry is the same as for all Foster Care Medicaid cases. Make sure to post the countable earned and unearned income. ERep will automatically calculate the spenddown amount and a notice will be sent. Document determination in notes.
- ✓ Medical expenses must exceed the cost of the spenddown each month.
 - Medicaid reimbursement for mental health treatment is counted as part of the medical expenses.
 - Prior medical expenses for a Medicaid client can be viewed in MMIS.

Procedure

- ✓ Notify Caseworker of required spenddown.
- ✓ See **Medicaid Spenddown Process**.
- ✓ Tanja Akiyama will notify you when the spenddown has been cleared. The Medicaid card should mail automatically from eRep after the spenddown is cleared. If the card does not mail, you may request a new card to be mailed from the program home in eRep.
- ✓ An MI-706 may be issued to provide coverage until the spenddown process is complete and the card can be issued.
- ✓ Spenddowns must be cleared by the 10th of the month following the eligibility month or the eRep case should be closed. Policy 415 goes over the time limit for meeting spenddowns. Due to the nature of DCFS and DJJS cases, the spenddown payment is allowed up to 1 year after the needed eligibility month. The case in eRep must be reopened to allow the spenddown to be cleared.

MEDICAID SPENDDOWN PROCESS

DCFS

- Make sure benefit month shows on the eRep benefit issuance screen for the month you are paying spenddown.
- Print the benefit issuance screen with the monthly medical payment details.
- Highlight the benefit month and the amount of the spenddown for that month.
- Fill out the DCFS Medicaid Spenddown form, making sure to fill in all areas.
- Forward to Representative Payee Account Technician.
- Representative Payee Account Tech will cut a check, fill in the “Date sent to State Office” and mail.
 - *Check is mailed to Linda Moon.
 - *Linda will query SAFE and eRep to verify child’s SCF eligibility and spenddown amount.
 - *Linda Moon will notify Tanja Akiyama to clear spenddown
 - *Tanja Akiyama will forward check and spenddown information to DCFS Finance.
- DCFS Finance will deposit check and do IAT transfer to ORS.
 - *DCFS Finance coordinates with Joe Torres at ORS.

DJJS

- Make sure benefit month shows on the eRep benefit issuance for the month you are paying spenddown.
- Print the eRep benefit issuance screen.
- Highlight the benefit month and the amount of the spenddown for that month.
- Fill out the DJJS Medicaid Spenddown form, making sure to fill in all areas.
- FAX or scan and e-mail the request to Tom Darais
- FAX to Linda Moon.
- Tom Darais will coordinate the spenddown process with Tanja Akiyama.

Spenddown Worksheet

Suzy Q is removed from the custody of her mother and placed in DCFS custody by court order on Oct 27, 2004. The eligibility worker has determined that Suzy is not IV-E eligible because the income of the AFDC group exceeds the IV-E need standards. Suzy receives monthly SSA income because her father is deceased. The amount of her SSA check is currently \$974.00 monthly. Suzy has no assets.

Is Suzy eligible for Foster Care Medicaid?

Yes

No

With a spenddown

<u>Spend Down Calculation</u>	
Child Countable Income	\$ _____
Minus Program Income Limit	\$- _____
Total Spend Down Amount	\$ _____

On Oct 27, 2004 Suzy is placed at the Christmas Box House (SHN). She is moved to a structured foster home on Nov 13, 2004 (SFD). She remains in that foster home until Jan 3, 2005, when she is moved to a residential treatment placement (DLR). She remains in this placement.

MMIS indicates that following total expenditures for Suzy: (not including any placement associated treatment costs or TCM billings)

October 2004	\$ <u>275.00</u>
November 2004	\$ <u>303.00</u>
December 2004	\$ <u>978.00</u>
January 2005	\$ <u>10,062.00</u>
February 2005	\$ <u>97.00</u>

Which months did the Medicaid related expenses exceed the spenddown amount?

Oct 2004 Nov 2004 Dec 2004
 Jan 2005 Feb 2005

Medicaid Section
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DCFS MEDICAID SPENDDOWN FORM

To: Linda Moon
DCFS Federal Revenue Team
195 N 1950 W
Salt Lake City, Utah 84116

Caseworker	Eligibility Worker	Representative Payee
Phone #	Phone #	Phone #

Child's Name	
Child's Social Security Number	
Child's Client ID Number	
eRep Case Number	
Month/Year Spenddown Applies To:	Amount:

Date Sent to State Office:

Date Received at State Office:

Date Sent to ORS:

Date Spenddown Cleared:

DJJS MEDICAID SPENDDOWN FORM

To: **DJJS/Tom Darais**
DCFS/Linda Moon

Eligibility Worker	Caseworker
Phone #	Phone #

Child's Name	
Child's Social Security Number	
Child's Client ID Number	
ERep Case Number	
Month/Year Spenddown Applies To:	Amount:

Date Sent to ORS:

Date IAT Cleared:

Date sent to DCFS:

Date Spenddown Cleared:

Emergency Medicaid



Rule of Thumb

If a procedure can be scheduled in the future the service will rarely qualify as an emergency.

Medicaid Policy 205-6

- ✗ Emergency Medicaid is not a separate type of Medicaid. Emergency Medicaid provides coverage for only emergency services to individuals who meet all the requirements for a Medicaid program but are not a U.S. citizen or qualified alien.
- ✗ Who may be eligible?
 - ✓ Any alien who does not meet the alien status requirement to be eligible for full Medicaid coverage may be eligible for Emergency Medicaid.
 - Undocumented aliens.
 - Aliens who are in the country legally but are not qualified aliens.
 - Qualified aliens who are barred from Medicaid for 5 years.
 - Citizens of Freely Associated States who meet state residency requirements.
- ✗ To be eligible for Emergency Medicaid, the individual must indicate that he or she has received emergency service in the application month or retro period, or is currently in need of emergency medical services. The eligibility worker does not need to determine if Emergency Medicaid will cover the services. All claims for Emergency Medicaid cases are reviewed by Medicaid Operations to determine if the service meets the criteria for coverage under Emergency Medicaid.
 - ✓ **Do not deny Emergency Medicaid because you suspect there is not an emergency medical need.**
- ✗ The applicant must meet all other Medicaid eligibility rules except Social Security Number.
 - ✓ The individual must meet the eligibility requirements for a Foster Care Medicaid program.
 - ✗ If this is a new Foster Care case, in eRep proceed as usual with application registration, case and program evidence entry. In addition to the usual case evidence entry you will also enter evidence in the Medicaid Emergency Section.

Medicaid Section
12/2014

- ✓ Select Medical Emergency in the Medical Section on the eRep Site Map
- ✓ Select the Household Member from the drop down box. This is the person for whom you are requesting an Emergency Medicaid eligibility.
- ✓ Enter the emergency start and end dates
- ✓ Save

The screenshot displays the 'Medical' section of a web application. It features a grid of categories for medical evidence, including TPL, Medical Bills, Dependent Family Member, Available Health Insurance, Medical Condition, Bus Pass, Medical Insurance, Medical Emergency (highlighted in red), Spousal Cooperation/Allowance, Voluntary Terminated Health Insurance, NPCR Opt Out, In-Kind Food and Shelter, Medical Institution/Waiver, Income Reporting, CHIP/PCN/UPP Exception, Removal Home, and Forced Evidence and Reassessment. Below the grid are 'Save', 'Save & New', and 'Cancel' buttons. The 'Medical Emergency Details' section includes a dropdown menu for 'Household Member' and two date input fields for 'Emergency Start Date' and 'Emergency End Date', all highlighted in red. A link for 'Add New Note' and another set of 'Save', 'Save & New', and 'Cancel' buttons are also present.

✗ If this is an existing Foster Care case, add the Medicaid Emergency information, apply this evidence and check the effective dates to ensure that the correct date range for the emergency is identified.

- ✓ Reopen the foster care program, using the reason of “New Evidence”
- ✓ Check eligibility on the program home page.

Foster Care Maintenance Payment



Medicaid Policy 354

Foster Care Medicaid provides medical coverage to children who have been removed from their home, are in the custody of the State and are in an out of home placement to which a Foster Care maintenance payment is being paid.

When a child is placed back in the home with a parent or other specified relative, DWS will determine eligibility for another Medicaid program even if the child is in State custody. The eRep Foster Care Case and Program homes will display a message to alert DWS workers that the child is not currently receiving a Foster Care Medicaid Benefit.

“ ‘Child’s Name’ is not eligible for a foster care medical program. This child may be eligible for other medical programs.”



Citizenship & Qualified Aliens

Medicaid Policy 205



● What is a U.S. citizen?

- ✓ **Birth in the U. S.** U.S. citizenship is automatic for individuals born in any of the 50 states, the District of Columbia, Puerto Rico, Guam, the Virgin Islands, the Northern Mariana Islands, American Samoa, and Swain's Island. Citizenship is verified by proof of the place of birth.
- ✓ **Naturalization.** Citizenship may be granted to an individual who was not born in the U.S. or one of its territories if that individual satisfies the legal requirements for naturalization. A naturalization certificate verifies naturalization.
- ✓ **Born outside of the U.S. to a U.S. Citizen Parent.** If a child is born outside of the U.S. to a person who is a U.S. citizen at the time the child is born, the child is also considered a U.S. citizen for Medicaid purposes.
- ✓ **Automatic citizenship.** Children both biological and adopted, born in a foreign country automatically become U.S. citizens when they meet **ALL** of the following criteria at the same time on or after February 27, 2001.
 - 1. At least one parent is a U.S. citizen either by birth or naturalization. The parent may become naturalized after the birth or adoption of a foreign born child; **AND**
 - 2. The child is under age 18. If an individual has turned 18 before February 27, 2001, or if the child turns 18 before a parent becomes a U.S. citizen, automatic citizenship does not apply; **AND**
 - 3. The child is living in the U.S. pursuant to a lawful admission for permanent residence and resides in the legal and physical custody of a U.S. citizen parent. Permanent resident status could have been granted before, on or after February 27, 2001. The child must be residing with the U.S. citizen parent on or after February 27, 2001; **AND**
 - 4. For an adopted child born outside the U.S., the adoption has been finalized either in the country from which the child is being adopted or in the U.S. The adoption can take place in another country or in the U.S., and finalization may occur before, on or after February 27, 2001.

Summary: To receive automatic citizenship, the child simply has to have been adopted by or be the biological child of the U.S. citizen parent; the child must have permanent resident status in the U.S., and be residing with a U.S. citizen parent and still be under age 18, on or after February 27, 2001.

● **Who is a qualified alien?**

- ✓ A qualified alien is an alien who is lawfully admitted for permanent residence under various sections of the Immigration and Nationality Act. Some qualified aliens are barred from receiving full service Medicaid and may receive coverage only for emergency services for five years from the date they obtained qualified alien status. After determining that an alien is a qualified alien, it is necessary to determine if the alien is subject to the five-year bar.
 - See Medicaid Policy Section 205-2 for a complete list and description of persons meeting qualified alien status.
 - Only immigrants who entered the country on or after August 22, 1996, can be subject to the five-year bar. See Medicaid Policy Section 205-2 for complete details.
- ✓ **Verification of alien status.** Workers must use the SAVE Program to verify the alien status of all people who are not U.S. citizens, except for American Indians born in Canada.
 - SAVE is an electronic automated status verification system used to obtain INS status and to confirm the validity of alien status information that the alien provides.
 - Follow SAVE System instructions to complete the INS verification of immigration status. Complete SAVE System instructions are contained in the Verification Section of the Eligibility Training Manual.
 - A copy of the SAVE verification information should be printed and filed in the eligibility record.
 - Alien registration cards have expiration dates must be renewed. An expired registration card does not change the person's status and does not affect the Medicaid eligibility.
 - The date of entry may be other than the date on the INS documentation and other than the date of "legal residency".
 - If a foster child has been in the U.S **continuously** since prior to August 22, 1996, they are not subject to the five year ban and they can be eligible for Medicaid immediately upon obtaining Qualified Alien Status. You must be able to prove that the child has been in the U.S. continuously since that time. An absence of more than 30 days or multiple absences totaling more than 90 day interrupt the continuous residency. You can use school records, statements from relatives or other people who know the child, or any other record or combination of records that establishes the continuous residency since prior to August 22, 1996.

Citizenship and Identity Requirements



New Medicaid Policy Effective July 1, 2006

Proof of Eligibility (Section 205-2)

- ☀ Under the Deficit Reduction Act of 2005 (DRA) as of July 1, 2006, individuals now must present **documentary evidence** to establish both identity and citizenship. The State Medicaid agency is now required to obtain this information for all current Medicaid recipients and applicants. **All documents must be either originals or copies certified by the issuing agency. Copies or notarized copies obtained from the applicant are not acceptable.**
 - ✗ New applicants beginning July 1, 2006, must meet this requirement.
 - ❖ The requirement must be satisfied for new applicants before Medicaid eligibility can be established.
 - ✗ Current Medicaid recipient must meet the requirement at their first review after July 1, 2006.
 - ❖ Current Medicaid recipients must be given a reasonable opportunity to provide the information to satisfy the requirement. Medicaid eligibility may be continued as long as a good faith effort is being made to obtain it. There are no specific time frames. Workers will need to set alerts and document the efforts to demonstrate that the effort to obtain the documents is being made.
 - ✗ Children eligible for Foster Care Subsidized Adoption Medicaid are exempt from these requirements. Citizenship must be documented

New Law in Town.....

Practice and Procedures

What do we do now?



July 1, 2006, is the start date. If the application was received prior to July 1, 2006, but not being approved until that date or later the new requirements must be met before Medicaid eligibility can be approved.



To establish U.S. citizenship the document must show a U.S. place of birth or that the person is a U.S. citizen. To establish identity a document must show evidence that provides identifying information that relates to the person named on the document. The only documents that meet both requirements are in Chart 1 on Table IV. For most foster and subsidized adoptive children you will need two documents from Table IV. A document from Charts 2-4 will be needed to verify citizenship and a document from Chart 5 to verify identity. Table IV is located on the DOH website <http://utahcares.utah.gov/infosourcemedicaid/>



The original document or a certified copy of the original document used to verify citizenship and identity must be in the case record. Copies or notarized copies are not acceptable.



The worker must be satisfied that they are viewing an authentic **ORIGINAL** document. Make the best photocopy of the document possible. Front and back if applicable. In clear and legible writing, complete the label and attach it to the photocopied document. Do not cover identifying information on the document. If it is necessary attach the label to the back of the photocopied document. Return the original documents to the client. If the caseworker brings you a copy of the document and verifies that they have seen the original document, you may certify the copy as a copy of the original if you are confident that they could produce a copy of the original if requested.



This requirement applies to Subsidized Adoption Medicaid cases that are **STATE** eligible. It also applies to ongoing Medicaid for youth exiting foster care or subsidized adoption assistance at or after age 18.



ALL new Medicaid applicants must meet this requirement beginning on July 1, 2006. Current Medicaid recipients must meet the requirement at the first review after July 1, 2006.



Vital Statistic Look Up is an acceptable form of citizenship verification. The record can be printed and filed in the case record. The record is an electronic match and does not need to be certified as a copy of the original document. If you have a copy of a birth certificate in the file and you can match the information on the certificate with the information in Vital Records you may certify the birth certificate as a copy of the original.

Vital Records information will soon be available in eFind. DWS form 125 may also be used as a verification of citizenship.



You may certify a birth certificate as a copy of the original if you call the parent or caseworker and they verify that they have a copy of the original document in their possession and that they could produce that document if requested. Only authenticate the documents of those that confirm they can produce the document.



Souvenir birth certificates that have been issued by a hospital may not be used as citizenship or identification verification.



For new **STATE** eligible Subsidized Adoption cases it is reasonable to use the pre-adoptive information while waiting for the new birth and identity documents. There are no specific time limits, but a good faith effort must be made to obtain the new citizenship and identity information. Set alerts and document the efforts made to get the citizenship and identity verifications on the CAAL screen.



The person acting as the authorized representative for the client can sign the 61-IC, "Affidavit of Identity".



Expired documents such as a driver license or student ID can be used to verify identity.



<http://www.cdc.gov/nchs/> This is a national web site that can be used to provide clients with information of who to contact to order birth certificates.



Workers may treat a baby born to a Medicaid recipient as a Medicaid recipient; this means benefits can be continued while the client is given the opportunity to meet the new requirements.

What is Acceptable Verification?

Medicaid Policy 731-3 and 4



- ➔ **Some types of verification are preferred over others; however, in the absence of a preferred type of verification, workers may use other methods to verify items of eligibility.**
 - ❖ **Client's statement (prudent person concept).** This is when an eligibility worker decides to accept the client's statement as verification. Client statement or self-declaration can be accepted for all eligibility factors **except citizenship, identification, alien status and income.**
 - ❖ **Hard copy verification.** Verifications may be those items listed on the Verification Tables or other documents accepted by the worker. You do not need to re-verify eligibility factors that don't change such as citizenship and date of birth. For items subject to change, such as income and assets, re-verify them at regular intervals.
 - ❖ **Computer interface matches.**
 - ❖ **Collateral contacts.** A collateral contact is when an eligibility worker contacts a third party to verify an item for eligibility.
 - ❖ **When an SSI recipient is the Medicaid client.** Use the SOLQ interface or SDX interface to verify the receipt and the amount of SSI benefits. The BDX interface can verify the amount of other SS benefits.



Subsidized Adoption Medicaid

- ✚ A child is eligible to receive Subsidized Adoption Medicaid when a current adoption assistance agreement is in effect with a state or local government.
- ✚ There is no income test.
- ✚ There is no asset test.
- ✚ DHS determines the Medicaid eligibility.
- ✚ Subsidized Adoption Medicaid is the program of choice over Family Medicaid programs.
- ✚ The adoption agreement usually ends the month that the child turns 18. However, the adoption assistance agreement may be extended if the child is determined to be eligible by the state or local government agency that originated the adoption assistance agreement. Subsidized Adoption Medicaid may continue beyond age 18 if the following two requirements are met.
 - ❖ **The child has been determined IV-E eligible for adoption assistance.**
 - ❖ **A current adoption assistance agreement remains in effect.**
- ✚ An adopted child eligible for State funded adoption assistance **is not** eligible for Subsidized Adoption Medicaid after age 18, even if an adoption agreement is in place.
- ✚ Children eligible for adoption assistance from another State can be eligible for Utah SA Medicaid through the ICAMA process. Utah's ICAMA specialist will send the required ICAMA paperwork and approval to the regions eligibility staff.

Kinship Care

The first priority of Child and Family Services is to maintain children at home with their family if they can safely do so. If a child cannot safely remain at home, the next best option is placement in the home of someone familiar – a kinship caregiver. Kinship caregivers are preferred placements for children due to their knowledge of and relationship with the family and the child. Because of their personal attachment to the child, kinship caregivers are generally willing to provide a permanent home for children who are unable to return home.

When kinship caregivers are identified, Child and Family Services will conduct an assessment to determine the ability and willingness of the kinship caregivers to promote safety, well-being, stability, and permanency for the child. When children are placed with a kinship caregiver, the relative can become a licensed foster care provider in order to get extra supports and services, while custody of the children remains with Child and Family Services. Custody can also be given to the relative, with the court often ordering In-Home Services be provided by Child and Family Services. We encourage kinship caregivers to become licensed foster parents so they will have the extra supports they need as they begins to care for the child.

The kinship caregiver:

- ✿ Signs a kinship caregiver Preliminary Placement Agreement.
- ✿ Is able and willing to keep the child safe and provide daily care and nurturance.
- ✿ Agrees not to allow the custodial parent or guardian to have any contact with the child unless authorized by the court or Child and Family Services in writing.
- ✿ Agrees to contact law enforcement and Child and Family Services if the custodial parent or guardian attempts to make unauthorized contact with the child.
- ✿ Is able and willing to take the child to medical, mental health, dental, and educational appointments at the request of Child and Family Services.
- ✿ Agrees to allow Child and Family Services and the child's GAL to have access to the child
- ✿ Is willing to support the child's permanency plan, including, assisting, the custodial parent or guardian in reunification efforts at the request of Child and Family Services.
- ✿ Is will to follow all court orders.
- ✿ Has been informed and understands that Child and Family Services may continue to search for other possible placements for long-term care of the child, if needed.
- ✿ Agrees to submit a background screening application, copy of photo identification, and fingerprints through Live Scan or hard copy cards for a fingerprint-based background check within 10 business days of placement of the child
- ✿ Agrees to inform Child and Family Services of any changes or circumstances that might affect the child's well-being such as a change in health, address, or caregiving arrangements

SAFE Placements for SCF Cases

~Kinship Care~

BHR = Unlicensed kinship placement

- ✿ No foster care maintenance payment made to provider.
- ✿ Child not eligible for foster care Medicaid.
- ✿ Child not IV-E eligible or IV-E reimbursable.
- ✿ Medicaid eligibility determined by DWS.

FCI = Licensed kinship placement

- ✿ Foster care maintenance payment made to provider.
- ✿ Child eligible for foster care Medicaid
- ✿ Child can be IV-E eligible during probationary license period.
- ✿ Child can be IV-E eligible and IV-E reimbursable once placement is fully licensed.
- ✿ Medicaid eligibility determined by DHS.

Specified Relative

When a child lives with a non-parent specified relative, that relative may apply for the child. An unlicensed relative kinship placement should be encouraged to apply for Specified Relative Medicaid and Financial Services through DWS. DCFS' Kinship Program Manager has worked extensively with DWS Administration to develop a process for DCFS kin placements to become eligible for services through DWS. The process flows through the DCFS Home Study Workers.

Specified relatives are: (DWS policy section 340-3)

- ✿ **Parents and Step-parents**
- ✿ **Grandmother and grandfather**
- ✿ **Brother or sister; including step, half or adopted brother or sister**
- ✿ **Uncle or aunt**
- ✿ **Nephew or niece**
- ✿ **Persons of prior generations designated by the prefix, grand, great, great-great**
- ✿ **Spouses or former spouses of any person listed above.**

DWS will determine eligibility for financial and medical assistance under the specified relative program. Eligibility for LIFC Medicaid program will be determined first.

1. The non-parent specified relative must be one of the relatives listed above.

2. Both of the child's parents must be absent from the relative's home.
3. The child must be living with the relative and not just visiting. A visit has a temporary reason such as school attendance, vacation, summer employment, medical treatment, etc.
4. Ask the relative to complete the medical support enforcement on the child's parents.
5. DWS will contact the parents if possible and ask them to complete Form 544, Financial support Statement. The form may be completed by phone.
6. Any payments paid by the parent to the child or relatives, counts as income for the child.
7. The income and assets of the relative do not count.

Specified Relative Month Grant Amounts

Household Size	Assistance Amount
1	\$288
2	\$399
3	\$498
4	\$583
5	\$663
6	\$731
7	\$765
8	\$801
9	\$839
10	\$874

DCFS Kinship/Home Study Workers

Name	Office	Phone #
Judy Hull	State Admin	801-556-5246
Jean Marie Morris	Ogden	801-629-5866
Chelsea Montgomery	Brigham/Logan	435-881-2218
Alicia Anderson	Ogden	801-452-1661
Kristina Gerlach	Ogden	435-730-7301
Debra Rogers	Clearfield	801-776-7393
Ken McCauley	Fashion Place	801-867-4451
Sean Green	Fashion Place	801-859-9575
Barry Richards	Fashion Place	801-755-6476
Stormi Soffe	Fashion Place	801-755-6736
Jamie Luna	Fashion Place	801-755-7458
Darcie Oliva	Fashion Place	801-888-2638
Julie Root	Fashion Place	801-755-7456
Tammy Scarbrough	Fashion Place	801-755-6950
Dennis Brooks	Spanish Fork	801-362-8599

Name	Office	Phone #
Eliana downing	Spanish Fork	801-310-1466
Stella Andes	Provo	801-319-7729
Janalee Burdette	American Fork	801-319-5942
Lisa Dent	American Fork	801-362-2678
Trish Hartzell	Heber	801-368-9045
Trent Kowalis	Vernal	435-781-4219
Lance Whitesel	Price	435-381-4740
Melissa Moss	Cedar City	435-865-5612
Annette Orton	Panguitch	435-676-1402
Tina Call	St George	435-619-6718



SUBMITTING AN INVESTIGATION REFERRAL

New: 5/03/10

Effective: 5/03/10

Home Page: [Overpayments/Underpayments/Investigations](#)

INTRODUCTION: Eligibility specialists will use this procedure when they discover a discrepancy on a case record that potentially could result in a payment error, or change to ongoing eligibility. There are two types of referrals that a worker can make in this instance. If worker is sure that all the evidence is present to calculate an overpayment, the worker will make an overpayment referral on that case. If all the necessary evidence is not present, or the worker is in doubt which evidence is needed, then the worker will make an investigation referral following this procedure. The investigator will submit an overpayment referral when appropriate.

Eligibility Specialist should do the following:

1. Determine that there is potential overpayment on the case.
2. Go to the Case Home page.
3. Click on New Investigation Referral under Options, or on the left navigation bar.
4. Enter the alleged Start and End dates of the overpayment. Chose the dates when potential overpayment occurred.
5. Choose "Eligibility Specialist" form the Investigation referral Source drop down box.
6. Enter the Investigation Reason in the text box.
 - Explain the potential overpayment and the reason for investigation.
7. Click on Create Investigation referral button to save and send investigation referral.
8. Narrate in the case notes that investigation referral was sent and the investigation referral number.