STATE/COUNTY SPECIAL ASSISTANCE MANUAL

North Carolina Division of Social Services

Special Assistance Program

Revised: January 2025

NC DEPARTMENT OF HEALTH AND HUMAN SERVICES
Division of Social Services

State/County Special Assistance Program
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SA-3100 ELIGIBILITY REQUIREMENTS

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SA-3100 ELIGIBILITY REQUIREMENTS

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I. INTRODUCTION

State/County Special Assistance (SA) is a Supplemental Security Income (SSI) state supplement that pays cash benefits to eligible beneficiaries who reside in licensed facilities authorized to receive SA payments. The SA payment is funded by 50% county dollars and 50% state dollars. SA beneficiaries are automatically eligible for Medicaid. Effective January 1, 2023, SAIH beneficiaries are also automatically eligible for Medicaid.

To be eligible for SA, an individual must be eligible for SSI, or ineligible for SSI **solely due to income**. Each applicant/beneficiary (a/b) for State/County Special Assistance must apply for **all** benefits to which he/she may be entitled, including receiving the maximum benefit for which the applicant is eligible. This includes, but is not limited to, SSI. If the a/b's income is less than the Federal Benefit Rate (FBR) for SSI, after applying appropriate income exclusion up to $20, the a/b is required to apply for SSI. See SA-3110, Application Process.

This section outlines basic eligibility requirements for the receipt of Special Assistance.

Note: Throughout SA policy any references to the a/b, always apply to the a/b's Authorized Representative as well.

II. GENERAL ELIGIBILITY

A. All beneficiaries must meet the following requirements:

1. Be an individual who is age 65 or older; or is 18-64 and disabled or legally blind; or an individual who is under 18 and is legally blind.

2. Reside in North Carolina with the intent to remain and meet residency requirements.

3. Reside in a licensed facility authorized to receive SA payments, except for temporary absence not expected to exceed 30 days.

4. Require the level of care provided in licensed adult care homes or supervised living and have a valid FL-2 that is signed and dated by a physician, physician assistant, or nurse practitioner.

5. Not be an inmate in a jail or prison.

6. Receive SSI or is financially ineligible for SSI solely due to income.

7. Be a U.S. citizen or qualified alien.

B. SSI Beneficiaries

A current SSI beneficiary automatically meets the categorical and financial requirements for SA.

C. Non-SSI Beneficiaries

To receive SA, non-SSI beneficiaries must meet the eligibility requirements for SSI except for income. In addition, non-SSI beneficiaries must meet the following requirements:

1. Provide documentation of U.S. citizenship or a qualified alien status. Refer to SA-3240, Citizenship and Identity.
2. Provide documentation of identity. Refer to SA-3240, Citizenship and Identity.
3. Meet the SA income requirements. Refer to SA-3210, Income.
4. Meet resource requirements. Refer to SA-3200, Resources.
5. Not have made a non-allowable transfer of resources (or established a non-allowable trust). Refer to SA-3205, Transfer of Resources.

D. NC Innovations Waiver and Special Assistance

Depending on individual circumstances and need, an individual can potentially receive both Community Alternatives Program (CAP) via the NC Innovations Waiver **and** SA in an ACH (or SAIH) at the same time if they reside in a 5600C Supervised Living facility that is licensed and eligible to receive SA payments (and which is acceptable per the CAP Innovations program). The client must still meet all eligibility criteria for SA as outlined in the SA policy manual.

CAP services via the NC Innovations Waiver are the **only** type of CAP services that a Special Assistance or SAIH beneficiary may receive.

E. SA and PACE Cannot Be Received At The Same Time

Individuals who receive Special Assistance cannot receive NC Program of All-Inclusive Care for the Elderly (PACE) coverage at the same time, as PACE provides all-inclusive care.

When an active PACE recipient applies for Special Assistance, the PACE recipient must disenroll from PACE by the end of the SA application processing time standard (45th/60th day) and meet all other SA eligibility criteria in order for the SA application to be approved.

- If the individual **has not** been disenrolled from PACE by the 45th/60th day, the SA application must be denied.
- If the PACE recipient **has** been disenrolled from PACE by the 45th/60th day of the SA application **and** meets all other SA eligibility criteria, **the effective date of SA benefits cannot be on or prior to the PACE disenrollment date**.
- "Disenrolled" refers to all parts of the PACE disenrollment being completed, with an effective end-date for PACE in NC FAST.

Important: For any month in which an SA payment is received while the SA beneficiary is also enrolled in PACE, that SA payment is an overpayment which must be recouped. **There can be no overlap of SA and PACE services.**

III. AGE AND DISABILITY ELIGIBILTY REQUIREMENT

A. SAA (Special Assistance for the Aged)

Be age 65 or older.

B. Verification of date of birth for SAA is required.

1. Verify applicant's age by SOLQIS.
2. If the applicant's age cannot be verified by SOLQIS or OLV and is not questionable, accept applicant's statement.
3. If applicant's age cannot be verified by SOLQIS or OLV and the applicant's statement of age is questionable, any one of the following sources can be used.
    a. Birth certificate issued by a governmental body, or
    b. Hospital records established at time of birth (including a hospital-issued birth certificate).
4. If neither of the verification documents are available and the applicant's statement of age is questionable, use any two of the following documents:
    a. Driver's license
    b. Marriage license
    c. Family Bible records

d. Church documents such as baptismal or confirmation records
e. Passport
f. Military records
g. School records
h. Department or institution records
i. Court records, including adoption records
j. Immigration records
k. Naturalization records
l. U.S. census records
m. Witnessed statement from an individual having specific knowledge about the age of the a/b including:
    (1) The name of the child;
    (2) Date and place of birth;
    (3) Name of father;
    (4) Maiden name of mother;
    (5) Why the verification is needed;
    (6) A signed statement authorizing release of the information.

Other Verification Sources for Age

1. Individuals born in NC:
    a. NC Vital Records
    1903 Mail Service Center
    Raleigh, NC 27699-1903

    OR

    b. The County Health Department where the individual was born. For individuals born in other states, contact the state vital records office to determine what agency to contact for birth verification.

2. Verification of age of children born to U.S. citizens who were in overseas governmental services may be accomplished by contacting:

    Office of Authentications
    U.S. Department of State
    CA/PPT/S/TO/AUT
    44132 Mercure CIR PO BOX 1206 Sterling, VA 20166 1206
    Telephone: 202-485-8000

C. SAD (Special Assistance for the Disabled)

1. Be age 64 and under, and

2. Be determined permanently and totally disabled or legally blind by Social Security standards. Refer to SA-3110, Application Process for procedures to establish disability for applicants who have not had disability or blindness established.

3. If under 18 the a/b must have established that he/she is legally blind. The child or adolescent must reside in a specialized community residential center. A child or adolescent is eligible to receive SA in a specialized community residential center only until he/she turns 18. When he/she becomes **18**, he/she may be eligible for SA in an adult care home or other adult SA facility if he/she continues to meet all other SA requirements.

IV. STATE RESIDENCE REQUIREMENT

A. An individual must be residing in North Carolina voluntarily with intent to remain.

1. To be eligible for SA, the individual must be a resident of North Carolina for at least 90 consecutive days immediately prior to receiving this assistance. See IV. D. below for only exception.

2. When an individual moves into North Carolina, and states his or her intent to remain, a written statement of intent must be obtained.

3. An individual visiting in the state without a stated intent to remain is not considered a North Carolina resident.

4. An applicant cannot declare an intent to remain in North Carolina and sign an intent to return home to exclude their home site in another state. Refer to SA-3200, Resources, for information on intent to return.

B. Verification

If the applicant's statement of residency is questionable, obtain one of the following documents for verification:

1. Post-marked letters
2. Public utilities records or credit accounts records
3. Voter Registration Records
4. Rental records
5. Real property ownership records
6. Employment records
7. Other documentary evidence presented by the applicant. (Example: whether applicant has their belongings in this residence)

C. Date of application and eligibility

1. If the applicant applies before the 90-day requirement is met, the a/b is not eligible for SA. Deny the application and document the date the applicant moved to North Carolina (with the intent to remain) and when the 90th day of state residency will be met, unless the 90-day requirement can be met during the processing time. The application may be approved if the residency requirement will be met during the application processing time frame and if all other eligibility criteria are met. The SA benefit cannot be authorized prior to the applicant meeting residency requirements.

3. If an applicant applies on or after the 90th day of state residency, the a/b is eligible for SA effective the day all other eligibility requirements are met. If the 90th day falls after the first day of the month, authorize a partial payment for that month, prorated from the 90th day of state residency, even if the applicant was in an SA facility on the first day of that month. A Special Assistance payment cannot be made for any days in an SA facility during the waiting period. The effective date for retroactive payments cannot be earlier than the 90th day of residency in the state. As always, when computing a partial payment, include the full personal needs allowance, but do not count the applicant's income for that month.

4. Ask the a/b when he/she voluntarily moved and decided to remain in North Carolina to determine the 90th day of residency. Beginning with, and including the date of intent to remain, count forward 90 days (or add 89 days to the date of intent to remain). Payment may begin effective the 90th day, if all other eligibility criteria have been met.

D. Exception to the 90-day residency requirement:

When the applicant is discharged from a State facility who was a patient in the facility because of an interstate mental health compact.

1. There is no 90-day waiting period for applicants who meet this criterion. The state facility discharging the applicant must provide the county DSS with verification that the applicant was a patient in the state facility on a DMA-5010, Referral for Inpatient Hospital and Intermediate Care Facilities.

2. For purposes of this provision in the law, a state facility is a facility listed under G.S.122C-181. This includes the three state psychiatric hospitals (Cherry, Central Regional, Broughton); the three regional developmental centers (Caswell, Murdoch, J. Iverson Riddle); the three alcohol/substance abuse centers (Julian F. Keith, R.J. Blackley, Walter B. Jones); Whitaker Psychiatric Residential Treatment Facility; and the neuro-medical treatment centers (Black Mountain, O'Berry, Longleaf).

3. A person who was a patient in a state facility because of an interstate mental health compact arrangement and who is discharged from the state facility directly into an SA facility becomes a legal resident of the county in which the SA facility is located.

V. LICENSED SA APPROVED FACILITIES

To receive SA, an a/b must reside in a licensed facility authorized to receive SA payments, except for temporary absence not expected to exceed 30 days.

Civil Rights Agreement: all facilities accepting SA residents must have a Civil Rights Agreement, DSS-1464-(ia) signed by the facility owner or operator on file with the NC Division of Social Services (DSS). Once verified by the DHHS Special Assistance section, NC FAST will reflect on the Facility Inquiry screen that a facility has a valid Civil Rights Agreement. Combination nursing facilities and hospitals (with adult care beds) for Medicare and Medicaid Certification must have signed these agreements and submitted them to the Centers for Medicare and Medicaid Services as a requirement of licensure. If the facility shows "Medicaid Certified", it meets the criteria for the Civil Rights Agreement.

Verification of Facility Record in NC FAST: Verify in NC FAST that the facility is an SA eligible facility by utilizing Facility Search. Click on the facility in Search results to view the Facility Inquiry screen. There will be a "Y" in the SA Eligible Indicator for the facility if it is a facility approved to accept SA. Print the NC Fast Facility Inquiry results for the facility that is the a/b's physical residence. Use the printed NC FAST Facility Inquiry screen to verify/document the facility's correct name, physical location, licensure status, facility code and other important eligibility data. The IMC must obtain and file the Facility Inquiry screen printout in the SA case record to show verified facility eligibility at every application, recertification, and any a/b change/move to a new facility residence.

The following facility types may accept Special Assistance:

A. Adult care homes (ACHs)

B. Family care homes

C. Adult care home beds in some nursing facilities and hospital facilities (combination facilities).

NC FAST will only allow one facility type to display. If the facility is a combination/dual facility, it will display "Nursing Home" on the Facility Search Screen rather than "domiciliary."

D. Residential hospice facilities

E. Certain mental health facilities licensed under G.S. 122C

1. A facility, designated with the letter "A" which serves adults whose primary diagnosis is mental illness, but who may also have other diagnosis. This facility type is designated in NC Administrative Code 10A NCAC 27G.5600.

2. A facility, designated with the letter "C" which serves adults whose primary diagnosis is a developmental disability, but who may also have other diagnoses. This facility type is designated in NC Administrative Code 10A NCAC 27G.5600.

3. Facilities known as Specialized Community Residential Centers designated in NC Administrative Code 10A NCAC 27G.2100. In this group, only mental health facilities with a designation of 27G.2101 for children and adolescents under age 18 are SA eligible facilities. Facilities which are ICF/MR are not eligible for SA funds. (Only children and adolescents underage who are legally blind are eligible for SA.)

4. Licensed facilities listed by type are found on the Division of Health Service Regulation website.

VI. CONFLICT OF INTEREST

A. General Statute 108A-47

North Carolina General Statute 108A-47 prohibits payments of Special Assistance to any person residing in an adult care home that is owned or operated, in whole or in part, by any of the following:

1. A member of the Social Services Commission, any county board of social services, or any board of county commissioners;

2. An official or employee of the Department, unless the official has been appointed temporary manager of the facility pursuant to NCGS 131E-237, or of any county department of social services; ("County department of social services" means a county department of social services, consolidated human services agency, or other local agency designated to administer Special Assistance.)

3. A spouse of any person in (1) or (2).

B. Contact for Questions Regarding NCGS 108A-47

If your county agency has any questions regarding this provision, or if a situation exists in your county that may violate this provision, please contact a Special Assistance Representative via DSS-9000SA to the SA listserv at specialassistance@dhhs.nc.gov.

VII. VALID FL-2 REQUIREMENT - LEVEL OF CARE

To receive SA, in an adult care home or for Special Assistance In-Home, the a/b must have a valid Adult Care Home FL-2. A legible copy of the FL-2 must be placed in the eligibility record. FL-2's are valid for 12 months. Also, refer to SA-3110, Application Process.

A. Applications

1. At application the FL-2 must be dated no more than 90 calendar days prior to the date of application to be considered valid if the applicant is not already a resident of an SA facility.

2. If the applicant resides in an SA facility prior to the date of the SA application, and has a valid FL-2, the FL-2 cannot be dated more than 12 months prior to the processing deadline for the SA application. If the FL-2 will be over 12 months old by the end of the processing deadline, the Income Maintenance Caseworker (IMC) must request an updated FL-2 via the DHB-5097 12 calendar days before the FL-2 becomes invalid.

3. When an FL-2 form is submitted as level of care verification, the IMC must thoroughly examine the FL-2 to determine if it is valid. **The minimum requirements for an FL-2 to be considered valid are:**

    a. It must be legible.

b. It must be signed and dated by a physician, physician assistant, or nurse practitioner.

c. The a/b's name (Box 1), date of birth (Box 2), attending physician's name and address or Practice name (Box 8), and admitting diagnosis (Box 15) must be indicated on the FL-2.

d. The Recommended Level of Care must be indicated in Box #11.

e. The Recommended Level of Care must indicate the need for **Domiciliary** care, which is a term that includes care provided in ACHs, assisted living, supervised living, mental health group homes, hospice residential facilities, rest homes, or specialized community residential centers. Any of these terms (or "Domiciliary") are acceptable if written in block #11.

f. The Adult Care Home FL-2 (DMA-372-124-ACH) is posted on the DMA Forms website and should be used for SAIH cases.

g. An electronic FL-2 or a Long Term Care FL-2 can also be accepted as long as the form contains, at a minimum, the items listed in a - e above.

h. If the FL-2 form presented to the IMC is invalid due to missing information and/or needs correction, explain that the original physician/physician assistant/nurse practitioner who signed the FL-2 can correct the form by completing the blank or incorrect boxes and adding their initial and date by each correction.

Note: No one other than the medical originator who *initially completed* the FL-2 can alter the information on the FL-2.

i. A valid FL-2 which meets all the requirements listed above is required for SA Basic, SA SCU, SAIH and the SAIH / TCL program.

4. SA benefits can begin no earlier than the date the FL-2 is appropriately signed for an adult care home SA case. For SA In-home cases see SA-5200. The FL-2 must be received during the application processing time standard.

5. Be mindful that any information provided on an FL-2 may provide eligibility leads or leads on situation changes that need further exploration. It is the county's responsibility for assuring all leads are followed up.

6. Ensure that the date of the FL-2 is recorded correctly in the Certification Start Date field of Level of Care Evidence in NC FAST.

7. Assignment of the correct SA rate in NC FAST requires that the correct *Level of Care Type* is selected in Level of Care evidence on the NC FAST dashboard. For each placement type (facility, SA In-Home, and TCL) there is both a "Basic" and an "Enhanced" rate option. Choosing the correct *Level of Care Type* ensures appropriate rate budgeting. (Refer to NC FAST's *Special Assistance – Level of Care Evidence* Job Aid in FAST Help for more information.)

B. Ongoing Cases

1. For ongoing cases, a new FL-2 must be obtained within 12 months from the date of the last one, before reauthorizing assistance. This could occur during the redetermination process or at any time during the certification period.

2. A new FL-2 must also be obtained when the beneficiary returns to the SA facility following time spent in a facility with higher level of care, or

3. A new FL-2 must also be obtained when the beneficiary enters a different SA facility following hospitalization.

4. For ongoing cases, the minimum requirements for an FL-2 to be valid are the same as those listed in VII. A. 3. of this manual section.

C. Additional Requirements for Special Care Unit Payments at the SA Enhanced Rate

There is a higher SA rate for SA beneficiaries in an adult care home who reside in an SCU for Alzheimer's or a related disorder. This higher rate is known as the Enhanced rate. To qualify for the Enhanced rate in a Special Care Unit, a/b's must meet additional requirements.

1. To approve SA in an adult care home for the Enhanced rate, the FL-2 must have a diagnosis of Alzheimer's disease or other forms of dementia, characterized by dementing or memory impairing conditions with irreversible memory dysfunction, and the a/b must be placed in a licensed SA-approved SCU. For a list of licensed SCUs, see the Division of Health Service Regulation website for

licensed SCU's.

2. For an a/b in a SCU, a visit to the facility by a DSS employee must be completed at both application, every redetermination, or when a move from "basic" to SCU is reported, to verify placement in the SCU unless the facility only has SCU beds. The onsite visit may be completed and the residence in an SCU verified by any DSS staff.

3. Document the findings listed below.

4. If the facility has both ACH Basic beds and SCU beds, verify the date the a/b entered the SCU by viewing the a/b's facility record.

   a. Verify the a/b is currently in the SCU by viewing the a/b's room.
   b. If the ACH has only SCU beds, telephone the facility to verify the date of entry.
   c. If the a/b is not a resident of the county of eligibility, a request to the DSS where the facility is located should be made to complete the required visit for verification purposes.

D. Requirements for Enhanced Rate Payments for SAIH Beneficiaries With a Diagnosis of Alzheimer's Disease or Dementia

The Enhanced rate is also available for SAIH beneficiaries in in-home living arrangements who have a diagnosis of Alzheimer's disease or dementia. To approve SAIH for the Enhanced rate, the SAIH a/b's FL-2 must have a diagnosis of Alzheimer's disease or other form of dementia. (See SA-5200 II.)

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SA-3110 APPLICATION PROCESS

North Carolina Division of Social Services

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SA-3110 APPLICATION PROCESS

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I. INITIAL CONTACT

A. Contact Via Mail

If the applicant requests a Special Assistance (SA) application by mail, send the DSS-3000, Follow-up Letter Regarding Special Assistance Request within three business days of receiving the request. The letter specifies that if the DSS does not hear from the applicant within 15 calendar days of the date of the letter, it will be considered that the applicant is no longer interested in applying for benefits.

B. Contact Via Phone

If the applicant requests a SA application by phone, explain that an application cannot be accepted by phone, fax, or email. Inform the applicant that a face-to-face interview is required. Request that the applicant come to the DSS for an interview. If the applicant states they cannot come into the agency for the face-to-face interview, offer a facility/home visit to complete the interview. Consider other arrangements to accommodate the applicant when reasonable circumstances prevent the individual from coming into the agency. Explain that an application must be signed to initiate the application process and a delay in signing an application may result in the loss or delay of benefits. Send the DSS-3000 Follow-up Letter Regarding Special Assistance Request. The form specifies, that if the DSS does not hear from the applicant within 15 calendar days of the date of the letter, the agency will assume that the applicant is no longer interested in applying for Special Assistance.

C. Contact Via Mail-in Medicaid Application

If a DHB-5200 or DHB-5201 Application for Health Coverage & Help Paying Costs is received and in talking to the individual or authorized representative, it is determined the individual intended to apply for SA, the DSS-8190 SSI/Non-SSI Application Workbook and other required application documents shall be completed as appropriate in an intake interview. Send a DHB-5097,Request for Information with a scheduled interview appointment for the individual and/or authorized representative to come into the Department of Social Services to complete the SA application. If the applicant does not show for the interview appointment send the DSS-3000 Follow-up Letter Regarding Special Assistance Request. The form specifies that if the agency does not hear from the applicant within 15 calendar days of the date of the letter, the agency will assume that the applicant is no longer interested in applying for SA.

D. Applicant is Currently Residing in a State Institution

If the applicant is currently residing in a state institution, a properly completed referral, DMA-5010, Referral for Inpatient Hospital and Intermediate Care Facilities, may serve as an application document. The date the referral is received by the agency is the date of application.

E. Contact Via Agency Visit

When an individual comes into the agency and requests to apply an application for SA, explain the following:

1. An individual has a right to apply on that day.

2. An individual has the right to apply on her/his own behalf.

3. The official application for SA is the DSS-8190 SSI/Non-SSI Application Workbook.

4. A face-to-face interview is required.

5. If the individual wants to apply on that day but cannot stay for the interview, an interview appointment will be scheduled. The DSS worker will:

    a. Have the individual sign a DMA-5094, Notice of Your Right to Apply for Benefits to protect the application date.

    b. Explain that a completed Special Assistance application and a face-to-face interview is required to complete the application process.

    c. Explain that the application cannot be processed unless an application interview is completed.

    d. Obtain the name of applicant, the name of the person requesting the appointment, the address, and contact information.

    e. Schedule a mutually agreeable appointment time for the interview. When possible, make the appointment for the next business day.

    f. Give or mail the DHB-5097 Request for Information, with the scheduled date and time for the interview.

6. If the individual decides not to apply that day, explain that they may apply at any time. An inquiry (DMA-5095 Notice of Inquiry) must be completed with areas of eligibility discussed, offered, and complete documentation of why the applicant chose not to apply for assistance. The following must be included with each inquiry and given to the individual:

    a. Have the DMA-5094, Notice of Your Right to Apply for Benefits completed and signed and retain a copy. This will protect the application date.

    b. Have the DMA-5095 Notice of Inquiry completed and signed and retain a copy.

F. All Special Assistance applications must be entered and submitted into NC FAST within <u>three</u> business days from the date the application is signed by the applicant.

G. Discouragement

An applicant or representative must not be discouraged from applying for any assistance. Discouragement can occur with or without a signed application and can be discovered in several ways, including a report by the applicant or potential applicant through a second-party review, or by the application monitor. Please refer to the ABD Medicaid Manual, MA-2295 Discouragement.

II. PARTICIPATION IN THE APPLICATION PROCESS

A. Who Can Sign The Application?

1. An Adult (age 18 or older in the month of application) who is mentally and physically capable, must sign the application.

2. If the applicant is under 18, mentally incompetent, or physically unable to sign, an authorized representative can sign the application.

3. In certain situations, a non-authorized representative may sign an application if either one of the following conditions are met:

    a. To prevent the applicant from losing benefits because of a delay in filing the application, when there is valid reason why the applicant cannot sign the application.

b. If the applicant resides in a state institution (mental hospital, developmental center, or prison), information shall be obtained from a responsible person or staff member of the institution.

NOTE: If the applicant is currently residing in a state institution, a properly completed referral, DMA-5010, Referral for Inpatient Hospital and Intermediate Care Facilities, may serve as an application document, therefore no DSS-8190 is required. The date the referral is received by the agency is the date of application.

c. The circumstances to meet either condition must be clearly documented in the case file.

B. When an individual other than the applicant makes an application

Identify if the individual is an *authorized representative* or *non-authorized representative*.

1. A non-authorized representative is someone who applies on behalf of an individual but does not have the legal authority to sign on behalf of the individual. Non-authorized representatives are not allowed access to that individual's personal information used to determine eligibility. Information regarding the application cannot be shared with a non-authorized representative without written approval from the applicant or an authorized representative.

2. An Authorized representative is any individual who is legally authorized or designated in writing by the applicant to act on the applicant's behalf.

   a. Types of Authorized Representatives listed below in hierarchy order:

      - Legal Guardian (includes DSS with custody or guardianship);

        Guardianship is appointed by Clerk of Superior Court. Guardianship is the legal relationship where an individual's authority to make decisions is replaced with the authority of another (the guardian) when the Clerk of Superior Court finds the individual no longer capable of making decisions for themselves. In North Carolina, the laws concerning

guardianship are found in NC General Statute 35A Incompetency and Guardianship - Proceedings To Determine Incompetence.

- Power of Attorney (POA);

  Appointed by the competent adult, the Power of Attorney (POA) is an official document by which a competent person (adult) appoints another competent person or persons to assist in managing affairs of the person making the appointment. The scope of the POA's authority may be broad or narrow as specified in the official document. Both general and durable POA's serve as attorneys-in-fact to act in legal matters. The POA ends when the person who made the POA appointment dies, or as a competent adult, revokes the POA authority.

- Health care power of attorney;

  A health care power of attorney designates an individual to make health care decisions for an individual when the individual no longer has the capacity to do so.

- Department of Social Services (placement responsibility only);
- Spouse (Not Separated);
- Parent (For children under21);
- Authorized representative;

  An individual designated in writing and signed by the applicant to assist with eligibility issues and who can have access to the information in the case file.

  NOTE: The DMA-5202-Appendix C, Designation of Authorized Representative is the authorized representative form for Medicaid and accepted for Special Assistance. A handwritten note stating such authority may also be accepted but should be verbally verified with the applicant at the start of the application process.

- Authorized representative as designated by SSA;

  An individual who applied for and was approved by SSA to be an authorized representative for the individual. Obtain a copy of the *SSA-L1697-U3 Notice to Representative of Claimant Before the Social Security Administration*.

NOTE: A representative payee and an authorized representative are *two separate appointments*. **Ensure that you have verification of the authorized representative and not the representative payee**. OVS only identifies the representative payee, not the authorized representative.

b. The IMC must enter the authorized representative on the Person Page in NC FAST. The pathway is Person Page/Client Contact/Contacts folder. Add new or select from a registered individual. As a best practice this should be done prior to dispositioning the application but can be done at any time during the application process. Each type of Authorized Representative must be identified by type in NC FAST.

C. When an Authorized Representative Makes an Application

1. Obtain verification of the authorized representative's appointment.

2. The authorized representative may then complete the application/interview.

3. Add the authorized representative to the Person page/Client Contact/Contacts folder in NC FAST. Ensure the correct authorize representative type is selected in NC FAST.

D. When A Non-Authorized Representative Makes an Application

Explain to the non-authorized representative(s) that information regarding an application and/or ongoing case cannot be released to the non-authorized representative without written authorization by the applicant or the applicant-authorized representative. Ask and document the answers to the following questions:

1. Does the applicant have a legal power of attorney or guardian appointed by the court system?
   a. If the answer is **yes:**

      (1) Document the POA or legal guardian's name, address, and phone number.

      (2) Contact the POA to ensure they are aware that an application is being requested and if they wish to complete

the application, they must answer all the questions on the DSS-8190 SSI/Non-SSI Application Workbook.

(3) Have the non-authorized representative sign the DMA-5094, Notice of Your Right to Apply for Benefits, to protect the application date. Also give them a DSS-3000 Follow-up Letter Regarding SA Assistance Request with a scheduled appointment on it, and instruction that the application must be completed and signed by the POA, guardian, or an authorized representative.

Remind the non-authorized representative (and the POA or guardian, if they can be reached) that the POA or guardian may choose to appoint another individual as an authorized representative by signing a DMA-5202C. The IMC must mail the DMA-5202C to the POA or guardian. However, until it is returned, no one other than the applicant or POA/guardian can complete the application or sign the DSS-8190 SSI/Non-SSI Application Workbook.

(4) Obtain a copy of the legal guardianship or POA appointment and file the document in NC FAST.

(5) Include the guardian or POA on all case correspondence.

(6) As per the DSS-3000 Follow-Up Letter Regarding SA Assistance Request, if the DSS does **not** hear from someone who is authorized to act on the applicant's behalf within 15 calendar days of the date of the letter, the county department of social services may assume the applicant is no longer interested in applying for Special Assistance. The date on the DMA-5094 is no longer protected as the application date.

b. If the answer is **no**, proceed to the next question.

2. **Why is the individual not applying on their own behalf?** Is the individual competent to answer the questions and able to sign the application?

a. If the answer is **yes,** the applicant is competent, and the applicant can sign (this includes making a mark):

(1) The applicant or an authorized representative must complete the interview and sign the application.

(2) Have the non-authorized representative sign the DMA-5094, Notice of Your Right to Apply for Benefits, to protect the application date. Give the non-authorized representative a DSS-3000, Follow-up Letter Regarding SA Assistance Request with a scheduled appointment on it, and instruction that the application must also be completed and signed by the applicant or an authorized representative.

(3) If applicant is unable to come into the office, complete a facility/home visit or make alternative arrangements. Alternative arrangements may include, but are not limited to, interviews conducted via a phone or skype.

Note: Questions regarding approved alternative arrangements should be submitted to the SA listserv.

(4) As per the DSS-3000 Follow-Up Letter Regarding SA Assistance Request, if the DSS does **not** hear from someone who is authorized to act on the applicant's behalf within 15 calendar days of the date of the letter, the county department of social services may assume the applicant is no longer interested in applying for Special Assistance. The date on the DMA-5094 is no longer protected as the application date.

b. If the answer is **yes** that the applicant is competent, but the applicant is unable to sign:

(1) The applicant or their authorized representative must complete the interview. Document the reason why the applicant cannot, at the current time, sign on the signature line.

(2) Examples include, but are not limited to, both arms in traction, burn victim whose hands are bandaged and immobilized, and an individual who recently had eye surgery and is unable to see to sign.

(3) Inform the non-authorized representative that the alleged incapacity must be supported by a *written statement* from a medical professional, such as a physician or nurse, who is knowledgeable about the applicant's condition. The written statement must include:

- An explanation of the reasons the applicant is alleged to be physically incapacitated

- The approximate onset of the applicant's incapacity
- A brief explanation of the nature of the incapacity, including medical conditions or diagnosis that caused it
- Expected duration of the applicant's incapacity, AND
- The basis for the knowledge or opinion of the individual providing the explanation of incapacity
- The written statement and any related materials or documentation must not be older than 90 days prior to the application date.

(4) Have the non-authorized representative sign the DMA-5094, Notice of Your Right to Apply for Benefits, to protect the application date. Also give them a DSS-3000 Follow-up Letter Regarding SA Assistance Request with a scheduled appointment on it, and instruction that a written statement is needed from a medical professional regarding the physical incapacity that renders the applicant unable to sign application documentation.

(5) Once the written statement is received, the application may then be signed by the non-authorized representative to prevent a loss of benefits for the applicant. If the applicant is unable to come to the DSS, make immediate arrangements to interview the incapacitated applicant via phone or facility visit in order to get information to complete the DSS-8190.

(6) Documentation of the above questions and answer to support the reason for a non-authorized representative signing the application must be in the case file, along with the written medical statement.

(7) As per the DSS-3000 Follow-Up Letter Regarding SA Assistance Request, if the DSS does **not** hear from someone who is authorized to act on the applicant's behalf within 15 calendar days of the date of the letter, the county department of social services may assume the applicant is no longer interested in applying for Special Assistance. The date on the DMA-5094 is no longer protected as the application date.

c. If the answer is **no**, indicating the applicant is not competent:

(1) Inform the non-authorized representative that the alleged incompetence must be supported by a *written statement* from either a physician, a nurse, a social worker, or a psychologist. The written statement must include:

- An explanation of the reasons the applicant is alleged to be incompetent
- The approximate onset of the alleged incompetence
- The ending date of alleged incompetence, if the person has improved, AND
- The basis for the knowledge or opinion of the individual alleging the incompetence.

(2) Make a referral to the agency's Adult Services or Adult Protect Service (APS).

(3) Have the non-authorized representative sign the DMA-5094, Notice of Your Right to Apply for Benefits, to protect the application date. Also give them a DSS-3000 Follow up Letter Regarding SA Assistance Request with a scheduled appointment on it, and instruction that a written statement is needed from a physician, nurse, social worker, or psychologist regarding the applicant's alleged incompetence.

(4) Once the written statement is received, the application may then be signed by the non-authorized representative to prevent a loss of benefits for the applicant.

(5) Documentation of the above questions and answer to support the reason for a non-authorized representative signing the application must be in the case file, along with the written medical statement.

(6) If the DSS does **not** hear from someone authorized to act on the applicant's behalf within 15 calendar days of the date of the DSS-3000, the county DSS may assume the applicant or non-authorized representative is no longer interested in applying for Special Assistance (and the DMA-5094 no longer protects the application date).

Alternatively, and depending upon circumstances, the county DSS may contact the SA Listserv via a DSS-9000SA form to explain the situation and determine what can be done to prevent a loss of benefits and to avoid potentially endangering the applicant.

3. **Is the non-authorized representative attempting to make a courtesy application?**

   If a *non-authorized representative* wishes to make a courtesy application in a county DSS which is not the applicant's legal SA county of residence:

   a. Address all questions in this policy section (II. D.) with the non-authorized representative. Follow the appropriate instructions provided in this policy section based on the answers to the related questions.

   b. Have the non-authorized representative sign the DMA-5094, Notice of Your Right to Apply for Benefits, to protect the application date. Also give them a DSS-3000 Follow-up Letter Regarding SA Assistance Request with a scheduled appointment at the DSS potentially taking the courtesy application. Check off any/all appropriate items on the first page of the letter.

   c. As per the DSS-3000 Follow-Up Letter Regarding SA Assistance Request, if the DSS that gave the DSS-3000 to the non-authorized representative **does not** hear from someone acting on the applicant's behalf within 15 calendar days of the date of the letter, the county department of social services may assume the applicant is no longer interested in applying for Special Assistance. The date on the DMA-5094 is no longer protected as the application date.

   d. If someone appropriate **does** act on the applicant's behalf within 15 calendar days of the date of the DSS-3000 to complete the SA interview (and provides any other documentation requested on the first page of the DSS-3000), they may complete and sign the application. The date on the DMA-5094 can then be used as the application date. The DSS taking the courtesy application must follow all guidelines regarding taking, submitting, and forwarding courtesy applications in SA-3110 IV.D.1-2. The county receiving the courtesy application still has the responsibilities given in IV.D.3.

4. NC Administrative Code related to authorized representatives can be found in 10A NCAC 71P .0602.

III. ACCEPTING THE APPLICATION

A. Allow the applicant to apply without delay when the applicant requests a SA application.

Without delay is defined as allowing the application on the same day the applicant, or a representative of the applicant, appears at the county department of social services. Refer to SA-3110 IV. Applications and County of Residence.

B. Allow the applicant to apply when there is an anticipated need if the need will occur within the time standard for completing the application.

C. Explain that an applicant may apply for the program of their choice.

Discuss the advantages and disadvantages of both the SA and SAIH programs.

D. Use the DMA-5094, Notice of Your Right to Apply for Benefits to inform the applicant verbally and in writing that a decision must be made concerning eligibility within 45 days of the date of the application for SAA or 60 days for SAD.

The 45- or 60-days includes the time from date of application to the date that the approval or denial notice is mailed. Exceptions to these time frames include:

- The application may pend up to 6 months if the only remaining verification is citizenship and/or identity and the applicant is cooperating to the best of their ability or when it is the county's responsibility to pursue verification on behalf of the applicant based on policy requirements.
- The application may pend up to 12 months when the applicant is not receiving, but may be eligible for, SSA Retirement, Survivors, or Disability Income (RSDI), or SSI, and is awaiting the SSA decision of eligibility.

E. When the interview cannot be completed on the same day, a DSS staff member must:

1. Have the individual sign a DMA-5094, Notice of Your Right to Apply for Benefits on the day the request for financial assistance is received.
2. Explain the DSS-8190 SSI/Non-SSI Application Workbook is the Special Assistance application and a face to face interview is required

to complete the application process. The signed DMA-5094, Notice of Your Right to Apply for Benefits protects the application date.

3. Explain that the application cannot be processed unless an application interview is completed.

4. Document the reason an application appointment was made and/or requested.

5. Obtain the name of applicant, the name of the person requesting the appointment, the address and contact information.

6. Schedule a mutually agreeable appointment for the interview. When possible, make the appointment for the next business day.

7. Give or mail the DMA-5094, Notice of Your Right to Apply for Benefits, with the scheduled date and time for the interview.

8. If the individual fails to keep the scheduled appointment, send a second DHB-5097, Request for Information, scheduling a second appointment. Schedule the appointment at least 13 days after the first appointment so there are 12 calendar days between appointments. If the individual fails to keep the second appointment, see SA-3110, Types of Disposition, for procedures to deny the application.

IV. APPLICATIONS AND COUNTY OF RESIDENCE

The DSS staff begins the application process by determining the county of residence. This is important because SA benefits are 50% State and 50% county funds. When an individual or their authorized representative appears at a county DSS outside of the individual's county of residence, an application must be taken following all guidelines in III. 'Accepting Applications,' above.

The applicant shall not be required to travel to another county or DSS to submit an application. NC Administrative Code 10A 71P .0601 (1)-(3) requires that an application for SA may be made in any county DSS without delay or on the same day the applicant appears at the county department. Applications taken in a county DSS outside of the individual's county of residence are referred to as 'courtesy applications.'

A. County of Legal Residence for SAIH Cases

The county of residence/responsibility for Special Assistance In-Home is the county where the individual resides in private living **with the following exception**:

- Identified Transitions to Community Living (TCL) individuals who are Special Assistance In-Home Approvals with Verified Supported Housing Slots are approved in the county of SA/Medicaid origin and then transferred to the county in which the applicant is currently residing in private living. ***These cases are the only SA cases that are allowed be transferred to another county and transferred as a SAIH case.*** See SAIH 5250.

B. County of Legal Residence for Facility Cases

The county of legal residence for SA facility cases is the county in which the applicant last resided in a private living arrangement or intended to establish a private living arrangement. Document the applicant's prior (or intended) living arrangement and county prior to entering the SA facility, **with the following exceptions**:

- If the applicant states an intent to return home, thereby excluding the real property home site, the county of residence must be the county where the property is located.

- A child (under age 18) is always a resident of the State and County which is the legal residence of the parent(s) who have legal custody of the child. If the parent(s) with legal custody of the child move(s) out of a county and the child remains in a specialized community residential center, the new county of residence of the parent(s) will be financially responsible for the child the month following the month the parent(s) move to the new county. Transfer the case to the new county following transfer procedures in the relevant NC FAST Job Aids.

- If a child is in the custody of a county department of social services, that county is the child's legal residence and thus financially responsible for the child until the child turns 18. Once a child turns 18, if a county DSS becomes the legal guardian of the adult, then the adult continues to be a resident of the county named as guardian.

- A disabled adult child (DAC) in a facility is a resident of the county and state in which the DAC's parent(s) had residence immediately prior to the DAC reaching age 18.

C. Applicant's County of Residence Cannot Be Established:

1. The county of residence is the county in which the applicant is currently applying for SA.

2. If the applicant resides in a facility at the time of application, the county of residence is the county in which the SA facility is located.

D. Applicant Presents For An Application in a County DSS Which is Not The Applicant's Legal SA County of Residence:

When an applicant presents for an application in a county DSS which is not the applicant's legal SA county of residence **the DSS will complete a courtesy application**.

1. Obtain the following:

   - A completed, signed and legible, DSS-8190 SSI/Non-SSI Application Workbook with complete name, address, and contact number for applicant and/or authorized representative;
   - A DMA-5094, Notice of Your Right to Apply for Benefits;
   - A signed DMA-5052SA, State/County Special Assistance Beneficiary Estate Subject to Medicaid Recovery Notice;
   - A DSS-3431, Request for Financial Information, if appropriate;
   - Register of Deeds/property check (including parents' names, spouse's name(s), spouse's parents' names), and any other leads, if appropriate
   - Verify all other available online verifications (SOLQI, OVS, On-Line Data, AVS) as appropriate;
   - A DHB-5097, Request for Information (which must include the request for FL-2, if not provided)

   NOTE 1: If a disability determination is necessary or being requested, refer to Medicaid policy.

   NOTE 2: If an applicant applies in more than one North Carolina county, the county of legal residence will process the application protecting the first date (earliest date) of application.

   NOTE 3: If there is a dispute between counties concerning the above procedures, contact SA Program Representatives by sending a DSS-9000SA form to the listserv at specialassistance@dhhs.nc.gov.

2. The DSS *taking the courtesy application* has the following responsibilities:

a. Submit the application in NC Fast. Follow the relevant NC FAST Job Aid to transfer the application to the county of residence within two (2) business days.

b. Contact the county of residence to ensure that they are aware of the application. The application should appear as a task in the county of residence's work queue for processing.

c. **Send all items concerning the complete application electronically or by US Mail to the DSS in the applicant's county of residence within 24 hours or one business day.** If the application date falls on the day before a weekend or holiday, forward all the information the following business day.

d. Notify the contact person at the applicant's county of residence that the application has been mailed.

e. Maintain a copy of all the application information, in case the information is lost or destroyed in the mailing process.

f. Any additional information received must be delivered to the county of residence within two business days of receipt.

g. The date of application is the date the applicant and/or authorized representative requested financial assistance and signed the DMA-5094 Notice of Your Right to Apply for Benefits.

h. A suggested form to notify the beneficiary of the change in the county DSS which will be maintaining the case is the DSS-3001 Notice of County of Residence Reassignment/Transfer form.

NOTE: If more than two business days have passed after taking an application and the DSS learns that the applicant is a resident of another county, the DSS with the open application must process the application. Once the application is approved, clearly document the beneficiary's SA case file with verification of the correct county of residence. Initiate reassignment of the now ongoing case to the correct county of residence. A suggested form to notify the beneficiary of the change in the county DSS which will be maintaining the case is the DSS-3001 Notice of County of Residence Reassignment/Transfer form.

3. The county *receiving the courtesy application* has the following responsibilities:

a. Document the initial contact from the county taking the courtesy application.

b. Acknowledge receipt of the application in writing.

c. Process the application following SA procedures.

d. Maintain the case.

NOTE: Courtesy applications accepted from another county become the responsibility of the receiving county. It is recommended that, after receiving a courtesy application, the receiving county review the case for accuracy and contact the processing county to correct any errors.

4. For situations in which a ***non-authorized representative*** wishes to make a courtesy application, refer to policy in II.D.3.

V. EXPLAIN TO EACH APPLICANT THE ELIGIBILITY REQUIREMENTS AND THE APPLICATION PROCESS

A. The SA program is a state supplement to the federal SSI program. If the applicant's income is less than the federal benefit rate (FBR) for SSI, the individual is required to apply for SSI. The FBR is the basic standard used in computing the amount of SSI benefits for individuals and couples. The FBR may be increased annually to reflect increases in the cost of living.

B. Special Assistance provides a cash payment.

C. Special Assistance and Special Assistance In-Home automatically qualifies the applicant for Medicaid for non-SSI Recipients.

This does not apply to the SA for Certain Disabled Program.

D. Explain Retroactive Medicaid and discuss if there is a need for retroactive Medicaid benefits.

If the applicant does not request or is clearly not eligible for Medicaid that is retroactive to the SA application month, document in the SA case file

that retroactive Medicaid was offered and the reason that no retroactive application was taken.

E. When the applicant accepts Medicaid, they assign their right to third party insurance benefits to the state.

Inform the applicant that it is a misdemeanor to fail to disclose the identity of any person or organization against which they have the right to recovery of medical expenses paid by Medicaid.

F. Each applicant must apply for all monetary benefits to which the applicant may be entitled to, including receiving the maximum benefit for which the applicant is eligible. The individual cannot waive or renounce benefits that they may be eligible to receive, this includes but is not limited to SSI.

G. Special Assistance benefits cannot begin prior to the month in which an application is signed. There are no retroactive benefits for SA prior to the month of application.

H. If an applicant is required to apply for SSA benefits, SA benefits cannot begin until SSA has made a determination of eligibility, including disability for a person under age 65.

NOTE: Because SA is a state supplement to the federal SSI program, to be eligible for SA an individual must apply and be eligible for SSI or be found ineligible for SSI solely due to income. For additional information on SSI and the SA application, see SA-3110, VIII Establishing Disability for SAD.

I. The SA application may pend up to 12 months, if awaiting a decision from SSA.

J. If the applicant applied for SSA and was denied, and their appeal time frame has not lapsed, they may appeal the SSI/RSDI denial.

It is in the best interest of the individual to appeal the SSI/RSDI denial. For example, if they appeal the SSI/RSDI denial and win the appeal two years later, the SSI/RSDI benefits will be retroactive to the original SSI/RSDI application date. If they are denied and do not appeal, they would have to reapply for SSA/SSI and even if found eligible back to the original application date, the SSI/RSDI benefits will only go back to the most current application date.

NOTE: SA does not pend the SA application while waiting for the SSI/RSDI *appeal process*. The SA application must be denied. Explain to applicant that if the SSA appeal results in a reversal to approve SSI/RSDI retroactive to the date of SA denial, the SA application can be re-opened and SA benefits approved if all other eligibility conditions are met.

K. If SSA denies the SSDI/SSI application based on non-disability or not meeting criteria for legal blindness, or denies based on eligibility criteria other than income (such as resources, transfers, fleeing felon, etc.), the SA application will also be denied. This is because in order to qualify for SA an individual must be eligible for SSI or ineligible solely due to income.

L. If the DSS denies an SA application based on an SSA denial, advise the applicant that he may appeal the SSA decision. If SSA reverses their denial, the SA application may be reopened. See instructions in SA-3110, VII. Application Process for reopening applications due to SSA appeal reversals.

M. Explain what a change in circumstance is, and when to report it.

N. Explain the meaning of fraud and provide the Public Assistance Fraud Pamphlet to the applicant or Authorized Representative.

O. Explain the annual recertification process. Refer to SA-3320, Redetermination of Eligibility.

P. Discuss other available services and make appropriate referrals.

Q. Discuss how the applicant will receive the SA payment unless they, or their authorize representative, choose to have a substitute payee. Refer to SA-3200 Administration of Benefits.

R. The applicant must choose direct deposit or EBT cash card as their payment method and fully explain each option. A facility cannot require a SA payment to be deposited into a collective account.

VI. EXPLAIN TO THE APPLICANT THE REQUIRED INFORMATION NECESSARY TO PROCESS THE APPLICATION

A. Social Security numbers will be used to match information with other agencies such as the Internal Revenue Service (IRS), Employment Security Commission (ESC) and Social Security Administration (SSA).

Matches will be done unless withdrawal of the application is requested.

A DHB-5001N, Notice on the Use of Social Security Numbers, must be given to all applicants (in person, or via mail when necessary). The DHB-5001N is not required to be signed or returned. The form is for notification purposes only. Documentation should be added to the case record indicating when the form was given (or sent).

B. Inform the applicant that when other verification cannot be provided, it is the county's responsibility to use collateral sources to substantiate or verify all necessary information to establish eligibility.

Collateral sources of information include knowledgeable individuals (landlords, business organizations, public records, and documentary evidence. Failure to provide collateral contacts can result in the application being denied for failing to cooperate in establishing eligibility.

C. The IMC may visit the applicant's residence or SA facility if necessary, to verify eligibility requirements.

The application will not be denied if the applicant is unavailable during an unannounced visit.

D. Discuss Carolina ACCESS, the managed health care program for Medicaid and North Carolina Health Choice (NCHC) recipients.

Refer to MA-2425, Community Care of North Carolina/Carolina Access (CCNC/CA) for instructions.

E. SSI payments and any other income the applicant receives will be considered in calculating the SA payments.

F. SA eligibility is based on need as indicated by the recommended level of care.

If the FL-2 form presented to the IMC is invalid due to missing information and/or needs correction, explain that the original physician/physician assistant/nurse practitioner who signed the FL-2 can correct the form by completing or correcting the blank boxes and by adding their initial and date next to each correction. No one other than the medical originator who initially completed the FL-2 can alter the information on the FL-2. Refer to SA-3100 Eligibility Requirements for instructions regarding the Adult Care Home FL-2 requirement and what constitutes a valid FL-2.

G. The county must verify their residence.

H. If requested verification cannot be obtained by the second due date, the applicant should notify the IMC to request an extension of an additional 12 days.

I. The IMC must inform the SSA via DMA-5049 Referral to Local Social Security Office of the change in living arrangements.

Remind the applicant/authorized representative that it is their responsibility to notify SSA within 10 days of any change in situation.

J. When the applicant accepts Medicaid; they assign their right to third-party insurance benefits to the state.

Inform the applicant that it is a misdemeanor to fail to disclose the identity of any person or organization against which the applicant has the right to recovery of medical expenses paid by Medicaid.

K. Explain that the meaning of fraud is when an individual willfully and knowingly (with the intent to deceive) makes false statements or misrepresentations, fails to disclose information, or fails to report a change in situation.

In such situations, the applicant/beneficiary may have to repay assistance received in error and that they may also be tried by the courts for fraud.

VII. EXPLAIN TO THE APPLICANT THEIR RIGHTS AND RESPONSIBILITIES

A. Explain, in detail, the applicant's rights:

1. The right to apply on their own behalf at any time.
2. The right to receive assistance if found eligible.
3. The right to have any information given to the agency kept in confidence, in accordance with the federal and state laws and policies
4. The right to be protected against discrimination on the grounds of race, creed, or national origin by Title VI of the Civil Rights Act of 1964. Appeals based on discrimination should be made to the DSS director.
5. The right to be the payee for the SA payment unless the applicant or their authorized representative designates a substitute payee for the payment.
6. The right to choose how they receive their SA payment, via EBT card or Direct Deposit into a personal account or a facilities collective account.
7. If approved, the right to receive their SA payment until the payment is terminated by appropriate action.
8. The right to appeal, if:
    a. Assistance is denied, changed, or terminated.
    b. Applicant believes the payment is incorrect based on the county's interpretation of state regulations.

c. A request for a review of his or her eligibility decision including payment amount was delayed beyond 30 days or the request for review was denied.

9. The right to reapply at any time, if found ineligible.

10. The right to withdraw from the SA program at any time.

B. Explain in detail the applicant's responsibilities:

1. To apply for all monetary benefits to which the applicant may be entitled, including receiving the maximum benefit for which the applicant is eligible. The individual cannot waive or renounce benefits that they may be eligible to receive. This includes but is not limited to SSI.

2. To apply for SSI if their income is below the SSI Federal Benefit Rate (FBR).

   a. Explain to the applicant who receives SSI but whose SSI payment amount is less than the FBR, that they will need to work with SSA to establish income up to the FBR.

   b. Explain that SA payments cannot be issued in an amount to make up for SSI income deficit when the total gross income is less than the FBR and is reduced for any reason other than:

      (1) Social Security Administration (SSA) overpayment recoupment (when SSI or RSDI income is garnished for any reason other than to recoup an SSA overpayment, the total monthly income, including the amount that is being garnished is entered as evidence and is countable;

      (2) SSI couple deeming;

      (3) SSI denials due to life insurance excess for those who had specific life insurance face/cash value policies prior to December 1, 2009; and

      (4) SSI determinations related to private living reductions for SAIH cases such as one-third reduced and in-kind support and maintenance.

3. To apply for RSDI/SSI within the SA application processing time standard, if required.

4. To reapply for SSI/RSDI by the SA application processing deadline, if the applicant was previously denied SSI/RSDI for any reason other than excess income and is not in appeal status and the appeal time frame has lapsed.

5. To provide the necessary information/verification required to determine eligibility, a DHB-5097, Request for Information will be given/sent identifying all required information. If assistance is needed in obtaining verifications, the applicant must notify the IMC and/or sign a release of information.

   NOTE: Only the applicant, the applicant's legal guardian or the applicant's duly appointed POA can legally sign the consent form. If a legal guardian or an appointed POA is signing for the applicant, they must sign the applicant's name followed by their own name. Refer to DSS-6969, Consent for Release of Information for a suggested form.

6. To report within 5 calendar days any change in situation that may affect SA eligibility. Explain the meaning of fraud. Notify the applicant they may be suspected of fraud if the applicant/beneficiary fails to report a change in situation. Explain that in such situations, the applicant/beneficiary may have to repay assistance received in error and that they may also be tried by the courts for fraud.

7. To provide information about any person or organization from which Medicaid has a right to recovery of medical expenses that were paid by Medicaid.

8. To sign a DMA-5052SA, State/County Special Assistance Beneficiary Estate Subject to Medicaid Recovery Notice because Medicaid is automatic for SA facility beneficiaries, inform applicants of the potential for estate recovery for the cost of PCS paid by Medicaid for beneficiaries age 55 and older. Regardless of age at application, have the applicant or their representatives sign the DMA-5052SA, State/County Special Assistance Beneficiary Estate Subject to Medicaid Recovery Notice. Provide a signed copy to the applicant and/or representative and retain a copy for the case file.

9. To report within five business days to the county DSS the receipt of a payment, which the SA beneficiary knows to be erroneous, such as two payments for the same month, or a payment in the wrong amount. Failing to report such payments, may result in the SA beneficiary being required to repay any overpayments.

VIII. ELIGIBILITY DETERMINATION PROCESS

The following steps shall be followed in determining eligibility. Review each eligibility factor following the policy in the appropriate manual sections. Document all factors of eligibility on the DSS-8190 SSI/Non-SSI Application Workbook. Date-stamp all information with date of receipt in DSS including electronic date received stamps. Document in the case record all applicant, collateral, and telephone contacts, including the full name and title of who provided the information and what they verified.

NOTE: SSI Recipients automatically meets the categorical, financial and resource requirements.

A. Verify and document each eligibility factor

1. Identity for non-SSI or non-Medicare applicant, if not already verified in NC FAST. (See SA-3240.)
2. Age or Disability Requirement
    a. Age (See SA-3100 III.)
    b. Disability or blindness if under age 65:

        View SDX Disability Onset, which indicates if there is a date of disability onset as alleged by the claimant during the period in which the case is awaiting a medical determination, or if the case has been medically denied.

    c. After a final disability or blindness determination has been made, the date of onset will be either the date of disability onset established for Title II (RSDI) purposes in a concurrent Title II/Title XVI allowance or the date of onset established for Title XVI only medical allowances.
3. Residency in a licensed adult care facility or in-home living arrangement, if applying for SAIH. Document the date of admission on the DSS-8190 SSI/Non-SSI Application Workbook.
4. Receives SSI or is ineligible for SSI solely due to excess income.
5. Level of Care required for applicants residing in an adult care facility. (SA-3100 VII.)
6. State Residency (SA-3100 IV.)

7. U.S. Citizenship for non-SSI or non-Medicare applicant's if not already verified in NC FAST and documented in the Permanent Verifications folder. (Refer to SA-3240, Citizenship and Identity.)

8. Not receiving Medicaid in the same month the applicant becomes eligible for SA if receiving under Certain\Disabled Program.

9. Transfer of resources (Refer to SA-3205.)

10. Resources (Refer to SA-3200.)

    a. For SSI recipients, view SDX resources, showing the resource information that the applicant has provided to Social Security. Recipients of SSI automatically meet the resource requirements of SA; however, SSI resource information could provide eligibility leads that need further exploration. For example, if the SDX reflects ownership of a home which is excluded for SSI, document the SA case file with the physical location of the home for purposes of state/county residency. SDX also provides information on transfer of assets.

    b. For non-SSI recipients, review all leads thoroughly for resources. (See SA-3200.)

11. Income (See SA-3210.)

12. Budgeting (See SA-3220.)

B. Automated Inquiry and Match Procedures: (SA-3400)

1. Complete an OVS/OLV and AVS Online Data request.

2. Ensure the correct base period is used to run matches. (See SA-3210 II.)

C. Review the Online Data to verify the SSI status of the SA applicant to correctly determine SA eligibility.

1. Competency Code indicates the representative payee's status as to legal guardianship and/or competency of the recipient.

2. Review to see if there is a substitute payee indicated for the SSI check.

3. Review the SSI Eligible Date, the date the recipient was first determined eligible or most recently re-determined eligible after a period of ineligibility. This is the effective date of the first SSI payment. SSA also calls this the Application Effective Date.

4. Review the Federal Eligibility Code which identifies eligibility for SSI payment in the current month.

5. Review the Payment Status, which consists of two data elements:

   - The first position reflects the status of the SSI payment.
   - The second and third positions reflect the reason for the status.

6. Review the current SSI benefit amount.

   NOTE: SA applicants with income/benefit evidence entered into NC FAST less than the FBR, excluding individuals that qualify for a 'Reason not receiving SSI FBR', will fail the income test in NC FAST.

7. If the applicant's income is below the federal benefit rate (FBR), determine if it is one the following valid reasons to be receiving less than the FBR. If so, the reason must be entered in NC FAST in the Benefit/Unearned Income evidence field. See details of the reasons and when to use them in SA-3210 V.B.

   a. One-Third Reduced SSI (Unearned Income Information). If the Online Data reflects unearned income code "J" for the SA applicant/beneficiary this indicates that the applicant's SSI payment is based on the applicant residing in the home of another person.

   b. SSI In Kind Support/Maintenance Ending
   If the online Data reflects SSI Recipients with SSI income based on SDX Code "H", In kind Support.

   c. Life Insurance (with) Cash Accruing Face Value Greater Than $1500. If the online data reflects LI indicator displays as "Yes" on Liquid Resource evidence/Liquid Resource Details/SA Special Review Code. See SA-3210 V. B.

   d. SSA Recoupment of Overpayment
   If the online data reflects a dollar amount in the Monthly Overpayment Recovery Amt field this is the monthly overpayment amount being reduced from the SSI payment.

   e. SSI Couple Deeming
   Required for cases with gross monthly income less than the FBR. Case Special Review Code, "N" 'SSI Couple Deeming'.

   NOTE: Refer to SA-3210 V. B. for Case Special review codes.

8. The Online Data Denial Code-Date provides the reason and date a claimant was initially denied for SSI.

   NOTE: A previous SSI denial for any reason other than excess income, would require the applicant to reapply for a current SSI decision. Remember, to be eligible for SA the individual must be SSI eligible or ineligible solely due to income.

D. Complete a SA facility Search in NC FAST

1. Verify in NC FAST that the facility is SA eligible by conducting a facility search. There are many facilities with the same or similar names, ensure the facility name address and license number display correctly in NC FAST. It is a best practice to obtain the facility license number and search via the license number.
2. For information on facilities that are designated as a SA Facility, see SA-3100.

   NOTE: If a facility is not found in the facility search or facility information is inaccurate such address, license number, or name contact the SA listserv.

E. For changes that occur during the application processing time, refer to SA-3310 Change in Circumstance

IX. TIME STANDARD

The time standard covers the time from the date the application or DMA-5094 / 5094S, Notice of Your Right to Apply for Benefits is signed to the date of disposition. Do not deny an application for failure to provide verifications *prior* to the 45/60th day.

A. Processing Time Standard

1. Process SAA applications within 45 days from the date the DMA-5094 Notice of Your Right to Apply for Benefits is signed.
2. Process SAD applications within 60 days from the date the DMA-5094 Notice of Your Right to Apply for Benefits is signed.

B. Applications may pend past the 45/60th days when:

1. The applicant applied for SSA, but is waiting for SSA/SSI determination. The SA application may pend up to 12 months while awaiting a determination of eligibility for benefits and/or a disability or blindness determination and/or other information needed from SSA. Refer to SA-3110 X. Establishing Disability for SA.

   NOTE: Do not pend an application if you are waiting for the SSI payment to increase to FBR. Refer to SA-3210 V. D.

2. If the citizenship or Identity verification is the only verification still pending and the applicant is cooperating to the best of their ability or when it is the county responsibility to pursue verification on behalf of the applicant based on policy requirements. The application may pend up to 6 months.

   NOTE: Assistance in obtaining Citizenship and Identity documentation must be provided upon the applicant's request or if the applicant has special needs, such as a mental or physical incapacity. Refer to SA-3240, Citizenship and Identity.

3. The applicant reports they need additional time to provide verification. Send a third DHB-5097, Request for Information allowing an additional 12 days to provide the verification and those 12 days extend past the 45/60th day.

C. Instances When an Application May Be Processed Beyond the Time Standard

There are certain situations that would require the application to be processed beyond the time Standard. These instances must be documented in the case record. This documentation and the reason will determine if the case is in error or not. If the application pends beyond the processing time standard, dispose of the application within 5 business days after the last piece of information is received or the last due date if verification is not received.

1. The requirement for two DHB-5097, Request for Information has not been met and/or they were not sent at least 12 calendar days apart for any required verification, including information discovered after a DHB-5097, Request for Information is sent but not previously requested.

2. If it is discovered that the applicant is over resources, and two DHB-5097, Request for Information, were not sent at least 12 calendar days apart to explain and request the spend down of resources.

D. Disposing an Application

- When disposing of a pending application, determine eligibility on a monthly basis for all months from date of application onward. Clearly document the application booklet for each month of non-eligibility listing the reason/s for non-eligibility. Notify the applicant accordingly. When all factors of eligibility are met, clearly document the basis for eligibility, including first-moment resource balance when applicable.

- If the applicant provides verification that resources were reduced prior to the 12-day period of the second DHB-5097, Request for Information, determine eligibility based on the new resource amount.

- **Eligibility begins the month after the month in which resources were reduced to allowable limits.** The exception to this rule is if the burial exclusion is sufficient to reduce resources to the allowable limit.

X. ESTABLISHING DISABILITY FOR SA

To be eligible for SAD, an individual must be age 64 or under, and must be determined disabled by Social Security meet criteria for legal blindness.

A. Currently Receiving SSI/SSDI

An applicant who is receiving SSI/SSDI based on disability meets the disability requirement.

B. Not Receiving SSI/SSDI, No Pending Application

1. If the SA applicant is not receiving SSI/SSDI based on disability or legal blindness has not been established, and does not have a disability application pending, advise the applicant that they must apply for Social Security benefits within 60 days of the date of the SA application.

2. Discuss the applicant's current and retroactive medical needs and advise the applicant that they may make a separate application for Medicaid. Refer to instructions in MA-2525, Disability for establishing disability for Medicaid. A Disability Determination Services (DDS) decision of disability for Medicaid does not apply to SA, except for situations described in D.

3. If the applicant applies for SSI/SSDI within the 60-day processing time standard, hold the SA application pending up to 12 months awaiting the SSA decision.

4. If SSA denies the application due to not meeting criteria for disability or legal blindness, deny the SA application. Advise the applicant that if he appeals the SSA decision and the denial is overturned, the SA application may be reopened.

C. SSI/SSDI Application Pending

1. If the applicant has an application for SSI/SSDI pending with SSA, hold the SA application pending for up to 12 months awaiting the Social Security decision. Check the SDX monthly to determine if a decision has been made and document this.

2. If the SSA disability application is denied due to not meeting criteria for disability or legal blindness, deny the SA application. Advise the applicant that the SA application may be reopened if he appeals the SSA decision and the denial is overturned in appeal.

D. SSA Makes No Disability Determination

1. In some cases, SSA may approve or deny benefits without determining disability. For example, the applicant may be financially ineligible for both SSDI and SSI and the application is denied without a disability determination, or an applicant may be approved for a benefit that does not require a disability determination such as early retirement.

2. When SSA approves, or denies benefits, determine the reason for the decision and whether a disability decision was rendered. Refer to the SDX, SOLQ, award or denial letter or contact with SSA.

3. In situations, where SSA will not make a disability determination, disability must be established by Disability Determination Services. Follow instructions in MA-2525, Disability to submit a request for a disability determination for an SAD applicant.

4. The only time DDS makes a disability determination for SAD is when SSA will not make a disability determination.

5. In situations where SSA will not make a legal blindness determination, blindness must be established by the Division of Services for the Blind.

Proof of an individual's visual acuity will be based on a completed eye examination report which reflects their current visual condition.

a. The eye examination report must be dated and signed by a medical or eye care professional. Acceptable report forms are:

(1) DSB-2202: Report of Eye Examination, which is completed, dated, and signed by a medical or eye care professional; or

(2) A written statement on official letterhead signed and dated by a medical or eye care professional which states, at minimum, the individual's visual acuity in both eyes with best correction, date of examination, and primary diagnosis.

b. Mail to:

Division of Services for the Blind
2601 Mail Service Center
Raleigh, NC, 27699-2601

XI. REOPENING A DENIED SA APPLICATION DUE TO APPEAL REVERSAL

A. SA Appeal Reversal

When a SA application was denied but is subsequently approved as the result of a state appeal, administratively reopen the original application within 5 business days of the date the Notice of Decision is final. Process the reversed decision.

B. SSA Appeal Reversal

If the SA application is denied based on a decision by SSA but the SSA denial is reversed on appeal, the reversal of the SSA decision is considered a reversal of the SA decision. The applicant is not required to make a separate SA appeal. This applies to determinations of eligibility based on disability or as well as other eligibility factors such as resources or transfers.

1. Administratively reopen the SA application back to the original date of app if:

a. The applicant or the representative notifies the county DSS within 60 days of the date of the reversal decision and requests SA, and

b. The onset date for disability or blindness (or the beginning date of eligibility) is the same as or prior to the date of the SA denial, and

c. There is a period of cost of care that SA can cover.

2. The IMC should check to determine if the appeal process has been completed, through the SDX or by contact with SSA or the applicant. If it is learned of the appeal decision through some source other than the applicant, contact the applicant to determine if they wish to reopen the SA application based on these criteria.

3. Approve assistance based on the original date of application if all other eligibility factors are met. Payment can begin no earlier than the month of SSI approval. Refer to SA-3110 XII. Effective Date of Payment.

4. Request a Medicaid Override, if the applicant is authorized for more than 12 months prior to disposition, send a letter to the Payment Benefits Section Also, if Medicaid is authorized more than 12 months prior to disposition, request an override of the 12 months Medicaid claims processing time limit.

XII. EFFECTIVE DATE OF PAYMENT

A. Do not authorize the SA payment prior to the date a current valid FL-2 is signed by a physician, a physician assistant, or a nurse practitioner for adult care home cases.

Calculate a partial payment beginning with the date the valid FL-2 is signed, and all other factors of eligibility are met, if that date falls after the first day of the month. In general, the effective date of payment is the day when the FL-2 is signed.

B. If an applicant is in a SA facility for an entire month and eligibility requirements are met after the first day of the month, the applicant is not eligible for a full month's payment until the following month.

An exception is for an applicant reaching age 65. In these situations, if the applicant meets all other eligibility requirements, they are eligible the month they attain age 65.

C. Do not authorize SA payment for months prior to the month of application.

D. For SA applicants who are also applicants for SSI, authorize SA payments the first month the applicant becomes eligible for SSI (even if no SSI payment was issued/received) if applicant resides in a licensed SA facility and applied for SA that month, and met all other factors of eligibility.

1. The first month the SSI applicant meets all factors of SSI eligibility is identified by SDX/SSI Payment Status Code E02. Code E02 indicates the SSI application month for which no SSI payment is issued. The first SSI payment is issued the month following the first E02 month of SSI eligibility.

2. Because the SSI payment will not be issued to the SSI applicant for the E02 month, the SA payment will be calculated for the SSI E02 month at zero SSI payment. The SA payment will need to be recalculated for subsequent months for which the SSI applicant is awarded/issued SSI payments ongoing. These months are coded on the SDX as C01 months.

   NOTE: If SSI ongoing payments are not awarded at SSI FBR for the current calendar year, budget the case per the instructions in SA 3210 V.

3. Do not authorize SA payment prior to the date the state residency requirements are met. Calculate the partial month payment beginning with the day the residency requirement is met, and all other factors of eligibility are met, if that date falls after the first day of the month.

XIII. TYPES OF DISPOSITION

Notify the applicant/authorized representative of the county's decision in accordance with SA-3330, Notices. The application must be dispositioned with one of the following determinations:

A. Approvals

Approve assistance when all factors of eligibility have been verified and eligibility has been established. Complete the DSS-8108, Notice of Benefits or a DHB-5002 Important Notice About Your Medicaid or Special Assistance Approval Notice.

B. Open/Shut

An application is approved and terminated at the time of disposition. Complete the DSS-8108 Notice of Benefits or a DHB-5002, Approval Notice. Refer to SA-3220, Budgeting Principles.

C. Denials

Deny assistance anytime ineligibility has been established and complete the DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn. Always evaluate for Medicaid eligibility when SA is denied. Do not deny an application prior to the 45/60th day. Ineligibility is established when:

1. Applicant fails to keep two scheduled interview appointments.

2. The applicant does not apply for Social Security benefits within the 60-day processing time standard.

3. The applicant failed to reapply (if previously denied for a reason other than excess income) for Social Security benefits within the 45/60-day processing time standard.

4. If SSA denies the SSDI/SSI based on non-disability or not meeting criteria for legal blindness; or being denied based on eligibility criteria other than income (such as resources, transfers, fleeing felon, etc.).

   NOTE: Do not deny the SA application if the reason for the SSA denial of SSI benefits is a transfer of resources that occurred prior to November 1, 2002. See SA-3200.

5. The applicant is over resources, was provided the option to spend down the resources but failed to verify how the resource was spent down by the application processing time standard.

6. Applicant fails to provide a valid FL-2.

7. Applicant failed to provide any appropriately requested verifications.

D. Withdrawals

Withdraw the application anytime the applicant voluntarily requests withdrawal of the application and complete the DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn. Explain all options to withdrawal, including a separate application for Medicaid, and that the applicant may reapply for SA at any time.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3200 RESOURCES

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3200 RESOURCES

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I. INTRODUCTION

This section outlines the resource requirements used in determining eligibility. Resources are all financial assets that an a/b owns or has the right, authority, or power to convert to cash, and are legally available for the a/b's support and maintenance, including month of entry into an eligible licensed facility. The resource limit is $2000 for an applicant/recipient. **The budget unit is always one.**

Follow the steps below for SSI and Non-SSI recipients.

A. SSI Recipients

1. SSI recipients automatically meet the resource requirements for SA**.**
2. Verify and document on the DSS-8190 SSI/Non-SSI Application Workbook, that the a/b is an SSI recipient. Do not evaluate the a/b's resources.
3. If you have specific knowledge of resources that could impact SSI eligibility, notify your local Social Security Administration by the DMA-5049, Referral to Local Social Security Office. SA eligibility continues unless the SSA changes their determination of eligibility for SSI.

B. Non-SSI Recipients

At each application and redetermination, document the a/b's statement and verification of all resources on the DSS-8190 SSI/Non-SSI Application Workbook. Also complete the DMA-5030, Reserve History Sheet.

For reported changes in resources, verify and document continued resource eligibility. Review all available records and verify whether resources are countable. Use the DMA-5030, Reserve History Sheet, to reflect changes in resources.

1. Solely owned resources

   The availability of all solely owned resources must be verified, documented, and evaluated using the procedures outlined in this section.

2. Jointly held resources

   The availability of resources owned jointly by the a/b and another person must be verified, documented, and may be counted:

   a. If the other person is a recipient of another public assistance program (Work First, Medicaid, Special Assistance, or SSI):

(1) Count one-half of the value of the jointly owned resource, or

Note: If more than two owners, then divide the value equally among the owners.

(2) If there is a legally binding agreement specifying how the resource is to be divided, count the share specified in the agreement as owned by the a/b.

b. If the other person is not a recipient of another public assistance program, count the value of the a/b's share of resources owned if:

(1) The a/b can dispose of the resource without the consent and participation of the other person(s), or

Note: If the a/b can dispose of the resource without the other's consent, the entire resource may be countable, such as a bank account held by two people who both have full access to the account.

(2) The other person(s) agrees to and, if necessary, participates in the disposal of the resource.

Verify other owner(s) statement regarding their consent to sell the resource.

(a) If the owner(s) consents to the disposal of the resource, count the a/b's share of the resource.

(b) If the other owner(s) does not respond/cannot be located, do not count a/b's share of the resource.

(c) If the other owner(s) do not consent to the disposal of the resource, do not count the a/b's share of the resource.

3. Unsettled Estates

The availability of resources, whether solely or jointly owned, may be impacted by heir property and inheritances left to the a/b which are not yet settled. Unsettled estates must be verified, documented, and evaluated using the procedures outlined below.

a. Verify if the a/b has the legal right to any heir property or inheritance that is unsettled.

(1) Assets are normally unavailable until the estate is settled (probated).

(2) An estate that has been filed for probate is normally open up to 12 months unless there is a continuation approved by the Clerk of Court.

(3) Liquid assets may be available earlier if the account was joint with a "right to survivorship" held by the a/b. (Contact financial institution for verification).

b. Contact the Clerk of Court to determine availability.

(1) Count any resources acquired by the a/b from a settled estate pursuant to the policies in SA-3200 Resources.

(2) Exclude any resources from an estate to the a/b until verification is received from the Clerk of Court that the heir property or inheritance has gone through probate and is released.

Note: Document the date on which the estate should be probated and flag the record to contact Clerk of Court.

4. Base Period for Resources

a. Applications – The month of application, or, if there are excess resources, the month the resources are reduced.

b. Redeterminations – For eligibility reviews, there is some flexibility as long as the “verification month” is:

(1) No earlier than the month of in which the review process (verifications, appointment letter, etc.) is started, and

(2) No later than the last month of the current payment review period during which the redetermination process is initiated.

(3) Establish the first moment date for verification of resources using the appropriate base from items (1) or (2) above.

(4) Document the established first moment date on the DSS-8190 booklet in the section/s provided for liquid resources.

(5) Verify all liquid resources as of the established first moment date.

(6) Clearly document all verified liquid and other resources in the appropriate section/s of the DSS-8190.

c. Changes In Situation – Verify resources for the month of change. Refer to SA-3310, Changes in Situation for further instructions.

Resources (in alphabetic order):

Resource	Count	Do Not Count	Verification
Agent Orange Benefits		X	Refer to Lump Sums Exclusion Chart II.I.5.
Annuities (if principal is available)	X		Refer to II.E. below
Bank Accounts (includes checking, savings, EBT, CDs, and money market accounts)	X		Refer to II.C. below
Boats, boat motors, and boat trailers (if not primary homesite)	X		Refer to II.O. below
Burial Contracts • Prepaid Irrevocable (cannot be sold or "cashed-in")		X	Refer to II.N. below
• Revocable (can be sold or "cashed-in")	X		Refer to II.N. below
Burial Insurance	Must evaluate to determine if resource is countable or not countable		See Life Insurance, II.M. below
Burial Plots/Spaces and Other Burial Items (Excluding all burial property ended with applications effective December 1, 2009)	Must evaluate to determine if resource is countable or not countable		Refer to IV.B. below
Business, Discontinued Proceeds (including farm)	X		Refer to II.L. below.
Business Equipment • Not used to produce income	X		Refer to II.O. below

Resource	Count	Do Not Count	Verification
• Used to produce income		X	Refer to II.O. below
Campers (if not primary homesite)	X		Refer to II.O. below
Cash	X		Refer to II.A. below
Cash and in-kind receipts for repair or replacement of lost, damaged, or stolen excluded resources		X*	Refer to II.I.
Disaster Relief		X	Refer to II.I.
Farm Equipment • Not used to produce income or to produce goods for home consumption	X		Refer to II.O.1.i. below
• Used to produce income		X	Refer to II.O.1.i. below
• Used to produce goods for home consumption (up to $6,000 in total combined equity		X	Refer to II.O.1.i. below
Heir Property – when part of an unsettled estate		X	Refer to I.B.3. above
Investments (Bonds, Mutual Funds, Stocks/Securities)	X		Refer to II.F. below
Jointly Owned Property • Tenancy-in-Common	X		Refer to III.C.5. below
• Tenancy-by-the-Entirety	Must evaluate to determine if resource is countable or not countable		Refer to III.C.4. above
Life Estate (Lifetime Right)	X		Refer to III.C.2. below
Life Insurance (that accrues cash value (CV) • Total face value (FV) $1,500 or less for the a/b (The excludable FV changed from $10,000 to $1,500 for applications taken on after December 1, 2009).		X	Refer to II.M. below

Resource	Count	Do Not Count	Verification
• Total FV over $1,500 for the a/b. (The excludable FV changed from $10,000 to $1,500 for applications taken on after December 1, 2009).	X		Refer to II.M. below
Life insurance (which does not accrue CV)		X	Refer to II.M. below
Liquid assets of a business		X*	Refer to IV.F.
Lump Sum Payment	Must evaluate to determine if resource is countable or not countable		Refer to II.I.
Mobile Home (if not primary homesite)	X		Refer to II.O.1.c. below
• Motor Vehicles	Must evaluate to determine if resource is countable or not countable		Refer to II.O.4.b.(1)
Motorized Mobile Home (if not primary homesite)	X		Refer to II.O.
Resident Personal Funds Accounts	X		Refer to II.B.
Personal Effects (i.e. Household goods)		X	
Proceeds from sale of excluded homesite		X*	Refer to Lump Sums Exclusion Chart, II.I.5.
Promissory Notes • Non-Salable		X	Refer to II.J.
• Salable	X		Refer to II.J.
Real Property • Homesite and contiguous property (unless it meets homesite exclusion- see V.A. below)	X		Refer to III.
• Not Homesite	X		Refer to III.

Resource	Count	Do Not Count	Verification
Real Property – during reasonable efforts to sell		X	Refer to V. D.
Relocation Assistance from State or local government		X*	Refer to II.I.
Relocation Assistance Payments Received under Title XX of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970		X	Refer to II.I.
Remainder Interest	X		Refer to III.C.3.
Restricted allotted land owned by an enrolled member of an Indian tribe		X	Refer to IV.H.
Resulting Trust / Legally Binding Agreements		X	Refer to IV.E.
Retirement Accounts (401(K), IRA, KEOGH) • Accessible	X		Refer to II.D.
• Non-accessible		X	Refer to II.D.
Reverse Mortgage • Month of Receipt		X	Refer to II.G.
• Amount Remaining Month after Receipt	X		Refer to II.G.
Rights of Use (Mineral, Timber, Hunting, Fishing, etc.)	X		Refer to V.C.1.c.(4)
Safe Deposit Box		X	Refer to II.H.
Tobacco Buyout Payments	X		Refer to IV.G.
Trust Funds • Revocable	X		Refer to II.K.
• Irrevocable		X***	Refer to II.K.

Resource	Count	Do Not Count	Verification
Victim's Compensation Payments		X**	Refer to Lump Sums Exclusion Chart, II. I.4.

* Time limited exclusion

** May be time limited or permanently excluded

*** May be time limited exclusion, permanent exclusion, or countable depending on other conditions of trust

NOTE: All income produced by a countable or excluded resource must be considered when determining eligibility for the a/b.

II. LIQUID RESOURCES

Includes but not limited to cash, bank accounts, certificates of deposit or any resource that can be converted to cash.

A. Cash

Accept a/b's statement for cash on hand as of the first moment of the first day of the month as verification.

NOTE: Count as resources all cash except cash that is counted as income.

B. Resident Personal Funds Accounts

If the a/b has a resident personal funds account, verify with the business office manager of facility or the bank (if it is deposited in an account for the a/b), the "closing balance" as of the last calendar day of the month preceding the verification month (in order to obtain the "1st moment" balance).

1. Document the countable amount and the verification of the account balance in the DSS-8190, including the date verified, how it was verified, who verified it and the 1st moment date used.

2. For all SA reviews (and applications when client enters an SA facility prior to the month of application), the IMC must always contact the facility and verify the following:

   a. Whether the facility maintains a resident personal funds account for the a/b:

b. If the facility maintains a resident account for the a/b, verify the account balance as of the first moment of the first day of the verification month.

NOTE: The requirement to contact the facility to verify patient account balances includes contacting the nursing facility if client moves from a nursing facility to an SA facility.

C. Bank Accounts (includes checking, savings, EBT, CDs, money market accounts)

1. Always verify bank accounts as of the first moment of the first day of the verification month. Request the account balance as of **"**close of business**"** on the last **calendar** day of the preceding month.

   a. Verify the first moment balance or value by:

      (1) Reviewing the last account statement;

      (2) Reviewing automated teller statements that identify account owner and/or account number;

      (3) Contacting the financial institution using the DSS-3431, Request for Financial Information.

      At the top of the form, write in a request the account balance as of "close of business" on the last calendar day of the preceding month.

      NOTE: Require the a/b to sign a separate DSS-3431, Request for Financial Information. for each bank or financial institution and explain the Financial Privacy Act as outlined on the form.

      Explain to the a/b that:

      (a) Once consent is given, it may not be revoked;

      (b) The consent is valid for a period not to exceed twelve months; and

      (c) Giving consent is not a condition of doing business with any financial institution.

      (d) He/she has the right not to give consent; however refusal to give consent will result in denial or termination of benefits for failure to cooperate in establishing eligibility.

(e) Financial institutions cannot provide information on joint accounts without the consent of all account holders. It is the responsibility of the a/b to obtain consent from all the joint owners.

(f) If the client reports that he has an EBT account, verify the cash balance through the North Carolina EBT Production System that is located in each county.

NOTE: Verify the 1st moment balance of the EBT account by viewing the credits at the end of the previous month and subtracting what was spent (debits) to get the 1st moment balance.

2. Count the total value of the a/b's checking, savings, EBT, CDs, money market accounts, in the a/b's countable resources.

NOTE: Subtract any penalties/fees for early withdrawal of CDs and count the remainder as the countable balance from the CD.

D. Individual Retirement Accounts (IRA'S), Keogh Plans, and 401 (K) Plans

Determine and document if the a/b owns an IRA, Keogh, or 401(K) account. If a/b acknowledges an IRA, Keogh, etc. verify the following:

1. The type of fund or plan, and

2. The name of the company that offers the IRA, Keogh Plan, or the 401(K) Plan, and

3. The account number, and

4. The accessibility of the account

To verify, contact the employer or company administering the account/plan to determine the circumstances under which the funds can be withdrawn. Accessibility of the account/plan must be verified at application and each redetermination.

NOTE: If non-accessible by a/b, do not count the value of funds in the account.

5. The value of the account/plan as of the last calendar day of the month preceding the verification month. To verify;

a. Contact the financial institution using the DSS-3431, Request for Financial Information. On the form, request the account balance as of "close of business" on the last calendar day of the preceding month.

b. Count the value of the funds in the account/plan minus the fees and penalties for converting the account/plan to cash.

E. Annuities

1. Document if a/b has any annuities.
2. To verify:
   a. Request a copy of the terms of the annuity.
   b. Contact the source of the annuity.
3. Determine the value of the resource.
   a. Annuity principal that is available is a countable resource.
   b. Evaluate a policy that has not been annuitized (method of payment selected) as whole life insurance to determine if the CV is countable.
   c. Burial annuities are considered as an irrevocable burial trust.

NOTE: *Payments by an annuity are counted as income.*

F. Investments (Stocks, Bonds, Mutual Funds/Securities)

1. Determine if the a/b owns any securities (stocks, bonds, mutual funds).
2. Document the a/b's statement on the following:
   a. The name of the stock or mutual company or financial institution where the security (stocks, bonds, mutual funds) was purchased, and

      NOTE: Verify series and date of issuance for all bonds.

   b. The account numbers, and
   c. Number of shares, and
   d. The value of the security (stocks, bonds, mutual funds).
3. Verify security (stocks, bonds, mutual funds) by:
   a. Viewing the last monthly or quarterly statement from the brokerage firm.

b. Using the stock values listed in the newspaper or Wall Street Journal.

c. Obtaining information from a brokerage, investment firm, or bank.

4. Determine the countable value by:

   Subtracting the cost of selling the shares on any day from the value of the stocks or mutual fund. Verify this cost by contact with a stockbroker or financial institution.

G. Reverse Mortgage

1. Determine if the a/b has a reverse mortgage.
2. Verify the monthly amount received by:
   a. Copy of check or check stub, or
   b. Contact with the issuing lending institution
3. Count only any amounts of payment remaining the first day of the month following the month of receipt.

H. Safe Deposit Box

1. Determine if the a/b has a safe deposit box,
2. At application and redetermination accept a/b's statement of contents if the a/b reports items that are not a countable resource (such as jewelry, wills, etc.).
3. If a/b discloses a potentially countable resource item (such as stocks), verify and document that resource.

I. Lump Sum Payment for Non-SSI Recipients

Lump sum payments are payments received in one payment rather than recurring payments.

1. Lump sum payments include, but are not limited to:
   a. Retroactive RSDI payments – Exclude as a resource for 9 months.
   b. Retroactive SSI payments – Exclude as a resource for 9 months.
   c. Retroactive VA benefits

d. Retroactive Railroad Retirement benefits

e. Lump sum insurance settlements

f. Proceeds from sale of excluded homesite

2. Verify lump sums by determining:

a. The source of the lump sum, and

b. The amount of the lump sum, and

c. When the lump sum was received, and

d. How much of the lump sum is still available to the a/b.

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3. Verification of the lump sum can be obtained from:

a. The a/b's records such as:

(1) An award letter

(2) A statement of benefits

(3) A check stub or copy of check

b. A contact with the source of the payment, such as VA, retirement system, workman's compensation, insurance companies.

c. Social Security and SSI lump sum payments can be verified by the state on- line query (SOLQ).

4. Countable Lump Sums

a. If lump sum is received prior to the month of application, count as resources the amount remaining as of the first moment of the first day of the month of application. Do not count as income.

b. If the lump sum is received in an ongoing case, count as resources the amount remaining as of the first moment of the first day of the month following the month of receipt. Do not count as income.

c. If the lump sum is receiving during the application process and it is not for unearned income (such as an insurance settlement or cash from the sale of an asset), count as resources the amount remaining as of the first moment of the first day of the month following the month of receipt. Do not count as income.

d. If the lump sum is received during the application process and it is for unearned income (such as VA, retirement, etc.), determine the months in the application process that it covers and count as income in determining the payment for those months. See SA-3210, Income, IV. C.8.a. Count the amount remaining as of the first moment of the first day of the next month as resources.

Example: Workman's Compensation Payment

Mr. Jones was awarded a workman's compensation lump sum payment of $2,000 on July 6. He applied for SA in June. The award letter indicated that the lump sum covered December through July. He received $160 for December, $260 per month for January through June and $280 in the month of July.

Month of Application:	June
Lump sum received in July:	$2,000
Minus part of lump sum counted as income for June:	- 260
Minus part of lump sum counted as income for July:	- 280
Equals amount to count in resources in the first moment of the first day in August	$1,460

5. Lump Sum Exclusions

Exclusion Period				
Type of Lump Sum	*3 Months*	*6 Months*	*9 Months*	*Permanent*
Proceeds from sale of excluded homesite (if used to purchase another excluded home)	X			
Social Security / SSI Retroactive Payments			X *	
Cash and in-kind receipts from any source for the replacement or repair of lost, damaged, or stolen excluded resources **			X	
Victim's compensation payments ***			X	
Relocation Assistance (state/local issued) ****			X	

Relocation Assistance (federally issued)****				X
Presidentially Declared Disaster Relief (all funding sources)				X
Agent Orange Benefits				X
Earned Income Tax Credit	Exclude for 9 months **			

* Apply Social Security and SSI Lump Sum payments as income for the intended retroactive months to calculate the Special Assistance payment for each month when approving an application. See SA-3210, Income,

** Exclude for up to an additional 9 months for cash receipts if for the first nine months, circumstances beyond the a/b's control prevent repair or replacement of the lost, damaged, or stolen property, and keep the a/b from contracting for such repair or replacement. The interest earned on these funds is excluded from income and resources for the same time period.

*** To be excluded, the a/b must demonstrate that the payment was compensation for expenses incurred or losses suffered as a result of crime. Count interest earned from lump sum payment as resources or income. Refer to SA-3210, Income.

**** Count interest earned from lump sum payment as resources or income. Refer to SA- 3210, Income.

J. Promissory Notes

Exclude the value of any property agreement which is not legally negotiable (cannot be sold). This includes promissory notes, loan agreements, etc. A property agreement (usually a promissory note) which can be sold is a countable resource.

1. Verification of the promissory notes is required, and may consist of:
   a. Client records;
   b. Copies of agreement; or
   c. Statements from the client, as well as from the borrower.

2. Verify with the following procedures:
   a. Examine the terms of the agreement or note to determine if the owner has the legal right to sell their interest without the participation of the buyer/borrower. If salable, count the balance due on the note as an available resource.

b. If there is a clause that prevents sale or transfer of the note, it is not a countable resource.

c. Contact the agency/county attorney for assistance if negotiability cannot be determined from the terms of the agreement.

d. Count as income when:

(1) The loan is a non-countable resource, count payments received as unearned income. This includes any interest payments.

(2) The loan is counted as a resource to the a/b, count only the interest received as unearned income.

K. Trust Funds

1. Types of Trusts

a. Revocable Trust - A trust which can be revoked by the grantor or modified or terminated by petitioning the court. A trust which is called irrevocable, but which terminates if some action is taken by the grantor, is a revocable trust for purposes of this section.

b. Irrevocable Trust - A trust whose terms and provisions cannot be revoked or changed in any way by the grantor or any other party.

c. Special Needs Trust - A specific trust that meets all the following conditions:

(1) Created on or after April 1, 1994, and

(2) Created for the sole benefit of a disabled individual (as determined by SSA) under age 65, and

(3) Established for the disabled individual (can use the a/b's assets or assets given by someone else) under age 65 by action taken by their parent, grandparent, legal guardian, or by a court, and

(4) Establishes that upon the death of the beneficiary the State will receive the principal balance remaining in the trust not to exceed the total amount paid by Medicaid on behalf of the individual.

(5) The a/b cannot create a special needs trust for himself by his own actions, with their own funds. If established by the a/b it must be set up as a pooled trust. See II.K.1.d. below.

(6) A trust established by a power of attorney (POA) for the a/b is considered to be a trust established through the actions of the disabled individual himself/herself.

d. Pooled Trust - A type of trust that includes funds of more than one disabled individual combined for investment and management purposes. A pooled trust has all the following requirements:

(1) Created on or after April 1, 1994, and

(2) Created for the sole benefit of a disabled individual (as determined by SSA) of any age, and

(3) Established by the disabled individual, his parent, grandparent, legal guardian, or by a court, and

(4) Managed by a non-profit association with a separate account maintained for each beneficiary.

(5) Establishes that upon the death of the beneficiary the State will receive the principal balance remaining in the beneficiary's account not retained by the trust not to exceed the total amount of Medicaid paid on behalf of the individual.

2. Terms of the Trust

The terms specify what portion of the principal is available and what disbursements can be made from the trust. Common terms:

a. Discretion of the trustee - allows the trustee to decide what portion (up to the entire amount) of the principal of the trust he will make available to the beneficiary.

b. Full discretion - allows the trustee to disburse up to the entire amount of the trust to the beneficiary.

c. Designated for medical expenses - allows the trustee to use the trust to pay the medical expenses of the beneficiary. The amount of the trust that is designated for medical expenses is considered an available asset to the beneficiary. Payments are a third party resource.

d. Income beneficiary - allows payments to the beneficiary from the proceeds of the trust. The principal is not available for disbursement.

e. Ultimate beneficiary - Indicates the entire principal of the trust will be available at a specific point in time.

f. Exculpatory clause - Language in the trust that legally limits the authority of the trustee to distribute funds from a trust if the distribution would jeopardize eligibility for government programs, including Medicaid.

g. Corpus – Principal of the trust. All property and other interests held by the trust, including accumulated earnings and any other addition to the trust after its establishment.

3. Whose Assets Are Used to Create a Trust

In determining whose assets (the grantor) are used to create the trust, consider the following:

a. Any assets owned by the a/b.

b. A settlement of an insurance claim or civil suit is considered the a/b's asset.

c. Assets contributed directly into a trust by individuals other than the a/b or by a public organization are not considered the a/b's assets.

EXAMPLE: Community fundraiser for an adult in need of an organ transplant contributes the money directly into a trust.

d. Assets used to form a trust created by a will from the estate of a deceased person (including a deceased spouse) are not considered the a/b's assets. This is also known as a Testamentary Trust.

NOTE: Assets, which are willed to an a/b and then used to establish a trust, are considered to be the assets of a/b.

4. Procedures

a. Obtain a copy of the trust document and any supporting documentation detailing investments and distributions from the a/b, the a/b's legal representative, trustee, or attorney.

b. Review the trust document to determine the core elements of the trust:

(1) What type of trust is it? (Is it a Special Needs or Pooled Trust?)

(2) Is the trust revocable or irrevocable?

(3) Whose funds were used to create the trust (grantor)?

(4) Who is the beneficiary (grantee)?

(5) When was the trust established? (Different time periods are covered by different rules. January 1, 2000, is a critical date.)

(6) What was the value of the trust when it was created?

(7) What are the terms of the trust, including what disbursements can be made from the trust principal and whether the trustee has discretion to disburse funds?

(8) Are there any special provisions?

c. Contact the trustee to verify:

(1) The current value of the trust, and

(2) Actual disbursements paid from the trust in the base period, and

(3) To whom the disbursements were made, and

(4) The dates of disbursement.

d. Contact your agency/county attorney about any questions concerning the type of trust or the terms of the trust.

5. Determine Countable Income to the a/b

a. Income from a trust that is countable to the beneficiary is determined the same way no matter what type of trust, who created the trust, when it was created, or any special requirements.

b. Count as income to the a/b in the month received the actual money disbursed by the trustee from the trust principal or proceeds directly to the a/b (spouse, legal representative)

6. Determine Countable Resources

a. Revocable Trust

(1) When the a/b is the beneficiary of a revocable trust created with the funds of an individual other than the a/b, do not count the principal as an available resource to the a/b. The trust principal is a resource to the grantor who created the trust and who has the power to revoke the trust.

(2) When the a/b is the grantor of a revocable trust for himself or for the benefit of another individual count the current principal plus proceeds that have not been distributed.

NOTE: This does not include a trust created by the will of a spouse. Refer to II.K.3.d.

b. Irrevocable Trust

(1) When the a/b is the beneficiary of an irrevocable trust, if the a/b does not have the legal authority to revoke the trust or direct the use of the trust assets for their own support and maintenance, the trust principal is not a countable resource regardless of the date the trust was established (based upon the terms of the trust).

(2) For irrevocable trusts established after January 1, 2000, when the a/b is both the grantor and the beneficiary, count as a resource the amount of the principal that can be made available to or for the benefit of the a/b under any circumstances, no matter how unlikely or distant those circumstances may be.

If the terms specify that the trustee has discretion, assume the trustee exercises full discretion and count the full amount that could be disbursed. In determining what is available to be disbursed, DISREGARD:

(a) The purpose for which the trust was established,

(b) Whether the trustee has discretion,

(c) Any exculpatory clause restricting disbursements which affect Medicaid eligibility,

(d) Any other restrictions on when disbursements can be made or the use of the distributions.

This means that if the terms allow ANY circumstances by which all or a portion of the principal or proceeds can be disbursed to a/b, that portion is considered an available resource to the a/b.

EXAMPLE: An irrevocable trust was established for the a/b using his own funds on 3/1/00. It contains $75,000. The terms stipulate that the trustee can disburse up to $50,000 to the grantor only in the event he needs a heart transplant. Count $50,000 in resources because it can be paid under some circumstances, although remote. Or if the terms stipulate $50,000 can be disbursed to the grantor on some date in the future, count $50,000 in current resources because there is a circumstance where a disbursement can be made.

c. Special Needs or Pooled Trust

When the a/b is the beneficiary of a Special Needs or Pooled Trust established on or after April 1, 1994 do not count the trust principal or undistributed proceeds.

d. Trust Earnings

(1) Trust earnings are not income to the trustee or grantor unless designated as belonging to the trustee or grantor under the terms of the trust. (For example, fees payable to the trustee or interest paid to the grantor)

(2) Trust earnings are not income to the a/b who is the trust beneficiary unless the trust directs, or the trustee makes, payments to the a/b.

(3) Additions to the trust principal made directly to the trust are not income to the grantor, trustee, or beneficiary except under SA-3200, III.k.6d(1) and (2) above.

e. Income Diversionary Trusts

Certain payments are non-assignable by law and are therefore income to the individual entitled to receive the payment. Count these payments as income following procedures in SA-3210 Income. The following income sources may not be paid directly into a trust to establish eligibility, and no attempt to assign these income sources will be acceptable for eligibility purposes:

(1) Temporary Assistance to Needy Families (TANF)

(2) Railroad Retirement Board-administered pensions

(3) Veteran pensions and assistance

(4) Federal employee retirement payments (CSRS, FERS) administered by Office of Personnel Management
Social Security Title II and SSI payments

(5) Social Security Title II and SSI payments

(6) Private pensions under the Employee Retirement Income Security Act (ERISA) (29 U.S.C.A. Section 1056(d))

L. Net Proceeds from a Business or Farm which have been Discontinued

1. Determine if the a/b has stopped operating a business or farm.

2. Verify if there was any money left from the business or farm when the operation was stopped by examining the business or farm records provided by the a/b.

3. Count any remaining capital of farm or business operation in resources.

M. Life Insurance

1. The CV of life insurance policies are accessible and are a countable resource when the original FV of all cash accruing policies owned by the a/b exceeds $1,500. (the excludable FV changed from $10,000 to $1,500 for applications taken on after December 1, 2009).

2. Eligibility for SA is not affected for ongoing recipients who were eligible for SA prior to 12/1/09 and had life insurance policies purchased prior to 12/1/09 with FVs over $1,500 but $10,000 or less. Document this in the case file. These individuals must also be noted with the Case Level Special Use Code “LI” in EIS at the next change in situation or redetermination, whichever comes first.

3. When entering the ‘LI’ code in EIS, the begin date is the date the code is entered in EIS. The end date is ‘999999’.

4. Effective December 1, 2009, if an ongoing recipient purchases cash accruing life insurance with a total FV that exceeds $1,500.00, **treat it as a change in situation**. Verify the available CV and count toward the individual resource limit of $2,000.00.

5. If SA correctly terminates, and the exempted client later reapplies for SA, beginning December 1, 2009 the applicant will be subject to the new resources policy, counting the CV of all cash accruing life insurance polices if the FV exceeds $1,500.00.

6. Determine if the a/b owns or has recently purchased life insurance at application and each redetermination.

7. If the policy does not accrue CV, DO NOT count the FV as a resource.

    a. A burial insurance policy is a contract whose terms preclude the use of its proceeds for anything other than payment of the insured’s burial expenses. If a burial policy has a CV to which the owner has access, the policy is not burial insurance.

    b. Most term life policies do not accrue CV and are not countable resources. However, some term life policies do accrue CV.

        Note: If it is determined that a term life insurance policy does accrue CV, verify and count CV the same as other life insurance policies which accrue CV.

8. Verify life insurance policies by:

   a. Examining the actual policy for:

      (1) The name of the Insurance Company

      (2) Policy number

      (3) Name of the insured (on whose life the policy is written)

      (4) Owner of the policy

      (5) Original FV

      (6) Whether policy is participating or non-participating; or

   b. Contacting the life insurance company using the DMA-5155, Verification of Cash Value of Life Insurance, to verify the following:

      (1) All policies owned by the a/b, including type and policy number(s);

      (2) Original FV;

      (3) Whether policy is participating or non-participating and how dividends are paid;

      (4) Cash Value;

      (5) Loans against policy (loan amount and date); and

      (6) Name of the insured

      NOTE: Irrevocable arrangements, such as absolute assignment, irrevocable beneficiary, and collateral assignment, are excluded from being counted as resources for the a/b. The insurance company must verify irrevocable arrangements funded by life insurance. The policy is considered irrevocable the month the insurance company official signs the form acknowledging the change is in effect.

2. Participating Policies

   a. A non-participating policy does not pay dividends. Use the FV and current CV.

   b. A participating whole life policy pays dividends to the owner of the policy. Universal life policies are a common type of participating whole

life. If the policy is participating and pays dividends, verify how dividends are paid as it may affect the CV or FV of the policy. Verify dividend payment by a copy of the annual premium notice. The owner receives this on the anniversary date of the policy and it includes an accumulation of all benefits, the amount of dividends, and how dividends are being used or paid. If the owner does not have the premium notice, contact the insurance company.

(1) Dividend Additions

Dividend additions may be used to purchase additional FV; or increase the policy's CV. Usually the cash surrender value table that is issued with the policy does not reflect the value of dividend additions to CV.

(2) Dividend Accumulations

Dividend accumulations may be applied to premiums, or remain in the "custody" of the insurance company for the purpose of accumulating interest. Dividend accumulations that are not used to pay a premium are treated the same as money in a savings account. Dividend accumulations count regardless of FV.

(3) Dividend Payments to Owner

Dividend payments to the owner are income in the month received and a countable resource if retained until the following month.

N. Prepaid Burial Contracts

1. Document if the a/b has a prepaid burial plan. If this plan is funded with insurance, see final note in II.M. above regarding irrevocable arrangements.

2. At application, verify the following by reviewing the contract or contacting the funeral home or burial trust company. Document the findings/verification in the DSS-8190. The value of the plan

   a. If it is irrevocable or revocable:

      (1) If irrevocable, do not count it as a resource.

      (2) If revocable, count the value as a resource, including accrued interest. NOTE: Revocable prepaid burial plans can be converted to irrevocable and excluded as a resource effective the date the contract becomes irrevocable. Refer to reduction of resources, VI., below.

O. Personal Property

1. Personal Property includes, but is not limited to:

   a. Motor vehicles (including motorcycles)
   b. Junked motor vehicles
   c. Mobile Homes
   d. Boats
   e. Boat Trailers
   f. Boat Motors
   g. Campers
   h. Trailers
   i. Farm Equipment

      NOTE: If resource is considered farm equipment and is used to produce income or to produce goods for home consumption, do not count the value of the resource. Refer to IV.D. below.

   j. Business Equipment

      NOTE: If resource is considered business equipment and is used to produce income, do not count the value of the resource.

2. Document the a/b's response and appropriate verifications to the following questions:

   a. The name of the owner(s) of the resource

   b. The year, make, and model of the resource

   c. Whether the vehicle is licensed

   d. How the resource is used

   e. If there is an amount owed on the resource and where it is financed

   f. If a/b states they no longer own the resource, document the details and verification in the SA case file.

3. Verify ownership and value at application and each redetermination by:

   a. Conducting an on-line inquiry on the a/b through the Department of Transportation (DOT) file. (Refer to the EIS-1101 for instructions for DOT Inquiries.)

b. If the information is not available in the DOT online inquiry, obtain the resource's value from:

(1) Tax records; or

(2) A dealer;

(3) An insurance company; or

(4) A bank, finance company, or other financial institution.

4. Determine the equity value (value minus encumbrances). Evaluate each resource individually.

   a. Use the value determined in #3 above.

   b. Motor Vehicles Used for Transportation

5. Motor Vehicles used for transportation

   a. Vehicle Exclusion (For resulting trusts and vehicles see IV. E. 1 and 2 below.) Exclude one motor vehicle, registered or unregistered, from countable resources regardless of the value. When an individual owns more than one automobile apply the exclusion in the manner most advantageous to the individual.

   b. Evaluating vehicle usage for possible resource exclusion.

      (1) Assume the motor vehicle is used for transportation unless there is evidence to the contrary. For example, the vehicle may not be licensed or an individual cannot travel by car but must be transported by ambulance.

      (2) If there is doubt as to the use of the vehicle, obtain a statement regarding how the vehicle is used for transportation for the individual.

      For example, for a vehicle owned by an individual in an ACH to be excluded, it would have to be used to transport the applicant/recipient. Obtain a statement from the person who has the vehicle that the vehicle is used to transport the recipient and the nature of the transportation.

      (3) Junked Vehicles

      A "junked vehicle" is one beyond repair that can only be used for parts and is not licensed. It does not meet the definition of a

"motor vehicle used for transportation". **Effective December 1, 2009 the equity value of such a vehicle is a resource and is not eligible for resource exclusion.**

Eligibility for SA is not affected for recipients who were eligible for SA prior to 12/1/09 and ongoing, who had junked vehicles in their name prior to December 1, 2009. Document this in the case file.

If SA terminates and the client later reapplies for SA the applicant will be subject to the new resources policy, counting the value of junked vehicles.

(4) Other Vehicles Listed in DMV But A/B Denies Ownership

If a vehicle is listed in DMV as owned by the a/b, and the a/b states they do not own the vehicle, obtain a collateral statement from someone who can verify the client no longer owns the vehicle. Do not count the vehicle as a resource. However, if the vehicle in question is titled and currently tagged to the SA a/b the legal title stands. For further instructions see IV. E. 1 and 2 below.

(5) If the a/b owns a vehicle jointly with another person, refer to I.B.2. for treatment of jointly owned resources. See IV. E. 1 and 2 below.

c. Encumbrances Owed- Equity Value

(1) Determine if there are any debts or loans (encumbrances) owed on the resource. Verify the payoff amount owed as of first day of the verification month by contacting the creditor (bank, finance company, etc.). If there are no encumbrances, the value is the equity value.

(2) If there are encumbrances, subtract the amount owed on the resource from the value. The remainder is the equity value. If the encumbrances exceed the value, there is no equity value for the resource.

Example 1:		Example 2:	
2000 Motor Vehicle		1995 Mobile Home (non-homesite)	
Fair Market Value	$3500	Fair Market Value	$6000
Amount Owed	- 1000	Amount Owed	- 7000
Equity Value	$2500	Equity Value	$0

III. REAL PROPERTY

Real property consists of land and any attachments such as dwellings and other buildings. Property owned by the a/b, solely or with another person, may be a countable resource unless it can be excluded for one of the reasons in V. below.

Document the a/b's statement regarding ownership and location of real property.

A. Verify the ownership of real property by:

1. Copies of deeds (Grantee/Grantor books at the office of the Register of Deeds)
2. Documentation or printout of tax record showing property
3. Copies of wills
4. Tax bill or statement
5. Evidence of judgments, liens, or boundary disputes
6. For applications, request a tax record check from other counties/states if client has recently moved to their current county of residence**.**

B. Determine the equity value of all real property by:

1. Verifying the tax value by using tax records;
2. Verifying encumbrances with the lien holder

    a. Determine if there are any debts or loans (encumbrances) owed on the resource. Verify the payoff amount owed as of first day of the verification month by contacting the creditor (bank, finance company, etc.). If there are no encumbrances, the value is the equity value.

    b. If there are encumbrances, subtract the amount owed on the resource from the value. The remainder is the equity value. If the encumbrances exceed the value, there is no equity value for the resource.

    EXAMPLE: Property with a tax value of $120,000. Encumbrances include first mortgage, payoff is $32,000; home equity loan, payoff is $8200; Countable equity value is $79,800.

    NOTE: If the a/b reports that he/she owns property in another county, state, or country, and you are unable to obtain the verification, ask a/b to assist in obtaining the verification of the real property.

C. Countable Real Property

1. Fee Simple

   Fee simple ownership means absolute and unqualified legal title to real property. The owner(s) has unconditional power of disposition of the property during his or her lifetime. Upon his or her death, property held in fee simple can always pass to the owner's heirs. Fee simple ownership may exist with respect to property owned jointly or solely.

2. Life Estate Interest

   a. A life estate interest is created when a person transfers real property to another person but retains the rights to the property for the remainder of his/her life. To determine the value of a life estate interest, multiply the tax value by the life estate percentage from the Life Estate/Remainder Interest Unisex Table based on the age of the life estate holder. If there is more than one life estate holder, use the age of the youngest. Refer to https://secure.ssa.gov/poms.nsf/lnx/0501140120.

   b. If there is an outstanding lien/mortgage against the property, multiply the payoff amount by the same percentage from the Life Estate/Remainder Interest Unisex Table. Subtract the a/b's share of the lien/mortgage from his/her share of the tax value to determine the equity value.

NOTE: An **Enhanced** Life Estate Deed, sometimes called a "Lady Bird Deed," differs from the typical life estate deed as the property is transferred at death, not before. The life tenant (grantor) can sell the property and keep the proceeds, mortgage it and use the equity, and profit off of their property without having to consult the beneficiary. They can also revoke or amend the deed. This means the grantor/owner or "life tenant" retains complete control over their property while alive. Such an Enhanced Life Estate deed is not a transfer of resources for Special Assistance **IF** no interest of present value is being transferred to the grantee by the deed. All these grantor rights must be specified clearly in the deed for it to qualify as an Enhanced Life Estate with no interest of present value. Contact your agency/county attorney with any questions concerning the type of deed that's been received or about the terms of an Enhanced Life Estate deed and the potential for transfer of resources.

3. Remainder Interest

   a. A remainder interest is created when a person transfers real property to another person but retains the rights to the property for the

remainder of his/her life. The person to whom the property is transferred has a remainder interest. To determine the value of a remainder interest, multiply the tax value by the percentage from the Life Estate/Remainder Interest Unisex Table based on the age of the life estate holder. Refer to https://secure.ssa.gov/poms.nsf/lnx/0501140120.

b. If there is an outstanding lien/mortgage against the property, multiply the payoff amount by the same percentage from the Life Estate/Remainder Interest Unisex Table. Subtract the a/b's share of the lien/mortgage from his/her share of the tax value to determine the equity value.

4. Tenancy-By-the-Entirety

Property owned jointly by husband and wife is usually held by them as tenancy-by- the-entirety.

a. If the conveyance of the property is made to the couple during the marriage, they hold the property as tenants-by-the-entirety even if it is not specifically stated in the deed.

b. If the couple separates, whether legally or not, this does not dissolve tenancy- by-the-entirety. If they divorce, the tenancy-by the-entirety is dissolved, and they become tenants-in-common of the property, and either person can sell his half share.

5. Tenancy-In-Common Interest

a. Property owned by 2 or more persons who are not married to one another or given to 2 or more persons by gift, will, or by intestate succession is held as tenancy-in-common. Each person has an undivided fractional interest in the whole property. Each owner may sell or give his individual interest in the property to another without the consent and participation of the other owners, and he may file suit with the court for partition of the property. Though property owned jointly by husband and wife is owned by tenancy-by-entirety, a legally binding agreement can be made that creates tenancy-in-common between husband and wife.

b. If there is a legally binding agreement that specifies each owner's share, multiply the tax value by the fractional interest stated in the agreement for the a/b. If there is no legally binding agreement specifying shares, divide the tax value by the number of tenants in common.

c. If there is a lien/mortgage on the property, multiply the payoff by the a/b's ownership share of the property. Subtract the a/b's share of the

lien/mortgage from his/her share of the tax value to determine the equity value.

IV. SPECIAL INSTRUCTIONS FOR RESOURCE EXCLUSIONS

A. Homesite Property

The home site is the one dwelling the a/b considers his/her established or principal home, along with all contiguous property, regardless of type of ownership (sole ownership, life estate, tenancy-in-common, tenancy-by-the entirety, etc.). It can be fixed or mobile and located on land or water (e.g., house, mobile home, camper, houseboat, motor home).

Do not count the value of the homesite if one of the following applies:

1. The a/b states his subjective intent to return home. “Subjective intent” means that it is his/her intent to return regardless of the circumstances of the absence from the home. If the a/b is mentally competent, do not consider other factors such as the a/b’s age, physical condition, mental capacity or other circumstances. The time of return may be indefinite, and there is no time limit on this exclusion. The property must have been the individual's home prior to the time the individual left the property.

    a. Verify the following at application and each redetermination by obtaining a signed statement of the a/b’s responses to following:

        (1) When and why he left the home;

        (2) Whether he intends to return, and If he does not intend to return, when that decision was made.

    b. If the a/b is competent and the statement is not self-contradictory, the a/b’s statement supersedes all other statements made by any other individuals.

    c. If the a/b has been found legally incompetent, or if the a/b’s statement is self- contradictory, obtain the signed statement from his representative (guardian, POA, spouse or family member).

        Examples of self-contradictory statements:

        “Sometimes I want to go home and sometimes I don't.”
        “I intend to go home, but I want to stay here.”
        “Yes, I want to go home, but I really don’t know if I should.”

2. There is a spouse or dependent relative remaining in the home. Dependency may be of any kind. The relative may depend upon the a/b for housing, financial support, food, clothing, etc. Accept the a/b's statement, or if the a/b is unable to provide a statement, the written statement of the representative (guardian, POA, spouse or family member). The homesite continues to be excluded if the relative is temporarily absent from the home but intends to return.

   Verify by obtaining a signed statement at application and redetermination showing:

   a. Who is living in the home,

   b. How they are related. Eligible relatives are:
      (1) Spouse
      (2) Child, stepchild or grandchild
      (3) Aunt, uncle, niece, nephew
      (4) Brother or sister (including step and half siblings)
      (5) Cousin
      (6) In-law

   c. How the person is dependent upon the a/b.

3. If the one of the above exclusions ends (spouse or dependent relative is no longer living on the property, or the a/b states he no longer intends to return home), reevaluate the use of the property. Count the property's equity in resources beginning the first day of the month following the month the exclusion ends, unless the property can be excluded for another reason.

B. Jointly Owned Property and Undue Hardship

Effective April 1, 1988, the value of an individual's ownership interest in jointly owned real property is an excluded resource for as long as sale of the property would cause undue hardship, due to loss of housing, to a co-owner.

1. Undue hardship would result if such co-owner:

   a. Uses the property as his or her principal place of residence;

   b. Would have to move if the property were sold; and

   c. Has no other readily available housing.

2. Obtain a statement from the co-owner regarding whether he or she:

a. Uses the property as his or her principal place of residence;

b. Would have to move if the property were sold; and

c. Has other living quarters readily available.

Accept any reasonable allegation from the co-owner that there is no readily available housing (e.g., no other affordable housing available or no other housing with necessary physical modifications for a handicapped individual).

If undue hardship ceases to apply because the joint owner moves off the property or dies, etc., the property may be excluded to allow reasonable efforts to sell as outlined in V.D.

C. Burial Spaces (Plots Burial Spaces (Plots, Crypts, Vaults, Mausoleums, Caskets and Urns)

Effective with applications on or after December 1, 2009, SA no longer excludes from countable resources the value all burial spaces, plots, vaults, mausoleums, casket and urns in the a/b's name. A burial space or agreement which represents the purchase of a burial space held for the burial of the a/b, his or her spouse, or any other member of his or her immediate family is an excluded resource, regardless of value.

Eligibility for SA is not affected for recipients who were eligible for SA prior to 12/1/09 and ongoing, who had all burial spaces, plots, vaults, mausoleums, casket and urns in their name prior to December 1, 2009. **Continue to exclude from countable resources even those burial items purchased for someone other than an immediate family member prior to December 1, 2009.** Document this in the case file.

Beginning December 1, 2009, if an ongoing recipient purchases a burial space, crypt, vault, mausoleum, casket or urn that is not designated for an immediate family member **treat it as a change in situation**. Count the value toward the individual resource limit of $2,000.00. If SA correctly terminates and the client later reapplies for SA the applicant will be subject to the new resources policy, counting the equity value of burial spaces, plots, vaults, mausoleums, casket and urns not purchased for members of the a/b's immediate family.

"Immediate family" also includes the spouse of the immediate family member. If the relative's relationship to the a/b is by marriage only, the marriage must be in effect in order for the burial space exclusion to continue to apply. For example, a burial space held for a sister- in-law is no longer excludable if she and the a/b's brother divorce.

The a/b's immediate family includes his or her:

1. Parents, including adoptive parents;

2. Minor or adult children, including adoptive and stepchildren;

3. Siblings (brothers and sisters), including adoptive and stepsiblings

.

4. Of items that serve the same purpose, **exclude only one per person**. For example, exclude a cemetery lot and a casket for the same person, but not a casket and an urn.

5. **General Exclusion Procedures:**

   a. If an a/b alleges owning only one burial space, or an individual and spouse (joint ownership) allege owning no more than two spaces, **assume** that the spaces are excluded.
   b. If an a/b, or a/b and spouse (joint ownership), allege owning more than one or two spaces, respectively, obtain a signed statement showing:

      (1) The name of the person for whose burial each space is intended; and

      (2) The relationship of each such person to the a/b.

      (3) Exclude only those spaces that are alleged to be for the burial of the a/b, the spouse, or a member of the immediate family.

6. **Verifying the Value of Non-excluded Burial Property**

   Determine amount the a/b paid for the property by examining the deed, contract or bill of sale. This includes plots, crypts, vaults, mausoleums, caskets and urns. If the a/b still owes payment for the property, subtract the amount owed from the agreed upon cost, and count the equity toward the allowable SA resource limit of $2,000.

D. Exclude personal and real property used by the a/b:

1. In the operation (actively conducting business) of a trade, business, farm operation, or self-employment enterprise regardless of its equity value or amount of income.

2. For home consumption (such as land used to tend a garden or a boat used to fish). This exemption is limited. Only exempt up to $6,000 in total combined equity of all personal and real property used for this purpose.

3. If the a/b is blind or disabled, exclude resources that are identified as necessary to fulfill a plan for achieving self-support (PASS) which is in writing, has been approved by Social Security, and is being actively pursued by the a/b. A PASS is usually designed for up to 18 months, but may be

extended by Social Security for up to 48 months. Begin counting the resources the first day of the month following the month in which the a/b fails to follow the conditions of his plan or reaches the goal of his plan.

E. Resulting Trusts/Legally Binding Agreements

1. Policy

   a. It is presumed a resource owned by an individual is available to him, unless there are circumstances that make the resource unavailable.

   b. The terms of a divorce decree, will, deed, court order, resulting trust or legally binding agreement may cause a resource technically owned by an individual to be unavailable to him.

   c. A resulting trust exists when a person has a resource in his/her own name but is holding it for the benefit of another person and he:

      (1) Retains no legal interest in the resource, and

      (2) Will not benefit from the disposal of the resource.

   d. If the a/b or a person financially responsible for the a/b alleging that a resource is held in trust for someone else continues to retain a legal interest in the resource and/or will receive the proceeds from the disposal of the resource, it is not considered to be held in trust for someone else and is a countable resource.

   e. If the a/b or a person financially responsible for the a/b claims a resource is not available because of a resulting trust/legally binding agreement, he/she must cooperate by presenting necessary documentary evidence to show that the resource is unavailable.

   f. A legally binding agreement may be either a written or a verbal contract. The evidence must be sufficient to:

      (1) Convince others of the validity of the agreement,

      (2) Show that the agreement existed at the time of the purchase/deposit of the resource, and

      (3) Show that the legal titleholder holds the resource/property in trust for the party applying the purchase price or making the deposit.

2. Procedures

   a. When a resource is apparently owned by an individual who has applied for Special Assistance, determine whether it may not be

actually available to him because of a legally binding agreement or resulting trust. Obtain verification at application or any change in situation involving a resulting trust/legally binding agreement. It is not necessary to reverify at redetermination.

(1) Written Contract

(a) Review the contract and determine if it affects the availability of the resource.

(b) Determine the intent and terms of the agreement between parties, including the type of resource, the date of the contract, reason for its existence, and specific terms of the agreement.

(c) Contact the county or agency attorney if there are questions regarding the terms or validity of the written contract.

(2) Verbal Contract/Agreement

Ask the a/b to submit 2 different types of the following evidence:

(a) Written statement(s)/affidavit(s) from the parties involved in the verbal agreement:

1. Giving the type of resource,
2. The intent and terms of the agreement, and
3. Describing the involvement of the parties to the agreement.

(b) Canceled checks or receipts for payments on a mortgage, loan, etc., showing who is making payments on the resource,

(c) Letter(s) or statement(s) from finance companies, banks, credit unions, loan officers, automobile salespersons, insurance companies or agents, or others identifying the type of resource and supporting claims that the resource is held for another individual who is making payments on the resource, or

(d) Written statements from at least 2 knowledgeable persons:

1. Identifying the type of resource, and
2. Giving the circumstances surrounding ownership, and
3. Availability of the resource and the basis for their knowledge.

(3) Real Property

(a) Contact the county attorney to request assistance in determining availability if the resource in question involves real property.

(b) Only a court can set aside a deed to real property.

(4) Liquid Assets/Bank Accounts

Obtain the following documentation for a bank account the a/b alleges is in his/her name only for check cashing purposes or because the other individual needs the a/b or financially responsible person's name on the account in the event of absence, illness, or for other reasons:

(a) Primary Verification

A written statement from each individual whose name is on the account, attesting to actual ownership of the funds and why the a/b's or financially responsible person's name is on the account.

(b) Alternative Verification

A statement regarding the ownership of funds from the a/b or financially responsible person and one other knowledgeable source, such as:

1. The parties involved in the agreement,

2. Finance companies, banks, credit unions, loan officers, automobile salespersons, insurance companies or agents, or

3. An individual who knows the circumstances surrounding ownership and availability of the resource.

(5) Motor Vehicles

Obtain the documentation in (a) below and one of the documents listed in items (b), (c), or (d), below for a motor vehicle in the name of the a/b or financially responsible person who alleges that he is not the owner:

(a) Written statement(s) or affidavit(s) from the a/b and the other party(ies) involved in a verbal contract:

1. Giving the intent and terms of the agreement and the involvement of the parties to the agreement, and

2. Stating that the true owner, who is not the a/b or financially responsible person, makes monthly payments on the vehicle and pays the insurance premiums or taxes on the vehicle.

(b) Cancelled checks or receipts for payments on a loan, etc., showing who is making payments on the vehicle.

(c) Letter(s) or statement(s) from finance companies, banks, credit unions, loan officers, automobile salesmen, insurance companies or agents, or others supporting claims of the cost or of responsibility for the vehicle.

(d) Written statements from at least 2 knowledgeable sources as to the circumstances surrounding ownership and availability of the vehicle. Include the basis for their knowledge.

b. Do not count the resource for the a/b who shows by the evidence that i it is held in trust for another individual.

c. If the other individual applies for SA/MA, it must be counted as a resource for that individual.

F. Liquid Assets of a Business

1. Determine if the a/b has liquid assets needed to operate a business.

2. Verify the status of bank accounts used in the operation of a business.

   a. DBA (doing business as) account- Verify with the bank and the records of the DBA account that these funds are not used for personal bills

   b. Combined with personal funds- If the bank account is used for personal and business transactions, the business assets must be separately identified to be excluded.

3. Exclude a business account in the name of the business or corporation that is totally separate from personal funds. Count the income of the business. Refer to SA-3210, Income.

G. Tobacco Buyout Payments

Tobacco allotments were administered by the Farm Service Agency and provided the right to produce a certain number of pounds of tobacco for harvest. Effective November of 2005 the Tobacco Transition Payment

Program (TTPP) **eliminated the tobacco quota or allotment system**, calculating the value of lost quota and providing compensation in the form of cash installment payments to both owners and producers. Essentially the quotas were bought by the federal government. An initial payment was made to each quota owner and to each quota producer in November 2005.

Beginning January 2006, both tobacco quota owners and tobacco quota producers were given the option to receive annual payments over a ten year period or receive all payments in one lump sum.

Payments are distributed during the first couple of months each calendar year. Based on SSI policy, it has been determined by SSI that these payments will be treated differently for quota owners than they will be for quota producers.

1. TTPP payments to quota owners are a conversion of a resource, i.e., quota for cash. The rationale for treating the compensation to quota owners as a conversion of a resource is that the quota is assigned to the land ownership. Land meets the definition of a resource.

    a. If the quota owner converts the quota to like property, i.e., another resource, treat the transaction as a conversion of a resource.

    b. If the quota owner assigns the contract to a third party because he or she does not want the payments, i.e., gives it away, follow the transfer of resource policy.

2. TTPP payments to quota producers, or those who rent the land, are net earned self- employment income (NESE). The compensation for producers represents the value of lost price support in the sale of tobacco and should be treated as NESE.

    If the quota producer assigns the contract to a third party because he or she does not want the payments, i.e., gives it away, follow the transfer of resource policy in SA-3205.

H. Restricted Allotted Land Owned by an Enrolled Member of an Indian Tribe

In determining the resources of an individual (and spouse, if any) who is of Indian descent from a federally recognized Indian tribe, any interests of the individual (or spouse) in trust or restricted lands are excluded from resources.

If a/b alleges an interest in trust or restricted land as a member of an Indian Tribe:

1. Obtain for the file a copy of any document or documents that might identify it as such; and/or

2. Verify the allegation with the appropriate Indian agency.

3. If a/b is a member of a recognized Indian Tribe, exclude all interest in trust or restricted land.

I. Incompetency

If an a/b does not have resources that exceed the resource limit, incompetence is not an issue. When an a/b has excess resources and he is alleged to be incompetent or has been ruled incompetent by a North Carolina court, use the following policy to determine if the resources may be excluded.

1. General

   a. Resources owned by a/b or where the a/b has a legal interest are not available to the a/b if:

      (1) He is alleged to be incompetent and has no legal representative/guardian/durable POA to make the resources available,
      or
      (2) He has a legal representative/guardian/durable POA who does not act to make the resources available.

2. Policy Rules

   a. Otherwise countable and available/accessible resources, held solely or jointly by an alleged to be incompetent a/b, are exempt prior to a formal declaration of incompetency if:

      (1) A written statement as described in IV.I.3.a. (3), below, from a knowledgeable source supports the allegation of incompetence, and

      (2) The a/b is alleged to be incompetent for a period of at least 30 consecutive days or until his/her death, and

      NOTE: If applicant is not alleged to be incompetent for 30 days hold application for the 30-day period.

      (3) The resources cannot be accessed on behalf of the a/b because:

         (a) He has no legal representative/guardian/durable POA, or

         (b) His/her legal representative/guardian/durable POA is unable, fails, or refuses to act to make the resources available.

b. Incompetency for Special Assistance eligibility purposes may be:

(1) Alleged by someone who is in a position to know, as indicated in IV.I.3.a. (2) , below, or

(2) Adjudicated incompetent by a North Carolina court.

c. Incompetency may be alleged:

(1) At the application interview, or

(2) When an a/b receives new resources, or

(3) When unreported resources are discovered, or

(4) When a change in situation causes a previously exempt resource to become countable, or

(5) When the value of a resource increases.

d. Exclude otherwise countable resources of an alleged incompetent individual if a representative has not been previously established who is legally authorized to act on the alleged incompetent individual's behalf, including accessing his/her resources.

e. For purposes of Special Assistance eligibility, a formal judgment of incompetence is not required if the a/b has previously executed a valid durable POA and his/her attorney-in-fact is able and willing to act in the a/b's behalf.

(1) Resources held by the alleged incompetent a/b with a valid durable POA are considered available and countable.

(2) If the durable POA is unable or unwilling or otherwise fails or refuses to act on the a/b's behalf to make the resources available, the resources are unavailable, a legal guardian of the estate may be established to act for the a/b. IMC may refer to Adult Services for guardianship services. Continue to exclude resources until situation is resolved. See IV. H.3., below for procedures.

f. When the a/b has been adjudicated incompetent by a North Carolina court and the court has appointed a guardian of the estate, resources are available under certain conditions described in procedures below.

3. Procedures

a. Alleged Incompetence

Inform the family member or legal representative of an a/b who may be incompetent, including a public agency acting on the a/b's behalf, that:

(1) Otherwise countable resources may be exempt for a certain period of time if the a/b is alleged to be incompetent for a period of at least 30 consecutive days or until his/her death, and

(a) The a/b does not have someone legally authorized to act on his/her behalf to access his/her resources, or

(b) His/Her legal representative/guardian/durable POA is unable, fails or refuses to act to make the resources available, and

NOTE: The individual must have been alleged incompetent for at least 30 consecutive days or have died before resources may be exempt.

(2) The alleged incompetence is supported by the written statement of one of the following:

(a) A physician, or

(b) A nurse, social worker, or psychologist, and

(3) The statement/testimony includes:

(a) An explanation of the reasons the a/b is alleged to be incompetent,

(b) The approximate onset of the alleged incompetence,

(c) The ending date of alleged incompetence, if the person has improved, and

(d) The basis for the knowledge or opinion of the individual alleging the incompetence.

b. Exclude Resources

Exclude all resources, beginning with the first month for which assistance is requested:

(1) For all months that the evidence as defined in IV.I.1. above clearly shows that the a/b was incompetent, and

(2) Until one of the following occurs:

(a) A North Carolina court rules that the a/b is incompetent and appoints a guardian of the estate or general guardian, or

(b) The court rules that the a/b is not incompetent, or

(c) The court does not rule and dismisses the case because of the death or recovery of the a/b.

c. Requirement to Formally Establish Incompetence

Inform the a/b's family or representative that steps must be taken to establish the a/b's incompetence formally in a North Carolina court. If the a/b's representative states that he is willing and able to act on the a/b's behalf, explain that:

(1) All documents and petitions necessary to have the a/b formally declared incompetent must be filed with a North Carolina court in order to have a guardian of the estate or general guardian appointed by the court, and

(2) The necessary legal documents must be filed with the court within 30 calendar days of the latter of:

(a) The date of application for Special Assistance, or

(b) The discovery of a previously unreported resource or receipt of a new resource in an ongoing case.

d. Referral for Guardianship Services

Refer the case to the Adult Services Unit at any point that the a/b's representative:

(1) Requests guardianship services, or

(2) If the family or representative pursues guardianship, but only guardian of person is appointed, or

(3) States that he is unwilling or unable to pursue guardianship, or

(4) Refuses to participate or cooperate in the court proceedings required to make the resources available to the a/b, or

(5) Fails to take the necessary steps outlined in IV.I.3.c. , above, within 30 calendar days of contact by the IMC regarding his/her responsibilities.

e. No Ruling of Incompetence

Count resources at the beginning of the next month if:

(1) The court finds that the a/b is not incompetent, or

(2) The court dismisses the case, or

(3) The services unit determines that guardianship is not the appropriate alternative to meet the a/b's needs.

f. Incompetence Is Established by the Court

When an adjudication of incompetence has been established by a North Carolina court and a general guardian or guardian of the estate has been appointed, regard the resources as follows:

(1) Count liquid resources and personal property resources beginning with the first day of the month immediately following the month in which the legal guardian is appointed.

(2) Count real property resources only after the Court has given final approval for sale of the property.

(a) Inform the guardian that it may be in the a/b's best interest to petition the Clerk of Court for approval to dispose of or convert the real property resource.

(b) Count the value of the real property resource on the first day of the month immediately following the month in which the Court issues an "Order Confirming Sale", unless the guardian has taken steps to exclude it by making it income-producing.

(c) The "Order Confirming Sale" is a document issued to the guardian authorizing final sale of the property and must be signed by the Clerk of Court and a Superior Court Judge. It is only issued after a sales contract has been executed and no further bids have been received during a period of time allowed by the Court.

g. Failure of Legal Guardian to Act

(1) If a legal guardian fails to access liquid resources or fails to begin the process to access real property for the a/b's use within 30 calendar days of appointment, make a referral to Adult Services.

(2) The Social Worker may:

(a) Determine if the guardian is acting in the a/b's best interests, and

(b) Inform the IMC either that the present guardian is acting in the a/b's best interests or that a new guardian should be appointed.

(3) The Social Worker may notify the Clerk of Court for intervention if he determines that the a/b's interests are not being served or are questionable.

(4) Continue to exclude the resources until the Clerk of Court acts to appoint a successor.

(5) Count the resources as described in IV.I.3.f. , above, if the Social Worker determines that the a/b's best interests are being served or if the Clerk of Court appoints a new guardian. Continue to exclude resources until the new guardian has “Order Confirming Sale.”

h. Documentation

(1) File copies of the durable POA and/or Letters of Guardianship in the a/b's case record.

(2) File the copy of “Order Confirming Sale” in the a/b’s case record.

(3) File copies of documents to show that all required steps have been taken to establish formal guardianship and that the guardian has taken the necessary actions to make the a/b's resources available.

i. Computation of Countable Resources

(1) Exclude all resources for any month or portion of a month for which assistance is requested and there is documentation that the a/b is alleged incompetent to access his/her resources.

(2) Count all resources that are available to the a/b if competency is restored by a court beginning with the first day of the month following restoration of legal competency.

V. REDUCTION OF RESOURCES

The purpose of this section is to outline procedures for reducing resources to establish eligibility for Special Assistance. If countable resources exceed the SA limit on the first moment of the first day of the month, the a/b does not meet resource requirements until the next calendar month. The exception to this rule is if the burial exclusion is sufficient to reduce resources to the allowable limit.

The a/b may reduce resources by spending down excess liquid assets, designating certain types of resources for burial, meeting the $6,000/6% test for income-producing property, making a reasonable effort to sell excess personal or real property, and rebutting the established value of resources.

A. Reduction of Liquid Assets (Spending Down)

The a/b can reduce cash resources by paying for goods and services at fair market value that benefit the a/b (e.g., paying for room and board at an adult care home, purchasing needed items, or paying off debts).

1. Verification

   a. Cash

      (1) Ask a/b to provide receipts for purchases.

      (2) A/B's written statement.

   b. Bank Accounts

      (1) Determine the amount of any outstanding checks. Do not consider a check as outstanding if it is more than six months old.

      (2) Evaluate whether checks were written and either mailed or delivered to the payee prior to the first moment of the verification month BUT had not cleared the bank prior to the first moment of the verification month.

      (3) Once the check has cleared the bank, verify the date it cleared from the bank statement or by written or verbal contact with the bank.

      (4) If available, compare the checkbook register (or check stubs) to the bank statement.

         (a) Use the a/b's checkbook register (or check stubs) to verify the:

            1) Date the outstanding check was written,

            2) Check number,

            3) Payee of the check, and

            4) Sequential order of dates and check numbers.

         (b) Use the bank statement to verify that the check did not clear the bank prior to the first day of the month.

(5) If the checkbook register (or check stubs) is not available, incomplete, or the order of dates and check numbers is not clearly sequential, verify outstanding status of the check by:

(a) Written or verbal verification from the bank that a stop payment against the check has not been requested, and

(b) A signed, dated statement from the a/b (or the person who actually signed the check) which includes:

1) Check number,

2) Date the check was mailed or hand delivered,

3) Amount of the check, and

4) That the check is for payment of a valid expense.

2. Determine the countable resource amount.

a. Use the verified checking account balance.

b. Subtract verified outstanding checks from the balance.

c. Do not deduct a check written in advance for prepayment of cost of care.

d. If the a/b's Social Security and/or SSI is direct deposited and either one or both checks are deposited early (prior to the first day of the month in which the check counts as income), deduct the early payment(s).

e. Count the remainder as the countable resource amount from the checking account.

f. It there is excess resources, and the a/b uses the account to deposit income from rental property or self-employment, deduct outstanding or future expenses incurred to produce the income using the following guidelines:

(1) Convert the gross income and expenses to a monthly amount per SA-3210, Income.

(2) Deduct from the opening balance any portion that is counted as income or can be deducted as an operational expense for the current month and any future month.

(3) Do not deduct any portion that was income or expenses for past months.

For example, the a/b receives $240/month countable rental income. His operational expense is $600/year in property taxes, which converts to $50/month. Deduct from the first moment balance the $240 income and the $50 for property taxes.

g. Document the SA case file with the countable amount and the verification of the account balance and outstanding checks.

B. Burial Exclusion

Burial exclusion is used only when the a/b has excess countable resources. It is a method to exclude up to $1500 of otherwise countable liquid resources for burial expenses of the a/b.

1. Burial Exclusion Rules

a. Always ask the a/b if there are resources that are intended to be used for burial purposes.

b. Use the $1500 burial exclusion to reduce countable resources when the a/b has excess liquid resources in:

(1) A revocable burial contract for his/her burial expenses,

(2) CV of life insurance on his/her own life, or

(3) Cash/bank accounts.

c. Do not use the burial exclusion if the a/b has irrevocable burial arrangements valued at $1500 or more. Irrevocable contracts are not a countable resource but they are applied to and use up the burial exclusion.

d. If excluding $1500 of the a/b's countable resources listed above is sufficient to reduce countable resources to the limit:

(1) Inform the a/b that liquid resources (except life insurance) designated as a burial asset cannot be excluded if commingled (held in the same account) with non-burial resources. Request proof that resources have been separated.

(2) When burial resources are no longer commingled, exclude $1,500 of the value of liquid resources for the a/b's burial expenses.

(3) Exclude the liquid resources in the burial exclusion back to the first month assistance is requested.

e. If applying the $1,500 burial exclusion does not reduce resources below the limit, resources must be reduced within the 45/60-day standard for applications. In this case, eligibility cannot begin until the month after the month in which resources are reduced.

2. Burial Exclusion Procedures

Follow the steps in this section to apply the burial exclusion. Always deduct the value of burial resources until the burial exclusion is depleted (you reach zero dollars) or all resources have been deducted. Deduct resources in the order specified in the Burial.

Burial Exclusion Guide

Deduct from the $1,500 burial exclusion:	**If the total value is more than $1,500 or more than the amount remaining in burial exclusion:**
Value of irrevocable arrangements	Do not count excess.
FV of life insurance when less than $1,500 . (The excludable FV changed from $10,000 to $1,500 for applications taken on after December 1, 2009).	Reduces $1,500 exclusion but never counts.
Value of revocable contract	Count excess, ignore interest earned once designated and excluded at application.
CV of life insurance (greater than $1,500 FV). (The excludable FV changed from $10,000 to $1,500 for applications taken on after December 1, 2009).	Count excess at application, ignore increases once designated for burial.
Cash or funds in a bank account (separately identifiable)	Count excess. If result is excess resources, a/b must reduce resources.

3. Irrevocable Burial Arrangements

Follow these steps to determine if there is an irrevocable arrangement. Deduct any irrevocable burial arrangement from the $1,500 burial exclusion. If there is any amount of exclusion left, continue to the next excludable item.

a. Irrevocable Trust/Contract/Absolute Assignment

(1) Review the contract or contact the funeral home or burial company to determine the value of the plan, the name of the beneficiary and that it is irrevocable.

(2) Do not require that the contract include a listing of goods and services to be provided unless the information is needed for evaluation for transfer of resources. Refer to SA-3205 for transfer rules.

b. Irrevocable Designation of Beneficiary

(1) The designation may be made when the policy is taken out, or

(2) The beneficiary may be irrevocably changed by a rider filed with the insurance company.

(3) Verify with the insurance company that:

(a) The designation has been filed with the company,

(b) The designation is irrevocable, and

(c) The client cannot access the CV of the policy.

(4) The services purchased do not have to be selected in advance.

Note: The reserve reduction is effective the first day of the month that the life insurance company acknowledges the transfer in writing.

4. **FV of Life Insurance** – Recipient Eligible for and Received SA Prior to December 1, 2009 and Ongoing

a. **The excludable FV of cash accruing life insurance changed from $10,000 to $1,500 for applications taken on after December 1, 2009.** Eligibility for SA is not affected for recipients who were eligible for SA prior to December 1, 2009 and ongoing, who had cash accruing life insurance policies purchased prior to December 1, 2009, with a FV over $1,500.00, but less than $10,000.00. SA does not count the CV unless the FV exceeds $10,000.00.

b. **For redeterminations**, if a recipient is eligible for, or receiving SA prior to December 1, 2009 and ongoing, continue to exclude up to $10,000.00 FV in cash accruing life insurance purchased prior to December 1, 2009, before counting the CV.

c. A new Case Level Special Use code ‘LI’ (Life Insurance Face Value Over $1500) was created in EIS for the SAA and SAD programs only and is valid with ambulation capacity codes ‘B’, ‘C’, ‘E’, and ‘H’ in order to track these individuals and identify them for redeterminations and for State reporting purposes. Make certain the new Case Level Special Use code ”LI” is keyed in EIS, identifying the recipient as an SA recipient who was eligible for SA prior to December 1, 2009, with cash accruing life insurance purchased prior to December 1, 2009, with a total FV over $1,500.00 and a FV up to $10,000.00.

d. Beginning December 1, 2009, if an ongoing recipient buys cash accruing life insurance with a total FV that exceeds $1,500.00 **treat it as a change in situation**. Verify the available cash value and count toward the individual resource limit of $2,000.00.

e. If SA terminates and the client later reapplies for SA, the applicant will be subject to the new resources policy, counting the CV of face value of all cash accruing life insurance polices if the FV exceeds $1,500.00.

f. After deducting irrevocable burial arrangements, if the total FV of all life insurance policies owned by the a/b does not exceed $1,500.

(1) Deduct the FV of all whole life policies that insure the life of the a/b from the amount left in the a/b’s $1,500 burial exclusion.

(2) FV is not a countable resource, but it must be applied to the burial exclusion.

(3) Term life and burial association policies do not generally accrue CV. If they do not accrue CV, they are not a countable resource and are not deducted from burial exclusion.

(4) If there is any amount of exclusion left, continue to the next excludable item.

5. Revocable Burial Arrangements

After deducting irrevocable burial arrangements and FV of non-countable life insurance, deduct the value of a revocable burial contract with a funeral home or other revocable trust or annuity established for burial expenses from the amount left in the $1,500 burial exclusion.

a. Revocable means the funds are available and can be withdrawn.

b. A revocable trust or annuity that is not limited to payment of burial expenses within the body of the agreement cannot be excluded under burial exclusion policy.
c. Deduct the value of the revocable burial arrangement from the amount left in the $1,500 burial exclusion.

d. A revocable burial trust may appreciate in value or accumulate interest.

(1) Verify the value at application. At redetermination, ignore any subsequent increase in value due to interest/accumulation of a revocable burial trust that has been excluded through burial exclusion.

(2) If the case is later terminated and the a/b reapplies, count the full value of the revocable trust in the verification month.

e. If the value of the revocable burial arrangement exceeds the amount left in the $1,500 burial exclusion:

(1) Burial exclusion is used up; AND

(2) The excess amount of the revocable arrangement counts in reserve.

f. In the record, document the amount of the revocable arrangement that was counted in resources and continue counting this amount in resources at subsequent reviews unless the revocable arrangement is changed to irrevocable.
g. If there is any amount of exclusion left, continue to the next excludable item.

6. Cash Value (CV) of Life Insurance

When total FV of all whole life policies owned by the a/b exceeds $1,500 (the excludable FV changed from $10,000 to $1,500 for applications taken on after December 1, 2009):
a. After deducting irrevocable burial arrangements, FV of non-countable insurance and revocable burial arrangements, deduct the CV of whole life policies designated for burial on the life of the individual from the amount remaining in that a/b's $1,500 burial exclusion.

b. Accept the verbal statement of the policy owner or his/her representative that the policy is designated for burial.

c. If there is any amount of exclusion left, continue to the next item.

d. If burial exclusion is used up:

(1) At application, CV which exceeds the $1,500 burial exclusion limit of a designated policy is a countable resource;

(2) At redetermination, the original amount of CV that exceeded the $1,500 burial exclusion (counted at application and not excluded as part of the $1,500 burial exclusion) continues to count in resources. However, increases in CV are ignored as long as the policy(s) is designated for burial.

Example: The a/b has one life insurance policy with FV of $13,000 and a CV at application of $3,000. The a/b stated it is intended and needed for burial expenses. There are no other resources.

$3,000	CV of insurance intended for burial
-1500	Burial exclusion (no other burial asset)
$1500	Excess counts in resources.

At review the CV has increased to $3,500. The a/b continues to state that it is needed for burial and has acquired no other resources to be applied to the burial exclusion. Continue to count only $1,500 of CV as a countable resource. Increases in CV after SA eligibility begins are ignored.

e. An applicant may designate remaining CV for burial when there is an existing loan on the policy or it is collateral on an outstanding loan. If a new loan/cash withdrawal occurs after designation for burial, designated status is lost. That policy cannot be re-designated for burial. Any CV remaining on that policy counts in reserve at that time and in the future. Once the loan is paid off the policy can be re-designated.

f. Once an application has been dispositioned and there is a policy designated for burial expenses, any action that reduces or depletes the CV of life insurance (except to pay the premium), revokes the burial designation. Burial exclusion can no longer be applied to the policy. Stop excluding the CV when:

(1) A loan has been taken against the CV subsequent to designation; Or

(2) The policy has been used as collateral subsequent to the Exclusion

(3) A policy is “designated” and action is taken during the application

processing period to reduce the value. Do not consider the policy as having been designated for any period of time for which eligibility is being determined.

g. Always count the CV of policies owned by the a/b, regardless of the insured, if the a/b's total FV of all cash accruing policies exceeds $1,500. (The excludable FV changed from $10,000 to $1,500 for applications taken on after December 1, 2009).

h. A revocable change in beneficiary of an insurance policy to a funeral home does not make the CV unavailable to the a/b.

Example 1: Mr. Brown owns a whole life insurance policy with a FV $1,500 on himself, a whole life insurance policy with a FV of $1,500 on his grandson, and a $1,000 term life (non-cash accruing) on himself. The total FV of all whole life policies owned by Mr. Brown is $11,500, which exceeds $1,500 so CV is countable. Only the CV of a/b's (Mr. Brown) whole life policy can be deducted from his burial exclusion. The $1,500 whole life on his grandson cannot be applied to Mr. Brown's burial exclusion because he is not ' the insured. The $1,000 term life insurance policy is not applicable to burial exclusion.

Example 2: Mr. Jones has a whole life insurance policy with FV of $15,000 and no other burial resources. The current CV on the policy is $2,500. Mr. Jones has changed the beneficiary of the policy to be the local funeral home. The change is revocable. $1,500 of the CV of the designated policy can be excluded through burial exclusion, but the remaining $1,000 CV counts in resources.

7. Cash/Funds Held in a Bank Account

a. These countable liquid resources:

(1) May be used to purchase burial assets to reduce resources in any amount within the 45/60 day processing time; BUT

(2) May be excluded under burial exclusion ***only*** when $1,500 burial exclusion will reduce resources and establish eligibility.

b. If exclusion of the amount remaining in burial exclusion is enough to reduce resources:

(1) Inform the a/b of the amount of funds that can be designated for burial.

(2) Obtain a/b's written statement as to whether he intends to use the funds for burial expenses.

(3) Inform the a/b that cash funds intended for burial expenses must not be commingled with other funds.

(4) For an application, the funds *must be separated,* and proof must be provided within the 45/60 day processing time.

(5) For a recipient, proof must be provided prior to the effective date of termination.

(a) Send a timely notice informing the recipient of the amount of excess resources.

(b) Inform the recipient that a signed statement that the funds will be designated and separated for burial expenses must be received within the 10-day notice period.

(c) Proof that action has been taken to separate the funds must be provided within 30 days of the timely notice.

(d) If proof is not received within 30 days, send an adequate notice and terminate the case.

(e) Proof must show, at a minimum that the necessary paper work was submitted to the insurance company or funeral home, or funds held in a bank are designated and separated.

c. If the applicant dies before the application is disposed, the amount of countable resources excluded for burial expenses is $1,500 regardless of the actual cost of burial. If excess funds have not been separated, burial exclusion does not apply.

d. Once cash/funds have been designated for burial, any interest accrued is not a countable resource. It is not necessary to reverify at redetermination.

8. If the amount remaining in the burial exclusion is not enough to reduce resources to the allowable limit, inform the a/b of the amount of excess resources and any other methods to reduce, including purchasing an irrevocable burial resource.

Example:

Mrs. Stanly applied on June 4 for ongoing SAA and for retroactive Medicaid benefits for May. She has one life insurance policy with FV of

$1,000 and a savings account with $2,500 which she states is intended and needed for burial expenses.

$1,500	Burial exclusion
- 1000	FV of life insurance
$ 500	Amount left for burial exclusion

$2,500	Liquid resources designated for burial
- 500	Amount which can be excluded through burial exclusion
$2,000	No excess resources

Even though there is no excess, the applicant must separate the excess funds. Because eligibility is established using the $1,500 burial exclusion, the applicant has until the processing deadline to provide proof that at least $500 in liquid resources is separately identifiable.

C. Exclusion of Income Producing Real/Personal Property ($6,000/6% Test)

This test is used to determine if real or personal property (usually rental property) that cannot otherwise be excluded is exempt from countable resources because it is "income producing." To exclude property, it must produce a net annual income of at least 6% of its equity after all expenses related to producing the income are deducted. **Any countable equity value in excess of $6,000 is countable in resources.**

Even though all or a portion of property that meets the $6,000/6% rule may be excluded, the a/b is subject to a sanction if income producing property is transferred. Refer to SA-3205, Transfer of Resources.

1. Determine the Equity Value of the Property:
   Tax Value - Encumbrances/liens = Equity Value.

   a. Real Property Value
      Tax Value - Always use the tax value when counting real property as a resource and to calculate the countable equity value.

   b. Personal Property Value

      Use the tax assessed value to determine the equity.

   c. Rights of Use

      (1) The a/b may own rights of use in non-business real property. Rights of use are tied to land or the natural resources of land and may have countable value separate from the land.

(2) The value of the right of use, if owned by the a/b, is exempt if it meets the $6000/6% income producing criteria.

(3) Land is also income-producing if the a/b owns the land and rents or leases a right of use which produces net income based upon $6000/6% test.

(4) Types of rights of use:

(a) Mineral Rights-ownership interest in certain natural resources, such as coal, oil, sulfur, gas, etc., coming from the ground.

(b) Timber Rights-ownership of timber growing on land, with or without ownership of the surface of the land.

(c) Hunting or fishing rights.

2. Determine Net Annual Income

a. Calculate the gross annual income.

(1) If the same amount is received monthly, multiply this amount by 12 months (amount x 12 months = gross annual income).

(2) If received other than monthly, calculate a gross annual income amount according to instructions in SA-3210, Income.

(3) If gross annual income has changes in the past 12 months (base period), use the amount currently being received to determine gross annual income.

b. Determine the gross annual allowable operational expenses.

(1) Verify operational expenses for the previous calendar year based on expenses on the tax form if using tax statements to determine income.

(2) Verify operational expenses for the twelve months prior to the application or redetermination interview for a business if using business records.

(3) Allowable Expenses

Deduct predictable expenses paid by the a/b which are necessary for the production or collection of income. Unexpected expenses are not included as part of the 6% test for reserve.

Allowable expenses include but are not limited to the following:

(a) The interest portion of a mortgage payment,

(b) Property taxes,

(c) Insurance,

(d) Maintenance,

(e) Utility costs paid by the a/b,

(f) Labor costs,

(g) Real estate agent's fees,

(h) Sales taxes,

(i) Advertising for tenants,

(j) Verified transportation costs related to a rental property operation,

(k) Interest payments on loans for equipment necessary to produce the rental income.

(4) Non-Allowable Expenses

Do not deduct the following expenses from rental income:

(a) Expenses paid by a third party unless reimbursed by the a/b.

(b) The principal portion of a mortgage payment. The principal is deducted from the tax value as an encumbrance in reserve.

(c) A capital expenditure. This is an expense for an addition to or increase in the value of the property and is subject to depreciation for tax purposes (e.g., principal portion of mortgage payment, additions to existing structure).

(d) The property depreciation amount claimed as a federal income tax deduction.

(e) Replacement of an existing feature of the property which could have been repaired. (e.g., furnace could be repaired but is replaced with new heating system).

(f) Replacement of an existing feature of the property which could not be repaired with one that is greater in value (e.g., replacement of shingle roof with brick tile roof) which results in improvement and increases the value of the property.

c. Calculate net annual income.

Gross Annual Income
– Gross Annual Allowable Operational Expenses
= Net Annual Income (DO NOT ROUND)

d. Determine $6000/6% net annual income test.

The equity value of property multiplied by 6% equals the net annual income that must be produced to exclude property. DO NOT ROUND.

(Equity value x .06)

e. Compare net annual income amounts.

Compare V.C.2.c., net annual income to V.C.2.d., net annual income that must be produced to exclude property.

(1) If the net annual income is equal or greater than the net annual income that must be produced, then the property produces 6% net annual income. Proceed below to determine the equity value to exclude for each classification.

(2) If the verified net annual income is less than the net annual income that must be produced, then the property does not produce 6% net annual income. The property is not excludable and the total equity value is counted towards the resource limit.

Example: A/B pays all expenses himself. There is no mortgage on the property.

Tax value of property	$7,000
Property tax per year	$ 95
Other operational expenses per month	$ 10
Insurance per year	None
Monthly gross rent	$75

*Determine equity for $6000/6% test.

$7000	Tax Value
- $0	Encumbrances (if any)
$7000	Equity

*Determine annual income.

$75	Gross monthly rent (x 12 months)

$900	Gross annual rent
- $95	Property taxes
- $0	Insurance
- $120	Other expenses annualized ($10 X 12=$120)
$ 685	Net annual income ($900 - $95- $120)

*Determine the $6000/6% net annual income that must be produced.

$7000	Tax Value
x .06	
$ 420	= 6% Net annual income that must be produced

*Compare annual income to 6% of equity to determine if property produces 6% net annual income. In this case, $685 is greater than $420 so the property meets the $6000/6% test. $1000 (equity amount above $6000) is countable resources.

NOTE: If income is verified according to instructions in SA-3210, Income, and included in the monthly budget, then the income is considered received for purposes of the $6000/6% income test. This is true even if it is discovered that the income was not actually paid to the a/b. The income is counted in the a/b's budget.

3. The net annual income requirement is waived when property that has formerly produced annual income produces no income due to natural disaster such as storms, drought, fire, hurricanes, etc.

   a. A statement to this effect from the local FSA office (for crop damage), insurance company, FEMA, or county extension agent is necessary as verification.

   b. The property would have to produce an income in the next 12 months for the income producing exemption to continue, unless the conditions that prevented the production of income were beyond the a/b's control.

4. The resource is income-producing on the day that a contract for rental/lease is signed or a verbal agreement is made (rent may be paid monthly, quarterly, semi-annually, annually, etc., and may be due at some point after the date of the contract/verbal agreement). If there is no contract or prior agreement, the resource is income producing on the day that the first payment is paid.

D. Reasonable Efforts to Sell Personal or Real Property

An a/b who meets all non-resource eligibility requirements, but is ineligible solely due to excess personal or real property, may receive SA for a limited period of time while attempting to sell the excess property.

1. Requirements for Exclusion of Property Due to Reasonable Efforts to Sell

   To exclude personal or real property while the a/b attempts to sell it, both of the following conditions must be met:

   a. The a/b's countable liquid resources may not exceed the $2,000 resource limit.

   b. The a/b must agree in writing to make reasonable efforts to sell excess personal or real property at current market value (as established using procedures in SA-3200, Resources) within a specified period, and to use the proceeds of sale to refund the benefits received during the period the resources are excluded.

2. Explanation of Exclusion of Property Due to Reasonable Efforts to Sell

   Explain these provisions to any anyone who could take advantage of the provision if aware of it. This includes:

   a. Individuals who inquire about eligibility and who may have excess resources.

   b. Applicants with excess non-liquid resources whose liquid resources do not exceed the resource limit or are close to the resource limit.

   c. Recipients whose benefits are about to be terminated due solely to excess non- liquid resources.

3. Exclusion Period for Real Property

   a. The initial exclusion period for real property is 9 months.

   b. After the initial 9 months, real property that a beneficiary has made reasonable but unsuccessful efforts to sell throughout a 9-month period continues to be excluded for as long as:

      (1) The individual continues to offer the property for sale; and

      (2) Including the property as a countable resource would result in a determination of excess resources.

4. Exclusion Period for Personal Property

   a. The initial exclusion period for personal property is 3 months.

   b. The recipient is allowed an additional 3 months exclusion period for

personal property for good cause. Good cause exists when circumstances beyond a recipient's control prevent him/her from making reasonable efforts to sell.

Good cause is defined as:

(1) No Offer to Buy - The recipient makes reasonable efforts to sell the property throughout the initial 3 month exclusion period but receives no offer to buy them.

(2) Offer That Does Not Result in a Sale - A legitimate or apparently legitimate offer to buy the personal property stops further efforts to sell it for a prolonged period of time, and the prospective buyer subsequently cannot or will not complete the purchase.

(3) Sale Begins But Closing Does Not Take Place Within Initial Exclusion Period - The recipient accepts an offer to buy, which precludes acceptance of another offer, but the sale (at which full or partial payment and transfer of title are exchanged) does not take place within the initial exclusion period.

(4) Incapacitating Illness or Injury - The recipient becomes ill, injured and/or hospitalized for a prolonged period and cannot take the steps necessary to sell the resource or to arrange for someone to sell it on his/her behalf.

(5) Joint Owner Dies - A joint owner dies, and administration or probate of the estate delays efforts to sell the resource (assuming that the property continues to be a resource).

5. The exclusion period begins:

a. Only after it is determined that the a/b meets all non-resource eligibility requirements, including disability/blindness, if applicable; and

b. The dss accepts the a/b's signed DSS-3002, Agreement to Sell Property form.

(1) Send a written notice once all non-resource eligibility requirements are met.

(2) Acceptance of the agreement is defined as the date the a/b receives written notice that the agreement is in effect.

(a) Allow 5 days for the a/b to receive the notice. The date of acceptance is 5 days from the date on the notice unless the individual proves he/she did not receive it within the 5-day period.

(b) If the written notice is handed to the individual, the date of acceptance is that date.

6. The exclusion period ends at the earliest of the following:

   a. Sale of the property;

   b. The month after the month in which continued reasonable efforts to sell end, absent good cause;

   c. The a/b signs a written request for cancellation;

   d. Countable resources fall within the applicable limit (e.g., the individual depletes resources); or

   e. The a/b reaches the end of the full exclusion period including any allowable extensions.

7. Effective Dates of the SA Payment During the Exclusion Period

   a. The SA payment can begin no earlier than the month after the month in which the exclusion period begins.

   b. The SA payment ends the month in which the exclusion period ends.

   Example: Mr. Vance's exclusion period for selling his $12,000 boat begins on January 12. He sells the boat on March 20, which ends the exclusion period. He is eligible for SA for February and March.

   If no sale had occurred, the exclusion period would have ended on April 11 and he could have received SA for the 3 months of February, March and April. The boat would have become a countable resource on May 1 (unless the period was extended due to good cause).

8. Signing the "Agreement to Sell Property"

   a. Complete a DSS-3002, Agreement to Sell Property. Have the a/b or representative sign the form once you determine that the a/b meets all but the resources requirements for eligibility (including disability/blindness).

   b. Give or mail the a/b or representative a copy and file the original in the case record.

   c. Advise the a/b or representative about the requirement to make continuing reasonable efforts to sell, including not refusing any reasonable offer to buy; the types of evidence required; and the necessity for periodic follow-up contacts.

   d. Request For Cancellation Of The "Agreement To Sell Property"

   The a/b may at any time cancel the agreement and keep the excess resources. Make sure the a/b understands that he/she will be ineligible and will have to refund all benefits received during the exclusion

period. If possible, obtain the a/b's written statement that he/she wishes to cancel the Agreement to Sell Property stating that he/she understands the consequences of cancellation. Terminate the SA with timely notice and begin recovery action.

9. Reasonable Efforts To Sell Real Or Personal Property

The a/b must make reasonable efforts to sell excess real or personal property by taking all necessary steps to sell it through media serving the geographic area in which the property is located.

a. Within 30 days of signing the agreement to sell, the a/b must:

(1) List the property with an agent or begin to advertise in at least one of the appropriate media, or

(2) Place a "For Sale" sign on the property, or

(3) Begin to conduct open houses or otherwise show the property to interested parties on a continuing basis, or

(4) Attempt any other appropriate methods of sale such as posting notices on community bulletin boards, distributing fliers, etc.

b. Except for gaps of no more than 1 week, the a/b must maintain efforts to sell as described in this section. The a/b must not reject any reasonable offer to buy the property and must accept the burden of demonstrating to the county's satisfaction that he rejected an offer because it was not reasonable. An offer to buy property is reasonable if it is at least two-thirds of the estimated CMV, or two thirds of the value established through the rebuttal process.

c. Contacts With A/B To Verify Reasonable Efforts to Sell

(1) For personal property, make a contact every 30 days during the 3 month exclusion period (and the extension if applicable).

(2) For real property, make a contact 35 days following the date of acceptance of the agreement to sell, and every 60 days thereafter until the end of the 9 month period.

(3) Remind the a/b of the responsibility for selling the property and the time remaining in the exclusion period. Verify and document the efforts being made to accomplish a sale whether there has been an offer to buy since the prior contact, and good cause in the absence of reasonable efforts to sell if applicable.

(4) Document the a/b's allegations regarding ads, listings, consignments, and other efforts to sell the resources. Obtain any supporting evidence or third party evidence available to support the a/b's allegations. These may include a copy of the listing agreement with the real estate agency in current use, dated advertisements indicating the property is for sale, contracts with media to advertise the property, a photograph of the "For Sale" sign on the property, copies of fliers or posted notices; and/or any other evidence of reasonable efforts to sell property.

(5) Verify only those allegations necessary to establish that the a/b is making reasonable efforts to sell. Verifying duration of an ad, listing or consignment at the outset will prevent the need to verify its continuing existence at subsequent follow-up contacts.

d. Document the following at each contact:

(1) Whether there have been any offers to buy since prior contact;

(2) The amount of the offer and whether the a/b accepted it; and

(3) If the a/b has refused an offer that was at least two-thirds of the estimated CMV, his explanation for refusal.

e. If the a/b is making continuing reasonable efforts to sell, flag the case for follow-up contact.

f. If the a/b is not making continuous reasonable efforts to sell:

(1) Investigate whether there is good cause. Record the a/b's allegations as to why he/she is not making reasonable efforts to sell. Obtain any evidence the a/b or a third party has to support allegations of good cause.

(2) If you determine the a/b is not making reasonable efforts to sell and there is no evidence to establish good cause, send timely notice to terminate SA effective with the month following the month in which reasonable efforts cease. Begin recovery action following procedures in V.D.13.

10. Documentation of Sale

Obtain evidence of:

a. The gross purchase price (whether in cash, on a contract, or both),

b. Any encumbrances on the property (taxes due and payable by seller, mortgage or other lien balance, etc.), and

c. Any expenses incurred in connection with the sale (advertising costs, realtor or other listing fees, consignment or auction fees, attorney fees, etc.).

11. Real Property Unsold

a. If real property remains unsold at the end of the 9 month exclusion, and the recipient continues to make reasonable efforts to sell, continue to exclude the property the real property until one of the conditions in V.D.6. ends the exclusion.

b. No further regular follow up is required except at the regular eligibility redetermination. At that time, ask the recipient if he/she still has the property and if it is still available for sale. If so, continue to exclude the property.

c. If the property is sold after the end of the 9 month exclusion, the exclusion ends. Redetermine eligibility based on resources held the month after the month in which the property is sold. Refer to Overpayment Procedures V.D.13. to begin recovery. The recipient must refund only the first 9 months of benefits.

12. Personal Property Unsold

If the personal property remains unsold at the end of the 3 month exclusion, and any applicable extension, add the equity value of the excess personal property to the value of other countable resources at the beginning of the payment period to determine the overpayment. Refer to Overpayment Procedures in V.D.13.

13. Overpayment Procedures

When an exclusion of real or personal property ends, compute an SA overpayment. This is the amount of SA that would not have been paid had the resource not been excluded. The total overpayment also includes amounts still due from any prior exclusion periods.

a. Disposal At or Above Current Market Value

Consider the net proceeds to be available to repay the overpayment. Net proceeds are the sale price minus any encumbrances on the property and the expenses of sale.

b. Disposal At Less Than CMV

Calculate the overpayment the same as for disposal at current market value, but include the uncompensated value as well as the net

proceeds. However, the a/b has the right to provide rebuttal evidence to establish a value less than current market value. If the property sells for less than current market value but there is evidence to support a lesser value, do not include the uncompensated value in the overpayment.

c. Property Not Sold

(1) Personal Property - Calculate the overpayment using the current market value rather than the net sale proceeds.

(2) Real Property - The exclusion may continue. Do not calculate an overpayment unless or until the exclusion period ends for one of the reasons outlined in V.D.6.

d. Amount of the Overpayment

(1) Recalculate total countable resources. Add the net sale proceeds from the sale (or the current market value if unsold) to the countable resources in the first month of the exclusion period. If the property was sold for less than the current market value, add the uncompensated value.

(2) The overpayment is the lesser of:

(1) The amount by which the revised total countable resources exceeds the resources limit in effect at the beginning of the exclusion payment period; or

(2) The amount of SA benefits actually paid during the exclusion period.

(3) Establishing a Lesser CMV

Before computing the overpayment, remind the recipient of the right to rebut the value of the property.

(4) Burial Exclusion

When recalculating the amount by which total countable resources exceeded the limit at the beginning of the payment period, you can exclude up to $1,500 of funds set aside to meet burial expenses. Apply this exclusion only if the a/b alleged having such funds set aside at the beginning of the exclusion period.

(5) Sale For Other Than Cash

(a) If the a/b sells property on a contract for sale, promissory note, installment payment contract or other property agreement, this satisfies the terms of the agreement to sell. For overpayment purposes, the purchase price is the down payment in cash (if any) plus the principal amount of the contract.

(b) In determining the value of the contract for continuing eligibility purposes, consider any amount that must be refunded as an encumbrance on the contract. Evaluate the availability of the contract or promissory note. If the contract is an excess resource, the a/b may enter into another agreement to sell the contract subject to the 3 month disposal period for personal property.

(6) Exchange of Excess Property

The exchange or trade of property does not satisfy the terms of the Agreement to Sell Property. If the newly acquired property is an excluded resource, the recipient no longer has excess resources so the exclusion period ends. Calculate an overpayment based on the benefits received during the exclusion period.

If the newly acquired property is a countable resource and the recipient still has excess resource, the a/b can still satisfy the agreement by selling the new property within what remains of the exclusion period. The new property cannot qualify for a new conditional benefits agreement.

e. Refunding Overpayments

(1) Complete the DSS-1656, Refund Receipt, when a refund of an overpayment is made either by cash or personal check. Refer to SA-3300 VI.C.4.

(2) Deposit the payment into the DSS account. Prepare a county DSS check in the amount of the refund and submit with the DSS-1656.

(3) Mail to:

Program Benefits Payment Section
2019 Mail Service Center
Raleigh, NC 27699-2019

14. Resources Within Limit

If, at any time during the exclusion period, the a/b reduces or converts resources so that there are no longer excess resources, without the exclusion:

a. Calculate an overpayment using the original current market value (unless the a/b establishes a lower value through rebuttal); and

b. Determine ongoing eligibility for SA based on countable resources after the refund of the overpayment.

15. Transfer of Resources During the Exclusion Period

Transfers of real or personal property that is excluded under “Reasonable Efforts to Sell” provisions are non-allowable transfers and are subject to transfer sanctions. Refer to SA-3205, Transfer of Resources.

E. Rebuttal Procedures

The a/b may rebut the value of countable resources including real property (sole or partial ownership interest), promissory notes, and personal property.

The tax value of real property and the current market value of a promissory note may be rebutted by documentary evidence to establish a lesser value.

If the a/b wishes to rebut the value of real property, the rebuttal applies to the value of the entire parcel. **However, the a/b may rebut the market value of a life estate separately from the value of the entire parcel.**

1. Documentary evidence is a statement from a knowledgeable source located in the same geographic area as the property. Geographic area is the same area as covered by local radio, television, newspaper and other media.

2. The statement from the knowledgeable source must be written, signed and have enough information to identify the source easily.

   a. It must be specific as to the value and the point in time for which the estimate is made; and

   b. It must include the basis for his/her knowledge or expertise.

3. If the statement is questionable, the county may obtain an estimate from a knowledgeable source and use the average value.

4. Examples of types of knowledgeable sources are:

   a. For real property and promissory notes:

      (1) Licensed real estate brokers;

      (2) Local Farm Service Agency office**;**

      (3) Local office of the Farmer's Home Administration;

      (4) Commercial banks, savings and loan association, mortgage companies and similar lending institutions;

      (5) An official of the local real property tax jurisdiction, or

      (6) County Agricultural Extension Service;

      (7) Professional appraisers;

      (8) Companies which are in the business of buying and selling promissory notes.

   b. For personal property a statement from a car dealer or dealer of the item in question. The statement must include the make, model, year, color, and general description of the vehicle/personal property, as well as the market value.

5. Updating Rebuttal Evidence

   a. Real Property/Promissory Notes – reverify at each redetermination

   b. Personal Property – do not reverify the rebuttal value at redetermination unless the DMV/tax value has increased or there is some indication of a change in the value of the property.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3205 TRANSFER OF RESOURCES

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3205 TRANSFER OF RESOURCES

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I. TRANSFER OF RESOURCES POLICY

If an applicant/beneficiary or their legal representative gives away or sells resources for less than the current market value, the a/b may be ineligible for Special Assistance. To apply a sanction, the transfer must have occurred on or after a specific date called the lookback date. For SA, the lookback date can never be earlier than November 1, 2002.

Inform all individuals who apply for or make an inquiry about SA about transfer of resources sanctions. Give each applicant/recipient or their legal representative a copy of the DSS-3003, Important Information about Special Assistance and Your Resources.

II. WHEN TO APPLY TRANSFER RULES

A. SSI Recipients

1. General Rule for SSI Recipients

   SSI recipients automatically meet the resource requirements for SA, including transfer of resources requirements. SSI policy requires sanctions for non-allowable transfers, except in situations where the sanction would create a hardship on individuals who have insufficient income/resources to provide for their basic maintenance.

2. A/B's Who Are Ineligible For SSI Due To Transfer of Resources

   In most cases an a/b who is ineligible for SSI due to transfer of resources is ineligible for SA. The exception is for transfers that occurred prior to 11/1/02. SSI implemented transfer sanctions effective 1/1/00. There may be a/b's who are ineligible for SSI because of transfers that occurred after 1/1/00 but before 11/1/02. These a/b's may be eligible for SA if they meet all other SA eligibility requirements.

3. SSI Hardship Provision

   If the a/b transfers a resource but is eligible for SSI under the SSI hardship exception, the a/b meets the resource and transfer of resources requirements for SA.

B. Non-SSI Recipients

1. Transfer rules in this section apply to all non-SSI applicants for and

recipients of Special Assistance, including the Special Assistance In-Home (SAIH) Program.

2. Apply these rules to transfers made by the a/b, or by any person with legal authority to act in place of or on behalf of the a/b.
3. Transfer rules apply to transfers of any real or personal property or liquid resources owned by the a/b. They also apply to transfers of income, including lump sums, which are transferred during the month of receipt.
4. Resources owned solely by the a/b's spouse (or by the spouse jointly with individuals other than the a/b) are not considered in determining eligibility for SA. The budget unit for SA is always one. The a/b may transfer any resource to a spouse at any time with no sanction. Refer to V.D.
5. There is no hardship exception for a/b's who are financially ineligible for SSI.

III. LOOKBACK DATE – APPLICABLE TO TRANSFERS ON OR AFTER 11/1/02

The lookback date is a fixed point in time, on or after which all transfers of resources are reviewed. The lookback date for SA is 36 months prior to the date of application. For example, if the application is taken on December 15, 2005, counting back 36 months establishes a lookback date of December 15, 2002. The lookback date never changes once it is established. Evaluate all transfers that occurred on or after this date. Do not consider any transfers prior to this date. Document the lookback date in the case record.

The earliest lookback date is November 1, 2002. DO NOT apply transfer sanctions to any transfer that occurred prior to November 1, 2002.

IV. VERIFICATION AND DOCUMENTATION

A. Verification

Ask at every application and redetermination whether the a/b or the a/b's representative has given away or sold any resources for less than fair market value since the lookback date (no earlier than 11/1/02). At any time you learn from any source that there has been a transfer of resources on or after the lookback date, verify the following information based on policy in SA-3200, Resources.

1. A description of the resource transferred (homesite, other real property interest such as tenancy-in-common or life estate, cash, vehicle, stock, bank account, etc.).
2. The person who transferred the resource.
3. The name of the person to whom the resource was transferred.
4. The a/b's relationship to the person to whom the resource was transferred.
5. The countable value of the resource at the time of the transfer.
6. The compensation (money or other benefit) received or expected for the transferred resource, if any.
7. The date the resource was transferred.
8. Whether the a/b was the sole owner of the resource at the time of the transfer, and if not, the name of any co-owners.
9. Whether the a/b still retains any ownership right in the resource.

B. Documentation

Document the above information in the case record.

V. ALLOWABLE TRANSFERS (NON-TRUSTS)

Certain transfers are allowable. Do not apply a sanction to the following transfers.

A. Spending Down Liquid Resources

Spending down cash is a valid transfer of resources if the a/b purchases items or services on the open market for his/her use. Obtain the a/b’s statement as to how the cash was spent. The a/b does not have to provide an exact “to the penny” accounting but a reasonable accounting is acceptable. If the allegations are questionable or unreasonable, request evidence from the a/b to substantiate the expense, such as receipts for purchases, bank statements showing withdrawals, etc.

B. Compensated Transfer

A compensated transfer is one in which real or personal property or liquid resources are transferred or exchanged in return for money or some other tangible object, service, or benefit that is equal to or greater in value than

the fair market value of the transferred resource. Determine fair market value based on procedures in SA-3200, Resources. Compensation can be in the form of cash, real or personal property, services, or assumption of the legal debt of the person making the transfer.

Transfers for services to be provided in the future are allowable only if there is a written legally binding agreement (contract, bill of sale, deed, etc.) for provision of services in effect at the time of the transfer. The contract must specify the current market value of the services and the frequency and duration of services. If the services are "for life," Use the Life Expectancy Table located at http://www.ssa.gov/oact/STATS/table4c6.html to determine the beneficiary's life expectancy at the time of the transfer. You may request additional verification of the current market value of the service if it was not purchased on the open market.

C. Transfer of the Homesite to Allowable Persons

1. Refer to SA-3200, Resources, for the definition of homesite.

2. Transfer of the homesite is an allowable transfer only when it is transferred to one of the following:

   a. Legal spouse, including a separated spouse, or

   b. Natural or adopted child under age 21 at the time of the transfer, or

   c. Blind/disabled child of any age (as determined by SSA).

      Note: For purposes of determining whether an exception applies, child means biological child, adopted child, or stepchild of any marital status unless otherwise stated.

3. Transfer of the homesite is an allowable transfer when the a/b enters a nursing facility (or a medical treatment facility for whom payments are made by Medicaid at a nursing facility rate) or enrolls in CAP if the transfer is to certain family members who lived in the home with the a/b immediately prior to entering the nursing home/CAP. This type of transfer is not allowable when the a/b enters an adult care home directly from the community.

When evaluating transfers that occurred during the lookback period, do not impose a sanction period if the a/b transferred the homesite to one of the family members below:

a. A child aged 21 or older who resided in the home for at least 2 years immediately before the a/b entered a nursing facility or enrolled in CAP, and who provided care to the a/b that permitted him to live at home rather than in a nursing facility (or CAP) throughout the 2 year period. The a/b must provide documentation that the adult child resided in the home during the two years and provided necessary care.

   NOTE: According to Medicaid policy, there is no minimum time requirement for placement in NF or CAP for this rule to apply. If you have questions, please discuss with your Medicaid supervisor.

   Example: Ms. Sampson's daughter lived with her for more than 2 years and provided care that enabled her to remain at home. On Oct. 15 Ms. Sampson enters the hospital and on Oct. 25 is admitted to a nursing facility. On Nov. 2 Ms. Sampson, through her power of attorney, transfers her homesite to her daughter. Her condition improves and on Jan. 5 she moves to an adult care home and applies for SA. There is no sanction for this transfer.

   Example: Mr. Johnston's son lived with him for more than 2 years and provided care that enabled him to remain at home. On Nov. 3 he enters an adult care home. He transferred his home to his son on Nov. 5. This transfer is subject to a sanction.

b. A sibling of the a/b who has an ownership interest in the home (including life estate) and who was residing in the a/b's home for at least 1 year immediately before the a/b entered a nursing facility or enrolled in CAP.

D. Transfer of Resources To A Spouse

1. There is no sanction for transfers of any resources to a legal spouse, including separated spouses. Advise the couple that this type of

transfer may affect eligibility for Medicaid if either of them applies for Medicaid benefits.

2. If the a/b transfers resources to a spouse, and the spouse then transfers the resource, there is no sanction for the a/b. If the spouse later applies for SA, determine if that transfer is subject to a sanction for the spouse.

3. If the a/b owns property owned with a spouse, follow procedures in SA-3200, Resources, to determine if the property is countable. If it is a countable resource, it is subject to a transfer sanction if the a/b and spouse together transfer the resource to another person, unless the transfer is allowable based on other rules in this section.

   Example: Mr. Graham applies on SAA on 1/15/03. Mr. and Mrs. Graham had a joint savings account with a balance of $25,000. Either of them could access the funds ("or" account) so the full amount in the account would have been a countable resource. On 12/18/02 the Grahams closed the account and reopened it in Mrs.

   Graham's name only. This is an allowable transfer to the spouse and there is no sanction.

   Example: Mr. Hyde is an SAD recipient. Mr. and Mrs. Hyde jointly own a lakefront cabin. Mrs. Hyde states she will not consent to sell the property and it is excluded. Two months after Mr. Hyde is approved for SA, they transfer ownership of the property to their son. This is an allowable transfer because it is an excluded resource.

   Example: Mr. Scotland applies on 9/4/03 for SA. The caseworker learns that Mr. and Mrs. Scotland had a certificate of deposit valued at $7,500, which they cashed in and transferred to their son on 7/15/03. This was a joint account that either spouse could access and would have been a countable resource. Mr. Scotland is subject to a 3 month sanction from August through October ($7,500 / $2,000 = 3.75 rounded down to 3).

4. Special Assistance transfer rules in this section take precedence over prenuptial or postnuptial agreements and formal or informal separation agreements.

E. Transfers to the A/B's Blind/Disabled Child

Any resource transferred to a/b's blind/disabled child of any age, in addition to the homesite, is allowable. The blind/disabled child must be determined blind/disabled by SSA.

> **Note**: For purposes of determining whether an exception applies, child means biological child, adopted child, or stepchild of any marital status unless otherwise stated.

F. Excluded Resource at the Time of Transfer

Any resource, except the homesite, which was excluded as a countable resource at the time of the transfer or would have been excluded had an application been made, is an allowable transfer. Examples of excluded resources that may be transferred without sanction are: personal effects and household goods, excluded vehicles, life insurance when the cash value is excluded, etc. Refer to SA-3200, Resources, to identify excluded resources.

G. Intent to Dispose at Current Market Value

1. Do not apply a transfer sanction when the a/b sells resources at less than current market value but he can prove he intended to dispose of the resource for current market value or for other valuable consideration.

2. The a/b must supply documentary evidence of two attempts to dispose of the resource for current market value or documentary evidence from two knowledgeable sources to support the value at which the resource was disposed. Refer to rebuttal procedures in SA-3200, Resources, to establish a lesser value of a resource.

   Example: The applicant owns a non-homesite mobile home with a tax value of $18,500. There are no encumbrances on the property. He listed the property a year ago but was unable to sell it. He again lists the property with a realtor for the current market value of $18,500. After several weeks the a/b receives a firm offer for $14,500 and no other offers. He accepted the offer. This example documents that the a/b intended to sell his property at the current market value, but he only received a portion of that amount. Do not apply sanction to the difference between the current market value and the compensation received.

3. If the a/b establishes that he cannot sell a resource at the current market value, it remains subject to a sanction if he transfers the resource. Apply the sanction based on the lesser value established through the rebuttal process.

H. Resource Transferred Exclusively for Other Reasons

Except for the allowable transfers outlined in this section, presume all other transfers are made to make the individual eligible for SA. The a/b or representative may rebut the presumption and provide evidence that the transfer was made exclusively for a reason other than to establish eligibility for SA. Each situation must be evaluated by the county agency on a case-by-case basis. It may be done as part of the application process, redetermination, change in situation, or appeal.

1. When a non-allowable transfer is verified, presume the transfer was made to establish eligibility for SA and determine the sanction.
2. Advise the a/b he may rebut the presumption that the resource was transferred to establish or retain SA eligibility. The a/b must show by the greater weight of evidence that the resource was transferred exclusively for a reason other than qualifying for SA. The evidence presented (written or oral) must be more persuasive than all evidence presented to the contrary.
3. The rebuttal evidence may include:
    a. The a/b's or legal representative's statement regarding the circumstances of the transfer. This includes the specific reason the resources were transferred, the date of transfer, the name and relationship of the person to whom the resources were transferred, and any compensation received. Question the a/b on how he expected to meet his living expenses and/or medical expenses without the resource and/or its income, **OR**
    b. Evidence from other sources to support the allegation. Examples of evidence are oral or written statements from persons knowledgeable about the situation, medical records, and bank records.
4. Evaluate the evidence presented. The evidence might establish another reason for the transfer. However, if establishing eligibility for SA was also considered, the transfer was not exclusively for a purpose

other than to establish or retain SA eligibility. In making the determination, consider the following:

a. The a/b's age, general health, living arrangement, and amount of resources retained to meet future needs at the time of the transfer, and

b. Whether the case record documents any inquiry by the a/b, legal representative or other interested party about resource limits for SA, income budgeting, etc., and

c. Whether the a/b consulted or hired an attorney for estate planning purposes, and

d. Whether the individuals who provided the knowledgeable statements stand to gain in any way from the transfer.

I. All Transferred Resources Are Returned

1. Do not apply a transfer sanction when all transferred resources have been returned to the a/b at the time of application, or if the resources are returned the same month as the transfer.

2. If a sanction period has already been assigned when all or any portion of the resources is returned, refer to VIII.D. for instructions on lifting the sanction.

J. A/B Has Been Defrauded

Do not apply a transfer sanction when it appears the a/b is a victim of fraud and did not take the action with the intent of becoming eligible for SA. Refer the case to Adult Services, and/or the Clerk of Court if there is a legal representative, to pursue possible reversal of the action and return of the resource to the a/b.

VI. ALLOWABLE TRANSFERS TO A TRUST/ANNUITY

A. Transfers to A Countable Trust

There is no sanction for transfers to a trust if the resources transferred to the trust continue to be a countable resource, or the entire trust is a countable resource. For example, if the a/b transfers $3,000 into a

revocable trust, the trust is a countable resource and no transfer sanction applies.

B. Transfers To A Trust/Annuity For The "Sole Benefit" of an Allowable Person

1. Transfers by the a/b to a trust for the "sole benefit" of another person are allowable. An allowable person is:

   a. The a/b's spouse, or

   b. The a/b's blind/disabled child (determined by SSA) of any age, or

      Note: For purposes of determining whether an exception applies, child means biological child, adopted child, or stepchild of any marital status unless otherwise stated.

   c. Any other unrelated disabled individual (determined by SSA) who is under age 65 at the time the trust is established.

2. To be allowable, a transfer to a third party for the "sole benefit" must meet the following criteria:

   a. The resource cannot benefit anyone in any way but the allowable person at the time of the transfer and for the remainder of that person's life.

   b. The transfer must be in the form of a trust document (or similar legal document) which legally specifies the conditions under which the transfer was made, who can benefit, and the amount of the benefit.

   c. Trustee Rule: The trust may provide for reasonable compensation for a trustee to manage funds. Reasonable compensation is based on the time involved to manage the trust and the prevailing rate of compensation. Evaluate each situation on a case-by-case basis to determine if the compensation is reasonable.

3. If the beneficiary of the trust applies for SA, evaluate the trust for its effect on the beneficiary's eligibility.

C. Transfers to Special Needs or Pooled Trusts

1. In addition to transfers to trusts for the "sole benefit" of a disabled/blind individual, transfers of the a/b's resources to a Special Needs or Pooled trust are an allowable transfer when the terms of the trust meet all the criteria in SA-3200, Resources.

2. Forward a copy of the trust document to DMA, Third Party Recovery Section, 2508 Mail Service Center, Raleigh, N.C. 27699-2508. The telephone number is 919-814- 0240.

D. Purchase of an Irrevocable Burial Contract

Resources used to purchase an irrevocable burial contract are an allowable transfer and create a trust when:

1. It is purchased for the benefit of the a/b or the a/b's spouse, child under 21, or blind/disabled child of any age, and
2. The contract lists each burial item and/or service.

VII. SPECIAL CONSIDERATIONS FOR CERTAIN NON-ALLOWABLE TRANSFERS

After excluding the above allowable transfers and exceptions, apply transfer policy to all remaining transfers in the lookback period. Do not apply a sanction for transfers prior to 11/1/02. Some transfers have special rules based on the type of resource transferred. Apply the following rules:

A. Date of Transfer for Real Property

The date of transfer for real property is the day the deed is signed by the grantor, delivered, and accepted by the grantee. Unless fraud is suspected, it is presumed this is the date recorded on the front of the deed. The deed does not have to be notarized or registered in order to be a valid title transfer. It must be signed by the grantor, delivered, and accepted by the grantee. However, a deed of gift must be registered within two years of the date the deed is signed to remain valid.

B. Date of Transfer for Liquid Resources

The date of transfer for liquid resources is the date the owner gives or mails the cash, check, or other liquid resource to another person. This is the date the a/b no longer has access to or control of the resource.

Example: A/B withdraws writes and mails a check to his son on August 28 but it does not clear the bank account until September 12. The date of transfer is August 28.

C. Tenancy-in-Common Property Interest

1. Evaluate for transfer of resources when the a/b changes ownership interest in property from sole ownership or tenancy-by-the-entirety to tenancy-in-common interest.

   a. The date of transfer is the date the ownership interest is changed to tenancy-in- common.

   b. The uncompensated value is the equity value of the a/b's percentage of the property that is changed to tenancy-in-common, less any compensation received.

      Example: The a/b owns property with an equity value of $65,000. He gives his brother a 1% share (worth $650) and receives no compensation. The uncompensated value is the value of the 1% share changed to tenancy-in- common, $650.

2. If the a/b transfers an existing tenancy-in-common interest in property, the value transferred is the equity in his tenancy-in-common share. Refer to SA-3200, Resources, for instructions on determining the equity in the tenancy-in-common share.

   Example: The a/b owns property with his three brothers, and each brother owns 25%. The tax value of the property is $100,000 and there are no liens. The value of the a/b's share is $25,000. He transfers his share to his sister. The uncompensated value of the transfer is $25,000.

D. Life Estate

1. Evaluate for transfer of resources when the a/b transfers real property and retains a life estate.

   a. The date of transfer is the date the remainder interest is granted.

   b. The uncompensated value is the equity value of the remainder interest granted, less compensation received. Refer to SA-3200, Resources, for instructions on determining the equity in a remainder interest.

NOTE: Enhanced Life Estate Deeds, sometimes called "Lady Bird Deeds," differ from the typical life estate deeds as the property is transferred at death, not before. The life tenant (grantor) can sell the property and keep the proceeds, mortgage it and use the equity, and profit off of their property without having to consult the beneficiary. They can also revoke or amend the deed. This means the grantor/owner or "life tenant" retains complete control over their property while alive. Such an Enhanced Life Estate deed is not a transfer of resources for Special Assistance IF **no** interest of present value is being transferred to the grantee by the deed. All these grantor rights must be specified clearly in the deed for it to qualify as an Enhanced or Lady Bird Deed with no interest of present value. Contact your agency/county attorney with any questions concerning the type of deed that's been received or about the terms of an Enhanced Life Estate deed and its potential as a transfer of resources.

2. Evaluate for transfer of resources when the a/b transfers a life estate in real property.

   a. The date of transfer is the date of the deed or agreement transferring ownership of the life estate.

   b. The uncompensated value is the equity value of the life estate less any compensation received. Refer to SA-3200, Resources, for instructions on determining the equity value of a life estate. If the a/b has provided rebuttal evidence to establish that the life estate has no market value, the uncompensated value of the transfer is $0.

E. Joint Ownership of Liquid Resources

1. If the a/b has access to a joint bank account without the consent of the other account holder, the full amount of the account is a countable resource. Transfer of a countable resources is subject to a sanction if transferred by the a/b or by the other account owner (unless it is transferred by the a/b to the spouse).

   NOTE: If it appears the a/b has been defrauded, refer to V.J. for referral to Adult Services.

2. Determine if a resulting trust exists. If a resulting trust is verified, there is no sanctionable transfer.

3. Determine the ownership of funds to determine if there has been a non-allowable transfer of resources. If both owners have deposited money into an account and both have equal access, either owner may spend the funds without a sanction period.

   Example: Mr. Durham and his brother Mr. Greene live together and have had a joint bank account for a number of years. Both deposit their Social Security income into the account and they pay their shared household expenses from the account. The account balance is about $5,000. Mr. Durham applies for SA and the full balance of the account is a countable resource. To reduce resources, Mr. Durham uses money from the account to pay off some outstanding medical bills. Mr. Greene uses money from the account to pay off a credit card balance and to repair his car. This is not a transfer because the funds belong to both account holders and the money was spent down to meet their needs.

4. Evaluate for transfer of resources when the a/b takes any action that eliminates his ownership or reduces his control of a liquid resource. Examples include when the a/b adds another individual to a bank account or certificate of deposit.

5. The date of transfer depends on the action:

   a. The date of transfer for an "or" account is the date the resource is actually reduced.

      Example: The a/b added his niece's name to his $30,000 savings account in January so either party could access the account independently. This is an "OR" account. (For SA purposes, the entire $30,000 would still be considered available to the a/b.) In April, the niece withdraws the $30,000 from the joint account and puts it into her own account. The date of transfer is the date the niece actually withdrew the funds. However, if the niece withdraws the money and uses it on behalf of the a/b, there is no transfer.

   b. The date of transfer for an "and" account is the date the a/b reduces his control of the resource.

      Example: The same situation as above, but the account is changed to an "AND" account. An "and" account requires the signature of both parties to access. The date of transfer is the

date the niece's name was added to the account because that is the day the a/b reduced his control of the resource.

F. Transfers Involving Countable Trusts

Any time you learn the a/b created a trust or is the beneficiary of a trust, report it to DMA, Third Party Recovery Section. The telephone number is 919-647-8100.

1. Except for the specific trusts described in VI., evaluate trusts created by the a/b with his funds as either:

   a. An available resource to the a/b, or

   b. A transfer of resource.

2. Refer to SA-3200, Resources, to determine what portion of the trust is an available resource to the a/b. The amount that is unavailable to the a/b is subject to a transfer sanction.

3. Revocable Trust

   a. The date of transfer for a revocable trust is the date a disbursement from the trust is made to someone other than the a/b.

   b. The uncompensated value of the transfer is the actual amount paid to an individual other than a/b.

4. Irrevocable Trusts

   If the a/b uses his own funds to establish an irrevocable trust, a portion of that trust may be countable. Refer to SA-3200, Resources to determine if an irrevocable trust is countable. The portion of the trust that is not countable is subject to a transfer sanction.

   a. The date of transfer is the date the trust is established.

   b. The uncompensated value is the portion of the trust that was made unavailable to the a/b on the date the trust is established. Do not subtract any payments made from the trust after the trust was established.

c. Treat additions to existing trusts as a new transfer based on the date of the addition. Additions include undistributed interest earned on the trust principal.

G. Stream of Income Or Income Diversionary Trusts

1. A stream of income is income received on regular basis such as a pension or rental income.
2. A diversionary trust is one in which the a/b diverts regular income into a trust. Refer to SA-3200, Resources, for rules regarding treatment of diversionary trusts.
3. When a stream of income is transferred or diverted, treat each payment as a separate transfer.

H. Transfers for "Love and Consideration"

Evaluate for transfer of resources when an a/b gives cash or other resources to a family member, relative, or friend for care or services that were provided for free in the past. Unless there was a written agreement for compensation at the time the care or service was received, the transfer is uncompensated.

I. Transfer of Income Producing Property, Other than Income Producing Home sites

If non-home site income producing property is transferred, evaluate for transfer of resources. The sanction is based on the full amount of the uncompensated value, regardless of whether the property met the 6% test. Do not deduct $6,000.

VIII. SANCTION PERIOD FOR TRANSFER OF RESOURCES

A. Determine the Uncompensated Value of the Transfer

1. List each non-allowable transfer occurring on or after the lookback date through the current date.
2. Determine the date of transfer.

3. Determine the uncompensated value of each transferred resource based on policy in SA-3200, Resources.

    a. Establish the current market value of the transferred resource at the time of the transfer. The value of certain transferred resources can be rebutted. If a resource's value has already been successfully rebutted as part of the application process, use the established rebutted value, or zero value if proven non-salable or no current market value.

    b. Subtract any encumbrances from the current market value to establish the equity value of the resource.

    c. Establish the amount or value received for the transferred resource.

    d. Subtract from the equity value the amount received. This is the uncompensated value.

B. Determine the Sanction Period

1. The **maximum length** of each consecutive sanction period is **36 months**.

2. To determine the sanction period for a single transfer:

    a. Divide the total uncompensated value of the transfer by **$2,000**.

    This is based on the current average private rate for cost of care in an adult care home and is subject to change. DSS will issue changes in the rate as appropriate.

    b. Round this number down to the lowest whole number.

    c. The result is the number of months in the sanction period.

    Uncompensated Value ÷ $2,000 = Months of Sanction

    d. Begin the sanction period with **the month following the month in which the transfer occurs**.

e. There is no sanction if the uncompensated value of the transfer is less than $2,000.

Example: Applicant transferred property valued at $12,500 on 12/12/02. The sanction period is 6 months, 1/03 – 6/03.

($12,500 ÷ $2,000 = 6.25 round down to 6)

3. When there are multiple transfers in the lookback period, determine when the uncompensated value of the transfers equals $2,000. Begin the sanction period with **the month following the month in which the transfers equal $2,000**.

a. Once the transfers equal $2,000, evaluate the transfers separately unless the sanction periods overlap.

b. If the sanction periods overlap, add the uncompensated value of all overlapping transfers in the lookback period and divide by $2,000.

c. Round this number down to the lowest whole number.

d. The result is the number of months of sanction.

e. Stop adding and end the sanction period with the first month in which:

(1) No transfer occurred, and

(2) No sanction applies to that month from an earlier transfer.

Example of Multiple Transfers That Do Not Overlap: Application made for SA on 12/10/03. Mr. Pitt transferred a non-homesite trailer valued at $8,000 on 11/5/02 and $10,000 in cash on 8/10/03.

Sanction period for trailer transfer = 12/02– 3/03 ($8,000 ÷ $2,000 = 4 mo).
Sanction period for cash transfer = 9/03–1/04 ($10,000 ÷ $2,000 = 5 mo).

These sanction periods do not overlap and are imposed separately. Mr. Pitt is ineligible until 2/04.

Example of Multiple Transfers That Do Overlap:

Application made for SA on 4/12/03. Ms. Burke transferred real property valued at $26,000 on 11/5/02, a boat valued at $2,800 on 12/5/02 and stock valued at $7,325 on 6/8/03.

Sanction period for property transfer is 12/02–12/03

($26,000 ÷ $2,000 = 13 mo).

Sanction period for boat transfer is 1/03

($2,800 ÷ $2,000 = 1 mo).

Sanction period for stock transfer is 7/03–9/03

($7,325 ÷ $2,000 = 3 mo).

These sanction periods do overlap, so add the total of all transfers together.

$26,000 + $2,800 + $7,325 = 36,125 ¸ $2,000 = 18.063 round down to18 mo.

The sanction period is 12/02 – 5/04. Ms. Burke is ineligible until 6/04

4. If other transfers occur during an established sanction period, add the uncompensated value of those transfers to the total and divide the total by $2,000. Round down each total. This is the revised number of months in the sanction period. The beginning month of the sanction period does not change.

5. For transfers that occur after the sanction period has ended, begin a new sanction period with the month following the month the total transfers equals $2,000.

C. Sanction Period When An Individual Leaves the Facility

A sanction period runs continuously from the first month of the sanction period through the last month of the sanction period, regardless of whether the individual stays in the adult care home or is otherwise eligible for SA.

D. Lifting or Reducing the Sanction Period

1. When transferred resources are returned to the a/b prior to application, do not apply a sanction.
2. When transferred resources are returned during the same month the transfer occurred, do not apply a sanction. Determine eligibility based on the value of resources on the first moment of the month.
3. When transferred resources are returned to the a/b after a sanction period has already been assigned, the sanction period continues until the month after the resources are returned. Beginning the month after the resource is returned; determine eligibility including the returned resources.
4. Resources are considered returned when:
    a. The actual resource is transferred back to the a/b, or
    b. The a/b receives fair market value as compensation for the resource after the transfer. Value may be received in cash or money spent on the a/b's behalf. Examples of money spent on the a/b's behalf are: paying for cost of care, or purchasing a burial plot for a/b, or paying outstanding bills for the a/b. The cash or money spent on the a/b's behalf does not have to come from the person to whom the resource was originally transferred.
    c. Verify any money spent on the client's behalf is, in fact, paid. For example, the adult care home verifies the outstanding bill has been paid.
5. When only a portion of the transferred resource is returned or money spent on the recipient's behalf, the sanction period can be modified. For example, when half the value of the resource is returned, the sanction period is reduced by one-half. You must still reverify resources to determine whether the a/b is eligible based on the resource limit.

E. Budgeting During Sanction Period

1. An individual who is sanctioned due to transfer of resources is totally ineligible for SA. Always evaluate for Medicaid. Because of differences in transfer policy, an individual who is ineligible for SA due to a transfer may be eligible for Medicaid.

2. Determining the Sanction When Both Spouses Are Recipients

If a married couple transfers jointly own resources, and both spouses are SA a/b's, divide the sanction between them. Divide the total value of the transferred resources by the average cost of care; then divide by two to get the number of months in the sanction period for each spouse.

Example: Mr. and Mrs. Tyrrell are private pay residents in an assisted living facility. They make a non-allowable transfer of $40,000 in stocks to their church on August 10. In November the couple applies for SA. They meet the income requirements but each of them is subject to a 10 month sanction ($40,000 ÷ $2,000 = 20 months ÷ 2 = 10 months) beginning December.

Example: Mr. and Mrs. Macon transferred cash and stocks valued at $60,000 to their daughter on September 10. In January Mr. Macon suffers a stroke and enters a nursing home. Mrs. Macon is unable to live alone and enters an adult care home in February. They both apply for assistance with cost of care. Mrs. Macon is subject to a 15 month SA sanction beginning in October ($60,000 ÷ $2,000 = 30 months ÷ 2 = 15).

Mr. Macon is subject to a 7 month Medicaid sanction beginning in September ($60,000 ÷ $4,200 = 14 months ÷ 2 = 7).

IX. NOTIFICATION OF SANCTION PERIOD AND OPPORTUNITY TO REBUT

When it is established that the a/b has a sanction period due to a non-allowable transfer, notify the a/b of the sanction period. The a/b may rebut the value of the transferred resource or that the transfer was made exclusively to qualify for SA. This may be done at application, redetermination, change in situation, or through the fair hearing process.

A. Applications

1. Use the DHB-5097, Request for Information, to notify the applicant:
   a. He is ineligible for SA due to transfer of resources without receiving adequate compensation.
   b. The transfers considered, the sanction period, and the right to rebut the presumption and provide evidence to prove the transfer

was made exclusively for a purpose other than establishing eligibility. Refer to SA-3200, Resources, for rebuttal requirements.

2. Pend the application to allow the applicant an opportunity for rebuttal. If the a/b states he does not rebut the sanction, or if the rebuttal evidence does not establish an allowable transfer, deny the SA application.

B. Ongoing Cases

Upon learning of a non-allowable transfer and determining the sanction period, send a timely notice to propose termination for transfer of assets. Advise the recipient of the sanction period. Refer the case to the local dss Program Integrity staff if it is determined an overpayment has occurred due to unreported resources or transfer of resources.

C. Hearing Process

The a/b has the right to a hearing if he disagrees with the transfer sanction. Refer to SA-3340, Hearings, regarding the hearing process.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3210 INCOME

North Carolina Division of Social Services

Special Assistance Program

Revised: January 2025

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3210 INCOME

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I. INTRODUCTION

This section explains the steps to verify and calculate countable income for Supplemental Security Income (SSI) and Non-SSI applicants/beneficiaries of SAA/SAD and SAIH. This section also contains instructions for assisting the Special Assistance (SA) applicant/beneficiary (a/b) to access their maximum entitlement income amount. All documentation referred to in this section must be completed at each application on the DSS-8190 SSI/Non-SSI Application Workbook, for SSI SA and Non-SSI SA applicants and at each recertification on the DSS-8191 Special Assistance Re-Enrollment Information Notice.

Special Note: Special Assistance program rates and income limits are not covered in this section of policy. That information is covered in **SA-3220 II.E.** and **VIII** of this manual, as well as in **SA-5200 V.D.** of the SAIH Manual.

Each SA a/b and/or their authorized representative must be informed that they must apply for all benefits to which they may be entitled, including receiving the maximum benefit for which they are eligible. This includes SSI, Social Security Retirement, Survivors, and Disability Insurance (RSDI), Veteran's benefits, Railroad Retirement, Black Lung, Worker's Compensation, a union or private employer pension, a civil service pension, or other such income. SA-3210 V. SA Requirement to Obtain Maximum Entitlement Income provides in-depth guidance and instructions to ensure the a/b is receiving all income to which they are entitled and is receiving, at a minimum, the SSI Federal Benefit Rate (FBR). **SA eligibility cannot be authorized until SSI eligibility has been established and addressed.** (Refer to SA-3210 V.)

NOTE: The SA a/b cannot waive or renounce benefits to which they may be entitled to receive in order to become eligible for SA.

II. BASE PERIODS FOR SA APPLICANTS/BENEFICIARIES

A. Base Period for Applications and Recertifications

The base period is a set time for verification of income when determining eligibility for the SA certification payment review period. Evaluate for all income that will be available during the certification period. Clearly document in the case file the income source, and how often the income is received. Certain incomes have different base periods. To calculate gross monthly income, divide the total income by the number of months in the base period.

1. For Applications:

   Unless income has changed, the base period is the month prior to the recertification or application except for farm income, income from self-employment, and for rental income received other than monthly.

2. For Recertifications:

   For eligibility reviews, there is some flexibility as long as the "verification month" is:

   a. No earlier than the month in which the review process (NCFAST mails the DSS-8191 60-days prior to certification period end-date) is started, and

   b. No later than the last month of the current certification period, during which the recertification process is initiated.

3. Special Base Periods for Income Received Other Than Monthly

   a. Farm Income, Income from Self Employment, or Rental Income Received Other than Monthly

      (1) Discontinued Income - All Cases

      If the farm operation or business is being discontinued, show the remaining portion of the current year's total net income as reserve.

      (2) Continuing Income - Applications and Recertifications

         (a) The base period is the prior year's income as listed on tax records.

         (b) If there are no tax records, use current business records for up to twelve months of income prior to the month of application or recertification.

         (c) If the a/b has income less than twelve calendar months, count income for the number of calendar months received. To convert to a monthly amount, divide the total gross by the number of months the income was received in the base period.

         (d) If the a/b states that there has been a significant change, use gross net ratio based upon prior year's

earnings. See II. B. 4 - 5 below for how to calculate terminated income, and III. C. Self-Employment Income below for how to calculate self-employment income.)

b. Alimony and Child Support

(1) Six calendar months prior to the month of application or the recertification interview, or

(2) The number of months receiving if less than six calendar months.

c. Gross Annual Operational Expenses (for income producing property only)

(1) The base period is the prior year's income as listed on tax records.

(2) If there are no tax records, use current business records for up to 12 months of income prior to the month of application or recertification.

(3) If the a/b has income less than 12 calendar months, count income for the number of calendar months received.

(4) If the a/b states there has been a significant change, use gross net ratio based upon prior year's earnings.

B. Changes in Income at Application

A change in income occurs when there is an acquired source of new income, a change in rate of pay that will continue (not fluctuating income), or when income is terminated.

NOTE: For changes in income on active cases, refer to SA-3310, Changes in Circumstance.

1. If income changes during the base period, use income received during the month of application (or unearned income awarded for the month of application).

   Example: Mr. Brown applied for SA on November 5 and he was placed in a SA Facility on November 1. His income decreased effective October. The application was processed in December. November income is used to determine eligibility and the payment for November and subsequent months.

2. If income changes during the month of disposition:

   a. Consider the actual income received in the month of disposition (or unearned income awarded for the month of disposition).

   b. Convert to a monthly amount using II.C. to determine eligibility and payment for that month.

   Example: Mr. Brown applied for SA on November 5, and he was placed in a SA facility on November 1. His income decreased effective December. The application was processed in December. October income is used to determine eligibility and the payment for November. December income is used to determine the December payment and subsequent months.

3. If income changes after the month of disposition:

   a. Consider the actual income received in or awarded for the month of disposition.

   b. Convert to a monthly amount using II.C. below.

   c. Flag the case to recompute income when the a/b has received the new monthly amount.

      Example: Mr. Brown applied for SA on November 5, and he was placed in a SA facility in November 1. The application

was processed in December. His income decreased effective January. October income is used to determine eligibility and the payment for November and December. Flag the case and recompute payment in January using the new income amount.

4. If income is terminated in any month prior to the month of application, do not count the terminated income.

   Example: Mr. Brown applied for SA on November 5, and he received his last paycheck on October 3. Since the income terminated in the month prior to the month of application, do not count the terminated income to determine eligibility and the payment for November and subsequent months.

5. If income terminates in the payment effective month, count the actual income in the month received prior to the date of disposition.

   Example: Mr. Brown received his final wages November 30. He applied for SA and entered an ACH facility on November 1. His SA application was approved December 14, with a payment effective date of November 1. Since the income terminated in the payment effective month, count the actual income received in November to determine eligibility and the payment for November. Do not count any of the terminated income for December and subsequent months.

C. Conversion to a Monthly Amount

1. Add income received in the base period month and divide by the number of dates paid. Clearly document in the SA case file how often the a/b is paid and on what day of the week.

2. Income for the base period is converted to a monthly amount using the following formula:

   a. Multiplying by 4.3 if paid weekly.

   b. Multiplying by 2.15 if paid biweekly.

c. Multiplying by 2 if paid semimonthly.

d. Using the monthly amount if paid monthly.

NOTE: These formulas apply even if income fluctuates month to month. *It is unnecessary to recalculate income monthly*. Review again at recertification.

III. DETERMINING COUNTABLE INCOME FOR NON-SSI APPLICANTS/BENEFICIARIES

To determine eligibility or amount of payment, count the gross incomes as indicated below. Complete Electronic Verification (OVS/OLV) for all income types at application and at recertification.

A. Countable Unearned Income

Type	Countable Unearned Income (and Verification)
Alien Sponsor Income	An alien sponsor is a person who signed an affidavit or other statement accepted by the U.S. Citizenship and Immigration Service (USCIS) agreeing to support an alien as a condition of the alien's admission for permanent residence. A sponsored alien is subject to sponsor-to-alien deeming unless an exclusion in POMS SI 01320.910 applies. An alien may have more than one sponsor. **Note:** Organizations and institutions (ex. churches, service clubs) are **not** considered sponsors. For qualified aliens who are potentially eligible for Special Assistance that were admitted to the U.S. due to a sponsor, the sponsor and/or the sponsor's spouse: • are financially responsible for the qualified alien by deeming their income to the qualified alien a/b, • are not considered part of the budget unit, and • do not need to live with the alien.

Type	Countable Unearned Income (and Verification)
Alimony and Spousal Support	**1** - When the a/b is **receiving** alimony or spousal support, the amount is countable income. Accept the individual's allegation of relationship of the payer to the payee unless you doubt the allegation. **2** - When the a/b is **paying** alimony or spousal support, *do not exclude the amount paid* when determining countable income. **Example:** Mr. Brown is an a/b and receives $800 Social Security monthly. He pays $200 alimony per month. His countable income is $800. **3** - To verify alimony and spousal support**:** Confirm amount / frequency of the alimony or spousal support via Clerk of Court.
Annuities and Pensions	If payments are made by an annuity to the a/b, they are counted as income. Annuities are paid yearly or at specified intervals. Pensions are typically paid at specified intervals. To verify**:** • Contact the responsible insurance company, financial institution, trust executor/administrator, employer or payer of the benefit • Examine current check • Examine current award letter or contract agreement
Black Lung/Brown Lung Benefits	**1** - Black lung benefits are paid to a disabled worker, dependents, or survivors, usually as the result of working in a coal mine. To verify **Black Lung benefits:** • Obtain written or verbal confirmation with the US DOL, Black Lung District Office, or • Obtain a current award letter. **2** - Brown lung benefits are paid to persons disabled by lung disease resulting from exposure to raw cotton dust. To verify **Brown Lung benefits:** • Obtain written or verbal confirmation with the Industrial Commission, Dept. of Economic and Community Development, or • Obtain a current check/award letter.
Cash Contributions	Determine if a/b receives cash on a consistent basis to help meet their needs. **1** - Verify monthly cash contribution by contacting provider of the cash. Ask the individual to submit a statement showing amount of contribution and period it's for. If a/b statement and provider statement disagree, accept a/b's statement. **2** - Count the monthly cash contribution received by the a/b **Example**: Mr. Brown's family sends him $10 per week spending money. This must be counted as income. Convert to a monthly amount by multiplying $10 times 4.3. Show $43.00 as countable unearned income.

Type	Countable Unearned Income (and Verification)
Child Support	**1** - When the a/b is **receiving** a child support payment, the payment amount received is countable income. Child support paid for a child is always payment to the child. It is never payment to the parent, guardian, or relative. **Example 1:** Mr. Brown is an a/b and receives a $200 monthly child support payment for the support of his child, Jane. The $200 is payment to the child Jane – not to Mr. Brown who is the parent. Therefore, the $200 is not income that is included in Mr. Brown's SA budget. **Example 2:** Mr. Brown is an a/b and receives a $200 monthly child support payment for the support of himself, as he himself is the child/adult child for whom the child support order was created. As child support paid for a child is always payment to the child, and as Mr. Brown IS the child/adult child, the $200 is countable income in Mr. Brown's SA budget. **2** - When the a/b is **paying** child support, do not exclude the amount of support payments when determining countable income. **3** - When a parent or other person receives a child support **arrearage payment** on behalf of an adult child: • Any amount of the arrearage payment that the parent or other person receives but *does not give to the adult child* is unearned income to the parent or other person (not income to the adult child) • Any amount of the arrearage payment that the parent or other person *gives to the adult child* is unearned income to the adult child (not income to the parent or other person) • Any child support arrearage payment an adult child receives *directly from the absent parent* is unearned income to the adult child **Example:** A non-custodial father pays child support on behalf of his 19-year old disabled son who lives in a SA facility. Consider the son an *adult child*. The former custodial mother receives a $100 child support payment. The $100 child support payment consists of both a current payment of $75, and $25 to pay for an arrearage. The mother keeps the child support arrearage payment of $25 and gives her son his current $75 child support payment. The arrearage payment, which the mother kept, is unearned income to her. The current child support payment of $75, which the mother gave to her adult son, is unearned income to the son. **To verify:** • OVS/OLV (ACTS) • Provision of the separation agreement or divorce decree, if up to date • Absent Payer Contribution statement
Court Ordered Restitution or Legally Obligated Payments	Restitution is an order of the court by which offenders are held accountable for the financial losses they caused to the victims of their crimes, and they make payments on such restitution or legal obligation *to a Special Assistance a/b*. **Count this income only if the payments do not go directly to the a/b, and if payments are not used for the a/b's benefit.** Verify using county or state records or examine current award letter/contract.

Type	Countable Unearned Income (and Verification)

Deemed Income for a Community Spouse or Dependent	Count income deemed from the Medicaid budget of an institutionalized spouse**:** • to a SA a/b who is the community spouse, or • to a SA a/b who is a legal dependent of the institutionalized spouse and/or the community spouse, and lives with the community spouse. Verify deemed income amount by obtaining a copy of the Medicaid budget.

Federal Employee's Compensation Act (FECA) Benefits	These payments provide compensation benefits to Federal employees for work-related injuries or illnesses, and to their surviving dependents, if a work-related injury or illness results in the employee's death. The Department of Labor, Office of Workers' Compensation Programs (DOL/OWCP) administers FECA payments via the Division of Federal Employees' Compensation (DFEC). The Department of Labor (DOL) claim number for FECA payments is a nine-digit number that begins with a two-digit code separated from the other seven digits by a hyphen. The first two digits identify the DOL district office that handled the claim. If the worker relocates, the originating office retains jurisdiction. To verify FECA payments: • Current award letter from the Department of Labor (Be mindful that a general increase may have occurred since the date of the letter.) • Submit a request for verification to the Department of Labor in writing. Generally, DOL does not respond to faxed requests. Do not send a fax unless DOL requests that you do so. Include the DOL claim number and Social Security Number (SSN) on any correspondence to DOL. *Mail request for payment verification to:* U.S. Department of Labor DFEC Central Mail room P.O. Box 8300 London, KY 40742-8300 (DOL scans the requests into a database, then forwards electronically to the appropriate DFEC district office.)

Income from Trust Funds	When an a/b is receiving income from a trust fund, determine the availability of income according to the terms of the trust. To verify trusts**:** • Contact the executor or administrator of the fund who may be**:** a family relative, the Clerk of Court, a lawyer, or the trust department of a local bank • Contact the lawyer who handled the legal aspects of the trust fund; or • If there are questions, contact the attorney who represents DSS

Type	Countable Unearned Income (and Verification)
Inheritance Payments	An inheritance payment is cash received as the result of someone's death. Count as unearned income if paid in installments. If received in a lump sum, refer to III. A. Lump Sum Payments. To verify: • Request verification from the responsible insurance company, financial institution, trust executor/administrator, employer or payer of the benefit • Review a current check (only if it is confirmed the check shows gross income) Examine current award letter or contract agreement
Interest and Dividends from stocks, bonds, other investments	Refers to interest paid from stocks, bonds, bank accounts and other investments, including dividend payments from a life insurance company's annual surplus earnings. To verify dividends or other investments**:** • Review the most current dividend check, or • Review the dividend statement, or • Contact the stockbroker or brokerage firm that sold the stock or bonds to the a/b, or • Contact the company in which the a/b owns the stocks, bonds, or other investments.
Living Needs Benefits	A living needs benefit is a provision that allows a terminally ill person to receive all or part of the proceeds of their life insurance policy while living. Depending on the circumstances, these payments can be received either as a lump sum OR on an ongoing basis. **1** - If an a/b has a life insurance policy that allows them to receive their death benefit while living and he meets the insurance company's requirements for receiving the proceeds, he will not be required to file for such proceeds. **2** - If the a/b does file for and receives the proceeds, the payment is considered *income in the month received*. Any portion remaining in the following month is an available *resource*. **3** - If payment is received *on an ongoing basis*, verify the proceeds with the insurance company administering the policy and *count as a monthly benefit*. **4** – If payment is received as a lump sum, refer to III.A. Lump Sum Payments
Loans and Promissory Notes **(When A/B Is Holder of the Loan or Note)**	**1** - When the loan *is a non-countable resource*, count payments received as unearned income. This includes any interest payments. **2** - When the loan *is a countable resource to the a/b*, count only the interest received as unearned income. **3** - When the a/b is not the holder of the loan, but instead *receives* a loan, it is **not** countable income. Treat as a lump sum. Refer to 3 in III.A. Lump Sum Payments.

Type	Countable Unearned Income (and Verification)
Lump Sum Payments	A lump sum payment is a one-time payment received by the a/b (not expected to be recurring). **1** - If a lump sum payment of unearned income is received in the *month of application* or *during the application process*, determine the months it covers. For months the applicant is eligible for SA, count the amount of the lump sum that is designated for that month of eligibility as income. **2** - A lump sum received for an *ongoing case* is not counted as income. It is considered as reserve the following month. Benefits received prior to receipt of a lump sum payment cannot be reduced. See SA-3200, Resources for RSDI or SSI lump sums. **3** - If a lump sum is received as a loan, other than educational loan by the a/b, do not count as income if there is an agreed upon timetable and plan for repayment. Obtain a written statement from the parties involved if there is no formal loan agreement.
Military Allotments	This refers to benefits received by dependents of military personnel. To verify military allotments received by dependents of military personnel, obtain**:** • Copy of the check (if the check shows the gross income amount) • Current award letter (Be mindful that an increase may have occurred since the date of the letter.) • Leave and Earnings Statements • The **a/b** or **financially responsible person** may call to request a copy of a military allotment. ➢ The military allotment verification contact telephone number for a member in the Army Reserves is 1-877-462-7782. ➢ The military allotment verification contact number for a member in the Army National Guard is 1-877-276-4729.
Native American Gaming Proceeds	These proceeds include Cherokee tribal per capita income paid to adult family members which have **not** been held in trust by the Secretary of the Interior (e.g., tribally managed gaming revenues). **Note:** Per capita distributions of all funds which are, conversely, *held in trust* by the Secretary of the Interior to members of an Indian tribe (including payments to minors or incompetent adults paid into trust funds administered by the tribe or fiscal agent) are excluded from income. Payments are generally received twice a year in June and December. **1** - Applications: Count the full amount of the payment as unearned income in month received. Any amount remaining after the month of receipt is a countable resource. **2** – Ongoing Count the full amount of the payment as unearned income in month received. Payment will not affect the ongoing case as income. Any amount remaining after the month of receipt is a countable resource.

Type	Countable Unearned Income (and Verification)

Native American Gaming Proceeds (continued)	(continued) To verify: • Obtain a copy of the check • Obtain a copy of the award letter • Contact the source at the following address: Eastern Band of Cherokee Indians Post Office Box 455 Cherokee, North Carolina 28719 (828) 497-7040

Private Disability	Payments made by a private entity to an individual who is incapacitated or does not have the ability to engage in substantial gainful activity (SGA). To verify, obtain**:** • Current award letter • Written/verbal confirmation from the source of the benefit • Current check stub (only if check stub shows **gross** income

Railroad Retirement Benefits	The potential for Railroad Retirement Benefits is based on an individual's railroad work history. Social Security Numbers that begin with a 7 indicate the possibility of Railroad Retirement Benefits. The a/b or financially responsible person may access Railroad Retirement Benefits information from the website at: www.rrb.gov. Additionally, they may request an award letter by calling the local RRB field office at 1-877-772-5772. Railroad Retirement Benefits (RRB) information may be requested by letter. Provide the applicant's name and social security number or railroad retirement claim number. *Mail written requests to**:*** Quorum Business Park 7508 E. Independence Blvd., Suite 120 Charlotte, NC 28228-9409 Telephone (877) 772-5772 **/** Fax (704) 344-6429 To verify, obtain: • Current award letter (Be mindful that a general increase may have occurred since the date of the letter.) • Copy of a current check (only if check stub shows **gross** income) • The client's Railroad Retirement (RRB) *suspension notice* is verification of *suspended payments*

Type	Countable Unearned Income (and Verification)
Rental Property	This includes income from rentals of real or personal property, such as land, housing, machinery, or leased farmland. **1** - Verify income by reviewing: • a/b's tax statements, • a/b's business records, • renter's statements or receipts, or • information available from banks or real estate agents. **2** - Verify actual paid **operational expenses** directly related to producing the income for the corresponding base period. For instructions on calculating base period, refer to II. Use the a/b's records, including tax records, or information from banks, real estate agents, or collateral contacts with renters. These actual operational expenses include but are not limited to**:** • interest and escrow portions of a mortgage payment (at the point the payment is made to the mortgage holder), • Property taxes and insurance, • Maintenance, • Utilities, if paid by the a/b, • Labor costs, • Real estate agent's fees, • Repairs (i.e., minor correction to an existing structure), • Sales taxes, • Advertising for tenants, • Verified transportation costs related to rental property operation, • Interest payments on loans for equipment necessary to produce rental income • Replacement of an existing feature that cannot be repaired or the cost of the repair exceeds cost of replacement, with a feature of comparable value and function (i.e., furnace that cannot be repaired). Obtain a statement of a knowledgeable source to verify whether the feature can be repaired.
Royalties (Unearned) ***See also Royalties (Earned) in III. C.**	Royalties include compensation paid to the owner of property for the use of the property, usually copyrighted material (e.g., books, music, or art) or natural resources (e.g., minerals, oil, gravel or timber). Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced. To be considered royalties, payments for the use of *natural resources* also must be received**:** ➢ under a formal or informal agreement whereby the owner authorizes another individual to manage and extract a product (e.g., timber or oil), **AND** ➢ in an amount that is dependent on the amount of the product actually extracted. Royalties are unearned income *unless* they are received as part of a trade or business, or are received by an individual in connection with any publication of their work. Refer to III. C. Royalties (Earned).

Type	Countable Unearned Income (and Verification)
Royalties (Unearned) ***See also Royalties (Earned) in III. C.** **(continued)**	(continued) To verify: • Verify that payments received meet the definition of royalty (above) by examining the agreement between the parties involved. If the agreement is unclear, unavailable, or informal, contact the company or source of the payment. • Verify the amounts of royalty payments by examining documents in the individual's possession. If documents are unclear or unavailable, contact the company or source of the royalty.
Severance Pay	Severance pay is extra pay given to an employee by his former employer when the employee is dismissed through no fault of his own. Count gross when considering severance pay. **1** - Severance pay may be paid out in one of the following ways: • In one payment, treat as a lump sum payment. Refer to III. A. Lump Sum Payments. • In a series of payments, treat as income received on a regular basis (monthly, weekly, etc.) **2** - If the severance pay has ended, treat it as terminated income. Refer to II. B. To verify the payment amount and payment schedule: • Examine the check stub (only if check stub shows gross income) • Obtain wage verification form from employer • Obtain a copy of the award letter
Sick Pay	When an a/b indicates they are on "sick leave" from an employer, determine if they are now (or will be) receiving sick pay for more than 6 months after the work stopped. Sick pay and accident payments made *after the first six months*, paid from an employer or the employee's own contribution, are *treated as unearned income*. **Note:** Sick pay and accident payments made *during the first six months* are treated as *earned income*. Refer to III. C. To verify benefits: • Examine a current check stub (only if check stub shows **gross** income) • Contact with the employer
Social Security Benefits (RSDI)	Determine from the a/b or their representative if a/b is receiving or has been awarded Social Security (RSDI). If the a/b is not receiving such benefits, explore the possibility. The a/b is responsible for applying for RSDI if he is potentially eligible. Complete a DMA-5049, Referral to Local SSA Office to assist the SA applicant with the application for Social Security (RSDI) benefits. **Note:** If a/b chooses to waive, delay or renounce RSDI benefits, count the amount to which he would be entitled as unearned income.

Type	Countable Unearned Income (and Verification)

Social Security Benefits (RSDI) **(continued)**	(continued) **1 -** Use one of the following methods to verify Social Security benefits: • Use the OVS/OLV SOLQ and BENDEX tabs. • Examine the current award letter. Be aware that an increase may have occurred since the date of the award letter. • If there is concern of a discrepancy with information obtained, use the DMA-5049, Referral to Local SSA Office form to clarify. **2 -** Determine the gross monthly benefit received by or awarded to the a/b. Deduct the amount withheld to recoup an SSA overpayment. Do not make any other deductions. **Note:** SA counts income for budgeting purposes the way SSI policy does. Therefore, unearned income garnished for any reason *other than to recoup an SSA overpayment* is still counted as received income when budgeting. **3 -** SSA Recoupment of RSDI Overpayment(s)**:** SA policy provides for SSA overpayment recoupment of the SA a/b's RSDI (Title II) benefit. If it is discovered that the a/b's RSDI benefits are subject to recoupment for overpayment, the recoupment must be waived by SSA or reduced to the minimum amount. See V. B. 4 for further instructions.

Tobacco Transition Payment Program **(TTPP)**	Effective November 2005, the Tobacco Transition Payment Program (TTPP) eliminated the tobacco quota or allotment system, calculating the value of lost quota and providing compensation in the form of cash installment payments to owners and producers. Both tobacco quota owners and tobacco quota producers were given the option to receive annual payments over a ten-year period or receive all payments in one lump sum. Payments are distributed during the first two months each calendar year. Based on SSI policy, the payments for *quota owners* are treated differently than those for *quota producers*. **1 -** TTPP payments to **quota owners** are a conversion of a resource, i.e., quota for cash. • Count as a resource the first moment of the first day of the month following the month of receipt • If the quota owner converts the quota to like property (i.e., another resource), treat the transaction as a conversion of a resource If the quota owner assigns the contract to a third party because they do not want the payments (i.e., gives it away), follow the transfer of resources policy in SA-3205. **2 -** TTPP payments to **quota producers**, or those who rent the land, are counted as net earned self-employment income (NESE). The compensation for producers represents the value of lost price support in the sale of tobacco and should be treated as NESE.

Type	Countable Unearned Income (and Verification)

Tobacco Transition Payment Program (TTPP) (continued)	(continued) • Count as annualized net income beginning the month of receipt. Project out for 12 months. • If the quota producer assigns the contract to a third party because they do not want the payments, i.e., gives it away, count the payments as a transfer of resources. Follow policy in SA-3205 Transfer of Resources.
Trade Readjustment and North America Free Trade Agreement (NAFTA) Payments	*Trade Readjustment Allowance* (TRA) provides payments to individuals who have exhausted Unemployment Compensation and whose jobs were affected by foreign imports as determined by a certification of group coverage issued by the Department of Labor. *NAFTA-TRA Program* provides payments to workers who lose jobs or whose work hours and wages are reduced due to trade with, or a shift in production to, Canada or Mexico. To verify**:** Examine the current award letter or contact a representative of the source of the benefit.
Unemployment Insurance	Public or private income received by an individual as compensation for loss of employment due to layoff, suspension, or firing. To verify**:** • Examine OVS/OLV • Examine current award letter • Examine current check stub (only if check stub shows **gross** income) • Obtain written/verbal confirmation from the source of the benefit
Veteran's Benefits (VA)	At application and recertification, ask the a/b if he is receiving or has been awarded VA benefits. If the a/b is not, then also**:** • Discuss whether the individual or any family member served in the military. • Explore any possible survivor benefits. A SA a/b with the potential to be eligible for VA benefits must complete an application for any Veteran's payments, whether retirement benefits, disability compensation, or dependent benefits, in order to qualify for SA benefits. **1** – VA verification Send the DMA-5027, Veteran's Benefits Verification letter to: **VA Regional Office Claims Division** 251 N. Main Street, Winston-Salem, North Carolina 27155 The request must include (see next page)**:**

Type	Countable Unearned Income (and Verification)
Veteran's Benefits (VA) (continued)	(continued) • VA Claimant's full name (SA a/b eligible for VA benefit), and • VA claim number or veteran's Social Security number; or • If VA claim number and Veteran's Social Security number are not available, submit the following: (a) Veteran's name and military service number. The veteran's military service number may be verified by the local VA service office, or (b) Veteran's date of birth **2** - Other VA verification methods (The following methods of verification *may* not always give an accurate picture of countable income. Only utilize verifications if they do give a complete, accurate picture of VA income.) • Call Department of Veteran's Affairs Toll-Free Number (800) 827-1000. When using this number, you will need the veterans' Social Security number. This method will verify the amount of benefits, the dates the benefits began, and the spouse or children associated with the veteran. (It may not identify specific benefit type, unless speaking directly to a Claim's Representative) • Award letter (a general increase may have occurred since the date of award letter) • Current check (may not show total countable amount). **3** - If VA rates are increased, the new pension rates are not automatic. The veteran or survivor must file an application with VA to establish entitlement to increased benefits under the Pension Improvement Act. **4** – Determine VA benefit • Count monthly VA benefits the a/b is entitled to receive • All VA pension payments except those exceptions listed in (a)-(c) below are federally funded income that is based on need. **As such, these payments are unearned income to which the $20 SA general income exclusion does not apply.** Assume that a VA pension is partly or entirely needs-based unless there is evidence to the contrary. (a) VA Aid and Attendance, VA Aid to the Homebound, and VA Reduced Improved Pension are **not countable income**. (b) VA Unreimbursed Medical Expenses (reimbursements from VA for medical bills that the veteran has paid) are not income. (c) Certain pensions paid to veterans or their dependents are *not needs based*. This exception applies only to pensions paid on the basis of a Medal of Honor; or a special act of Congress. These pensions are **unearned income** *and the $20 general exclusion applies.*

Type	Countable Unearned Income (and Verification)

Veteran's Benefits (VA) (continued)	(continued) ➢ Pension payments are usually paid monthly; however, when the monthly payment due is less than $19, VA will pay quarterly, biannually, or annually. VA may also make an extra payment if an underpayment is due. Count such VA payments as income in the month the payment is received. ➢ Veterans' compensation payments to a surviving parent of a veteran are federally funded income based on need. As such, these payments are unearned income to which the $20 SA general income exclusion does not apply. ➢ Veteran's compensation payments to a veteran, spouse, child, or widow(er) are unearned income subject to the $20 SA general income exclusion.

Winnings from Gambling, Lottery, Bingo, Cash Prizes	Gambling winnings, lottery winnings and prizes are generally things won in a game of chance, lottery or contest. Count these winnings as unearned income. (Do not subtract gambling losses from gambling winnings in determining an individual's countable income.) If an individual has a choice between an in-kind item and cash, count the cash offered as unearned income. This is true even if the individual chooses the in-kind item and regardless of the value of the in-kind item. **1** - If a beneficiary receives winnings or prizes, use documentation that the individual has in his possession to verify the income. If there is not sufficient documentation to verify the income, obtain a signed statement from the individual regarding: • The date the item was received, • Type of item received, • Individual's estimate of the value of the item if not cash; and • Source of the item **2** - Accept an individual's signed estimate of the value of the item or actual value if cash, unless you have reason to doubt the estimate. If you doubt the estimate, determine the item's current market value with an independent source. Determine the nature of the item and apply the appropriate instructions pertaining to income.

Worker's Compensation	Workers' compensation insurance is a type of business insurance that provides benefits to employees who suffer work-related injuries or illnesses. To verify**:** • Examine a current check stub (only if check stub shows **gross** income) • Examine the current award letter • Contact a representative of the source of the benefit

Type	Countable Unearned Income (and Verification)

Work Release Payments	The Work Release Program provides selected inmates the opportunity for employment in the community during imprisonment. Recently released inmates can sometimes receive a Work Release payment to assist in transition back to the community. Victims may receive restitution and an inmate's dependents may receive support payments from work release earnings as well. To verify work release payments**:** • Check county DSS records • Run an On-line Department of Correction inquiry • Confirm payments directly with the source of the benefit

B. Non-Countable Unearned Income

Adoption Assistance	Adoption assistance programs provide payments and/or services for children whom unassisted adoption is unlikely because of age, ethnic background, physical, mental or emotional disability, etc. Usually adoption assistance will be formalized in a written agreement between adopting parents and the agency involved.
Assistance from Other Agencies and Organizations	This includes financial assistance, in kind goods (clothing, food, etc.) Work First/TANF, or services received from a governmental, civic, or charitable organization as long as such aid is for rehabilitation purposes, special training, or educational opportunities, and no duplication exists. This includes VA Aid and Attendance, VA Aid to the Homebound, and also VA clothing allowance.
Benefits Received by an A/B as a Representative Payee for Another Individual	Benefits received by an a/b as a representative payee for another individual who is incompetent or incapable of handling their affairs. Such benefits must be accounted for separately from the a/b's own income/resources.
Bills Paid by a Third Party to a Vendor/Provider	Payment of an individual's bills (including supplementary medical insurance under title XVIII or other medical insurance premiums) by a third party *directly to the supplier* is not income. This includes Long Term Care (LTC) insurance payments. **Note:** anything received in-kind as a result of the payment *is income if it is food or shelter*.
Disaster Assistance	At the request of a State governor, the President may declare a major disaster when Federal assistance is needed. Disasters include such things as hurricanes, tornadoes, floods, drought, earthquakes, snowstorms, etc. Assistance provided to victims of a presidentially-declared disaster includes assistance from: • Federal programs and agencies; • joint Federal and State programs; • State or local government programs; • private organizations (e.g., the Red Cross).

Experimental Housing Allowance Program (EHAP) Payments	EHAP payments made under Annual Contributions Contracts entered into prior to January 1, 1975, under Section 23 of the U.S. Housing Act of 1937, as amended.
Housing Improvement Grants from NC Commission of Indian Affairs	Housing improvement grants to low income families approved by the North Carolina Commission of Indian Affairs or any funds distributed per capita to or held in trust for members of any Indian tribe under P.L. 92 254, P.L. 93 134, or P.L. 94 540.
HUD Community Development Block Grant Funds	HUD Community Development Block Grant funds received to finance the renovation of a privately owned residence.
HUD Section 8 or USDA Rural Development Housing Payments	The value of any assistance paid with respect to a dwelling unit is excluded from income if funded by HUD housing assistance or U.S. Department of Agriculture's Rural Housing Service (RHS) assistance.
In-Kind Support and Maintenance	In-kind Support and Maintenance (food, and shelter) from any source not paid directly to the a/b.
Irregular or Infrequent Income	To be excluded as irregular or infrequent, it must not be received more than once in a calendar quarter and be $20 or less.
Payments for Supportive Services	Payments for supportive services or reimbursement of out-of-pocket expenses made to volunteers serving as/in: • foster grandparents, senior health aides, senior companions • Service Corps of Retired Executives (SCORE) • Active Corps of Executives (ACE), • Retired Senior Volunteer Program (RSVP), • Action Cooperative Volunteer Program (ACVP), • University Year for Action Program (UYA), • Volunteers In Service To America (VISTA), • Other programs under Titles I, II, and III of Public Law 93-113
Payments by Medicare to Home Renal Dialysis Patients	Payments made by Medicare to a home renal dialysis patient as medical benefits.
Payments to Certain Indian Tribes	Payments to certain Indian tribes permitted by Public Law 94-114.
Plan for Achieving Self-Support (PASS) Account Deposits	Income diverted to a plan for achieving self-support (PASS) through the SSI. The PASS must be a written, formal plan, for a specified period of time, for eventual economic self-sufficiency.

Reverse Mortgage Payments	**Note:** Any amounts of payment remaining the first day of the month following the month of receipt are considered a resource. If proceeds of a reverse mortgage are given away in the month of receipt, apply transfer policy in SA-3205.
Social Services Block Grant Funds	Social Services Block Grant funds used to pay for services rendered by another individual or agency.
Special Energy or Weatherization Assistance	Special one-time payments, such as energy or weatherization assistance, including General Assistance payments to clients through DSS.
Special Government Compensations	Includes Payments to Victims of Nazi Persecution, German Reparation payments, Alaska Native Claims Settlement Act payments, Japanese-American and Aleutian Restitution, payments from Radiation Exposure Compensation Act, Title II Uniform Relocation Assistance or Real Property Acquisition Act of 1970 payments (including State displacement assistance that is comparable to Title II Federal relocation assistance), Agent Orange Settlement payments, Eugenics Asexualization and Sterilization Compensation (EASCP).
Tuition/Educational Assistance Programs	The portion of educational loans/grants/scholarships (including Pell Grants, assistance from civic groups, educational institutions, athletic scholarships, a payment under the Veterans Educational Assistance Program G.I. Bill, programs administered by the U.S. Department of Education, or Bureau of Indian Affairs) used for tuition, books, fees, equipment, transportation, required school insurance, and childcare services necessary for school attendance.
Value of Food and Nutritional Services Allotments	Value of the allotment received from the Food and Nutrition Services program.

C. Countable Earned Income

Type	Countable Earned Income (and Verification)
Farm Income	Determine if the a/b has farm income from production of crops or livestock. **Note:** Income from a farm *that is leased to another individual* is counted as **rental income**. Refer to III. A. To verify**:** • Use tax statements or business records. • Determine all income received from the sale of farm products such as**:** crops, livestock such as beef, poultry, etc., livestock products such as milk, eggs, etc., proceeds from the Soil Bank, cash rent, or other sources of farm income such as insurance payments for damaged crops.

Type	Countable Earned Income (and Verification)
Farm Income (continued)	(continued) • Verify actual paid operational expenses directly related to producing the income. This includes**:** fertilizer, insecticides, seed, crop insurance, livestock maintenance, rent payments, taxes on farm property or equipment, labor, building and equipment maintenance/insurance, interest payments on debts or loans directly related to producing the income (such as interest on loans for seed and fertilizer), interest portion of mortgage (principal not allowed), and verified costs of transportation (related *only* to the farm operation). **Note:** **1** – If tax statements are used to verify the income**:** Use the previous year's tax statement. (Operational expenses included on tax returns which are not allowable, must be added back in when computing gross countable income. Do not allow depreciation as an operational expense.) OR **2** – If business records are used to verify the income**:** Use a/b's records or landlord's records, or use information from farm suppliers, banks, Production Credit Association, farm agents, or ASCS/Farm Service Agency. Determination of Countable Gross Farm Income**:** • If the a/b states there has been **no** change in the farm earnings in the past year: (a) Base the current year's profits on the prior year's profits. (b) Subtract the total operational expenses paid from gross income received in the base period. (c) Divide by 12 (or the number of months used) to determine a countable net monthly income • If the a/b states there **has** been a change in income, apply the Gross Net Ratio. Determine the ratio between the net profit and gross income for last year from the a/b's tax return or business records. **Net Profit \ Gross Income = Gross Net Ratio** (see below for an example)

Type	Countable Earned Income (and Verification)

Farm Income (continued)

(continued)

Example: Mr. Brown stated his income in *this* calendar year is different from *last year*. Last year's net profit was $1,200 and gross income was $6,000 for a 20% profit.

Net Profit	1200
Gross Income	÷ 6000
Gross Net Ratio	20%

FIRST - Determine the actual gross receipts for the current taxable year thus far from the a/b's records and project it for the remainder of the year.

Mr. Brown has $4,000 in net profit for the first 6 months of the *current* calendar year, projecting an assumed gross of $8,000 for the entire year.

Net Profit (first 6 months)	4000
# of Months you have receipts for	÷ 6
Average monthly profit	666.67
# Months in the Year	x 12
Estimated Gross Annual Income	$8000

NEXT - Apply the gross net ratio (e.g., 20% of $8,000 is $1,600) to the gross receipts projected for the current calendar year to obtain an estimate of net profit.

Annual Gross	8000
Gross Net Ratio	x 20%
Net Profit	$1600

THEN - Prorate the net profit equally into the 12 months of the taxable year.

Net Profit	1600
Gross Income	÷ 12
Gross Net Ratio	$133.33

Foster Care (Supplemental Payments

When discussing Foster Care with an a/b, ask if supplemental foster care payments in excess of State maximum foster care payment rates are being received by SA a/bs who serve as foster parents.

1 - Foster care payments made under Title IV-E (both Federal and State amounts) are considered income to the individual in care and are not income to the foster care provider. However, amounts paid to a provider of foster care in excess of the foster care payment **are income to the provider**.

Type	Countable Earned Income (and Verification)

Foster Care (Supplemental Payments) (continued)	(continued) **2** - An agency may make an additional payment to the foster care *provider* for his/her own use (for example**:** an incentive or service payment not intended to support the child). Be aware that while these two payments *may* be combined and termed the "foster care payment" by the issuing agency, only the part which is provided to meet the needs of the individual in care is the foster care payment for SA purposes. *All amounts in excess of that part of the foster care payment are income to the provider.* **3** - Verify using county records. **4** - Count the full amount of the supplemental payment as gross income.

Royalties (Earned) *See also Royalties (Unearned) in III. A.	Royalties include compensation paid to the owner for the use of property, usually copyrighted material (e.g., books, music, and art) or natural resources (e.g., minerals, oil, gravel or timber). Royalty compensation may be expressed as a percentage of receipts from using the property or as an amount per unit produced. To be considered *natural resource royalties*, payments for the use of natural resources also must be received: - under a formal or informal agreement whereby the owner authorizes another individual to manage and extract a product (e.g., timber or oil), **AND** - in an amount that is dependent on the amount of the product actually extracted. Royalties are <u>earned</u> income when they are received: • As part of a trade or business, or • By an individual in connection with any publication of his/her work (e.g., publication of a manuscript, magazine article, or artwork) Also refer to III. A. Royalties (Unearned). To *verify* payments received meet the definition of royalty (above) and to determine amount: • examine the agreement between the parties involved. If it is unclear or unavailable, contact the company or source of the payment. • Verify the amount of royalty payments by examining documents in the individual's possession. If documents are unclear or unavailable, contact the company or source of the royalty.

Self-Employment Income	When a/b has income from self-employment: **1** - Verify income using prior year's federal tax returns (must include at least some of the months in the base period), or business records (including but not limited to accounting records, ledgers, lease agreements)

Type	Countable Earned Income (and Verification)

Self-Employment Income (continued)

(continued)

2 - Verify actual paid operational expenses related directly to producing the income for the corresponding base period. Use the previous year's tax statement if it is used to verify the income. Use the a/b's records or information from suppliers, banks, and purchasers of the goods or services if business records are used to verify the income. These actual operational expenses include, but are not limited to**:**

- Interest portion of mortgage (principal not allowed)
- Utility costs paid by the a/b
- Business related transportation costs

3 - Operational expenses included on tax returns, which are not allowable, must be added back in when computing gross countable income. Do not allow depreciation as an operational expense.

4 - Determination of Countable Gross Business Income

- If a/b states <u>there has been no change</u> in the business earnings in the past year, base the current year's profits on the prior year's profits.

  (a) If there are no tax records, use the a/b's business records to determine gross income and operational expenses.
  (b) Subtract the total operational expenses paid from gross income.
  (c) Divide by 12 (or the number of months used) to determine a countable net monthly income.

- If a/b states <u>there has been a change</u> in income, apply the Gross Net Ratio

  (a) Determine ratio between net profit and gross income for last year from a/b's tax return or business records.

  Example: Mr. Brown stated that his income in this calendar year is different from last calendar year. The net profit was $1,200 and the gross income was $6,000 for a 20% profit.

Net Profit	1200
Gross Income	<u>÷ 6000</u>
Gross Net Ratio	20%

  (b) Determine the actual gross receipts for the current taxable year thus far from the a/b's records and project it for the remainder of the year.

  Example: Mr. Brown has $4,000 in net profit for the first 6 months projecting an assumed gross of $8,000 for the entire year.

Type	Countable Earned Income (and Verification)

Self-Employment Income (continued)

(continued)

Net Profit (first 6 months)	4000
# of Months for which you have receipts	÷ 6
Average monthly profit	666.67
# Months in the Year	x 12
Estimated Gross Annual Income	$8000

(c) Apply the gross net ratio to the gross receipts projected for the current calendar year to obtain an estimate of net profit.

Annual Gross	8000
Gross Net Ratio	x 20%
Net Profit	$1600

(d) Prorate the net profit equally into the 12 months of the taxable year.

Net Profit	1600
Gross Income	÷ 12
Gross Net Ratio	$133.33

Wages

At application and recertification, determine if the a/b is employed.

Sources of wages may vary, but can include**:**

- Employment, tips, seasonal employment, baby sitting in another person's home, domestic employment
- Advanced/deferred wages
- Contract wages
- Seasonal employment
- Commissions
- Severance pay
- Adult Developmental Activities Program (ADAP).
- Annual leave pay subject to tax deductions
- Sheltered workshops
- Sick pay for the first six months after work stops due to disability or illness (Sick pay is unearned income after six months. Refer to III.C.)
- Vacation pay
- Title V Program for adults age 55 or older (through U.S. Department of Labor).
- Training allowances, earnings, and payments received by an a/b

1 - To verify wages**:**

- Examine a current pay stub (only if pay stub shows **gross** earned income)
- Verify the client's status, rate of pay, and average hours worked with employer, either verbally or in writing.

2 - Count the gross monthly benefit received by the a/b (after converting to a monthly amount).

D. Non-Countable Earned Income

Earned Income Tax Credits	This is income is due to allowable tax credits which can include EIC and Dependent Care Tax Credits.
Foster Care Payments Equal To or Less Than State Maximum Rates	This refers to Foster Care payments that are **equal to or less than** the State maximum Foster Care payment rates which are made to SA a/b's who serve as foster parents. As referenced in III. C., foster care payments made to the foster care provider for the purpose of meeting the needs of the individual in care are not income to the provider.
Foster Care – Title IV-E Section 477	Individuals who are age 16 or over making the transition from foster care to independent living may be receiving foster care payments under Section 477 of the Title IV-E (Independent Living Initiatives) program. Payments made under Section 477 of Title IV-E are cash assistance from a governmental social services program and, therefore, are not income.
Foster Care – Title IV-B or Title XX	Foster care payments involving funds provided under Title IV-B or Title XX of the Social Security Act are not income.
Irregular Income	Income that is unpredictable, or which is received irregularly or infrequently. (Examples are occasional yard work, sporadic babysitting, winnings from gambling or bingo, etc.)
Supportive Services Payments	Income for supportive services or reimbursement of out-of-pocket expenses to volunteers serving as foster grandparents, senior health aides, senior companions, Service Corps of Retired Executives (SCORE), Active Corps Executives (ACE), and any other programs under Titles I, II, and III of Public Law 93-113.
Tax Refunds	A tax refund or tax rebate is a payment to the taxpayer when the taxpayer pays more tax than they owe.

IV. INCOME COMPUTATION FOR NON-SSI A/B

A. Unearned Income

1. Use countable **monthly** unearned income.
2. Subtract the $20 SA General Income Exclusion.

Do not give the $20 exclusion to an individual whose only income is a need-based VA Pension or a VA Compensation payment received as a surviving parent of a veteran.

3. Apply the SA General Income Exclusion to unearned income first. Apply any remainder to earned income.

B. Earned Income

1. Compute net self-employment farm income, if applicable. (Gross income minus operational expenses equals (=) countable net income.) Add to any other earned income.
2. Subtract any portion of the $20 monthly SA General Income Exclusion, which has not been excluded from unearned income.
3. Subtract the $65 Earned Income Exclusion.
4. Deduct Impairment Related Work Expenses (IRWE) if applicable.

   IRWE are expenses for items or services which directly enable a person with a disability to work and which are incurred by the a/b because of a physical or mental impairment. These expenses can be excluded from the a/b's earned income when certain conditions are met.

   a. Apply the IRWE exclusion only to earned income. Deduct only the amount paid by the individual for the expenses.

   b. Exclude IRWE from the monthly earned income of an a/b that is used to meet any expenses attributable to earning the income if the person is:

      (1) Disabled; and

      (2) Under age 65; or

      (3) Age 65 or older and received SSI or RSDI as a disabled person in the month prior to becoming age 65.

   c. IRWE can be given to the a/b when:

      (1) The severity of the impairment requires the a/b to purchase or rent or use items and services in order to work, and

      (2) The expense is reasonable. "Reasonable" is the standard charge for the item or service in the person's community, and

(3) The cost is paid in cash by the a/b and is not reimbursable from another source (e.g., Medicaid, Medicare, private insurance), and

(4) The a/b made payment for item/services in a month that he worked and received income for working and obtained item/services, or

(5) The a/b worked and received the item/service before receiving a paycheck.

d. Verification of IRWE

(1) To verify the need of the item/service, request that the a/b provide a statement for the need of the item/service for themselves.

(2) To verify payment for the item/service, request that the a/b provide copies of cancelled check(s) or paid receipts. Exclude the basic cost of the item/service as IRWE.

(3) If the cost is unknown to the agency or it appears to be unreasonable, contact a provider of that item/service.

(4) Ask the provider for basic cost of the item/service. Use basic cost amount.

(5) If the a/b provides receipts for recurring items/services paid for one week, convert that amount to a monthly amount and allow the monthly amount.

e. At application and recertification, verify the expense the a/b had for items/services for the past 12 months or for the number of months the a/b had the expense.

f. If the a/b incurred an expense in the past 12 months for items/services but no payments were made, do not allow in the budget.

g. If the a/b incurs the expense in the month of recertification, treat it as a change in circumstance. If the a/b paid for the item/service in full, deduct the expense from the income for that month.

h. If the a/b is paying for the item/service in installments, deduct from the income the monthly installments.

i. Items/services that can be used for IRWE include but are not limited to:

(1) Attendant care services.

(2) Prescriptions and expendable medical supplies such as bandages, catheters, face mask.

(3) Guide dog, including cost of purchasing the dog, its food, and veterinary care, etc.

(4) Medical devices such as braces, inhalers, pacemakers, respirators, wheelchair and the repair of that item.

(5) Physical Therapy.

(6) Prosthetic devices required to work and the maintenance and repair of these devices.

(7) Structural modifications to the a/b's home to create a workspace or to allow the a/b to get to and from work.

(8) Training to use impairment-related items related to work, such as Braille, cane travel, use of special equipment. Training does not include general education courses.

(9) Other work-related equipment/services such as one-handed typewriters, special tools, typing aids, uniforms, safety shoes, if impairment-related.

(10) Transportation to and from work.

(11) Vehicle modifications.

j. Non allowable deductions

(1) In kind payments,

(2) Expenses which will be reimbursed,

(3) Items that are furnished by a third party, and

(4) Expenses deducted in determining net countable earned income.

(5) Subtract ½ of the remaining earned income. Never reduce earned income below zero.

C. Add A/B's Unearned Income and Earned Income Together

Example: Mr. Jones is a SAD beneficiary. He had Social Security of $**920.00** and gross monthly **(converted)** earned income of **$600.00** for January. He paid a total of **$50.00** for wheelchair rental and medical supplies in January. You have determined that these items meet the IRWE requirements.

Monthly Gross Unearned Income (already converted to a monthly amount)	**$920.00**
SA General Income Exclusion	- 20.00
Countable Net Unearned Income	$ **900.00**
Gross Earned Income	$600.00
Earned Income Exclusion	- 65.00
	$535.00
IRWE	- 50.00
	$485.00
½ of the remainder ($485.00)	- 242.50
	$242.50
Countable Net Unearned Income	$**900.00**
Countable Net Earned Income	+242.50
TCMI	**$1142.50**

V. SA REQUIREMENT TO OBTAIN MAXIMUM ENTITLEMENT INCOME

The SA a/b cannot waive or renounce benefits to which he/she may be entitled in order to become eligible for SA. If income is waived, the gross amount for which the individual is entitled is countable. This section contains instructions for assisting the Special Assistance (SA) applicant/beneficiary (a/b) to access the maximum income for which he/she is entitled.

The Income Maintenance Caseworker (IMC) must inform each SA a/b and/or his/her authorized representative that he/she must apply for all benefits to which he/she may be entitled, including receiving the maximum benefit for which he/she is eligible. This includes SSI, Social Security Retirement, Survivors, and Disability Insurance (RSDI), Veteran's benefits, Railroad Retirement, Black Lung, Worker's Compensation, a union or private employer pension, a civil service pension, or any income to which he/she is legally entitled.

All documentation referred to in this section must be entered in NC FAST and should also be completed in the DSS-8190 SSI/Non-SSI Application Workbook at application, and in the DSS-8191 Special Assistance Re-Enrollment Information Notice at redetermination.

A. Evaluate Applicant/Beneficiary's SSI Status

SA is a state supplement to the SSI Program. If the a/b's total gross income is less than the Federal Benefit Rate (FBR) for SSI, the a/b is required to apply for SSI, or for an additional amount of SSI, to equal the FBR. Often, an individual's income, even when receiving SSI, is less than the FBR. The current FBR is posted on the Social Security website.

1. Verify the a/b's SSI status using SOLQIS/SDX on OVS/OLV. Pursue other methods only when there is a discrepancy or when electronic verification is not available.
2. SA payments cannot be issued in an amount to make up for SSI income deficit when the **total gross income** is less than the FBR and is reduced for any reason other than:
    a. Social Security Administration (SSA) overpayment recoupment (when SSI or RSDI income is garnished for any reason other than to recoup an SSA overpayment, the total monthly income, including the amount that is being garnished is entered as evidence and is countable;

b. SSI couple deeming;

c. SSI denials due to life insurance excess for those who had specific life insurance face/cash value policies prior to December 1, 2009; and

d. SSI determinations related to private living reductions for SAIH cases such as one-third reduced and in-kind support and maintenance.

3. If the a/b's income is less than the FBR for one of the above reasons, the reason must be entered in NC FAST in the Benefit/Unearned Income evidence field.

4. If the a/b currently has income at or above the FBR, a referral to SSA to apply for SSI is not required.

   EXCEPTION to #4: If the most recent SSI determination of eligibility in the SOLQ/SDX records (regardless of how long ago that determination was) shows that the a/b was found to be ineligible for SSI for any reason other than excess income, the a/b is ineligible for SA. This is due to the SA eligibility requirement in SA-3100 I. which states, "To be eligible for SA, an individual must be eligible for SSI, or ineligible for SSI solely due to income."

   - In this situation, if the individual is a SA applicant, is not in SSI appeal status, and the appeal time frame has lapsed, instruct the applicant via DHB-5097 to reapply for SSI. See SA-3110 VIII. B. 3.

     If the individual is a SA applicant who is in SSI appeal status or opts to appeal a recent SSI denial, the SA application will need to be denied. SA does not pend applications while waiting for the SSI/RSDI appeal. Explain to the applicant that if the appeal results in a reversal to approve SSI/RSDI retroactive to the SA denial, the SA case can be reopened. See SA-3110 VIII. B. 4.

   - If the individual is a SA beneficiary, propose termination via DSS-8110. See SA-3330 Notices. Refer the beneficiary to SSA to apply for SSI, or appeal the prior SSI denial, if applicable. Remember to evaluate for any overpayments. See SA-3300 Administration of Benefits.

B. Special Review Codes Required for Cases with TCMI Less Than the FBR

If the total gross monthly income entered is less than the FBR, the "reason not receiving at the Federal Benefit Rate" must be entered on the Income evidence. Also, document in NC FAST electronic case file the details of the reason and how the information was verified.

The purpose of this is to either allow certain exceptions to cases having income below the FBR or to allow a window of time for the a/b to obtain the FBR. The reasons for not receiving SSI at the FBR are only to be used for a specified situation and for the specified timeframe designated. Reasons that can be used for a/b's who are not receiving SSI at the FBR, their definitions, and instructions are listed below:

1. **SSI 1/3 Reduced**: This applies to SSI beneficiaries whose SDX Code is "J": One-Third Reduced Income.

    a. Use this reason when the total gross monthly income is less than the FBR for SA applicants who have recently moved into a SA eligible facility from a private living arrangement where he/she was receiving SSI at the one-third reduced income rate.

    b. This reason is **time limited** for SA Basic and SCU cases and provides for budgeting of the SA payment for not more than a two-month period following the a/b's month of admission to a SA eligible facility. *IMC should track the time-limit for these cases*.

    c. **This reason is not time limited for SAIH cases. The living arrangement for SAIH cases must be periodically evaluated for changes that would affect SSI.**

        (1) Verify/document date of admission/move into a SA facility.

        (2) Budget the individual for SA based on the FBR beginning the third month following the month of living arrangement change even if the SSI is not yet at the FBR.

        (3) The IMC must submit a DMA-5049, Referral to Local SSA Office, to inform SSA of the date of the SA a/b's admission to an SA facility and request SSA reinstate the FBR accordingly. The IMC must also issue a DHB-5097 as appropriate requesting the a/b contact SSA for reinstatement of SSI benefits at the FBR.

2. **SSI In Kind Support/Maintenance Ending**: This applies to SSI Beneficiaries with SSI income based on SDX Code "H", In-Kind Support and Maintenance.

a. Use this reason when the total gross monthly income is less than the FBR for SA applicants who have recently moved into an SA eligible facility from private living arrangement where he/she was receiving SSI income based on In-kind Support and Maintenance (ISM) SDX Living Arrangement Code “H”.

b. This reason is time limited for SA Basic and SCU cases. This provides for budgeting of the SA payment for no more than a two-month period following the a/b’s month of admission to a SA eligible facility.

c. This reason is not time limited for SAIH cases. The living arrangement for SAIH cases must be periodically evaluated for changes that would affect SSI.

3. **Life Insurance (with) Cash Accruing Face Value Greater Than $1500**: These cases were converted from EIS with a “Yes” indicator and is allowed ongoing protection until the SA case is correctly terminated. The converted product delivery case must remain active for NC FAST to recognize the cash value as an excludable resource (a new application or administrative application cannot be authorized).

   Use of this reason, once assigned to a case, is allowed ongoing until the SA case is correctly terminated. It is not time limited. This is required for ongoing SA beneficiaries who:

   a. Applied for SA prior to December 1, 2009;

   b. Were approved for SA based on eligibility policy prior to December 1, 2009;

   c. Had continuous SA benefits; and

   d. Were denied SSI because of excess resources due to cash accruing value of life insurance policies with a face value greater than $1,500 but less than $10,000.

   When budgeting income for beneficiaries who were SA eligible prior to December 1, 2009, but whose income is less that the FBR, due to LI, do not use the FBR in budgeting the income. Budget only the income they receive.

   Do not require them to reapply for SSI unless there is a change that could make them SSI eligible.

When a case with SA Special Review Code from EIS displays "Yes" in Liquid Resource evidence/Liquid Resource Details, is correctly terminated, and the former beneficiary reapplies for SA, they must meet the current SA Life Insurance policy requirements. The new case created when the application is authorized will not display the "Yes" indicator.

4. **SSI/SS Recoupment**: Use this reason when there is an SSA overpayment recoupment of SSI (Title XVI), and/or RSDI (Title II). In the case of an SSA recoupment, the recoupment amount must be waived or adjusted to the lowest possible monthly amount. In many cases this can be $10.00. The time limit on the use of this reason varies for each SA beneficiary depending on the projected end date for recoupment.

5. **SSI Couple Deeming**: Required for cases with gross monthly income less than the FBR. Case Special Review Code, "N" 'SSI Couple Deeming'.

   a. This reason is valid for SA residential facility cases where a couple resides in the same room or SSA views the a/b as a member of a couple.

   b. It is also valid for SA In-Home cases. See SA In-Home policy section SA-5200.

C. Instructions When the SA Applicant/Beneficiary Is Receiving or Has Been Awarded SSI at the FBR

If SSI has been issued at the FBR, enter the SSI benefit amount from OVS/OLV in Benefit evidence in NC FAST. If SSA is using earned income to determine the FBR, enter the monthly wage found in OVS/OLV from SOLQIS/SDX. Do not count any other earned income unless the income is used to evaluate the full FBR as indicated in OVS/OLV.

1. Do not request wage verification; SSI has already determined the FBR based on the wages. SSI earned income verification must be used even if pay stubs or other wage verification conflict.

2. Complete a DMA-5049 to SSA to report the change in income and continue using the On-Line Data until SSI makes a change in the earned income.

New SA applicants do not always appear in OVS/OLV on SOLQIS/SDX. If this is the situation, verify the SSI benefit amount by viewing the SSI award letter. 'Award Letter' must be selected as the verification type for the application SSI benefit evidence. A copy of the award letter must also be placed in the case file. Workers must enter the SSI Award Letter payment amount in the Benefit evidence in NC FAST.

D. Instructions When the SA Applicant/Beneficiary Is Not Receiving at the FBR

1. If the applicant is **not receiving SSI**, the applicant must apply for SSI.
    a. The IMC must offer to assist the applicant with the SSI application process.
    b. Issue at least two (2) DHB-5097's, at least 12 calendar days apart, requesting applicant apply for SSI.
    c. If the applicant applies for SSI, by the 45/60 day of processing time standards, pend the SA application for up to 12 months awaiting the SSA decision.
    d. If the applicant refuses to apply or has not applied for SSI by the SA application processing deadline, deny the application on the 45/60 day.
    e. If the SSI application is approved, but not at the FBR, verify the reason for the reduced payment and unless it meets one of the exceptions below, follow the steps below. Exceptions to SSI FBR for SA applicants:
        (1) Individuals who are receiving less than the FBR due to recoupment of SSI or RSDI.
        (2) When SSA is considering an individual as part of a married couple.
        (3) When SSI is one-third reduced for a private living arrangement and application is for SAIH.

2. If applicant is **receiving SSI, but not at the FBR**, the applicant must cooperate in and follow through with the request for assessment/reinstatement of the FBR as applicable. The IMC must offer to assist the applicant in obtaining the FBR.

a. Send a DMA-5049, Referral to Local SSA Office to SSA, informing SSA of any changes that may affect SSI eligibility and/or the SSI payment.

b. Send at least two DHB-5097's, at least twelve calendar days apart, requesting that the SA applicant contact SSA and request assessment/reinstatement of SSI up to the FBR. Be specific in requiring that the SA applicant both:

(1) Request assessment/reinstatement of SSI eligibility up to the FBR, and, Individuals who are receiving less than the FBR due to recoupment of SSI or RSDI.

(2) Obtain an SSI eligibility decision from the SSA.

c. Utilize SOLQIS/SDX on OVS/OLV to verify and track the following:

(1) Whether SSI has been reinstated at the FBR (date of increase to the FBR) or,

(2) The reason the FBR was not awarded and,

(3) Whether an SSI eligibility decision is still pending.

d. If the SA applicant's SSI is not yet at the FBR by the 12th calendar day, after the date of the second DHB-5097, and all other factors of eligibility have been met, approve the SA application based on the FBR amount. Exceptions to SSI FBR:

(1) Individuals who are receiving less than the FBR due to recoupment of SSI or RSDI.

(2) When SSA is considering an individual as part of a married couple.

(3) When SSI is one-third reduced for a private living arrangement and application is for SAIH.

E. Instructions for Assisting the SA Applicant/Beneficiary to Obtain the FBR

1. The IMC must track and verify the a/b's reinstatement to FBR using SOLQ/SDX on OVS/OLV.

2. When SSA incorrectly applies federal living arrangement SDX code "D" (a facility such as a nursing home where Medicaid is paying more than 50% of the cost of care) to residents of an SA approved facility, this results in a reduced or terminated SSI assistance amount for SA applicants or beneficiaries. The IMC must offer to assist the applicant in obtaining the FBR.

   a. Send a DMA-5049, Referral to Local SSA Office to SSA, informing SSA of any changes that may affect SSI eligibility and/or the SSI payment. Include on the DMA 5049 that the SSI beneficiary does not reside in a Title XIX (Medicaid) institution and request an assessment of the SSI beneficiary's entitlement to reinstate benefits at the FBR. Specify the date the SA applicant or ongoing beneficiary moved to the SA facility. Provide the SA facility name and contact information as currently reflected on the Living Arrangement evidence in NC FAST.

   b. Check the SDX living arrangement code and verify that it reflects the correct current living arrangement and a payment status code of "C01." Verify via SOLQ/SDX to ensure the a/b is receiving FBR.

   c. SA applicants moving from a nursing home to a SA facility will be eligible for the FBR the month following the month of change in living arrangement.

   d. If the SA applicant moves to a SA facility after the first day of the SA application month, budget the application month based on zero income. Budget the ongoing month(s) based on FBR even though the applicant may not yet be receiving at FBR.

   e. If the applicant is already a resident of the SA facility on the first day of the month for which eligibility is being determined, budget

the SA payment on the reduced amount of SSI for that one month. Budget the ongoing month(s) based on the FBR even though the applicant may not yet be receiving FBR.

3. **Instructions for Married Couples**: For married couples, consider only the income of the a/b when calculating the SA payment. The a/b cannot deem any portion of his/her income to a spouse or non-spouse for SA. The IMC must evaluate each individual applying for SA to determine if his/her income, considered separately, is less than the FBR.

4. If a SA applicant is receiving or has been awarded SSI at **less than** the individual FBR:

   a. Follow SA application processing time standard policy found SA-3110, Application Process. Issue at least two (2) DHB-5097's, at least 12 calendar days apart, requesting applicant apply for SSI at the FBR. Request that the individual provide a copy of the individual payment contract with the facility.

   b. Send a DMA-5049, Referral to Local SSA Office, to notify SSA of the SA beneficiary's current living arrangement and date of admission to the SA approved facility, noting whether the applicant and his/her spouse reside in the same room in the facility. Request SSA to assess/reinstate the beneficiary's SSI to FBR.

   c. If a married individual, living with his/her spouse, applies for SAIH, and the couple's income is at or above the SSI couple FBR, do not require the applicant to apply for the individual FBR.

5. **Instructions Regarding SSA Recoupment of SSI and/or RSDI Overpayments**: The a/b must cooperate in requesting that SSA either reduce the recoupment amount to the minimum possible or waive the recoupment amount. The IMC must assist in the request to have the recoupment reevaluated asking for it to be waived or reduced to the minimum amount possible.

   SA policy provides for Social Security overpayment recoupment of the SA beneficiary's SSI, and/or RSDI monthly entitlement. However, Social Security policy allows for evaluation of reduction or waiver of

the recoupment when the beneficiary's income or financial need changes. The a/b must request that SSA reduce their recoupment amount to the minimum amount possible allowed under SSA law based on the fact that the a/b has moved into a residential care facility and is receiving or has applied for public assistance (SA) to supplement the cost of care. Although SA budgeting deducts the SSA recoupment amount from the entitlement amount, increasing the SA payment to make up the recoupment, SA must not be used to fund the a/b's SSA overpayment when the monthly amount recouped has not been reduced to the minimum possible amount allowed by SSA, if it cannot be waived.

a. The IMC must assist the a/b in obtaining the FBR.

(1) Use the DSS-3004, Referral to SSA for Waiver or Reduction of Overpayment Recoupment, to send to SSA. Complete the top portion of DSS-3004 and check the appropriate box for the request (waive or reduce the overpayment.) Request that the a/b or his/her representative payee sign the bottom of the DSS-3004, Request to SSA for Waiver or Reduction of Overpayment Recoupment.

(2) To expedite this process, the IMC should also print the SSA-632-BK Request for Waiver of Overpayment Recovery and assist in the completion of this form.

(3) Complete necessary items on the SSA-632-BK and request the required signature on that form. The requirements for completion of the items on the SSA-632-BK vary based income source. If receiving SSI, SA or other public assistance, complete through page 3 and check the "YES" box in #12. Attach proof of public assistance. Instruct the a/b to return both forms to the IMC.

(4) If needed, send at least two DHB-5097's, at least 12 calendar days apart, informing the a/b that if they fail to cooperate with the reduction or waiver request, the gross SSI/RSDI entitlement will be budgeted for SA.

b. The IMC will submit the forms to the local SSA field office. SSA will evaluate this request and may contact the SSI or RSDI beneficiary to request additional information.

c. If the county DSS is representative payee for the a/b's RSDI or SSI check, the county should make all requests on behalf of the a/b regarding recoupment waiver or reduction.

d. If the a/b cooperates with the process to request a reduction in, or waiver of the SSI/RSDI recoupment, the recoupment amount will be disregarded when budgeting income for the SA payment.

e. The IMC must monitor the requests made to SSA for the recoupment waiver or reduction and assist in obtaining necessary information to reduce the recoupment to the lowest amount possible.

f. Recoupment may be temporarily suspended by SSA when a request for a waiver or reduction is received. The IMC must track this closely, react to the change, and should not assume that the suspension is permanent.

g. If SSA does not respond with a decision in three months, contact the SA Listserv via DSS-9000SA at Specialassistance@dhhs.nc.gov

h. Once SSA responds with a decision:

(1) If the recoupment amount is partially reduced by SSA, the IMC will count only the SSI/RSDI amount received by the a/b after the recoupment is deducted. Send the required notice of change to the SA beneficiary. See SA-3330 Notices.

(2) If the recoupment is fully suspended/waived by SSA, begin to count the gross SSI/RSDI entitlement effective the month of change. Send the required notice of change to the SA beneficiary. See SA-3330 Notices.

(3) The IMC must monitor the time frame for the recoupment to be completed.

(4) If SSA responds, but will not consider the request for recoupment adjustment, contact the SA Listserv via DSS-9000SA form at Specialassistance@dhhs.nc.gov

i. If the a/b fails to cooperate in the process to request a reduction in, or waiver of the SSI/RSDI recoupment, budget the gross SSI/RSDI.

6. Instructions for SSI 1619(B) Applicant/Beneficiary

A few SSI beneficiaries fall into the federal SSI 1619 (b) category. The SSI 1619 (b) beneficiary is not eligible for an SSI payment unless/until his/her countable earnings are less than the FBR amount. The special SSI 1619 (b) status allows for continuance of Medicaid eligibility and for reinstatement of SSI (without further filing of an application for SSI) should his/her countable earned income be less than the FBR.

a. On the SOLQ/SDX of OVS/OLV, the SSI 1619 (b) beneficiary's Federal Eligibility Status will be coded as "N" for months in which the countable earning precludes award of SSI payments.

b. Because SSI does not report current countable earned income for 1619 (b) beneficiaries in SOLQ/SDX of OVS/OLV, you must complete an independent income verification for SA budgeting purposes. It is possible for an SSI 1619 (b) a/b to have income above the SA maintenance, and therefore be found ineligible for SA.

c. Follow base period, the set period of time for which income verification is required, guidelines and income calculation instructions for earned income in this income section of the policy manual.

d. If the IMC verifies that the SSI 1619 (b) beneficiary's verified net countable income, when added to other unearned income, if any, is less than the FBR, follow instructions below and require the a/b to apply for SSI FBR.

Important: Because the SSI payment may be reinstated if the individual's countable income falls below the FBR, always check the SDX at each redetermination, and at each change in situation.

e. If SSI is **reinstated**, cease using county verified earned income, and count only the income SSA counts toward the SSI benefit via OVS/OLV.

   If the a/b **again loses** the SSI payment, but remains 1619 (b), treat this as a change in situation and take steps to verify earned income.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3220 BUDGETING PRINCIPLES

North Carolina Division of Social Services

Special Assistance Program

Revised: January 2025

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3220 BUDGETING PRINCIPLES

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I. INTRODUCTION

A fixed methodology for determining Special Assistance (SA) eligibility and payment amount is applied for each applicant and beneficiary, whether they are eligible for the SA Basic rate or the Enhanced rate for individuals in Special Care Units (SCU) or in-home living arrangements with a diagnosis of Alzheimer's disease or dementia. The methodology assures fair, impartial, and consistent execution of every application and review. A budget will be computed once an a/b meets all eligibility criteria. This may result in a full, partial or open/shut payment. Only consider the income of the applicant/recipient regardless of marital status.

NOTE: SA is always a budget unit of one. Count only the income of the SA applicant/recipient.

II. BUDGETING PROCEDURES FOR SPECIAL ASSISTANCE RECIPIENTS

A. SA Basic Rate

The SA Basic rate is established by the General Assembly and is reviewed annually. The SA rate is the maximum monthly amount that an SA facility may charge an SA recipient.

The current SA Basic rate, effective January 1, 2025, is $1,359. The SA Basic rate is used for beneficiaries requiring basic facility care and for SAIH beneficiaries who are eligible for basic care in a licensed residential care facility but who desire to, and can safely remain in, private living.

A facility may choose to offer a lower rate to SA recipients. Should this occur, the actual rate charged to the recipient, rather than the legislative established SA facility rate, is used in the calculations addressed in this chapter.

IMPORTANT NOTE: Assignment of the correct SA rate in NC FAST requires that the correct *Level of Care Type* is selected in Level of Care evidence on the NC FAST dashboard. (Refer to SA-3100 VII.A.7.)

B. SA Enhanced Rate

The SA Enhanced rate is established by the General Assembly and is reviewed annually. The Enhanced rate is the maximum monthly amount that may be utilized for:

1. SA facility beneficiaries residing in a licensed SA Special Care Unit (SCU) with a diagnosis of Alzheimer's or related dementia disorders,

   and

2. SAIH beneficiaries residing in in-home living arrangements with a diagnosis of Alzheimer's or related dementia disorders.

The current Enhanced rate, effective January 1, 2025, is $1,743. A facility may choose to offer a lower rate to SA recipients. Should this occur, the actual rate charged to the recipient, rather than the legislative established SA Enhanced rate, is used in the calculations addressed in this chapter.

C. Personal Needs Allowance

A $70 personal needs allowance is added to the monthly rate for all SA recipients in SA facilities. These funds (and where applicable the $20 General Income Exclusion) are available to meet the costs of certain expenses not covered by the monthly rate such as personal articles, Medicaid co-payments (Refer to MA-2905, Medicaid Covered Services, for co-payment amounts), clothing, etc. The amount of the monthly personal needs allowance is subject to change by legislative action. The last legislative action established by the General Assembly increasing the monthly personal needs allowance was effective January 1, 2022.

D. Maintenance Amount

1. The maintenance amount is the sum of the SA facility rate and the personal needs allowance.

   Example #1: Facility charges the SA facility Basic rate.

Maximum SA facility Basic Rate	$1,359.00
Personal Needs Allowance	+ 70.00
Maintenance Amount	$1,429.00

   Example #2: Facility charges the SA Enhanced rate (for SCU care).

Maximum SA Enhanced Rate	$1,743.00
Personal Needs Allowance	+ 70.00
Maintenance Amount	$1,813.00

Example #3: Facility charges a rate less than the SA Basic rate.

Rate charged by home	$ 995.00
Personal Needs Allowance	+ 70.00
Maintenance Amount	$ 1,065.00

2. The maintenance amount for ambulation capacity code "M" recipients can vary, depending on the total amount of verified Medical Care Special (MCS) costs per recipient. The variable maintenance amount for "M" recipients should always equal the total of the TCMI + the SA payment. See the DSS-8190 Attachment A for complete budgeting instructions.

Note: Only SAB cases that were active with Services for the Blind prior to September 1, 2010, and transferred to the SA Program in September 2010, can have MCS.

Example #1: Facility charges the established SA facility Basic rate

Maximum SA facility Basic Rate	$1,359.00
Personal Needs Allowance	70.00
Medical Care Special Costs	+ 125.00
Variable Maintenance Amount	$1,554.00

Example #2: Facility charges the SA Enhanced rate (for SCU care)

Maximum SA facility SCU rate	$1,743.00
Personal Needs Allowance	70.00
Medical Care Special Costs	+ 125.00
Variable Maintenance Amount	$1,938.00

Example #3: Facility charges a rate less than the SA facility rate

Rate charged by home	$ 995.00
Personal Needs Allowance	70.00
Medical Care Special Costs	+ 125.00
Maintenance Amount	$1,190.00

E. Income Limits

1. Compute Total Countable Monthly Income (TCMI) after all deductions according to instructions in SA-3210, Income.

2. The $20 general income exclusion, when applicable, is applied when calculating the TCMI. Do not apply this exclusion again when calculating the SA payment.

3. For the SA Basic rate, if the a/b's TCMI is $1,428.51 or more, the a/b is not eligible for Special Assistance.

4. For the SA Enhanced rate, if the a/b's TCMI is $1812.51 or more, the a/b is not eligible for Special Assistance.

III. CALCULATING FULL MONTHLY SPECIAL ASSISTANCE PAYMENTS

A. Determine the monthly SA payment

1. Determine the Maintenance Amount. See II.D.

2. Determine the TCMI.

3. The monthly SA payment amount is determined by deducting the TCMI from the Maintenance Amount.

4. When determining the SA payment amount, always round to the nearest dollar: reduce values $0.01 through $0.49 to the next lower whole dollar amount. Raise values $0.50 through $0.99 to the next higher whole dollar amount.

B. Full Monthly SA Payment Examples

Example #1: Facility charges the SA facility Basic rate.

Maximum SA facility Basic Rate	$ 1,359.00
Personal Needs Allowance	+ 70.00
Maintenance Amount	$ 1,429.00
Total Countable Monthly Income (after applicable deductions and exclusions including $20 general income exclusion)	- 984.47
Difference (Round to the nearest dollar.)	$ 411.53
SA Payment	**$ 412.00**

Example #2: **"M" Recipient -** Facility charges the SA facility Basic rate.

Maximum SA facility Basic Rate	$ 1,359.00
Personal Needs Allowance	70.00
Medical Care Special Costs	+ 125.00
Variable Maintenance Amount	$ 1,554.00
Total Countable Monthly Income (after applicable deductions and exclusions including $20 general income exclusion)	- 984.47
Difference (Round to the nearest dollar.)	$ 569.53
SA Payment	**$ 570.00**

Note: Only SAB cases that were active with Services for the Blind prior to September 1, 2010, and transferred to the SA Program in September 2010, can have MCS.

Example #3: **"M" Recipient -** Facility charges the SA Enhanced rate (for SCU care)

Maximum SA Enhanced Rate (for SCU care)	$ 1,743.00
Personal Needs Allowance	70.00
Medical Care Special Costs	+ 125.00
Variable Maintenance Amount	$ 1,938.00
Total Countable Monthly Income (after applicable deductions and exclusions including $20 general income exclusion)	- 1044.47
Difference (Round to the nearest dollar.)	$ 893.53
SA Payment	**$ 894.00**

Note: Only SAB cases that were active with Services for the Blind prior to September 1, 2010, and transferred to the SA Program in September 2010, can have MCS.

Example #4: Facility charges less than the SA facility Basic rate

Rate charged by home	$ 995.00
Personal Needs Allowance	+ 70.00
Maintenance Amount	$1065.00
Total Countable Monthly Income (after applicable deductions and exclusions including $20 general income exclusion)	- 944.47
Difference (Round to the nearest dollar.)	$ 120.53
SA payment	**$ 121.00**

Example #5: **"M" Recipient -** Facility charges less than the SA facility Basic rate.

Rate charged by home	$ 995.00
Personal Needs Allowance	70.00
Medical Care Special Costs	+ 125.00
Variable Maintenance Amount	$1190.00
Total Countable Monthly Income (after applicable deductions and exclusions including $20 general income exclusion)	- 944.47
Difference (Round to the nearest dollar.)	$ 245.53
SA payment	**$ 246.00**

C. Ineligible for SA Due to Income

If an individual's SA payment when rounded to the nearest lower whole dollar is $0.00, the individual is not eligible for Special Assistance.

IV. PARTIAL MONTH PAYMENTS

A. **Request a partial month payment** for the first month when an applicant enters an adult care home after the first day of the month, meets all elements of eligibility, and remains in the facility for the remainder of the month.

Request a partial month payment if the applicant is in an SA private pay room and is not financially eligible for SA Basic pay solely due to income, but moves to an SCU after the first of the month, and becomes eligible for SA SCU, due to the higher Enhanced rate for SCU care and SA income limit. Also request a partial month payment if the applicant is in the facility on the first day of the month but is not eligible for payment until a later date in the month due to state residence or FL-2 requirements.

1. The applicant's income for the month of entry is not counted if he/she enters the facility or meets all eligibility criteria after the first day of the month.

   a. Determine number of days in the month of entry (28, 29, 30, and 31).

   b. Determine date of entry (using day 2 through day 31.)

c. Determine number of days for which payment is needed by subtracting date of entry from number of days in the month of entry and adding 1.

d. Determine monthly SA rate.

e. Divide the monthly SA rate by the number of days in the month of entry to determine per diem rate (Round to the nearest hundredth).

f. Multiply cost of care per diem times the number of days of care in the month to compute the cost of care.

g. Add personal needs allowance ($70.00) to the adult care home rate

h. Round amount to the nearest dollar for partial month payment.

B. Partial Payment for SA/ACH Basic Rate

Example: Mr. Smith enters the SA facility on October 5. Since he entered after the first day of the month, he is entitled to a partial month payment. His October income is not counted in determining his partial payment amount. The SA facility Basic rate is $1,359 a month. The personal needs allowance is $70 a month. The example is calculated below.

ACH charges the SA Basic rate:

Number of days in month of entry: 28, 29, 30, 31	31
Subtract Date of entry from number of days in the month	- 5
Result plus one = Number of eligible SA days	= 26 + 1 = 27
SA facility Basic Rate	$1,359.00
Divide by number of days in month	÷ 31
Result equals the Per Diem Rate (Round to nearest hundredth)	= 43.838, or 43.84
Multiply by number of eligible days	x 27
Result is total room and board for eligible days	=$1,183.68
Add the Personal needs allowance	+ 70.00
Total SA Partial Payment (Round to nearest dollar.)	= 1,253.68
Partial SA Payment	**$ 1,254.00**

C. Partial Payment for SA Enhanced Rate

Example: Mr. Bailey entered the SA facility on October 5 in SCU care. Since he entered after the first day of the month, he is entitled to a partial month payment. His October income is not counted in determining his partial payment amount. The SA Enhanced rate for his SCU care is $1,743 a month. The personal needs allowance is $70 a month. Example is calculated below:

Number of days in month of entry: 28, 29, 30, 31	31
Date of entry - Enter the **DAY** of entry (from 2 through 31)	- 5
Result plus one = Number of eligible SA days	= 26 + 1 = 27
SA facility SCU Rate	$1,743.00
Divide by number of days in month	÷ 31
Result equals Per Diem Rate (Round to nearest hundredth)	= 56.225 = 56.23
Multiply by number of SA eligible days	x 27
Result is total room and board for eligible days	=$1,518.21
Add the Personal needs allowance	+ 70.00
Total SA payment (Round to nearest dollar.)	= 1,588.21
Partial Payment	**$ 1,588.00**

D. Partial Payment When an SA facility Private Pay A/B in Basic Care Becomes Financially Eligible for SA Due to Moving to a Licensed SCU After the First Day of the Month

Example: Mr. Bailey entered the SA facility on October 1. He was placed in a section of the SA facility that was for those needing SA facility Basic care. His current FL-2 showed a diagnosis of Dementia. He applied for SA facility Basic assistance. However, due to his income he was ineligible for the SA facility Basic rate.

On October 5 he moved to the SCU of the facility. His countable income was then within the SA Enhanced limit. Since he became eligible for SA after the first day of the month, he is entitled to a partial month payment. His October income is not counted in determining his partial payment amount. The SA Enhanced rate for his SCU care is $1,743 a month. The personal needs allowance is $70 a month.

The example is calculated below:

Number of days in month of entry: 28, 29, 30, 31	31
Date of entry - Enter the **DAY** of entry (from 2 through 31)	- 5
Result plus one = Number of eligible SA days	= 26 + 1 = 27
SA facility SCU Rate	$1,743.00

Divide by number of days in month	÷ 31
Result equals Per Diem Rate (Round to nearest hundredth)	= 56.225= 56.23
Multiply by number of SA eligible days	x 27
Result is total room and board for eligible days	=$1,518.21
Add the Personal needs allowance	+ 70.00
Total SA payment (Round to nearest dollar.)	= 1,588.21
Partial Payment	**$ 1,588.00**

V. SUPPLEMENTAL PAYMENTS - MOVING FROM SA BASIC FACILITY TO SA SCU FACILITY

1. Calculate a partial month supplement when the recipient has been issued a full month payment at the SA facility Basic rate then moves to SA facility SCU after the first day of the month.

2. Request a partial month supplement for the first month when recipient moves into an SCU after the first day of the month and remains in the SCU for the remainder of the month.

Verify all SA facility SCU eligibility factors are in place. Verify date of move from an SA facility Basic to an SA facility SCU.

a. Determine number of days in the month of entry (28; 29; 30; 31).

b. Determine date of entry into an SA facility SCU (using day 2 through day 31).

c. Determine number of days for which an SA facility SCU supplement payment is needed by subtracting date of entry into an SA facility SCU from number of days in the month of entry and adding 1.

d. Establish the difference in the SA/ACH Basic rate and the SA Enhanced rate for the SCU care by subtracting the SA Basic rate from the SA Enhanced rate.

e. Divide the difference in the monthly rates by the number of days in the month of entry to determine the additional daily (per diem) rate.

f. Multiply the additional per diem rate by # of SA facility SCU eligible days.

g. Round result to nearest dollar for partial month SA facility SCU supplemental payment.

Example: Mr. Smith resides in the SA facility in October. The IMC verifies he moved to the SA facility's SCU on October 5th, and met all SCU eligibility requirements. Since he entered the SCU after the first day of the month, he is entitled to a partial month supplement.

His SA facility Basic rate is $1,359 a month. The personal needs allowance is $70 a month.

The example below shows how to determine his new monthly SCU payment:

Number of days in month of entry into SCU: 28, 29, 30, 31	31
Date of move - Enter the DAY of move (day 2 through 31)	- 5
Number of days for which additional SA facility SCU payment is needed (A. - B.) + 1 (to account for the day of move into SCU)	26 +1 27

SA Enhanced Rate per Month (for the SCU care): $1,743

SA Basic Rate per Month: $1,359

Calculate payment supplement:

Calculate rate difference per month SA facility Enhanced rate (for SCU care) =	 $1,743
SA facility Basic rate =	- $1,359
Difference in the two rates =	$ 384
Divide result by number of days in month / 31 days = Daily rate (per diem) Round results	12.387 12.39
Daily rate (per diem) Multiplied by number of SCU days	12.39 x 27 days
Results Round to nearest dollar amount	$334.53 $335
Supplemental SA facility **SCU Payment**	**$335.00**

VI. OPEN/SHUT PAYMENTS

A. An open/shut payment can occur only when the applicant resides in an SA facility for some portion of the application processing period, but is discharged prior to disposition of application. To determine open/shut payment(s), apply the appropriate budgeting procedures below.

1. The applicant is admitted after the first day of the month and discharged prior to the end of the month:

   NOTE: The applicant's income for the month of entry is not counted if he/she enters the facility after the first day of the month.

   a. Determine date of discharge.

   b. Determine date of entry (using day 2 through day 31).
   c. Determine number of days for which payment is needed by subtracting date of entry from the date of discharge and adding 1.

   d. Determine SA payment.

   e. Determine number of days in the month of entry (28, 29, 30, 31).

   f. Divide monthly SA payment by the number of days in the month of entry to determine cost of care per diem (Round to nearest hundredth).

   g. Multiply cost of care per diem times the actual number of days of care in the month to compute the cost of care.

   h. Add personal needs allowance ($70) to the cost of care.

   i. Round amount to nearest dollar for open/shut payment amount.

2. Basic Rate Open/Shut Example

   Mr. Smith was admitted to the SA facility on January 8. He applied for SA on January 9. Mr. Smith decided he didn't like the food and left the facility on January 14. He was discharged the same day. Mr. Smith's application was still pending when he moved out of the SA facility. The application was completed, and it was determined that he met all eligibility criteria.

Mr. Smith is eligible for an open/shut payment for January 8 through January 14. The SA facility Basic Rate is $1,359 and personal needs allowance is $70 a month.

Date of Discharge	14
Date of Entry	- 8
Number of days for which payment is needed	6 + 1= 7
SA facility Basic Rate	$1,359.00
Number of days in month	÷ 31
Per Diem Rate	= 43.838= 43.84
Actual number of days of care	x 7
Cost of Care (7 days)	$ 306.88
Personal Needs Allowance	+ 70.00
SA Open/Shut Payment	$ 376.88
SA Open/Shut Payment (Rounded)	**$ 377.00**

3. SA Enhanced Rate for SCU care - Open/Shut Example

Mr. Bailey is admitted to the SA facility SCU for Alzheimer's/dementia on January 8. He applied for SA on January 9. Mr. Bailey's daughter, also the POA, decided to take him to live out of state on January 14. He was discharged the same day. Mr. Bailey's application was still pending when he moved out of the SA facility. The application was completed, and it was determined that he met all eligibility criteria.

Mr. Bailey is eligible for an open/shut payment for January 8 through January 14. The SA Enhanced Rate is $1,743. The personal needs allowance is $70 a month.

Date of Discharge	14
Date of Entry	- 8
Number of days for which payment is needed	6 + 1= 7
SA Enhanced Rate (for SCU care)	$1,743.00
Number of days in month	÷31
Per Diem Rate	= 56.225 = 56.23
Actual number of days of care	x 7
Cost of Care (7 days)	$ 393.61
Personal Needs Allowance	+ 70.00
SCU Open/Shut Payment (Round to the nearest dollar)	$ 463.61
SCU Open/Shut Payment	**$ 464.00**

4. The applicant is admitted or residing in the SA facility on the first day of the month and is discharged prior to end of the month:

   a. Determine SA rate.

   b. Subtract total countable monthly income from maximum SA rate.

   c. Divide SA portion of cost of care by number of days in month (28, 29, 30, 31).

   d. Multiple SA portion of cost of care per diem by date of discharge.

   e. Add personal needs allowance ($70.00) to SA portion of cost of care.

   f. Round to nearest dollar for open/shut payment.

Example 1: Ms. Ray is admitted to the SA facility on July 1. She applied for SA on July 3. Her total countable monthly income is $990.00. Ms. Ray died on July 13th and was officially discharged the same day. Ms. Ray's application was still pending at her death. The application was completed and it was determined that she met all eligibility criteria.

Ms. Ray is eligible for an open/shut payment for July 1 through July 13. The SA Basic rate is $1,359 and personal needs allowance is $70 a month. The budget for this example is calculated below:

SA Basic Rate	$1,359.00
Total Countable monthly income	- 990.00
SA Portion of Cost of Care (Personal Needs not included)	$ 369.00
Number of days in the month	÷ 31
SA Portion of Cost of Care Per Diem Amount	$ 11.903 = $11.90
Date of Discharge	x 13
SA Portion of Cost of Care (13 days)	$ 154.70
Personal Needs Allowance	+ 70.00
SA Open/Shut Payment (Round to the nearest dollar)	$ 224.70
SA Open/Shut Payment	**$ 225.00**

Example 2: Mr. Bailey is admitted to the SA facility SCU for Alzheimer's/dementia on July 1. He applied for SA on July 3. His net countable income is $998.00. Mr. Bailey died on July 13 and was officially discharged the same day. Mr. Bailey's application was still pending at his death. The application was completed and it was determined that he met all eligibility criteria.

Mr. Bailey is eligible for an open/shut payment for July 1 through July 13. The SA Enhanced rate for Mr. Bailey's SCU care is $1,743 and personal needs allowance is $70 a month. The budget for this example is calculated below.

SA facility SCU Rate	$1,743.00
Total Countable monthly income	- 998.00
SA Portion of Cost of Care (Personal Needs not included)	$ 745.00
Number of days in the month	÷ 31
SA Portion of Cost of Care Per Diem Amount	$ 24.032 or $24.03
Date of Discharge	x 13
SA Portion of Cost of Care (13 days)	$ 312.39
Personal Needs Allowance	+ 70.00
SCU Open/Shut Payment (round to the nearest dollar)	$ 382.39
SCU Open/Shut Payment	**$ 382.00**

B. Example of a Combination of Partial, Full and Open/Shut Payments:

NOTE: Although the example given is for the SA Basic rate, the same budgeting principles apply to the SA Enhanced rate for SCU care.

a. Partial Payment: The applicant enters the facility after the first day of the month and remains the rest of the month. Applies for SA.

b. Full Payment: The applicant still resides in the facility for the full following month.

c. Open /Shut Payment: The applicant is in SA facility on the first day of the third month and discharged prior to end of the month while the application is still pending.

Example: Ms. Jackson is admitted to the SA facility on September 10. She applied for SA on September 29th. Ms. Jackson had a stroke and was admitted to a nursing facility on November 3rd. Ms. Jackson's SA application was still pending upon her transfer to a higher level of care. The application was completed and it was determined that she met all eligibility criteria.

Ms. Jackson's application was processed as an open/shut case. Ms. Jackson is eligible for a partial payment from September 10 through September 30, a full month payment for October, and an open/shut payment for November 1 through November 3. The SA Basic rate is $1,359 and the personal needs allowance is $70 a month. The budgeting for this example is calculated below.

Step 1. September (Partial Payment Month)

Number of days in month of entry: 28, 29, 30, 31	30
Date of entry - Enter the **DAY** of entry (from 2 through 31)	- 10
Number of eligible days	= 20 + 1 = 21
Monthly SA facility Basic Rate	$1,359.00
Divided by Number of days in month	÷ 30
Per Diem Rate (Round to the nearest hundredth)	= $45.30
Multiplied by number of eligible days	x 21
SA facility Basic rate	= 951.30
Add personal needs allowance	+ 70.00
Total needs (Round to nearest dollar.)	= 1,021.30
Partial Payment	**$ 1,021.00**

Step 2. October (Full payment month)

SA facility Basic Rate	$ 1,359.00
Personal Needs Allowance	+ 70.00
Maintenance Amount	$ 1,429.00
Applicant's Gross Countable Monthly Income	$ 990.00
General Income Exclusion	- 20.00
Total Countable Monthly Income	$ 970.00
Maintenance Amount	$ 1,429.00
Total Countable Monthly Income	- 970.00
Difference	$ 459.00
SA Payment (Rounded)	**$ 459.00**

Step 3. November (Open/Shut Payment)

SA facility Basic Rate	$1,359.00
Total Countable monthly income	- 990.00
SA Portion of room and board (Personal Needs not included)	$369.00
Number of days in the month	÷ 30
SA Portion of room and board Per Diem Amount	$ 12.30
Date of Discharge	x 3
SA Portion of room and board (3 days)	$ 36.90
Personal Needs Allowance	+ 70.00
SA Open/Shut Payment	$ 106.90
SA Open/Shut Payment (Rounded)	**$ 107.00**

VII. BUDGET DOCUMENTATION REQUIREMENTS

Record budget information on the DSS-8190 SSI/Non-SSI Application Workbook, or other county approved budget form.

VIII. SPECIAL ASSISTANCE RATES AND FBR CHART

RATE & FBR REFERENCE		
2025	**2024**	**2023**
Basic Rate	**Basic Rate**	**Basic Rate**
$1,359	$1,326	$1,285
Basic Maintenance Rate	**Basic Maintenance Rate**	**Basic Maintenance Rate**
$1,429	$1,396	$1,355
Enhanced Rate	**Enhanced Rate**	**Enhanced Rate**
$1,743	$1,700	$1,647
Enhanced Maintenance Rate	**Enhanced Maintenance Rate**	**Enhanced Maintenance Rate**
$1,813	$1,770	$1,717
FBR	**FBR**	**FBR**
$967	$943	$914

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3240 CITIZENSHIP AND IDENTITY

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3240 CITIZENSHIP AND IDENTITY

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I. INTRODUCTION

The purpose of this section is to provide instructions for determining U.S. citizenship, identity and immigration status of the Special Assistance applicant/recipient.

The Federal Deficit Reduction Act of 2005 (P.L. 109-171) mandated requirements that affect all Special Assistance applicants and recipients claiming to be citizens of the United States, effective September 1, 2006.

To be eligible for Special Assistance, an individual must be an identifiable U.S. citizen or an alien admitted to the United States by U.S. Citizenship and Immigration Services (USCIS) under a specific immigration status.

Regardless of immigration status, each a/b must meet all eligibility requirements for Special Assistance.

A. Exceptions to Requirements to Provide Documentation of Citizenship and Identity, and Immigration status

Do not determine citizenship, identity or immigration status for SA applicants who currently receive or formerly received Supplemental Security Income (SSI), Social Security Disability (SSDI), or Medicare, and are current or former Lawful Permanent Resident (LPR) applicants/recipients. Citizenship, identity or immigration status is verified prior to receipt of SSI, SSDI, and Medicare.

B. Responsibility to Provide Documentation of Citizenship, Identity and Immigration Status

It is the applicant's responsibility to provide verification of citizenship and/or immigration status; however, the caseworker must offer assistance to the applicant in obtaining the required verification.

1. The county dss must assist the applicant in acquiring the documents if:

    a. The applicant cannot obtain the necessary documents, or

    b. The applicant requests assistance obtaining the necessary documents, or

    c. The applicant demonstrates a need for assistance or if the applicant has special needs such as a mental or physical incapacity and lacks someone who can act on his behalf.

II. U.S. CITIZENSHIP

U.S. citizens are entitled to receive Special Assistance benefits provided all other eligibility requirements are met. All applicants and recipients claiming U.S. Citizenship, excluding current or former SSI, SSDI, or Medicare recipients, and documented LPR's, must provide or cooperate in obtaining proof of citizenship and identity. Below is a list of who is a U.S. citizen but it is not an all-inclusive list.

A. A U.S. Citizen is:

1. Any person born in one of the 50 states, the District of Columbia, Puerto Rico, Guam, Virgin Islands, Northern Mariana Islands, American Samoa, Swain's Island, or

2. Any person born outside the U.S. to a U.S. citizen, or

3. A person born outside the U.S. who has been approved by USCIS as a naturalized citizen, or

4. A person born outside of the U.S. who was under the age of 18 on February 27, 2001, and who meets all of the following criteria:

   a. Had at least one U.S. citizen parent (by birth or naturalization) at time of birth, and

   b. While under the age of 18 he resided permanently in the U.S. in the legal and physical custody of the U.S. citizen parent, and

   c. Was a lawful permanent resident before age 18.

B. Procedures to Document Citizenship and Identity

1. Applications

   a. Beginning September 1, 2006, each applicant or recipient claiming U.S. citizenship must provide acceptable proof of both citizenship and identity. To document citizenship and/or identity follow these procedures.

   b. Review the case record and all county records, including other program records such as Food Stamps, for citizenship and/or identity evidence the agency may have on file.

   c. If evidence is located, make a copy of the evidence documentation for the Special Assistance file and clearly document:

(1) Where the evidence was located,

(2) The date the documentation was provided to the county, and

(3) What hierarchy code it falls in (see II.C).

If the date of receipt by the county is unknown, note the date the worker located the document.

d. If the applicant cannot obtain the necessary documents, requests or demonstrates a need for assistance due to a mental or physical incapacity and lacks someone who can act on his behalf, the county must assist the applicant/recipient in acquiring the documents. See SA-3110, Application Process.

e. If documentation is provided within 45/60 days, process the application. See SA-3110, Application Process.

f. Pend the application up to 6 months with a “CID” entry on the DSS-8125 when:

(1) The applicant is making a good faith effort to provide the documentation, or

(2) The county has not received citizenship/identity verification requested from a third party.

Reference SA-3110, Application Process, for other reasons to pend the application.

If additional items in SA-3110, Application Process, are also needed prior to processing the application, pend the application with the item most likely to take the most time to obtain. Process the application when all information is received.

g. Unless pending for an SSA/SSI decision, deny the application after pending 6 months if:

1. Information needed to obtain the source for documentation is not received, or

2. The documentation request is returned as unable to confirm, and

3. All other efforts to obtain the documentation fail.

h. Applications pending for SSA/SSI decision may pend up to 12 months.

2. Redeterminations

   Beginning September 1, 2006, at redetermination review all agency records to determine if at least the citizenship and identity has been documented. If documentation is needed, make two requests of the recipient for the needed information. Follow procedures in SA-3320, Redetermination of Eligibility. Use the DHB-5097, Request for Information. Ensure that requests are made at least 12 days apart.

   a. If the recipient states he does not have documentation and is making a good faith effort to obtain the needed documents or the county DSS is responsible for assisting, document the record, complete the re-determination, and use Special Review Code "Z" on the DSS-8125 to follow up on the status of obtaining the documents.

   b. Use the third month of the new certification period for the date on the DSS-8125. Begin to follow up on all documentation needs when the Special Review Code first appears on the Case Management Report. Contact the recipient to determine if the recipient has obtained the documents or needs assistance in obtaining them.

      Note: Once documentation has been obtained it will not need to be provided again, unless it is subsequently discovered that the documentation is questionable.

   c. If it is documented that the recipient is not a U.S. Citizen or a qualified alien send a DSS-8110, Timely Notice to terminate assistance. Follow procedures in SA-3330.

3. Citizenship – Sources of Documentation

   a. Use OLV to access SDX and SOLQ to locate documentation of citizenship and identity for former or current SSI, SSDI, and Medicare recipients, and current or former Lawful Permanent Resident (LPR) applicants/recipients. Use SDX for former or current SSI recipients and SOLQ for former or current Medicare recipients. Refer to SA-3240 III. B. 1., Non-Citizens, for instructions on obtaining documentation of LPR status.

   b. If possible in your county, establish citizenship through electronic data matching with the local register of deeds. Screen print the data. The county may also go to the register of deeds and locate the birth record. Document the birth record observed and the

location at the register of deeds. Place documentation in the Permanent Verification sub-folder, labeled Citizenship/Identity file. See II.B.6.

Certified copies of North Carolina birth records/certificates require an authorization from the applicant/recipient or legal guardian for the county to make a request for a birth certificate. When the a/b requests or needs assistance in obtaining citizenship documentation, use SA-3240 Figure 2, U.S. Citizenship Documentation Birth Certificate Request, to send to the county register of deeds or State Vital Records a request for a birth certificate. Only the a/b or legal guardian can authorize this request. A copy of the legal guardianship papers must accompany the request.

Instructions on obtaining a North Carolina certified birth record/certificate are also on the North Carolina Vital Records web site at http://vitalrecords.nc.gov. Links to other state's Vital Records web sites are at http://www.cdc.gov/nchs/howto/w2w/w2welcom.htm.

c. Documents must be either originals or copies of documents certified by the issuing agency. Do not accept notarized copies.

To establish U.S. citizenship the document must show:

(1) A U.S. place of birth, or

(2) That the person is a U.S. citizen.

Note: Children born in the U.S. to foreign sovereigns or diplomatic officers are not U.S. citizens. However, children born to U.S. citizens in a foreign country have U.S. citizenship as well as citizenship in the foreign country. The parents or child chooses his citizenship.

4. Identity – Sources of Documentation

a. Conduct an SOLQ social security number inquiry for each applicant or recipient at redetermination. The a/b's SSN must match the information on the SOLQ. If the inquiry returns a validated social security number match, print the screen and follow procedures in II. B.6. below. If the social security number does not validate, pursue another form of identity.

b. To establish identity a document must show evidence that provides identifying information relating to the person named on the document.

5. Exceptions to Providing Proof at Application/Redetermination

a. Citizenship and identity documentation are not required at an SSI ex parte review. Use hierarchy code 99 at the ex parte review and obtain the documentation at the next scheduled redetermination.

b. A current or former SSI recipient and a current or former SSDI, and/or Medicare recipient had citizenship/identity established. Use OLV to access the SDX to prove current or former SSI status. Use OLV to access SOLQ to prove current or former SSDI and/or Medicare status. Print the screen with the evidentiary information and put in the Citizenship/Identity Documentation sub-folder in the recipient's Permanent Verification folder. Use hierarchy code 50.

c. Use SAVE, Systematic Alien Verification for Entitlement Program, to verify the authenticity of the LPR Document. Print the screen with the evidentiary information and put in the Citizenship/Identity Documentation sub-folder in the recipient's Permanent Verification folder. Use hierarchy code 50.

6. Documentation of Citizenship/Identity

a. Place copies of the original documents, certified copies, or data match screen prints used to document citizenship and identity in a sub-folder or file in the a/b's permanent record labeled "Citizenship/Identity Documentation".

Document in the permanent record:

(1) The type of document used,

(2) How it was obtained (e.g. applicant, located in food stamp program files, etc.),

(3) The date it was provided, and

(4) Any other information the worker feels pertinent.

If a screen print is used, document the source of the evidence. Once citizenship and identity documentation is obtained, do not request documentation again unless you learn the previous document is questionable.

b. Document the hierarchy code in EIS where the provided documents are listed. (See EIS 4000, Codes Appendix) Use the following Citizenship/Identity (C/I) codes:

(1) 10 is a document from Chart 1 (no identity needed).

(2) 25 is a document from Chart 2 & a document from Chart 5.

(3) 35 is a document from Chart 3 & a document from Chart 5.

(4) 45 is a document from Chart 4 & a document from Chart 5.

(5) 50 is a document showing permanently exempt, SSI, SSDI, and/or Medicare, or Lawful Permanent Resident status.

(6) 99 is used for ex parte situations where the individual is not required to provide verification until the next redetermination.

C. Hierarchy of acceptable evidence of U.S. citizenship and/or identity

The following charts list acceptable evidence of U.S. citizenship and/or identity in a hierarchy of reliability. Obtain documents from the highest tier of hierarchy available. Pursue documents from Chart 1 first. If the a/b presents documents from the highest tier, Chart 1, Primary Documents, no other information is required.

If the a/b does not have documents from Chart 1, then pursue documents from Chart 2 and so forth until the highest verification documentation is obtained. If the a/b presents documents from Charts 2-4, then an identity document from Chart Five, Documents to Establish Identity, must also be presented.

If the county is waiting to receive documentation from a higher level but can easily obtain documentation from a lower level, pursue the lower level documentation so the application will not pend. Continue to pursue the higher level of documentation. For example, a birth certificate is requested from Vital Records and the a/b has a hospital record indicating citizenship per Chart 3. Change the C/I code level when the higher documentation (Birth Certificate) is received.

1. Primary Documents
   Primary documents are of the highest reliability and conclusively establish both citizenship and identity of the a/b.
   A/B’s born outside the U.S. who were not citizens at birth must submit a document listed under primary evidence of U.S. citizenship.

Chart 1 (EIS Code 10)

U.S. Passport	Does not have to be currently valid. Do not accept as evidence of U.S. citizenship when it was issued with a limitation. However, such a passport may be used as proof of identity.
Certificate of Naturalization (N-550 or N-570)	
Certificate of Citizenship (N-560 or N-561)	

2. Secondary Documents to Establish U.S. Citizenship

Accept any of the documents listed in Chart 2 as secondary evidence of U.S. citizenship if the document meets the listed criteria and nothing indicates the person is not a U.S. citizen (e.g., lost U.S. citizenship). Require an additional document from Chart 5 to prove identity.

Chart 2 (EIS Code 25)

A U.S. public birth record showing birth in: • One of the 50 U.S. States; • District of Columbia;	A data match with the local register of deeds or State Vital Records or a copy of a certified birth certificate is acceptable.
• American Samoa • Swain's Island • *Puerto Rico (if born on or after January 13, 1941); • *Virgin Islands of the U.S. (on or after January 17, 1917; • *Northern Mariana Islands (after November 4, 1986; or • Guam (on or after April 10, 1899)	The birth record document may be issued by the State, Commonwealth, territory or local jurisdiction. It must have been issued before the person was 5 years of age. A birth record document that is amended after 5 years of age is considered fourth level evidence of citizenship. Refer to Chart 4. Note: if the document shows the individual was born in Puerto Rico, the Virgin Islands of the U.S., the individual may be a collectively naturalized citizen: *See Figure 3 for additional requirements for Collective Naturalization.

Data Match with other state agency's database that is known to verify citizenship.	Agencies and programs such as child support, child protective services. Screen print the pertinent page and place in the file.
Certification of Report of Birth (DS-1350)	
Consular Report of Birth Abroad of a Citizen of the United States of America (FS-240)	
Certification of Birth Abroad (FS-545)	
United States Citizen Identification Card (I-197 or I-179)	
American Indian Card (I-872)	
Northern Mariana Card (I-873)	
Final adoption decree	Must show the child's name and U.S. place of birth.
Evidence of civil service employment by the U.S. government	Must show employment by the U.S. government before June 1, 1976.
Official Military record of service	Must show a U.S. place of birth.

3. Third Level Documents to Establish U.S. Citizenship

When primary or secondary evidence cannot be obtained within the 45/60 day processing time period and the a/b reports being born in the U.S., use the third level of evidence. Also use third level evidence when documents from level one or two are unavailable or do not exist. The place of birth on the non-government document and the application must agree. Require an additional document from Chart 5 to prove identity.

Extract of hospital record on hospital letterhead established at the time of the person's birth and was created at least 5 years before the initial	Do not accept a souvenir "birth certificate" issued by the hospital (also known as a "Mother's Copy").

Chart 3 (EIS Code 35)

application date and indicates a U.S. place of birth.	
Life or health or other insurance record showing a U.S. place of birth and was created at least 5 years before the initial application date.	Life or health insurance records may show biographical information for the person including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth.

4. Fourth Level Documents to Establish U.S. Citizenship

   Use fourth level evidence in the rarest of circumstances. When primary, secondary or third level evidence cannot be obtained within the 45/60 day processing time period and the a/b reports being born in the U.S., use the fourth level of evidence. Also use fourth level evidence when documents from levels one, two or three are unavailable or do not exist. The place of birth on the non-government document and the application must agree. Require an additional document from Chart 5 to prove identity.

Chart 4 (EIS Code 45)

Federal or State census record showing U.S. citizenship or a U.S. place of birth (Generally for persons born 1900 through 1950)	The census record must also show the applicant's age. Note: Census records from 1900-1950 contain certain citizenship information. To secure this information, the a/b or DSS should complete and submit Form BC- 600, Application for Search of Census Records for Proof of Age. Add in the remarks portion "U.S. citizenship data requested." Also add that the purpose is for Special Assistance eligibility. This form requires a processing fee.
One of the following documents that show a U.S. place of birth and was created at least 5 years before the application for Special Assistance. This document must be one of the following and show a U.S. place of birth:	• Seneca Indian tribal census. • Bureau of Indian Affairs tribal census records of the Navajo Indians. • U.S. State Vital Statistics official notification of birth registration. • An amended U.S. public birth record that is amended more than 5 years after the person's birth. • Statement signed by the physician or midwife who was in attendance at the time of birth.

Institutional admission papers from a nursing facility, skilled care facility or other institution (does not include adult care homes).	Admission papers generally show biographical information for the person, including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth.
Medical (clinic, doctor, or hospital) record created at least 5 years before the initial application date that indicates a U.S. place of birth.	Medical records generally show biographical information for the person including place of birth. The record can be used to establish U.S. citizenship when it shows a U.S. place of birth. Note: An immunization record is not considered a medical record for purposes of establishing U.S. citizenship.
Written Affidavit	Use only when the DSS is unable to secure evidence of citizenship listed in any other Chart. There must be at least two affidavits by two individuals who have personal knowledge of the event(s) establishing the a/b's claim of citizenship. At least one of the individuals making the affidavit cannot be related to the a/b. Neither of the two individuals can be the a/b. The person(s) making the affidavit must be able to provide proof of his/her own citizenship and identity for the affidavit. If the affiant has information which explains why documentary evidence establishing the a/b's claim of citizenship does not exist or cannot be readily obtained, the affidavit should contain this information as well. A separate affidavit from the a/b or other knowledgeable individual (guardian or representative) explaining why the evidence does not exist or cannot be obtained must also be provided. The affidavits must be signed under penalty of perjury by the person making the affidavit.

5. Evidence of Identity

   When a document from charts 2-4 is presented, a document from chart 5 is also required.

Chart 5 (EIS Code 25, 35, 45)

SOLQ Social Security number inquiry	Must have a "Social Security number verified" statement returned from the inquiry. Screen print the pertinent evidence for the file.
Data Match with other state agency's data systems	The data match must indicate that an identity has been verified. Examples of such agencies or programs include food stamps, child support, child protective services, motor vehicle, corrections, juvenile detention. Screen print the pertinent evidence for the file.
School identification card	Must have a photograph of the individual.
U.S. military identification card or draft record	Does not have to be current.
Identification card issued by the Federal, State, or local government with the same information included on driver's license.	Does not have to be current.
Military dependent's identification card	Does not have to be current.
Certificate of Degree of Indian Blood, or other U.S. American Indian/Alaska Native tribal document	Must have a photograph of the a/b or have other personal identifying information relating to the individual.
Native American Tribal document	
U.S. Coast Guard Merchant Mariner card	

D. Procedures When No Documentation or Information is Provided

1. Individuals who meet the criteria in II.A.4. are not automatically issued proof of citizenship by USCIS. The parent may apply for a certificate of citizenship for his child with the USCIS and/or for a passport for his child with the Department of State.

2. If an applicant is a naturalized citizen and cannot provide documentation of citizenship, refer the applicant to U.S. Citizenship and Immigration Services (USCIS) at:

Charlotte Sub Office
6130 Tyvola Centre Drive
Charlotte, North Carolina 28217
Telephone: (800) 375-5283

3. Treat this individual as an ineligible alien until verification is provided.

III. NON-CITIZENS

A. Overview

Individuals who live in the U.S. but are not citizens are aliens. Coverage for Special Assistance is based on their immigration status with USCIS and the date they are admitted by USCIS under that status. A non-qualified alien is not eligible for Special Assistance.

This section defines qualified aliens and non-qualified aliens, when they are eligible for Special Assistance based on the date admitted, USCIS documentation of alien status, and DSS procedures to establish status.

B. Qualified Aliens

The two main categories of immigrants established by USCIS that are considered qualified aliens are described in III.B.1. and 2., below. They each have different disqualification periods based on the immigrant's status at the time he was admitted to the U.S. by USCIS. The qualified aliens described below are the only aliens eligible for Special Assistance. (This list is all-inclusive).

1. Lawful Permanent Resident (LPR)

   a. Definition

      An LPR is an alien who is legally admitted to the U.S. by the USCIS to live and work on a permanent basis. An LPR is often referred to as a "resident alien." USCIS issues each LPR an I-551. This is known as a "green card", even though it is not green. Aliens recently admitted to the U.S. as a LPR, or who have applied for a replacement I-551 may only have the I-94 with a temporary I-551 stamp.

   b. Five Year Disqualification Period of LPRs

LPRs admitted to the U.S. on or after August 1, 1996, are not eligible for Special Assistance for 5 years from the date they are admitted to the U.S. as an LPR. This is a mandatory 5-year disqualification period. After the 5-year disqualification period has expired, LPRs meet immigration eligibility requirements for Special Assistance. Reverify their status with USCIS.

(1) For example, an immigrant admitted as an LPR by INS in January 2004 is ineligible for SA until January 2009.

(2) The 5-year disqualification period does NOT apply to an LPR:

(a) Admitted to the U.S. as an LPR prior to August 1, 1996, or

(b) Who adjusts his/her status to U.S. citizen during the 5-year disqualification period, or

(c) Who is an honorably discharged U.S. veteran or active duty military or his/her spouse and dependent child under 21, or

(d) Originally admitted by USCIS to the U.S. under a political designation who has adjusted to LPR status within the first 5 years. Refer to III.B.2. below, or

(e) An American Indian born in Canada to whom the provisions of section 289 of the INA apply, or who is a member of an Indian tribe as defined in section 4(e) of the Indian Self-Determination and Education Assistance Act.

2. Aliens Admitted Under a Specific Political Status

a. Definition

Aliens can be legally admitted to the U.S. by the USCIS as a type of refugee for many different political reasons. For example, an individual may be admitted to the U.S. because he is fleeing persecution in his own country, or USCIS determines it is in the public interest. Aliens admitted by the USCIS under a specific

section of the Immigration and Nationality Act (INA) identified below are considered qualified aliens (This list is all inclusive):

(1) A refugee admitted under section 207 of the Immigration and Nationality Act (INA), or

(2) An asylee admitted under section 208 of the INA, or

(3) A refugee whose deportation is withheld under section 243(h) of the INA, or

(4) An alien paroled under section 212(d)(5) of the INA for at least 1 year, or

(5) An alien granted conditional entry under section 203(a)(7) of the INA in effect prior to April 1, 1980, or

(6) An alien granted status as a Cuban/Haitian entrant as defined in section 501(e) of the Refugee Education Assistance Act of 1980, or

(7) An Amerasian immigrant admitted pursuant to Section 584 of the Foreign Operations, Export Financing, and Related Programs Appropriations Act, 1988.

b. Seven Year Limitation Period for Aliens Admitted Under a Political designation

(1) Aliens admitted to the U.S. under one of the political designations listed above are potentially eligible for Special Assistance for 7 years from the date they are admitted to the U.S. under that status. This is a 7-year period of potential Special Assistance. (This is just the opposite of aliens admitted, as LPR's who are ineligible for SA for the first 5 years.) After the 7-year period has expired, the alien is ineligible for SA if his status remains the same. If the alien has adjusted his status after the 7-year period, determine eligibility for these individuals under their current status.

(2) Political admissions can adjust their status to LPR within the 7-year period. However, he remains potentially eligible for SA for 7 years from the date he was admitted as a refugee/asylee, etc. For example, an individual is admitted as refugee in January 2004. He adjusts his status to LPR in

2005. Regardless, he remains potentially eligible for SA based on being admitted as a refugee/asylee through December 31, 2010.

(3) The 7-year period of eligibility does not apply to honorably discharged U.S. veteran or active duty military and their spouse or dependent child under 21.

C. Procedures to Verify and Document Qualified Alien Status

Verification of qualified alien status is a two-step process. First, verify the date the alien was admitted to the U.S. and the status under which the SA applicant was admitted. Secondly, based on the date of admission determine whether the 5 year disqualification period or 7 year optional eligibility period applies.

1. Request the alien's original USCIS documents:

   a. If the documents verify that the SA applicant is a qualified alien as defined above, continue with these procedures. Document the status under which the SA applicant was admitted.

   b. If the applicant is not a "qualified alien," he is not eligible for SA. The application must be denied.

   c. If the SA applicant's status cannot be verified because the documents are not readily available or are incomplete, refer the applicant to USCIS.

2. Write the applicant's current immigration status on the SA application. Explain that by signing an SA application, the applicant is certifying his/her immigration status.

3. Document the date the applicant was admitted to the U.S.

4. Determine whether the 5-year disqualification period OR the 7-year period of potential SA eligibility applies:

   a. If the applicant's current status is LPR, determine whether the 5-year disqualification period applies based on the SA applicant's admission date.

Note: This does not apply to LPR's who were admitted as LPR's prior to August 1, 1996, or veterans/active duty military and spouse/unmarried dependents, or LPRs originally admitted under a political designation, as described in this procedure.

b. If the applicant's status is one of the political designations defined above, determine whether the 7-year period of SA eligibility applies.

c. If the applicant's current status is LPR, but he/she claims he was a political admission within the past 7 years, he remains potentially eligible for 7 years from the date he was admitted. This is verified when the I-551 indicates a code of RE-6, RE-7, RE-8, or RE-9.

d. Document the date the 5-year disqualification period or 7-year eligibility period expires at each application and redetermination. The SA case should be flagged as to when the 5-year disqualification period or 7-year eligibility expires.

5. Verify the authenticity of the alien document and the date of admission using the web- based Systematic Alienage Verification for Entitlements (SAVE) Verification Information System (VIS). For secondary verifications, refer to the G-845 form.

6. File a copy of the USCIS documentation in the applicant's record.

7. Reverify alien status when the alien status is subject to change.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3300 ADMINISTRATION OF BENEFITS

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3300 ADMINISTRATION OF BENEFITS

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I. INTRODUCTION

County departments of social services (DSS) are responsible for determining initial and continuing eligibility and ensuring that payments are correct according to procedures and regulations of the Special Assistance (SA) Program.

II. ESTABLISHING A PAYEE

A. Beneficiary Is Payee

The beneficiary is payee for his or her own SA payment unless he or she (or his or her authorized representative) designates another individual to serve as a substitute payee.

B. Substitute Payee

If the beneficiary is unwilling or unable to manage their assistance to the extent that deprivation or hazard to the beneficiary (or other) results, a substitute payee must be established. If necessary, the director of the county department of social services (DSS) may invoke the procedures set forth in General Statute 108A-37 - Personal representative for mismanaged public assistance.

Substitute payees are responsible for receiving and disbursing payments to meet the beneficiary's needs. Obtain a copy of legal documents such as the power of attorney (POA) or guardianship appointment and attach to the record.

1. **A substitute payee may be:**

    a. Representative chosen by the applicant/beneficiary (a/b)

    b. Trustee

    c. Power of attorney

    d. Legally appointed guardian, or

    e. County DSS

2. **The following persons <u>may not</u> serve as payee:**

    a. Member of the board of county commissioners

    b. Member of the county board of social services

c. The administrator and other staff of the facility where the a/b resides. The facility may, however, utilize a resident collective account for direct deposits

III. RECEIPT OF PAYMENT

All SA payments are issued electronically. Beneficiaries or their authorized representatives can choose from two electronic issuance methods: **EBT cash card or Direct Deposit into an account (personal bank account or collective bank account).**

The DSS worker should fully explain each option to the a/b and/or authorized representative. The election of the direct deposit payment method is documented on the DSS-5023 Direct Deposit Authorization Form If the a/b has indicated they want direct deposit, request the return of a completed and signed DSS-5023 Direct Deposit Authorization Form with the application or at changes in situation, via DHB-5097 Request for Information. Do not deny an application for failure to return the DSS-5023 Direct Deposit Authorization Form. Explain that if the form is not returned during the time frame requested, the payment will be issued on an EBT cash card. Refer the a/b to NCDHHS.gov's Electronic Benefit Transfer page and Frequently Asked Questions about Electronic Benefit Issuance for information on using their North Carolina EBT Card.

A. Direct Deposit into a Bank Account

SA a/b's may use direct deposit into a personal bank checking or savings account. This account may be owned by the a/b or if the a/b has a substitute payee, the payment can go into the payee's designated account. Fees associated with individual accounts are the responsibility of the beneficiary. The a/b should be informed that if he/she does not provide bank account information for direct deposit, the benefits will be issued to an EBT card.

1. Personal Checking or Savings Accounts

   A DSS-5023 Direct Deposit Authorization Form must be completed for direct deposit transactions. The SA a/b or representative must sign Section 1 of the DSS-5023. A voided check (for a checking account) should be attached. If a check is not available to assure accuracy, the a/b should submit an official bank document with the name on the account, the account number and the routing number or have a financial institution official complete and sign Section 2 of the form.

2. Collective Accounts

A collective account is a checking or savings account that is used for transactions for more than one individual. SA a/bs may elect to have their payments deposited into collective accounts which are opened and maintained by the facility or the DSS.

Note: A DSS-5023 must be completed for each SA beneficiary.

a. For Facility Collective Accounts OR DSS Collective Accounts: Below are instructions for a facility or DSS to complete the DSS-5023 Direct Deposit Authorization Form.

(1) Section 1: Leave the box labeled "Name of Payee (if different than Case Head)" BLANK. Note: For the purposes of this form, Case Head is the name of the resident

(2) Section 1: Fill in the box labeled "Name(s) on Account" with the word <Collective>

(3) Section 1: In the box labeled "Nominee/Payee's Mailing Address"—write the address where the case head resides

(4) Section 1, last row: Leave the box BLANK that is labeled "Print Name of Payee (if different than Case head)".

(5) Section 2: The facility staff may make copies of the voided check if available. If not available, the bank or facility staff may complete and sign Section 2 or submit other documentation to assure that the bank account information is correct.

b. For Facility Collective Accounts:
Below are important instructions for determining if the facility collective account submitted with a DSS-5023 Direct Deposit Authorization Form is an acceptable account for Special Assistance payments or not:

(1) **A collective account cannot be the facility's operating account, individual personal account, or business account.** Federal Deposit Insurance Corporation (FDIC) insurance covers only properly titled collective accounts.

(2) A collective account must have a correct fiduciary title. The term "fiduciary" means the facility may not seek personal benefit from managing the money of those they represent. A

fiduciary title shows the facility manages the account but *does not own or have a personal interest in* the account. The beneficiaries own the account, but do not have access to the account.

Some examples of acceptable and unacceptable facility collective account titles:

If the Collective Account title is:	Acceptable	Reason
Brian Healthcare Corp.	No	It is a corporate account, **not** a fiduciary account
Mitchell Assisted Living, LLC	No	It is a business account, **not** a fiduciary account
Mary Scott Manor – Resident's Fund for Social Security Beneficiaries	Yes	
Julia's House - Resident's Account for Benefit Payments	Yes	
Grateful Hearts Living Center, LLC Resident Trust Account	Yes	
Grateful Hearts Trust (a traditional trust account)	No	A facility cannot use a traditional trust fund as a collective account

3. **In order for payments to be correctly credited to a collective account's bank statement OR correctly credited to a personal account (as applicable), the following instructions are critical:**

   a. DO NOT enter the facility name or the DSS name as "payee" or "protected payee" in NC FAST.

   b. In Bank Accounts evidence in NC FAST, accurately mark whether a bank account is an Individual account or a Joint account

   c. Add comments in Bank Accounts evidence on the Person page in NC FAST, to include:

      (1) whether the account is "personal" or a "facility collective account"

(2) when the account belongs to anyone other than the applicant or facility, enter both the account holder's name and relationship to the applicant (e.g., Authorized Representative or Legal Guardian)

d. Be extremely careful when entering bank account information into Bank Accounts evidence on a Person page NC FAST. **Always double-check Routing Numbers and Account Numbers after entering them to ensure they are accurate.**

4. Direct Deposit Processing Information

a. The monthly SA payments should be available by the 7th business day of the month. Funds are usually released by the State on the first business day of the month, but no later than the fifth business day, and may take two additional days to be available in the account.

b. If there is a dispute or question relating to debits or fees assessed on the direct deposit account, the beneficiary and/or authorized representative should contact the financial institution who holds the direct deposit account.

5. If a Payment Goes into an Incorrect Account

a. The SA payment is paid to the beneficiary based on their eligibility. **Once benefits are deposited into either a bank account or on an EBT card, funds are considered cashed and are not replaceable.**

b. Benefits deposited into a collective account are the responsibility of the owner of the collective account, either the facility or the DSS. The facility contracts for the payment with the resident (the SA rate for SA residents) per the adult care licensure rules. A facility owner who receives funds into a collective account for an individual for which the facility is not entitled is obligated to return the funds to the beneficiary or their authorized representative at the new facility, if applicable, or to the DSS.

If the facility fails to return the funds within a reasonable amount of time, the DSS should send a letter requesting immediate return of the funds. If the facility does not return the funds, the DSS should pursue legal action to recover the funds under the General Statute 108A-39, Fraudulent Misrepresentation.

Appendix 1 has a sample of three letter templates that can be used by the DSS to send to the facilities in this situation.

(1) **Letter 1 (A):** The First letter is to the Facility that was Incorrectly Paid—and is requesting the payments

(2) **Letter 2 (B):** The Second letter is to the Facility in 10 days if the payment has not been returned or could be changed if partial amount was returned.

(3) **Letter 3 (C):** This letter is intended for the new facility of residence explaining the situation and stating that the DSS is attempting to recoup the payments from the former facility.

c. Facilities may return the pro-rated amount (the per-diem rate times the number of days in the facility during that month) to the DSS via a check. The county may forward a check **made out to the beneficiary** at the new facility or return the benefits to DHHS via a check and a DSS-1656 Refund Receipt.

d. Funds cannot be reissued until the county DSS verifies with the Controller's Office that the DSS-1656 has been received and the original SA benefit has been credited back to the case. Once the funds have been credited back to the case, **they will be viewable in NC FAST** on the Financials tab of the PDC by clicking on the payment month in question, then clicking on 'Adjustments'. (If no corresponding activity is seen under 'Adjustments' then the funds have not yet been credited back.) Documentation regarding this verification must be included in the case record. If the DSS has returned the payment to the DHHS Controller's Office but has been unable to verify a payment adjustment in NC FAST, contact the DHHS Controller's Office at 919-527-7799 to verify the Controller's Office has received the funds.

Once verified, the county may issue benefits to the beneficiary at the new facility via NCFAST using Forced Cash Eligibility. Always include comprehensive notes, comments and documentation when using Forced Cash Eligibility. Do not reissue payment(s) to the beneficiary for month(s) when payments were issued, but have not been returned and accounted for.

6. If Direct Deposit Transactions Are Rejected

a. Payments can be rejected for various reasons: a closed account, incorrect routing number or account number, account does not exist, incorrect address, etc.

b. Rejected payments will be displayed in NC FAST on the Financials tab with the message-Rejected or Canceled. The NCXPTR report DHREJA CASH ISS REJECT RECORDS contains rejected payments per county. In addition, NC FAST may generate a task to notify the caseworker that a payment has been rejected. If such a task is received, locate the subject of the task and then take steps to correct the issue.

c. If a direct deposit has been rejected by a financial institution, the DSS caseworker must contact the beneficiary to determine if either a change in the direct deposit account is needed or if there is good cause to change the issuance method to EBT cash card.

7. Direct Deposit Changes in Situation

a. Anytime there is a change in situation, the caseworker should verify that the beneficiary wants to continue with the current method of payment. A new DSS-5023 Direct Deposit Authorization Form must be completed anytime there is a change in bank information.

b. When it is reported that the beneficiary has moved from the facility (the owner of the beneficiary's collective account) and the SA benefit is still going into that facility's account, immediate action is required to ensure the following month's SA payment will not go into the ineligible account. Send a DHB-5097 Request for Information requesting a new DSS-5023 Direct Deposit Authorization Form be completed to determine the payment method for subsequent payments. It is imperative that the workers take immediate action to enter the new bank account or other preferred method of payment for the next month's benefit issuance.

c. If the county cannot immediately obtain appropriate verification of the new method of benefit issuance and the payment date for the SA payment is imminent, the county should **suspend the SA product** until a preferred method of issuance is obtained. This will eliminate the a/b's funds from being directly deposited into a bank account that is not eligible to receive the a/b's funds. Do not suspend the Medicaid product.

Reminder: all appropriate actions must be completed within 30 calendar days after the county department of social services learns of the change.

Send a DHB-5097 Request for Information requesting a new DSS-5023 Direct Deposit Authorization Form be completed to determine the payment method for subsequent SA benefit payments. Once the preferred method of payment is established and verified, enter the new information into NCFAST according to the appropriate job aids, and unsuspend the SA case. This must be completed within 5 days of the county receiving the new verification.

B. EBT Card

The a/b can choose for the electronic SA benefit to go on an EBT cash card. When this payment method is chosen, provide the a/b with a copy of the EBT brochure, How to Use Your North Carolina EBT Card.

1. The initial EBT Cash Card must be processed by the county DSS. Replacement EBT Cash cards may be completed by contacting the EBT Customer Service Line, 1-888-622-7328.

2. If the beneficiary is a SAIH a/b and receives Food and Nutrition Services (FNS), the SAIH payment and Food and Nutrition Services benefits will be issued on the same card.

3. Information that is mailed out with the EBT card instructs beneficiaries to contact EBT Customer Service to activate the EBT card, by selecting a personal identification number (PIN). The beneficiary can select a PIN for the card and access the account without visiting the county DSS office.

4. Beneficiaries can change their PIN number when needed by calling the EBT Customer Service line using the automated system, Interactive Voice Response (IVR). The contact number for the EBT Customer Service line is 1-888-622-7328. Cardholders will need to know the last four digits of their Social Security Number.

5. Refer to NCDHHS.gov's Electronic Benefit Transfer page and Frequently Asked Questions about Electronic Benefit Issuance for details on fees, how to use the card, reporting a lost or stolen card, etc. Share with the a/b or authorized representative how and where to access this information.

6. The EBT Cash Card can be used at the same retail outlets that accept the EBT FNS card. Cash from the EBT Cash Card can be withdrawn at selected ATMs with the Quest CASH logo.

7. **Once benefits are deposited onto an EBT card, funds are considered cashed and are not replaceable.**

8. If an EBT card is lost, stolen or not received, the beneficiary must contact the EBT Customer Service line at 1-888-622-7328 to request a replacement card.

9. Misuse of the EBT card benefits is against the law. It is a crime to defraud the system or sell the EBT card to others. An EBT card cannot be used in any liquor store; any casino, gambling casino, gaming establishment; or any retail establishment which provides adult-oriented entertainment.

10. Misuse of the card may result in criminal charges against the individual and their benefits may end. Criminal charges may result for any individual misusing the card of a SA beneficiary.

11. After 365 days of EBT account inactivity, the EBT Vendor will expunge the remaining benefits and deactivate the card. When the entire account reaches 365 days of inactivity; all benefits are expunged at once. Benefits cannot be restored once expunged.

    Note: All benefits on a case are accessed on a first-in/first-out basis. The aging process is defined by case activity, and then by each individual benefit authorization's Last Date Used to determine whether or when there has been any activity.

IV. PAYMENTS TO A DECEASED BENEFICIARY

If a beneficiary resided in a facility on the first day of the month, his or her estate is entitled to the remainder of the SA month's payment after the date of death. Adult care licensure rules indicate how much of the payment needs to be refunded to the estate and the last day of payment for room and board to which a facility is entitled. It also provides a time frame of 30 days after the resident's death for the refund to be sent to the estate.

If payments are made for subsequent months, follow the procedures below:

A. Payment by Direct Deposit

The owner of the account must refund the payment to the county DSS that the beneficiary is not entitled to receive. If the funds were deposited into a joint account or co-owner account, contact the other owner of the account

or the authorized representative to request repayment. A check should be made out to the county DSS. The DSS will deposit the payment into the county account and send a DSS-1656 Refund Receipt (Collection of Overpayment) to the DHHS Controller's Office.

If the funds went into the beneficiary's personal account for which he/she was the sole owner and the account is "frozen", the county should contact the clerk of court and file a claim against the estate for repayment of the benefit for which the beneficiary was not entitled.

B. Payment by EBT Cash Card

If the benefits are on an EBT card, obtain the card, and send the EBT card to the clerk of court. The clerk of court will make the determination to retrieve any funds off the card that are payable to the estate, the county DSS and/or to the facility.

NOTE: If a county DSS needs to forward a deceased beneficiary's SA benefits by check to the clerk of court, be certain the check is made out to "The Estate of [Beneficiary's Name]". Do not make the check out to the clerk of court. When returning a deceased SA beneficiary's EBT cash card to the clerk of court, remember to reference that it belongs to "The Estate of [Beneficiary's Name]".

V. UNDERPAYMENTS FOR ONGOING BENEFICIARIES

A. Reasons for Underpayment

An underpayment occurs when the beneficiary receives a payment less than he or she is eligible to receive due to:

1. Error in applying program regulations, or
2. Error in computing the payment, or
3. Error in processing, or
4. Beneficiary fails to report a change in situation timely

NOTE: Always thoroughly examine cases for potential (or previously unrecognized) underpayments. Underpayments should be addressed

promptly and handled within 30 calendar days after the county department of social services learns of the underpayment.

B. Reimbursing Underpayments

Promptly reimburse the beneficiary for all county and State responsible underpayments when:

1. The case continues to be active, or

2. The beneficiary reapplies for assistance and is found to be eligible, or

3. The case would have been active if the error had not occurred

NOTE: Do NOT authorize assistance or modify payments for more than 12 months prior to the month the underpayment is discovered.

C. Computing an Underpayment

1. Verify all changes according to the appropriate SA Manual section.

2. Determine and document the date the change occurred.

3. Determine incorrect payment period. The overpayment/underpayment period includes the month when a change should have been made effective until the month the change is made effective.

4. Determine eligibility for the error period as it would have been done had the error not occurred.

5. Follow all regulations, including notice requirements.

6. Change the evidence(s) in NC FAST.

7. Follow all relevant Job Aids in NC FAST.

NOTE: Do not count an underpayment as income or as a resource.

VI. OVERPAYMENTS FOR ONGOING BENEFICIARIES

Overpayments can only be determined for ongoing SA beneficiaries. (For changes during the application process and prior to disposition of the application, refer to SA-3110 Application Process and SA-3220 Budgeting).

A. Reasons for Overpayments

An overpayment occurs when the beneficiary received a payment for which he is not eligible due to:

1. Error in applying program regulations, or

2. A/B fails to report a change in situation timely, or

3. A/B provides false or incorrect information, or

4. A/B fails to report the receipt of an assistance payment greater than the authorized payment, or

5. A/B fails to report timely a move from an adult care home to independent living, or

6. A/B receives continued assistance during hearing process, and the hearing officer affirms the reduction or termination (Refer to SA-3340 Hearings).

   Note: Always thoroughly examine cases for potential (or previously unrecognized) overpayments. Overpayments should be addressed promptly and handled within 30 calendar days after the county department of social services learns of the overpayment.

B. Computing an Overpayment

1. Verify all changes according to the appropriate SA Manual section.

2. Determine and document the date the change occurred.

3. **For changes involving a reported or unreported move to a private living situation**, NC FAST calculates the overpayment when new evidence is correctly entered as per related Job Aids in FAST Help, and when the methodology below is correctly applied:

   a. Apply the 5/10 day rule. If the change is related to living arrangement, NC FAST will apply this rule when the caseworker selects the “5/10 Rule” checkbox in Living Arrangement evidence on the case Dashboard. NC FAST will then automatically calculate the 5/10 day rule based on the actual end date the individual is

expected to leave the living arrangement (as entered in Living Arrangement evidence). Follow all related Job Aids in FAST Help.

Note: Manually verify the accuracy of 5/10 day rule calculations by doing the following:

(1) Step 1 - Using a calendar, count 5 **calendar** days beginning the day following the date the change occurred, and add 10 **working** days.

(2) Step 2 - Subtract that date from the number of days in the month of overpayment. This determines the number of days for which the overpayment was made.

(3) Step 3 – The beneficiary's monthly SA payment minus the $70 Personal Needs Allowance is divided by the number of days in the month to determine the per diem rate for that month.

(4) Step 4 - Multiply the number of days of overpayment from Step 2 above times the per diem rate from Step 3 to determine the amount of overpayment for the month.

b. If the beneficiary was not eligible for SA payment for any month, the overpayment is the full amount.

Note: The 5/10 day rule does not apply for changes involving a move from the ACH to a higher level of care or when the beneficiary dies. In those situations, the beneficiary is entitled to the payment for the entire month of change if he was in the facility on the first day of the month. The facility is required by licensure rules to refund to the beneficiary or his estate the portion of the payment after his discharge or death.

4. For changes involving unreported income
NC FAST calculates the overpayment by using the following methodology when the new evidence is correctly entered:

a. Verify date new income was received and enter into evidence in NC FAST.

b. The 5/10 day rule is calculated and applied by NC FAST, based on the start date of the new income evidence that is entered . (To

manually verify the 5/10 day calculation, using a calendar, count 5 calendar days beginning the day following the date the change occurred and add 10 working days.)

(1) If the 5/10 day rule ends in the same month in which change occurred, there is no overpayment because the beneficiary was eligible for the full amount on the first day of the month.

(2) If the 5/10 day rule ends in the next month after the change occurred, the end date of the 5/10 rule is subtracted from the number of days in the month. Recoup overpayment for that number of days.

c. To calculate the overpayment for a partial month, NC FAST calculates the change by following methodology when new evidence is entered.

(1) The new SA amount is determined.

(2) The new SA payment is subtracted from the former SA payment.

(3) The difference is divided by the number of days in the month to determine the daily SA payment amount.

(4) The new SA daily payment amount is multiplied by the number of days of recoupment.

5. For unreported changes resulting in excess resources NC FAST calculates the overpayment by using the following methodology <u>when the new evidence is correctly entered</u>:

a. NC FAST determines the number of months the beneficiary was over the resource limit on the first moment of the first day of the month.

b. The overpayment period begins the <u>second</u> month following month of receipt of excess resources.

<u>Note:</u> The month following the receipt of resource is not included in the overpayment period due to the notice requirement.

c. Recoup the full SA payment for any subsequent months.

6. For unreported death of beneficiary:

   Recoup the full SA payment for any month following the month in which death of the beneficiary occurred. (Refer to SA-3300 IV Payments to a Deceased Beneficiary.)

C. Collecting an Overpayment

1. Beneficiary Responsible Overpayments

   If an overpayment is caused by the failure of the beneficiary or his or her Authorized Representative to report a change in circumstance, and if fraud is not suspected, the county Department shall direct the recipient to refund the overpayment. If fraud is suspected, refer to SA-3410 Recipient Fraud.

   The collection of beneficiary responsible overpayments is the responsibility of the legal county of residence.

   a. If beneficiary refuses to refund an overpayment, the SA payment can be reduced up to 10% of the payment amount if there is disregarded earned income or countable resources greater than the amount of the overpayment to be recouped.

   b. If there is no disregarded earned income or countable resources greater than the amount of the overpayment to be recouped, ask the beneficiary to sign an agreement to repay if either disregarded earned income or countable resources greater than the amount of the overpayment to be recouped are acquired while they are a Special Assistance beneficiary.

   c. Repayment agreements must contain, at a minimum:

      (a) Amount of the overpayment

      (b) Repayment schedule

      Provide beneficiary with a dated copy of the repayment agreement and file a copy in the record.

   d. This overpayment recoupment must be tracked by the county DSS. *Do not track in EPICS.*

2. County Responsible Overpayments

   a. If an overpayment occurs because of a county office error in applying program regulations, the overpayment will be charged to the county.

   b. When an overpayment occurs because of a county error in processing the payment, recoup the overpayment from the beneficiary only if the beneficiary was properly notified of the correct amount they were eligible to receive. Refer to notice requirements in SA-3330 Notices.

      NOTE: The county is responsible for paying the State share for SA overpayments identified and resulting from the county's error in applying program regulations. All county responsible overpayments will be determined by reviewing the date of discovery that resulted in ineligibility for SA. The overpayment will be charged back to the county based on, the later of, the date of discovery or the most recent certification period which resulted in the overpayment. If the date of discovery is the first ineligibility determination, the overpayment will be charged to the county no longer than 12 months prior to the date the overpayment is discovered. Discovery constitutes discovery by report to the DSS, being known to the DSS agency, and/or a State review of the case file. Chargebacks will be required when the error affects case eligibility or incorrect payment has been issued. The county must also evaluate for Medicaid overpayments as spelled out in Medicaid policy.

   c. For all county responsible SA overpayments, complete a DSS-8201, County Responsible Overpayment form, and submit the form to the address below:

      DHHS Controller's Office
      Program Benefit Payments Section
      2019 Mail Service Center
      Raleigh, NC 27699-2019

      When completing the DSS-8201, you must fill in the full amount(state and county portion) of the SA overpayment in the "Amount" column. The county share of the overpayment will be adjusted and will reflect on the Public Assistance Adjustment Register (adjustment code 20) that the State will recoup its 50% share of the state/county payment. A copy of the Public

Assistance Adjustment Register and a notification adjustment letter is provided to the county DSS director.

3. State Responsible Overpayments

   a. If an overpayment occurs because of a State office error in interpreting program regulations, the overpayment will be charged to the State.

   b. If an overpayment occurs because of a State office error in processing the check, but the beneficiary has received notification of the correct amount, collect overpayment from the beneficiary.

   c. Processing State Responsible Overpayments:

      (1) Complete a letter on county DSS letterhead providing beneficiary's name, dates of overpayment, overpayment amount(s), and NC FAST PDC number.

      (2) Fax or scan and send a copy of the letter to your Special Assistance Program Representative or to the Special Assistance Listserv (Specialassistance@dhhs.nc.gov),and wait for approval from the DHHS Special Assistance section.

      (3) If the State Responsible Overpayment is approved by the DHHS Special Assistance section, the county will receive a follow-up email acknowledging the approval and confirming when it was forwarded to the Controller's Office for processing.

      (4) If the State Responsible Overpayment is not approved by the DHHS Special Assistance section, the county will receive a follow-up email requesting additional information, or a follow-up email relaying a determination that the overpayment in question was a County or Beneficiary Responsible Overpayment rather than a State Responsible Overpayment.

4. Returning Overpayments to the State

   a. When a refund of an overpayment is made either by cash or personal check, deposit overpayment refund into DSS account.

b. Prepare county DSS check in the amount of refund and submit completed DSS-1656 Refund Receipt (Collection of Overpayment) with the check to Program Benefits Payment Section at the address below for cancellation and financial adjustment for the county DSS.

Program Benefits Payment Section
2019 Mail Service Center
Raleigh, NC 27699-2109

NOTE: If fraud is suspected, refer to SA-3410 Recipient Fraud.

VII. Appendix 1 - Sample Letter Templates to Facilities

Letter Template A – Incorrectly Paid Facility

<County DSS Name and Address>

<Insert Date>

<Provider Name>
<Address Line 1>
<Address Line 2>
<City, State, Zip>

Re: <Beneficiary/Resident name>

Dear Administrator:

It has come to our attention that a Direct Deposit payment for the above-referenced Special Assistance beneficiary was made into your facility collective account that you hold for direct deposit of residents' funds. We have verified that $_____ was deposited into the bank account jointly held by the facility and patient at (name of bank) on (mm/dd/yyyy). This payment was for services provided to the resident during the following time frame _____. It has come to our attention that the resident was not present in your facility during that time frame. Therefore, your facility was not entitled to the aforementioned payment.

Per licensure rules 10A NCAC 13 F. 1106 and 13 G. 1106 for facilities licensed under G.S. 131D: the facility shall refund the resident the remainder of any advance payment within 14 days from the date that the resident provided a notice, if required, that they are leaving the facility. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility.

If the resident and their authorized representative, if any, agrees, the payment can be made directly to the new facility. If you have issued a payment to the resident or the new facility on the resident's behalf, please provide verification to the _____ County Department of Social Services.

If you have not returned the funds to the resident or the facility, or you are unsure of the resident's location, we are asking that you return the amount of _____ to this agency so that the funds can be deposited into the correct bank account for the correct facility or otherwise reissued to the resident. Send the payment to:

_____ County Department of Social Services
<Attention>
<Address Line 1>
<Address Line 2>
<City, State, Zip>

You must return the money. We will not take the money directly from the account in question. Therefore, you do not have to be concerned about any duplication of payment to the department of social services.

Please return the aforementioned money within ten (10) days of the date of this letter, so that we can expedite payment to the correct provider and so that there is no interruption of service to the resident. Thank you for your assistance in this matter.

Sincerely,

Letter Template B – Incorrectly Paid Facility 10 Day Follow-up

<County DSS Name and Address>

<Insert Date>

<Provider Name>
<Address Line 1>
<Address Line 2>
<City, State, Zip>

Re: <Beneficiary/Resident name>

Dear Administrator:

We are writing to follow up on our letter dated (mm/dd/yyyy), in which we advised you of the erroneous Direct Deposit payment for the above-referenced Special Assistance beneficiary was made into your facility collective account that you hold for direct deposit of residents' funds. Specifically, $_____ was deposited into account number _____ on (mm/dd/yyyy). This payment was for services provided to the resident during the following time frame _____, however the resident was not present in your facility during that time frame. Therefore, your facility was not entitled to the aforementioned payment.

In our last letter, we requested that your facility refund the aforementioned payment to the county department of social services, so they can redeposit the money to the correct bank account for the correct facility. To date, we have not received the requested refund.

Please refund the aforementioned money to:

_____ County Department of Social Services
<Address Line 1>
<Address Line 2>
<City, State, Zip>

within five (5) business days of the date of this letter. The failure to do so will result in the initiation of legal action against your facility, in which this department of social services will ask a court to order the return of the erroneously paid funds, in addition to any and all damages available under the law resulting from the delay in refunding the money.

If you have any questions regarding this matter, please do not hesitate to contact us.

Sincerely,

Letter Template C – To Facility Awaiting Payment

<County DSS Name and Address>

<Insert Date>

<Provider Name>
<Address Line 1>
<Address Line 2>
<City, State, Zip>

Re: <Beneficiary/Resident name>

Dear Administrator:

We are writing in response to your claim for payment in the amount of $_____for the above-referenced Special Assistance beneficiary for services provided to her/him during the following time frame _____. It has come to our attention that a payment for this resident for the aforementioned time frame was inadvertently paid to another facility.

This office is taking all necessary steps to recover the erroneously paid funds and will provide payment to your facility in due course. As for now and going forward, this situation has been corrected in our system and your facility will be paid in a timely manner for all services rendered from this point forward.

We ask for your patience in this matter while we work to resolve the payment error. Should you elect to discharge the resident for non-payment, N.C. Gen. Stat. §131D-4.8(b) requires that adult care homes/family care homes give the resident at least 30 days advance notice in writing before the

discharge. The resident also has the right to appeal a facility's attempt to discharge. In the event that you elect to proceed with the discharge of the resident, we ask that you notify this office immediately, so that we can assist with finding a new placement for her/him.

We appreciate your cooperation in this matter. If you have any questions, please contact this office.

Sincerely,

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3310 CHANGES IN CIRCUMSTANCE

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3310 CHANGES IN CIRCUMSTANCE

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I. GENERAL INSTRUCTIONS APPLICABLE TO ANY CHANGE IN CIRCUMSTANCE

This section contains the procedures for conducting local and State hearings when an a/b appeals a county DSS action.

A. The a/b or a/b's representative is required to report any change in the a/b's circumstance within five (5) calendar days.

B. When the county learns of a change in circumstance from any source, evaluate the change to determine if the eligibility and/or the SA payment is affected.

C. When a change in circumstance is reported, ask if other changes have occurred. Be alert to any change that affects more than one eligibility requirement.

D. When more than one change in circumstance is reported during the same month, implement changes with the same effective date at the same time. When there are different effective dates, implement separately in the order in which they occurred.

E. Document all information, including dates, verifications obtained and telephone contacts. Be specific with full name, title, and organization, if applicable.

F. Enter changes in NC FAST refer to the relevant NC FAST job aids.

G. Send the a/b notice of any change in benefits according to SA-3330, Notices.

H. The county department of social services must react to all changes within 30 calendar days of the reported change.

II. CHANGES DURING APPLICATION PROCESS

A. Applicant Moves From SA Facility To SA Facility

1. Verify and document the change occurred.

2. Update the Living Arrangement evidence. End date the old living arrangement evidence and add new evidence with new facility name.

3. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

B. Applicant Moves From SA Facility To Private Living Arrangement (PLA)

1. Verify and document the date change occurred.

2. Evaluate for open/shut SA payments, refer to SA-3220, Budgeting.

3. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

4. For SSI applicants complete and send the DMA-5049, Referral to Local Social Security Office, to SSA.

5. For non-SSI applicants, always evaluate for potential Medicaid eligibility and other programs of assistance.

C. Applicant Moves From Basic To SCU Or From SCU To Basic

1. Verify and document the date applicant moved to the new level of care.

2. Re-budget using the new rate effective the date the a/b moved. See SA-3220, Budgeting Principles.

3. Verify the diagnosis on the current FL-2 is for Alzheimer's or a related form of dementia disorder. If the appropriate diagnosis is not present

on the current FL-2, a new valid FL-2 will be required in order for SA benefits to be paid at the Enhanced rate for SCU.

NOTE: If the FL-2 is valid and both a partial Basic rate and a partial Enhanced rate for SCU are to be budgeted in the same month, contact the SA listserv via DSS-9000SA for guidance on processing.

4. Verify the applicant is in a licensed SCU bed.

   a. If the facility is an all-inclusive SCU facility, document that as the reason why no facility visit was conducted.

   b. If the facility has both SCU and Basic beds, conduct a facility visit to verify the applicant is in a SCU bed. Documentation must include the date of visit, who conducted the visit (name and title) and how the verification was made. In situations where the applicant cannot be viewed in the SCU bed, viewing of facility records may be used to verify the applicant is occupying a SCU bed.

   c. The list of Licensed SCU is found on the DHSR website.

      NOTE: If the facility is in a different county than the county processing the application, the local DSS of that county can conduct the SCU visit as a courtesy. Contact the Adult Home Specialist in that county.

5. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

D. Applicant Moves From SA Facility To Long Term Care (Not expected to return within 30 days)

1. Document date agency received FL-2, Level of Care Recommendation/Mental Retardation Services, in the record;

2. If a bed is available, evaluate for open/shut SA payments, refer to SA-3220, Budgeting. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

The SSI applicant must still be evaluated for long-term care Medicaid by appropriate IMC. If the applicant is Non-SSI, they must be evaluated for Private Living Medicaid and Long-Term Care Medicaid.

NOTE: If the applicant or representative chooses not to accept the bed, applicant is no longer eligible for SA.

3. If there is no bed available at the appropriate level of care you may approve SA at the current rate until a bed is located. Review and document placement progress with the appropriate services staff each month until the applicant is placed. (Refer to DSS-8194, Income Maintenance Transmittal Form, for a suggested documentation format on these cases.)

E. Applicant Moves From SA Facility To Hospital Acute Care

1. If the applicant returns to the SA facility within 30 days, continue to process the application. Do not update the Living Arrangement evidence.

2. If the applicant is hospitalized for more than 30 days:

   a. Evaluate for open/shut SA payments.

   b. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

   c. For SSI applicants, complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

   d. For Non-SSI applicants, always evaluate for potential Medicaid eligibility and other program assistance, including long-term care Medicaid.

F. Applicant Moves From SA Facility To A Public Institution

1. Verify and document the date change occurred.

2. If the applicant is admitted to a public institution other than jail or prison and is expected to return to the SA facility within 30 days, continue to process the application. Do not update the Living Arrangement evidence.

3. Flag the case to ensure the applicant returns prior to the 30th day.

4. If the applicant is admitted to a public institution and is not expected to return within 30 days, or if the applicant is incarcerated:

   a. Evaluate for open/shut SA payments, refer to SA-3220, Budgeting.

   b. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

   c. For SSI applicants complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

   d. For non-SSI applicants, always evaluate for potential Medicaid eligibility and other programs of assistance.

      NOTE: SAD applicants under age 21 (or under age 22, who had their 21st birthday while in the state mental hospital), and all SAA applicants must be evaluated for Long-Term Care Medicaid.

G. Applicant Has A Change In Resources

1. For applicants receiving SSI, complete and send a DMA-5049, Referral to Local Social Security Office to SSA. Refer to SA-3110, Application Processing for instructions for pending an application while awaiting information from SSA.

2. For applicants not receiving SSI, verify and document change in resources according to instructions in SA-3200, Resources.

   a. Record all verifications, including those items that are excluded from resource determination, on the DSS-8190 State/County Special Assistance Application Workbook

   b. Process all changes in resources and determine if the value of resources affects eligibility (i.e., real property, personal property and liquid assets) in accordance with SA-3200, Resources.

   c. If eligibility is not affected by the value of the resource, continue to process the application.

   d. If the value of all resources exceeds the resource allowance, send

a DHB-5097, Request for Information, listing all the countable resources, an explanation of ways the client could spend down the resources and latest date required to have the spend down information in the agency in order to process the application. Refer to SA-3200 V. Reduction of Resources.
If resources are reduced to allowable limits within the processing time standards, continue to process the application.

e. Authorize SA payment effective the month after the month the resource was reduced to the allowable limit and all other eligibility requirements are met. Refer to SA-3110, Application Process, for application processing time standards.

f. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

H. Applicant Has a Change of Income

A change in income is defined as an acquired source of income, a change in rate or pay that will continue (not fluctuating income), or a termination of an existing source of income. Do not react to change until income is received.

1. For applicants receiving SSI, complete and send a DMA-5049, Referral to Local Social Security Office, to SSA. Refer to SA-3110, Application Process for instructions for pending an application while awaiting information from Social Security.

2. For applicants not receiving SSI, verify and document change in income according to instructions in SA-3210, Income.

   a. Calculate the amount of the new SA payment. Refer to SA-3210, Income for information on determining base period for changing income during the application process.

   b. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

   c. If applicant is denied for SA payments, always evaluate for potential Medicaid eligibility.

I. Applicant Cannot Be Located

1. If an applicant moves, but leaves no forwarding address, and you are unable to contact the representative, deny the application. Refer to Refer to SA-3110, Application Process.

2. For applicants receiving SSI, complete and send a DMA-5049, Referral to Local Social Security Office, to SSA. Refer to SA-3110, Application Process.

J. Applicant Has A Change In State Residency

1. Evaluate for open/shut SA eligibility. Refer to SA-3220, Budgeting.

2. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

3. For SSI applicants complete and send DMA-5049, Referral to Local Social Security Office, to SSA

K. Death of Applicant

1. Verify and document date of death.

2. Evaluate for open/shut SA payments. Refer to SA-3220, Budgeting.

3. Send one of the following notices to disposition application: DSS-8108, Notice of Benefits, DHB-5002, Important Notice About Your Medicaid or Special Assistance Approval or DSS-8109, Your Application for Benefits Is Being Denied or Withdrawn.

4. For SSI applicants, complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

5. For any payments issued after death of applicant refer to SA-3300, Administration of Benefits.

III. CHANGES FOR ONGOING CASES

A. Beneficiary Moves From SA Facility To SA Facility

1. Verify and document the date change occurred.

2. Verify the new facility displays in NC FAST and that facility details are correct, refer to the relevant NC FAST job aid.

3. Update living arrangement evidence in NC FAST (Refer to relevant NC FAST job aid.)

B. Beneficiary Moves From SA Facility To Private Living

1. Verify and document the date change occurred.

2. Send a timely DSS-8110, Your Benefits Are Changing to terminate Special Assistance payments observing required time frames. Refer to SA-3330, Notices.

   a. For SSI recipients , transfer to MA, refer to the relevant NC FAST job aid. Complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

   b. For non-SSI recipients, always evaluate for potential Medicaid eligibility and other programs of assistance.

3. Determine amount of SA overpayment owed by the beneficiary.

   a. Apply 5/10-day rule. Using a calendar, count 5 calendar days beginning the day following the date the change occurred and add 10 working days.

   b. Subtract the date determined by applying the 5/10-day rule from number of days in the month.

   c. Divide the beneficiary's monthly SA payment minus the $70 personal needs allowance (PNA) by the number of days in the month to determine the per diem rate for that month.

   d. Multiply the number of days of recoupment times the per diem rate to determine the amount of SA overpayment.

      EXAMPLE:

      Mr. Brown was discharged to a Private Living Arrangement (PLA) circumstance on January 2. His January SA payment after subtracting the PNA of $70 is $500. Mr. Brown would receive an SA payment for 5 calendar days (5 days allowed to report change

to IMC) plus 10 working days (10 days timely notice period) after the day he left.

Mr. Brown is eligible for SA payment through January 20 (Refer to calendar below). The amount of SA payment to be refunded is calculated below.

Number of days in month	31
Date 5/10-day rule ends	- 20
	11
SA Payment (Minus $70 PNA)	500
Number of Days in Month	÷ 31
Per Diem Rate	16.13
Number of Days of Recoupment	x 11
Amount of refund	177.42
Amount of refund (rounded)	**$177.00**

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
1	2 CHANGE OCCURRED COUNT 5 **CALENDAR** DAYS	3 Day 1	4 Day 2	5 Day 3	6 Day 4	7 Day 5
8 COUNT 10 **WORKDAYS** FOR TIMELY NOTICE REQUIREMENT	9 Day 1	10 Day 2	11 Day 3	12 Day 4	13 Day 5	14
15	16 Day 6	17 Day 7	18 Day 8	19 Day 9	20 Day 10	21 RECOUP PAYMENT FOR REMAINING DAYS OF THE MONTH
22	23	24	25	26	27	28
29	30	31				

e. Ask the beneficiary to refund the recoupment voluntarily. Refer to SA-3300, Administration of Benefits for collection options.

f. If the beneficiary refuses to refund the recoupment, refer to SA-3410, Recipient Fraud.

g. The 5/10-day rule does not apply for changes involving a move from the SA facility to a higher level of care or when the beneficiary dies. In those circumstances, the beneficiary is entitled to the payment for the entire month of change if he was in the facility on the first day of the month. The facility is required by licensure rules to refund to the beneficiary or their estate the portion of the payment after his discharge or death.

4. The IMC may be asked for guidance regarding the settlement of payment disputes among adult care homes and the beneficiary when the beneficiary leaves the adult care home.

In all situations, settlement of payment to the SA facility is between the SA facility and the resident, as stipulated in the SA facility's admission policy. Referrals should be made to the agency's Adult Services Staff or Adult Protective Services (APS), who is familiar with all SA facility rules.

Adult Care Home Rules state:
10A NCAC 13F.1106 SETTLEMENT OF COST OF CARE

(b) If a resident moves out of the facility without giving notice, as may be required by the facility according to Rule .0702(h) of this Subchapter, or before the facility's required notice period has elapsed, the resident owes the facility an amount equal to the cost of care for the required notice period. If a resident receiving State-County Special Assistance moves before the facility's required notice period has elapsed, the former facility is entitled to the required payment for the notice period before the new facility receives any payment. The facility shall refund the resident the remainder of any advance payment following settlement of the cost of care. The refund shall be made within 14 days from the date of notice or, if no notice is given, within 14 days after the resident leaves the facility.

(c) When there is an exception to the notice, as provided in Rule .0702(h) of this Subchapter, to protect the health or safety of the resident or others in the facility, the resident is only required to pay for any nights spent in the facility. A refund shall be made to the resident by the facility within 14 days from the date of notice.

(d) When a resident gives notice of leaving the facility, as may be required by the facility according to Rule .0702(h) of this Subchapter, and leaves at the end of the notice period, the facility shall refund the resident the remainder of any advance payment within 14 days from the date of notice. If notice is not required by the facility, the refund shall be made within 14 days after the resident leaves the facility.

(f) If a resident dies, the administrator of his estate or the Clerk of Superior Court, when no administrator for his estate has been appointed, shall be given a refund equal to the cost of care for the month minus any nights spent in the facility during the month. This is to be done within 30 days after the resident's death.

C. Beneficiary Moves From Basic To SCU Or From SCU To Basic

1. Verify and document the date beneficiary moved to the new level of care.

2. Re-budget using the new rate. See SA-3220.

NOTE: If the beneficiary moved from SCU to Basic skip to step 5. If beneficiary moved from Basic to SCU follow the additional steps below:

3. Verify the diagnosis on the current FL-2 is for Alzheimer's or a related form of dementia disorder. If it is not, a new valid FL-2 will be required in order for SA benefits to be paid at the Enhanced rate for SCU.

4. Verify the beneficiary is in a licensed SCU bed.

   a. If the facility is an all-inclusive SCU facility, document that as the reason why no facility visit was conducted.

   b. If the facility has both SCU and Basic beds, conduct a facility visit to verify the beneficiary is in a SCU bed. Documentation must include the date of visit, who conducted the visit (full name and title) and how the verification was made. In situations where the beneficiary cannot be viewed in the SCU bed, viewing of facility records may be used to verify the beneficiary is occupying a SCU bed.

c. The list of Licensed SCU is found on the DHSR website.

5. Send either the timely or adequate DSS-8110, Your Benefits Are Changing accordingly, based on the change.

D. Beneficiary Moves From SA Facility To Long Term Care (Not expected to return within 30 days)

1. Document the date the agency received FL-2, Level of Care Recommendation/Mental Retardation Services, in the record.

2. If a bed is available, send an adequate DSS-8110, Your Benefits Are Changing, to terminate SA benefits. Refer to SA-3330, Notices. If the beneficiary receives SSI, transfer the case to Private Living Medicaid. The SSI recipient must still be evaluated for long-term care by the appropriate IMC. If the beneficiary is Non-SSI, evaluate for Medicaid.

3. If the beneficiary or authorized representative chooses not to accept the bed, the beneficiary is no longer eligible for SA.

4. If there is no bed available at the appropriate level of care, you may continue SA at the current rate until a bed is located. Review and document placement progress with the appropriate services staff each month until the beneficiary is placed using the DSS-3005, Documentation Regarding Continuation of Special Assistance When the LOC Is Upgraded, But No Bed Is Available.

E. Beneficiary Moves From SA Facility To Hospital Acute Care

1. If beneficiary returns to SA facility within 30 days make no changes.

2. If beneficiary is hospitalized for more than 30 days:

   a. Send an adequate DSS-8110, Your Benefits Are Changing to terminate SA benefits observing required time frames. Refer to SA-3330, Notices.

   b. For SSI recipients, transfer to MA. (Refer to the relevant NC FAST job aid.) Complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

   c. For Non-SSI recipient, always evaluate for potential Medicaid eligibility and any other program assistance.

NOTE: SAD applicants under age 21 (or age 22 who had their 21st birthday while a patient in the state mental hospital) and all SAA applicants must be evaluated for Long-Term Care Medicaid.

F. Beneficiary moves from SA Facility To A Public Institution

When an SA beneficiary moves from an SA facility to a public institution and is not expected to return within 30 days, or is incarcerated, regardless of when they may return, take the following actions:

1. Verify and document the change.

2. Send an adequate DSS-8110, Your Benefits Are Changing to notify of termination observing required time frames. Refer to SA-3330, Notices.

3. For SSI recipients, transfer to MA, refer to the relevant NC FAST job aid. Complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

4. For non-SSI recipients, always evaluate for potential Medicaid eligibility and other programs of assistance.

   NOTE: If SAD beneficiary is under age 21 (or age 22 and had 21st birthday while a patient in the state mental hospital), evaluate for long term care.

   NOTE: If/When prior approval for nursing level of care is received, transfer to MA in accordance with MA, LTC eligibility criteria.

G. Beneficiary Has A Change In Resources

1. For SSI recipients, complete and send a DMA-5049, Referral to Local Social Security Office, to SSA. Do not take any action to terminate SA unless the change affects SSI eligibility.

2. For non-SSI recipients, verify and document change in resources according to instructions in SA-3200, Resources.

   a. Record all verifications, including those items that are excluded from resource determination, on DSS-8191 Special Assistance Re-Enrollment Information Notice.

   b. Process all changes in resources (i.e., real property, personal

property and liquid assets) in accordance with SA-3200, Resources.

c. Contact the beneficiary. Verify and document the resource the first day of the month following receipt.

d. If resources have been reduced to the allowable limit, verify and document the reduction of resources. SA benefits continue.

H. Beneficiary Has A Change In Income

A change in income is defined as an acquired source of income, a change in rate or pay that will continue (not fluctuating income), or a termination of an existing source of income. Do not react to change until income is received.

1. For SSI recipients, send a DMA-5049, Referral to Local Social Security Office, to SSA. Do not take any action to change the SA payment unless the change affects SSI.

   NOTE: Suspension of an SSI payment is not considered a change that effects the SSI payment and does not require an action to be taken, other than sending the DMA-5049 and flagging the case for monthly checks for SSI payment changes.

2. For non-SSI recipients, verify and document change in income according to instructions in SA-3210, Income.

   a. To calculate the amount of new SA payment for increased or new income:

      (1) Re-budget the payment effective the month the income is increased, or the new source of income is received. Refer to SA-3220, Budgeting Principles.

      (2) Send a timely DSS-8110, Your Benefits Are Changing to terminate or reduce SA payment observing required time frames. The effective date of the revised payment is the month following expiration of the DSS-8110, Your Benefits Are Changing.

      (3) If the SA payment terminates, evaluate eligibility for Medicaid.

EXAMPLE 1: Increased/New Source of Income:

On July 30, Mr. Brown reports that he will begin receiving his VA benefits effective August 1. IMC verified receipt of VA income on August 4 and re-budgeted beneficiary's September and ongoing SA payments, including the new source of income. IMC sends a timely DSS-8110, Your Benefits Are Changing on August 4 to notify the beneficiary of change. Due to notice requirements, Mr. Brown's VA benefits do not affect his August SA payment.

b. To calculate the amount of the new SA payment for terminated or decreased income:

(1) Re-budget the payment effective the month the income changed and ongoing months.

(2) Send an adequate DSS-8110, Your Benefits Are Changing to notify beneficiary of the change in payment, including any supplemental payments for months prior to the month of the effective date of the change. Issue these supplemental payments via NC FAST.

EXAMPLE 2: Decreased/Terminated Income:

On July 29, Mr. Brown reported that his VA benefits decreased effective May 1. Re-budget a/b's May, June, July August and ongoing payments using decreased income.

Send an adequate DSS-8110, Your Benefits Are Changing to notify beneficiary of change in September payment, including any supplemental months.

c. To determine impact of overpayment and underpayment, refer to SA-3300, Administration of Benefits.

I. Beneficiary Cannot Be Located

If the beneficiary moves but leaves no forwarding address and you are unable to contact the representative:

1. For SSI recipients, transfer the case to MA, refer to the relevant NC FAST job aid. Complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

2. For non-SSI recipients, send a timely DSS-8110, Your Benefits Are Changing to terminate case, observing required time frames. Refer to SA-3330, Notices.

J. SAD Beneficiary Reaches Age 65

1. NC FAST automatically transfers the case from SAD to SAA for both SSI and non-SSI recipients. This occurs at the end of the month in which the beneficiary turns age 65.

2. Assure that Medicaid begins paying Medicare premiums. Refer to MA 2410 Medicaid Enrollment and Buy In. Evaluate for classification change to “Q” (Dual eligibility).

K. Beneficiary Is No Longer Disabled

1. Verify and document when a beneficiary is determined no longer disabled.

2. Send a timely DSS-8110, Your Benefits Are Changing to terminate Special Assistance observing required time lines. Refer to SA-3330, Notices.

    a. For SSI recipients, transfer to MA. (Refer to the relevant NC FAST job aid.)

    b. For non-SSI recipients, terminate SA and evaluate for potential Medicaid eligibility and other programs of assistance.

L. Beneficiary Is Deceased

1. Verify and document the date of death.

2. Send an adequate DSS-8110, Your Benefits Are Changing to terminate Special Assistance.

    a. For SSI recipients, transfer to MA. (Refer to the relevant NC FAST job aid.) Complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

b. For non-SSI recipients, terminate the case.

3. For any payments issued after death of the beneficiary, refer to SA-3300, Administration of Benefits.

M. Beneficiary Has A Change In State Residence

1. Document change of residence.

2. Send a timely DSS-8110, Your Benefits Are Changing to terminate Special Assistance payment observing required time lines. Refer to SA-3330, Notices.

   a. For SSI recipients, transfer to MA, referring to the relevant NC FAST job aid. Complete and send DMA-5049, Referral to Local Social Security Office, to SSA.

   b. For non-SSI recipients, terminate the case

N. Ongoing Case Is Discovered To Be In The Wrong County Of Residence

1. Document the beneficiary's SA case file with verification of correct county of residence.

2. Call the designated contact person in the correct county of residence to notify of the case transfer of the active SA case in NC FAST.

O. Active SA Beneficiary Becomes Enrolled In PACE

Individuals who receive Special Assistance **cannot** receive NC Program of All-Inclusive Care for the Elderly (PACE) coverage at the same time. The reason for this is because PACE provides all-inclusive care for PACE recipients, so duplicative care must be avoided.

The effective date of PACE enrollment cannot be on or prior to the termination of SA benefits. If an active Special Assistance beneficiary becomes enrolled in PACE, any SA payments received on or after the effective date of the PACE enrollment are an SA overpayment that must be recouped. **There can be no overlap of SA and PACE services.** As a result, good communication between program staff and effective time management are crucial**.**

IV. UNREPORTED CHANGES (CHANGES NOT REPORTED WITHIN THE REQUIRED 5 CALENDAR DAYS)

When an unreported change is discovered, evaluate the beneficiary's current eligibility based on the current situation.

A. If the beneficiary's current situation results in current eligibility:

1. Verify and document the change(s)

2. Flag the case if the change would require an action in 30 days, due to a temporary absence and proceed accordingly
3. Send the beneficiary notice of any change in benefits according to SA-3330, Notices.

4. Evaluate if at any past months resulted in ineligibility. If so, recoup the overpayments for any ineligible months

B. If the beneficiary's current situation results in current ineligibility:

1. Verify and document the change(s)

2. Send the beneficiary a timely DSS-8110, Your Benefits Are Changing

3. Evaluate if at any past months resulted in ineligibility. If so, recoup the overpayments for any previous ineligible months.

V. TERMINATION OF SA PAYMENT

A. Evaluate for Medicaid

When SA payment terminates, always evaluate ongoing eligibility for Medicaid prior to terminating Medicaid coverage.

B. Medicaid Pass-Along

The evaluation of terminated SA cases for Medicaid must include evaluating eligibility for Medicaid pass-along protection. Special Medicaid

eligibility provisions allow certain groups of beneficiaries, whose SA terminates to retain their Medicaid coverage through a disregard of certain RSDI benefits if they remain in the adult care home. This is called Medicaid pass-along. Refer to MA-2110, Pass-along, in the Aged, Blind, and Disabled Medicaid manual for instructions on evaluating and documenting pass-along eligibility when an SA payment terminates.

The following are two examples of Medicaid pass-along for terminated SA cases. Note that there are a number of pass-along provisions applicable to SA that are explained in detail in the Aged, Blind, and Disabled Medicaid manual.

Example 1: (COLA Pass-along): Mr. Stokes is an SAA beneficiary living in an SA facility. He received $1,210 RSDI in 2008. After the 2009 COLA, his RSDI increased to $1,281. The RSDI COLA increase caused his countable monthly income to exceed the SA/ACH Basic monthly rate, making him ineligible for SA. Under Medicaid pass-along regulations, he is eligible for continuation of his Medicaid coverage (if he remains in the SA facility) because after disregarding the COLA his countable income is less than the current SA income limit.

Example 2: (DAC Pass-along): Ms. Alleghany is an SAD **beneficiary** living in an SA facility. She receives a monthly annuity payment of $600. In In March 2009 her father died, and she became eligible for RSDI of $1,400 on his record based on her disability. She is no longer eligible for SA due to excess income. Under Medicaid pass-along regulations, she is eligible for continuation of her Medicaid (if she remains in the SA facility) because disregarding her RSDI check leaves countable income that is less than the SA income limit.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3320 REDETERMINATION OF ELIGIBILITY

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3320 REDETERMINATION OF ELIGIBILITY

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I. INTRODUCTION

This section outlines the procedures for redetermination of eligibility for Special Assistance A redetermination/recertification of eligibility factors subject to change is required once every twelve (12) months for all Special Assistance (SA) and Special Assistance In-Home (SAIH) cases. A signed SA redetermination form, DSS-8191 Special Assistance Re-enrollment Information Notice must be completed at every redetermination/recertification. Redeterminations/recertifications for SA and SAIH are not completed as an ex parte process.

II. REDETERMINATION FORM DSS-8191

The redetermination/recertification form DSS-8191 is sent automatically by NC FAST to all **SA beneficiaries**, including SSI beneficiaries, to be completed and returned. The DSS-8191 is sent the first of the month prior to the month in which the certification period ends. The beneficiary is instructed to return the completed DSS-8191 by the first day of the month in which the certification period ends.

All SA beneficiaries must complete, sign, and return the Redetermination/recertification form. This has been required since August 1, 2015.

An interview for SA redetermination/recertification is not required. Because the North Carolina Families Accessing Services Through Technology system (NC FAST) is not currently able to send the DSS-8191 to the authorized representative, the caseworker must manually send the DSS-8191 to the authorized representative.

III. PROCEDURE FOR ALL SA REDETERMINATIONS

A. The redetermination/recertification form DSS-8191 must be completed by the beneficiary or their representative.

B. The SA facility administrator/designee or other individual may assist with completing the redetermination/recertification with a written, signed designation appointing that person to be an authorized representative, provided by the beneficiary (if they are unable to complete the DSS-8191 and has no authorized representative). Request this written designation via DHB-5097, Request for Information if there is none on file and the beneficiary has not completed their information on the DSS-8191.

C. Eligibility factors and the verifications required are found in SA-3100.

D. If necessary, the county should also send a release of information form for completion by the beneficiary and explain that it will be used to make necessary contacts.

E. Complete on-line verifications. This includes SOLQ, AVS, DMV, RSDI, SSI, BENDEX, local property searches and any other available online verification.

F. Verify that the facility is still a licensed SA facility by conducting a facility search in NCFAST.

G. Request third party verifications, if necessary, to verify income, resources, and all other eligibility criteria. Do not verify resources or transfer of resources for SSI beneficiaries.

H. Verification of residence in the facility is required for all SA facility cases. Contact with the facility should be made to verify the beneficiary continues to reside in the facility.

I. If more information is needed, send a DHB-5097, Request for Information informing the beneficiary/representative of items needed to complete the redetermination/recertification. If the information is NOT received within twelve (12) calendar days after the date on the DHB-5097, send a DSS-8110, Notice of Benefits Changing to propose termination of the SA benefits.

J. All evidence, including any changes, must be documented/entered into NC FAST. Attach the returned, completed, and signed DSS-8191 to the case file.

K. End date/update evidence in NCFAST and conduct recertification procedures in NCFAST.

IV. IMPORTANT REMINDERS

A. If the DSS-8191 and required verifications are not completed by the end of the current certification period and entered into NC FAST, SA benefits will not be issued for the subsequent months.

B. FL-2's are valid for one year from the date of signature. If there is not a valid FL-2 entered into NC FAST, benefits will not be issued.

C. Verify that the current method of payment delivery is correct. If the method of payment requested is direct deposit, a valid DSS-5023 Direct Deposit Authorization form must be in the record. A new DSS-5023 Direct Deposit Authorization form only needs to be completed when there is a change to the delivery method or bank account.

D. SA does not allow exparte reviews except for Transitions to Community Living cases (see SA-5250).

E. For an a/b in a Special Care Unit (SCU), a visit to the facility by a DSS employee must be completed at every redetermination to verify placement in the SCU unless the facility only has SCU beds. The onsite visit may be completed and the residence in an SCU verified by any DSS staff. If the facility has ACH Basic beds, and SCU beds, verify the date the a/b entered the SCU by viewing the a/b's facility record.

1. Verify the a/b is currently in the SCU by viewing the a/b's room.

2. If the a/b is not a resident of the county of eligibility, a request to the DSS where the facility is located should be made to complete the required visit for verification purposes.

3. The SA applicant and/or beneficiary must be notified in writing when an application is denied, withdrawn, approved, when there are any intended changes to the Special Assistance (SA) benefit or authorizing continuing eligibility with no change in benefits.

F. The DSS-8108 is the proper notice for all SA approvals at application and redetermination. However, it has come to our attention the DHB-5002 is also a correct approval/renewal notice for Special Assistance. Counties may use either the DSS-8108 that will be issued by NCFAST or may complete a manual DHB-5002 for SA redeterminations.

V. SA BENEFICIARIES WITH MEDICAL CARE SPECIAL EXPENSES (MCS)

A. Only cases that were active with Services for the Blind prior to September 1, 2010, and transferred to the SA Program in September 2010, can have MCS. If you need the original list, contact specialassistance@dhhs.nc.gov

B. At redetermination/recertification, the income maintenance caseworker (IMC) must also re-verify the MCS expenses for each beneficiary. Request verification of expenses for the past year via the DHB-5097.

C. Acceptable verification of MCS expenses can be an itemized, including costs, on the DSS-3006, MCS Medical Expense Form, signed by the facility pharmacist, or dated receipts for MCS items purchased by the facility for the beneficiary during the applicable verification period. Attach the verifications to the case file.

D. Divide the annual total verified expenses for MCS items (those not covered by Medicare or Medicaid) and divide by 12 months to determine the monthly MCS expense amount to use in the SA payment calculation.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3330 NOTICES

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3330 NOTICES

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I. INTRODUCTION

This section contains regulations and procedures for notifying the client of case action/status. The a/b has a right to a written notice when the application is approved, denied, or withdrawn and when the payment is to be continued, changed, or terminated. The a/b also receives a notice when there is a need for additional information.

NOTE: A written notice of approval at application or recertification, whether manually generated by the IMC or generated by NC FAST, must show the approved certification period when it is sent to the a/b.

II. NOTICE REQUIREMENTS

A. DSS-8109 and DSS-8109A – Your Application For Benefits Is Being Denied Or Withdrawn

1. The DSS-8109, Your Application For Benefits Is Being Denied Or Withdrawn, is used for denying or withdrawing an application. It notifies the applicant of the denial/withdrawal action, the reason for the denial/withdrawal and his right to appeal if he disagrees with the denial/withdrawal.

2. EIS automatically generates a DSS-8109A unless you override the automated notice. Refer to EIS-2150 for override instructions.

3. When you override the automated notice, document the reason for the override in the case record and manually complete the DSS-8109.

    a. Denials

        (1) Indicate on the notice the type of assistance being denied and the reason for the denial.

        (2) Always use the appropriate denial code when denying an application. Avoid the use of “other” codes wherever possible. It is important that the text on the notices clearly explain to the recipient the reason for the denial.

        (3) If you find a situation for which there is no appropriate denial code, please notify the EIS Unit so that needed codes can be developed.

b. Withdrawals

(1) Indicate on the notice the type of assistance being withdrawn and that the application is being withdrawn at the applicant's verbal or written request, whichever is appropriate.

(2) Carefully document in the record the reason for the applicant's withdrawal and that all alternatives to withdrawal were explained.

4. Enter the policy manual section that supports the denial or withdrawal.

5. Complete WHEN TO ASK FOR A HEARING. Begin counting the 60 calendar days on the day following the date of the notice. If the 60th day falls on a non-workday, the applicant has until the end of the next workday to request a hearing.

6. Mail or give the original to the applicant. File a copy in the case record.

B. DSS-8108 and 8108A- Notice of Benefits

1. Use a manual or automated DSS-8108 when:

a. Approving an application.

b. Approving a portion of a payment period and denying another portion of the payment period. This includes, but is not limited to, open-shuts and applications when resources are reduced.

c. Authorizing continuing eligibility with no change in benefits.

2. Always complete a manual DSS-8108 when:

a. An application is approved which includes CAP-MR/DD.

b. Benefits are issued on the DMA-5022, EIS Retroactive Eligibility Checks/ID Cards.

c. Transferring a case from Special Assistance to Medicaid.

3. Generating and Overriding the Automated DSS-8108

a. EIS automatically generates a DSS-8108A for approvals and redeterminations with no change in benefits, unless you override the automated notice. The notice text is based on the approval or redetermination reason code entered on the DSS-8125 screen. Refer to EIS-4000, Codes Appendix for instructions.

b. You may choose to override the automated notice and complete a manual DSS-8108. Refer to the EIS Manual for override instructions. If using a manual notice, mail or give the original to the a/b and file a copy in the case record.

C. DSS-8110 and 8110A – Your Benefits Are Changing

The DSS-8110, Your Benefits Are Changing, is used to notify the recipient when benefits are changed, reduced or terminated. It notifies the recipient of what the change is, when it will take place, the reason for the change, and of his right to appeal if he disagrees with the case action. The manual DSS-8110 may be used for timely or adequate case actions.

1. Adequate Notice

The recipient must be informed in writing of a change in benefits prior to the change. The effective date of an adequate notice is the day it is mailed. Use adequate notice only in the following situations:

a. The change is beneficial to the recipient,

b. A recipient dies.

c. A recipient is admitted to a public institution and no longer qualifies for assistance.

d. A recipient signs and dates a written statement or requests to have his assistance terminated or reduced.

e. A recipient is placed in skilled nursing care, intermediate care, or long-term hospitalization.

f. A recipient's whereabouts are unknown and agency mail sent to him has been returned by the post office indicating no known forwarding address.

g. Assistance authorized for a specific period is terminated and the recipient was informed in writing at approval that such benefits would stop at a specific time. (An example of this would be the approved certification period that is included on approval notices.)

2. Timely Notice

   Use a timely notice any time assistance is reduced or terminated, except for situations described in II.C.1. immediately above.

   You must inform the recipient in writing of the intended change prior to taking the action. Do not reduce or terminate benefits until 10 workdays following the effective date written on the notice.

3. Always use a manual DSS-8110 notice when:

   a. Benefits are issued using a DMA-5022, EIS Retroactive Eligibility Checks/ID Cards.

   b. The case includes CAP-MR/DD.

   c. The case is transferred from Special Assistance to Medicaid

4. Generating and Overriding the Automated DSS-8110A

   a. When you make a change to reduce or terminate benefits by entering a timely reason code on the DSS-8125 screen, EIS produces and mails an automated DSS-8110A. The word “TIMELY” is printed at the top of the automated notice next to the type of action being taken

   b. When you make a change to reduce or terminate benefits by entering an adequate reason code, EIS produces and mails an automated DSS-8110A. The word “ADEQUATE” is printed at the top of the automated notice next to the type of action being taken

   c. When the DSS-8125 screen is correctly entered following instructions in the EIS Manual, the automated notice is produced and mailed the day after the form processes.

d. You may choose to override an automated timely or adequate notice and complete a manual notice. If using a manual notice, send the original to the a/b and file a copy in the case record.

5. Notice Texts

a. Refer to the EIS Codes Appendix for notice text for automated notices. The texts are tabled in EIS and are printed on the automated notice based upon the change or termination reason code.

b. Use the appropriate change or termination reason code based on the reason for the change. If an automated notice text does not exist that covers the change or termination, use the change reason “other”. If you use “other,” use the Notice Text feature to provide the appropriate message for the automated notice. Or, you may choose to complete a manual notice.

c. When using a manual notice, use text that clearly explains the reason for the change. Avoid the use of “other” codes wherever possible. It is important that the text on notices clearly explain the reason for the change to the recipient.

d. If you find a situation for which there is no appropriate code, please notify the EIS Unit so that needed codes can be developed.

6. Automated Notice Effective Dates

a. Timely Notice

(1) When you enter a timely reason code in EIS, the date of the automated notice is the first State workday after the DSS-8125 screen successfully processes in EIS. The notice is also mailed on this date.

Example: The DSS-8125 screen is entered August 2 (Friday). The notice is dated and mailed on August 5 (Monday).

(2) The 10 workday timely notice period begins the first State workday after the day the notice is mailed.

Example: The DSS-8125 screen is entered August 2 (Friday). The notice is dated August 5 (Monday). The 10 workday period begins on August 6 (Tuesday). Therefore the 10th workday is August 19 (Monday).

(3) The change in the case will process on the night of the first State workday immediately following the 10 workday period unless the action is rescinded or deleted. See instructions in II.C.6.e-f, below for rescinding or deleting a timely action.

b. Timely Notice with Override of Automated Notice

When you enter a timely reason code and you override the automated notice by keying “Y”, EIS will count 10 workdays and update the system on the same schedule as it does when the notice is not overridden. Overriding the notice does not prevent EIS from processing the timely action on the night of the first State workday following the 10 workday period.

c. Adequate Notice

When you enter an adequate reason code, the date of the automated adequate notice is the first State workday after the DSS-8125 screen processes. The notice is also mailed on this date. EIS is updated with the changed information the night the change is entered. When you use an adequate reason code and you override the automated notice by keying “Y”, EIS will process the action that night. Therefore, the manual adequate notice must be dated and mailed on the same day the action is entered in EIS.

d. In certain situations, you may choose to use a combination of timely and adequate actions.

(1) Complete and mail a manual timely notice to the recipient. On the workday following the 10th workday of the manual notice, enter the DSS-8125 with an adequate reason code and override the automated notice. The recipient has already been notified; therefore, another notice is not required.
OR

(2) On the workday before the manual notice is mailed, enter the correct timely reason code and override the automated notice. If the recipient comes in during the 10 day period and establishes ongoing eligibility with no change, delete the

timely action. The timely action will not occur in EIS until after the 10th workday even if you override the notice.

e. Deleting Timely Action

If you use a timely reason code and the recipient responds within the 10 workdays, and eligibility continues with no change in benefits, delete the timely action.

f. Rescinding Timely Action

(1) If you use a timely reason code and the recipient responds within the 10 workdays, and eligibility continues with a change in benefits, rescind the timely action. This means that EIS will not process the pending timely action; it will be replaced by the new action.

(2) If a timely action is pending and you enter a new action in EIS that produces a notice, EIS will rescind the pending timely action. This is true for any new action, whether timely or adequate (requires reason code). Even if you override the notice on the second action, the new action will rescind a pending timely action. This also includes continuation of benefits after a review, terminations, etc.

Example: Timely termination was keyed on Friday, May 15. The notice was mailed Monday, May 18. The termination will process on the night of Tuesday, June 2. If you key another change action (timely or adequate) during the 10 workday period of May 19 through June 1, the first action is rescinded. Overriding the automated notice on the second change will not prevent the first from being rescinded.

(3) During the 10 workday period of a timely notice, adequate changes may occur which would have the same effective date as the timely negative action. If the recipient responds to the timely notice by successfully establishing continuing eligibility but there is also an adequate change to the case:

(a) Enter a new DSS-8125, EIS Data Sheet screen with the adequate change reason and the changes to the case. The adequate notice may be automated or manual.

(b) The adequate change will rescind the pending timely action. If that action should still take place, enter another DSS-8125 screen. Use an adequate change code and enter “Y” in notice override. Enter this DSS-8125 screen on the first workday following the day the timely change processes (the 11th workday).

Another timely notice is not required because the first one has already been produced and mailed.

(c) If no notice is produced because there is no change code or the notice is overridden, the pending timely action will not be rescinded. It will take place on the 11th workday. A notice is not produced when demographic information, such as the address, is changed.

g. Demographic Changes During the Timely Notice Period

You can enter in EIS case changes that do not affect the type, amount or duration of assistance while the timely action is pending, except on the last day of the 10 workday period. These include address changes or any changes to individual data other than date of death.

h. If the DSS-8125, EIS Data Sheet screen is entered too late in the month (after pull cutoff) to make the termination or change effective the next calendar month, EIS automatically changes the effective date.

Example: DSS-8125 screen showing a termination effective date of March 31 and a timely reason code is entered on March 14. The day after the 10th workday is March 30. Pull cutoff is March 22. Because the action effective day falls after pull cutoff, EIS will change the termination effective date to April 30.

7. Schedules of Timely Actions Pending in EIS

a. Automated Timely Notice Schedule When EIS Issues A Notice

FRI Mar 13	MON Mar 16	TUES Mar 17	MON Mar 30	TUES Mar 31	Night of Mar 31

Workday #1 8125 entered	Workday #2 Notice is mailed	Workday #3 Notice day #1	Workday #12 Notice day #10 - 10 days expires	Workday #13 Notice day #11 5:00 deadline to delete or rescind action	Night of Workday #13 EIS updated

b. Processing Schedule for Timely Actions When Notice Is Overridden

FRI Mar 13	MON Mar 16	FRI Mar 27	MON Mar 30	Night of Mar 30
Workday #1 8125 entered with override IMC mails notice	Workday #2 Notice day #1	Workday #10 Notice day #10 - 10 days expires	Workday #12 Notice day #11 5:00 deadline to delete or rescind the action	Night of Workday #12 EIS updated

D. Additional Message Capability

There are some situations in SA approvals and changes when part of an eligibility period is affected. For these situations, EIS has two additional notice message features.

1. Secondary Notice Codes

   Use a secondary notice code only when an application is approved. Refer to the Secondary Approval Code Table in EIS-4000. You may use only one secondary code with an approval code.

   Example: Mrs. Brown applied for SA in August. August is denied because Mrs. Brown was over the resource limit. SA was approved effective in September. Use the approval code for the automated notice. Use the secondary notice code for month denied on the basis of excess reserve. The following message will print on the notice: “SA was denied for other months for which you applied because you were over the resource limit.”

2. Free Form Text Capability (Notice Text)

If the case situation calls for a message for which there is no reason code, you may use the Notice Text capability of EIS rather than send a manual notice.

a. Approvals

When an appropriate secondary approval code is not available, you may use the Notice Text. The automated notice will include the message from the approval code and the Notice Text message.

b. Changes and Terminations

If the change or termination reason is “other,” you must supply the text of the notice by using the Notice Text capability. The notice will not be generated if the text is not entered.

III. AUTOMATED NOTICE REGISTER

EIS does not provide counties with a copy of each individual notice it produces and mails. Instead, EIS produces a register each night, listing each adequate, timely and approval notice that was generated. It also lists cases for which the notice was overridden, deleted, or rescinded. The notice register is mailed to the county the next workday. The register is also available in XPTR. Refer to ES-2304, Notice Register Report and EIS-1061, XPTR Report Distribution System.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3340 HEARINGS

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3340 HEARINGS

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I. INTRODUCTION

This section contains the procedures for conducting local and State hearings when an a/b appeals a county DSS action.

II. APPLICANT'S/BENEFICIARY'S RIGHTS

A. The a/b has the right to appeal any action taken, including but not limited to the following:

1. When the county department denies an applicant the opportunity to make an application on the day the applicant first appears at the agency and wishes to apply.

2. When a substitute payee is appointed and the a/b disagrees with this action.

3. When the individual alleges he/she improperly withdrew his/her application.

4. When a replacement check is denied.

5. When assistance has been approved, denied, modified, or terminated.

   NOTE: It is not necessary to conduct a hearing when either state or federal law requires automatic adjustments for classes of recipients unless the reason for the hearing is incorrect computation or there is a factual issue regarding whether the change applies.

6. When the county DSS fails to act within the required time standards.

7. When the county department fails to act promptly on a request for a review of the case situation.

B. The a/b may request the hearing verbally or in writing.

C. The a/b must request a hearing within 60 calendar days from the date the notice of action is mailed or given, unless the a/b can show good cause for a later request. If good cause exists, the request must be no later than 90 days from the date of the notice of action.

1. For appeals based on allegation of discouragement, improper withdrawal, or improper denial, the time limit for requesting a hearing shall be 60 days (or 90 days with good cause) from the date the applicant became aware or should have known that incorrect or incomplete information given by the county DSS caused the applicant not to apply, caused the applicant to withdraw their application, or that the denial was improper.

2. Good cause is defined as:

    a. Failure of the a/b to receive the notice of action,

    b. Extended hospitalization of the a/b or the spouse, child, or parent of the a/b,

    c. Failure of a representative acting on the a/b's behalf to meet required time frames, or

    d. Illness resulting in incapacity, incompetence, or unconsciousness of the a/b and there is no representative acting on the a/b's behalf, or

    e. Death of the a/b or their representative, or

    f. Failure of the county DSS to provide sufficient or correct information regarding appeal rights.

3. Evidence of good cause, which must be provided by the a/b, includes but is not limited to:

    a. Physician's written statement,

    b. Hospital bill, or

    c. Written statement of a/b, their representative, or other individual knowledgeable of situation.

D. The a/b has the right to be represented at hearings by the person of their choice, including an attorney obtained at the a/b's expense.

E. In cases involving issues other than disability, an a/b has the right to request a state hearing <u>only</u> after a local hearing has been held and a decision has been rendered.

F. The a/b must request a state hearing within 15 calendar days of the mailing of the local hearing decision unless he can show good cause for a later request as defined in II.C.3., above.

G. In cases involving a question of disability, an a/b has the right to request a state hearing. Do not conduct a local hearing.

H. If, at any point, the a/b does not exercise their right to a hearing or the right to continued assistance, the a/b still has the right to reapply.

I. Right to Continued Benefits

A recipient whose benefits are changed or reduced may be entitled to continued benefits while awaiting a hearing decision. Continuation of benefits applies only to recipients. It does not apply to applicants who are denied assistance because there are no benefits to continue.

1. Recipients Who Receive Timely Notice

   a. If a recipient appeals a reduction or termination of benefits on or before the effective date of the change (10 workdays after the notice is mailed or given to the recipient), he has the right to continued benefits until the end of the month in which the local hearing decision is rendered, except when the reduction or termination involves a disability determination by DDS or the recipient waives his right to continued benefits. If the reduction or termination involves a disability decision by DDS, the recipient has the right to continued benefits until the end of the month in which a State hearing decision is rendered.

   b. The recipient is not entitled to continued benefits if the appeal is not requested within the 10 workday period.

   c. When the recipient requests the hearing, advise him that:

      (1) If the reduction or termination of benefits is affirmed by the local or state hearings officer, he may be required to repay the benefits he received while awaiting a decision, and

(2) He has the right to choose not to continue to receive benefits.

d. In some cases, a hearing decision upholding the county's action will be rendered prior to the termination of benefits. In these situations, no additional action is necessary. If benefits must continue for an additional period, administratively reopen the case for one month at a time until a decision is rendered. Complete any required case actions during the extended period.

2. Recipients Who Receive Adequate Notice

Recipients who receive adequate notice and appeal do not have the right to continued benefits.

III. PROCEDURES FOR HANDLING HEARINGS ON DISABILITY ISSUES

In cases involving a question of disability, the county director or a designee must, within five calendar days of the request for a hearing, forward the request to the Chief Hearing Officer to schedule a state hearing. Refer to V. below for state hearing procedures.

IV. LOCAL HEARING

A. Purpose

The local hearing allows the county agency to explain the action in question and the appellant to explain why he feels that action should not take place.

B. Scheduling

1. Hold the local hearing within 5 calendar days after it is requested, unless the appellant has good cause for a delay.

2. The appellant has good cause to delay the local hearing when:

a. There is a death in the appellant's family.

b. The appellant or someone in their family is ill.

c. The appellant is unable to obtain representation.

d. The appellant's representative has a conflict with the scheduled date.

e. The appellant receives a properly dated and mailed notice of action proposing a reduction or termination of assistance after the 10 workday notice period expires.

f. The appellant is unable to obtain transportation.

g. The hearings officer determines that the hearing should be delayed for some other reason.

3. If the a/b has good cause, the hearing may be delayed up to 10 more calendar days. A local appeal hearing may not be held more than 15 calendar days after a request for a hearing is received.

C. Place

Hold the hearing in the county social services office unless the appellant is bedfast or has great difficulty moving. In such cases, the hearing may be held where the appellant lives.

D. Seeing the Record

Prior to and during the hearing, the appellant or their personal representative may examine the contents of the case file together with portions of other public assistance or social services case files that pertain to the appeal. They also may examine all other documents and records to be used at the hearing. The appellant or their representative may obtain copies of these materials without charge.

E. Summary

1. Prepare an original and two copies of a summary discussing the agency's action and the reasons for that action. Cite the regulation substantiating that action. Attach to the summary copies of pertinent documents.

2. Give the original to the hearing officer. Give one copy to the appellant. Following the hearing, file the other copy in the eligibility record.

F. Attendance

Attendance at the hearing is limited to the appellant, their representative, appropriate representatives of the county department, and any witnesses which the appellant or the county wish to call upon for testimony.

G. Conducting the Hearing - Refer to "Local Appeal Hearing Officer's Handbook"

1. The appellant and the county may be represented by attorneys or other representatives obtained at their expense.

2. Hold the hearings before the county director or their designee, provided that whoever hears the appeal was not involved directly in the initial decision, which resulted in the appeal. The designee can include another county employee, a board member, or an employee of a social services agency in another county.

3. It is not required that the hearing be recorded. However, a written summary of the hearing must be maintained.

4. The County and the appellant must each name someone to present the testimony and to call witnesses. Any person testifying must be sworn in.

5. The county's representative must read the summary and explain the county's action, or call upon someone to do so. They may call witnesses, one at a time. When the county's testimony has ended, the appellant or their representative may question the county's witnesses or representative.

6. The appellant or their representative may then explain why they feel the county's action should not take place. They may call witnesses, one at a time. When the appellant's testimony has ended, the county or its representative may question the appellant, their witnesses, or representative.

7. Representatives for the county and the appellant may present closing statements summarizing their view of the situation in question.

H. Decision

1. The county director or their designee will make a decision in the case, based on appropriate regulations and evidence presented at the hearing. Those factors must be cited in a written statement of the decision.

2. The written statement of the decision must be sent to the appellant by certified mail within 5 calendar days of the local hearing.

3. Put a decision upholding the appellant into effect within two weeks after the decision is rendered.

I. Recovery

If a reduction or termination of assistance is affirmed, any benefits received during the time of the appeal are subject to recovery.

J. Further Appeal

If the appellant is not satisfied with the local hearing decision, they may, within 15 calendar days of the mailing of that decision, request a state hearing through the local Division of Social Services, or within 90 days of the date of the original notice of action, if they can show good cause for a later request, as defined in II.C.3., above. The request can be either verbal or written and is made to the department of social services.

V. STATE HEARING

A. Purpose

The state hearing safeguards the interest of the individual client and assures fair and equitable administration of assistance programs.

B. Request for Hearing

1. Submit DSS-1473, Request for State Appeal, to the Chief Hearing Officer, Hearing and Appeals Section, Division of Social Services:

    a. On the day the appellant requests a state hearing that does not involve a question of disability.

b. Within 5 calendar days of the date the appellant requests a state hearing that involves a question of disability.

2. Attach a copy of the local hearing decision.

3. Attach to the DSS-1473, Request for State Appeal, all medical records dated within the last twelve months when denial or termination of assistance was due to lack of disability. If older information is needed, it will be requested following a review of the more recent information.

C. Scheduling

1. The hearing officer designated to handle the hearing will give reasonable notice to the county and the appellant of the time and place of the hearing.

2. The appellant may request and is entitled to receive a postponement of the scheduled hearing with good cause. The appellant has good cause to postpone the hearing when:

   a. There is a death in the appellant's family.

   b. The appellant or someone in their family is ill.

   c. The appellant is unable to obtain representation.

   d. The appellant's representative has a conflict with the scheduled date.

   e. The appellant receives a properly dated and mailed notice of action proposing a reduction or termination of assistance after the 10 workday notice period expires.

   f. The appellant is unable to obtain transportation.

   g. The hearings officer determines that the hearing should be delayed for some other reason.

3. The postponement may not exceed 30 calendar days from the date the hearing was originally scheduled.

D. Place

Hold the hearing in the county social services office unless the appellant is bedfast or has great difficulty moving. In such cases, the hearing may be held where the appellant lives.

E. Seeing the Record

Prior to and during the hearing, the appellant or their personal representative may examine the contents of his case file, together with portions of other public assistance or social services case files that pertain to the appeal. They may also examine all other documents and records to be used at the hearing.

F. Summary

1. Prepare an original and two copies of a summary discussing the agency's action and the reasons for that action. Cite the regulations substantiating the action. Attach to the summary copies of pertinent documents.

2. Give the original to the hearing officer. Give one copy to the appellant. Following the hearing, file the other copy in the eligibility record.

G. Attendance

Attendance at the hearing is limited to the appellant, their representative, appropriate representatives of the county department, and any witnesses which the appellant or the county wish to call upon for testimony.

H. Conducting the Hearing

1. The appellant and the county may be represented by attorneys or other representatives obtained at their expense.

2. A hearing officer from the Division of Social Services presides at the hearing and administers the oath to all participants. The hearing officer will also record the hearing. No transcript will be prepared unless a petition to Superior Court is filed.

3. The county and the appellant must each name someone to present their testimony and to call witnesses.

4. The county's representative must read the summary and explain the county's action, or call upon someone to do so. They may call witnesses, one at a time. The hearing officer may question witnesses during their testimony. When the county's testimony has ended, the appellant or their representative may question the county's witnesses or representative.

5. The appellant or their representative may then explain why they feel the DSS' action should not be implemented. They may call witnesses, one at a time. The hearing officer may question witnesses during testimony. When the appellant's testimony has ended, the DSS representative may question the appellant, witnesses, or representative.

6. Representative for the DSS and the appellant may present closing statements summarizing their view of the situation in question.

VI. IMPLEMENTING DECISIONS

A. Time Standards for Hearing Officers

1. The hearing officer must render a decision not more than 90 calendar days from the date of the request for the local hearing.

2. The hearing officer will prepare a tentative decision on the DSS-1894 which will be sent to the appellant by certified mail.

B. Time Standards for Applicant/Recipients or County DSS

1. The DSS and the appellant may present oral and/or written agreements, for and against the Notice of Decision no later than 10 calendar days from the date of the notice. Both must contact the chief hearing officer to present arguments. No new evidence will be accepted at this level of the appeal process.

2. If no written argument or request for oral argument is made within 10 calendar days of the tentative decision, the tentative decision becomes final 10 calendar days after the date of the DSS-1894.

3. If the party that requested oral argument fails to appear at the hearing for oral argument, the tentative decision becomes final. If contested,

it is final when the final decision is signed. The final decision is forwarded on the DSS-1893, by certified mail.

4. Further Appeal

   If the appellant is not satisfied with the final decision following the state hearing, he may, within 30 calendar days of the receipt of that decision, file a petition for judicial review in Superior Court. For appeals filed after 30 calendar days, a Superior Court judge may issue an order permitting a review if the judge believes good cause exists for the delay in filing.

C. Time Standards for Implementing Hearing Decisions on Applications

1. All information needed to determine eligibility must be requested within 5 days of the date of the final decision of the appeal.

2. If there is a subsequent need for additional information, it must be requested on a DHB-5097 within 5 workdays of the date that the need for the additional information became known to the DSS.

3. Dispose of the application within 5 workdays of receipt of the last piece of information needed to determine eligibility. Mail the check within five workdays that all information is received.

4. Application processing standards apply to hearing decisions.

D. Time Standards for Implementing Decisions on Terminations/Modifications of Assistance

1. Implement the appeal decision within 14 workdays from the date the decision is received by county DSS.

2. To reopen a terminated case, enter a date of application that is the first day of the month following the effective date of termination. Complete a DSS-8124, Application Data Processing Form. If there is a signed application in the file, this application need not be signed.

E. Overrides

If eligibility is approved for any period more than 12 months prior to the date of the decision, send a cover letter to the payment benefits section. Refer to MA-2395, Corrective Actions and Responsibility for Errors, for instructions for Medicaid overrides.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3400 AUTOMATED INQUIRY AND MATCH PROCEDURES

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3400 AUTOMATED INQUIRY AND MATCH PROCEDURES

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I. REQUIREMENTS

This section contains the procedures for conducting local and State hearings when an a/b appeals a county DSS action.

A. The Income and Eligibility Verification System (IEVS) requires that certain matches be conducted using the social security numbers (SSN'S) of each a/b in the assistance unit.

B. The a/b must furnish to the county all SSN's which they have used or under which they have received benefits. The a/b must be informed in writing at application and at each redetermination that these SSN's will be used for matching with other agencies and that this information may affect their eligibility. The a/b must be advised that if they do not wish to participate in the matches, they may withdraw their application or terminate their assistance.

C. When a match is found in an ongoing case, the county must take any necessary action within 45 days of the date of the match. Taking necessary action is defined as sending the appropriate notice to the a/b notifying them that their application is denied or that their benefits are changed/terminated.

II. ONLINE INQUIRIES

Special Assistance (SA) policy requires that certain matches and inquiries be conducted using all social security numbers/names used by the a/b. These matches and inquiries are required at each application, redetermination, and change in situation. The purpose of completing these matches and inquiries is to assure that eligibility and payments are accurate, and to detect and reduce the incidence of fraud, waste, and abuse in the SA Program. The online inquiries are as follows:

A. Eligibility Information System (EIS)

B. State Online Query (SOLQ)

C. State Data Exchange (SDX)

D. Beneficiary Data Exchange System (BENDEX)

E. Department of Transportation (DOT)

F. Department of Corrections (DOC)

G. Master Client Index (MCI)

H. Common Name Database System (CNDS)

I. County Property Tax Records (if available)

J. Employment Security Commission/Unemployment Insurance (ESC/UI)

If ESC has the incorrect social security number:

1. Notify the Economic Independence Section, Programs Operations Branch in writing at 2420 Mail Service Center, Raleigh, N.C. 27699. Include in the letter:

    a. the a/b's name

    b. a/b's correct SSN

    c. incorrect SSN

    d. a/b's place of employment.

2. Verify the SSN before notifying the Fraud Prevention and Corrective Action Branch.

III. MATCH REPORTS

A. Social Security Number Validation Discrepancy Report

1. An SSN Validation Discrepancy Report is generated when:

a. Validation cannot be accomplished based on the match with NUMIDENT or BENDEX, or

b. Program data differs in MCI.

2. Counties must resolve discrepancies to ensure more accurate automated matches. Reports are sorted in worker number order and include all identifying case information along with a discrepancy message.

   The report is generated for the program (PROG) specified. The report gives the district/worker number (DIST#), county case number (CTY CASE) and case ID number (SYS CASE).

   The following discrepancy messages will appear on the report:

   a. DOB Does Not Match

   b. Name Does Not Match

   c. SSN Not in SSA File

   d. SSN Does Not Match

   e. * Items Do Not Match

   f. DOB Does Not Match Bendex

3. If the report message consists of only one line, your individual data was used to attempt the validation when it was sent to SSA. This also indicates no other program's data has been validated for your individual. The reason for non-validation is indicated by the discrepancy message and an asterisk (*).

   a. Research the individual to ensure that EIS contains the correct SSN, name and date of birth. Be sure to check for keying errors. If you are successful in resolving the discrepancies in the vital data, update the data field in question in the Name Change screen in EIS. This causes the data to be re-sent for validation.

   b. If the individual's correct SSN has already been used in EIS:

      (1) Call DMA staff at (919) 857-4019 if the individual with the incorrect SSN is a SSI recipient.

(2) Call the Medicaid worker for the case in all other situations to resolve the discrepancy.

4. Resolving Two Line Messages

   If you receive a two line error message on your discrepancy report, this indicates that the individual record in MCI for the program listed on line 01 has validated with SSA. The report is sent to the worker to resolve a discrepancy for the individual on line 02.

   a. If you find that the first line lists an individual who is not the same person who is listed on the second line, then these individuals have been matched in MCI erroneously.

   b. To verify this is the problem, follow the instructions below.

      (1) First do a client inquiry using either of the two individuals listed on the discrepancy report.

      (2) Obtain the Match ID.

      (3) Then do a Match ID inquiry with the Match ID. You should see the other individual who was listed on your report.

      (4) To correct this problem, follow instructions found in EIS User's Manual, EIS 1057, VI.B. for client unmatching.

      (5) After unmatching the individuals in MCI, the unvalidated record is submitted to SSA for validation.

5. Allowing Time for Systems to Work

   When you respond to a SSN Validation Discrepancy Report by correcting information in EIS or MCI, you must allow at least 60 days for the validation process to work.

6. Requests for Manual Validations

   Before pursuing manual validations, compare your EIS profile to the SS card and birth information in the record. If the information in EIS matches the information on the SS card and birth verification, pursue manual validation. If you are unable to enter the SSN into EIS, determine if another individual in EIS had this number. Refer to III.A.3.b. above.

a. When requesting a manual validation, you must send all of the following to IEVS Coordinator:

IEVS Coordinator (check all these)
1985 Umstead Drive
Raleigh, NC 27626-0529

(1) Copy of the discrepancy report.

(2) Your name and telephone number.

(3) Copy of the SS card showing same name and number as in EIS. If you don't have a copy of the SS card, send a copy of the on-line SDX.

(4) Copy of the birth certificate or copy of BENDEX showing same DOB as in EIS.

(5) Copy of the most recent EIS case profile.

If the IEVS Coordinator has questions, he/she will contact you. If the request is not pursued, the IEVS Coordinator will return your request with an explanation. Requests are not pursued when the information received is not complete according to the above list. Another reason may be that your request does not require the manual validation process such as the client needs to go to SSA or EIS needs to be updated.

b. The IEVS Coordinator will confirm with SSA that this is the correct SSN for this individual. If all information is correct, State staff will enter a validation code "M" on the MCI validation screen. The "M" code indicates that a manual validation has been completed for that SSN. The IEVS Coordinator will send you a letter if SSA's data is incorrect. At the next review, inform the a/b that he may want to contact SSA to make corrections in their data. Inform the a/b that this will not affect their eligibility.

This manual validation process takes some time to complete. It is possible that these individuals will appear on the SSN Discrepancy Reminder Report. Do not send the information to the IEVS Coordinator a second time.

However, once the "M" code appears on the MCI validation screen, EIS will no longer generate the Discrepancy or Reminder Reports.

7. Resolving Discrepancies When Incorrect Data Validates

   Because SSA does not require an exact match for validation, there are cases where the SSN with wrong vital data validates and the program with the correct data shows a discrepancy. The program with the wrong data must make the necessary corrections to its base system, regardless of whose data validated.

   Whenever a change is made in the vital data in EIS, the SSN is automatically resubmitted for validation. At that time, the SSN will validate and MCI automatically validates the other matched program since they are now identical.

B. SSN Validation Reminder Report

In addition to the SSN Validation Discrepancy Report, you receive an SSN Validation Reminder which includes individuals from earlier discrepancy reports on which no action has been taken. The report is printed in the same format as the Discrepancy Report.

1. The report is generated when:

   a. No action has been taken within 45 days of the original discrepancy report, or

   b. An individual has been in EIS more than 125 days with no SSN.

      If action has been taken but it has not had time to be completed (such as requesting manual validation), these individuals continue to be listed on the Reminder Report. It is not necessary to take the action a second time.

2. "Needs SSN" Message

   This message appears on the SSN Validation Reminder Report and indicates that the individual is in EIS without an SSN. You should obtain an SSN and update EIS.

C. BENDEX

1. The BENDEX system is a monthly computer match by SSN's between the public assistance recipient files and SSA records. All recipients with SSN's in EIS will be included in the match.

2. In addition to the on-line BENDEX, the computer prints an individual BENDEX information sheet identifying the recipient and the current status of their SSA benefits. The IMC will receive a BENDEX sheet on an a/b when:

    a. the a/b first receives Social Security,

    b. the a/b becomes entitled to an increase or decrease in benefits,

    c. there is a change in hospital benefits,

    d. the a/b is entitled to insurance or supplemental Medicare insurance,

    e. there is any other change in SSA's Master Beneficiary Records (MBR).

3. Because the BENDEX sheets indicate a change in the a/b's SSA data, compare this information with the case record each time a BENDEX sheet is received. Take any necessary action within 45 days of the date on the BENDEX sheet, or no later than the next case action or redetermination, whichever is earlier.

    a. If the record indicates this information has already been reported and verified, document the record and take no further action.

    b. If the charges were previously unreported, document the record to substantiate that the BENDEX was checked and to reflect the results of the match.

D. SDX

1. Paper updates are generated on a daily basis to provide current input on accretions, deletions, changes of address, or other changes in situation occurring after the monthly tape is run.

2. In addition to the on-line SDX, the computer generates an individual SDX information sheet identifying the recipient and the current status of their SSI benefits. The IMC will receive a SDX sheet when:

    a. the a/b first receives Supplemental Security Income; or

    b. certain information has changed in their SSI record. Changes that will cause an SDX sheet to be produced are:

(1) Payee name and address
(2) Date of birth
(3) Living arrangement
(4) Marital status
(5) Title II claim number
(6) SSI gross amount
(7) SSI assistance amount
(8) Pay status
(9) Death date
(10) Denial code
(11) PASS
(12) Resource code-house
(13) Resource code-income producing property
(14) Resource code-life insurance
(15) Resource code-vehicle
(16) Resource code-other
(17) Countable earned income
(18) Countable unearned income
(19) Unearned income information:
    (a) Type
    (b) Start
    (c) Stop
    (d) Amount
    (e) Frequency
    (f) Claim/ID number

Note: The Changed data element will be preceded by an asterisk (*).

3. Because the SDX sheets indicate a change in the a/b's SSI data, compare this information with the case record each time an SDX sheet is received. Take any necessary action within 45 days of receipt of the SDX sheet, or no later than the next case action or redetermination, whichever is earlier.

4. SDX Update Report

    a. A master list entitled "SDX Updates" is produced annually reflecting Cost-of-Living Adjustment (COLA) information.

    b. One copy of the annual SDX Updates Report must be kept until receipt of the Next printout and must be available for review by Income Maintenance or Quality Control staff.

E. Quarterly ESC Match

1. The quarterly match reports are produced through a computer match of the ESC/UI and eligibility files. Reports are transmitted to counties within one month following the end of the quarter. Due to ESC procedures for compiling data, there is a quarter lag in the information received. The match is produced in addition to the online inquiry to keep the agency informed of changes between application and review and from review to review.

2. Within 45 days from the date on the match report, complete the appropriate actions outlined below:

    a. Upon receipt of the report, check each match against your caseload.

    b. If the report shows reported employment of or UI for a/b, compare the place and period of employment or UI to that in the record.

    c. If the record shows the employment or UI has already been verified, document the record that the report was checked and take no further action.

    d. If the record shows that employment or UI was not reported, contact the recipient to determine possibility of overpayment, underpayment or potential fraud. Contact the employer to verify employment and available TPL.

    e. Document the record to substantiate that the Quarterly ESC Report was checked and the results of the match.

F. BEER (Beneficiary Earnings Exchange Report)

1. This match identifies recipients who have earnings reported to SSA. This match is run on the third work day of each month.

2. Since BEER data is obtained by Social Security from the IRS, the data must be safeguarded. The BEER report must be received by a central person in the county. This person is to distribute data to IMC's, who must take any necessary action within 45 days and return the report to the central person.

3. This person must secure all BEER data in a locked file for retention purposes.

4. Within 45 days from the date on the BEER report, or no later than the next case action or redetermination, whichever is earlier, complete the appropriate actions for income involving self-employment earnings and pensions, outlined below:

    a. Upon receipt of the BEER report, check each match against your caseload.

    b. If the record shows that this information has already been verified, document the record that the report was checked and return the report to the central person. Take no further action.

    c. If the record shows the earnings were not reported, contact the recipient to determine the possibility of overpayment, underpayment or potential fraud. Contact the employer to verify the earnings.

    d. Document the record to substantiate that the BEER report was checked and the results of the match.

G. IRS Monthly Match

1. The IRS match is conducted monthly in each aid program/category for pending applicants and newly approved recipients with a valid social security number. (Refer to II.H., below, for information on the yearly match for ongoing recipients). Monthly match information is mailed to the counties in a "Financial Resource Report" (FRR). If the a/b's SSN is not matched, no information is provided on the report.

2. IRS safeguards require that IRS data be received by a central person in the county. This person is to distribute data to IMC's, who must take any necessary action within 45 days and return the list with appropriate responses to the central person as per instructions in DMA Administrative Letter 39-87. This person must secure all IRS data in a locked file for retention purposes.

3. Within 45 days of the date on the report, or no later than the next case action or redetermination, whichever is earlier, complete the appropriate actions outlined below:

a. Upon receipt of the report, compare it to case record information.

   (1) Matches showing the codes "A", "B", "C", and "D" must be completed within the 45-day time standard.

   (2) Multiple matches for individuals with any combination of codes "A","B", "C" and "D" with a "Z" or and "L" code must be completed within the 45-day time standard.

   (3) Matches with code "L" only indicate that this match was reported to you in the last annual report or on a monthly report. If actions on all the reports were completed and all matches resolved and you have the documentation to support, these matches may be worked at the next change in situation or review.

   (4) Matches with a code of "Z" may be completed at the next change in situation or review.

b. If the report shows information that has already been verified, document in the case record that the list was checked and return the report to the central person. Take no further action.

c. If the information is not known and there is a current release form (signed within the last 12 months), contact the appropriate agency to verify the information. If a current release form is not on file, contact the recipient and obtain a new signed release form.

d. Income reported and investigated in a prior year's match as well as income from in- state unemployment and prior year's federal and state refund may be excluded from follow-up.

e. Document the eligibility record to substantiate that the "Resource Report" was checked and the results of the match.

f. Document actions taken on the Resource Report. The following are suggested codes (use all codes that are appropriate for each case):

   CODE DESCRIPTION
   MR Information matched record information
   VC Third party verification complete
   VO Third party verification outstanding

CO Client notified of verification needed but still outstanding
NC Information did not change benefits
BD Benefits decreased - notice sent
BT Benefits terminated - notice sent
DR Documented record - action to be taken at next change in situation or review

H. IRS Yearly Match

1. The IRS match is conducted yearly in each aid program/category for recipients with a valid social security number. The yearly match information is mailed to the counties in a "Financial Resource Report" (FRR). If the a/b's SSN is not matched, no information is provided on the report.

2. IRS safeguards require that IRS data be received by a central person in the county. This person is to distribute data to IMC's, who must take any necessary action within 45 days and return the list with appropriate responses to the central person as per instructions in DMA Administrative Letter 39-87. This person must secure all IRS data in a locked file for retention purposes.

3. Counties are responsible for assuring the FRR has been completed. If there is a QC error with an "L" match and the county has not completed the report within 45 days or if the documentation verifying that the match was unresolved when it was first reported, the error will be county responsibility. If the value of the resource has changed and causes an error, it will be a client or county responsible error. It is the county's responsibility for assuring all leads are followed up.

4. Within 45 days of the date on the report, or no later than the next case action or redetermination, whichever is earlier, complete the appropriate actions outlined below:

    a. Upon receipt of the report, compare it to case record information.

        (1) Matches showing the codes "A", "B", "C" and "D" must be completed within the 45-day time standard.

        (2) Multiple matches for individuals with any combination of codes "A","B", "C" and "D" with a "Z" or and "L" code must be completed within the 45 day time standard.

(3) Matches with code "L" only indicate that this match was reported to you in the last annual report or on a monthly report. If actions on all the reports were completed and all matches resolved and you have the documentation to support, these matches may be worked at the next change in situation or review.

(4) Matches with a code of "Z" may be completed at the next change in situation or review.

b. If the report shows information that has already been verified, document in the case record that the list was checked and return the report to the central person. Take no further action.

c. If the information is not known and there is a current release form (signed within the last 12 months), contact the appropriate agency to verify the information. If a current release form is not on file, contact the recipient and obtain a new signed release form.

d. Income reported and investigated in a prior year's match as well as income from in- state unemployment and prior year's federal and state refund may be excluded from follow-up.

e. Document the eligibility record to substantiate that the "Resource Report" was checked and the results of the match.

f. Document action taken on the Resource Report. Refer to III.G.3.f. above for suggested codes to document the cases.

g. Resource Types

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

SA-3410 RECIPIENT FRAUD

North Carolina Division of Social Services

Special Assistance Program

Revised: July 2024

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
SA-3410 RECIPIENT FRAUD

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I. INTRODUCTION

This section contains regulations and procedures for notifying the client of case action/status. The a/b has a right to a written notice when the application is approved, denied, or withdrawn and when the payment is to be continued, changed, or terminated. The a/b also receives a notice when there is a need for additional information.

II. LEGAL RESPONSIBILITY

Both the state and the county departments of social services have a legal obligation to assure proper administration of public funds and an obligation to take necessary legal steps in cases of fraud and/or overpayments. This obligation rests on the efficiency, thoroughness and integrity of the processes by which initial and continuing eligibility are determined.

A. Designation of Fraud Staff

The county DSS director should designate at least one staff member to be responsible for suspected fraud investigation. The staff member need not have law enforcement authority but is responsible for thorough investigations, preparing the case for presentation to the county board of social services and assisting the district attorney as needed.

B. Confidentiality (10NCAC 24B, 10NCAC24B.0205, 10NCAC24B.0206)

All county DSS staff are bound by rules of confidentiality.

C. Legal Restrictions

1. The Privacy Act permits an individual to have some control over the accuracy and disclosures of records maintained by Federal Agencies. However, the Privacy Act of 1947 (P.L. 93-579) Section 552 b(7) allows a caseworker/fraud investigator to obtain information necessary to conduct a civil or criminal investigation.

2. The a/b and legal counsel have the legal right to view and have a copy of the information in the eligibility or services record at any time with the exception of:

    a. Information that the county DSS is required to keep confidential by

state or federal statute or regulation.

b. Confidential information originating from another source.

c. Information that would breach another individual's right to confidentiality. (Reference: 10 NCAC 24B.0306 and 20 NCAC.32S.0306)

d. Investigative records.

III. FRAUD VS. MISREPRESENTATION

A. General

Although fraud is a question for the courts to determine, the county DSS must determine whether there is a basis for belief that fraud may have been committed. In making this decision, intent and the mental capacity of the individual must be considered. Also, a clear distinction, based on verified facts, must be made between misrepresentation with intent to defraud and mis-statements due to the misunderstanding of eligibility requirements or of the responsibility for providing the county DSS with information. It is also important to distinguish between intent to defraud and omission, neglect or error by the county DSS in helping an a/b to understand their responsibilities and in securing and recording pertinent information.

NOTE: For the purposes of fraud, a/b includes the representative/provider.

B. Fraud vs. Misrepresentation

1. Fraud

Fraud is, by law, a crime against society which can only be determined in a criminal court. It is the willful and intentional act that creates the crime, rather than the resulting overpayment.

An a/b is suspected of fraud when the a/b willfully and knowingly and with the intent to deceive:

a. Makes a false statement or misrepresentation; or

b. Fails to disclose a material fact; or

c. Does not report changes in income or other eligibility factors that affect the benefit; and

d. As a result of their action or inaction, attempts to obtain or continues to receive assistance.

2. Misrepresentation

Misrepresentation causes monetary loss as a result of an a/b's action or inaction. Misrepresentation can be intentional or unintentional.

a. Intentional misrepresentation - The a/b gives incorrect or misleading information in response to either oral or written questions. The information is provided with the knowledge that it is incorrect, misleading or incomplete. This may or may not be fraud, but that must be decided by a court of law.

b. Unintentional misrepresentation - There is no proof that the a/b acted willfully and intentionally to obtain more benefits than those to which he/she was entitled. The a/b gives incomplete, incorrect or misleading information because they do not understand the eligibility requirements or their responsibilities to provide the county DSS with required information.

3. Criteria for Fraud and/or Intentional Misrepresentation

To have a cause for action for fraud in public assistance cases, there must be proof of a statement made by the a/b, and the following conditions must be found with regard to such statement:

a. The statement is false; and

b. The a/b knows that the statement is false, or the a/b makes the statement recklessly and not while consciously ignorant of the truth or falsity of the statement; and

c. The statement is made by the a/b with the intent that it will be used by the county DSS and that it will result in assistance being authorized by the county DSS to which the a/b is not entitled or to assistance greater than that to which the a/b is entitled; and

d. The county DSS does in fact rely upon the statement given by the a/b and awards assistance to which the a/b is not entitled or assistance greater than that to the a/b is entitled; and

e. The county DSS has informed the a/b of the law relating to fraud and appropriate information has been entered in the agency record; and

f. The a/b has signed a statement that all information given by the a/b pertaining to their eligibility is correct and true to the best of their knowledge.

IV. PREVENTION

A. Interviewing

1. Prior to interviewing the a/b, examine all available case records. Take note of previous work history, income, prior resources (such as bank accounts, insurance policies, etc.) and other eligibility factors.

2. A key to fraud prevention is skillful interviewing during the initial application, at reviews, and when changes in situation occur. Ask the a/b specific questions, evaluate their reaction and document the responses thoroughly.

3. The interview process involves two-way communication. Be specific and thorough in the questions asked. Phrase questions in a way the a/b will understand. For example, identify/define specific items included as resources to avoid any misunderstandings. Provide the a/b an opportunity to respond in their own words without interruption. Always require an identifiable verbal response to all questions. Listen carefully to the a/b's responses.

4. At all applications and reviews:

   a. Explain to the a/b their obligation to report all changes in situation within five (5) days after the change occurs.

   b. Inform the a/b of the consequences of failure to report changes. Stress the penalties for fraud and misrepresentation.

c. Inform the a/b about computer matches in which the county DSS participates. Obtain all Social Security numbers and names used by the a/b.

d. Give the a/b a copy of the fraud pamphlet and explain the meaning of fraud.

e. If the a/b's living standards appear to exceed their income, question the a/b regarding unreported income.

f. Ask the a/b about any changes which have occurred since application or the last review.

B. Documentation and Verification

Thorough documentation and verification provides the caseworker necessary information for the next review or for a possible fraud case and avoids erroneous eligibility decisions and undetected cases of fraud. The following procedures are recommended at all applications and reviews as a method of fraud prevention:

1. Complete an EIS inquiry to ensure each a/b does not already receive assistance in your county or another county. Document the results of the inquiry.

2. Complete all available on-line inquiries, using all SSN's provided. Check all paper matches.

3. Document and verify all eligibility factors as required in policy.

4. When a change is anticipated, flag the case for review.

5. Review characteristics of fraud/error prone cases.

C. Other Preventive Measures

1. Intra-agency

   Establish communications among the various units in the county DSS. Fraud prevention is the responsibility of the entire agency. A systematic method of reporting changes and exchanging information would enhance communication.

2. Inter-agency

   To obtain prompt and accurate information needed to determine eligibility, it is important to establish a good relationship with other agencies, employers and institutions. Inform them of the program requirements and the importance of receiving prompt and accurate information.

3. Public awareness

   Informing the public about your county DSS's attempts to prevent fraud is important both as a deterrent and as a public relations measure. Information regarding court actions, amount of recoupments, etc., should be made public. Publicize the phone number to call to report cases of possible fraud, stressing that such reports are confidential. If the public realizes they will be supported in their efforts, the county DSS may be able to obtain much more information and cooperation.

V. DETECTION

Referrals for investigations may be received from the following sources:

A. State Office

Any leads received by the state office will be referred to the county DSS for investigation. Once the investigation is completed, advise the State Office of the outcome. If a fraud case or an overpayment is established, submit the appropriate reporting forms.

B. Quality Assurance Reviews

During their regular review, Quality Assurance staff sometimes detects possible fraud. Cases found in error or suspected of fraud will be referred to the county DSS for further investigation.

C. Private Sector and Other Agencies

If you receive information from other agencies, institutions, providers, other a/b's or private citizens, you are required to investigate the lead. Emphasize that such reporting will be kept confidential. Some people may be reluctant to report suspected cases of fraud if they feel their names will be disclosed.

D. Agency Staff

During the application and review processes, the county DSS staff may discover cases of possible fraud, abuse or misrepresentation.

E. Other sources include but are not limited to:

1. Computer matches such as the TPQY, SOLQ, DOC, DMV, ESC/UI, SDX, BENDEX, Financial Resource Report, BEER, etc.
2. Tax records (unreported personal property, automobiles, farm equipment)
3. Register of Deeds records (marriage, transfer of property)
4. Social Security records (increases, lump sum payments, dual benefits)
5. Court records (support, prior convictions)
6. HUD records (household composition, reported income)
7. School records (address, household composition, responsible party)
8. Utility company records (address, responsible party)
9. Landlords, neighbors, relatives (collaterals)
10. Newspaper reports (births, deaths, marriages)

VI. INVESTIGATIONS

A. Investigation Procedures

When a referral for possible Special Assistance fraud or misrepresentation is received from any source, or when there is an indication an a/b may have received benefits to which he/she was not entitled, the county DSS must conduct an investigation to assess whether eligibility has been correctly determined and documented according to policy regulations.

1. Review all county DSS case records for that a/b, including Medicaid, Work First, Food Assistance, Protective Services, etc. These records furnish basic information and must clearly show the findings on all eligibility factors and appropriate statements regarding information and explanations made to the a/b.

2. Determine from documentation and verification documents that adequate explanations were made to the a/b and that help was offered to ensure that the a/b understood and accepted responsibility for reporting changes in circumstances to the county DSS. If the county DSS failed to meet this obligation, any resulting overpayment is deemed an agency error. Refer to SA-3300, Administration of Benefits.

3. Determine from the case record if the information is already known to the agency.

    a. Any information reported in a timely manner to any county DSS staff is considered information known to the agency. If the information is known to-the agency but not communicated to the appropriate caseworkers, any resulting overpayment is deemed an agency error. Refer to SA-3300, Administration of Benefits.

    b. The IMC's who worked with the case during the period in question are valuable assets in the investigation. Discussion with the caseworkers involved may clarify unclear documentation and/or other critical points.

4. If the investigation establishes there is no fraud or misrepresentation, no further investigation is required.

    EXAMPLE: A private citizen calls to report that an a/b is employed. A review of the case record indicates that their income was reported and considered in determining their eligibility.

5. If the investigation gives the county DSS reason to believe fraud or intentional misrepresentation has occurred, continue the investigation. The investigation should continue until legal action is initiated, the case is resolved by seeking recoupment of the overpayment and/or the case is closed because of insufficient evidence to support the allegations or for other reasons.

    Note: The IMC must take appropriate action to correct the case regardless of the reason for the overpayment.

B. Verification of Reported Information

1. Verify reported information to establish whether fraud/misrepresentation exists. Obtain verifications by written or verbal contact with the a/b, employers, financial institutions, other agencies, collaterals, etc.

2. Document your findings in the investigative case file. Include complete names and dates.

C. Investigative Interview

1. Conduct an interview with the a/b if a case appears to be suspected fraud or an a/b responsible overpayment. If the case is resolved without a finding of a/b error, you may forgo the interview.

2. In cases in which no SA payments were made, the question of whether the a/b clearly understood the eligibility requirements may warrant an interview to clarify policy to avoid future overpayments.

3. The investigative interview with an a/b suspected of fraud or misrepresentation can be the most important element of the investigation. It is important to employ techniques of skillful interviewing.

    a. Interview the a/b in an area where you will have privacy. Document all of the evidence necessary to substantiate whether the overpayment is due to intentional/unintentional misrepresentation. Consider the a/b's:

        (1) Mental Capacity

        (2) Past History with the agency

        (3) Understanding of their responsibility

        (4) Educational level

        (5) Accountability (if he has a substitute payee, the payee is responsible

b. Discuss the subject of fraud. Explain the a/b's rights and responsibilities to determine if the a/b understands the concept of fraud. Ask the a/b to explain their understanding of their rights and responsibilities.

c. Inform the a/b that you are investigating for possible overpayments. Ask the a/b if there is anything they wish to tell you that they have not previously revealed to the county DSS.

d. Review the case file with the a/b. Cover the eligibility points in question. Confirm that the client came in to make application and did in fact make the statements documented on the signed form(s).

e. Ask again if the a/b wishes to change any of the statements made or has any new information to report.

f. If the a/b admits wrongdoing and wishes to acknowledge the truth, take a statement and have the a/b sign and date it. It is recommended that a witness also sign the statement.

g. Review the case file and have the a/b identify those statements which are false.

h. If the a/b continues to affirm that all statements previously made are true, question the a/b further with the known facts. Use open-ended questions and mirror questions. Allow the a/b as much time as needed to answer. Present any evidence gathered to substantiate the facts.

   Example: "How did you say you disposed of the property?" "Help me understand your statement and why you did not report it."

i. Document the interview thoroughly.

VII. NOTICES AND APPEALS

A. Notices

Follow requirements in SA-3330, Notices regarding adverse action notices. State the intended action, the reason for this action, applicable manual sections and hearing information. An a/b must be given the opportunity to present evidence to rebut any action affecting their claim, both past and present.

EXCEPTION: In the case of probable fraud, the timely notice may be shortened to 5 days. However, the county DSS must have verified all pertinent information and concluded that the action must be taken because of probable continued fraudulent receipt of benefits.

B. Appeals

An a/b has the right to an appeal when benefits are modified or terminated. In the case of fraud/misrepresentation, the a/b may request an appeal of the corrected eligibility determination made during the investigation. Follow procedures in SA-3340, Hearings.

VIII. CALCULATING OVERPAYMENTS

This section provides rules for establishing overpayments for the Special Assistance program. Overpayments may result when the a/b is found ineligible because he/she no longer resides in an ACH, has excess resources, excess income, etc. Compute the amount of the overpayment and determine whether there is suspected fraud or an unintentional misrepresentation.

NOTE: If there is a Medicaid overpayment, refer to MA-2900, Recipient Fraud and Abuse Guidelines.

A. General Rules

1. Allow time for the change to have been made (i.e., 5 calendar days for a/b to have notified county DSS of the change, 10 working days for timely notice of change in eligibility).

2. Use the appropriate resource and income levels for the time period in question.

3. Re-budget using actual verified resources available or income received during the period of ineligibility.

4. For cases with unreported income, compute eligibility separately for each payment period.

5. For ineligible money payment cases, the overpayment period begins with the first month of ineligibility for money payment.

IX. INVESTIGATIVE SUMMARY

A. Prepare a summary upon completion of the investigation, detailing all factors causing the overpayment and the period and amount of the overpayment.
For details on computing and collecting refer to SA-3300, Administration of Benefits.

B. The summary should contain recommended action based upon the investigator's knowledge of the situation.
Weigh the merits of the alternatives for that case to determine the case objectives.

C. The overall objectives for any fraud investigation are restitution, legal action, and deterrence or protection of society.

D. Present the completed summary to the County Board of Social Services or it's designee for a decision on whether to refer for prosecution or to use administrative procedures for collection.

E. All available procedures must be utilized to attempt collection on any debt owed to Special Assistance.

NOTE: If a Special Assistance a/b is found ineligible for Special Assistance money payment, assess the a/b's eligibility for Medicaid. See MA-2900 Recipient Fraud and Abuse Guidelines.

X. CONCLUSIONS AND RECOMMENDATIONS

A. Administrative Action

1. Voluntary a/b Refund: If the agency accepts repayment by a voluntary refund, the amount should not be less than the amount that would be collected in an involuntary grant reduction. The a/b must be asked to sign a written agreement regarding the method of repayment, the time period, and the amount. Give the a/b a copy and file a copy in their record.

2. Voluntary Grant Reduction: Obtain an agreement, dated and signed by the a/b, showing the amount of the reduction, the length of time the reduction will be made and the reason for the reduction. Give the a/b a copy and maintain a copy in the file.

3. Involuntary Grant Reduction: In domiciliary care cases, grant reduction may be required only if the a/b has disregarded earned income or excess resources. The amount of reduction may not exceed the amount available as disregarded earned income or excess resources. If the a/b has no resources, the board may direct the agency to require him to sign a statement that he will repay the overpayment if he acquires resources in the future.

B. Referral to County Board of Social Services

1. The County Board of Social Services or their designee is responsible for the review of the case circumstances and the final decision on whether to recommend referral for prosecution in accordance with state statutes.

2. The following factors must be given consideration:

   a. Was there a violation of policy?

   b. Was the violation of policy against the law?

   c. Were the elements of criminal action present?

   d. Did an a/b willfully and knowingly, with intent to deceive:

      (1) Make a false statement or representation,

      (2) Fail to disclose a material fact,

      (3) And as a result, obtain, attempt to obtain or continued to receive Special Assistance.

   e. Mitigating factors

      (1) Prior/repeat offenses

      (2) A/B's physical and/or mental capacity

(3) Recommendation of County District Attorney

(4) Any other factors pertinent to the case (such as the Statutes of Limitations)

C. Determining Court Action

Factors to consider in deciding whether to initiate court action include the amount of the overpayment, the cost of court action, and the likelihood of satisfying a judgement given under the North Carolina exempt property law in G.S. lC-1601. Under the law each individual can keep a certain amount of property (called exempt property) that a state or county department of social services cannot obtain even after judgement. Consult the county attorney for assistance.

1. Statutes of Limitations

When referring cases for prosecution in either criminal or civil court, the county DSS must be aware of the statutes of limitations that apply to these cases. These statutes affect the amount of overpayment presented in court and the specific charges brought against the recipient.

a. The North Carolina Attorney General's opinion:

(1) An act is determined as the initial false statement, misrepresentation, and/or omission of fact, running to the next recertification or contact with the client at which time false statement, misrepresentation, and/or omission of fact could have been corrected.

(2) Each certification period or period between contacts, thereafter, during which time the recertification, misrepresentation, and/or omission of fact is perpetuated, is considered a separate offense.

b. Criminal Statute (NCGS 15-1 statute of limitations for criminal misdemeanors)

(1) Allows prosecution action of misdemeanors (case involving less than $1000.00) to be taken no later than two years after the fraudulent act occurred.

(2) No statute of limitations for felonies (cases involving over $1000.00).

c. Civil Statute - The civil statute of limitations, NCGS 1-52, runs for three years from the date the act is discovered, or should have been discovered through the exercise of reasonable care.

NOTE: If the recipient has signed a repayment agreement containing the word "Seal" next to the signature, the civil statute of limitations for enforcement of collection is ten years from the date the document was signed. However, the word "Seal" must be circled by the client. The investigator should contact the county attorney for further information regarding this point.

2. Civil court action

a. Small claims court is limited to amounts of $4000 or less. This process is designed to be used without an attorney although one may be helpful. A booklet entitled "How to Use the Magistrate's Court to Resolve Claims" is available at the county courthouse or through the Consumer Protection Division of the Attorney General's office.

b. District court handles cases of $4,501-$10,000 while Superior Court handles cases of over $10,000. The county or agency attorney will handle these cases with the investigator's assistance.

c. Judgement by confession may be awarded by the clerk of court if the a/b willingly acknowledges the debt to the State/county. This would eliminate the need for a court trial while still giving the county a legal judgment against the a/b. The attorney will assist in getting the judgment finalized. If a person is asked to sign, they must be told that they are waiving their right to a trial, that they are entitled to consult a lawyer and that they may be eligible for free legal aid.

3. Criminal Court Action

Criminal court is for punishment and not collection, however the judge may include a repayment order in the judgement. If no repayment order is given, the agency may refer the case back to the board for consideration of civil action or administrative action for restitution. If

the County Board of Social Services determines that a case should be referred for prosecution, there are several actions that will help ensure the case is justly dispositioned.

a. Relationship with the Prosecuting Attorney

(1) The county DSS should establish a good working relationship with the district attorney or county attorney, whichever handles prosecution of fraud cases. The worker responsible for the case should assist the attorney by:

(a) Explaining program requirements as they relate to the case,

(b) Providing all case documentation, including a clear and concise investigative summary,

(c) Answering any questions that the attorney may have about any specific case or about program policies, procedures and regulations, and

(d) Explaining exactly how the overpayment amount was computed and the time restraints on social services actions (timely notices, 5-day reporting requirement).

(2) The county DSS should expect advice on cases for prosecution from the attorney on whether the case is a good one for prosecution, whether further evidence is required or the type of information the attorney considers necessary for successful prosecution.

(3) The attorney should be expected to help the agency in such areas as issuing warrants, appearing as a witness in court, etc.

b. Relationship with Law Enforcement

(1) It is important to maintain a good relationship with the law enforcement branch that serves warrants in cases that have been referred for prosecution.

(2) Provide them with clear directions to the a/b's home, hours the a/b may be home and any other information which might expedite the serving of the warrant.

c. Classes of Criminal Action

It is imperative that the fraud investigator and the person designated to prosecute suspected fraud cases have a good working relationship. Each must be able to rely fully on the other for assistance and advice. Although the prosecuting attorney determines the direction taken in criminal court actions, the following will be helpful:

(1) A misdemeanor involves less than $1000.

(2) A felony involves more than $1000 and has no statute of limitations.

(3) Although most cases are prosecuted under General Statute 14-72, "Larceny," they may be prosecuted under General Statute 14-100, "Obtaining Property by False Pretenses", under which an act is a felony regardless of the dollar amount involved. There is no statute of limitations for felony cases.

NOTE: Even though non-monetary restitution may be ordered by the court, federal regulations require that all overpayments be collected, regardless of any court action. When the court imposes an active sentence, this is punishment for the crime. The county must continue to seek restitution for the SA overpayment. If the dismissal of restitution is a part of the court order, it is advisable for the county, in collaboration with its attorney, to work with the court to have the order amended.

4. Federal Prosecution for Fraud and False Statements

a. Legal Base

The Office of Inspector General, Department of Health and Human Services, may prosecute SA a/b's in federal courts for fraud and/or false statements. The legal base for such prosecution can be found in 18 U.S.C. Section 1001 and in the case of U.S. of America v. Lewis, No. 77-5376.

b. Worker Responsibility

The a/b must be informed that making false statements to receive SA can lead to prosecution in federal courts.

5. Court Jurisdiction

   a. If the a/b moves to another county in North Carolina, the first county can still pursue civil or criminal action against him. The action is done in the first county, where the suspected fraud occurred.

   b. If the a/b moves out of North Carolina, the county has two options:

      (1) If the suspected fraud would be a felony the agency may request that the district attorney have the a/b extradited for prosecution.

      (2) If the county does not request extradition or the offense would be a misdemeanor, the county should flag the case for future reference should he return.

   c. If the county cannot determine the a/b's whereabouts, file all the evidence gathered on the suspected fraud case in the a/b's record "for future reference if he returns".

6. No Action Taken Due to Hardship

D. Appearing in Court

1. When appearing in court in a possible fraud case, know the case thoroughly before taking the stand to testify. If you do not know the answer to a question, state you do not know. However, if the answer can be found in the record, state this fact and look in the record.

2. Only testimony from the case file should be given to avoid violating confidentiality and to avoid giving opinions. For this reason, the case summary should be a complete history of the investigation and should include all documentary evidence. Do not give opinions. If the case is fully developed, everything needed for testimony will be contained in the investigative summary.

3. Answer all questions as concisely as possible. Organize your thoughts before answering a question. Avoid giving unnecessary or confusing information.

4. Remember the following:

    a. Prepare and present the evidence as a professional; do not get personally involved in a case.

    b. Stop your testimony immediately when there is an objection. Do not resume until the objection has been ruled on and instructions are given to continue or answer another question.

    c. Have all witnesses or materials to prove your case.

    d. Always dress neatly and be well-groomed.

    e. Be on time.

    f. Assume a comfortable position.

    g. Never chew gum; avoid nervous habits

    h. Always be completely honest.

    i. Speak clearly, slowly and loudly enough to be heard.

    j. Address the judge as "Your Honor" in the courtroom. "Judge" is proper outside the courtroom.

    k. If addressed by a court official when you are not in the witness stand, it is proper to stand before answering.

    l. Call witnesses the day before the court date to remind them of the time and place of the trial.

    m. Do not react to the disposition of the casein court.

XI. COLLECTION OF DELINQUENT ACCOUNTS

For current accounts, refer to SA-3300, Administration of Benefits.

Upon notification of delinquent accounts, take the following actions:

A. Voluntary Repayments

1. When an individual misses the first payment of a voluntary repayment agreement, send a reminder letter. If a payment is not received within 30 days, take action to establish personal and/or telephone contact with the individual.

2. If the individual continues to refuse to repay, consider small claims court, civil court action.

3 In the case of the death of an individual with an outstanding debt, the county DSS must file a claim against the deceased's estate for restitution.

B. Court Ordered Restitution

1. Probation Office: For individuals who fail to comply with the terms of court ordered restitution and are on probation, contact the probation office to determine appropriate follow-up action.

2. Clerk of Court: For individuals who fail to comply with the terms of court ordered restitution and are not on probation, contact the Clerk of Court to determine appropriate follow-up action.

   NOTE: Investigators are encouraged to seek permission from the Clerk of Court to issue non-compliance orders.

C. Liens and Recoveries

The county DSS may place a lien against an individual's property, both personal and real, because of claims paid or to be paid on behalf of that individual following a court judgement which determined the benefits were incorrectly paid for that individual.

XII. AGENCY RESPONSIBILITY

A. Continue to Work with A/B

Regardless of what the board or its designee decides or what action is taken by the court, the agency must continue to work with the a/b. Promptly notify the a/b of any action taken in the case. If the a/b remains eligible, the case cannot be terminated just because fraud is suspected.

B. Agency Records

1. The agency must maintain records on the number of cases referred for investigation, the number of suspected fraud cases referred to the board, action taken to recover overpayments and the amounts recovered.

2. The agency must keep in the record or separate fraud file, copies of all documentation, evidence and summaries for future reference.

3. Reporting Requirements and Forms

   a. Complete a DSS-1656, Refund Receipt, when a Special Assistance (SA) recipient refunds an overpayment either by cash or personal check. Submit the DSS-1656 according to instructions in SA-3300 VI.C.4.

      Remit to:
      Program Benefits Payment Section
      2109 Mail Service Center
      Raleigh, NC 27699-2109

   b. Notify DMA Program Integrity of any possible Medicaid fraud. Refer to MA-2900, Recipient Fraud and Abuse Guidelines.

STATE/COUNTY SPECIAL ASSISTANCE MANUAL

Appendix C – Special Assistance to the Certain Disabled

North Carolina Division of Social Services

Special Assistance Program

Revised: June 2022

STATE/COUNTY SPECIAL ASSISTANCE MANUAL
Appendix C – Special Assistance to the Certain Disabled (SCD)

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I. INTRODUCTION

Special Assistance to the Certain Disabled (SCD) is a program that provides a limited monetary payment each month to a beneficiary who meets the program's eligibility requirements. SCD beneficiaries are not eligible to receive Medicaid. County participation in this program is voluntary. It is each county's individual decision whether or not they choose to participate.

II. ELIGIBILITY REQUIREMENTS

To receive assistance as a Certain Disabled person, and individual must:

A. Be age 18 through age 64.

B. Be a U.S. citizen or an alien lawfully admitted for permanent residence or an alien considered to be residing in the U.S. under color of law.

C. Be residing in North Carolina voluntarily with the intent to remain in the state.

D. Live in a private living arrangement.

E. Not be a patient in an institution for mental disease.

F. Not be an inmate of a public institution.

G. Not be a beneficiary of SSI (must have applied for SSI and been found ineligible on the basis of disability).

H. Be disabled according to the following definition of disability adopted for this group.

1. A disabled person is one who has some physical or mental impairment that substantially precludes him from obtaining gainful employment, and such impairment appears reasonably certain to continue without substantial improvement throughout their lifetime.

2. Disability is evaluated by the Disability Determination Section by a medical review based on medical and social information.

III. APPLICATION PROCEDURES

A. Verify SSI Ineligibility

1. An applicant/beneficiary (a/b) must be found ineligible for SSI on the basis of disability.

2. Verify this by:

   a. SOLQ.

   b. Contacting Social Security Administration.

   c. Viewing the notice of denial from SSA.

B. Taking the Application

1. Refer to SA-3110, Application Process.

2. Applicants may apply for SCD and MAD at the same time.

3. Refer a/b to the Social Security Office for SSI reapplication since the a/b's condition may have changed.

4. When an a/b applies for SCD only, submit the following materials to DDS stapled together in the order listed:

   a. DMA-4037, Disability Determination Transmittal

   b. DMA-5009, Social History Summary

   c. DSS-1653, Report of Medical Examination

   NOTE: Refer to MA-2525, Disability, for instructions to complete these forms. File a copy of the contents listed in a-c. above in the case record

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5. When an a/b applies for both SCD and MAD, submit the following materials to DDS stapled together in the order listed:
   a. A cover letter explaining that the a/b has applied for both SCD and MAD and that a disability determination is needed for both categories.

b. Two DMA-4037, Disability Determination Transmittal (one for each application). Enter in the remarks section on each DMA-4037 that there are 2 being submitted, both SCD and MAD.

c. DMA-5009, Social History Summary.

d. DSS-1653, Report of Medical Examination

NOTE: Refer to MA-2525, Disability for instructions to complete these forms. File a copy of the contents listed in a-d. above in the case record.

6. When the a/b is receiving SCD and applies for MAD, submit the following material to DDS stapled together in the order listed.

a. If a review of disability is due in SCD, submit two DMA-4037, Disability Determination Transmittal with current medical evidence, along with the prior SCD file.

b. If a review of disability is not due in SCD, submit the DMA-4037, Disability Determination Transmittal. Cross reference to the current SCD case. Send all medical, social, and DDS evaluations in the SCD case with the current MAD-4037.

7. Discuss the Food Assistance program with the a/b

C. Procedures for Applicant Moves

1. If a SCD applicant moves but leaves no forwarding address and you are unable to contact their representative, deny the application using a DSS-8109, Notice of Denial/Withdrawal.

2. If an applicant in a private living arrangement moves to a second county before eligibility is determined, verify whether or not the second county has a SCD program.

a. If the second county does have a SCD program, deny the application using a DSS 8109, Notice of Denial/Withdrawal and advise the applicant to apply in the second county.

b. If the second county does not have a SCD program, deny the application using a DSS 8109, Notice of Denial/Withdrawal.

3. The second county must request the applicant's record and process the application based on the application date in the first county.

4. If the second county approves an application before learning that the individual applied earlier in the first county, the second county must request the record and process the earlier application.

D. Disability Determination Decision

1. If the MAD is approved by DDS, no disability decisions will be made by DDS on the SCD DMA-4037, Disability Determination Transmittal. The SCD DMA-4037, Disability Determination Transmittal will be marked N/A. The county can adopt the approved decision for either program.

2. If disability is approved for both programs, discuss with the applicant which program better suits their needs.

E. Determining Eligibility

1. If the a/b does not meet the disability requirements for either program, deny the application using a DSS-8109, Notice of Denial/Withdrawal.

2. If the a/b is approved for benefits, notify the a/b using the DSS-8108, Notice of Approval.

IV. RESOURCES

A. Budget Unit

1. Single Individual

   Include countable resources of the a/b only.

2. Individual with a Spouse or Essential Person

   Include countable resources of both the individual and the spouse or essential person.

   NOTE: The essential person is a person who gives an essential service to an a/b, and if in need, is eligible to be included in the assistance unit.

B. Computation

Refer to SA-3200, Resources.

C. Transfer of Resources

1. If the a/b transfers any real property, personal property, or liquid resources out of their name without receiving compensation equal to the fair market value for the transferred resource, the transfer may result in a period of ineligibility (sanction) of:

   a. Up to 36 months for SCD

   b. Up to 36 months if the a/b needs assistance now or in the future for long term cost of care during the period of sanction.

2. Refer to MA-2240, Transfer of Resources, to determine the sanction period.

V. INCOME

A. Budget Unit

1. Single Individual

   Include countable income of the a/b only.

2. Individual with a Spouse or Essential Person

   Include countable income of both the individual and the spouse or essential person

   NOTE: An essential person is a person who gives an essential service to an a/b and if in need, is eligible to be included in the assistance unit.

B. Computation

Refer to SA-3210, Income.

VI. BUDGETING AND PAYMENTS

A. Individual A/B

1. Budget $127.00 for maintenance at home. This is the maximum payment that can be received.

2. Subtract net income from the above maintenance amount. Refer to SA 3210, Income.

3. The difference, rounded to the nearest dollar, is the amount of the SCD payment.

4. The minimum SCD payment that can be received is $1.00.

B. A/B with Spouse or Other Essential Person Residing in own Home or in a Multiple Household

1. Budget $165.00 for maintenance at home. This is the maximum payment that can be received.

2. Subtract the combined net income of the a/b and spouse or essential person from the above maintenance amount. Refer to SA-3210 Income.

3. The difference, rounded to the nearest dollar, is the amount of SCD payment.

4. The minimum SCD payment that can be received is $1.00.

EXAMPLE:

Bob Brown received no income. He applies for the SCD program and meets all eligibility requirements.

127 Maintenance
- 0 Income
$127.00 Monthly SCD payment Mr. Brown receives

VII. REDETERMINATION

A. Follow all policies in SA-3320, Redetermination of Eligibility

B. Include the entire budget unit in the verification of eligibility process

VIII. ONGOING CASES

A. Temporary Absence from the Home

Temporary absence from the state/county of residence with subsequent return or intent to return does not make the SCD beneficiary in a private living arrangement ineligible. Acceptable reasons for temporary absence include but are not limited to:

1. Visits to friends or relatives residing in another county/state. If a visit to another county/state exceeds three months:

   a. Request a signed statement from the beneficiary or his representative stating intent to return home.

   b. Document reason for continuing absence, which may include, but is not limited to:

      (1) Illness of the beneficiary.

      (2) Continued illness of someone the beneficiary had been caring for in another county/state.

   c. Determine whether a home is being maintained in the responsible county.

      (1) Are rent/house/utility payments being made?

      (2) Has electricity or water been turned off?

      (3) Has the address been changed with the post office?

2. Need for hospitalization, skilled nursing, intermediate care, or treatment for emotional disturbance.

B. Moves

1. First County Responsibilities

a. When a SCD beneficiary or his representative notifies you that he/she plans to move to a second county, determine whether the other county has a SCD program.

(1) If the second county does not have a SCD Program, send a DSS-8110 and terminate the case.

(2) If the second county has a SCD program,

(a) "Flag" the case for review in the month of anticipated move.

(b) Explain reassignment procedures.

(c) Request that the beneficiary notify you as soon as he/she moves.

b. When the beneficiary notifies you that he/she has moved,

(1) Inform him/her verbally when possible, and always by use of the reassignment letter that:

(a) The first county will continue assistance for at least one month following the month he moves.

(b) The a/b must immediately contact the second county to request a review of eligibility.

(2) Reassign the case to the second county.

(3) If a beneficiary's review is overdue or due the month of move, and overpayments are discovered, the first county is responsible.

(4) Upon receipt of a request for records, immediately send the records to the second county.

(5) Retain the case profile in your records.

2. Second County Responsibilities:

a. When the reassignment letter is received:

(1) Establish a case record.

(2) Refer the record to the appropriate worker for action.

(3) Contact the beneficiary immediately.

(4) Redetermine SA eligibility.

b. If a beneficiary's review is overdue or due the month of the move and overpayments are discovered, the first county is responsible.

c. If the case remains eligible, proceed with the county reassignment.

(1) Request the beneficiary's record.

(2) Send the beneficiary a notice of any changes in his case.

d. If the beneficiary is no longer eligible, send him/her an advance notice and terminate the case according to policy in SA-3330, Notices.

e. If a beneficiary notifies DSS he/she has moved from another county but has no reassignment letter, contact that county immediately. Inquire about their assistance status there.

IX. OVERPAYMENTS

If a/b moves to a Second County

1. Responsibility of collection remains in first county unless the case becomes active in a second county.

2. When the second county assumes the administrative costs for collection, it will not reimburse the first county when collections are received.